

Nursing Education in Bangladesh: Analysis Through an Ethnonursing Lens and Critical Social  
Theory

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A project submitted in partial fulfillment of the requirements for the degree of  
Masters in Nursing

In the School of Nursing, Faculty of Human and Social Development, University of Victoria

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### **Acknowledgements**

I would like to acknowledge the following individuals for sharing their expertise and knowledge in my journey of becoming globally mindful educator. In particular, I would like to thank Dr. Karen Lund, Alex Berland, Mr. Mohammad Ulla, and Professor Miyan. I want to give very special thank you to my supervising committee of Dr. Anne Bruce and Dr. Joan MacNeil for your patience, guidance, and support. To my students, my deepest gratitude, you have been the greatest teachers.

I would also like to thank my niece Gurvir Gill. You have been my inspiration in completing this part of the journey.

### **Abstract**

Bangladesh, like many other countries, is facing a nursing shortage. Overall, Bangladeshi nurses are inadequately trained, poorly paid, and disrespected as professionals. The Prime Minister of Bangladesh recognizes these challenges and has committed to upgrading nursing education. In 2009, she set a goal to revise the nursing education curriculum to International Council of Nurses standards, which in turn she hopes will enhance the social dignity of Bangladeshi nurses and the quality of care provided. In addition, the Bangladeshi Nurses Council acknowledges the need to educate nurses as critical thinkers. This context impacts how nursing education is offered.

The purpose of this project is to holistically explore the social, historical, educational, and economical factors that influence nursing education in Bangladesh, with the goal of recommending teaching strategies that are culturally contextual and imbedded in the Caring Science Curriculum (Hills & Watson, 2011) for Canadian nursing volunteers teaching at International University of Business and Technology (IUBAT). I draw on my personal experience as volunteer nurse educator at IUBAT and the theoretical lens of Critical Social Theory to frame an analysis and an understanding of nursing education in Bangladeshi context. In addition, I employ Leininger's theory of Culture Care Diversity and Universality and the Sunrise Enabler Model (Leininger, 1998; Leininger & McFarland, 2006) to develop pedagogical strategies for visiting Canadian Faculty. The goal of the project is to assist volunteer educators to deliver culturally contextual nursing education that aims to transform didactic education, presently utilized in Bangladeshi nursing education, to student-centered education embedded in critical thinking and the Caring Science Curriculum.

*The ultimate goal of a professional nurse-scientist and humanist is to discover, know and creatively use culturally based care knowledge with its fullest meanings, expressions, symbols, and functions for healing, and to promote or maintain wellbeing (or health) with people of diverse cultures in the world (Leininger, 1991)*

Despite the significant progress in the last decade in both health and education, Bangladesh nurses are inadequately trained, poorly paid, and disrespected as professionals (Hadley et al., 2007a; Rahman & Hashem, 2000). In 2004, the International University of Business, Agriculture, and Technology (IUBAT) in Bangladesh, in collaboration with an advisory group operating through the Mid-Main Community Health Centre in Vancouver, Canada, created a four-year Bachelor of Science in Nursing (BSN) program. The program currently relies on foreign volunteer instructors to train both faculty and students because there is a lack of expertise in nursing education in Bangladesh. Unfortunately, based on anecdotal evidence with the BSN program at IUBAT, volunteers' naiveté of cultural awareness and pedagogies create barriers in promoting nursing education.

In this project, I employ Leininger's (Leininger & McFarland, 2006) Theory of Culture Care Diversity and Universality along with The Sunrise Enabler model, in order to holistically explore the social, historical, educational, and economical factors that influence nursing education in Bangladesh. The ultimate goal is to use information from this project as a resource that will assist Canadian nursing volunteers teaching at IUBAT to tailor pedagogical material that is culturally contextual. An underlying assumption of this project is that if nursing volunteer instructors recognize students' cultural references in all aspects of their teaching/learning interactions, then students will more likely be engaged as learners and critical thinkers.

### **Background and Significance of the Project**

Nursing is often the backbone to providing quality health; unfortunately, nursing development in Bangladesh has been seriously hampered by social stigma. Religion plays a role;

there are significant numbers of Christian and Buddhist Bangladeshis, but the majority are Muslims (about 80%) and a sizeable minority (about 9%) Hindus (Rozario & Samuel, 2010). The nursing profession, as we know it in the Western world has not been acceptable as a profession to Muslim families. For example, traditional Islamic culture does not condone the physical contact between non-family females and males; therefore, it is mostly non-Muslims, males, widows, and unmarried women who apply for the nursing programs (Hadley et al., 2007). Nursing has often been perceived as “dirty work” that involves staying away from home at night and touching bodies of strangers; for female nurses, this has even led to an association between nursing and prostitution (Hadley et al., 2007). It is this very association that not only decreases the value of the “bride market,” a term used to convey the desirability of a woman for marriage, but also encourages nurses to distance themselves from direct patient care (Hadley et al, 2007).

Because of the poor image of nursing in Bangladesh, Aminuzamman’s (2007) study revealed that 35% of the undergraduate students from various institutions would consider entering into the nursing profession, but only if they immigrated to North America or to Europe. None of the respondents would consider a nursing career in Bangladesh. The government of Bangladesh recognizes that in order to improve its citizens’ health, the poor image of nursing must change. Yet it has failed to make any significant financial commitment to nursing education.

Bangladesh is facing a nursing crisis because nurses lack the necessary skills due to poor training and because the government does not fill the posts that are vacant (Ahmed, Hossain, Rajachowdhury, & Bhuiya, 2011; Berland, Richards, & Lund, 2010). By April 2011 the population of Bangladesh had reached over 162 million, and yet the nurse population is very low at 1 nurse per 2700 people and physicians comprise 1 per 3000 people (World Health Organization, 2011). Bangladesh is the only country that appears to have a higher physician

nurse ratio (Ahmed & Hossain, 2007; Ahmed, Hossain, Rajachowdhury, & Bhuiya, 2011). In addition to the social stigma described earlier, the low status of Bangladeshi nursing is related to the perception of nursing as an unskilled profession. The Prime Minister of Bangladesh in recognition of this has committed to upgrading the nursing education. In 2009, she promised to revise the nursing education curriculum to the International Council of Nurses (ICN) standards, which in turn she hopes will enhance the social dignity of Bangladeshi nurses and the quality of care provided.

Besides social, economic, and cultural factors, a lack of local nursing education expertise may be contributing to the inferior quality of nursing and nursing education in Bangladesh. The Bangladesh's nursing regulatory body, the Bangladesh Nursing Council (BNC) acknowledges that in order to meet the complex care needs of patients and communities, Bangladeshi nurses must be critical thinkers; but, many of the local nursing educators do not appear to have the necessary theoretical skills and knowledge or the required clinical skills to teach students effectively. Access to technology is limited for both faculty and the students, which in turn limits access to nursing resources; thus, maintaining and delivering education that is current and relevant is challenging. In addition, nursing resources are mostly available in English and this creates an additional barrier to education. Importantly, traditional Bangladeshi education is based on rote learning, and therefore, the instructors themselves may lack critical thinking and problem solving skills necessary in nursing. Consequently, IUBAT has been hosting five to seven volunteer nurses, from Canada, every semester, to teach the BSN curriculum at IUBAT.

IUBAT is a nonprofit university founded by Dr. Alimulla Miyan in 1991 and is located in Uttara Model Town in the outskirts of the capital city of Dhaka. Approximately 6,000 students are registered in a variety of programs such as business, agriculture, engineering, computer sciences, hospitality management and nursing. Following consultation with the Ministry of

Education, the Bangladeshi Nursing Council (BNC), the Directorate of Nursing Services and other nursing bodies, the BSN program was initiated. During the 2012 annual IUBAT conference, Dr. Myian argued that if Bangladeshi people's health is to improve, nursing education must move away from traditional teacher-centered education to a student-centered curriculum. Due to a lack of local expertise in nursing education, in 2004, IUBAT invited the non-profit Mid-Main Community Health Centre located in Vancouver, Canada, to partner in delivering the BSN program, also referred to as the "Bangladeshi Project." The objective of the Bangladeshi project is to educate Bangladeshi nurses to the level of international competency to enable them to teach nursing education (for example as a train-the trainer initiative). The faculty for the BSN program relies on Canadian volunteer nurses who teach the BSN program in English. Students progress through four years of three semesters each, with lectures, clinical labs, and clinical practice experience in hospitals and community agencies. Besides connecting Canadian nursing students and educators with their counterparts in Bangladesh, the volunteers have an opportunity to gain an in-depth understanding of global health issues, social and cultural determinants of health, as well as the problems of delivering culturally congruent nursing education (Berland, Richards, & Lund, 2010; Chavez, Bender, Hardie, & Gastaldo, 2010; Leininger, & McFarland, 2006).

### **Volunteer Teaching at IUBAT**

Except for four local faculty members, the IUBAT nursing program is taught and run by Canadian volunteers who are predominately registered nurses. In 2011, as part of my degree requirement, I observed and analyzed teaching/learning strategies and methodologies employed by nursing instructors at IUBAT. The following year, I volunteered to teach a 2<sup>nd</sup> year course on nutrition in the program. The nursing program hosts approximately 15 to 20 foreign volunteers to teach every year. The volunteers must be committed to teach a minimum of six weeks but

preferably a full semester of 16 weeks. Many volunteers are not prepared for the culture shock upon arrival in Bangladesh. For example, the difference in weather, language, traffic, food, pollution, and noise, are just some of the factors that can cause anxiety, which the volunteer may not immediately recognize. Even though instructors at IUBAT are committed to the value of delivering culturally congruent nursing education in Bangladesh, they may not have adequate knowledge of the challenges or barriers that influence nursing education in Bangladesh. Furthermore, many volunteers are expert nurses but may not have an understanding of pedagogical strategies that can be employed to teach nursing education to promote critical reflection.

### **Aim of the Project**

The aim of this project is to provide a lens into Bangladeshi people's worldviews, social structures, environment, cultural values, language, religion, and history and its influence on nursing education so that the visiting faculty can be better prepared to teach culturally contextual nursing education. The ultimate goal is to use this information to tailor orientation material for the Canadian volunteer nursing instructors at IUBAT, a pilot international standards program, to help better deliver nursing education. In particular, purpose and objectives of this project will be as follows:

- To provide information regarding Bangladeshi people's worldviews, social structures, environment, cultural values, language, religion and history's influence on nursing and nursing education in Bangladesh. I also acknowledge the diversity among Bangladeshi people, values, and religions.

- To produce a guide, from the perspective of a Canadian nurse, that will orientate IUBAT volunteer educators to Bangladeshi culture and history to overcome social and cultural barriers to nursing education.
- To recommend to IUBAT visiting instructors pedagogical strategies that are student centered and culturally appropriate.

### **Philosophical and Theoretical Underpinning of the Project**

#### **The Theory of Culture Care Diversity and Universality**

There are a plethora of models and theories that can be applied to study cultures. Leininger's (1991) Theory of Culture Care Diversity and Universality (TCCDU), has been utilized internationally in nursing to obtain in-depth understanding of cultural care practices. Madeline Leininger believes that knowledge of both culture and care can transform nursing and health in both education and practice worldwide. Culture Care Theory is appropriate for this project, as it provides a framework to holistically explore and analyze the worldview, social structures, and environmental factors that have influenced nursing education in Bangladesh. Leininger (1991) postulates that all cultures have forms, patterns, expression, and structures of care that can be discovered, known, and explained to predict the health and wellbeing of cultures. Understanding of these various factors is imperative for Canadian nursing educators who are volunteering in Bangladesh. Importantly, the theory focuses on discovering the diversities and universalities related to care, health and hence nursing education in Bangladesh.

Leininger's (1998) Theory of Culture Care Diversity and Universality is based on her beliefs that people are born, live, become ill, and die within their specific cultural belief and values, as well as with their historical and environmental context. Notably, people are dependent upon human care for growth and survival (Leininger, 1998). Leininger (2007) asserts that people

“have human rights to receive meaningful care that reflect their cultural values and lifeways” (p.12). Leininger has developed and defined a number of key concepts for basic tenets of her theory (Appendix 2). The two major concepts of Leininger’s theory are caring and culture (Nelson, 2006). Leininger believes that care is inextricably linked to culture and is the central focus of nursing (McCance, McKenna, & Boore, 1999). These concepts are integral for nursing and nursing education and are explored in further detail below.

### **Caring**

“Know me as a caring person in the moment and be with me as I try to live fully who I truly am” (Schoenhofer, 2002).

Caring is considered fundamental to the practice of nursing (Brilowski & Wendler, 2005; Lee-Hsieh, Kuo, & Tsai, 2004; Watson, 2009). Not surprising then that Leininger (1998) considers care to be the “essence of nursing and the central, dominant, and unifying feature of nursing” (p.152). Yet, the concept of caring remains ambiguous, elusive and vague (Paley, 2001; Sumner & Danielson, 2007); the concept becomes even more nebulous when caring for people of different cultures (Watson & Smith, 2002). Thus, it becomes even more significant that the foreign faculty at IUBAT explore how caring is defined and understood in the Bangladeshi culture. Leininger has defined care as those “assistive, supportive and enabling experiences or ideas toward others with evident or anticipated needs to ameliorate or improve a human condition or lifeway” (Leininger & McFarland, 2006, p. 12). Leiniger (1998) identified that care and beliefs about health and illness are imbedded in the values, worldviews and life patterns of people. Although there is some diversity and similarities in expression and patterns of caring in cultures, these particular expressions and patterns can have significant influence on health and hence on the delivery of nursing education (Leininger, 1997).

Caring is a concept central to nursing and therefore the locus of education needs to move away from a technical paradigm to humanism, holism and to one of social responsibility (Duchscher, 2000; Watson, 2009). Consequently, the concept of caring must be reflected and be woven throughout the nursing curriculum. Since caring can transpire only between people who share power equally, (Duchscher, 2000; Hern, Vaughn, Mason, & Weitkamp, 2005), it is only fitting that this concept of power sharing is reflected in the nursing curriculum. The Caring Science Curriculum developed by Hills and Watson (2006) is a curriculum that seeks to create an authentic, egalitarian, human-to-human relationship. The Caring Science curriculum is based on the assumption that for an equitable relationship to take place, there must be sharing of power, knowledge and control (Hills & Watson, 2011). Thus, I urge foreign nurse educators to adapt pedagogical practice to accommodate Leininger's Culture Care Theory and to employ nursing curricula that is grounded in the science of caring.

### **Culture**

Culture is the second major construct central to the Theory of Cultural Care Diversity and Universality. There are those who claim that culture is an ambiguous term and oversimplified (Duffy, 2001; Gray & Thomas, 2006), but nevertheless, nursing theorists agree that culture is an integral part of humanity and an essential component of nursing (Gray & Thomas, 2006; McFarland & Eipperle, 2008). Leininger defines culture as "the learned, shared, and transmitted values, beliefs, norms, and lifeway of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally" (Leininger & McFarland, 2006, p. 13). In other words, culture is more than social interactions or symbols; culture is a map or a blueprint that guides person's actions and decisions. Leininger (2002) postulates that culturally competent nursing care is meaningful, satisfying, and beneficial to patients.

When foreign faculty members are studying the cultural beliefs and practices of Bangladeshis, emic and etic ways of knowing should be considered. Emic refers to an insider's views and knowledge of the culture, whereas etic refers to the outsider's viewpoint, specifically to professional nursing knowledge (Fawcett, 2002; Mixer, 2008). Through the use of the Leininger's theory and her model, IUBAT foreign nursing faculty may be able to tease out what constitutes culturally appropriate nursing education in Bangladesh. When nursing education is culturally congruent and imbedded in the Caring Science Curriculum (Hills & Watson, 2011), visiting faculty may be better prepared to promote nursing education that will advance health and wellbeing for the people of Bangladesh.

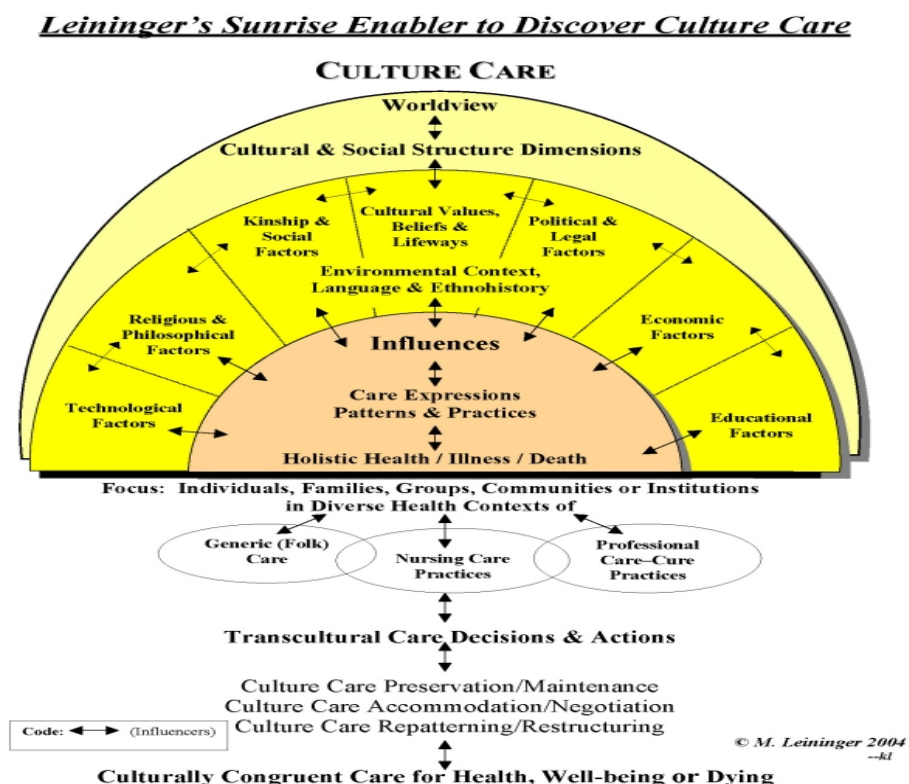
### **The Sunrise Enabler: Model for Exploring Factors Influencing Nursing Education**

The Sunrise Enabler Model (see Table 1) developed by Leininger (1991) is a comprehensive, pictorial representation and a conceptual guide. I used this tool in data collection of the various interactive elements that are influencing nursing education in Bangladesh (Mixer, 2008; Parker, 2006). While gathering and interpreting data, I must remind myself that I will never fully comprehend the various structures that are shaping and influencing nursing education in Bangladesh.

Who I am and where I am situated influences the lens through which I am critiquing and analyzing culture and nursing education in Bangladesh. I was nine years old when my family and I emigrated from India to Canada. Since my arrival in Canada, I have been educated through a Eurocentric lens. I have also witnessed the multigenerational effect of colonialism on the First Nations; people who were socially dismembered and disempowered. Despite my attempts to unwrap my colonized beliefs and values, I cannot escape influences of the Eurocentric lens that accompanies me on this journey. Nevertheless, this model has been helpful in assisting to

explore care meanings, patterns, symbols, and expressions of care of Bangladeshi people, and consequently nursing education at IUBAT.

**Table 1—Sunrise Enabler Model**



The goal of this project is to develop an overview of Bangladeshi culture from my perspective as a Canadian nurse using the Sunrise Enabler model, for the benefit of future volunteer nurses. I have explored all dimensions of the Sunrise Enabler model to assist me in providing a holistic and comprehensive overview that will assist volunteer faculty to develop culture care. Furthermore, I focus on the students at IUBAT, the foreign and local instructors, partner sites of the IUBAT nursing program, nursing professional organizations in Bangladesh and other nursing programs in Dhaka. The more in-depth the data, the better understanding volunteer instructors will have of educational processes and delivery required at IUBAT.

The model focuses on influences that explain emic (insider) and etic (outsider) phenomena within historical, cultural, and environmental contexts (Leininger, 1997). The Sunrise Enabler model has been modified to reflect the goals and purpose of this project. The upper part of the model represents the educational worldview of the Bangladeshis. The intersecting arrows suggest the various elements that influence pedagogical practices of instructors when teaching the nursing curricula at IUBAT. The central model depicting overlapping circles represents the generic and professional education system. The lower part of the model indicates three modes of actions or decisions the nurse educator can focus on: 1) curriculum and pedagogical preservation/maintenance, 2) pedagogical and curricular accommodation/negotiation, and 3) pedagogical and curricular repatterning/restructuring.

The first mode, curriculum and pedagogical preservation/maintenance mode can refer to maintaining the existing pedagogical strategies that are appropriate, relevant, and contextual. The second mode refers to action or decisions that the volunteer faculty can take to either adapt to the existing pedagogies and curricular philosophy or negotiate with others to seek improvement in nursing education. The third and the final mode can refer to supporting significant changes to nursing curriculum and delivery of nursing education in Bangladesh. Regardless of the mode of action, teaching/learning strategies and nursing curriculum must be culturally contextual so that it meets the needs of the Bangladeshi nursing student and the population of Bangladesh.

### **Critical Social Theory: Critiquing Structures of Nursing Education in Bangladesh**

In addition to Leininger's Theory of Culture Care and Universality, I draw on Critical Social Theory (CST) as a valuable framework to critique the dominant ideology of nursing education in Bangladesh. Kincheloe and McLaren (2002) claim that CST can encourage equality through critical reflection within the student-educator relationship. Importantly, CST can be

employed to encourage Bangladeshi students and educators to question the structures that maintain and shape nursing curricula and the nursing profession in Bangladesh.

In the early 1980's, Western nursing scholars began to express concern that nursing science did not address the social, political, economic and historical conditions that influenced clients and nursing in health care (Sumner, 2010). Thus, to address the issues related to power, nursing turned to critical social theory as a theoretical and philosophical orientation (Browne, 2000). Browne (2000) asserts that in many respects, the aims of critical theory are very much compatible with nursing's social mandate, though she argues there are some significant incongruities. However, the most significant contribution of Critical Social Theory is that it can permit one to critique and challenge the ideological assumptions (Browne, 2000) of nursing education in Bangladesh.

CST can be utilized as Duchscher (2000), and Campbell and Bunting (1991) claim, to develop a critical perspective that would challenge traditional assumptions of power and knowledge in nursing education. The underlying assumption of this theory is that people adhere to rules, habits, and meanings constructed by the dominant social structure and that liberation can come only from praxis. For example, CST can play a significant role in examining the effect of patriarchal values, cultural values, and beliefs and the role of religion and its influence on the profession of nursing and nursing education.

The intention of Critical Social Theory is to produce emancipation. For the purpose of this paper, emancipation is defined as "that which frees one from the oppressive constraints of domination and facilitates a reflective consciousness" (Duchscher, 2000). Critical Social Theory seeks to liberate students and educators from conscious and unconscious controls that interfere with equal participation in social interaction, which is imperative in a nursing curriculum (Wilson-Thomas, 1995). What this means, according to Duchscher (2000), is that Critical Theory

can expand mindfulness of values and beliefs that influence interactions between students and educators, consequently, awakening the critical consciousness so that new knowledge is generated while previously held ideologies are challenged and reconstructed. Accordingly, this is an opportunity for students and educators to question their own beliefs and biases about nursing education and practices at IUBAT.

Critical Social Theory has been widely accepted in the Western world as a mode of inquiry to examine oppressive discourse, and is based on the assumption that groups who are subordinated can become liberated (Mooney & Nolan, 2006). Again, I am reminded that similar to the Theory of Culture Care Diversity and Universality, Critical Social theory is developed through a Eurocentric lens. I may be erroneously assuming that Bangladeshi nurses are an oppressed group and the various factors that are influencing nursing education are oppressive. Another assumption is that the Bangladeshi students want to be empowered. I would caution volunteer educators in their application of the Critical Social Theory and encourage them to reflect on these assumptions.

Both the Theory of Culture Care Diversity and Universality and the Critical Social Theory were employed in this project. The Culture Care Theory along with The Sunrise Enabler model have assisted me in analyzing the various influencing factors of nursing education in Bangladesh. Similarly, Critical Social Theory was fundamental in examining beliefs and values dominating the structures of nursing education. In other words, since the Culture Care Theory focuses on discovering influences and not the causes in traditional nursing education in Bangladesh, then Critical Social Theory can be utilized to unveil the causes in order to improve nursing education. Lastly, Hill and Watson's (2006) Caring Science Curriculum plays a central role in guiding pedagogical strategies at the nursing program at IUBAT that are culturally appropriate and congruent with the theoretical lens used here.

In this next section I will apply the Sunrise Enabler Model as a valuable tool for understanding the various factors influencing nursing education in Bangladesh and for developing culturally contextual pedagogical strategies. This is followed by a discussion of Hills and Watson's (2006) Caring Science Curriculum that is suggested for guiding pedagogical strategies at IUBAT.

### **The Sunrise Enabler Model: Exploring Factors Influencing Nursing Education**

The benefits of delivering culturally appropriate nursing education are indisputable. Yet, limited literature is available on worldview, ethnohistory, environmental factors, and cultural and social structures that influence nursing education in Bangladesh. The Sunrise Enabler model was employed to gather data of these various interconnected constructs, in order to tailor pedagogical material that is culturally contextual for the Canadian nursing volunteers teaching at IUBAT. The limitations of the model are presented later in the project.

#### **Worldview**

Worldview refers to the “way people tend to look out upon their world or their universe to form a picture or value stance about life or the world around them” (Leininger & McFarland, 2006, p. 15). It is this very worldview that influences the perspective of Bangladeshi people about life, health, and caring. The Bangladesh people appear to have a very strong sense of highly collective culture compared to Canadians. Family needs are often given higher priority than individual needs. Educational or occupational success of a family member is a great source of joy, whereas criminal behavior is source of shame for the entire family. The Bangladeshi people seem to have strong beliefs about spirituality on health as well as strong kinship and family ties. When ill, the Bangladeshis may look to the “supernatural causes of their disorder”

(Mayuzumi, 2004, p. 508). The life of the Bangladeshi is strongly intertwined with family and religious obligations.

### **Ethnohistory**

According to the Theory of Culture Care Diversity and Universality, ethnohistory is an important guide for obtaining data in order to deliver culturally congruent nursing education (Leininger & McFarland, 2006). Leininger and McFarland (2006) define ethnohistory as the “past facts, events, instances, and experience of human beings, groups, cultures, and institutions that occur over time in particular context that help explain past and current life ways about culture care influencers of health and wellbeing or the death of people” (p.15). Bangladesh’s colonial history and later its hard fought separation from Pakistan have shaped the Bangladeshi people’s cultural beliefs and values.

Historically, Europeans traders first arrived in Bengal (Bangladesh) in the 16<sup>th</sup> century and eventually Bengal became part of British India. The British colonized Bangladesh for almost 200 hundred years until 1947 when Pakistan and Bengal (both predominantly Muslim) divided from India (largely Hindu) and became East Pakistan and West Pakistan (Imam, 2005; Mayuzumi, 2004). Following a bloody war, in 1971, Bangladesh became an independent country and Dhaka its capital (Kabeer, 1991; Mayuzumi, 2004).

One legacy of the British rule was the introduction of British style nursing that emphasized the Florence Nightingale model (Mayuzumi, 2004). Unfortunately, despite the conflicting beliefs between the British model of nursing and the Bangladeshi societal norms, a Eurocentric lens remains pervasive in the Bangladeshi nursing curriculum, but not in nursing practice. In contrast to the Florence Nightingale image, the Bangladeshi nurse is not viewed as the “lady with the lamp” who is a noble, self-sacrificing and motivated to go into nursing to serve (Zaman, 2009). Instead, nursing in Bangladesh is often regarded as “dirty work” (Hadley et

al., 2007b) and therefore nurses tend to spend more time on administrative tasks than interacting with patients (Hadley & Roques, 2007; Zaman, 2004). According to Chowdhury (2002), only 5.3 % of nurses' time involves direct patient care. Bangladeshi nurses do not nurse; instead, unqualified hospital support workers, private caregivers or family members provide most of the direct patient care (Hadley et al., 2007a; Hadley & Roques, 2007; Zaman, 2004). Averseness to direct patient contact appears to be influenced by both cultural and social structures as well as gender inequities.

### **Cultural and Social Structure Dimensions**

Cultural and social structure factors are other major constructs of Leininger's theory. Social structure factors provide a broad and comprehensive overview of factors influencing care expressions and meanings. Understanding of these constructs is imperative for the volunteer instructors as these factors impact the health and well being (Leininger & McFarland, 2006; Rahman, 2000; Mayuzumi, 2004) of Bangladeshis. As depicted in the Sunrise Enabler model, for the purpose of this project, I explored the following social and cultural structures: education, technology, language, economics and politics, spirituality and philosophy of life, cultural beliefs and values, and gender and class differences.

### **Educational Factors**

Education, an element in the Sunrise Enabler Model, is one of the important constructs that influence the health of a population. Understanding of the Bangladeshi educational system is imperative for Canadian volunteer educators for curriculum development and for designing learning/teaching strategies for Bangladeshi nursing students.

***Education in Bangladesh.*** In order to not only enhance the image of nursing but also to standardize nursing education according to International Council on Nurses standards, IUBAT has adopted a nursing curriculum based on North American and European content.

Unfortunately, most of the Bangladeshi nursing students are neither academically prepared nor have the necessary critical thinking skills to complete the North American designed nursing program. In order to be admitted into the nursing program at IUBAT, the students must have completed twelve years of formal education in sciences, commerce, humanities or have equivalent qualifications. However, the quality of educational preparation significantly hinders the success of nursing students to meet the challenges demanded by the North American designed nursing curriculum.

Despite urging by the World Bank for Bangladesh to double its educational expenditure from 2% to address its high illiteracy rate of 58.7% compared to 24.6% in all developing countries, the education sector remains severely underfunded (Osman, 2008; Schuler, Bates, Islam, & Islam, 2006). Although the government of Bangladesh acknowledges the correlation between poverty, health and education, (The Daily Star, 2012) 47.1% of males and 70.1% of women over the age of 15 are illiterate (Imam, 2005). In addition to high illiteracy rates, the task of delivering quality nursing education is daunting due to political instability, poverty, and corruption. With average primary class size of 56 students and taught by 63% of teachers having minimal or no training as educators (Imam, 2005), it is not surprising that nursing students are struggling to complete the North American nursing curriculum.

A majority of the students enrolled at IUBAT completed their secondary education in the Bangla language except for English and Religious studies, which are taught in Bangla and Arabic (Imam, 2005). IUBAT and other nursing universities and colleges will admit approximately 5% foreign students. Compared to the students from Nepal and Nigeria (whose English language skills are stronger) in the nursing program at IUBAT, the Bangladeshi students appear to be the least prepared for the demanding curriculum requirements. Even though the Bangladeshi students have taken basic courses such as mathematics and sciences, prerequisites to

program admission, they may not have the rudimentary understanding of biology, physiology or basic mathematical skills necessary for safe medication administration. Since the majority of secondary education is in Bangla, except for private English medium schools, language becomes another significant hurdle for Bangladeshi students.

***Nursing Education in Bangladesh.*** The first nursing school opened in 1947 at the Dhaka Medical College. Since then, more than 44 hospitals have opened nursing programs. The hospital model is similar to the apprenticeship model previously common in Canada. Nursing programs consist of three years of general nursing instruction followed by one year of midwifery for female students and one year of orthopedics for the male students. In 2010, the government opened six institutions providing BSN programs. Both government (38 institutions) and non-government institutions (five institutions) offer nursing education, which are all affiliated with the Dhaka Medical University, except for IUBAT (Lund, personal communication, 2012). The Nursing College, under the University of Dhaka, offers a master's degree in clinical nursing. The Bangladesh Nursing Council (BNC) is ultimately responsible for nursing curriculum and approving and monitoring national exams for registration. However, due to a number of factors, thus far BNC appears to be ineffective in monitoring or reinforcing quality of nursing education in Bangladesh.

Many of the health care facilities are starting their own nursing programs. Anecdotally, one of the reasons is that the administration hopes to control the quality of nursing education. The second and most significant reason is the limited resources from the government. Nursing instructors at the International Centre for Diarrheal Disease and Research (ICDDR) in Dhaka admit that nursing students are viewed as free labor. The nursing labs toured were mostly empty except for minimal outdated equipment and models. Without adequate lab equipment, the students are unable to practice basic nursing skills. In fact, according to World Health

Organization, about 50% of the medical equipment in Bangladesh is unusable (Siddiqui & Khandaker, 2007).

***Bangladeshi Nursing Council.*** The Bangladesh Nursing Council is a nongovernment and non-profit organization whose purpose is to ensure standards of nursing education and practice (BNC, 2012). The council is funded through examination and registration fees. According to the BNC website, only 50% of the council members are nurses and the rest are from such disciplines as doctors, social workers, and educators. In addition to acting as the regulatory body for nursing, midwives, and nursing assistants; providing registration to practice; and creating questions for national exam, BNC sets the curriculum for nurses. In recognition of the changes in health care needs of its people, BNC, in collaboration with WHO, redesigned the nursing curriculum in 2006. BNC members are taking a lead by arguing that nursing must take a more advanced and proactive role in improving the delivery of health care services.

The nurses employed by the government receive poor wages and live in substandard housing (Hadley & Roques, 2007). Even worse, once employed in the government health care sector, it is difficult if not impossible to terminate employment or enforce disciplinary actions for substandard nursing care (Hadley & Roques, 2007). The concern is that selection to nursing positions is dependent on seniority and not necessarily qualification. Although, the Bangladeshi Nursing Council is mandated to monitor unsafe nursing care, scarcity of funds, political pressure, and shortage of staffing makes it difficult to enforce standards and ethics (Hadley et al. 2003, p. 45). Irrespective of BCN's mandate, a significant allocation of resources is required in order to improve the quality nursing education in Bangladesh.

***IUBAT Nursing Program.*** Nursing curriculum should be relevant to the needs of the community and consider local perspectives (Leininger & McFarland, 2006; Younger & Paterson, 2007). Otherwise, as Leininger (1997) fears, imposing Western ideas that are rarely questioned

can be destructive and oppressive. Dr. Lund, a microbiologist, is the nursing program coordinator at IUBAT admits that adapting a North American curriculum so that it is contextual to Bangladesh, has been challenging (personal communication, 2012) . Nonetheless, IUBAT and a number of other nursing universities and colleges have partnered to adopt curricula from partnership countries such as United Kingdom, Canada, and United States. Despite the challenges, the goal of the partnership is that foreign nurses from Bangladesh can help in alleviating the nursing shortage in the developing countries, while simultaneously enhancing the image of nursing in Bangladesh. The goal of the IUBAT program is to graduate students who are able to write the National Council Licensure Examination. (NCLEX). The curriculum content includes courses in Personality Development, Philosophy of Healing, Nurse/Patient Interaction, Microbiology, Pharmacology, Nutrition, Physiology/Anatomy, Pathophysiology, Acute Care, Maternal & Child Health, Medical/Surgical Nursing, Psychiatric Nursing and Community Health. For practicum experiences, the IUBAT nursing program is affiliated with both private and public organizations such as the International Centre for Diarrheal Disease Research Bangladesh (ICDDRDB), the Centre for Women and Child Health (CWCH), and the United Hospital in Dhaka.

Because of the short duration of teaching assignments by volunteers, PowerPoint presentations have been prepared, which the visiting faculty are expected to follow. Lack of access to educational resources and research relevant to the health of the Bangladeshi people appears to cause distress for the visiting volunteer faculty. This distress can be amplified by the dissimilarities in environment, educational system, and the differences in cultural beliefs and values between that of the volunteer faculty and students and people of Bangladesh. Despite articles provided by the IUBAT organizers to orientate volunteers to the nursing program and the

Bangladeshi culture, these differences can potentiate culture shock that the volunteers may not recognize.

### **Language**

Although most students and Bangladeshi educators struggle with the English language, nursing education is mostly delivered in English. Yet influence of globalization and the allure of working in the West, have drawn a number of students to enroll at IUBAT, an English medium, nursing program. Many of the students enrolled in the nursing program at IUBAT hope that a English medium nursing college, taught by English speaking faculty, will prepare them for a career at an international standard in the profession of nursing abroad (College of Nursing, IUBAT, 2010). In fact, many Bangladeshi consider English as the “global language” and believe it is necessary to achieve development and advancement (Imam, 2005). The first year nursing classes, according to Berland, Richards and Lund (2010), require only basic English skills, and courses, they insist, have been tailored to address language challenges. Many of the students, however, expressed concerns with complexity of education delivery in a language beyond their comprehension.

On one hand, both the Prime Minister Hasina and Education Minister Murul Islam Nahid of Bangladesh agree, “it is easier to impart education and acquire knowledge in mother tongue” (The Daily Star, 2006); on the other hand, the President of Bangladesh argues that to be globally competitive and technologically advanced, English must be taught along side the mother tongue of Bangla. A plethora of international schools in Dhaka continue to promote English as the main medium in allusion of “advancement and globalization”; yet, according to number of surveys and studies critiqued by Imam (2005), suggest that many of the students graduating from these programs experience difficulty in basic English comprehension and writing.

Despite the guidelines produced by the Bangladeshi Nursing Council (2006) emphasizing the importance of communicating in English, many of the nurses, nursing instructors, and students have difficulty participating in a professional exchange in English. In their review of the Bangladeshi nursing curriculum, Hadley and Thanki (2002) noted that the nursing instructors themselves could not meet English proficiencies to teach in English comprehensibly. If the instructors themselves do not understand content written in English, their ability to teach knowledge and skills accurately to nursing students is doubtful. Thus, instead of incorporating pedagogies in which critical thinking is encouraged and multiple ways of knowing explored, the teacher merely transmits information didactically.

While visiting the various community organizations, hospitals, and nursing colleges, I noted that except for the occasional interaction, communication between patients and health workers transpired in Bangla. Since care actions take place in Bangla, it is only appropriate that nursing education be supplemented, if not delivered, in Bangla. The ability to speak one's native language is imperative to communicate, connect, and build trusting relationships (Imam, 2005). Unfortunately, limited Bangladeshi resources are available to deliver quality nursing education. Meantime, Bangladeshi nursing colleges are attempting to utilize nursing knowledge collected by other Asian countries such as India. But for now, Bangladesh remains dependent on nursing curriculum developed in North America, Europe, written in English, and is infused with those cultures.

### **Technological Factors**

Exploring technological domain of the Sunrise Enabler model has been central to my understanding of the challenges and barriers in accessing resources and hence improving nursing education in Bangladesh. Understandably, access to technology is crucial if Bangladesh is to train nurses who meet international nursing standards. Bangladesh, one of the poorest countries

in the world, is experiencing an “informatics-divide”: those who have access to technology and those that do not. Unfortunately, the divide is significant and it limits access to sharing of nursing knowledge and resources. The nursing curriculum, designed by the Bangladeshi Nursing Council, suggests an introductory course in computers to improve nursing education. But lack of information and communication technology, and inadequate information infrastructure, is grossly hindering advancement of nursing education in Bangladesh.

Many of the nursing schools are still utilizing the outdated projectors to deliver education. Improved access to technology would permit nursing students and educators increased collaboration of knowledge sharing not only within Bangladesh but internationally as well. Importantly, improved technology will allow nursing educators to access information that otherwise would not be available due to social, economic, or geographical circumstances. The IUBAT nursing office has three older computers, unfortunately, frequent power shortages and lack of technology support creates another challenge for both the faculty and the students in accessing resources.

### **Political and Economic Factors**

Leininger (1997) has identified exploration of political and economic factors vital in nursing research as both politics and economics play an important role in improving health status of a population. The political structures of Bangladesh are pivotal in determining health policies, allocation of funding to health and nursing education. As a developing country, Bangladesh faces many challenges such as limited economic growth, poor access to health, high illiteracy rate, and high-density population. High population has been linked with such diseases as tuberculosis, malaria and hepatitis A (WHO, 2011). In 2011, Bangladesh had a population of over 162 million (WHO, 2012). Domestic and international political forces appear to play a significant role in allocation of resources to nursing education in Bangladesh. Since its independence in 1971, the

government has made a strong commitment to health improvement, and despite being a resource poor country, Bangladesh, according to Osman (2008), has achieved impressive gains in health. Osman (2008) claims that fertility rate has fallen from 4.3 births per woman in 1990 to 2.7 in 2007 and child mortality has significantly declined. Nonetheless, insufficient funding for nursing education, lack of qualified nursing instructors, and minimal access to technology continue to hinder Bangladesh from achieving its healthy policy goals.

Despite the improvements to health policy, Osman (2008) contends that accessible and affordable health care for the poor is still a challenge. When sick, going to the doctor and not working is not always an option for a majority of Bangladeshis who live in poverty. Even free hospitals are not free, as patients must provide their own medication, food, and personal care. The financial burden worsens, when in addition to the “official” hospital related payment, the patients are frequently required to pay *bakshees* (tips) for basic health care services (Zaman, 2004). Thus, the poor are more likely to seek health care from unqualified practitioners such as drug retail vendors or the unregistered village doctor who can provide inexpensive services (Ahmed & Hossain, 2007; Siddiqui & Khandaker, 2007). While the affluent Bangladeshi are travelling abroad or using private hospitals for their health care needs, the poor continue to receive inferior nursing care from the public health sector. The private hospitals such as Apollo, Square, United and Sikder are recruiting nurses from other countries, particularly, India and Sri Lanka because the Bangladeshi nurses are poorly trained and do not meet global standards (RMMRU, 2008).

### **Spirituality and Philosophy of Life**

The Sunrise Enabler model depicts spirituality and philosophy of life as factors that affect care expression and practices of culture. There is diversity within every culture (Leininger & McFarland, 2006). The visiting faculty cannot assume that all Bangladeshis have similar beliefs.

Muslims believe health is a blessing from god and encompasses spiritual, physical, emotional and psychological dimensions. Illness, on the other hand, is considered a test of one's faith and an opportunity to engage in prayer, charity and self-reflection (Wehbe-Alamah, 2008). In a qualitative study of exploring meaning of health conducted by Raihan and Dutta (2012), the participants indicated that health is good and when you have lots of energy and no 'tension' (stressors or ailments). Other participants stated that they feel tension when they are not healthy; however, in order to reduce tension, praying and thinking positively is encouraged. The participants viewed education positively to reduce tension and to improve health. The Bangladeshis interviewed perceived a strong correlation between financial stability, health and tension (Raihan & Dutta, 2012). Another participant from their study suggested that inability to provide his family with food or education is a great source of stress and tension and hence poor health.

Islamic beliefs support positive life style choices (Grace, Begum, Subhani, Kopelman, & Greenhalgh, 2008). Sadly, many Bangladeshis erroneously believe that obesity indicates health. My IUBAT nutrition class recognizes the importance of exercise and weight management, and over 80% of the males play sports. As the Islamic culture emphasizes the importance of modesty (Wehbe-Alamah, 2008) and discourages display of the female body, none of the females in this class participated in any formal exercise program. Fortunately, expatriates and the affluent have an option of attending private health clubs and spas. Unfortunately, it appears that Bangladesh is no exception in that social determinants are firm predictors of "good health."

### **Cultural Values, Gender, and Class Differences**

Cultural values, gender and class differences are interweaved and intersect nursing education. Cultural values, according to Leininger (2006), are powerful means to know and

support people. Understanding of these cultural values is crucial in examining intersectionality of gender and class differences and its influence in Bangladeshi nursing education.

***Women and Education.*** During an informal discussion with male students at IUBAT nursing school, the men indicated their preference for wives who are educated, tall and fair (light colored). Although marriage is still the only acceptable path for girls (Arends-Kuenning & Amin, 2001), education is considered a desirable attribute in the marriage market. In particular, women's education is valued for its positive impact on children's health and schooling (Arends-Kuenning & Amin, 2001). Although Bangladeshi women are aware of the relationship between education, income, and empowerment (Mayuzumi, 2004), many remain powerless and subordinate to men in almost all aspects of their life. Education, economics and gender equality have been clearly linked to health and wellness. The subordination of women, according to Wehbe-Alamah (2008), is incongruent with the teaching of Islam; in fact, the Prophet Muhammad encouraged both men and women to pursue knowledge. Moreover, the "Qur'an makes it clear that both men and women are complementary and not subservient to each other" (Wehbe-Alamah, 2008, p. 85). It appears, then, that subordination of females in nursing and health can be attributed to cultural beliefs and not as a claim to religious beliefs.

***Women, Poverty and Nursing.*** Bangladesh is a patriarchal society in which a woman's place is largely determined by her father and husband's position (Hadley et al., 2007a). A woman's life revolves around social and family's obligation and maintaining the family's reputation, whereas the man's life is revolves outside the home, ensuring employment and investment decision. Generally, women are discouraged from working outside the home and the concept of *pardah* (seclusion) is prevalent. Out of necessity, widowed, divorced or abandoned women will cross the boundary of *pardah*, but only to seek work as casual laborers, in self-employment, or in the garment industry. The men, on the other hand, tend to dominate formal,

mainly public sector employment in government, bank and other industries where pay and working conditions are much superior and trade unions very active (Kabeer & Mahmud, 2004). This disparity in wages, working conditions, and access to health has resulted in “abnormal” inverse sex ratios (more men than women) compared to the rest of the world (Hadley et al., 2007a; Kabeer & Mahmud, 2004).

The practice of *purdah* has significant influence on women entering the nursing profession. The woman who works in the nursing profession is risking her family’s reputation by not only working outside the house at night but also in touching bodies of non-family members. Since female physicians are accorded the same higher status as male physicians (Hadley et al., 2007a), it is understandable that parents would prefer their daughters to go to medical school instead of nursing. Unlike the female nurses, the female physicians are able to work during the night and have direct patient contact while upholding the family’s reputation without affecting their character.

Unquestionably, as Wehbe-Alamah (2008) asserts, direct patient contact is considered a pre-requisite to caring and is essential in providing patient care. And, despite caring being an important element in the Islamic religion and health care, Bangladeshi nurses are avoiding direct patient contact (Siddiqui & Khandaker, 2007). Nurses, instead of caring for patients, were observed spending considerable amount of time on administrative paperwork. This avoidance of patient contact is an intricate and multifaceted phenomenon and I would urge volunteer educators to examine and question religion, culture, gender, and social and cultural structures that may be influencing caring in Bangladeshi nursing.

***Bangladeshi Patients.*** For teaching/learning purposes or when accompanying students for practical experience, it is vital that the foreign nursing educator understands the role of the Bangladeshi patient in his/her health and well-being. Generally, a Bangladeshi person does not

seek care from a medical profession unless he or she has a life-threatening disease (Chakraborty, Islam, Chowdhury, Bari, & Akhter, 2003). Unfortunately, many patients may not recognize the seriousness of their symptoms. One woman who visited the free IUBAT health clinic, in which I participated, had not received any prenatal care despite being in the third trimester. Another complained of weakness, frequent and heavy hemorrhaging since the delivery of her infant 8 months ago, yet failed to seek professional care. Besides the inability to recognize symptoms of serious illness, costs associated with travelling, distrust of the professional caregiver, and woman's decision-making power in the household appear to be some of the barriers in seeking professional health care (Gayen & Raeside, 2007).

When care is sought, most patients, especially the poor, neither advocate nor participate in their treatment, but look to health care experts to direct their care. This is not surprising when patients do dare ask questions, they are scolded or even shouted at. In fact, on a few occasions, Zaman (2004) reported witnessing patients being slapped by doctors for not following instructions. During a clinical practicum, I observed a family with a newborn with a cleft palate, terrified of the baby's prognosis, yet afraid to ask questions. The physician, refusing to consult with the family replied, "These are uneducated village people, and they don't know what questions to ask." Refusal to communicate with the family is detrimental to patients' well being especially since the family members play a central role in caring for the patient. Unless a patient is able to afford a professional caregiver, family members are responsible for personal care, assisting with exercise, administering medications and dressing changes. Even though family plays a central role in patient's care, nurses often consider family to be obstacles who interfere with ward routine (Zaman, 2004).

### **Environmental Factors**

The Sunrise Enabler illustrates that an environment is an important factor that influences people's health. Therefore, it is important that the volunteer educators have an understanding of the various environmental issues facing the people of Bangladesh. Bangladesh is a small Southeast Asian country bordered by India, Bay of Bengal and Burma. Many people are landless and forced to live and cultivate on flood-prone land, and according to the recent census, almost 73% of the people live in rural areas (CIA, 2008). One research study concluded that geographical distance was one of the important determinants of health care service utilization in rural Bangladesh (Chakraborty, Islam, Chowdhury, Bari, & Akhter, 2003). The poor can neither afford travel expense nor time off from work to seek health care. Furthermore, due to lack of qualified doctors and nurses in rural areas, the poor are left to seek medical assistance from the drug retailer/ vendors/shop-keepers who are unqualified or semi-qualified (Ahmed & Hossain, 2007; Shaheen & Rahman, 2002). In fact, a study conducted by Siddiqui and Khandaker (2007) confirmed that unqualified providers provide 60% of the health care services in Bangladesh. If the government is to achieve its health policy goals, nursing education must be accessible and appropriate to rural Bangladesh.

***Environment and Health.*** Environment plays a central role in promoting health. The streets from faculty housing to IUBAT are lined with numerous new apartment buildings alongside houses made from bamboo and hay and have mud floors. The engineer responsible for one of these new apartment constructions admits that due to poor regulations, the sewer system may not be adequately installed, hence, affecting the quality of drinking water. Safe drinking water is also an issue for squatters who live in stilt houses, along the river, across from IUBAT. According to Rahaman (2000) only 44% of the population has access to sanitary latrines. Open defecation and urination are common practices, especially along the rivers and streams.

Flooding, an annual phenomenon in Bangladesh will cause rivers and latrines to overflow resulting in further contamination of drinking water.

In order to address surface contaminated water, UNICEF, World Bank, and the United Nations Development Program began installing tube wells throughout Bangladesh (Escamilla et al., 2011; Toxipedia, 2010) The wells, however, were dug without testing and became contaminated with arsenic. Although the tube wells provide water that is less contaminated than surface water, the high level of arsenic from the wells has become a major new health hazard. The Bangladeshi government and various NGO's are searching for safer alternatives; however, solutions are still a long way off (Hassan, Atkins, & Dunn, 2005)

***Environment in Classroom.*** Although the importance of creating a caring environment by the nursing educator in the classrooms has been extensively cited throughout this paper, limited space and resources can create challenges in creating such an environment. For example, in promoting caring pedagogy, Rockwood and Samuels (2011) discuss the importance of creating sacred space for the students where they can bring objects that are deeply meaningful and personal to them. The caring classroom, they urge, should be aesthetic and emotive. To create a classroom that is open, energetic, welcoming and imbedded in humanistic values, Rockwood and Samuels (2011) suggest soothing music, art supplies, art on walls, beautiful fabrics on the tables, and food. These suggestions are difficult to implement at IUBAT where space and resources are limited. The walls at IUBAT are devoid of any art except in the main lobby and private offices. Nursing is forced to share classrooms with other departments and therefore, making the space personal and meaningful is challenging. Besides tightly packed student desks in rows, there is a small desk at the front of the classroom that has a computer, locked behind a cupboard, to which only the security guards have the key. The only other item on the wall is the blackboard.

Facilitating group work, participating in narrative story telling, or analyzing and exploring case studies are best conducted in a space where students can easily interact with each other. However, the physical limitations of the classroom and the constant noise from construction at and around the university, poses challenges in creating a classroom as proposed by theorist of caring and critical pedagogy.

### **Educational Theory: Caring Science Curriculum**

Employing Leininger's Sunrise Enabler model, I have explored the various factors that may be influencing nursing education in Bangladesh. I have selected Hills and Watson's (2011), Caring Science Curriculum, to guide the development of teaching strategies and pedagogies for Canadians volunteering at IUBAT. The cultural knowledge collected using the Sunrise Enabler was imperative in guiding contextually appropriate teaching/learning strategies. I selected the Caring Science Curriculum as it supports Bangladeshi Nursing Council's directive that for learning to occur, instructors must provide a caring environment in which students are respected, critical thinking encouraged and multiple ways of knowing explored. The Caring Science Curriculum has the potential to detour Bangladeshi nursing education from a traditional method of knowledge transmission to one that focuses on critical thinking, learning, and problem solving.

Caring Science is defined as an "evolving ethical epistemic field of study that is grounded in the discipline of nursing and informed by related fields" (Watson & Smith, 2002, p. 456). Hills and Watson (2011) claim that there are significant differences between conventional and a Caring Science Curriculum. Specifically, the Caring Science proposes that mindbodyspirit-environment-universe is one entity and that we are all connected and jointly form this circle. People, according to Hills and Watson (2011) cannot be broken down into components and importantly, social, cultural, political and historical background impacts their health. Preserving

humanity, human caring, dignity, human spirit, wholeness, integrity, and unity, are values central to the Caring Curriculum. Values are roadmaps to our actions and therefore I urge volunteer educators to explore their own moral-ethical values before implementing pedagogies rooted in Hills and Watson's Caring Science.

In creating a Caring Science Curriculum, Hills and Watson (2009) have incorporated the following crucial ingredients drawing on the work of Noddings (1984):

- Modeling-not role modeling in the sense of modeling after someone else; rather assisting other to model their best self;
- Practice-living day-to-day experiences in the living relationships between and among students and faculty, and between and among students, in and out of the classroom, virtual settings, and clinical setting-creating a community of caring environment that hold the entire program;
- Authentic dialogue-in keeping with the realization that imparting knowledge is not learning, a caring curriculum creates space for students to have authentic dialogue, allowing questions and discussions, exploration of ideas and knowledge to come together for new insights, process discover, and transformation of consciousness;
- Confirmation-or Affirmation- This philosophical perspective guides the educator to hold the student in their highest ethical ideal or self, even if the student cannot see that ideal for themselves in the moment (p.17).

These four ingredients are the philosophical and ethical foundations of the Caring Science curriculum. Although beliefs and assumptions related to humanity, health and healing, as described within the Caring Science, are not commonly evident in the Bangladeshi nursing practice; they are, predominant in the Bangladeshi society as a whole. Hills and Watson (2011) have identified the following key, interconnected, elements crucial for transformational learning in the Caring Science: creating collaborative caring relationships, engaging in critical caring dialogue, and reflection-and-action.

### **Creating Collaborating Caring Relationships**

In order to create caring relationships, Hills and Watson (2011) claim that there must be elements of collaboration, power/empowerment and participation. These are elucidated below.

**Collaboration.** Constructivist learning theory proposes that learning is a relational process that is shared between the educator and the student. In other words, learning, as suggested by Vygotsky, is “sociogenetic” (Young & Paterson, 2007). What Vygotsky and advocates of the constructivist theory are implying is that knowledge is socially constructed through collaborative interactions between equals. Collaboration, Hill and Watson (2011) emphasize, must not be confused with cooperation, participation, partnership or compromise. Collaboration, they argue, is the “creation of synergistic alliance that honors and utilizes each person’s contribution in order to create collective wisdom and collective action” (p. 71). Collaboration is an important part of the interdisciplinary team in health care. Yet one of the reasons the Bangladeshi patients, especially the poor, are underutilizing health care services is because of uncooperative and inappropriate interaction with staff, patients and informal providers (Ahmed & Hossain, 2007). Thus, the collaborative skills learned in the classroom have the potential to significantly improve the adversarial relationship that presently exists between Bangladeshi nursing, patients and other health care providers.

In order to create collaborative relationship with students, educators must resist hiding behind the veil of “expert” and instead move toward authentic caring relationship in which the student is seen holistically. In short, teaching is not something that is done to the students; rather it is an exploratory journey shared by both teacher and the student in pursuit of knowledge.

### **Power/Empowerment.**

“Power-over demands that we do things we don’t choose to do. Power-of-presence means we choose carefully and understand our intentions.” (Grace R. Rowan, 1984).

Knowledge and power as Hills and Watson (2011) reminds us are inextricably intertwined, and for emancipatory learning to occur, there must be authentic sharing of power and co-creation of knowledge. Chinn (1995) views power as “the energy from which action

arises (p.9). I would agree with Hills and Watson (2011) in that it is not always possible to have “equal” power. The Bangladeshi student is neither accustomed to power sharing within the classroom nor with the patient in the health care system. Conversely, some faculty may be reluctant to empower students for fear of diminishing their own power position of control. Practice of power sharing must begin in the classroom in order to be later reflected in the nursing practice.

Despite the emphasis of power sharing and fostering empowerment, Hills and Watson (2011) fail to clearly define empowerment. Empowerment, Chinn (1999) implores is not self-indulgence, but rather growth of personal strength, power and ability to enact one’s will while respecting others. She warns that empowerment requires listening inwardly as well as actively listening to others. Importantly, Chinn (1999) advises that empowerment is not power-over other but power-with others. According to Tengland (2008), a “change (internal or external to the person) is an increase in empowerment if (if and only if) it is an increase in the person’s ability or opportunity) to control her own life” (p. 82). Within the Bangladesh context, empowerment should consist of and lead to increase control of nursing education by the Bangladeshi people themselves. If Paulo Freire’s argument that acquiring knowledge about the conditions that oppress us can lead to empowerment (Duchscher, 2000; Henry, 2011) is correct, then the nursing educators have an obligation to provide learning opportunities in which Bangladeshi nursing students can examine the various structures that are oppressive to nursing education.

Those who link empowerment to critical social theory believe that empowerment can only be understood in relation to history (Fulton, 1997) and social and cultural beliefs and practices. According to many, nurses in Bangladesh are an oppressed group (Hadley et al., 2007a; Hadley & Roques, 2007; Zaman, 2009; Zaman, 2004), and violence, according to Freire, is a symptom that moves horizontally between people in oppressed groups. The Bangladeshi

physicians are accorded higher social hierarchy in which subordination of patients and nursing is inescapable. The Bangladeshi nursing's treatment of the patients could be indicative, as Fulton (1997) claims, to emulate the dominant group to in order to be powerful as they are.

Unquestionably, Bangladeshi nursing has a very negative image of its education. If the purpose of the emancipatory education is human liberation, then the Bangladeshi nursing students must be, as Wallerstein and Bernstein (1988) contend, subject and the actors in creating their own knowledge. The major challenge and goal of the visiting faculty should be to encourage students to believe that they have knowledge and it should be incorporated and celebrated.

If empowerment for students is to occur, they must be provided with opportunities to examine the discursive structures that are maintaining this oppression. Educators must provide teaching strategies that are empowering for the students so that they in turn can empower their patients. For example, educators can create a learning activity in which the students are asked to examine power relations in the classroom as well as ones witnessed in clinical. This is valuable opportunity for both the educator and the students to examine and reflect upon the power dynamics in Bangladesh between and among health providers and patients.

**Participation.** Participation, Hills and Watson (2011) caution, is not to be confused with involvement, and is the third element essential to the Caring Science curriculum. There is an extensive literature attesting to the value of participation in learning and development of critical thinking skills necessary in nursing. Loftin, Davis and Hartin (2010) claim that students who actively participate in classroom discussion, learn better than students who do not. To transition from the traditional passive learning style presently employed in the Bangladeshi nursing curriculum to one that fosters critical thinking, educators must employ pedagogies that encourage student participation. Hills and Watson (2011) have summarized the major differences between involvement and participation. Involvement includes asking for opinions of students and

some power sharing to occur; however, ultimately decision rests with the teacher. Participation, on the other hand, includes negotiated and formalized relationships in which decision-making and the reasonability of teaching and learning is shared. Notably, in participation, power is shared, whereas, in involvement power remains with the teacher.

At IUBAT and other nursing colleges visited, PowerPoint presentation is the main mode of delivering nursing education. When using PowerPoints, some students will take notes, but the majority are inclined to stare at the screen blankly and will rarely ask for clarification. In the class I taught at IUBAT, the students contributed a lack of participation to the language barrier and cultural differences. Specifically, many of the students state that they are embarrassed at their inability to argue academically in English, while others claim that they are used to being “lectured” and consider it disrespectful and are reluctant to appear critical of the instructor. Students interviewed accused some Bangladeshi teachers of yelling, belittling and ridiculing the students. One student claimed that she was slapped for asking a question the teacher considered inappropriate. Fear of disapproval or ridicule can be a powerful influence on student participation (Loftin, Davis, & Hartin, 2010). Rolling of eyes, giggling and frowning has been witnessed from other classmates when a student has mispronounced or misused words in English. Overall, I noticed greater classroom participation from males than the females and therefore when designing participatory strategies, faculty must consider the gender inequities that replay in the classroom.

Hills and Watson (2011) have summarized the following strategies to consider for encouraging participation. While these were designed with a Western student audience in mind, they can be considered mindfully when used in other cultural contexts:

- Give every perspective full voice

- Demystify all processes and structures
- Fully respect different points of view
- Rotate and share leadership according to ability and willingness
- Value learning new skills so that the opportunity is accessible to all
- Share responsibility or the processes of the group equally among everyone present

To increase participation, let the students know that they are expected to engage and participate in the classroom. In fact, I have made it part of the grading criteria. When students perceive that their grade will benefit, they are more likely to contribute to classroom discussion. Therefore, the volunteer educators should consider assigning grades for participation.

### **Engaging in Critical Caring Dialogue**

Engaging in critical dialogue is the second component of Hills and Watson's (2011) Caring Curriculum and consists of the following three elements: listening, critical questioning, and critical thinking. Dialogue is simply a discussion, whereas, critical dialogue, they claim, is well planned, somewhat structured, and always purposive (p. 88). Braa and Callero (2006) theorize that dialogue is an active participation of student and teacher in which critical social consciousness is developed. For Freire, critical dialogue is "The encounter between [humans], mediated by the world, in order to name the world; it is an epistemological process that cannot exist...in the absence of profound love for the world and for people...cannot exist without humility...and requires an intense faith in humankind" (as cited in Kaufman, 2010, p. 457). Critical dialogue Hills and Watson (2011) insist can provide answers to the "how" questions as well as create opportunities to generate new knowledge. When designing teaching/learning strategies, the volunteer educators instead of giving answers, should allow the students opportunities to explore "why" and "how."

**Listening.**

“Most people do not listen with the intent to understand; they listen with the intent to reply.”  
— Stephen R. Covey, *The 7 Habits of Highly Effective People*

Listening, Hills and Watson (2011) submit is the heart of an emancipatory relational curriculum and a fundamental component of nursing care. Despite emphasis placed on communication skills by the BNC, Bangladeshi nurses often seem to fail to demonstrate empathetic communication skills crucial in a therapeutic relationship (Aminuzamman, 2007; Andaleeb, Siddiqui, & Khandakar, 2007; Hadley et al., 2007b). Arguably, there are interrelated and intersecting factors affecting nurses' ability to empathetically listen in the nurse/patient relationship in Bangladesh. Fortunately, it is a skill that can be learned, a skill necessary to the art of nursing. Hence, the nursing educator must incorporate strategies that foster active listening skills so that students can form caring, respectful, trusting and meaningful relationships with their patients. One strategy the faculty can utilize to foster active listening is “student summary of another student's answer.” In this exercise, a student must summarize the answer given by another student. Following, clarification must be sought to determine the accuracy of the communication. The second exercise suggested by Hills and Watson (2011) involves a token (pen or piece of paper) passed between two students. The person holding the token states their opinions or their feeling and the other must earn the token by demonstrating that he/or she has understood and listened to other student empathetically.

Listening is an important part of the learning process (Shipley, 2010). Listening can create a trusting atmosphere resulting in an environment in which the students can share their knowledge, experience, challenges and meanings related to nursing education and health in Bangladesh. This role modeling will also encourage the students to be more competent and effective listeners themselves. Stickley and Freshwater (2006) eloquently describe listening to be

“ more than a biological function between the ears and the brain. Therapeutic listening hears the sigh developed over a lifetime, or the anxiety in the tone of voice or despair in a facial expression” (p. 15). Hills and Watson (2011) contend that listening requires one to put his/her own thoughts and prejudices aside in order to be open to the world of others. It is only through listening that we can truly understand the meaning of health and caring for the students. However, educators must not underestimate the importance of silence in listening (Shipley, 2010). Silence is an opportunity for both the students and the faculty to engage in formulating questions/answers, and importantly, reflection. Through caring acts of listening, the educator can provide a safe environment, which can encourage emancipatory dialogue in the classroom. But before educators can develop the art of listening to others, it is important that they develop the art of listening to their own hearts.

**Critical Questioning.** The goal in critical dialogue is to pose questions in such a way that the participants are able to uncover the socioeconomic, political, cultural, and historical causes of their place in society (Wallerstein & Bernstein, 1988). During one of the class discussion, men indicated their preference for brides who are tall, educated and fair (light skinned). In Bangladesh, “Shundor” (beautiful or good-looking) is associated with women of light skin and “khalo” (dark-skinned) and “moyla” (dirty) is used to describe someone with dark skin (The Daily Star, 2006). This was an ideal opportunity to incorporate Wallerstein and Bernstein’s (1988) acronym SHOWED, a questioning strategy, to examine “white skin” and “dark-skin” and its association with beauty in the Bangladeshi context.

S     See-What do I see here? Is there a problem with measuring beauty with the color of woman’s skin?

H     Happening-What is really happening here?

- O Our-The students related to their lives. How did they feel about it? What is their experience of being dark-skinned?
- W Why-questioning the root cause of the stigma associated with being “khalo”
- E Empowered-What is our new social understanding?
- D Do-What can we do about changing the negative association between beauty and being “khalo”?

The above questioning strategy moves the discussion from person to social and importantly to action level. Besides class discussion in my example, educators can utilize pictures, films, or personal stories to encourage critical dialogue that is relevant to the students in their nursing education. Instead, lecturing with PowerPoint is the main method of delivery at IUBAT. Unfortunately, most of the faculty observed used PowerPoints ineffectively. Delivering content by reading from slides that have too much information is overwhelming and intimidating for students who already struggle with content and language. At the same time, due to poor comprehension skills in English, students are not learning from (English) textbooks but instead use PowerPoint presentation to study for exams. Young and Paterson (2007) suggest that the PowerPoint presentation should have only the main concepts and the educator should ask questions about these concepts to actively engage the students.

To be situated in emancipatory relational pedagogy, Hills and Watson (2007) urge educators to move away from lecturing toward dialogical teaching. As Young and Paterson (2007) so eloquently state, when students are “lectured” they are ingesting and not digesting. I am not disputing the importance of dialogical teaching, but the value of lectures to disseminate technical knowledge is undeniable. Specifically, lectures can do the following: save time, teacher have more control over the content, useful for reviewing complex concepts, provide educators’ personal overview, and provide information not found in texts (Hills & Watson, 2011;

Matheson, 2008; Young & Paterson, 2007). Regardless of the benefits in lecturing, many consider lecturing to be an oppressive teaching strategy that hampers critical thinking (Hills & Watson, 2011; Mikol, 2005; Mooney & Nolan, 2006; Tiwari, Lai, So, & Yuen, 2006). However, I would argue that lectures can encourage critical thinking by making them more interactive with pauses, reviews, activities, and questioning. Nonetheless, lectures should not be used on their own but combined with other teaching methods so that they expressive and interactive.

**Critical Thinking.** BNC has identified that critical thinking is an essential skill for nurses in order to deliver competent care. Yet, in the review of Bangladeshi nursing education, Hadley and Thank (2002) conclude that passive learning was the method mainly in use and critical thinking rarely encouraged. Throughout the literature, positive correlation between critical thinking and nursing competence is well documented. Critical thinking, a key element in critical dialogue, has been described as a process that requires an ability to collect and assimilate data to arrive at logical conclusion (Chang, Chang, Kuo, Yang, & Chou, 2011; Hills & Watson, 2011; Krupat et al., 2011). While some people have the natural “disposition” to be critical thinkers (Krupat et al., 2011), it is an ability that can be developed through nursing education. Ability to think critically, Atkinson (1997), however, argues, is a “social practice” (p. 72). What he is suggesting is that an individual learns critical thinking unconsciously, through social interactions within their culture. When designing teaching strategies, educators need to consider these cultural differences.

Young and Watson (2010) have summarized the following components essential in critical thinking as demonstrated in my example:

- *Identifying and challenging assumptions*—Going back to my previous example I asked the students “How do you know that beauty is associated with fair skin?”

“Who told you that is true?” and “Why does that have to be the case?” Critical thinking challenged the students to examine the taken-for-granted assumptions about beauty and color.

- *Challenging the influence of context*—As critical thinkers we are open to the various structures and practices that have shaped the idea of beauty and the color of woman’s skin in the Bangladeshi culture.
- *Imagining and exploring alternatives*—What this means is that we are aware that there are different ways of defining beauty besides the color of woman’s skin.
- *Reflective skepticism*—critical thinker knows that the best way to understand a situation is to be critical and to raise questions as we did in the above example.

Additional strategies to enhance critical thinking are clinical journals, student-led class presentations, and clinical case studies.

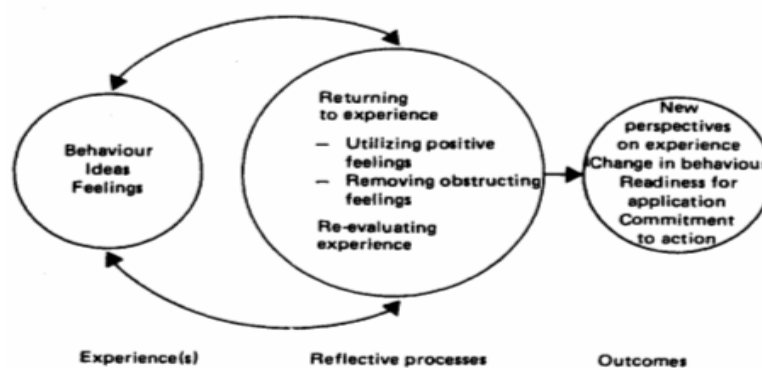
### **Reflection and Action**

“Reflection and action, imagining and doing, are closely connected. We cannot act what we have not in some way thought.” (Elise Boulding, 1988)

Critical reflection-in-action is the third element of Hills and Watson’s emancipatory relational pedagogical framework. They assert that in order to create transformational learning, “students must be provided with actual experience in which they can discover reflecting and acting in the moment” (p. 109). This experience of connecting feelings, knowledge, and action, is according to Young and Patterson (2007), an important quality for professional nurses and a crucial dimension of critical thinking. Hills and Watson (2011) argue that, “one of the most important ways to enhance learning is to strengthen the link between experience and the reflective activity that follows” (p. 112). They suggest that both reflection-on-action and reflection-in-action are important in nursing education because of the practice-based nature of

nursing. Reflection-on-action refers to the thinking subsequent to the event, whereas reflection-in-action refers to the process that occurs during the event and always leads to transformational actions to take place (Hills & Watson, 2011).

**Reflection-on-action.** Reflection, Boud, Keogh and Walker (1985) assert, is the response of the learner to an experience and experience, they explain, is the total response of the person to a situation or an event. Experience includes what the person thinks, senses, does, and determines at the time and immediately thereafter. Boud et al. claim that reflection is a three-stage process that involves preparation, engagement and processing. In the first phase, the learner anticipates the experience, in the second phase, the student engages in the experience, and in the final phase, participant reflects on the experience in order to come to greater understanding. Reflection they insist is purposeful and an intentional activity directed toward a goal. Reflection can be encouraged by having a debriefing session in which the students and teacher discusses experiences of the day and by encouraging reflective journaling. Below is a model developed by Boud et al. (2011), demonstrating the reflection process.



**Reflection-in-Action.** Hallet (1997) insists that “on-the-spot” reflection is not possible because of the chaotic and unpredictable nature of nursing. Hills and Watson (2011), on the other hand, claim that it is the complexity and unpredictability of nursing practice that demand “nurses be able to think about doing while doing what they are doing” (p. 115). But before students can

participate in reflection, they must first have an opportunity for an experience, as well as an understanding of the rationale of their actions. However, the rationale of actions is unlikely to occur in early stages of clinical placements (Hallett, 1997). This may take even longer for the Bangladeshi nursing students for whom critical analysis is a new concept. Nevertheless, to foster reflection during practice, the instructor should frequently ask open-ended questions such as “What do you think?” or “How do you feel about it?” Importantly, for reflection to transpire, the faculty must create an environment that is respectful, caring, trusting, and safe.

### **Teaching Strategies: Caring as a Pedagogical Approach**

*“The academy is not paradise. But learning is a place where paradise can be created. The classroom, with its limitations, remains a location of possibility. In that field of possibility we have the opportunity to labor for freedom, to demand of ourselves and our comrades an openness of mind and heart that allows us to face reality even as we begin to move beyond boundaries, to transgress.”* (Bell Hooks, 1994, p. 207)

If caring is indeed the essence of nursing, then it becomes the responsibility of the nursing educator to incorporate teaching strategies that promote caring behavior. Brown (2011) postulates that professional nursing behaviors are dependent on the teaching and learning transactions that transpire within the classroom and are eventually integrated into practice. The integration of caring behavior into practice may not be immediately evident as caring is a process and an outcome (Brown, 2011; Lewis, Rogers, & Naef, 2006; Watson, 2009). In other words, these authors warn that acquisition of caring skills occurs over time and only after the students have developed attitudes, beliefs, and values that are central to caring. After a personal communication with Jean Watson, Lewis, Rogers and Naef (2006) developed the following guidelines to promote the concept of caring, in nursing education, as summarized below:

#### **Developing a transpersonal caring relationship**

Show genuine interest in students and create an atmosphere for authentic caring within the learning experience:

- Use principles of cooperative learning in small group and plenary; encourage autonomy and sense of both individual and group responsibility for the learning process
- Develop mutual goals for learning that focus on success, individual, and group learning needs; learners participate in the development of course, group, and individual learning objectives
- Build confidence and encourage the expression of thoughts and feeling without judgment
- Facilitate independent and group problem solving through listening, respectful dialogue, and structured reflection
- Offer support and serve as resource for students; help each learner to find personal meaning in learning experience
- Stay within the frame of reference of the learner

The Bangladeshi nursing student is generally hesitant in participating in his/her learning goals as educators are viewed as experts who should be formulating learning objectives.

Encouraging them to be participants in course review or of learning objectives, although crucial in Caring Science, will be challenging. Nevertheless, it is essential that the students are encouraged to co-create nursing knowledge in Bangladesh.

### **Creating a caring-healing consciousness through intentionality and caritas/love-centered energy field**

- Remain flexible and open to the possibilities within the learning environment and within each learner. Let go the need to control the teaching experience and instead move like “leaf on water” with learning being directed by the learner within the frame of reference of the course goals and objectives
- Share yourself and your lived experiences with the intention of opening the space for learners to share of themselves, their values, and their own lived experiences
- Cherish all ways of knowing and facilitate the unfolding of these ways of knowing within the learning process
- See the spirit-filled person within each learner and create a learning space for learner to share this with each other

### **Evaluation of learning**

- Develop clear, transparent guidelines for progression that are negotiated with the learners and teacher

- Honor students self-learning process, self-pacing and self-correcting through the learning process
- Assess learning using methods that reflect multiple epistemological approaches and ways of knowing

The above learning/teaching strategies may produce anxiety and uncertainty not only for the educators but the Bangladeshi students as well. In discussion with both the foreign faculty and the nursing students, the anxiety and stress appears to be exacerbated by the philosophical differences in epistemological and pedagogical beliefs and values. Hence, I urge educators to participate in critical reflection to examine their own values and beliefs as these values and beliefs will guide your teaching practice. Despite these differences and the challenges, the value of incorporating a caring curriculum in which critical thinking is mandated is undeniable. Rockwood and Samuels (2011) have suggested the following pedagogical practices, embedded in the caring curriculum, to encourage critical thinking that I applied to my practice in Bangladesh.

**Journal Writing.** Journals are an opportunity for students to discover what they may not say out loud. Journals are mediums that allow the students to externalize their inner conflicts, anger, joy and pain.

**Music as Healing.** The Bangladeshi people have an incredible love for music, both traditional and Hindi. Almost every student has an access to cell phone to which they can download music. Nursing educators can utilize music to explore, painful situations, diseases, death, poverty, malnutrition, and abuse. Showing videos and listening to songs can create an opportunity for dialogue from which healing and enhanced awareness may emerge.

**Dancing.** Many Bangladeshi people seek every opportunity for festivity in which they can dance. Dance can create comfort and safety as well as encourage healing and group bonding.

**Drama.** Drama can give students an opportunity to go outside their comfort zone to share their own stories as well as empathize and learn from others students' experiences.

**YouTube Videos.** Both the nursing office and the computer library at IUBAT have access to computers and Internet. The visiting faculty, with students, can view YouTube videos to explore issues of poverty, acid violence, water issues and gender inequity.

Despite urging by the BNC and the National League for Nursing to transit from didactic education to more innovative pedagogies (Brown, Kirkpatrick, Greer, Matthias, & Swanson, 2009), teacher-centered approaches remain the prevalent pedagogical style. In order to meet the educational needs of the Bangladeshi nursing student, the educators must utilize a variety of teaching/learning approaches and strategies that promote critical thinking and caring behavior. Importantly, when designing teaching/learning strategies, the educators should consider the learning needs of the students in which the students are partners and co-learners. Significantly, the teaching strategies must address the language barriers and prior education level of the students. Finally, the educators must teach "according to the neighborhood," in other words, teach what is relevant to the Bangladeshi nursing student.

### **Critique of Leininger's Theory of Culture Care Diversity and Universality**

Since its emergence in the 1970, the foundation of nursing's knowledge about culture has been dominated by Leininger's theory of cultural care. Leininger's critics argue that Theory of Cultural Care and Diversity contain ambiguous terminology and lacks clarity in defining key concepts (Andrews & Boyle, 2002; Mulholland, 1995). Also, Leininger has been criticized for cataloguing of culture care values, meaning, and actions modes of the cultures she has examined. The concern is that this cataloguing or generalization can foster stereotyping and making generalizations about people, and possibly ignoring the differences (Duffy, 2001). In fact, Campesino (2006) claims that categorizing and cataloguing can actually reinforce rather than

ameliorate stereotyping. Further, cataloguing through a Eurocentric lens further promotes Colonial behavior (Gustafson, 2005). It has been argued that cultural diversity itself is a Eurocentric terms because it focuses on one's own behavior as being "normal" and anything different as being "wrong" or "inferior" (Lea, 1994). The white group is viewed as the norm against which the differences of the non-white are measured or compared.

Understanding and being aware of one's own culture or the culture of other can create tolerance and respect. But, Campinha-Bacote (2006) argues that simply being aware of one's own culture and learning about the cultures of others does not necessarily dismantle attitudes or biases that one may have internalized. Lastly, Leininger's model has been criticized for failing to recognize the relations between power and social, cultural, and historical structures (Campesino, 2008; Gustafson, 2005; Law & Muir, 2005). Hence, engaging with critical social, feminist and postcolonial perspective as well as works of Bell Hooks and Freire have offered a deeper understanding of root causes and challenges in Bangladeshi nursing education.

Despite the criticism of Leininger's theory, the Sunrise Enabler model was valuable in teasing out cultural knowledge that I may not have considered otherwise. Although, I explored all the dimensions in the model, I focused more on some constructs than others as required for my project. While I was aware of the limitations of the model; nevertheless, the model was easily transposable to the Bangladeshi context.

### **Recommendations**

Many more questions than answers have arisen in my exploration of nursing education in Bangladesh. I acknowledge that the underlying causes of the state of nursing education in Bangladesh are complex and multivariate. Nevertheless, based on my analysis using Leininger's theory, the Sunrise Enabler Model and CST lens, I offer the following recommendations.

**IUBAT Curriculum:** IUBAT's nursing curriculum was developed by Canadian volunteers and is based on the North American and European curriculum guidelines, and is mostly taught by Canadian volunteers. A curriculum revolution is required at IUBAT if the program is to be successful and transformative in nature. There are undeniable challenges in accessing research and resources that are relevant to nursing education in the Bangladesh context. Therefore, partnership between other nursing institutions and IUBAT would be beneficial in developing contextually appropriate nursing curriculum. The process of curriculum development should ideally involve the Bangladeshi nursing students and educators. Otherwise, the perceived sense of expertise or superiority may silence the voice of Bangladeshi nurses. Importantly, the curriculum should be appropriate and utilize resources that are relevant to the health care needs of Bangladeshis in urban and rural settings. The curriculum content should include research conducted by WHO, NGOs and the various Bangladeshi health organizations. Lastly, as Mid-Main partnership proposed, Bangladeshi educators should eventually teach the IUBAT nursing program. With the leadership of Mid-Main volunteers from Canada, the Bangladeshi Project has made significant strides in improving nursing education at IUBAT. Nonetheless, the Bangladeshi nursing leaders should be the navigators of nursing education in Bangladesh and co-constructors of nursing knowledge appropriate to their socio-cultural context.

**Guide for Volunteers:** An online resource will be available for the foreign volunteers teaching at IUBAT, that addresses the following areas:

- Historical, cultural, social, political, religious and economic factors influencing health and education in Bangladesh
- Introduction to learning theories

- Teaching/learning strategies and pedagogies that are contextually appropriate for Bangladesh nursing students
- Discussion board where volunteers can discuss their successes and challenges

### **Conclusion**

Leininger's Theory of Culture Care Diversity and Universality has dominated the nursing profession internationally to assist nurses in gaining in-depth understanding of cultures. For the purpose of this project, Leininger's Cultural Care Theory and Critical Social Theory were crucial in identifying the various factors influencing nursing education in Bangladesh, and in guiding appropriate pedagogical strategies that are contextual to Bangladesh. In particular, these theories were vital in identifying the challenges of delivering culturally appropriate nursing education at IUBAT. Significantly, this project has highlighted the importance of developing partnerships with the Bangladeshi educators to develop a nursing curriculum that promotes critical thinking and incorporates the concept of caring. I believe that implementation of a Caring Science Curriculum has the potential to shape a positive image of nursing in Bangladesh as well as create caring-healing relationship between nurses, physicians and patients.

*If I believe so much must change, I must be willing to change myself.*  
(Frances Moore Lappe', 1990)

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Appendix 1



## Appendix 2

## Terms and Concept Leininger (1997)

1. **Care:** The abstract and manifest phenomena or expression related to assistive, supportive, enabling and facilitating ways to help other with evident or anticipated needs to order to improve health, a human condition, lifeway, or to face death.
2. **Culture:** the lifeways of an individual or group with reference to values, beliefs, norms, patterns, and practices that are learned, shared and transmitted intergenerationally.
3. **Culture Care:** The culturally derived, assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated need which guides nursing decision and actions, and held to be beneficial to the health or the well being of people, or to face disabilities, death, or other human conditions.
4. **Culture Care Diversity:** The cultural variability or differences in care meanings, patterns, values symbols, and lifeways within and among cultures.
5. **Culture Care Universality:** The commonalities or similar culturally-based are meanings, patterns, values, symbols, and lifeways within and among cultures.
6. **Worldview:** The ways in which individuals or group looks out upon and understand their world to provide a value stance, picture, or perspective their life and the world
7. **Cultural and Social Structure dimensions:** Refers to the dynamic, holistic, and interrelated patterns or feature of culture (or subculture) related to religious or spirituality, kinship (social), political (and legal), economic, education, technology, cultural values, language, and ethno historical factors of different cultures.
8. **Environmental Context:** The totality of an
11. **Etic:** Refers to the outsider's views and values about a phenomenon
12. **Health:** A state of well being or restorative state that is culturally constituted, defined, valued, and practiced by individuals or groups that enables them to function in their daily lives.
13. **Nursing:** A learned humanistic and scientific profession and discipline that is focused on cultural care (caring) holistic knowledge and competencies to assist individuals or groups to maintain or regain their health (or well being) or to deal with human life and death in meaningful and beneficial ways.
14. **Culture Care preservation or Maintenance:** Refers to those assistive, supportive facilitative, or enabling professional actions and decisions that help people of particular culture to retain and/or maintain their well being recover from illness, or face handicaps and / or death.
15. **Culture Care Accommodations or Negotiations:** Refers to those assistive, supporting facilitative, or enabling professional actions and decisions that help a client (s) reorder, change, or greatly modify their lifeways for new, different, and beneficial health care patterns while respecting the client (s) cultural values and beliefs and still providing beneficial or healthier lifeways than before the changes were coestablished with the client(s).
16. **Culture Care Repatterning or Restructuring:** Refers to those assistive, supporting, facilitative, or enabling professional actions and decisions that help a client(s) reorder, change, or greatly modify their lifeways for new, different, and beneficial health care patterns while respecting the client(s) cultural values and beliefs and still providing beneficial or healthier lifeways than before the changes were coestablished with the client(s)
17. **Cultural Congruent Care:** Refers to those appropriate actions or decisions related to a)

event, situation, or related life experiences that give meaning and order to guide human expressions and decisions within a particular environmental setting, situation, or geographic area.

9. **Ethnohistory:** The sequence of facts, events, or development over time as known or witnessed by the people under study.
10. **Emic:** Refers to the local or insider's views and values and about phenomenon.

culture care preservation or maintenance; b) culture care accommodation or negations; and/or c) culture care repatterning or restricting which fir with or are specifically tailored to meet clients needs in order to improve or maintain their health and or well being or to fact death or disabilities.