

Generating Social Value through Online Communities: The Case of MedicineAfrica

Emergent Research Forum (ERF) Paper

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Abstract

Online communities have seen exponential growth over the last few years, and have thus attracted cross-disciplinary scholarly and practitioner attention. We extend literature on online communities by presenting them as social value creation entities. We use the case of MedicineAfrica—an online healthcare initiative that promotes knowledge sharing and learning to poorly resourced countries. Our approach is qualitative and draws primarily on interviews with different projects and groups of participants involved in MedicineAfrica. So far, our preliminary analysis begins to explain what social value creation means for the different stakeholders involved in MedicineAfrica. Thus, understanding the motives of the voluntary members is important for the sustainability of these communities. We also find that social value is created through the emergence of human and social capital which substantially benefits both those in the remote and fragile areas, as well as those giving up their time to share their knowledge and expertise.

Keywords

Online communities, social value creation, motivations, healthcare, online collaborations.

Introduction

Increasingly, online communities (OCs) are recognized as spaces for supporting virtual collaborations and co-production initiatives (Hiltz and Turoff 2002; Ganley and Lample 2009; Ross 2007). In addition, researchers recently identified the important role that OCs play in developing social value by reducing the divide between urban and rural health disparities (Goh et al. 2016). According to these researchers, OCs can reduce health capability gaps and subsequently generate social value for the participants involved and their regions. We extend research in this area with the study of MedicineAfrica—a text-based OC that was developed with the aim of supporting global health partnerships in the sharing of health education and research and, in doing so, supporting remote, fragile and post-conflict countries. Our aim is to study the emergence of social value creation through knowledge sharing and learning in this OC. We are specifically interested in understanding, for example, what forms social value might take in this context, who benefits from it, and what does it mean to the different stakeholders involved in MedicineAfrica. Further, studying our participants' motives will help us explain the significance of social value within this context. In the following sections, we start by discussing relevant literature and situating our study within it. Following, we present MedicineAfrica as our research site, our participants, and the different phases of our data collection strategy. We then provide selected themes that have emerged from our preliminary screening of the data collected so far, and we close with our expected contributions, future steps, and concluding remarks.

Online Communities and Social Value Creation

OCs present a form of a virtual organization that not only enables interactions among strangers (Bateman et al. 2011), but also allows collaboration to take place in unprecedented ways, not previously theorized (Faraj et al. 2011). They have been described as groups of people who communicate, interact and develop relationships within a technology-mediated organizing space that is symbolically defined by topic of interest (Lee et al. 2002) or a shared practice (Ren et al. 2007; Soekijad et al. 2011; Wasko and Faraj

2005). OCs are therefore user-centric as their success and growth depend on the active participation of their members who voluntarily give up their time and effort in community activities and are strangers among themselves. Due to their unique characteristics, OCs have become increasingly popular in studies on social interactions and online collaborations. Much attention has been paid to the role of OCs in co-productive initiatives such as open source software (e.g. O'Mahony and Ferraro 2007; Von Krogh et al. 2003). Less attention however has been paid to how OCs bridge the knowledge gap between different countries. Some recognition exists as indicated above on the role of OCs in social value creation.

The study of value creation within the field of information systems remains scant, with researchers focusing on social value creation in the contexts of inter-organizational (Weber et al. 2017) and public-private (Caldwell et al. 2017) collaborations. In the OC context in particular, Barrett et al. (2016) speak about financial, ethical, and other (not social) forms of value creation, and Goh et al. (2016) confirm—with their quantitative study—that social value can be generated within an OC environment. Though, therefore, OCs have been presented as social value creation entities (Ibid.), our understanding in this area remains limited. We thus take the case of MedicineAfrica, as we explain below, to address our aims presented earlier.

Research Approach

Research Site: MedicineAfrica

We adopted the single case study approach (Yin 2014) by focusing on MedicineAfrica—an online healthcare initiative that enables the development of OCs between UK-based healthcare professionals and healthcare practitioners and learners in countries with weak healthcare systems—e.g. in Somaliland and elsewhere—with the aim of promoting healthcare education. Per their website, “*MedicineAfrica connects the global healthcare workforce online. We support improved delivery of high quality patient care, the building of strong healthcare systems, and better health for all*” (MedicineAfrica website). MedicineAfrica is developed at low bandwidth to enable connectivity and interactivity with the OC dispersed members in the developing countries in which it is available. Its online courses—delivered every Sunday evening—are text-based, yet highly interactive, as they give learners the opportunity to interact with one another and to ask questions during the virtual teaching sessions. Virtual classes are often coupled with practical sessions, delivered by locally based instructors.

Research Participants

We have identified three distinct groups of MedicineAfrica stakeholders, who are involved in MedicineAfrica in different capacities:

- **Managers:** This group includes paid staff with management responsibility of the platform. They are UK-based in their majority (though there exist managers in Germany and in the poorly resourced countries as well) and have been with the organization for a number of years either on a full- or a part-time basis. Included here too are founding managers who retain management roles.
- **Doctor Volunteers:** In this category we have the doctors who deliver the online courses. Our interviewees from this group are practicing doctors from either the UK or the poorly resourced countries in which MedicineAfrica operates whose involvement in MedicineAfrica is completely voluntary. The former (UK-based doctors) have typically been with MedicineAfrica for a number of years, whereas the latter have been previously trained by the former. Though most of the teaching is delivered in an online fashion, doctors may teach face-to-face sporadically.
- **Learners:** We use the term learners as this category encompasses both those in poorly resourced countries currently studying toward a medical degree, and those who are already doctors in those countries, but who are being trained predominantly by UK-based doctors in order to take over part of the online teaching on the OC.

Data Collection and Analysis Strategy

In-depth interviews constitute our primary data collection method for this study. Once access to MedicineAfrica was gained (through a personal contact), we began interviewing. Our data collection is broken down to the following phases:

Phase 1

In Phase 1, which has been completed, our aim was to familiarize ourselves with the context of MedicineAfrica by understanding, for example, its history, aims, how it works, and the different groups of participants involved in it. Interviews were conducted on Skype and were audio-recorded. We conducted six interviews with managers based in the UK and Germany. Here, our approach was highly unstructured and we let the participants guide us. The first two interviews—with a manager and founding member, and with another manager—took the form of informal discussions; they were highly unstructured and exploratory in nature. During the first interview, we were also given a virtual tour on the MedicineAfrica online platform through Skype's 'screen-sharing' option, which gave us a real feel of the platform and helped us understand how the OC participants interact with one another. Moreover, the interviewees in this phase shared with us a number of documents and visual materials (e.g. public videos on MedicineAfrica) which helped us understand the context further. During our interviews with the six managers, we used the snowballing technique to identify more participants. We specifically asked them to recommend participants from other functional areas and geographical locations in order to get a stratified sample that could help us paint a rich picture of the organization (Eisenhardt, 1989).

Phase 2

Phase 2, which is still ongoing, involves interviews with Somaliland-based doctor volunteers and learners. Interviews in this phase are semi-structured, and our interview protocol was developed partially by the themes that emerged from our preliminary screening of the Phase 1 data, and partially by our understanding of the literatures on online communities and social value creation. It involved the following four sections:

- **Background:** First, we explore each participant's background, role in the OC, etc.
- **MedicineAfrica and social value creation:** Following, we focus on each participant's perceptions and views of MedicineAfrica in particular relative to its role in enabling social value creation.
- **Personal motives:** In this section, we explore what motivates participants to join MedicineAfrica and what is it that keeps them going.
- **Virtual interactions:** Here, we explore the nature of virtual interactions as part of the OC.
- **Conclusion:** In closing, we explore whether each participant has anything else to contribute, or themes that may have come up earlier in the interview, which need further elaboration.

So far, we have interviewed six Somaliland-based doctor volunteers and we are in the process of arranging interviews with Somaliland-based learners.

Phase 3

In Phase 3 we are focusing on doctor volunteers and learners from other countries in which MedicineAfrica operates (e.g. Iraq, Palestine) following the same interview protocol we use in Phase 2. We are also planning to re-interview participants from the management team (Phase 1) to follow up on issues that have emerged during the interviews in Phases 2 and 3.

Given that both researchers are involved in the interviews (with only one researcher acting as an interviewer for each interview), we conducted a number of meetings to share our thoughts about themes that are emerging as we were conducting the interviews. We send the audio files for professional transcription as we are conducting interviews, and have already received 12 transcripts, which we have inserted into QSR NVivo 10 together with the other materials mentioned above (e.g. documents). So far, we have scanned the transcripts and made notes of what we consider relevant to our aims. We are currently about to begin to analyze the data thematically (Braun and Clarke 2006) in parallel with further data collection. Presented next is a selection of what has come out of this process so far.

Emergent Findings

Though data collection and analysis are still underway, we present what we think is of relevance to this study based on our preliminary screening of our dataset. A dominant theme that is emerging relates to the motivations of different individuals to be members of MedicineAfrica. For those involved in MedicineAfrica's early planning activities before the 1.0 version of the OC was created, it is seeing the OC grow that acts as a motivator for further involvement. Moreover, for one of its founding members, the voluntary aspect is what makes it even more appealing to him:

“Committing to an approach, and committing to see that happen across a period of time is important. I think, for me, you know, it's on the whole, been an endeavor of love, rather than paid employment as such. And therefore... the motivation has to come from it being a created exercise, which did try to solve a problem, which I believe in. And I guess that's what's kept me motivated.” (manager)

But why get involved in the first place? A strong motive for many of the doctors, for example, has been their interest in global health and in making medical knowledge accessible in places that it was not before. Indeed, a topic that comes strong in our dataset is that of fulfillment among the doctors in the study. For one of our UK-based doctors (as is the case with the majority of them), training Somaliland learners on issues previously unavailable to them, such as that of pediatric surgical training, as seen as creating social value for the community. For one of the doctors, giving up her time teaching Somaliland learners in the OC is something that contributes to the greater good, thus making her experience fulfilling and rewarding, as she explains:

“But I know that I'm teaching a group of people that wouldn't necessarily get that teaching, and so they're very grateful for it. And a lot of the students don't get very much surgical training, so I can potentially impact patient outcomes by what I teach them. If patients are going to get better care as the result of what the students are learning, then that's very rewarding.” (doctor volunteer)

Thus, another theme that emerges from our data concerns the development of social value creation for both individual doctor volunteers, and also individuals and the wider region involved in the OC. On the one hand, doctor volunteers reflect in their interviews on their own learning about how to change their behavior and online teaching style to accommodate the needs of the OC and the learners within it. On the other hand, individual learners benefit from gaining learning and training opportunities that they would not have access to otherwise, and, by doing so, develop their human and social capital. Similarly, the poor-resourced regions develop medical expertise which is essential for their well-being and survival. Our preliminary analysis shows, therefore, that knowledge might take a two-way form with benefits for all involved in the OC under study.

Conclusion

Our study is still ongoing and our aim is to have completed both data collection and analysis by the time of the conference. At the conference, we are planning to present our emergent themes in the area of social value creation in OCs. We envisage to contribute to the emerging literature in this area (e.g. Goh et al. 2016), for example, by explaining what social value means to the different stakeholders involved in the OC under study here, or by showing what forms social value might take in this context. We are also exploring concepts that are beginning to emerge in our dataset, such as that of knowledge richness which shows that knowledge might take a two-way direction in this context, with doctor volunteers benefitting equally by their giving up their time to pass on knowledge in the poorly resourced countries wherein MedicineAfrica operates. We expect that our findings will be of significance to both researchers and practitioners. On the one hand, future researchers might consider assessing the statistical generalizability of our findings by focusing on larger samples and using quantitative methods. On the other hand, our study is likely to be of value to those involved in healthcare OCs, including learners and healthcare professionals, who wish to capitalize on the knowledge exchange that takes place in these environments, which might take a two-way form.

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