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Exploring the Challenges of Intercultural Qualitative Health Research and the Experiences of Doctors in Lesotho

Holdsworth, Laura

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**Exploring the Challenges of Intercultural Qualitative Health Research and the
Experiences of Doctors in Lesotho**

Bangor University

2023

Laura Holdsworth

Submitted as partial fulfilment of the Doctorate in Clinical Psychology (DClinPsy)

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Thesis Abstract

This thesis has a broad theme, exploring different aspects of intercultural research. The systematic review used meta-aggregation to investigate the challenges and solutions of conducting intercultural, qualitative, health research. Four synthesised findings were identified: being an 'outsider', retaining authenticity and meaning, the interpreter's impact on the research, and working in culturally and linguistically diverse research teams. The importance of working with cultural experts was highlighted in the research, however this came with its own challenges of working in diverse teams. The challenges of translation and using interpreters was a strong theme, but due to three of the 12 papers having a focus on the translation process it is possible that these themes overshadow others. Further research into researchers' experiences of conducting intercultural, qualitative, health research is required, particularly in relation to areas other than the translation process.

The empirical paper involved seven semi-structured interviews and explored how doctors in Lesotho understood and coped with their wellbeing during the COVID-19 pandemic. Using interpretative phenomenological analysis, five themes were identified: under pressure, unprepared and out of control; constant uncertainty and threat; Isolation and connection; attempts to cope independently and new perspectives. The challenges experienced by doctors extended beyond their working

environment, often affecting their personal lives and wellbeing. Key to managing their wellbeing was the support received from other people, relying on themselves for ways to cope and reflecting on the learning that they gained through undergoing the experience. Recommendations regarding how doctors are supported with their wellbeing at work are discussed.

The final paper discusses the implications of both the systematic review and empirical paper in relation to future research and clinical practice. This final paper also includes some of the authors personal reflections on the process of undertaking this research, particularly regarding the intercultural aspects of the participant recruitment and data analysis stages.

Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

Signed:

Date: 28/05/23

Acknowledgements

It feels like such a huge achievement that I am sat here writing the acknowledgements section to my completed thesis. It has been both a challenging and rewarding journey, and one which I could not have completed without the support of friends, family and colleagues. To the participants in my research, I am extremely grateful. It was an honour and a privilege to hear their stories and witness their emotions. I hope I have done justice to their words.

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name all the other individuals, both in Lesotho and the UK, who helped make my trip to Lesotho a success, but I am thankful for the help they provided and the memories they have given me.

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Appendices: 9798

	Chapter 1: Literature Review	Chapter 2: Empirical study	Chapter 3: Contributions to theory and clinical practice
Total (excluding title page, tables, figures and references)	6186	6318	3346
References	1125	1278	565
Tables and figures	788	72	0

Chapter One

Systematic Review

Intercultural Qualitative Health Research: A Systematic Review of the Challenges and Solutions

Intercultural Qualitative Health Research: A Systematic Review of the Challenges and Solutions

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Declaration of Conflicting Interest

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Abstract

Intercultural, qualitative, health research continues to increase in popularity and provides a valuable way to understand the health needs, perspectives and experiences of diverse populations. This systematic review investigated the challenges and solutions to conducting intercultural, qualitative, health research. A comprehensive search of five databases (CINAHL, ASSIA, PubMed, PsycINFO and Web of Science Core Collection) was conducted in March 2023 for papers published in English since 2003. Papers were screened utilising inclusion criteria and quality appraised. Included papers contained the perspectives of people with experience of conducting intercultural, qualitative research about experiences of health problems and discussed the challenges and/or solutions of this work. Quality appraisal utilised checklists from the Joanna Briggs Institute. Twelve papers of good quality were identified: three empirical papers (with a total of 22 participants) and nine reflective-discussion papers. Meta-aggregation was performed, resulting in four synthesised findings: being an 'outsider', retaining authenticity and meaning, the interpreter's impact on the research, and working in culturally and linguistically diverse research teams. Results provide guidance to researchers undertaking intercultural, qualitative, health research. However, due to the inclusion of non-empirical reflective pieces flexibility in following recommended guidelines for conducting qualitative systematic reviews was required and it was not

possible to follow all guidelines in full. Additionally, in three of the included articles, there was a focus on the challenges of the translation process, suggesting a need for further research into other aspects of the research process.

Keywords

Intercultural, qualitative, health, systematic review

Registration

This review was not registered with PROSPERO.

Intercultural health research works to understand the diverse cultural factors influencing health and thus reduce health disparities (Al-Busaisi, 2008). Culture profoundly shapes people's health beliefs, behaviours and outcomes (Congress & Lyons, 1992; Vaughn et al., 2009; Mackenbach, 2014). Cultural differences in attributions of health then affect what is seen as an appropriate treatment option (Congress & Lyons, 1992; Vaughn et al., 2009) and affect help seeking behaviours (Sheikh & Furnham, 2000). For example, differences between whether a health problem is attributed to a biological cause or curse affects whether seeing a doctor or traditional healer is chosen as an intervention. Differences in cultural customs/values, for example in relation to modesty, affect how individuals engage with health services and understand health (Kwok et al., 2006; Yosef, 2008).

Rapid expansion in the use of qualitative research methods has been seen across the field of health (Al-Busaidi, 2008; Morse, 2014). The use of qualitative methods is important for gaining in-depth understanding of the experiences and perspectives of individuals (Morse, 2014), something which is largely missing for the non-Western populations who are under-represented in research.

Cultural differences in perceptions of health vary greatly, and a lack of understanding of this can lead to failures in recognising how healthcare knowledge should be adapted and implemented across cultures (Napier et al., 2014).

Consequently, factors affecting a person's health and those which could improve a person's health could be dismissed or ignored and result in inequity in health outcomes (Napier et al., 2014). Intercultural health research can give insight into how healthcare practice can be adapted to better suit the needs of diverse populations and improve quality of care (Luciani et al., 2019; Pope et al. 2002; Renjith et al., 2021). The use of qualitative methodology can also promote culturally sensitive research practices, particularly approaches which explicitly encourage reflexivity from the researchers, for example phenomenological and ethnographical approaches (Al-Busaidi, 2008; Smith et al., 2021).

For the results of intercultural, qualitative research to be useful, it is vital that research is conducted with rigour. However, to achieve this, researchers must face and manage multiple challenges. It is therefore important for researchers to be aware of the challenges they may face when designing intercultural health studies and how these may be overcome.

This systematic review aims to answer the question, what are the challenges, and any solutions, in conducting intercultural, qualitative health research? It seeks to identify the challenges and solutions in conducting intercultural qualitative health research as identified by people with experience of conducting research in this field. It specifically focuses on qualitative research in relation to individuals' experiences of

health problems or related factors such as cancer screening procedures, and not topics indirectly related to patients' experiences (for example, health systems or public health). In doing so, it spotlights the challenges in relation to gaining in-depth understandings of lay people's personal, and often sensitive, experiences. A critical realist position was adopted by the first author to answer this question. The systematic review will draw the attention of researchers to some of the important factors to consider when designing and conducting their own research, as well as different solutions that have been implemented. In considering these factors, researchers will be better placed to approach their work with cultural humility, and to conduct high quality intercultural, qualitative, health research with cultural sensitivity.

Method

Inclusion and Exclusion Criteria

The Joanna Brigg Institute's (2014) PICO (Population, phenomenon of Interest and Context) framework was used to structure the inclusion and exclusion criteria which are shown in Table 1. Additionally, articles were only included if they were published since 2003 in English or had an English translation available. Quantitative research was also excluded.

Table 1

Population, Phenomenon of Interest and Context Framework with Inclusion and Exclusion Criteria

PICo	Inclusion criteria	Exclusion criteria
Population	Papers about people who have conducted intercultural, qualitative research.	Papers not about people's experiences of conducting intercultural, qualitative research.
Phenomena of Interest – Challenges of conducting research	A main focus of the paper is on the challenges in conducting intercultural qualitative research.	Any papers which discuss the challenges, but do not have a primary focus on this.
Phenomena of Interest – Qualitative research	Papers discussing research utilising qualitative methodologies.	Papers discussing quantitative methodologies only.
Context - Intercultural	Papers discussing intercultural or international research, as defined by the authors, evidenced by the discussion of different cultural groups, languages or countries.	Papers discussing sub-cultures
Context - Health	Papers discussing research into the experiences of health or mental health problems, illnesses or conditions. Papers discussing research into the experiences of factors relating to a health or mental health problem, illness, or condition (for example, medication use).	Papers discussing health infrastructure, health education, health systems, health policy, health financing, occupational health, evaluations of health/public health interventions.

Defining the term 'culture' is a complex and unresolved task, with multiple definitions in existence. It is recognised that there are different perspectives in relation to the suitability of different definitions, thus highlighting the complex nature of this topic. However, for the purposes of this review culture is defined as, a combination of shared attributes including knowledge, attitudes, beliefs and values which determine patterns of thinking, feeling and acting, and are passed down from generation to generation whilst undergoing continuous change. Different cultural groups are identified by differences between these attributes and are distinguished by race, ethnicity, nationality, language and/or geographical area. As illustrated in Jahoda (2012), this definition of culture draws heavily from Hong's (2009) and Triandis' (1996) definitions (see Appendix A), but has similarities with many others. Importantly, for the purposes of this review, this definition excludes the multifarious cultural groups such as those belonging to LGBTQIA+ culture, as these cultures are not based around generational patterns and shared racial, ethnic, national, linguistic or geographic features. This pragmatic decision was made to avoid vast heterogeneity in the included studies and instead focus on the challenges associated with the linguistic, geographical and cultural factors which may not be present in sub-cultural groups. It is likely that there are some similarities in the challenges experienced by the excluded and included cultural groups (for example, difficulties accessing culturally appropriate healthcare).

However, the differences between these cultural groups could mean there are numerous diverse or group-specific challenges; this review does not have scope to fully explore these.

The selected articles are a combination of qualitative empirical studies and reflective-discussion articles written by researchers in this field. The latter type of articles are included due to scoping searches indicating minimal empirical studies on this topic. As the authors of these reflective-discussion papers are experienced in research practice and reflexivity, it was felt that they would have appropriate skills and reflexivity to write high quality papers suitable for inclusion. To maximise reliability of the review's findings, only peer-reviewed articles are included, all included papers were quality assessed.

Search Strategy

Utilising the Preferred Reporting Items for Systematic Review and Meta-analyses (PRISMA) reporting guidelines (Page et al., 2021) and support from the human sciences academic support librarian a search strategy was developed and implemented across five computerised databases. CINAHL, ASSIA, PubMed, PsycINFO and Web of Science Core Collection were searched in March 2023 using the search terms relating

to the concepts of challenges, intercultural research, qualitative methodologies, health and mental health, and researchers (see Appendix B for full search terms).

Screening and Study Selection

The titles and abstracts of the articles were screened by the first author using the inclusion and exclusion criteria. Full texts of the articles screened in were reviewed to determine eligibility for the review. Triangulation was not used during screening or study selection.

Data Extraction and Synthesis

Data extraction and synthesis was carried out by the first author and followed the standard meta-aggregative three-step process of extracting findings, developing categories and developing synthesised findings (Lockwood et al., 2015).

Findings within these papers were identified as the author's analytical interpretation of the qualitative data in the results section of empirical papers. In the reflective-discussion papers, findings were identified as original reflections or observations from the authors regarding their work. Challenges and solutions which do not refer to the intercultural aspect of conducting research were not included. For example, any challenges relating to different levels of experience with qualitative

methods. A data extraction form was created to record study characteristics and the extracted data in the form of verbatim quotes from the articles.

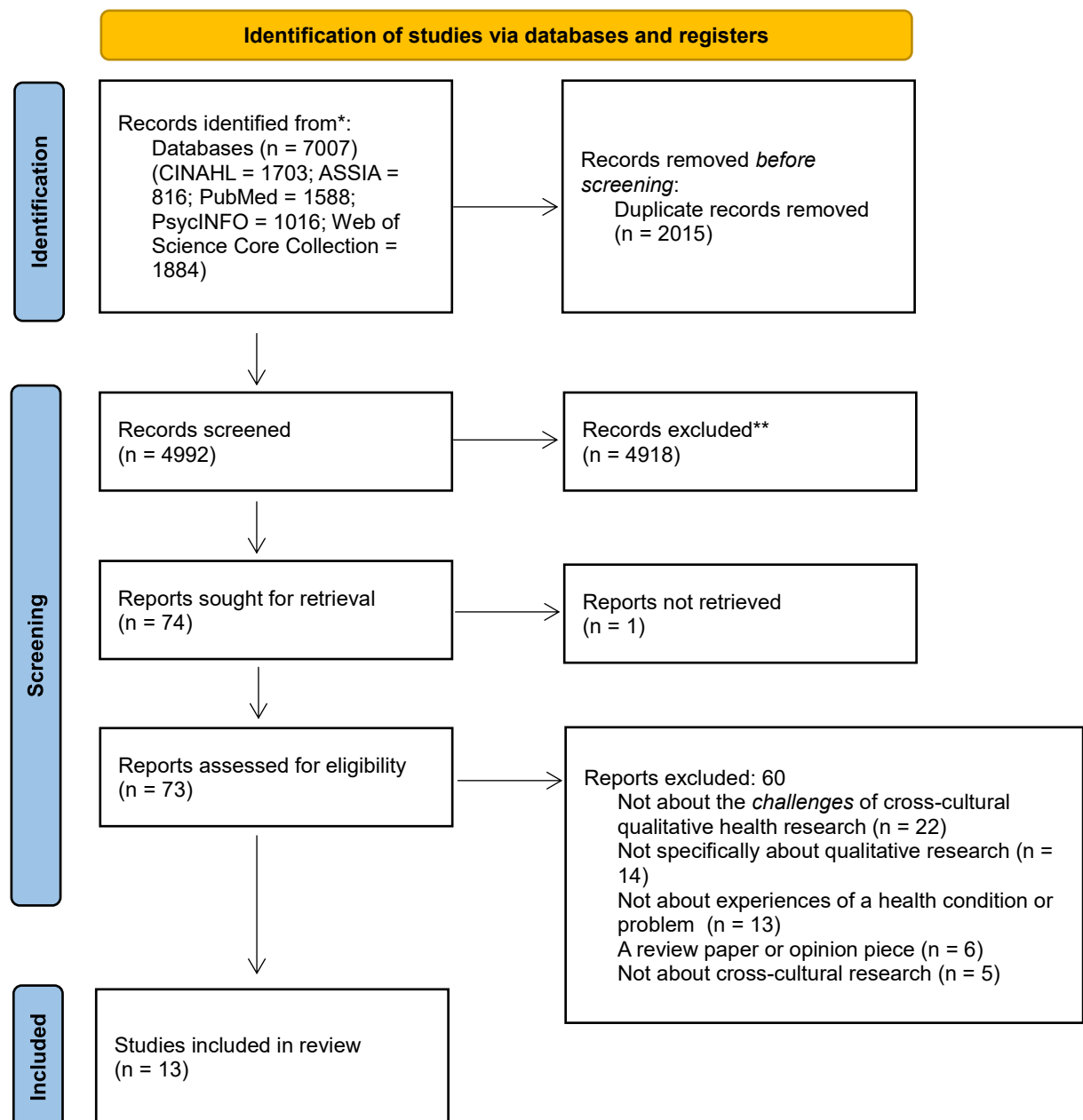
Findings were categorised according to conceptual similarity from multiple readings of the extracted data; the first author colour coded and recoded as required until clear categories were formed. Category descriptions were developed by the first author. Synthesised findings were then developed through identifying the conceptual similarities between the categories.

Results

Study Selection

The searches yielded 7007 results which were imported into RefWorks software and duplicates were removed. Initial screening reduced the results from 4992 to 74. Full texts of 73 articles were reviewed to determine eligibility for the review; 1 article (Grant & Luxford, 2009) was not available in full. The first author (Grant) was contacted to request the full text; as it was not provided within two weeks of being requested, this article was excluded from the analysis. This left 13 articles for inclusion in the review (four empirical papers and nine reflective-discussion papers). See Figure 1 for the PRISMA diagram displaying the screening and selection process.

Figure 1

PRISMA diagram of Screening and Article Selection

Quality Appraisal

The Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015) was used to quality assess the empirical papers. For the reflective-discussion papers, a checklist was created through amalgamating and adapting the aforementioned checklist and the JBI Critical Appraisal Checklist for Text and Opinion Papers (McArthur et al., 2015); see Appendix C. Papers which had fewer than 50% of the criteria marked as 'yes' were excluded. This resulted in one empirical paper (Suurmond et al., 2016) being excluded. This was due to the absence of the researchers recognising their influence on the research and locating themselves culturally or theoretically; lack of congruence between the philosophical perspective, methodology, data collection and conclusions; and ethical concerns regarding informed consent from participants. The reflective-discussion papers were all rated as very good quality, and the empirical papers were of good quality.

Using the CONqual method (Munn et al., 2014) to assess dependability, all empirical papers were assessed at the moderate level of dependability. It was not possible to calculate the credibility and overall CONqual score for the synthesised findings due to these findings relying on the reflective-discussion papers as well as the empirical papers. Due to the nature of the reflective-discussion papers it was not possible to identify what specifically counted as an illustration of the finding, thus

precluding the ability to calculate credibility rankings. During the quality appraisal process, triangulation was not used.

Study Characteristics

Twelve papers from 2008 to 2022 were included in this review; relevant information is displayed in tables 2 and 3. Eight papers had a general focus on the experiences and challenges of planning or conducting intercultural, qualitative, health research. Three focused specifically on the experiences and challenges of translation and/or working with an interpreter, and one on how to build trust. The articles spanned cultures across Europe, the middle East, Asia, South and North America. Translation was used in all but one (Burkett & Morris, 2015) of the studies discussed, utilising professional interpreters, lay interpreters or bilingual researchers who also acted as interpreters. Researchers were also a mixture of cultural and linguistical 'insiders', partial-'insiders' (for example, spoke the language but had been raised in another country) and culture and linguistical 'outsiders'.

In the three empirical papers, there were a total of 22 participants who were either interviewers or researchers. Data collection methods included two focus groups and one survey with open-ended questions which was supplemented with fieldnotes and analytical memos from the intercultural research.

Table 2

Relevant Information Pertaining to the Empirical Studies

Study	Study Location(s)	Population	Number of Participants	Phenomena of Interest	Data Collection Methods	Cultural Position of Authors	Synthesised Findings Present in the Article
Gwyther et al. (2022)	UK, Poland and Italy	Researchers	6	Experiences of conducting research into frailty across Europe.	Survey with open-ended questions, fieldnotes and analytical memos.	Each researcher was a cultural insider with their participants.	Being an “outsider” Working in culturally and linguistically diverse research teams
Lam et al. (2020)	Canada and China	Researchers	9	Experiences of conducting research into suicidal behaviours of women of Chinese descent.	Focus group	Mixture of cultural insider and outsider researchers.	Working in culturally and linguistically diverse research teams
Wilkinson et al., (2017)	UK	Interviewers of south-Asian participants.	7	Learning gained from conducting research interviews with end-stage kidney function patients about end-of-life care.	Focus group	Research team comprised of UK researchers and bilingual interpreters.	Retaining authenticity and meaning Being an “outsider”

Table 3

Relevant Information Pertaining to the Reflective-Discussion Articles

Article	Location of Original Study	Source of Reflection	Phenomena of Interest	Cultural Position of Authors	Synthesised Findings Present in the Article
Al-Amer et al. (2016)	Jordan	Authors	Challenges in a study among Arabic speaking participants.	Interviewers were cultural insiders. Research team was mixed and transcripts were translated to English.	Retaining authenticity and meaning
Arriaza et al. (2015)	USA and Chile	Authors	Methodological questions and challenges about how best to conduct cross-cultural qualitative research and research in a language other than English.	Bilingual and bicultural researchers who identified as cultural insiders/outsideers to varying degrees.	Retaining authenticity and meaning Being an “outsider”
Burkett & Morris (2015)	USA	Lead author	How to build trust with African American participants.	Not provided by authors.	Being an “outsider” The interpreter’s impact on the research
Chiumento et al. (2018)	3 south-Asian countries and the UK	Lead author	The role of the interpreter and methodological considerations in cross-language qualitative research.	Lead author is white British.	Retaining authenticity and meaning Being an “outsider” The interpreter’s impact on the research
Eklöf et al. (2017)	Finland	Authors	Planning focus groups with asylum seekers	Not provided by authors.	Retaining authenticity and meaning Being an “outsider”

					The interpreter's impact on the research
Karwalajtys et al. (2010)	Canada	Authors, team reflections/debriefings, feedback from fieldworkers and post-interview debriefings.	Methodological and practical learning from conducting focus groups with different ethnolinguistic immigrants	Not provided by authors.	Being an "outsider"
Oxley et al. (2017)	India and Turkey	Authors	The effects of the research process and interpreter on translating data to disseminate in English	Mixture of bilingual researchers who acted as translators and monolingual researchers.	Retaining authenticity and meaning Being an "outsider" The interpreter's impact on the research
Quintanilha et al. (2015)	Canada	Authors	Lessons learned from different approaches to cross-lingual focus groups with African immigrant women	Researchers were cultural outsiders.	Being an "outsider"
Smith et al. (2008)	China	Authors	How language and interpretation can impact rigour.	Researchers were a mixture of cultural insiders and outsiders.	Retaining authenticity and meaning Working in culturally and linguistically diverse research teams

Findings

Four synthesised findings were identified in relation to the challenges and solutions of conducting intercultural, qualitative, health research:

1. Being an 'outsider'
2. Retaining authenticity and meaning
3. The interpreter's impact on the research
4. Working in culturally and linguistically diverse research teams

Each finding integrates challenges with the relevant solutions.

1. Being an 'Outsider'

For those researchers who identified as an 'outsider' or as a partial-'insider' there were challenges relating to working with people who were culturally and linguistically different. Some of these challenges were practical in nature, for example difficulties in recruiting participants (Karwalajtys et al., 2010), identifying appropriate seating arrangements for interviews/focus groups (Quintanilha et al., 2015), sourcing interpreters and involving them in the dissemination stage (Chiumento et al., 2018) or budget constraints impacting on translation methods (Gwyther et al., 2022; Quintanilha et al., 2015). Engaging with organisations or people that already have a link to members of the community and incorporating cultural experts into the research

team can help overcome some of the practical challenges to being an outsider and increase trust (Burkett & Morris, 2015; Karwalajtys et al., 2010). Other challenges related to the limited knowledge held about the other culture and the impact of being an 'outsider' on the power dynamics with participants.

The limited knowledge of the other culture created difficulties with approaching the research in a culturally appropriate way (Arriaza et al., 2015; Eklöf et al., 2017; Karwalajtys et al., 2010; Oxley et al., 2017) and without introducing biases from the researcher's own culture (Oxley et al., 2017). For example, Arriaza et al. highlighted difficulties with creating culturally sensitive documents (such as consent forms and thank you letters), and Karwalajtys et al. the hesitation of participants to sign a written informed consent document. Engaging in reflexive practice and working with experts in the culture were seen as solutions to managing some of the challenges of being an outsider (Arriaza et al., 2015; Karwalajtys et al., 2010; Quintanilha et al., 2015). Specifically, these techniques were seen to support researchers in acknowledging and recognising their outsider status, belief systems and personal cultural views (Arriaza et al., 2015) rather than attempt to become more of an insider. Strategies used to enhance reflexivity include writing memos, field notes, engaging insiders in the reflexive process, building case summaries, and documenting follow-up questions for second interviews (Arriaza et al., 2015). Strategies were also used to

increase familiarity with the culture and population. This is likely to have happened organically from involving cultural experts, however some researchers also took proactive steps to learning more about the other culture. Chiumento et al. (2018) participated in training exercises with the interpreters designed to highlight important aspects of one's own life and culture and thus created the situation for them to learn about each other's cultures. Various papers also discussed becoming more embedded with the population through observations, spending time with members of the research population and, working and studying in the area of interest in the other culture (Burkett & Morris, 2015; Oxley et al., 2017; Quintanilha et al., 2015). Finally, Eklöf et al. found that networking with other researchers in the same field provided helpful knowledge regarding the population of interest.

The impact of being an 'outsider' on the power dynamics with participants was a challenge raised in four papers (Arriaza et al., 2015; Chiumento et al., 2018; Oxley et al., 2017; Wilkinson et al., 2017). Oxley et al. found that participants used the formal version of 'you' demonstrating respect, but also that the interviewer was seen as an expert and someone different. This issue with power caused concern for the rigour of the research. For example, Wilkinson et al. raised concerns that power issues may lead to participants feeling obligated to present their experiences in a certain way; this was particularly relevant to their research whereby the researchers were also medical

professionals. To overcome this, Wilkinson et al. report that ensuring participants were well-informed about the research prior to engagement would have helped. Oxley et al. worked to engage participants in a casual manner, as a friend or peer. Additionally, the use of cultural experts supported researchers in examining power issues and avoiding misrepresenting the data (Arriaza et al., 2015).

The challenge of power imbalance related not only to the situations where researcher/interviewer were interacting, but also in the process of data analysis and dissemination. As Chiumento et al. (2018) explain, the use of English as the main medium of communication and publication retains the power of intercultural research within the white-Western English-speaking population. Their solution to managing this was to involve interpreters' perspectives into the data analysis as much as possible.

2. Retaining Authenticity and Meaning

One of the most prevalent challenges found across the articles was the difficulty in translating interviews into another language whilst retaining authenticity, meaning and the participant's voice. Metaphors, medical terminology, other technical terms, and words which did not have a meaningful translation in the other language were particularly difficult to translate (Al-Amer et al., 2016; Arriaza et al., 2015; Chiumento et al., 2018; Oxley et al., 2017; Smith et al., 2008; Wilkinson et al., 2017).

Even those which could easily be translated with a literal translation approach provided challenges. Use of a literal translation could distort meaning (Al-Amer et al., 2016; Arriaza et al., 2015; Oxley et al., 2017) or significance of a word (Arriaza et al., 2015; Oxley et al., 2017). The interpreter also affects the meaning identified during the process of translation, therefore there was a challenge of losing the voice of the participant to the voice of the interpreter (Al-Amer et al., 2016; Oxley et al., 2017). This issue of translation occurs bidirectionally, and Eklöf et al. (2017) advised against the use of slang, colloquialisms and complicated sentences in interview questions to help with retaining meaning during the translation process.

Hiring interpreters with experience in research and the field of study was identified by Eklöf et al. (2017) as a solution. However, they also recognised that it can be difficult to find interpreters with this experience and competencies between professional interpreters can vary greatly (Eklöf et al., 2017). Alternatively, other papers identified that discussions with colleagues (for example, interpreters, language experts or research team members from the culture) provided opportunities to identify how best to proceed with the translation (Al-Amer et al., 2016; Arriaza et al., 2015). Solutions typically focused on how best to convey the meaning of what was said in the source language, for example, through adding words to clarify meaning (Oxley et al., 2017). Other techniques included adding footnotes to provide additional contextual

information (Oxley et al., 2017). Back translation, team meetings or checking by another bilingual team member were also used to check translation accuracy (Arriaza et al., 2015; Oxley et al., 2017; Smith et al., 2008). Using reflexivity can help reduce the impact interpreters and the research team have on the translation process (Arriaza et al., 2015; Oxley et al., 2017).

Similarly, there were challenges in retaining meaning and authenticity when disseminating the research in a language different to that which the interviews were conducted in. Publishing in a language different to what the data was collected in affects the presentation of verbatim quotes in particular (Smith et al., 2008), and depending on word limits allowed in journals, the presentation of quotes in both source and target language may be difficult (Smith et al., 2008). Providing clear information on the translation process used can increase transparency of the disseminated work and aid understanding (Al-Amer et al., 2016).

3. The Interpreter's Impact on the Research

The use of interpreters means including an additional person who can influence the research process. This challenge of managing how interpreters influence the research process reaches across all levels of conducting research as impacts in the data collection stage affect resulting narratives and the data analysis. For example,

Chiumento et al. (2018) reported that locally embedded interpreters act as gatekeepers, potentially biasing who is invited to participate in the research. This potential bias in the sample then could affect what narratives are identified in the data.

During interviews, participants may be influenced merely by the presence of an “insider”, and more explicitly by how the interpreter communicates with them, what they say and what style of interpretation is used (Chiumento et al., 2018; Eklöf et al., 2017). For example, Eklöf et al. discussed how in their research, an active interpretation method was chosen over a passive method as it focuses more on building trust in the relationship between those involved in the interview. This was seen as particularly important due to their research being with asylum seekers and they acknowledge that a passive method may be more suitable in other contexts. Over the process of conducting interviews, Chiumento et al. noticed that interpreters were becoming more familiar with technical terminology and that interviewers began recognising cues and aspects of the conversation before it was translated, thus creating changes in the data collection. They then posit that understanding and monitoring evolving positionalities is important for accounting for the impact they have on the resulting data (Chiumento et al., 2018). Finally, the act of translation is an interpretation in itself, so cannot be separated from the data analysis. For example,

aspects such as whether the translation occurs at the spoken or written level will impact the translation process and resulting data (Oxley et al., 2017).

Training interpreters, and exploring their own personal backgrounds and their positionality with them, provides a mechanism for reducing some of the above challenges and increasing awareness of how interpreters can and are influencing the research process (Chiumento et al., 2018; Oxley et al., 2017). Providing supervision to interpreters and maintaining an awareness of how interpreters' interview and translation styles alter over time, as well as their positionalities, can support better understanding of how the research process is influenced by this factor (Chiumento et al., 2018). Finally, having an open discussion between the interpreter and participants about the role and background of the interpreter can improve their relationship, increase trust and overcome barriers relating to their presence (Burkett & Morris, 2015; Eklöf et al., 2017).

4. Working in Culturally and Linguistically Diverse Research Teams

Whilst the experience of working in diverse teams has been discussed as an aid to overcoming some of the challenges of working interculturally, it was also highlighted as a challenge in itself. Differences between epistemological positions, value placed on qualitative methodologies within different countries, cultures, ethics and other

research practices created a challenge of working effectively together (Gwyther et al., 2022; Lam et al., 2020). There were also practical and linguistic challenges (Gwyther et al., 2022; Lam et al., 2020; Smith et al., 2008). An attitude of being open to learning from one another helped overcome some of these challenges (Gwyther et al., 2022).

Regarding the practical challenges of working in an international research team, communication and discussing the research was an issue when not based in the same place, particularly when working across different time zones (Gwyther et al., 2022). High levels of commitment were seen from the team which helped overcome this challenge, but often this meant that some team members were working outside of their normal office hours (Gwyther et al., 2022). Whilst face-to-face meetings were still seen as valuable for more effective team working and efficiency in the research process (Gwyther et al., 2022), the use of technology to gain quick responses to issues and topics for discussion was seen as an adequate solution, but came with its own problems such as issues with connectivity (Lam et al., 2020). Smith et al.'s (2008) use of systematically organising and tracking which team members are responsible for which pieces of work provided a crucial way for them to manage working as a team.

For others, finances and funding were more of an issue. For example, Lam et al. (2020) found there were challenges due to some inflexibility in how the budget was spent and the decision to analyse the data in English meant increased costs for

professional interpreters. No solutions to these challenges were identified in the literature.

Linguistic challenges related to both confidence in working in another language (Gwyther et al., 2022) and the exclusion of some team members or information due to limits in communication (Lam et al., 2020; Smith et al., 2008). For example, communication was limited by some team members having to communicate in a language other than their own in order for communication to occur across team members with different first languages (Lam et al., 2020). When engaging in data analysis, the language chosen to do this excluded team members who did not speak that language (Smith et al., 2008). Researchers utilised a number of different ways to overcome these challenges, one used interpreters to aid discussions within the team (Lam et al., 2020), Smith et al. analysed data in the source language and translated parts to English for discussion with the wider team, and Gwyther et al. wrote papers in a second language but had this reviewed by those who were first-language speakers of that language. In Smith et al.'s work the use of software for qualitative data analysis (MAXqda) and the approach of translating the code words into English made the participation in the data analysis of both Mandarin- and English-speaking team members easier despite the English speaker not being able to read the original text.

Discussion

To the best of the authors' knowledge this is the first systematic review on the challenges and solutions of intercultural, qualitative, health research. Initial searches across five databases yielded 4992 articles (after the removal of duplicates). Screening of titles and abstracts, followed by full text assessment for eligibility resulted in 13 articles being eligible for inclusion in the review. Quality appraisal resulted in one article (Suurmond et al., 2016) being excluded, with the remaining 12 papers being rated as of good or very good quality. The empirical papers were assessed at the moderate level of dependability using the CONqual method (Munn et al., 2014). Through meta-aggregation four synthesised findings were identified: being an 'outsider', retaining authenticity and meaning, the interpreter's impact on the research, and working in culturally and linguistically diverse research teams.

Being an outsider can cause challenges such as practical issues in recruiting interpreters or budget constraints impacting on translation. More noticeably, being an outsider caused other challenges relating to the researcher having limited knowledge about the other culture and power imbalances between researchers and participants. Reflexivity, recruiting a cultural expert and learning more about the culture were seen as keyways to manage these challenges. The use of multicultural researchers can help overcome the challenges of some research team members being outsiders (Chapple &

Ziebland, 2018). Discussions within the multicultural team should focus not only how to conduct interviews in a culturally sensitive way, but also about the wider socio-political context that is relevant to the study (Chapple & Ziebland, 2018). Other papers have highlighted the importance of building trust, but recognise that this is a challenge in itself which is likely to also need the support of a cultural expert (Delgado-Romero et al., 2018; Liu & Burnett, 2022). These challenges are not unique to qualitative methodologies, with research indicating their presence in intercultural research more generally. For example, Delgado-Romero et al. advised the inclusion of members of the Latinx community and bilingual researchers when working with this population to increase rigour in the research and overcome the challenge of researchers being outsiders. They also drew attention to the difference between being bilingual and a cultural insider, highlighting that being able to speak the language does not mean a person understands the culture. This is reflected in Arriaza et al.'s (2015) paper where some researchers had this reflection during their intercultural research experience.

Fitzgerald (2004) discussed the role of power in research with indigenous women in New Zealand and Australia. Through consideration of the principles of feminist research she highlighted the importance of giving participants' voices the power whilst avoiding creating further research which allows knowledge to be held onto by those who already have the most power. Reflexivity is an important aspect of

this process, as is taking the approach of doing research “with” rather than “on” participants from other cultures. Involving participants in the research process helps to challenge the dominant Western narratives, giving ownership to the participants themselves. However, Fitzgerald also acknowledged the current impossibility of completely removing power differences due to their embedded nature in our societies, histories and psychologies.

These results have implications for how intercultural researchers can conduct their research in order to overcome these difficulties. Incorporation of a diverse research team with support from cultural experts or members of the local community can help ensure rigour and make the research process more culturally appropriate. Whilst this review has focused on the challenges, finding that being an outsider can create a number of different challenges in the research process, Liu and Burnett (2022) noted that there are positives to being an outsider. In particular, they discussed how outsiders may be better able to see things which insiders are ‘culturally blind’ to and take for granted. This may allow the outsider to scrutinise concepts more than an insider due to a lack of assuming they understand them. Finally, an outsider, due to having less familiarity with the culture, is less likely to over-identify with the participants and may more easily separate their personal experiences, feelings and ideas from those of the participants. Having a multicultural research team is likely to

overcome some of the challenges of being an insider or outsider, providing additional capacity to question and reflect upon assumptions, thus improving rigour in the research. Whilst a multicultural team, collaboration with community members and involvement of cultural experts is ideal in relation to the challenge of being an outsider, this solution relates to one of the other challenges identified in this paper (the challenge of working in a culturally and linguistically diverse team). It would also increase the costs of the research, creating potential competing priorities between researchers and funders, and the need to find a balance between the financial costs of the project and conducting high quality research.

When translating interviews, a key challenge is how words are chosen in the target language. Some concepts do not easily translate (for example metaphors and idioms) and some words do not have direct translations. This presents a challenge to interpreters, particularly in qualitative research, where in-depth understanding of the meaning of participants' words are key to the analysis. Translating for meaning rather than literal translation often supports this process of gaining an in-depth understanding and helps retain authenticity in the participant's voice. Discussions within the team can aid interpreters in this process. This challenge applies not only to the translation of interviews for data analysis, as found in this review, but also during the interview itself; interpreters need to provide translations of meaning during

interviews with consideration of the cultural connotations a word has when translated (Chapple & Ziebland, 2018). The impact of translating a word differently can affect participants' understanding of questions and the in-depth content which is evoked (Chapple & Ziebland, 2018; Liu & Burnett, 2022). This challenge of retaining meaning and authenticity also relates to the dissemination process which is often restricted by the word limits imposed by journals. It can be difficult to present intercultural research in a culturally sensitive way when working with word limits which are typically based on expectations for quantitative research articles (Delgado-Romero et al., 2018). Therefore, journals should work to become more flexible with word counts allowing intercultural qualitative research to present findings in a comprehensive and culturally sensitive manner. This finding has implications for the entire research process. It is vital for researchers to consider the consequences of translation throughout the research process, focusing on meaning rather than literal translations. This suggests that the role of interpreters extends beyond translating interviews and transcripts; their involvement in the research process from creating interview guides, to writing up the final article is likely to be of benefit. However, as long as it is done with a clear goal of retaining authenticity and meaning. Training interpreters in the underpinning concepts of qualitative methodologies or using researchers as interpreters can support this process.

The interpreter affects the research not just through the choice of words used in translation, but also in biasing the research, thus creating challenges in their involvement in the research process. Biasing can occur through their role as gatekeeper at the recruitment stage, their mere presence as an 'insider', their positionality, their experience levels and any decisions they make during the interpreting process. This bias cannot be avoided as interpreters will naturally bring their own interpretations to their work in the same way that qualitative researchers bring their own interpretations to data analysis. Instead, it can be acknowledged and addressed in similar ways to those used by a qualitative researcher, for example reflexivity and supervision discussions. This suggests that engaging in reflexivity and consideration of positionality in qualitative research is a process which applies to interpreters as well as researchers. Training interpreters to better understand the qualitative research process and engaging them in reflexive practice is likely to raise a range of new challenges and would lengthen the research process. However, it could greatly benefit the rigour of the research, and in publications, to see not only statements regarding the researchers' backgrounds and positionalities, but also those of the interpreters.

The final synthesised finding of working in culturally and linguistically diverse teams highlights various challenges such as communicating when working at different sites, budget constraints, working with data in another language, and communicating

in a second language. Research suggests that these challenges are likely to result in further challenges; for example, Morrison-Smith and Ruiz (2020) identified how distance can impact upon team factors such as trust, awareness of colleagues, and work culture. Use of technology, flexibility in working styles, good organisation and teamwork were seen as methods for overcoming the challenges identified in this review. However, Chapple and Ziebland (2018) advocated for the use of face-to-face meetings at key stages of the research process to improve efficiency. Yet, they also recognised the challenge of balancing this with budget constraints as face-to-face meetings can quickly become expensive. A combination of face-to-face and online meetings is likely to be a more feasible method of communication, but should be appropriately budgeted for. It is likely that there is not a 'one size fits all' approach to managing these challenges and at the onset of research projects these challenges should be discussed to identify any solutions applicable to that team.

Limitations

This review followed the recommended guidelines for conducting qualitative, systematic reviews, however due to the inclusion of reflective pieces in addition to empirical research, it was not possible to follow all guidelines in full. Flexibility was required to balance the requirements for a rigorous systematic review alongside

including reflective insights directly from researchers experienced in qualitative methodologies in intercultural health research. This could be considered a limitation of this review.

Secondly, triangulation was not used in the article screening, selection, quality appraisal or synthesis stages. All processes within the systematic review were conducted by the first author. This limits the validity of the findings.

A final limitation is that three of the 12 included articles had a focus on the challenges of translation and working with interpreters. Whilst the role of interpreters and translation in this type of research creates unique challenges not found in non-intercultural research, it possibly overshadows other challenges in this area. For example, the challenges relating to being an 'outsider' or working in a multicultural and/or international team. Chapple and Ziebland's (2018) review of intercultural, qualitative, cancer research discusses challenges in relation to obtaining funding and ethical approval across different countries, and working to research governance and recruitment requirements applied by different institutions; areas which were not identified in the current review. Future research should take a wide exploration into the challenges faced by researchers and interpreters in this field.

Conclusion

This review explored the challenges and solutions in conducting intercultural, qualitative, health research and provides support to future researchers navigating the process of conducting intercultural, qualitative, health research. The use of meta-aggregation identified four synthesised findings which were, being an 'outsider', retaining authenticity and meaning, the interpreter's impact on the research, and working in culturally and linguistically diverse research teams. These results demonstrate the complex nature of conducting this type of research, but also provide solutions to encourage cultural humility and increase the cultural sensitivity of research. Future research should focus on developing a larger evidence base for the challenges and solutions to conducting this type of research considering not just the translation stage of the process, but broader methodological and practical aspects of the process.

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Chapter Two

Empirical Paper

Intercultural understandings: The experiences of doctors in Lesotho during the COVID-19 pandemic

**Intercultural understandings: The experiences of doctors in Lesotho during the
COVID-19 pandemic**

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Abstract

The COVID-19 pandemic dramatically increased pressure on healthcare staff who were trying to manage and adjust to the novel situation. For many healthcare workers, this came at a cost to their wellbeing. However, as research is predominantly focused on the Western world, less is known about the experiences of healthcare staff in places such as Africa. Using qualitative interviews, this study investigated the experiences of seven doctors in Lesotho regarding their wellbeing during the pandemic. Through interpretative phenomenological analysis, five themes were identified: under pressure, unprepared and out of control; constant uncertainty and threat; Isolation and connection; attempts to cope independently and new perspectives. These results indicate that these doctors experienced multiple challenges whilst working during the pandemic which extended beyond the work environment and negatively impacted their wellbeing. Despite this, they experienced support from friends, family and colleagues, found ways to support themselves and found points of learning from the experience. Implications for how doctors are supported at a national and local level are discussed. Further research should continue to explore doctors' wellbeing in relation to any long-term implications of the COVID-19 pandemic and during more typical work.

Keywords

COVID-19, doctors, IPA, Lesotho, qualitative, wellbeing

Across the globe, the COVID-19 pandemic has increased pressure on healthcare systems, affecting their functioning and ability to deliver quality care (Haqqi et al., 2020; Khetrpal & Bhatia, 2020, Mohamed Abdel Shafi et al., 2020). As the world attempted to comprehend and manage the virus, it was healthcare staff who faced the day-to-day challenges of managing the condition, treating patients and dealing with the vast loss of life. Research into the pandemic's impact on healthcare staff has found higher burnout rates, lower morale, poorer mental health or wellbeing, and increased worry (Lee, 2021; Sheehan et al., 2021). Harris et al.'s (2021) qualitative study of 1379 frontline UK and Irish doctors found themes of feeling exposed, unprotected, over-stretched and under-resourced, inhuman care, uncertainty, constant changes and others. Whilst Roberts et al. (2021) identified that 44.2% of the 5440 UK and Irish emergency, anaesthetic and intensive care department (ICD) doctors who completed the General Health Questionnaire-12 met criteria for 'psychological distress'.

Research has suggested an association between healthcare staff's poorer wellbeing and pandemic-related factors such as shortage of resources, worry about infection and exposure to the disease (de Brier et al., 2020; Gulano et al., 2021). Often healthcare staff experience increased feelings of pressure resulting from increased workload, and difficulties adapting to changing protocols and new PPE, caring for unwell colleagues, and caring for seriously ill patients (Walton et al., 2020). This raises

significant concerns regarding the wellbeing of healthcare staff, how they have managed, or not managed to care for themselves whilst working to care for others.

This issue of poorer wellbeing in healthcare staff may be particularly concerning in low- to middle-income countries such as Lesotho, where the factors associated with poorer wellbeing are more likely to be present. Afulani et al.'s (2021) online survey in Ghana found that staff's fear of infection was high and that they felt unprepared to manage the pandemic. These factors were associated with stress and burnout in staff. Ali et al. (2021) administered questionnaires to 171 nurses in Nairobi. Results found that almost 50% of respondents were experiencing depression, burnout and/or anxiety.

The Kingdom of Lesotho has a population of just over 2 million (2015) (World Health Organisation, n.d.). The government spends 11.1% (comparable estimate) of its total expenditure on health (WHO, 2023), with 1.8% of its health budget spent on mental health (WHO, 2022). A figure higher than the continent's average (7.3%), but lower than neighbouring South Africa's 15.3% and the UK's 19.5% comparable estimates (WHO, 2023). The presence of appropriately trained healthcare staff is low. World Health Organisation (2022) data indicates that there are only 4.73 medical doctors per 10,000 people (in 2018); compare this to the UK where there are 30.04 per 10,000 (in 2020). The overall picture in Lesotho is one of a low resourced healthcare

system serving a population with high health needs and thus raises concerns about staff wellbeing over the pandemic.

Lesotho has connections with Wales. The charity Dolen Cymru Lesotho Link works to enable sustainable projects, partnerships and relationships for the benefit of communities in Lesotho and Wales. The Betsi-Quthing Partnership Health Link supports healthcare development in Lesotho. During the COVID-19 pandemic, Clinical Psychologists from Betsi Cadwaladr University Health Board provided virtual staff wellbeing support to family medicine trainee doctors. Therefore, these links provided the opportunity for intercultural research exploring medical staff's experiences during the pandemic. With limited research into this geographical area on the topic of medical staff's wellbeing during the pandemic, this research asks how do doctors and nurses in Lesotho understand and manage their wellbeing in the context of COVID-19? Through exploring this, it is hoped that a better understanding of the experiences of doctors and nurses can be developed to inform policy and practice in staff wellbeing support. Whilst this research involved both doctors and nurses, this paper will focus on the findings from the doctors' data. A separate paper will address the findings from the nurses' data.

Method

Participants and recruitment

Seven medical doctors from four districts in Lesotho participated in the research. Mean age was 36 (range 31 to 48) and mean number of years as a doctor was 7 (rounded to the nearest year; range 2 to 15). Four participants identified as female and three as male. All but one of the doctors were Basotho; the non-Basotho doctor came from another sub-Saharan African country. All doctors were working in government facilities in Lesotho before, during and after the COVID-19 pandemic. Participants were recruited using purposive sampling; qualified doctors working in Lesotho during the COVID-19 pandemic with an ability to speak English to a standard enabling them to participate in the interview and without any major mental health concerns were eligible to participate. With the support of two charities working across Lesotho and Wales, senior medical professionals in one hospital, one clinic and Lesotho's family medicine training programme were approached to seek their support in recruiting participants. Initial emails introducing the research were followed up with face-to-face meetings led by the first author to provide further information. These senior professionals then identified staff who were eligible for recruitment. Face-to-face meetings with these individuals were arranged to discuss their participation; they were provided with verbal and written information about the research (see Appendix

D) and invited to ask any questions prior to participation. All doctors chose to participate and interviews either took place immediately or a later time, depending on the participant's preference.

Procedure

This study took a cross-sectional qualitative design. Interpretative Phenomenological Analysis (IPA; Smith, 1996) was utilised due to its focus on subjective phenomena and the lived experience of participants. The intercultural nature of this research meant IPA would be particularly advantageous in supporting cultural humility due to its social constructionist stance. Its use of the double hermeneutic encourages researchers to discover and examine their own assumptions and interpretations (Smith et al., 2021). IPA explicitly acknowledges the role of the researcher within the interpretation of the data allowing for recognition that the differing cultures of researchers and participants will have an impact on the results.

A semi-structured interview guide (see Appendix E) was created and reviewed by the research team. Interviews were conducted by the first author, in Lesotho, at participants' places of work. Due to the potentially distressing nature of the interview topics, it was planned for the first author (a trainee Clinical Psychologist) to utilise her clinical skills to support interviewees experiencing distress in the first instance. Senior

medical professionals in the different districts were consulted as to where interviewees could be signposted to should they require further support; approaching mental health staff within the local hospitals was advised as the only option available.

After gaining informed consent to participate in the study (see Appendix F), participants were reminded of their right to withdraw and confidentiality. Semi-structured interviews were conducted on a one-to-one basis in a private room at a location convenient to the participant. As per IPA tradition, the interview guide was used flexibly, with participants encouraged to explore aspects of experience that they felt were interesting or important. At the end of the interview basic demographic data and information regarding the participant's wish to review the results and/or final article prior to the report being submitted was collected. The mean duration of the interviews was 73 minutes (range 44 to 92). Interviews were conducted in English, audio-recorded and transcribed verbatim (with significant non-verbal communication such as laughter and long pauses) by the first author.

During the study preparation, interview and data analysis stages a reflective log was kept by the first author to support bracketing of assumptions and ownership of one's own perspective. The fourth author, a Lesotho-based researcher and medical doctor, acted as a cultural consultant during the study, particularly in relation to the cultural appropriateness of the interview guide, interview procedure and data analysis.

Ethical considerations

Ethical approval was granted by Bangor University and Lesotho's National Health Research Ethics Committee.

Data analysis

Utilising processes illustrated by Smith et al. (2021), each transcript was examined for its descriptive, conceptual and linguistic features pertaining to the study's aims. These initial exploratory notes alongside the transcript were transformed into experiential statements and then personal experiential themes (PETs). The cultural consultant then reviewed the exploratory notes, experiential statements and PETs providing feedback on the analysis' cultural appropriateness. Each transcript was analysed as an individual piece with the first author bracketing off outcomes from previous transcripts. Finally, the PETs were analysed to form group experiential themes (GETs). As suggested by Smith et al. (2021) a GET was only included if it consisted of data from at least four participants.

Four of the seven participants had opted to review the results for accuracy and cultural appropriateness before the report was finalised. The results were emailed to them, however no participants responded, and it was assumed there were no concerns regarding the results.

Epistemological approach

A social constructionist stance was adopted during this research, which assumes that knowledge is developed through interactions and discourse. This is appropriate for intercultural research whereby individuals' experiences and interactions are seen to shape their understanding and interpretation of subsequent experiences. This was important for this research as it was desirable to avoid imposing Western constructs onto the participants. Through taking a social constructionist approach, the authors were able to question and consider various elements of the research process and their acceptability for the participants. For example, the construct of 'wellbeing' was not assumed to have the same qualities across cultures, therefore part of the interview involved exploring with participants what their meaning of the word 'wellbeing' was.

Reflexive statement

The first author, a female, white British, trainee Clinical Psychologist, conducted the interviews and data analysis. Concerns regarding being a cultural and racial outsider, and power imbalances in relation to this, were managed through discussions with the cultural consultant, other professionals who had worked in Lesotho, and spending time in Lesotho familiarising herself with the culture and healthcare system.

Her previous work in Sub-Saharan Africa created assumptions about the nature of the results. These included an expectation that familial and community relationships would be seen as key to coping during the pandemic, that any mental health problems would be minimised due to fear of stigmatisation, and that staff would be experiencing stress due to a difficult work environment. As per the IPA approach, these assumptions were reflected upon and bracketed off prior to conducting the interviews and analysis (Smith et al., 2021).

Analysis was led by the data; however, the first author's individualistic cultural background and mental health training are likely to have influenced the results. Whilst this is acknowledged as an inevitable part in the IPA process, the use of reflexivity, bracketing, and consultation with the cultural consultant were vital in minimising the impact. To counteract the first author's predisposition to focusing on psychological phenomena, she made a conscious effort during interviews to ask follow-up questions about other phenomena when they naturally arose, and during analysis to consciously avoid dismissing non-psychological phenomena (for example, the physical impact of stress).

Results

Five GETs were identified across the participants' interviews (see Table 1). It was noted that within each theme there was a sense of change and development over time as the pandemic progressed. For example, participants talked more about feeling out of control during the onset and main part of the pandemic, whereas new perspectives developed as the pandemic progressed and eased.

Table 1.

Contribution of each participant to the group experiential themes and subthemes

Group Experiential Theme	Subtheme	Participant						
		Arabang	Ata	Kelvin	Makalo	Palesa	Tumelo	Tumisang
Under pressure, unprepared and out of control	Chaos		✓	✓	✓			✓
	Out of control, helpless and unprepared		✓	✓	✓	✓	✓	✓
	Expectation and pressure			✓	✓	✓	✓	
Constant uncertainty and threat		✓	✓	✓	✓		✓	✓
Isolation and connection	Isolated and alone	✓	✓	✓		✓	✓	✓
	Abandoned by the government		✓		✓	✓	✓	
	Support from others	✓	✓	✓	✓	✓	✓	✓
Attempts to cope independently		✓			✓	✓		✓
New perspectives	Changing Perspectives on what it means to be a doctor		✓	✓	✓			
	Connection with own mortality			✓	✓			✓
	Changing perspectives on self and life		✓	✓	✓	✓		✓

1. Under pressure, unprepared and out of control

Chaos. Participants' descriptions of working during COVID-19 painted a picture of chaos in which there was a lack of preparation, resources (such as PPE, oxygen and human resources), and knowledge about how to treat COVID-19. There was fear due to feeling more exposed to the virus and a sense of disorganisation within the hospitals:

In that time no one knew what was going on, no one knew what should be going on, how we go about it, how we help people, it was all a blur, and... it felt like, um, guidelines were just changing on a daily, today we do this, tomorrow we don't do it anymore. (Tumisang)

Here we can see Tumisang stress the lack of knowledge in multiple areas. Language used by participants illustrates the chaos and disruption caused by COVID-19. Makalo described the pandemic as an '*elephant*', '*battle*', '*war*' and a '*continuous storm*' (Makalo) conjuring images of power, fear, and widespread destruction. For Tumisang, '*COVID was like this, [chuckle] mystical creature right, with a sword, just waiting for you*' (Tumisang). In this image, the unknown nature of COVID-19 is brought to life as a mysterious creature, lurking and threatening everyone's life. It demonstrates

a palpable fear, but also that the lack of knowledge about COVID-19 contributed to that fear.

Out of control, helpless and unprepared. On a personal level many participants described feelings of being out of control or helpless, particularly in relation to seeing patients deteriorate and die. This has strong links with the previous subtheme, where the lack of resources and knowledge meant doctors were unable to provide patients with suitable treatment.

Participants experienced a disconnect with the purpose of their job role, which threatened their identity as a doctor and resulted in moral injury, as demonstrated by Kelvin, *'we are seeing people who are dying like every day. It's like... you can't help people... you were asking yourself questions, am I really a doctor or not?'* (Kelvin). Given that patients dying is not a new experience for doctors, this reaction suggests that participants felt helpless in a novel way and suffered moral injury through witnessing deaths.

The lack of control spread across various areas of their life and work. Tumisang expressed thoughts in relation to not being able to control the potential personal impact of the pandemic:

I mean other diseases, let's take hypertension, let's take diabetes... I see people who have it, but also I'm thinking... it's a secondary condition. If we try and look after ourselves, ... these are less likely to develop right. But with COVID it wasn't... anything extra that you had to do, all you had to do is breathe, which we all do... the sure way of really protecting yourself to say, yes, this will help, I do not have that... So, that for me was, we don't have control over this one, yeh. (Tumisang)

Other participants spoke about how they felt helpless or lacking control in their relationships:

In terms of, uh, my wife... I felt useless... I thought that what I had promised, I am not fulfilling, and her fears in marrying a doctor, was not going to give her time and everything, were now becoming manifest. So, I felt useless at that point, and the more I try hard to keep up with the requirements of the family, the more I was getting exhausted. (Ata)

Here we can see the impact of COVID-19 extending beyond its immediate vicinity of clinical work. The exhaustion from work had impacts on personal relationships, and resiliency was reduced as doctors attempted to deal with the situation unfolding in front of them. Participants found themselves questioning their

existence, autonomy, and identities in life. These elements are explored further in the theme, 'new perspectives'.

Expectation and pressure. Despite the experiences described above, doctors still felt an expectation and pressure to continue working despite the lack of knowledge and resources. This expectation stemmed from the external pressures to continue working and self-imposed internal expectations.

I was part of the team that went out to... the second recorded case of COVID... You're just being grabbed like, okay, we have to go. It's like ah, okay, I'm going [pause] but, have you even considered that we are talking about a person who has been diagnosed with covid? What do I have to wear? Prepare me mentally, prepare me psychologically, because this is also something new to me. Nothing is being done. (Palesa)

Palesa's description demonstrates the pressure put on her, with no consideration for how prepared she felt. The use of the word 'grabbed' suggests a lack of choice in the decision, thus creating a situation for moral injury. In contrast, Kelvin spoke about his internal sense of obligation and expectation to continue working.

Many colleagues got it [COVID-19] and it make me like to stop working [chuckle] but it was not easy. At the same time, you were saying, “no I am a doctor, I have to help people”, that duality in, in thinking, it was not easy, what should I do? But at least we are doctors we, we try to do our best. (Kelvin)

Here we witness Kelvin’s internal dilemma between his fear of contracting COVID-19 at work and his sense of duty as a doctor. There is a split between his sense of self as a doctor and sense of self as a person, as evidenced by his use of the world ‘duality’. Again, this appears to create a situation where moral injury could occur.

2. Constant uncertainty and threat

Participants’ wellbeing was impacted by the uncertainty and threat from COVID-19 which were experienced as constant, inescapable, and ‘*terrifying*’ (Tumisang). The uncertainty surrounding COVID-19 made the threat of death even more powerful, causing ‘*dread*’ (Ata) and ‘*fear*’ (Tumelo), and penetrating across time. *‘The stress was like, you don’t know what’s going to happen to you the next day. The future, you don’t know the future, what’s going to happen in future about yourself, about your family. That was eh the stress’* (Kelvin). Tumisang felt similarly:

After the pandemic hit, it was a scary time... Um, I mean in that time we really should dance with death a lot, right... I feel like we met face-to face often times and so the reality of it really was more heightened. (Tumisang)

Tumisang's fear of being 'face-to-face' with death; seeing healthy, young people die made the risk of death feel even more uncertain and that it could happen to anyone. *'With COVID, it had no respect for health or ill health, age, you know, everyone was just game'* (Tumisang). The use of 'dance with death' and 'face-to-face' highlights the closeness that she experienced with death during this time; she was confronted with it, trying to make the right moves to delay the inevitable.

3. Isolation and Connection

Isolated and alone. For six participants, the experience of isolation and aloneness were themes in their interviews. Isolation occurred in the workplace and home, both physically and psychologically. Teamwork was lost as healthcare staff were assigned to either the COVID-19 ward or not. The increased work stress and exhaustion had an impact on participants' personal lives. Relationships became more strained, and this created an unhelpful spiral of worsening wellbeing, as described by Ata, '[you]

don't have time for your friends anymore, and now they say you have changed. So, you don't have your support structure at that point' (Ata).

For many doctors, they were already living alone before the pandemic. This physical isolation left them struggling to manage their wellbeing and feeling psychologically alone, as they had no support after work. Palesa describes this:

When you go home, you need someone to talk to [pause]. Someone who'll just give you a hug... and say, it will be okay. [pause]. Someone you can just talk to about your stress, who'll guide you and give you advice, you know, someone who'll just listen, and I didn't have that (Palesa)

Despite the distress at being alone, some participants also noted positives in the protection it afforded their family who were not in physical contact with them:

I live on my own right, so I wouldn't visit my parents after having gone for my shifts because I was worried if I had the condition and so I didn't want them exposed... which really made the whole isolation thing so much easier. (Tumisang)

Abandoned by the government. The aloneness and isolation experienced by the doctors was partially created or exacerbated by the lack of support from authority

figures and the government. Participants felt that the government and their superiors did little to support them during the pandemic, instead abandoning them to '*fend for themselves*' (Ata). Participants reported feeling unappreciated by the government:

So, there was no sequential way of uh giving information out, uh, from our ministry unfortunately. So, it affected us and how we are supposed to work, and there was a lot that we're looking at from government to, to support us to make it easier for us to work... but there wasn't anything. You're frustrated at the end of the day. (Palesa)

Palesa's frustration links to an expectation of support and advice from the government, a sense of seeking for leadership and information, but ultimately finding nothing. Ata's description of the action healthcare staff took to gain support from the government demonstrates the severity of how abandoned and let down healthcare staff felt; '*we had to force them. We forced them to give us PPE, we forced them to give us, eh, the risk allowance, and it wasn't even enough, and they didn't even pay it in full*' (Ata). Ata refers to 'the risk allowance', a payment made in recognition of the increased risk healthcare staff were experiencing. Here we can see that he felt unappreciated by the government because the amount was little compared with the risks he was experiencing; healthcare staff's lives were worth so little to the government.

Support from others. There was the sense that family, friends and sometimes colleagues, partially made up for the gaps left by the authorities. Support from others was essential for the doctors in managing their wellbeing:

There were those periods that we'll feel that, no, man I cannot take this anymore...

However, the fact that the social, emotional aspects there, where those individuals that are significant to us who were at least closing that gap, it made us not to crash.

(Makalo)

Makalo's 'significant' others clearly helped him to keep going. Without these people his wellbeing would have deteriorated to a point where he 'crashed', giving an image of him being damaged and destroyed by the pandemic's impact. There was still a gap between how his wellbeing was and where it is typically, which refers to the need for further professional support.

4. Attempts to cope independently

Whilst they were abandoned by authorities, and experienced isolation and aloneness, participants were able to turn towards themselves for support. Some doctors turned to religion, others to managing their physical health and some to

emotion management strategies. Palesa described a journey of exploration in coping independently, sometimes reaching out for ways to cope which were ultimately not successful:

Sometimes you find yourself locking yourself in this office, you cry, you go home, you're only thinking can I get something that can sedate me, you start [pause] drinking, unnecessarily, just to numb yourself, just for something that will make you not to think about this environment that you're working in... I found myself doing things that I never had anticipated that I would do, just because I'm trying to relieve myself of the stress. (Palesa)

This extract shows Palesa's attempts to distract herself from the difficulties and emotions. Desperation is felt in her attempts to do anything to cope, reaching out to things she never thought she would. However, some doctors described more success in self-care:

Something that I do not have control over [the death of a patient], yes I may feel that guilt, but... it's a feeling and feeling is not um, the reality of what is going on, but now I had to understand that... and separate the feeling from the realities, yes, of life. (Makalo)

Here Makalo describes balancing his emotions with rational thinking.

Recognising that emotions are not necessarily a reflection of reality helped him to maintain his wellbeing.

Overall, relying on oneself during the pandemic was a key part of managing wellbeing, however the methods used varied between participants with varying degrees of success.

5. New perspectives

Despite the themes above, participants also spoke about the learning gained from working as a doctor during the pandemic. This impacted both their professional and personal lives. This view of the pandemic, as a time of learning and development, could be seen to mitigate the negative impact on wellbeing, as all the distress and loss were not for nothing.

Changing perspectives on what it means to be a doctor. Participants spoke about a deeper connection with patients and a recognition that as a doctor they can work more holistically, seeing the person as someone with a context to take into consideration and needs beyond just the physical. For example:

That is where now my eyes open, to see you are not just going to focus on the disease process here, but you need to also take care of other significant um, aspects of a patient, like psychological ones. Some of them would need the spiritual support.

(Makalo)

Makalo's increased awareness of the different facets of healthcare came about from witnessing fear in patients. It exposed him to their psychological and spiritual needs, and in a low resource setting, he was the only one available to help. For participants, the pandemic was seen as a chance to implement previous learning and a reminder that their learning did not stop at the end of their medical training.

Connection with own mortality. Experiencing the vast impact and indiscriminate nature of COVID-19, how '*it can affect anyone... it's not that because you know more about it, it's not going to progress towards [death]*' (Tumisang), appears to have led to some participants connecting with their own mortality in a new or more profound way. Participants recognised that they are '*vulnerable also*' (Kelvin); COVID-19 had just as much chance of affecting them. This was a scary reality check for participants who were working with COVID-19 patients, often without adequate protection.

Changing perspectives on self and life. The threat of death, connection with own mortality and the distress caused by the pandemic led to reflections on the doctors' personal lives. For example:

you realign yourself again to see really what is important, you always are busy, you don't have a lot of time to see your parents, because oh, I'm at work, so now in that time, it was, is it really worth it? Right. So you redefine that again, so you kind of have people who... you just never knew just how important they were until they fell ill... I took more time to check up on people, to find out how they are doing. (Tumisang)

Tumisang and others reflected on decisions in their lives which have taken them away from their family and the people they want to be. Participants discussed changes they wanted to make to be more engaged with the things they value; the pandemic was the spark which ignited this way of thinking. For other participants their changed perspectives related more to the world in general. Makalo found that his experiences during the pandemic taught him the importance of preparation. In his words there is sense of trepidation and new perspective of life as unstable:

COVID-19, it taught me, it taught us, and taught the whole world that the world is not a stable place... we need to always be prepared for anything. Because the consequences

of not preparing is, if some of these things come and hit us, we end up finding ourselves in a despair. (Makalo)

Discussion

Results indicate that these doctors, working in Lesotho during the COVID-19 pandemic, experienced a deterioration in their wellbeing evidenced by isolation, aloneness, abandonment, and fear relating to uncertainty, lack of control, pressure, and helplessness. However, self-care and connection with others provided an antidote. Experiences also led to new perspectives on life.

COVID-19 was experienced as an immense and dangerous entity instilling fear and creating an uncertain, chaotic environment. Other research has reported similar results; Afulani et al.'s (2021) survey in Ghana reported that staff felt unprepared. Chandra and Vanjare's (2020) literature review found that some of the main challenges to healthcare workers during the pandemic were related to preparedness and availability of resources. They also found that uncertainty related to concerns about how the pandemic would progress, how to manage COVID-19, and personal safety.

For staff in low- and middle-income countries, exposure to the virus may have felt particularly threatening due to witnessing deaths across high-income countries with better resourced healthcare systems. For example, the frequent lack of access to

safe hand washing facilities found across sub-Saharan Africa (Onigbinde et al., 2020) puts healthcare workers at higher risk. There are concerns for the wellbeing of staff in Lesotho as evidence indicates that increased contact with COVID-19 patients without adequate protective resources, lack of knowledge in how to manage the condition, and a lack of other resources are associated with worse mental health in healthcare workers across the globe (Mittermeier et al., 2023; Moitra et al., 2021).

The terrifying experience of feeling out of control, helpless, and unprepared was felt to be unrecognised by others who expected doctors to continue working in high-risk environments. This is reflected in Billings et al.'s (2021) finding that, across the world, some healthcare workers have felt “coerced” into working with patients or in unsafe conditions. Culturally, the Basotho value their elders, seeing them as wise and knowledgeable, with an important role in education and leadership (Obioha, 2012). Whilst this predominantly relates to familial and societal issues, it may still have been difficult for younger Basotho doctors to go against expectations to continue working. Psychological safety may play an important role here; the Basotho doctors may have felt unable to raise their safety concerns due to apprehensions of not being heard or personal negative consequences. This links to the participants’ feeling abandoned by the government. Continentally, there are public beliefs that political institutions cannot be trusted due to corruption (Lavalle et al., 2008, Transparency International, 2017)

and during the pandemic there was a lack of transparency and accountability across many African countries regarding how COVID-19 funds were used (Kwesiga et al., 2022). This provided a ready-made narrative for how the doctors could understand their experiences during the pandemic and likely decreased their psychological safety. Leadership style played an important role in levels of psychological safety in du Plooy and Parker's (2020) study; dominant leaders decreased psychological safety, and so for doctors in Lesotho, the pressure and expectations experienced from senior officials may have further decreased psychological safety.

As psychological safety is important for increasing helpful learning behaviours, performance, effective teamworking, and creative problem solving (Edmondson et al., 2016; Parker & du Plooy, 2021), it is plausible that a lack of psychological safety could have exacerbated the feelings of chaos and unpreparedness, creating a barrier to staff being able to make changes in helpful and safe ways. The experience of pressure and lack of psychological safety is likely to have led to moral injury, with participants feeling forced into engaging in actions which go against their own morals. This term, although of Western origin, has relevance in Africa where there are already local practices aimed at healing the impact of moral injury (Nwoye, 2021).

However, there were also internal expectations from the doctors themselves; a sense of duty and obligation to continue working to save other people's lives. This was

not an uncommon experience during the pandemic, as healthcare staff often experience a dilemma between feeling committed to helping patients, but also wanting to protect themselves and their families (Billings et al., 2021; Chandra & Vanjare, 2020). When considering medical ethics and morality, particularly the deontological practice of doing no harm, as pledged during the Hippocratic oath, and the very personal nature of the situation, wherein doctors knew that their own and their loved ones' lives were at risk, it is understandable that this experience led to psychological distress. Many doctors join the profession due to wanting to care for and help others; holding this value may have worsened this dilemma for them. The role of social identity can further enrich the understanding of why this dilemma of treating patients versus protecting themselves was so difficult. Participants' use of language in identifying as a doctor indicated that this social identity was important to them. Equally, some participants discussed their Christianity. Choosing to treat patients rather than prioritise their own safety may have been an attempt to remain within their identities as doctors and/or Christians and maintain the status of these groups.

Despite the isolation and lack of support experienced by staff, support from others and finding ways to cope independently helped the doctors through the pandemic. Billings et al. (2021) and Htay et al. (2021) also found that across multiple countries, family and friends were key sources of support during the pandemic. It is

well documented that social isolation has deleterious effects on wellbeing (Bhatti & Haq, 2017; Clair et al., 2021), thus support from others during the pandemic is likely to have been essential in preventing wellbeing from worsening further. As in the current study, Htay et al.'s (2021) multi-country survey found a wide variety of coping strategies, many of which involved self-care. Engaging with religion was of the most common self-care strategies used by doctors (Htay et al., 2021) and some participants in the current study also relied on this.

Amongst the challenges of the pandemic, the doctors in this study still found that they gained things from the experience. Most notably, they reported gaining new perspectives on different aspects of their lives. For some participants, the gains achieved may reflect post-traumatic growth, with fundamental shifts in how the world, self, and relationships with others are perceived (Tedeschi & Calhoun, 2004). Whilst 'post-traumatic growth' is a Western term, the concept of positive change following crises is not new and spans the globe (Maitlis, 2020). Research has found that post-traumatic growth occurs in work settings involving exposure to trauma, but that the organisation's response to the exposure impacts post-traumatic growth (Maitlis, 2020). This raises concerns for the opportunities for post-traumatic growth for the doctors in this study given the lack of organisational support received.

Implications

Whilst the current study was not designed to be generalised, research across Africa has found similar results in relation to healthcare staff's wellbeing being negatively impacted during the pandemic (Quadri et al., 2021; Shah et al., 2021; Theron et al., 2022). The current research suggests that those leading Lesotho's healthcare system should provide more wellbeing support to staff, particularly in relation to how leaders and the government communicate with, value, and protect healthcare staff. This study also advocates for the provision of mental wellbeing resources for healthcare staff.

As the COVID-19 pandemic has eased, it is important that research continues to investigate the wellbeing of doctors in Lesotho to gain a better understanding of any long-term implications of the COVID-19 pandemic and doctors' wellbeing during more typical work.

Limitations

All interviews were conducted in English, one of the official languages of Lesotho, but less frequently used than Sesotho. Whilst all doctors were able to communicate in English to a high level, this may still have limited their ability to fully express themselves. The interviews may have elicited even richer data had they been

conducted in Sesotho, however translation comes with its own limitations.

Furthermore, the use of English may have magnified any power differences between the interviewer and participants. Whilst this research aimed to be culturally sensitive, the use of English can be seen as a version of colonialism within research.

Similarly, the majority of psychological models, concepts, and narratives have been developed in Western contexts. Whilst efforts were made to analyse and interpret the data in a culturally sensitive manner, it cannot be ignored that Western narratives dominate, and it is impossible as a researcher from a Western population to completely detach oneself from these narratives. The use of IPA helped to keep this in mind and acknowledge that the first author has given a different perspective to the data than may have been achieved with a Basotho researcher. The inclusion of the cultural consultant helped develop cultural appropriateness during data analysis.

Conclusion

This research has highlighted the challenging experiences of doctors in Lesotho during the COVID-19 pandemic, finding five themes representing how these doctors experienced and coped with their wellbeing. The results paint a concerning picture, illustrating stress, worry, threat, and isolation. However, there were positives during the pandemic; a recognition of how participants' wellbeing was supported by others

and themselves, and how their experiences have led them to gaining new perspectives on life. It is imperative that governments and organisations invest in supporting doctors, whilst future research continues to investigate how we can better understand the needs of healthcare staff in Lesotho.

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Chapter Three

Reflective Paper

Contributions to Theory and Clinical Practice

Contributions to Theory and Clinical Practice

In the globalised world we live in, with its various means to connect and communicate with people from cultures other than our own, we can see and experience the rich diversity in food, customs, values, traditions, psychologies and more, experienced by humanity. Yet, psychological research has been dominated by Western perspectives (Steinmetz, 2022), with research participants often reflecting a global minority and theories being grounded in Western ideologies and worldview (Henrich et al., 2010). Typically, research has viewed the Western perspective as the “norm” or “original” perspective, with research into non-Western cultures viewed as studying the “other”, the variation from the norm (Henrich et al., 2010). However, there is an increasing move away from this perspective to valuing and respecting different worldviews. Intercultural research has an important role to play in this and the current literature review aimed to better understand the challenges and solutions to conducting intercultural, qualitative interview research in the field of health to support researchers in their endeavours to conduct rigorous research. The empirical paper, an example of intercultural research, examined the experiences of doctors’ wellbeing in Lesotho during the COVID-19 pandemic. In this discussion paper the implications for future research, theory and clinical practice are considered in relation

to the findings of the literature review and empirical paper. Within the following sections, personal reflections regarding my experience of undertaking this research are incorporated.

Implications for Future Research and Theory Development

Literature Review

One of the main limitations of the literature review was its reliance on reflective pieces written by intercultural, qualitative researchers in addition to empirical research. Within the literature there is limited availability of empirical evidence regarding the challenges and solutions of conducting intercultural, qualitative interview research in the field of health. The dearth of research in this area suggests we have a limited shared understanding of what is experienced during the research process and how rigour is maintained in the face of numerous challenges. As intercultural research continues to grow in popularity it is vital that we continue to develop our understanding of how to conduct high quality intercultural research. I conducted the literature review after designing my empirical study and conducting the interviews. Whilst I had read some papers to aid my understanding of methodological factors specific to the intercultural research process, the results from the literature review would have been extremely valuable to me and encouraged reflection on

factors I had not considered. Having conducted this review, in hindsight I would have made some modifications to my empirical research (these are discussed below), and I expect that many other novice intercultural researchers would feel similarly. Therefore, future research should focus on how researchers engage with the intercultural, qualitative health research process to better understand and further improve the quality of research being produced.

Future research should also consider a wide range of areas in which challenges are experienced. Three out of the 12 included studies focused on the challenges of translation and working with interpreters, and the language differences were a dominating finding in the current literature review. Whilst the role of interpreters and translation in this type of research creates unique challenges not found in non-intercultural research, it possibly overshadows other challenges in this area. For example, the challenges relating to being an 'outsider' or working in a multicultural and/or international team. Chapple and Ziebland's (2018) review of intercultural, qualitative, cancer research discusses challenges in relation to obtaining funding and ethical approval across different countries, working to research governance and recruitment requirements applied by different institutions; areas which were not identified in the current review. In my own research, practical aspects such as communicating across countries and planning recruitment strategies were a challenge,

with the ability to work flexibility and tolerate uncertainty making this process more manageable.

Additionally, in the literature review, there was limited indication in the included articles about any specific challenges relating to researching health in an intercultural context. Difficulties translating medical terminology were raised, Wilkinson et al. (2017) experienced power issues in relation to the researchers also being medical professionals and Smith et al. (2008) reported a reluctance from participants to discuss sensitive topics. In my own empirical study, I too had concerns about discussing sensitive topics with participants; discussing this with the cultural consultant was extremely valuable. However, I was surprised by the absence of challenges such as this in the results of the literature review. Further exploration of challenges relating to conducting health research specifically, and challenges in intercultural research other than with translation, would better prepare researchers exploring topics in this domain.

Empirical Paper

During the pandemic, Galbraith et al. (2021) called for the authorities to prioritise the mental health of healthcare staff. Whilst the threat of COVID-19 has largely subsided, a focus on the mental health and wellbeing of healthcare staff is still

valuable. However, this needs to be approached with cultural sensitivity, recognising that whilst healthcare staff across the globe had reduced wellbeing over the pandemic (Mittermeier et al., 2023; Moitra et al., 2021), the specifics are likely to have varied across cultures. Furthermore, the bias for research to recruit Western, education, industrialised, rich and democratic (WEIRD) populations (Henrich et al., 2010) needs to be rectified.

The empirical study was qualitative in nature, not designed to be generalised, and took an exploratory approach due to the scarcity of previous research in this topic and geographical area. Considerably more research is required in order to inform practice and policy. Even though the pandemic has eased, the longer-term impact of the pandemic is unknown. In order to safeguard healthcare staff from further harm and support post-traumatic growth, research should investigate the longer-term impact of the pandemic and culturally specific factors which support post-traumatic growth.

It would be interesting to explore similar topics with a predominantly Basotho research team. In qualitative research there is value in having both an outsider perspective with his/her 'fresh eyes' and possibility of recognising cultural patterns which an insider may be blind to, and an insider perspective, with his/her in-depth knowledge of the language and culture (Liu and Burnett, 2022). Having research from both insider and outsider perspectives would likely provide even richer information on

this under-researched topic. Furthermore, in my research, the decision to conduct the interviews in English was based on the anticipated high level of English competence in healthcare staff. It was felt that there were little comprehension difficulties in conducting the interviews in this way and in doing so, the challenges relating to translation (as identified in the literature review) were avoided. There is a sense that in using English, the participants' voices were retained and not modified by an interpreter. However, it is not clear if participants were able to fully express themselves and so for this reason further research by a Basotho research team would be interesting and valuable.

Greater exploration of the role that coping independently played would be valuable as doctors reported a range of strategies with differing levels of success. There seemed to be more heterogeneity in this theme than the others, suggesting that there is much more we need to understand regarding this area. Self-care, a part of independent coping, is a broad area, often used in relation to chronic illness management, it is defined as caring for oneself when ill or engaging in positive behaviours to prevent illness (Riegel et al., 2021). Riegel et al. discuss the complexity of self-care due to the wide variety of factors affecting a person's engagement in it, and whilst there are broad universal elements of self-care, they acknowledge that cultural factors influence the specifics. Future research could investigate the different cultural

factors and self-care strategies in relation to workplace wellbeing to gain a deeper understanding of the mechanisms at play. Indeed, Riegel et al. also advocate for further research into cultural norms and their link to wellbeing.

Implications for Practice

Literature Review

Whilst the literature review does not have any direct implications for clinical practice, it is assumed that more rigorous research would have a positive impact on clinical practice. Therefore, as the literature review does have implications for research practice, this will be the focus of this section. Findings from the literature review have direct implications for how intercultural, qualitative researchers in the field of health engage with the research and interview process. The findings did not have any unique relationship to the field of health, and therefore, it is likely that they will also be of use in guiding researchers in other fields.

One of the main findings is that the inclusion of cultural experts (whether they are other researchers, interpreters, or local members of the community) throughout the research process can help overcome some of the cultural, practical and linguistic challenges of conducting intercultural qualitative research. However, as the findings also demonstrated, working in multicultural research teams provides challenges of its

own. Community-engaged research approaches such as community-based participatory research involve members of the community as equal members of the research team throughout the process (Holkup et al., 2004) with the view that doing so will increase the relevancy and impact of the research conducted (Graham et al., 2019). The results from the current systematic review suggest that approaches such as this could be adopted more frequently to overcome some of the challenges of intercultural qualitative research. However, despite a growing interest in this approach, it is still relatively under-utilised (Graham et al., 2019) and investment into resources, and training community members and researchers is needed (Han et al., 2021).

Considering my empirical research, one of the changes I would make in hindsight, given the results of the literature review, would be to involve the cultural consultant at an earlier stage of the research. The cultural consultant was involved from the design of the interview guide onwards. However, it is likely that it would have been beneficial for her to be involved at the study design stage. Perhaps this would have led to a different methodological approach or changed some of the practical elements of my research. In particular, I am aware that my decision to conduct one-to-one, qualitative interviews was not guided by any culturally relevant factors. Whilst this did not appear to be problematic, it is possible that a different approach would have been more culturally appropriate.

Reflexivity and reflection were also identified as solutions to a number of the challenges identified in the literature review. Whilst reflexivity and reflection are already encouraged in qualitative research, the breadth of these requires expanding when conducting intercultural research. Specifically, bilingual researchers should be reflexive regarding their degrees of insider and outsider statuses, recognising the differences despite their shared languages. Interpreters should be encouraged to engage reflexively with their work, acknowledging the impact they have on the research and translation process. Additionally, power issues require reflection and reflexivity in order to manage them appropriately and sensitively. In my own research, I reflected that the use of English as the interview language and Western methodologies carries with it the history of colonialism and the power imbalances this brought. Throughout the research process, anxieties regarding power and colonialism arose, from concerns that participants would feel obliged to participate due to status differences, to a hesitancy to include comparisons between the UK and Lesotho in the finalised article (for example, in the introduction of the empirical paper I compare the number of doctors in Lesotho to the number in the UK).

Empirical Paper

The qualitative and exploratory nature of the empirical study does not enable it to make precise claims regarding the implications for clinical practice. Therefore, the following is based upon the results, but requires further investigation before it can be recommended with confidence.

The lack of support for doctors found in the empirical study suggests that infrastructure, policies and practices need to be developed to ensure that doctors feel better supported in their roles, particularly when faced with healthcare challenges. Increased financial investment into the healthcare system could help provide safer, better resourced, work environments and thus mitigate some of the practical challenges faced by doctors in the empirical study. This in turn may help to increase the sense of being valued and appreciated at work, and decrease moral injury as doctors would be better resourced to provide safe, effective healthcare.

Improved communications between healthcare staff and government officials could also provide an increased sense of support for doctors and improve the effectiveness and efficiency of the healthcare system. Hyland-Wood et al. (2021) discuss the importance of communication in relation to the management of the COVID-19 pandemic, not specifically in relation to government-healthcare systems communication, but about public health communication. However, aspects of their

argument could provide useful for communication with healthcare workers specifically. One of their points is that communication has to be bidirectional to lead to effective outcomes, with another being that governments should communicate with empathy. Doctors in the current empirical study felt that they were not being listened to or valued, instead, feeling that they had to force the government to listen. Lesotho's government could develop strategies to better collect, understand and empathise with healthcare staff's perspectives. Some of the doctors in the research mentioned the creation of a healthcare professionals association which gave them a collective voice to communicate with the government. Lesotho's government could continue to engage with this association and develop a stronger relationship with its healthcare workforce to improve communication and outcomes. Doing so could support the doctors to feel more valued and appreciated.

Finally, empirical study advocates for the provision of wellbeing resources for healthcare staff. This could involve training in mental health awareness and self-care for all healthcare staff, or as some participants of this study suggested, the availability of psychologically trained professionals to support healthcare staff in maintaining their wellbeing. One of the participants also mentioned online support received from a Clinical Psychologist in Wales as part of a Lesotho-Wales staff wellbeing support programme. The development of a staff wellbeing support programme in Lesotho

could help meet healthcare staff's needs, but exploration into the specifics of what this programme would involve and its appropriateness for this group of professionals, would be needed. Furthermore, interventions aiming to improve staff wellbeing occur across the globe, for example Blake et al. (2013) and Rosa et al. (2021). Lesotho could learn from these interventions adapting them to suit the local context, however further research is required in order to better understand how doctors in Lesotho can be best supported.

Personal Reflection

In addition to the reflections incorporated in the above sections, I also want to share some final reflections. I have been curious about other cultures for as long as I can remember, and consider myself to be an open, adaptable and accepting individual. However, from conducting this research and adopting a social constructionist stance, I feel I have a new depth of understanding, or maybe just questioning, when it comes to working with other cultures. This process has illuminated how culture can, and does, shape concepts and that we can easily make assumptions that a certain concept or perspective is shared or is the right way to view the world. At the start of the project, I was aware that I needed to consider factors such as my use of verbal language and body language, as parts of these may have different meanings to the Basotho people.

However, I am now questioning the use of research methods and psychological theories, their application across cultures, which at times is inappropriate. Academic literature has already made a start in addressing these concerns, developing more culturally appropriate research methodologies, involving community members in the research process, increasing awareness of culturally diverse theories and worldviews. In doing so it not only serves to avoid using potentially inappropriate Western concepts, but also to honour and value practices in non-Western cultures. For example, Laverack & Brown (2003) in their research in Fiji, incorporated important aspects of Fijian culture into their data collection; they made time for the formal ceremonies that start and end group meetings, and they arranged seating in line with traditional Fijian seating plans. These reflections have implications for my clinical practice too, with an increased desire to question whether the clinical practices and interventions I engage with are acceptable and appropriate for the diverse UK population.

It was an absolute honour and privilege to have the opportunity to travel to Lesotho and speak to the doctors there about their experiences during the COVID-19 pandemic. Due to my outsider status, I was not sure how easy it would be to recruit participants, but I was pleasantly surprised and found that it was not a problem at all. However, flexibility has been a key aspect of the participant recruitment and interview process. Prior to travelling to Lesotho, I had made email contact with a number of

senior medical professionals to ask for their support in participant recruitment, but over email it was difficult to ascertain how prepared individuals were to support me with my project. Even in the days leading up to travelling to Lesotho my schedule for my time there was looking fairly empty. This created some anxiety, but my previous experience in Africa has taught me that this is not necessarily something to be concerned about, and thankfully this proved to be true. Once in Lesotho meetings began to be scheduled and I travelled round meeting with senior medical professionals. Meetings were often arranged only a day or two in advance, with vague agreements on time; a very different way to working than in the UK, but one that I appreciated given my lack of knowledge regarding how long it would take to travel to places. Similarly, interviews with participants were often scheduled last minute meaning at the start of each day I did not know whether I would be interviewing anyone or no one. Working around the doctors' availabilities was essential, sometimes meaning that I spent the whole day not interviewing anyone, and then in the late afternoon two participants would be available. Working flexibly and having faith that the absence of clear plans does not mean interviews will not happen, prevented this experience from being stressful.

During interviews, doctors opened up about their personal and professional difficulties during the pandemic. I am touched by the emotion and vulnerability that

these doctors were willing to share with me, despite barely knowing me. This has meant that throughout the data analysis and write-up process I have wanted to do my best to respect and authentically represent the voices of the participants. At times it slowed me down greatly as I agonised over interpreting the data and questioning my own abilities. I had never conducted interpretative phenomenological analysis before and finding the balance between interpreting the data and staying true to the participants' words was a process I found overwhelming at times.

One particular challenge in relation to interpretation was making decisions regarding how much to analyse the language being used by participants. English is used differently across the world, and a word that seemed atypical to me as a British English speaker may have been common in Lesotho when speaking English, or perhaps reflects a word translated from Sesotho. To overcome this, when analysing language use, I focused on words which seemed uncommon to that particular participant and/or across all the participants. For example, the word 'demise' was frequently used in places where I would have said 'die', however, this was used consistently within and across interviews and was therefore not analysed as a significant word. I made a conscious effort to analyse and interpret aspects of language, not because they stood out to me as a white Westerner, but because they stood out within the context of the

interview. This was a challenge and the support from my supervisors was invaluable in progressing through this.

Overall, undertaking this research has taught me about the depth of the complexities of working with people from other cultures. It has implications for future research and my own clinical practice. Despite the challenges though, I hope the doctors feel that I have done them justice in the interpretations I have made.

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Appendices

Appendix A

Definitions of Culture as Illustrated in Jahoda (2012)

Hong (2009) defines:

... culture as *networks of knowledge* consisting of learned routines of thinking, feeling, and interacting with other people, as well as a corpus of substantive assertions and ideas about aspects of the world ... it is ... shared ... , among a collection of interconnected individuals who are often demarcated by race, ethnicity, or nationality; (b) externalised by rich symbols, artefacts, social constructions, and social institutions (e.g. cultural icons, advertisements and news media); (c) used to form the common ground for communication among members; (d) transmitted from one generation to the next ... ; (e) undergoing continuous modifications ... (Hong, 2009, p. 4)

Triandis (1996) defines a cultural syndrome as:

... a pattern of shared attitudes, beliefs, categorizations, self-definitions, norms, role definitions, and values that is organized around a theme that can be identified among those who speak a particular language, during a specific historical period, and in a definable geographic region. (Triandis, 1996, p. 408)

Appendix B

Search Terms for Each Database Searched

Resource Searched	Search Terms	Limiters/Filters (e.g. date, language, type of material, subject)
CINAHL Plus with Full Text	Tx(challeng* OR problem* OR difficult* OR issue* OR integrity OR rigor OR rigour OR quality OR solution* OR resolution* OR "lesson* learned" OR barrier* OR improv* OR guideline*) AND Ab ((cross-cultural OR crosscultural OR cultur* OR international OR cross-national OR crossnational OR "cross national" OR immigrant* OR intercultural OR inter-cultural OR language) N5 (qualitative OR "focus group*" OR interview* OR ethnograph* OR "thematic analysis" OR "discourse analysis" OR "grounded theory" OR "narrative analysis" OR "phenomenological analysis" OR "interpretive phenomenological analysis")) AND Ab(health* OR mental* OR illness* OR "ill health" OR medic* OR disease* OR "physical condition*" OR "chronic condition*" OR symptom* OR diagnos?s OR psychiatr* OR psycho* OR nurs* OR doctor*) AND Tx(researcher* OR research team* OR conduct*)	<ul style="list-style-type: none"> English Jan 2003- March 2023 Peer Reviewed
ASSIA	All text(challeng* OR problem* OR difficult* OR issue* OR integrity OR rigor OR rigour OR quality OR solution* OR resolution* OR "lesson* learned" OR barrier* OR improv* OR guideline*) AND abstract((cross-cultural OR crosscultural OR cultur* OR international OR cross-national OR crossnational	<ul style="list-style-type: none"> English Published after 31.12.02 Peer Reviewed

	OR "cross national" OR immigrant* OR intercultural OR inter-cultural OR language) NEAR/5 (qualitative OR "focus group*" OR interview* OR ethnograph* OR "thematic analysis" OR "discourse analysis" OR "grounded theory" OR "narrative analysis" OR "phenomenological analysis" OR "interpretive phenomenological analysis")) AND abstract(health* OR mental* OR illness* OR "ill health" OR medic* OR disease* OR "physical condition*" OR "chronic condition*" OR symptom* OR diagnos?s OR psychiatr* OR psycho* OR nurs* OR doctor*) AND all text(researcher* OR research team* OR conduct*)	<ul style="list-style-type: none"> • Dissertations and theses, scholarly journals and trade journals only • Exclude duplications
PubMed	(((challeng*[Title/Abstract] OR problem*[Title/Abstract] OR difficult*[Title/Abstract] OR issue*[Title/Abstract] OR integrity[Title/Abstract] OR rigor[Title/Abstract] OR rigour[Title/Abstract] OR quality[Title/Abstract] OR solution*[Title/Abstract] OR resolution*[Title/Abstract] OR "lesson learned"[Title/Abstract:~0] OR "lessons learned"[Title/Abstract:~0] OR barrier*[Title/Abstract] OR improv*[Title/Abstract] OR guideline*[Title/Abstract])) AND (cross-cultural[Title/Abstract] OR crosscultural[Title/Abstract] OR cultur*[Title/Abstract] OR international[Title/Abstract] OR cross-national[Title/Abstract] OR crossnational[Title/Abstract] OR "cross national"[Title/Abstract:~0] OR immigrant*[Title/Abstract] OR intercultural[Title/Abstract] OR inter-cultural[Title/Abstract] OR language[Title/Abstract])) AND ("qualitative research"[Title/Abstract:~2] OR "focus group"[Title/Abstract:~0] OR "focus	<ul style="list-style-type: none"> • English • Published on or after 01.01.03 • Limited to clinical trials, meta-analyses, RCTs and systematic reviews

	groups"[Title/Abstract:~0] OR interview*[Title/Abstract] OR ethnograph*[Title/Abstract] OR "thematic analysis"[Title/Abstract:~0] OR "discourse analysis"[Title/Abstract:~0] OR "grounded theory"[Title/Abstract:~0] OR "narrative analysis"[Title/Abstract:~0] OR "phenomenological analysis"[Title/Abstract:~0])) AND (health*[Title/Abstract] OR mental*[Title/Abstract] OR illness*[Title/Abstract] OR "ill health"[Title/Abstract:~0] OR medic*[Title/Abstract] OR disease*[Title/Abstract] OR "physical condition"[Title/Abstract:~0] OR "physical conditions"[Title/Abstract:~0] OR "chronic condition"[Title/Abstract:~0] OR "chronic conditions"[Title/Abstract:~0] OR symptom*[Title/Abstract] OR diagnos?s[Title/Abstract] OR psychiatr*[Title/Abstract] OR psycho*[Title/Abstract] OR nurs*[Title/Abstract] OR doctor*[Title/Abstract])) AND (researcher*[Title/Abstract] OR "research team"[Title/Abstract:~0] OR "research teams"[Title/Abstract:~0] OR conduct*[Title/Abstract])	
PsycINFO	(challeng* OR problem* OR difficult* OR issue* OR integrity OR rigor OR rigour OR quality OR solution* OR resolution* OR "lesson* learned" OR barrier* OR improv* OR guideline*) AND abstract((cross-cultural OR crosscultural OR cultur* OR international OR cross-national OR crossnational OR "cross national" OR immigrant* OR intercultural OR inter-cultural OR language) NEAR/5 (qualitative OR ("focus group" OR "focus groups") OR interview* OR ethnograph* OR "thematic analysis" OR "discourse analysis" OR "grounded theory" OR	<ul style="list-style-type: none"> • Search terms include: • English • Published after 31.12.02 • Peer Reviewed • Dissertations and theses, scholarly journals and

	"narrative analysis" OR "phenomenological analysis" OR "interpretive phenomenological analysis")) AND abstract(health* OR mental* OR illness* OR "ill health" OR medic* OR disease* OR ("physical conditioning" OR "physical conditions") OR ("chronic condition" OR "chronic conditions") OR symptom* OR diagnos?s OR psychiatr* OR psycho* OR nurs* OR doctor*) AND (researcher* OR research team* OR conduct*) AND stype.exact("Trade Journals" OR "Scholarly Journals" OR "Dissertations & Theses") AND la.exact("English") AND PEER(yes)	trade journals only
Web of Science Core Collection, all editions (A&HCI , ESCI , CPCI-SSH , CPCI-S , SCI-EXPANDED , SSCI)	((AB=(challeng* OR problem* OR difficult* OR issue* OR integrity OR rigor OR rigour OR quality OR solution* OR resolution* OR "lesson* learned" OR barrier* OR improv* OR guideline*)) AND AB=((cross-cultural OR crosscultural OR cultur* OR international OR cross-national OR crossnational OR "cross national" OR immigrant* OR intercultural OR inter-cultural OR language) NEAR/5 (qualitative OR "focus group*" OR interview* OR ethnograph* OR "thematic analysis" OR "discourse analysis" OR "grounded theory" OR "narrative analysis" OR "phenomenological analysis" OR "interpretive phenomenological analysis"))) AND AB=(health* OR mental* OR illness* OR "ill health" OR medic* OR disease* OR "physical condition*" OR "chronic condition*" OR symptom* OR diagnos?s OR psychiatr* OR psycho* OR nurs* OR doctor*)) AND ALL=(researcher* OR research team* OR conduct*)	<ul style="list-style-type: none"> • English • 1st January 2003-21st March 2023 • Citation topics were all minus those which were obviously not related to this topic e.g. agriculture, transportation topics

Appendix C

Quality Appraisal Checklist for the Reflective-Discussion Papers

This checklist was created from amalgamating and adapting the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015) and the JBI Critical Appraisal Checklist for Text and Opinion Papers (McArthur et al., 2015).

Reviewer.....

Author.....

Year.....

	Yes	No	Unclear	Not applicable
1. Is the source of the reflection clearly identified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the source of the reflection have experience in the topic being reflected upon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a statement locating the author/reflector culturally or theoretically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are the interests of the relevant population the central focus of the reflection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the stated position the result of a structured reflective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

process, and is there logic in the reflection expressed?

6. Do the conclusions drawn flow from the reflective process? ☐ ☐ ☐ ☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (including reason for exclusion)

Appendix D

Information Sheet for Participants in Empirical Study

Ethics System Reference Number: 17164

IRAS Reference Number (if applicable): N/A

How Do Medical Staff in Lesotho Understand and Manage their Wellbeing in the Context of Covid-19? A Qualitative Analysis

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and how it would involve you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you would like more information.

Please take your time to decide.

The Project

This project aims to understand how healthcare staff in Lesotho make sense of and manage their wellbeing.

The covid-19 pandemic has been difficult for many people. Research shows that healthcare staff have poor wellbeing and that covid-19 may have made this worse (de Brier et al., 2020; Gualano et al., 2021). Most of this research has been done in Western countries. Research shows that stress is experienced differently in different cultures (Denby et al., 2015) and that different cultures use different coping strategies (Chai et al., 2012; Shavitt et al., 2016; Shelley et al., 2007). There is not much research on people's experiences of managing their wellbeing in African countries.

This project wants to understand how covid-19 has affected healthcare staff in Lesotho. This project also wants to understand what healthcare staff do to cope with emotional difficulties, whether support that has been offered is helpful and, if further support is needed.

The main research questions are:

How do nurses and doctors in Lesotho experience their wellbeing in the context of covid-19?

How do nurses and doctors in Lesotho manage their wellbeing in the context of covid-19?

Why have I been asked to take part?

You are a nurse or doctor who currently works in Lesotho and was working here during the covid-19 pandemic.

What does the study involve?

The study involves one semi-structured interview; this will be audio-recorded and last up to 2 hours. A semi-structured interview means we can have a relaxed conversation and you can talk about the things you feel are most important.

The interview will also involve a set of demographic questions about your gender, job role etc.

All questions are optional; you would not have to answer anything you did not want to.

Interviews will take place in a location convenient to you, most likely in your workplace or nearby. Refreshments will be available, and you will be offered a payment of 400 maloti for your time. Everyone who attends the interview will be offered the refreshments and payment. The offer of refreshments and payment does not mean you have to answer all of the questions or stay for two hours.

What are the benefits of taking part in this study?

The study will be submitted to a professional journal, so you will be contributing to scientific literature and cross-cultural understanding. Taking part in this research will help us gain a better understanding of how wellbeing and emotional difficulties are experienced in Lesotho, what coping strategies might be helpful and what coping strategies might not be helpful. This could be helpful in developing support for medical staff in Lesotho and, it could provide valuable insights for health staff in other parts of the world.

Taking part in this study may help you to understand yourself more. It may help you to think about what it is like for you when you experience situations like Covid-19 and help you to recognise how you manage your wellbeing during potentially difficult work situations. It may help you to recognise what you can do to manage your wellbeing and some of the things you or others do which aren't helpful.

What are the possible risks?

This study has very few risks. However, some people may feel upset or distressed by talking about difficult experiences. The interviewer is a trainee Clinical Psychologist and will help you to manage these emotions in the session and find places you can get extra support from after the interview (if you want and need it).

What will happen to my data?

Your data (full transcripts and full analysis of your data) will be confidential and stored electronically in a secure way for 10 years. Bangor University is the data controller. Results (including verbatim quotes from your interview) will be published in the researcher's thesis for her Doctorate in Clinical Psychology. Every effort will be made to ensure that no individuals are identifiable in any publication which arises from this study. Data will be anonymised by using codes in the written data, pseudonyms in publications and, removing identifiable information from the data (for example, place names). Interview recordings will be erased after transcription is complete.

You have the right to withdraw and to request that your data is not used. This can be done by contacting the researcher (see below for contact information). You can withdraw at any time before data is anonymised. This means you can withdraw any time up until 1st January 2023.

Who is organising the research?

Bangor University is organising and funding the research, with logistical support from Dolen Cymru (a charity working in partnership with professionals in Wales and Lesotho).

What if I don't want to take part?

It is up to you to decide whether or not you would like to participate in this study. Deciding not to take part will not impact any other aspect of your employment, training or your relationship with Dolen Cymru.

Who do I contact about the study?

Name: Laura Holdsworth

Postal address:

North Wales Clinical Psychology Programme
Brigantia Building

Penrallt Road
Bangor
Wales, UK
LL57 2AS
Telephone: 00 44 (0) 1248 388365

Email: lrh20hsz@bangor.ac.uk

If you have any concerns or complaints about this study, or the conduct of individuals conducting this study, then please contact Huw Roberts (College Manager)

College of Human Sciences,
Bangor University,
Bangor,
Gwynedd
LL57 2AS
or e-mail huw.robertsbangor.ac.uk.

Appendix E

Semi-Structured Interview Guide

The main questions are numbered, with the primary follow-up questions below in boldface and then additional follow-up questions in roman typeface.

Introduction (either at start of interview or an earlier time)

- Thank them for their interest in participating in the research and offer refreshments.
- Re-introduce self, my role and that this research forms part of my doctorate in clinical psychology at Bangor University, UK.
- [Provide participant information sheet]
 - Check that they have previously received a copy and that they read through it.
 - Recap that this research is about understanding medical staff's experiences of working during COVID-19 with a focus on their wellbeing. Explain I want to hear about how they make sense of their wellbeing during this time and how they coped.
 - Remind them that I will ask some questions about their gender, job role etc., but that most of the time will be spent having a relaxed conversation about the things that are important to them.
 - They don't have to answer any questions they don't want to. They should tell me if they are finding a topic too difficult to talk about and we will change the topic or end the interview. I will try to help them through their difficulties and we will explore other forms of support if needed.
 - Check that they are available for up to two hours for the interview.
 - Remind them that they will be offered £10 (put in equivalent in local currency) but this doesn't mean they have to answer all of the questions.
 - Remind participants that the interview will be audio-recorded.

- Remind them that they can withdraw at any point, for any reason, during the interview or up until the 1st January 2023.
- Ask if they have any questions
- [Provide consent form x2]
 - Ask participant to read through, ask any questions and sign.

Interview

[start recording]

- Obtain verbal consent to participate and remind of right to withdraw.

1. Can you tell me about your job before the pandemic?

Possible prompts:

- **Where do you work – is it rural or in a city, hospital or clinic?**
- **What do you do in your job?**
- **What is the structure of the team around you?**
- What sort of patients/problems/illnesses do you work with?
- How many patients do you see a day – how do you feel about that?
- What are the hours like – how do you feel about that?
- **How do you feel about your work?**

2. What is your job like now and how has it changed during the COVID-19 pandemic?

Possible prompts:

- Have your hours of work changed or the number of patients you see?
- How have the tasks that you do in work changed?
- **What are the main differences between what your job has been like during the pandemic and how it was before the pandemic?**
- **How do you feel about any changes to your work that have happened because of COVID-19?**

3. What does the word “wellbeing” mean to you?

Possible prompts:

- How would you describe it?
- **Do your emotions, thoughts or your mind have anything to do with “wellbeing”? Can you tell me more about that?**

- **Are there other similar words you might use in Sesotho and/or in a different language?**
 - **Is there a word you would prefer to use?**
 - What are the similarities and differences between the meaning of these words?
4. Is it okay if we talk about your wellbeing at work now? How has working during COVID-19 impacted your wellbeing? (*remember to look for positive and negative impact or no impact*)

Possible prompts:

- What do you notice has (not) changed?
- **How have your thoughts or emotions changed? Sleep? Appetite?**
- **Have you noticed any fears/concerns/worries/depression/anxiety/stress/uncomfortable thoughts/times you felt threatened? Any positive emotions or thoughts like feeling strong, or close to people you love?**
- How have you coped with working over the pandemic?
- Can you tell me about what your wellbeing was like when COVID-19 first started affecting your work? How does that compare to other times during the pandemic?
- Can you tell me about how your wellbeing has changed over the course of the pandemic?
- **What tells you that your wellbeing has (not) changed?**
- **What are the main differences between times when your wellbeing has been good and times when it has not?**
- What things have affected you the most during the pandemic?
- Is it okay if I ask about other people in your life? What role have your family/friends/colleagues had in affecting your wellbeing over the pandemic? What was it like to experience that from/with them? How do you think your wellbeing would be without them in your life?
- What role have you had in affecting your wellbeing over the pandemic?
- Are there any things in your work which affect your wellbeing and feel out of your control?
- Are there any other factors which have affected your wellbeing?
- Have certain things affected you more or less at different times during the pandemic? Why do you think this is the case?

- **Have there been times where your wellbeing has been badly affected? What was it about these times that made it so difficult? What role did work have in affecting your wellbeing?**
- **Have there been times where your wellbeing has been good over the pandemic? What was it about these times that meant your wellbeing was maintained?**
- **What are the main differences between your wellbeing now and how it was before the pandemic?**
- What has it been like for you to have felt this way/noticed these changes in yourself?
- What do you think your friends/family/colleagues think about how your wellbeing has been over the pandemic? What do you think your colleagues would say about these changes in yourself? What about your friends and family?
- How do you think your wellbeing over the pandemic compares to that of your colleagues/bosses/subordinates?

4a. Would you be able to tell me about a time at work, during the pandemic, that was particularly difficult for you?

Possible prompts:

- **Can you tell me about any of the things in your life/work which have negatively affected your wellbeing during COVID-19? How have these things negatively affected you? How much have these things made a difference to your life?**
- What was this like for you?
- How did it affect you?
- How did it feel to experience that?
- What happened in the run up to this event?
- What happened after it?
- **Can you tell me about anything you did to help cope with the situation and how you were feeling?**
- **Did other people do anything that helped manage the situation or helped you with how you were feeling?**
- **Was there anything at work which helped you to cope?**
- **Was there anything the government did which helped you to cope?**

- What is the attitude towards wellbeing like in Lesotho? How does that affect your wellbeing and how you cope?
- How does it feel thinking back on it now?
- Does it still affect you now – if so how?
- Does this experience feel similar to other times you have experienced difficulties during the pandemic?
- How do you think it compares to what your colleagues have experienced? – (follow up – and why do you think that is?)

4b. Would you be able to tell me about a time at work, during the pandemic, where your wellbeing was good?

Possible prompts:

- **Can you tell me about any of the things in your life/work which have helped your wellbeing during COVID-19? How have these things helped? How much have these things made a difference to your life?**
 - What was this like for you?
 - What was happening around you at this time?
 - What factors meant that this was a more positive time at work for you?
 - **What role did you have in maintaining your wellbeing during this time?**
 - **What role did other people have in maintaining your wellbeing during this time?**
 - **What role did work have in maintaining your wellbeing at this time?**
 - Are there any other factors which affected your wellbeing during this time?
5. Could you tell me about things that would have helped your wellbeing at work, but weren't available to you?

Possible prompts:

- Are you aware of any resources or forms of support that aren't available where you work but are elsewhere?
- How do you like to access support for wellbeing? Was this available to you? How could it have been improved?
- How could your bosses have changed things to make them better for you?
- How could your colleagues have changed things to make them better for you?
- How could you have changed things to make them better for you?

- How do you think the partnership working between Lesotho and Wales could have better helped your wellbeing at work?
 - **If you could have changed anything at work to help your wellbeing what would it be?**
 - **If you could ask for anything to help with your wellbeing at work, what would you ask for?**
6. How does it feel to sit here and think about how your wellbeing has been over the pandemic?
- Possible prompts:*
- Can you reflect on what it means to you to have had this experience?
 - Do you think it has added/taken away anything from your life?
 - **How does your experience of your wellbeing (not) being affected by the pandemic fit with what you know about yourself? Or other experiences you have had?**
7. Is there anything we have not discussed today that you think it would be helpful for me to know?

Demographic questions:

1. Job title
2. Age or age range.
3. How would you describe your gender?
4. How long have you worked in your profession?
5. Did you train through the FMSTP? If so, when?
 - 4a. Did you receive any training on compassionate leadership?
6. Have you accessed any of the wellbeing resources on the padlet?
7. Did you use the staff wellbeing support service where you could have video conversations with a psychologist in Wales?

[stop recording]

Debrief

- Thank them for participating and making a contribution to our understanding of what it has been like for medical staff to work during the COVID-19 pandemic.
- Check if they feel okay and if they feel like they need any further support. Signpost to local resources as required.

- Explain that I will be using a qualitative methodology called interpretative phenomenological analysis which looks at how people make sense of and understand experiences in their lives.
- To help make sure that my research is culturally appropriate a sample of my analysis will be shared with Dr Kambulandu (a doctor based in Maseru, who will be soon be working in public health and with NGOs in Lesotho). She will be provided with anonymous extracts from some interviews and my analysis of these extracts. She will not be given any information about the name, job title or location of the participant. She has agreed not to share any of the information she receives, she will keep everything confidential. Do you want to opt out of part of your interview being shared with Dr Kambulandu?
- Ask them if they want to review the results (including the verbatim quotes) before publication [take down email address/contact details].
- Ask if they would like to receive a copy of the final report [take down email address/contact details].
- Ask if they know anyone else who might be interested in taking part and ask them to share my information with these people.
[put all details into the excel spreadsheet]

Appendix F

Consent Form for Participants in Empirical Study

How Do Medical Staff in Lesotho Understand and Manage their Wellbeing in the Context of Covid-19? A Qualitative Analysis

Name and Contact Details of Researcher(s): Laura Holdsworth

Postal address:

North Wales Clinical Psychology Programme
Brigantia Building
Penrallt Road
Bangor
Wales, UK
LL57 2AS

Telephone: 00 44 (0) 1248 388365

Email: lrh20hsz@bangor.ac.uk

Ethics System Reference Number: 17164

IRAS Reference Number (if applicable): N/A

Please read the following statements and write your initials in the boxes provided.

I confirm that I have read and understood the Participation Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I have been given a copy of this form and the Participation Information Sheet.	
I understand that my participation is voluntary and that I am free to withdraw at any time prior to data anonymisation.	

I understand that the interview will be audio recorded for use by the study team only (my recording will not be shared with others and will be destroyed after the data has been transcribed and anonymised).	
I understand that verbatim quotes will be used in publications; I will not be named and I understand that every effort will be made to protect my identity.	
I agree to take part in the above study.	

Name of Participant:

Date:

Signature:

Name of Person taking Consent:

Date:

Signature:

Note: When completed, one copy to be given to the participant, one copy to be retained in the study file

Appendix G

Research Protocol Reviewed by Bangor University Research Ethics Committee

Brief background to the study

Further details: Lesotho has a low resourced healthcare system serving a population with high health needs. Anecdotal reports indicate that healthcare staff in Lesotho find this a challenging and stressful environment to work in. Furthermore, research indicates that covid-19 has potentially decreased staff wellbeing in health settings. However, very little research has been conducted in non-WEIRD (Western, Educated, Industrialised, Rich and Democratic) countries. It is important to consider culture in relation to how stress is experienced and what helps alleviate it. Research into this area in non-WEIRD cultures is minimal. If effective psychological support for stress (and mental health problems more broadly) in non-WEIRD cultures is to be developed, then further research into how these cultures experience and cope with stress is required.

The hypotheses

Further details: N/A. However the main research question is "How do nurses and doctors in Lesotho experience and cope with stress in the context of covid-19?". Sub-questions include: • Do nurses and doctors in Lesotho make sense of stress in a way

that is comparable with WEIRD understandings of stress? • What are the similarities and differences between nurses' and doctors' experiences of stress and what WEIRD research says? • What coping strategies do the nurses and doctors use? • How helpful are these coping strategies? • What do the nurses and doctors think of input from WEIRD countries in relation to stress management and wellbeing? (what are their thoughts on the staff wellbeing support programme which was run by Psychologists in Wales, regardless of whether they participated or not? What are their thoughts on the compassionate leadership training? What are their thoughts on the wellbeing posters, information and videos on their online platform? Do Western methods of support work for them e.g. sitting in a room talking to someone, doing independent mindfulness or breathing exercises, or is there something more culturally appropriate e.g. getting out and doing something as a community?) • What are the nurses' and doctors' experiences of engaging in collaborative wellbeing projects between Lesotho and Western countries? How is this collaborative work perceived? Is it helpful? What are their experiences of intercultural working? • What input/support, if any, would the nurses and doctors want from a Western-Lesotho partnership? How can current practices be improved? What has been helpful and unhelpful so far?

Participants: recruitment methods, age, gender, exclusion/inclusion criteria

Further details: Nurses and doctors working in Lesotho. Access to participants will be gained through Dolen Cymru, a charity involved in the Family Medicine Speciality Training Programme (FMSTP) in Lesotho. Around 16-20 registrars have been involved in the training programme and purposive, opportunity sampling will be used to recruit from this pool of people, with a focus on those currently working in and around the Leribe area. Utilising a snowballing sampling method registrars' colleagues would also be reached, increasing the sampling pool to nurses and other doctors in the hospital and primary care clinics. Should it be difficult to recruit sufficient numbers of participants from the local area, registrars in the wider area would be approached. In order to aid recruitment, multiple contacts with potential participants will be made to build a relationship with them and increase their awareness of the research, trust in the trainee and willingness to be open and honest. A potential recruitment method, which would involve this, is as follows:

- Trainee to talk to Dolen Cymru's "man on the ground"/in-country contact and build a relationship with him. To also explore who to contact in the hospitals and clinics to start building relationships with them.
- Trainee to talk to the director of FMSTP and build a relationship with him. To also explore who to contact in the hospitals and clinics to start building relationships with them.

Can the trainee send out a group Whatsapp to all FMSTP registrars to ask for expressions of

interest in the research? Is there someone who would want to get involved in the research and help with recruitment and cultural sensitivity in the project (payment for them)?

- The trainee to attend (remotely) one of the FMSTP training sessions to introduce herself, give out information about the research and ask for expressions of interest. During this, the trainee can make clear the research involves a one-time interview which they will get payment for.
- Trainee to attend any further online sessions which Dolen Cymru are involved in, in order to further build relationships and the association between the trainee (an unknown person) and Dolen Cymru (an organisation with which the registrars are familiar).
- Trainee to attend another training session (remotely) to remind people of the research and how to get involved, answer any questions they have.
- Trainee to make 1:1 contact with people who have expressed an interest – Whatsapp calls to build a relationship, explain the research in more detail, see if they know anyone else who might be interested in participating, answer any questions, gain consent and arrange an interview.
- Trainee to go to Lesotho and spend the first day or two meeting the staff and relevant people, see where they work and the type of work they do, participate in opportunities that arise to socialise with them outside of work, continue to build up relationships and recruit any final participants.

Age: Above 18 years old. Gender: Any Inclusion criteria: Participants must be a doctor or nurse currently working in Lesotho (in the Leribe area)

and have been working in their profession during the covid-19 pandemic. Participants must have experienced stress at some point during the covid-19 pandemic and be willing to talk about this. Exclusion criteria: Anyone with a current/ongoing serious mental health problem whereby participation in the research could cause increased distress.

Research design

Further details: This study will utilise a qualitative design, specifically interpretative phenomenological analysis (IPA).

Procedures employed

Further details: All identifying information will be changed to maintain anonymity. Participants will be asked a number of optional demographic questions as part of the interview. The interview will be semi-structured in nature allowing for exploration of the research questions alongside in-depth exploration of the participants' personal experiences. Should it be possible to recruit someone from Lesotho to aid in the study design, then the questions selected for the interview will be checked with them for cultural appropriateness. Furthermore, they will be encouraged to make suggestions regarding additional helpful questions and other cultural considerations regarding how,

when and where the interviews will take place (for example, whether there are certain verbal or non-verbal cues which would be inappropriate and what setting may help participants feel most at ease).

Measures employed

Further details: None

Qualifications of the investigators to use the measures (Where working with children or vulnerable adults, please include information on investigators' CRB disclosures here.)

Further details: N/A

Venue for investigation

Further details: To be confirmed. This is likely to be either a room within the clinic/hospital in which the participant works or an alternative, private venue.

Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).

Further details: It is anticipated that recruitment will start in July and interviews will take place during a trip to Lesotho in October. No further data will be collected after this time.

Data analysis

Further details: Analysis will be done using interpretative phenomenological analysis (IPA) approach. Multiple readings of the data will allow for identification of initial themes. Main themes will then be chosen based upon their importance and representativeness of the data. Reflective practice via discussions in supervision and the use of a reflective log will aid the analysis and maintain validity within the study. Should it be possible to recruit someone from Lesotho to aid in the study design and data analysis, then codings and themes would be reviewed with them to support cultural sensitivity. This would most likely take the form of the individual from Lesotho checking a sub-sample of codings and themes, and providing their feedback on these.

Potential offence/distress to participants

Further details: Participants will be asked about stressful experiences/times in their lives. Recollection of these events could cause psychological distress or discomfort. The interviewer is a trainee Clinical Psychologist and will use her skills to manage this

situation within the interview. Participants who experience distress will be signposted to local resources/organisations to support them.

Procedures to ensure confidentiality and data protection

Further details: Recordings will be stored on an encrypted data stick and transferred onto the University's OneDrive as soon as possible. Recordings will be password protected and file names will not contain any identifiable information. Written data will be stored in an anonymised format (codes rather than participants' names/other identifiable information) and password protected.

***How consent is to be obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036)**

Further details: Necessary information will be provided to ensure that consent provided is informed consent. This will include essential information as detailed in the BPS Code of Human Research Ethics, such as the purpose and nature of the research, that participation is voluntary, who the main investigator is and how participants' data will be used. Written consent will be gained in English. At the start of the interview

participants will confirm that they have been given the appropriate information, give their verbal consent and be reminded of their right to withdraw.

Information for participants (provide actual consent forms and information sheets) including if appropriate, the summary of the study that will appear on SONA to inform participants about the study. N.B. This should be a brief factual description of the study and what participants will be required to do.

Further details: See attached consent forms and information sheets.

Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)

Further details: The director of the Family Medicine Specialty Training Programme has given his approval for the project. Advice will be sought from him regarding whether approval of other professionals is required (e.g. hospital/clinic managers and directors).

Payment to: participants, investigators, departments/institutions

Further details: Participants will be offered a payment equating to £10 per interview and a snack and drink at the interview. Should an individual from Lesotho become involved in the design and/or data analysis they will be paid for their work. It is estimated that this will be £10 for checking and consulting with trainee regarding

cultural appropriacy/sensitivity of interview questions. £30 for checking a sample of trainee's initial codes/emergent themes and providing feedback on this in relation to cultural appropriacy/sensitivity. £20 for checking a sample of the clustering of themes and providing feedback on this in relation to cultural appropriacy/sensitivity.

Equipment required and its availability

Further details: An encrypted audio recording device - the trainee has already been supplied with one by the university. Laptop - the trainee already has a personal laptop with access to university account and onedrive for secure data storage

If students will be engaged a project involving children, vulnerable adults, one of the neurology patient panels or the psychiatric patient panel, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

Further details: N/A

If students will be engaged in a project involving use of MRI or TMS, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

Further details: N/A

What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.

Further details: Participants will be given the option to receive a copy of the final article. The trainee will also offer to present her findings to the wider team in the form of a presentation and discussion. Dolen Cymru will be kept informed of the project's progress, offered a copy of the final article and for the trainee to present her findings to the team (this could include a discussion regarding what the research suggests as a way for Dolen Cymru to move forward with supporting healthcare staff in Lesotho).

Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.

Further details: No doubts

Appendix H

Research Protocol Reviewed by Lesotho's National Health Research Ethics Committee

1. Title

Experiences of Stress in Medical Staff in Lesotho in the Context of Covid-19: A
Qualitative Analysis

2. Authors and institutional affiliations

Status in the study	Name	Institutional/organizational affiliations
Principal Investigator (PI)	Dr Mike Jackson	Bangor University, UK
Co-Principal Investigator (CoPI)1	Laura Holdsworth	Bangor University, UK

2a. Are the CV/s attached with the protocol?

Y/N

3. Problem statement/ Reason for the study

Background

Lesotho: The country's healthcare system

The government spends 8.76% of its total expenditure on health, with 1.8% of its health budget spent on mental health (WHO, 2022). Whilst improvements to the healthcare system have been made, there are still large areas of unmet needs. Furthermore, the presence of appropriately trained healthcare staff is low. For example, WHO (2022) data indicates that there are only 4.73 medical doctors per 10,000 people (in 2018); compare this to the UK where there is 30.04 per 10,000 (in 2020). The overall picture in Lesotho is one of a low resourced healthcare system serving a population with high health needs, particularly in relation to communicable diseases. Anecdotal reports indicate that healthcare staff in Lesotho find this a challenging and stressful environment to work in.

The Impact of Covid-19 on Healthcare Staff

Across the globe, the covid-19 pandemic has increased pressure on healthcare systems, affecting their functioning/ability to deliver quality care (Haqqi et al., 2020; Khetrpal & Bhatia, 2020, Mohamed Abdel Shafi et al., 2020) and the wellbeing of staff (Lee, 2021; Sheehan et al., 2021).

Harris et al.'s (2021) qualitative study of 1379 frontline UK and Irish doctors found themes of feeling exposed, unprotected, overstretched and under-resourced, inhuman care, uncertainty, constant changes and others. Whilst Roberts et al. (2021) identified that 44.2% of the 5440 UK and Irish emergency, anaesthetic and intensive care department (ICD) doctors who completed the General Health Questionnaire-12 met criteria for "psychological distress".

Research has provided insight into some of the factors which are likely to be contributing to healthcare staff's distress. Lee (2021) reported staff experiences of social isolation and worry about the health of themselves, family and friends. van Hout et al.'s (2022) much larger survey of 2289 European healthcare staff found similar results, with 71% of respondents being concerned about becoming infected with covid-19 and 82% about their family becoming infected, as a result of their work.

The vast majority of this research has been conducted in Western, educated, industrialised, rich and democratic (WEIRD) countries, which represents only a small proportion of the people affected by this pandemic. Two studies were found which investigated the impact of covid-19 on medical staff in Sub-Saharan Africa. Afulani et al. (2021) conducted an online survey in Ghana. Their results indicated that staff's fear of infection was high and that they felt unprepared to

manage the pandemic. These factors were associated with stress and burnout in staff. Ali et al. (2021) administered questionnaires to 171 nurses in Nairobi. They found that almost 50% of respondents were experiencing depression, burnout and/or anxiety, with frontline nurses reporting more moderate to severe symptoms.

To conclude, staff wellbeing and mental health is a concern. It is unclear whether difficulties have increased due to covid-19 or if distress was already high. However, research indicates that there are covid-19 specific factors associated with poor staff wellbeing, for example concern about getting infected. Most research is conducted in WEIRD countries, which mean the vast majority of those affected by covid-19 are not adequately represented in research.

Culture and Stress

Stress, defined as “a state of mental or emotional strain or tension resulting from adverse or demanding circumstances” (Lexico.com, 2022) can affect physical and psychological wellbeing. However, experiences of stress and coping strategies appear to differ across cultures. This may be affected by how stress is conceptualised. For example, Weller et al. (2008) conducted interviews in Mexico about the Latin American folk illnesses of “susto” and “nervios”. Results indicated

that both have links to depression and stress, but are considered separate constructs. This may indicate that aspects of mental wellbeing are conceptualised differently in this culture. Differences in the causes and experiences of stress can also be seen in the research. Denby et al. (2015) investigated stress and strain in kinship caregivers of different ethnicities. Whilst caregivers had many of the same caregiver experiences, stress and strain were experienced differently.

Research has also investigated the helpfulness of different coping strategies across cultures in relation to stress, particularly that of social support. Shavitt et al. (2016) found that across different cultures within America, perceived stress was consistently negative correlated with physical and mental wellbeing. However, it was only Mexican Americans who benefited from social support as a stress management strategy. Pourmand et al. (2021) investigated differences in the impact of social support on stress and affection in participants from Singapore and the United States of America (US). They found that participants in Singapore experienced more stress following social support which focused on building their self-esteem compared to the US participants. In earlier research, Taylor et al. (2007) demonstrated that Asians and Asian Americans benefit more from implicit social support (experiencing comfort through knowing there is a support network available, without utilising this network for advice and emotional support) and

European Americans more from explicit social support (seeking and using advice and emotional support). These findings suggest that the type of social support received is important when considering its effectiveness as a coping strategy for stress across different cultures.

Beyond social support, other coping strategies also appear to differ across cultures. Chai et al. (2012) found that Asian university students were more likely to use religious coping strategies than European students, and that the use of these was effective in improving their psychological and social quality of life. Beagan et al. (2012) found that spirituality was an important coping strategy for racism-related stress in a sample of 50 African Nova Scotian women. Tweed et al. (2004) investigated the use of internally targeted control strategies for stress. They found that although these strategies were present in both East Asian and Western English-speaking participants, certain types were more prevalent in each of the different groups. Finally, Schultz and Weisæth (2015) conducted a case study on a former Ugandan child soldier who was participating in a local cleansing ritual. This ritual contained elements which were comparable to Western treatments for mental health, however they report that it was perhaps delivered in a more powerful way.

The research summarised here indicates the importance of considering culture in relation how stress is experienced and what helps alleviate it. The consequences of this are that different forms of support are likely to be more beneficial than others in different cultures. Furthermore, the use of local cultural practices and beliefs in stress management strategies may serve to enhance wellbeing in an effective or powerful way and should be considered in the implementation of psychological support across cultures. Unfortunately, cross-cultural research in this area is minimal and the evidence base continues to be dominated by outcomes from WEIRD cultures. If effective psychological support for stress (and mental health problems more broadly) in non-WEIRD cultures is to be developed then further research into how these cultures experience and cope with stress is required.

4. Research questions

The main research questions are:

- How do nurses and doctors in Lesotho experience stress in the context of covid-19?
- How do nurses and doctors in Lesotho cope with stress in the context of covid-19?

Sub-questions:

- Do nurses and doctors in Lesotho make sense of stress in a way that is comparable with WEIRD understandings of stress?
- What are the similarities and differences between nurses' and doctors' experiences of stress and what WEIRD research says?
- What coping strategies do the nurses and doctors use?
- How helpful are these coping strategies?
- What do the nurses and doctors think of input from WEIRD countries in relation to stress management and wellbeing? (what are their thoughts on the SWSS programme, regardless of whether they participated or not? What are their thoughts on the compassionate leadership training? What are their thoughts on the wellbeing posters, information and videos on their online platform? Do Western methods of support work for them e.g. sitting in a room talking to someone, doing independent mindfulness or breathing exercises, or is there something more culturally appropriate e.g. getting out and doing something as a community?)
- What are the nurses and doctors experiences of engaging in collaborative wellbeing projects between Lesotho and Western countries? How is this

collaborative work perceived? Is it helpful? What are their experiences of intercultural working?

- What input/support, if any, would the nurses and doctors want from a Western-Lesotho partnership? How can current practices be improved? What has been helpful and unhelpful so far?

These are the research questions it is hoped this research will address. Variations of these questions will appear in the semi-structured interview but will be adapted to meet the participants' needs and semi-structured nature of the interview.

5. Objective/s of the study

(a) To explore the experiences of workplace stress in nurses and doctors working in Lesotho, particularly during the covid-19 pandemic.

(b) To understand what coping strategies doctors and nurses in Lesotho already use, whether current support methods are helpful and what, if any, further support is required.

(c) To gain a richer understanding of the context in which participants are working and to make good use of the time in Lesotho.

6. Expected output/outcome of study

- It will contribute to our understanding of stress in Lesotho's healthcare staff including what helps and what does not. It may illuminate some of the experiences which are culturally unique or different from WEIRD experiences.
- It will contribute to our understanding of what may be culturally appropriate interventions for promoting staff wellbeing and reducing stress.
- It could help to identify whether current collaborative wellbeing projects are perceived as helpful by their recipients and what could be done to improve them.
- It may contribute to our understanding of how to use psychological knowledge and staff in supporting staff wellbeing during crises.
- It may also aid in our understanding of how Western and Sub-Saharan African countries can collaborate to support service planning and provision alongside promoting staff wellbeing. It may contribute to evidence in relation to this topic which could lead to further, larger research projects in the future.

7. Methodology

- a. **Study area and population:** Primarily in hospitals and clinics in Leribe, however clinics further afield will be contacted should it prove difficult to recruit sufficient numbers from the Leribe area. Participants will be doctors and nurses currently working in Lesotho

and have been working in their profession during the covid-19 pandemic. Participants must have experienced stress at some point during the covid-19 pandemic and be willing to talk about this.

- b. **Sample Size:** The aim is to interview as many nurses and doctors as possible within the data collection period. However, it would be hoped that from at least 6-10 nurses and doctors would participate in the research.
- c. **Sampling method:** Opportunity sampling will be used to recruit from staff who have participated in the Family Medicine Speciality Training Programme, with a focus on those currently working in and around the Leribe area. Utilising a snowballing sampling method registrars' colleagues would also be reached, increasing the sampling pool to nurses and other doctors in the hospital and primary care clinics. Should it be difficult to recruit sufficient numbers of participants from the local area, nurses and doctors in the wider area would be approached.

Inclusion criteria: Participants must be a doctor or nurse currently working in Lesotho (in the Leribe area) and have been working in

their profession during the covid-19 pandemic. Participants must have experienced stress at some point during the covid-19 pandemic and be willing to talk about this.

Exclusion criteria: Anyone with a current/ongoing serious mental health problem whereby participation in the research could cause increased distress.

- d. **Type of data:** Basic demographic details such as profession and age will be collected. Qualitative data will be collected in the form of semi-structured interviews. Interviews will be recorded and then transcribed and anonymized.
- e. **Study design:** This study will utilise a qualitative design, specifically interpretative phenomenological analysis (IPA). This approach will allow for a focus on the lived experience of participants and how they make sense of that experience. Due to the cross-cultural nature of this research, IPA is particularly advantageous as it will enable the trainee to discover, consider and examine her own assumptions and thus adopt an approach which is sensitive to cultural differences and individuals' own interpretations of their experiences.

- f. **The data collection method:** Semi-structured interviews.
- g. **Data management:** Recordings will be stored on an encrypted data stick and transferred onto Bangor University's One Drive as soon as possible. Data will be stored in an anonymised format and password protected. All identifying information will be changed to maintain anonymity. Recordings will be erased after they have been transcribed and anonymised.
- k. Are the instrument for the study attached with the protocol?
- ~~—Yes/No/NA~~

8. Limitations of the study

- Relies on the ability of the interviewer to create an environment in which the participants feel comfortable enough to share their honest opinions. Demand characteristics and social desirability may create biases in the data.
- Recruitment of participants is likely to be only from the Leribe area.
- There may be a sample bias as participants are likely to be those who have the time to engage in the study, meaning some of the most stressed and affected staff members may be excluded from the study.

9. **Ethical consideration** (Recruitment, Informed consent form, Privacy,

Confidentiality of data, Role of the sponsor (if applicable)

- The interviews may elicit difficult emotions and memories, and/or highlight any unresolved or ongoing difficulties that participants are experiencing. This could cause a re-emergence of or increase in psychological distress. This will be mitigated by the trainee using appropriate, sensitive therapeutic techniques (for example, providing compassion and empathy) and, signposting to further support and resources will be made available.
- The issue of a white, Westerner investigating the experiences of people from another culture. The issue of a white Westerner coming in and “getting what she wants and then leaving”. This will be mitigated by taking a collaborative approach where possible (inviting members of the Lesotho team involved in the implementation of the research and data analysis, as described in the relevant sections above). Appropriate remuneration being provided to participants will also aid this. Finally, providing feedback to participants and the team in Lesotho will help ensure that they gain knowledge from this experience which is of value to them and their future work.

- Participating will be voluntary and informed consent will be gained prior to including an individual in the research.
- Privacy will be respected and confidentiality will be maintained. See data management section for further information.
- Every effort will be made to ensure that individuals are not identifiable in any published reports.

9a. Are the informed consent form/s attached with the proposal?

Yes/~~No~~

Appendix I

Extract of Transcript with Exploratory Notes and Experiential Statements

‘??’ represents inaudible words in the recording.

Speaker	Transcript	Exploratory notes	Experiential statements
Makalo:	So, there were a lot of adjustments and as a medical doctor, that is where now my eyes open, to see you are not just going to focus on the disease process here, but you need to also take care of other significant um, aspects of a patient, like psychological ones. Some of them would need the spiritual support to say, hey, yes we are under this kind of distress coz of, um, the pandemic or covid-19 itself and here you are suffering from this, how is this affecting your spiritual life and people would say and would tell you, I still have hope, God won't leave me to die here, while I still haven't finished ?? I find that I have my significant others that I need to raise up, and all that. So, I was the only hope there, so it means, at some stage, I had to put aside art of doing a diagnosis and then treating,	He learned that as a doctor his job is about more than focusing on the disease, it is about more holistic care and how the patient is doing emotionally, spiritually and psychologically. Part of his job became about providing hope to patients through spiritual discussions.	Huge amount of emotional distress for patients because of the threat to life and the fear of covid. His job became about this as well as managing the physical condition. Learned to become a more holistic doctor, focusing on more than

but now, go in ?? where I had to counsel a patient. Not only that, but also extend to say, yes, if you are a believer, maybe let's say ?? from a Christian background or so, to some extent I have to touch some of those things. If he's a believer of other or traditional somebody, talking to ancestors and all that, then I have to go at least empathetically and address some of the needs and then at least say, during this time, [pause] where is your hope? Then because, any doctor wouldn't, one wouldn't want to impose his own beliefs or his own ideas patient, but to support what the patient believes in and say, you are not alone, this is a journey, we can try together, travel together, up until the stage where we'd say, okay, this is the last outcome, you know, yeh. Yeh, which is where I was saying, a couple of adjustments that we've seen in a medical fraternity, if we may say, yeh.

Change of perspective in his job – he needs to touch on spiritual/religious aspects now and address the patient's spiritual needs.

Being there for the patient, empathising and helping them through the spiritual ways that are most helpful to them. This became part of his job.

just the physical problem. Changed his perspective on what it means to be a doctor and how he can help in emotional and spiritual ways.

Laura: And how was that for you, having to make all of those adjustments and become this person who was also

	helping people spiritually and emotionally?		
Makalo:	<p>Personally, on the, it, it sort of developed me in my career, because some of the things we'll just be talking about, oh you know, when we are talking about health we are not just talking about absence of disease, but the um, being aware that this is another human being with social needs who is not um, that we are not just going to, um, consider infirmities and all that, but there are other aspects of life that define him or her as a human being, and those, if they are not met, it means this person won't function optimally, you understand. So, it sort of, made me to grow even in aspects that in the career, we were not really focusing much on, because as a medical doctor most of the time before covid-19 patients would come, if it's a mental health user, will come to you, will speak and tell, give you that narrative and then you make a diagnosis to say ah this one is more in the cluster of mental health, you understand. Then you, you focus more</p>	<p>Working through covid has helped him to learn more and develop in his career as it has given him first hand experience of how being a doctor is about more than treating a disease.</p> <p>The pandemic has helped him to better understand that the social aspects of a person are also important to his/her wellbeing.</p> <p>Previously would see certain presentations as a mental health problem that needed diagnosing and treatment. Now sees some of these emotions and problems as part of the human experience that he can help alleviate.</p>	<p>Developed his career as he has learned that being a doctor is about holistic care for patients.</p> <p>Changing perspective on emotional distress in patients; this is a part of human experience and not a mental health problem.</p>

on that and you treat. If you need to give psychoeducation, you give psychoeducation, then you discharge the patient, then you review after two weeks or so, but now, here, we were now bound to take into consideration all these fears, bringing them together nicely, rather than just focusing on what the patient is presenting with now, and then after addressing that, the patient goes home, is comfortable. So, here, all these things we saw them now being, uh, sort of revealed in ?? to say, yes there is a disease process, yeh, say psychological distress, yes, spiritual needs. Where is the pastor? Pastor is not there [chuckles]. Where is the psychologist? Psychologist is not there.

A lack of human resources means often he is the only one available to help a patient with all his/her holistic needs and he needs to provide him/her with hope.

Developing as a doctor to provide more holistic care helps him to overcome the lack of human resources.
