UNIVERSITAT DE BARCELONA

Standing on their own two feet. The role of nursing education in the life stories of nurse teachers from Bangladesh

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To all the people who care for others.

Especially to the nurses who shared their stories,

…y a mis padres.

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Abstract

The nursing profession in Bangladesh has undergone substantial development over recent decades but still faces significant challenges. A remarkable gap has been described between the institutionally-accepted image of nursing as the provision of hands-on care and the small amount of time that nurses allocate to it, especially in government hospitals. The reasons for this contradiction have shown a complex interaction between historical, socioeconomic and cultural factors. These are mainly related to the conflict between the British-inherited curriculum, with a strong emphasis on basic care activities, social and gender norms, and longstanding discrimination against nurses in their institutional settings and society.

This research aims to provide a theoretical analysis of the ways in which structural factors intersect with the professional and social experiences of a group of nurse teachers. The objectives of the thesis are to describe nurses' views about nursing care and their profession, to discuss to what extent nursing education has been an empowering tool, and to analyse how the nurses' socioeconomic background, personal experiences and life events have influenced their professional careers and their conceptualisation of nursing and care.

A critical phenomenological analysis of the nurses' life stories has been used, relating the stories to the broader history and political economy of nursing in Bangladesh. Twenty-two nurses were selected and interviewed over an eight-month fieldwork period, of which seven were selected as key informants. The discussion is mainly based on theoretical contributions from anthropology, practice theory, feminism and a critical analysis of nursing knowledge.

A common rhetoric was found among the nurses: namely that nursing care has 'deteriorated'. They tended to emphasise hands-on care and the 'old' apprenticeship model, while also approving moves towards a more professional model. Nursing care activities were understood as a mixture of service and management of the wards and patients, linked to a wish to 'utilise' the knowledge that they were continuously acquiring. Therefore, nursing education was broadly empowering in terms of knowledge, independence, and self-realization. Nevertheless, at some moments social and institutional discrimination made the m feel disempowered, frustrated and vulnerable. Even so, the nurses interviewed have achieved successful professional careers, together with a significant amount of social recognition. Without ignoring their outstanding individual capacities, the role that key people and institutions had in supporting them in their eagerness to learn has to be considered. Finally, the act of *caring* itself and the knowledge that it produces may also be a source of personal and collective agency. However, work is needed in order to create and maintain the necessary conditions for the *caring* experience to be *empowering*. This responsibility falls beyond the nursing field, as it involves structural changes, especially in terms of gender and class inequalities.

Keywords: Bangladesh, nursing, society, agency, knowledge, power, care

Resum

La professió infermera a Bangladesh ha experimentat importants avenços en les últimes dècades, tot i que encara presenta reptes considerables. La imatge institucionalment acceptada de la infermeria com la provisió de cures i contacte continuat amb els pacients contrasta amb la poca dedicació de moltes infermeres a aquestes activitats, especialment en els hospitals públics. Aquesta contradicció s'explica per una complexa interacció entre factors històrics, socioeconòmics i culturals. Existeix un conflicte entre un pla d'estudis heretat de l'època colonial Britànica, amb un fort èmfasi en les activitats de cures bàsiques, les normes socials i de gènere, i la històrica discriminació de les infermeres en els seus entorns institucionals i socials.

Aquesta tesi pretén teoritzar sobre les formes en què els factors estructurals s'intersecccionen amb les experiències professionals i socials d'un grup de professores d'infermeria. Els objectius de la tesi són: descriure les visions de les infermeres sobre el concepte de cura i sobre la seva professió; discutir fins a quin punt l'educació en infermeria ha estat una eina empoderadora, i analitzar de quina manera el context socioeconòmic, experiències personals i esdeveniments vitals de les professores han influït en la seva carrera professional i en la seva conceptualització de les cures infermeres.

La recerca ha realitzat una anàlisi fenomenològica crítica de les històries de vida de les professores d'infermeria, relacionant-les amb la història i economia política de la infermeria a Bangladesh. Vint infermeres van ser entrevistades durant un període de vuit mesos, entre les quals set professores van ser escollides com a informants clau. La discussió es basa principalment en les aportacions teòriques de l'antropologia, la teoria de la pràctica, el feminisme i l'anàlisi crítica del coneixement infermer.

Les infermeres entrevistades sostenien, en general, que les cures d'infermeria s'havien 'deteriorat'. Les seves narratives tendien a emfatitzar el 'vell' model d'aprenentatge pràctic, alhora que es valorava l'evolució cap a un model més professional. Les infermeres conceptualitzaven la *cura* com una barreja entre les nocions de servei i de gestió de les sales i dels pacients, juntament amb un desig d'utilitzar els coneixements que constantment adquiriren. Per tant, l'educació en infermeria ha estat en general empoderadora quant a coneixements, independència i sentit d'auto-realització. Tot i així, en certs moments, la discriminació social i institucional viscuda, els va fer sentir impotents, frustrades i vulnerables. Malgrat les dificultats, però, les infermeres d'aquesta tesi han aconseguit un exitós desenvolupament professional, així com un grau de reconeixement social considerable. Sense ignorar les seves notables capacitats individuals, cal considerar també el suport rebut per part de diferents persones i institucions en el seu constant desig de formar-se i aprendre. Finalment, l'acte de tenir cura i el coneixement que se'n deriva, són en si mateixos una font d'agència personal i col·lectiva. No obstant això, cal treballar per crear i mantenir les condicions necessàries perquè l'experiència *cura* sigui *empoderadora*. Aquesta és una responsabilitat que excedeix l'àmbit infermer, ja que implica canvis estructurals, especialment en relació a les desigualtats de gènere i classe.

Paraules clau: Bangladesh, infermeria, societat, agència, coneixement, poder, cura

List of Abbreviations

AAA	American Anthropological Association
AIDS	Acquired Immunodeficiency Syndrome
AL	Awami League (political party of Bangladesh)
BA	Bachelor in Arts
BANBEIS	Bangladesh Bureau of Educational Information and Statistics
BDNA	Bangladesh Diploma Nurses Association
BDNWA	Bangladesh Diploma Nurses Welfare Association
BDT	Bangladesh Taka (currency)
BHW	Bangladesh Health Watch
BNA	Bangladesh Nurses Association
BNC	Bangladesh Nursing Council
BNMC	Bangladesh Nursing and Midwifery Council
BNP	Bangladesh Nationalist Party
BSc	Bachelor in Sciences
CAMPE	Campaign for Popular Education (Bangladesh)
CBA	Community Skilled Birth Attendant
CGFNS	Commission on Graduates of Foreign Nursing Schools
CHT	Chittagong Hill Tracts
CO	Chief Officer
CoN	College of Nursing
DfID	Department for International Development (UK Government)
DNA	Diploma Nurses Association (Bangladesh)
DNS	Directorate of Nursing Services (Bangladesh)
DPHN	District Public Health Nurse
FAAEE	Federación de Asociaciones de Antropología del Estado Español
FYP	Five Year Plan
GAD	Gender and Development
GDP	Gross Domestic Product
GoB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
HPNSDP (Bangladesh)	Health Population and Nutrition Development Programme

HSC	Higher School Certificate
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IELTS	International English Language Testing System
IMS	Indian Medical Service
INS	Indian Nursing Service
IUAES	International Union of Anthropological and Ethnological Sciences
IV	Intravenous
MBBS	Bachelor in Medicine and Surgery
MOE/MoEDU	Ministry of Education (Bangladesh)
MOHFW	Ministry of Health and Family Welfare (Bangladesh)
MOMPE	Ministry of Primary and Mass Education (Bangladesh)
MPH	Masters in Public Health
NGO	Non-Governmental Organisation
OGB	Oppressed Group Behaviour
PTS	Preliminary Training Students
RCN	Royal College of Nursing (UK)
SA	Saudi Arabia
SIDA	Swedish International Development Agency
SNES	Strengthening Nursing Education and Services (Bangladesh)
SRN	Strengthening the Role of Nurses (Bangladesh)
SSC	Secondary School Certificate
TNAI	Trained Nurses Association of India
THC	Thana Health Complex
UK	United Kingdom
UN	United Nations
UNESCO	United Nations Education Science and Culture Organisation
UNPFA	United Nations Population Fund
US	United States
WB	World Bank
WHO	World Health Organisation
WID	Women in Development

Glossary

Adivasi	Indigenous
Apa/Apu	Older sister (Muslim terminology)
Apni	You (formal)
Baji	Fried
Bhaat	Rice
Bhai/Bhaia	Older brother (Muslim terminology)
Bhasa Andolon	Language movement during the East Pakistan period
Bhodrolok	Gentlemen
Boro lok	Wealthy person/people
Bua	Domestic worker, servant
Chacha	Paternal uncle (non-Muslim terminology)
Choto lok	Disadvantaged, 'lesser' people
Dada	Older brother (non-Muslim terminology) and also paternal grandfather (Muslim terminology)
Dai	Traditional midwife
Dalit	Literally oppressed, used to designate disadvantaged population groups in India. Coined by the Indian reformer Ambedkar in response to the offensive connotations of the term 'Untouchable' and the paternalism of the Gandhian notion 'Harijan'
Dhal	Lentil
Dhoni	Rich, opulent
Dhormo	Generally religion, but it can also refer to the broader notion of commitment, devotion above everything
Dekha-shona kora	To look after
Didi	Older sister (non-Muslim terminology)
Dusto	Naughty
Gorib	Poor
Gusthi	Patrilineage
Harijan	Literally, 'the child of Hari (God)', coined by Gandhi to refer to Dalits
Ijjat	Honour

Inter	Intermediate or Secondary School Certificate (SSC)
Jati	Caste as social grouping
Jowtuk	Dowry
Khala	Maternal aunt (Muslim terminology)
Khormo	Duty
Kobiraj	Traditional healer
Lojja	Shame, shyness
Maharjon	Money lender
Mama	Maternal uncle (Muslim terminology)
Mashi	Maternal aunt (non-Muslim terminology)
Matric	Matriculation, Higher School Certificate
Meddha	Intellect
Muhajirs	Urdu-speaking communities
Murkhu	Ignorant
Mukti Bahini/Jodda	Freedom Fighters
Nasta	Snack
Para	Village, neighbourhood
Phakibas	A person who eludes responsibilities
Purdah	Literally, curtain. Used also to refer to female seclusion norms
Rokto	Blood
Roti	Homemade bread, similar to tortillas
Samaj	Society
Sati	Widow-burning
Sepoy	Indian soldier
Shebika	Nurse
Sheba kora	To serve, to care
Taka	Bangladeshi currency
Tui	You (intimate or highly informal)
Tumi	You (informal)
Unna	Scarf
Varna	Caste as an ideal model
Zamindar	Landlord
Zenana	Female quarters inside some Indian households

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1. INTRODUCTION

Nursing care provision is a central element in contemporary health systems and its quality is directly related to the health of the population (World Health Organisation 2010; Berland 2014). In Bangladesh, the nursing profession has experienced substantial developments over recent decades. Nevertheless, there remain critical challenges in relation to nursing care delivery and the working conditions of the nurses. A historical nursing shortage is further worsened by a hospital and urban-centred, under-resourced public health system. Health and social inequalities are endemic in Bangladesh, and specifically affect women, children and disadvantaged population sectors. Corruption and mismanagement are widely-extended in government and the private sector and are a significant limitation in the delivery of basic services like health and education. Furthermore, most social, educational and health planning is heavily reliant on the political and economic interests of the government and international and bilateral agencies. The latter aspect has a significant impact on nursing education and service.

One of the most noticeable issues of the nursing profession in Bangladesh is the apparent gap between the institutionally-accepted image of nursing care and the observed practices of the nurses, especially in the government sector. On the one hand, the academic and institutional definition of the nursing profession involves intimate care for sick people (BNMC 2013). On the other hand, research has portrayed nurses as avoiding giving direct nursing care to patients (Hadley & Roques 2007). The reasons for this contradiction have already been studied, and have shown a complex interaction between historical, socioeconomic and cultural factors (Hadley et al. 2007), mainly related to the conflict between the British-inherited curriculum, with a strong emphasis on basic care activities and the local social and gender norms. Trying to further explore this apparent contradiction through the narratives of individual nurses was the original aim of this research.

1.1. ORIGINS OF THE RESEARCH AND INITIAL QUESTIONS

This research is the outcome of a personal, professional and academic journey. My first contact with Bangladesh started in Barcelona, when I began working as a nurse in the neighbourhood where most Bangladeshi migrants live. That led me to conduct preliminary research on motherhood and childcare for my Masters in Anthropology and Ethnography at the University of Barcelona. After this initial research, and due to an increasing interest in wishing to learn and become more familiar with the country, I decided to continue this research work in Dhaka. I arrived in Bangladesh in 2009 with the clear aim of learning more about the country and attaining a certain level of language fluency that would allow me to carry out more in-depth research into motherhood and care.

I began volunteering in a hospital and I later joined in a recently created nursing college as a teacher. My double role as a nurse and anthropologist, together with my experience working with nurses, turned my interest towards the analysis of the social and cultural aspects of the nursing profession in the country. This made me re-focus my PhD thesis proposal, which I finally submitted to the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) in 2011[1]. This new proposal derived from my experience with Bangladeshi nurses in both clinical and academic settings. As I started to work with them, I perceived an apparent contradiction between what was taught about nursing care and some nurses' practices. I started looking for previous research about nursing in Bangladesh and found out that this rhetoric-practice gap had already been described in hospital ethnographies and observational studies conducted in recent years (Leppard 2000; Afsana 2005; Zaman 2005; 2009; Hadley & Roques 2007; Hadley et al. 2007).

[1] ICDDR,B is one of the most renowned international health research institutions in the country. Although it started as an infectious disease-related research centre, it soon expanded its scope to other areas like reproductive health and neonatal and child health (ICDDRB 2015)(ICDDRB, 2015). This research project was approved by the Research Review Committee (RRC) and Ethical Review Committee (ERC) of ICDDR,B in December, 2011. The approval document is shown in Appendix A.
The research protocol was submitted under the title of "Narratives of the Nursing Profession in Bangladesh. Views and Experiences of Nurses Working in Dhaka". After completion of the data analysis, the PhD title was changed to the current one.

The hospital ethnographies were extremely useful in gaining a deeper understanding of the ways in which government hospitals functioned on a daily basis which, in many cases, were reflected in broader tensions in Bangladeshi society (Leppard 2000; Zaman 2005). Even if none of them focused exclusively on nurses, they all provided detailed descriptions of the challenges that nurses face in care provision. These studies also denounced the limitations for patients in terms of access to health care facilities and resources.

Later, Hadley and Roques (2007) published an observational study that concluded that nurses in government hospitals spent 5.3% of their working time providing direct patient care, whereas their colleagues from private institutions and NGOS spent 22.7% of their time on basic care activities. As part of a broader research project, the authors further analysed the reasons for this contradiction and found that they could be partially explained by the low status associated with the profession (Hadley et al. 2007). The nurses' lack of social recognition was mainly related to the nature of their work, which challenged the widely-accepted social image of women. This was further worsened by the polluting nature attributed to contact with bodily fluids. Partly because of that, but also due to the difficult working conditions in hospitals, nursing was historically undertaken by either Anglo-Indian women or those coming from disadvantaged sections of the population (Robson 2005). Hadley et al (2007) found that, in order to distance themselves from the stigma associated with direct care of unknown male patients, nurses in government hospitals tended to delegate these activities to their surrogates.

Zaman (2009), in a more recent article, described nurses as 'ladies without lamps', in allusion to the iconic image of Florence Nightingale as the 'lady with the lamp[2]'. The portrait was meant to be a representation of Nightingale and 'her nurses' during their rounds in the Crimean war. Bostridge (2008) highlighted how the Christian symbolism around the lamp subsequently inspired many of the later writings about Nightingale. She has traditionally been considered as the 'mother' of the profession for her role in nineteenth century nursing reform in England. Her work during the Crimean war has been praised and

[2] The portrait appeared for the first time in the English newspaper *Illustrated London News* in 1855 (Bostridge 2008).

often romanticised, and continues to be a key element in the rhetoric about nursing in the Indian subcontinent.

The 'ladies without lamps' metaphor points to a dichotomic view of nurses that does not account for the complexity of the nursing profession in Bangladesh. On the one hand, it reinforces a romanticised image of 'Nightingale nursing' without critically analysing the colonial and Victorian ideological roots behind this particular conception of care. On the other hand, it carries the risk of presenting a negative image of nurses as burned-out and frustrated. This aspect further contributes to their already low social image. Nevertheless, the most significant point about this contraposition between Western rhetoric and local practices is that it is based on a binary analysis. Nurses are portrayed as either carrying 'lamps' and caring for the patients or avoiding doing so. After having observed the working conditions of clinical nurses in the private and government sectors, I could not fully agree with the underlying statement that Bangladeshi nurses were avoiding nursing care. Taking a further look at the history of the nursing profession and its development in the Indian subcontinent, I started to analyse the traditional Western image of nurses more critically and discovered that the relationship between nursing and care had been reworked by feminist studies, anthropology and other social sciences.

My main thrust, therefore, was to delve further into nurses' experiences. I wanted to explore how being a nurse had affected their life path and *vice versa*; how their personalities, their immediate social background and their life events had influenced their career development as nurses. To achieve this, I decided to take a critical phenomenological approach, considering not only their narrated experiences, but also the broader context that shaped them. The concept of critical phenomenology was used by Good (1994, p.63) in an attempt to merge "political economy and interpretive perspectives, of integrating historical and global perspectives with rich cultural analysis in our ethnographic writing".

The starting point of this research was the gap between what Hadley and Roques (2007) termed "rhetoric and reality" of nursing in Bangladesh. The initial research question was formulated in this way:

> Previous research about nursing in Bangladesh has shown an apparent gap. On the one hand, the academic and institutional definition of the nursing profession involves intimate care for sick people. On the other hand, previous studies of nursing practice in the country have described its distant relationship with patients (Leppard 2000; Zaman 2005; Hadley & Roques 2007; Hadley et al. 2007). *How is this gap explained in nurses' narratives?*

This question led to the following objectives:

- To describe the professional history of nurses working in different organizations in Dhaka
- To understand their views about the profession
- To explore the implications of being a nurse in their professional and personal life
- To analyse how Bangladeshi nurses understand the concept of care and what place it occupies in their perceptions about the profession

I initially planned to conduct in-depth interviews with six nurses, who would be considered as key informants with respect to their professional experience as nurses. The number of nurses would then be increased according to the analysis of the first interviews. Nevertheless, as often happens in this kind of exploratory study, the 'field' obliged me to change methodological and theoretical orientation of the research.

For reasons that are explained in the methodological chapter, I ended up interviewing only female nurse teachers as key informants. Their experiences and professional career developments were, therefore, very different from those of clinical nurses. Moreover, as I learned more about the history and current situation of the nursing profession in Bangladesh, I realised that if I asked them directly about their views of nursing care, they

would mostly give me the academically- or institutionally-accepted views. This led me to modify the initial research question into a more general one. Methodologically, I decided to avoid starting interviews with questions about the nursing profession. Instead, they would be asked to reconstruct their life stories, with a specific, but not exclusive, emphasis on their experiences as nurse students, staff nurses and finally, nurse teachers.

1.2. REFORMULATION OF THE RESEARCH AIM AND OBJECTIVES

When I began to analyse the individual narratives, relating them to one another and to the broader context, a further challenge emerged. I kept going back to the initial research question and objectives, repeatedly asking myself what it *meant* to be a nurse in Bangladesh from a *practical* and *lived* experience. The first issue that began to concern me was that the key informants were not 'average' nurses. Several elements in their personal accounts made them stand out. On the one hand, they were all nurse teachers and were therefore expected to have a more Westernized and elaborate rhetoric of the nursing profession in Bangladesh. On the other hand, they had been able to overcome important hurdles during their childhood and youth and managed to be academically and professionally successful. They were definitely not the 'ladies without lamps' portrayed by Zaman (2009). A further review of the literature on the history and current situation of nursing in Bangladesh made me reformulate the initial question into an overall research aim.

As the research aim was still ambitious, I decided to divide it into more specific and achievable objectives. After reworking the theoretical approach, I reworded and slightly modified the initial objectives. Furthermore, I merged the nurses' conceptualisations about nursing and care in a single objective and added a final objective to include the broader theoretical discussion.

Overall research aim: To theorise about the ways in which structural factors *intersect*[3] with the individual experiences of nurse teachers in their personal and professional fields.

Research objectives

- To describe the nurses' views about nursing care and their profession
- To discuss to what extent nursing education has been an empowering tool for them
- To analyse how their socioeconomic background, personal experiences and life events have influenced their professional careers and their conceptualisation of nursing and care

Even though the analysis of nurses' views on nursing care and their profession was the first specific objective of the thesis, I decided to 'decentralise' the concepts of *caring* and *nursing care* for two main reasons. First, the word *care* is central in the hegemonic nursing narrative of the country, and I was worried about obtaining either theoretical definitions or a 'list' of care-related activities. Initially, I was not as interested in the rhetorics about care as I was about what becoming nurses had meant for them in their personal and professional experiences. Secondly, I realised that, being a nurse myself, I also needed to obtain some distance from the notion of caring, at least in the way I had understood it so far. This distance, however, was never total, as it is inadvisable, and indeed, impossible, to remove our own subjectivities and experiences.

Towards the end of the analysis, however, it became evident that the notion of *caring*, in its broadest and primary sense, was central to the nurses' experiences. Their opinions about the nursing profession and the changes it had undergone over time pointed to a common rhetoric about the 'deterioration' of nursing care. This aspect became crucial to understand the nurses' own representations and experiences around nursing care. When their reflections about what nursing care meant for them were put together with their

[3] Even though I used some of the ideas of intersectional theories of gender, this research does not strictly follow any particular school. I decided to use the notion because I believe it is a good way of accounting for the ways in which several factors, usually in the form of social inequalities, affect peoples' lives and the ways in which they narrate them.

biographical experiences and with the history and political economy of nursing in the country, a threefold relationship between caring, knowledge and power emerged. This aspect is analysed towards the end of the research.

1.3. STRUCTURE OF THIS THESIS

The body of this thesis is structured in three different parts. The first part presents the main theoretical and methodological issues. Chapter Two highlights a range of theoretical frameworks that have been used to articulate the discussion around nurses' experiences and their broader position in society. Initially, Critical Medical Anthropology was taken as a framework, and helped to conceptualise crucial aspects, such as the relationship between power and the biomedical system (Frankenberg 1980; 1981; 1988; Menéndez 1984; 1990; Baer et al. 2003; Pizza 2005; Singer & Erickson 2011; Singer & Baer 2012); the analysis of health inequalities as structural violence (Farmer 1997; 2004) and the drawing up of a critical phenomenology (Good 1994; Good & DelVeccio Good 2000). An analysis of nursing and care from an anthropological and critical, feminist perspective was also useful in identifying the position of nursing within society and the health system (Gamarnikow 1978; 1991; Holden & Littlewood 1991; Saillant 2009). This first analysis of nursing care in relation to broader structural aspects and to the ways in which they shape the nurses' subjective experiences, however, led to a more general discussion around the tensions between individual agency and broader power relations.

The work of practice theorists like Bourdieu (1977; 1984; 1990) and Giddens (1979; 1984), and the more recent contributions by Sherry Ortner (1984; 1989; 1991; 1996; 1999a; 2006) were key in bridging the individual *versus* society gap. Following Ortner, I decided to place a greater focus on the role of history and socioeconomic inequalities, as well as on the ways in which knowledge and meaning are socially constructed and how power relations are imbedded in this process. Contributions from the critical analysis of gender (Davis 1983; Hooks 1984; Moore 1988; Crenshaw 1989; Sacks 1989; Narotzky 1995; Stolcke 1996) and post-colonialist studies (Said 1978; Mohanty 1984; Kabeer 1994; Escobar 1995) have been helpful in the latter regard.

Finally, caring is analysed as a primary activity first and, later, in relation to nursing. This section includes discussions about nurse anthropologists (Collière 1998; Leininger 1988; Saillant 2009; Casadó 2009), nursing philosophers (Griffin 1980; 1983; Benner & Wrubel 1989), theorists of knowledge in nursing[4] (Chinn & Kramer 2015), and other theorists who analysed the relationship between caring and power from a feminist and post-structuralist perspective (Doering 1992; Falk Rafael 1996). The works of medical anthropologists who have focused on the different forms of care (Menéndez 1984; Haro 2000) are also included in this section.

Chapter Three describes in more detail the methodological aspects of the research, arguing why a biographical approach was chosen to contextualise the nurses' individual experiences. This section is mainly based on sociological and anthropological approaches to life stories (Betraux 1981b; 1981a; Magrassi & Roca 1986; Bourdieu 1989; Frigolé 1992; Terradas 1992; Behar 1993; Linde 1993; Rosenthal 1993; De Miguel 1996) and some of the discussions around the complexities of personal narratives (Rosenwald & Ochberg 1992; Linde 1993; Josselson & Lieblich 1993; McAdams et al. 2006).

The second part discusses the broader context of the two main fields of this research: the nursing profession and Bangladeshi society. Bourdieu's notion of fields where individual and structural factors interacted was very useful as an analytical tool, or in Giddens' (1979) terms, as a 'methodological bracketing'. This bracketing allows the identification of the different structural and ideological discourses are present in both fields. However, this distinction is, in many ways, artificial, given that in the personal narratives and in 'real' life, both personal and professional fields are intertwined. Chapter Four presents the key aspects of Bangladeshi society considered relevant in situating nurses' individual experiences. Similarly, Chapter Five contextualises the nursing profession in Bangladesh,

[4] Some authors refer to the analysis of the ways in which knowledge is developed in nursing as 'nursing epistemology'(Schultz & Meleis 1988; Antrobus 1997). Even though epistemology may be defined, in its broadest sense, as "the theory of knowledge" (Blackburn 2016) , it is also a branch of philosophy with its own theoretical developments and specific methodologies. For this reason, the more 'fluid' notions of *knowing* and *knowledge* are preferred in this research, as they account for both individual subjectivities and their sharing amongst the members of a collective or discipline (Chinn & Kramer 2015).
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taking a critical approach that focuses on the colonial heritage in contemporary nursing. By doing so, the ideological and structural roots of the uneasy position of nurses in Bangladesh may be better understood.

As the research progressed, it became evident that the nursing profession had played a crucial role in the lives of the nurse teachers. It had given them access to higher education, paid jobs and subsequent social recognition. Nevertheless, it would be too simplistic to conclude that they had reached all their social and professional achievements thanks to nursing. Reaching their present position as nurse teachers has not been easy for them. They had to overcome and, indeed, they still face, important challenges inside and outside the professional field. The third part of the thesis further explores these challenges and opportunities through a dialogical analysis of the nurses' life stories, with a special focus on the experiences related to nursing education and services.

In Chapter Six, the nurses' narratives about the motives and circumstances that led them to seek admission to the nursing institute are explored. The role of childhood events and family background in their decisions and actions is discussed towards the end of the chapter. Chapter Seven describes the process of becoming nurses, including both the ways in which nursing care was learnt and experienced, and the socialisation process that students underwent. The chapter also analyses the consequences of being a nurse in society and their first experiences in the medical setting. Chapter Eight looks at the nurses' development in their professional field and their transition from the clinical to the educational area. Following a brief discussion of the structural factors that shape the position of nursing within the broader health system, the strategies used by the nurses in trying to overcome these limitations are analysed. Finally, a summary of the main findings of the thesis and its conclusions are presented separately in Chapter Nine.

1.4. NOTE ON TRANSLITERATION

I am semi-literate in Bengali and, when formally studying Bengali, I used the language school's own transliteration scheme. During the fieldwork, however, I ended up using English phonetic transcription to write my own notes and interview transcriptions. As

happens with other languages, Bengali has many sounds that cannot be written in English. Several schemes have been developed in order to accurately transliterate the way words are pronounced[5] For the purpose of this research, and in order to make the text easy to read, I have kept it simple by writing the words in the way I heard them[6]. Apart from adding an 'h' after the aspirated consonants, I have not used any additional distinction (i.e. between dental and palatal sounds).

[5] The National Library at Kolkata romanisation is the most widely used, although it is too complex to be used in this thesis.

[6] Because my mother tongue is Spanish and not English, I am more used to pronouncing the vowels in the way they are written. This gave me a certain advantage in reading, writing and pronouncing Bengali. It also affected the way I transcribed the words, which is more similar to the way Bangladeshis would informally transcribe them.

PART I: THEORY AND METHOD

This first part of the thesis presents the main theoretical and methodological aspects. Although theory and method are presented as separated chapters, they are closely interrelated. In terms of the theoretical and methodological formulation, this thesis has been constructivist from its very beginning. Like many other researchers, I went to 'the field' with my own background, assumptions and initial questions. As the research advanced, this initial background proved to be insufficient to articulate the complexity of the nurses' narratives. As soon as I began reconstructing the nurses' life stories and trying to relate them to broader questions such as history, power or gender and social inequalities, I had to undergo a further immersion process.

A crucial question emerged through the exploration of the theoretical and methodological issues surrounding the use of life stories. I needed to further explore the articulation between subjectivity and structure, or in other words, between 'the individual' and 'society'. Helped by the works of practice theorists, I aimed to explore the main dilemmas of the longstanding individual-society tension in social sciences. Critical concepts emerged which had to be studied and reworked, such as discourse, history, ideology, power, and so on. Finally, the ways in which these tensions are articulated in the specific field of nursing and care had to be explored as well. Chapter Two presents a summary of this process. Even though some of the authors or ideas presented in this chapter are not explicitly taken up throughout the latter parts of the research, they undoubtedly helped in setting up my own framework and 'gaze'.

The methodological aspects are presented separately in Chapter Three, although they are markedly guided by the theoretical developments of the previous chapter. Even the methodology is something that has been constantly reworked and rethought throughout this research. At some points, this has made me feel lost and with a sense of 'lack of control', yet it has also been a source of reflection and enrichment. In any case, I aim to present all this reflective process clearly and smoothly for the reader.

2. THEORETICAL FRAMEWORK. SITUATING EXPERIENCES, KNOWLEDGE AND *CARING*: BETWEEN AGENCY AND STRUCTURE

"What I mean to gesture at is a mode of encountering the Other which does not assume that in the process of culturally translating other lifeworlds one's own certainty about how the world should proceed can remain stable. This attitude requires the virtue of humility" (Mahmood 2005, p.199)

2.1. INTRODUCTION

Linking the individual narratives of the nurses to the structural factors shaping them seemed an obvious thing to do in order to understand their complexity. Relating the stories to one another was relatively easy, especially because most nurses had studied in similar time periods between the late 1970s and 1980s. However, the big challenge emerged when trying to relate their subjective accounts to the broader historical and socioeconomic background; it was at this point where the theoretical discussion on the relationship between individual and society had to be faced. This individual/society distinction is made keeping in mind that it belongs to a specific (Western) epistemology (Scheper-Hughes & Lock 1987) and that the boundaries between the two realms are fluid and difficult to delimit.

Theorisation about the complex relationship between the individual subject, their immediate relations, social institutions, and broader categories, such as gender, religion or class, was challenging. I could not easily find a single explanatory model and I found myself swinging between acknowledgement of subjectivity/intersubjectivity and the more 'structural' theories. This made me investigate historical, political and philosophical theories that were often very complex and tended to take me away from the initial aim of the research. In this regard, I have to agree with Wright Mills (2000, p.121), when he stated that "when we pause in our studies to reflect on theory and method, the greatest yield is a re-statement of our problems". This re-statement goes beyond questioning and

reconfiguring our research 'problems' or questions and leads to a challenge of "one's own certainties" (Mahmood 2005, p.199).

Historical and sociological imagination has been crucial in this reflective process. Both were necessary to understand the nurses' accounts and to assess what things were like back in that time period. *Sociological imagination* "enables its possessor to understand the larger historical scene in terms of its meaning for the inner life and external career of a variety of individuals" (Mills 1959, p.5). The Comaroffs (1992) used the term *historical imagination* to describe a similar process. The authors admitted that individual life stories would remain just that, stories, unless the *making* of collective worlds and the effects of history upon the narratives are acknowledged.

This research follows a critical phenomenological approach, as it integrates interpretive perspectives and political economy within a broader historical view (Good 1994). When analysing complex social phenomena, a critical perspective is needed, moving "beyond what is usually assumed" (Chinn & Kramer 2015, p.70). This critical analysis often requires an interdisciplinary approach which crosses the "disciplinary and academic lines that (…) falsely fragment knowing and knowledge" (2015, p.83). This need was felt from the very beginning of this research, as it soon became clear that the anthropological analysis of experience would require contributions from the works of other disciplines like history (Comaroff & Comaroff 1992; Wolf 1982; Wright Mills 2000), narrative and biographical analysis (Riessman 1993; Linde 1993; Peacock & Holland 1993; De Miguel 1996) nursing (Salvage 1985; Doering 1992; Rafferty 1996; Falk Rafael 1996; Chinn & Kramer 2015), sociology (Schutz 1972; Bourdieu 1977; 1990; Giddens 1979; 1984) and philosophy (Taylor 1979; Benner & Wrubel 1989; Foucault 1977). In addition, the critical approaches of feminism(s) (Moore 1988; Narotzky 1995; Mahmood 2005; Yuval-Davis 2006), post-colonialist studies (Asad 1973; Mohanty 1984) and other critical political theorists (Gramsci 1970; Williams 1977; Willis 1977; Scott 1985; 1990) have been essential in framing this research.

There is not enough space here to develop each of the theories and authors behind the theoretical framework. A focused analysis of the key concepts and theoretical discussions, which are central to the discussion of the nurses' experiences is presented. The chapter has three different sections. The first focuses on the broad theoretical discussions around the notion of human agency (Giddens 1979; 1984; Comaroff & Comaroff 1992; Sewell 1992; Ahearn 2001; Ortner 2006). The following theoretical paradigms have been used to better understand the complexity of agency and human action: the sociology of knowledge (Berger & Luckmann 1971); practice theory (Bourdieu 1977; Bourdieu 1990; Bourdieu & Passeron 1990; Giddens 1979; 1984; Jaramillo Marín 2011); and the critical analysis of agency in relation to structural inequalities For the latter, the discussions of anthropological post-colonialist studies (Kabeer 1994; Cornwall 2010; Gardner & Lewis 2015) and feminism (Ortner 1999b; 1999c) have been crucial. Secondly, a brief introduction to the key structural inequalities that shape the nurses' experiences is presented. Finally, the notion of *caring*, which is central to the nurses' narratives and practices, is also analysed through the works of medical and nursing anthropology (Menéndez 1984; Collière 1998; Haro 2000; Leininger 2006; Casadó 2009; Saillant 2009) and the critical analysis of nursing knowledge (Doering 1992; White 2006; Chinn & Kramer 2015).

2.2. THE COMPLEXITY OF HUMAN AGENCY: BOUNDARIES AND POTENTIALITIES OF THE KNOWING SUBJECT

The notion of agency has become pervasive within the social sciences, mainly due to three interrelated factors: the emergence of approaches which highlight practice; the social movements of the 1960s and 1970s; and the poststructuralist critiques which questioned impersonal master narratives (Ahearn 2001). The way in which action is analysed by the anthropological sciences, however, differs greatly from the individualism embedded in the early philosophy of action (Ahearn 2001), and the behaviourist theories of action of social psychology[7] (Vincent 1978).

[7] In relation to the latter, Vincent (1978, p.175) explained clearly the different approaches: "Action theory in anthropology begins by locating the individual within the framework of both formal and interstitial social organization and then proceeds to the analysis of political action and interaction"

The notion of agency broadly suggests "intention or consciousness of action, sometimes with the implication of possible choices between different actions" (Barnard & Spencer 2010b, p.755). Nevertheless, the situated role of agency has to be emphasised, distinguishing it from the notion of free will (Giddens 1979; Comaroff & Comaroff 1992). Even if we understand agency as a universal human capacity, it can take different forms (Sewell 1992). Furthermore, the very concept of agency is culturally and historically constructed (Ahearn 2001; Ortner 2006). This section provides a contextualisation of the notion of agency within broader discussions around notions like practice, experience, social structures, ideologies, power and inequalities.

2.2.1. Situating human agency (I): Everyday life and meaningful experience

Berger and Luckmann (1971, p.13) argued that "reality is socially constructed and that the sociology of knowledge must analyse the process in which this occurs". The sociology of knowledge drew extensively from Schutz's (1972) social phenomenology, which applied the ideas of existential phenomenologists to the analysis of social action. Based on the assumption that "entities are given meaning through being experienced" (Ochs & Capps 1996, p.20), phenomenological approaches are used from a wide variety of disciplines and theoretical perspectives[8]. In spite of its internal diversity, the one thing which characterises phenomenology is the assumption that we can never access the totality of other people's experiences (Schutz 1972; Riessman 1993).

A crucial element in the reconstruction of experiences is their *meaning*, which may be defined as the "turning of the attention to an already elapsed experience, in the course of which the latter is lifted out of the stream of consciousness" (Schutz 1972, p.215). The meaning of an action does not lie in the act itself but in "the project which defines it" (1972, pp.62–63). Schutz acknowledged that not all actions are voluntary or 'free', as goals

[8] For a detailed analysis of the uses of phenomenology in anthropology see Desjarlais and Throop (2011). In addition, it is common to see phenomenological approaches in nursing research, especially Heidegger's hermeneutic phenomenology (Benner & Wrubel 1989). Thorough work has been conducted through the application of the philosophical discussion to nursing subjects in different parts of the world (Annells 1996).

do not exist before choices. Nevertheless, once the action had been completed, it appears as a unified act or projection. The notion of 'choice' is significant in relation to the narratives of the nurses. However, perhaps what is more interesting is the *meaningful* way in which they narrated some of their past decisions and events. According to Schutz, I try to move beyond a 'factual' narration in order to situate the narratives both as subjective experiences and in relation to broader structural events.

Human action is better understood when analysed as an intersubjective experience. According to Schutz, there are three different levels of intersubjectivity, which vary according to the degree of anonymity between the subject (or actor) and the Other. At the most immediate level of face-to-face situations, we establish a 'We-relationship' with our consociates. At the other extreme of the continuum is the indirect social experience, or what Schutz termed 'Thou-relationship[9]', understood as a broad 'Other-orientation'. People at this level can either be our predecessors, our successors or simply anonymous people. Between these two realms or levels of intersubjectivity there is a range of intermediate situations, grouped by Schutz under the notion of 'They-relationship' or 'Real Other-orientation'. The most interesting issue for this research is the acknowledgement that interpersonal relations go far beyond the relationship between two subjects. This idea will be taken up again towards the end of the chapter in relation to the caring experience.

Intersubjective experiences also include different forms of socialisation, understood as processes where people "are made to take on the ideas and behaviour appropriate to life in a particular society" (Toren 2010, p.646). Berger and Luckmann (1971) added a significant element to the study of socialisation through their analysis of the *internalisation* process, defined as "the immediate apprehension or interpretation of an objective event as expressing meaning" (1971, p.149). The authors further developed the idea of shared or intersubjective meanings through their notion of *social stocks of knowledge*. This particular

[9] It is assumed that Schutz took the notion of 'Thou' from the German philosopher Buber (Wagner 1977). Smith (1937), in the introduction to Buber's classical work *I Thou*, clarified that even if the second person singular pronoun 'Thou' was not used in contemporary English, it remained in use to address God in prayers. It was in this transcendental meaning that Buber used it, albeit in Schutz's work it took a different perspective.

form of social knowledge is shared and transmitted from one generation to the other in the form of symbolic universes.

Similarly, Giddens (1979) refuted the idea of passive imprinting of society upon individuals, understanding socialisation as a lifelong process. Therefore, the notion of agency should be understood as a process of subject formation, where categories such as 'I' or 'us' are not unified entities but, instead, are constantly shaped by cultural and political practices (Brah 1992). This research is more aligned to the latter view. Key socialisation moments are identified for analytical purposes, including primary socialisation in the family, and subsequent socialisation processes like schooling, joining nursing education or entering the professional field. Significantly, some nurses attended boarding schools during childhood and all lived in nursing institutions throughout their education. The implications this had for their socialisation into the nursing field are obvious, not only in the more subjective processes of identity formation, but also in relation to their material and living conditions.

2.2.2. Situating human agency (II): The embodiment of social structures and the role of practice, consciousness and intention

The previous section suggested that human agency was closely related to the notion of meaning, which should be analysed in relation to the social construction of knowledge. Furthermore, meanings and knowledge are not constructed only in an abstract, conscious way. Practical experience becomes crucial in this regard, even if its role is not always acknowledged. This is especially important for nurses and nursing knowledge, as the profession draws its knowledge base from practice (Antrobus 1997). At the same time, however, the relevance of practical knowledge has often been used to undermine the knowledge generated from the caring experience (Benner & Wrubel 1989; Antrobus 1997). This issue will be taken up again later in this chapter but, for now, mention should be made of the key dimensions of practical experience and the roots of its devaluation in rational, scientific epistemologies.

2.2.2.1. The distinction between objective/subjective knowledge: Questioning Cartesian dualism

Cartesian philosophy and its dualisms (mind/body, objective/subjective) have dominated Western hegemonic thought for centuries (Benner & Wrubel 1989; Scheper-Hughes & Lock 1987). This particular way of understanding human beings was mainly developed by the English empiricists in the seventeenth and eighteenth centuries, and was taken up again by the North American behaviourists in the twentieth century (Benner & Wrubel 1989). Phenomenology emerged as a crucial step in overcoming the Cartesian dichotomy, with the development of notions like *embodied intelligence*[10], *situated knowledge*[11] or *background meaning*[12]. From the phenomenological viewpoint, ontology precedes epistemology. We *know* because we *are* in the middle of meaningful situations. Similar to phenomenology and post-structuralism, feminist authors, and especially those who focused their efforts on the overcoming of the dichotomic or binary representation of gender, have also resulted in a significant shift in the acknowledgement of the fluid nature of concepts and categories (Stolcke 1996; Butler 1999; Lázaro 2014).

Relevant to this analysis is the notion of *situated knowledge(s),* which was first developed by Haraway (1991) in her analysis of the contentious relationship between feminism and science. Through this notion, the author attempts to overcome the dichotomy within feminism between radical constructionism and critical empiricism. Haraway refused both the extreme forms of 'unlocatable' relativism and the totalising claims of scientific authority and suggested instead:

[10] Embodied intelligence is defined as "embodied knowledge [that] enables us to move through situations and encounter situations in terms of meaning and in rapid, nonreflective ways" (Benner & Wrubel 1989, p.42). The notion of *embodied knowledge* drew from the phenomenology of Merleau-Ponty and can be defined as "a type of knowledge in which the body knows how to act" (Tanaka 2013, p.47).

[11] This notion is defined below, using the theoretical developments of Haraway (1991).

[12] The term was defined by Heidegger (1962, cited in Benner & Wrubel 1989, p.46) as "what culture gives a person from birth; is that what determines what counts as real for that person. It is a shared, public understanding of what is" (Benner & Wrubel 1989, p.46)

> "Politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims. These are claims on people's lives; the view from a body, always a complex, contradictory, structuring and structured body, versus the view from above, from nowhere, from simplicity" (1991, p.195)

In summary, we can say that phenomenologically, situations are directly grasped in terms of their *meaning* (Benner & Wrubel 1989), which, in turn, is socially and culturally constructed. In this respect, the contributions of Clifford Geertz (1973) and other interpretive anthropologists are of great interest. Geertz's analysis merged the classical North American concept of culture as a world view and the philosophical analysis of the construction of meaning (Ortner 2006). The most relevant development for the theoretical discussions in this section is his understanding of 'common sense' as a particular cultural system (Geertz 1983). By doing so, he challenged the association between 'common sense' and 'truth'.

When applying the former discussion to medical and nursing knowledge, significant issues emerge. First, the Cartesian roots of the biomedical system, with its subsequent separation between mind/body, subject/object, agent/patient, and so on (Frankenberg 1981; Menéndez 1984; Scheper-Hughes & Lock 1987; Baer et al. 2003). Second, with the advent of phenomenology and studies of the notion of *embodiment*, it became clear that mind and body could not be separated in the analysis of meaningful human experience. Scheper-Hugues and Lock (1987, p.7) suggested an understanding of the body as "simultaneously a physical and symbolic artefact, as both naturally and culturally produced, and as securely anchored in a particular historical moment". Nevertheless, abstract and intellectual knowledge continued to be more highly valued than other, embodied forms of knowledge (Doering 1992). This is significant in relation to the unequal values attached to nursing and medical knowledge.

Therefore, notions of meaning and knowledge, that is, the different ways in which we understand the world and the value attached to them, must be analysed in relation to social

power. Foucault (1977) opened a crucial discussion in this regard, which Doering (1992, p.25) summarised as: "Power limits what is acceptable to be known, and knowledge develops in response to and sometimes in resistance to the limits set by power relations". Therefore, power is, at the same time, generative and representative. Critical discourse analysts like Van Dijk (1993) focused on the role of text and talk, as well as understanding the meanings found in the production and reproduction of domination. Nevertheless, knowledge is not only about language. Berger and Luckmann (1971) had already discussed the ways in which knowledge is related to action.

Long and Arce (1992) used the term *knowledge interfaces* to account for the power relations embedded in any form of knowledge exchange and in the value assigned to different forms of knowledge. The following quotation illustrates this aspect:

> "Knowledge emerges out of a complex process involving social, situational, cultural and institutional factors (…). Moreover, knowledge is constructive in the sense that it is the result of a greater number of decisions and selective incorporations of previous ideas, beliefs and images, but at the same time destructive of other possible frames of conceptualization and understanding" (Long & Arce 1992, p.211)

In summary, some forms of knowledge are more 'powerful' than others, even if everyday life is usually dominated by a pragmatic form of knowledge (Long & Arce 1992). Over time, various disciplines have challenged the Western Cartesian worldview. Amongst them, feminist and anthropological theories are especially significant for this research. Feminism questioned central elements like the binary analysis of gender or the Western ideal of womanhood (Moore 1988; Narotzky 1995; Butler 1999; Stolcke 2000). Anthropology and cultural relativism, in turn, posed a crucial challenge to ethnocentric and historically-Eurocentric epistemology[13] (Stolcke 1996; Gardner & Lewis 2015). In any case, both interpretive and critical theories have demonstrated that practice and the less reflective

[13] Stolcke (1996) highlighted how the contribution of anthropology has been crucial in demonstrating that our own notions of 'person' and 'individual' are cultural and historical constructions, and not ontological foundational realities.

forms of knowing are central to the human experience. Nevertheless, the role of social structures and institutions in individuals' experience should be analysed as well. In order to do so, the contributions of practice theorists have been found more useful than the interpretive approaches.

2.2.2.2. Overcoming the dichotomy: The embodiment and transformation of social structures

During the 1970s, a big effort was made within the social sciences to transcend old dichotomies like those between objectivism/subjectivism, structure/action, micro/macro, quali/quanti, material/ideal, etc. (Jaramillo Marín 2011). A good way of overcoming dichotomic analyses was to focus on human practices, which generally include "what people do, as opposed to what people say" (Barnard & Spencer 2010b, p.780). Instead of 'bracketing' structural factors, however, practice theorists took them as a central element in human experience, which could be analysed from three perspectives (Ortner 1989). First, everyday practice can be analysed in the form of internalisations and broader structural reproduction/change processes. A second approach highlighted the intentional action or projects and the ways in which they are structurally constituted. Finally, the Marxist notion of *praxis*[14] was also relevant, involving the engagement of routine activity and the potential of reshaping it from alternative logics and "novel contexts of practice" (Ortner 1989, p.195).

Practice theory was initially developed by Bourdieu (1977; 1990), who took as a starting point the "practical mode of knowledge which is the basis of ordinary experience of the social world" (1990, p.25). This form of knowledge occurs in the form of *habitus*[15], defined

[14] Generally, the notion of *praxis* moves beyond that of practice, as it implies that "all patterns of knowing are integrated in a way that supports social justice" (Chinn & Kramer 2015, p.2). Ahearn (2001) observed that some sociologists prefer the notions of *praxis* or practice to the term agency, as it moves beyond the capacity to act to the action itself. In this text, a critical view of agency which also integrates the notion of *praxis* is used. This concept will be taken up again in relation to the ways in which nursing knowledge is constructed.

[15] The whole definition is more complex and includes a "system of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively 'regulated' and 'regular' without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them, and being all this,

as a particular form of embodiment of social structures. To make it simple, we could say that through habituated practice we internalise, reproduce but also transform social structures and collective meanings. There is, therefore, a particular interaction between the individual and the social context that happens beyond the realm of conscious reflection or abstraction. This idea was further developed by Giddens (1979) even though, for him, the notion of agency and the *knowing subject* was more relevant. Practice theorists demonstrated that social structures are fluid and liable to be transformed. This is what Giddens conceptualised as *duality of structure*, the latter being both enabling and constraining:

> "The same structural characteristics participate in the subject (the actor) as in the object (society) (…). Every process of action is a production of something new, a fresh act; but at the same time all action exists in continuity with the past, which supplies the means of its initiation" (1979, pp.69–70)

As action is situated in time and space, this degree of 'penetration' of 'system reproduction' varies greatly between groups and 'spaces', even if is somehow shared by members of the same group. This is related to what Bourdieu termed *class habitus*[16] and Giddens (1984) understood as *mutual knowledge,* defined as the "knowledge of 'how to go on' in forms of life" (Giddens 1984, p.375), which fell closer to Schuz's (1972) notion of *social stocks of knowledge*. According to Giddens, there are two significant elements in the maintenance of mutual knowledge over time and space: *institutions* and *routinisation*. Institutions are defined as "the most deeply-layered practices constitutive of social systems" (Giddens 1979, p.65), which involve a threefold relationship between signification, domination and legitimation. In their broader sense, social institutions legitimise certain patterns of knowledge and conduct (Berger & Luckmann 1971; Giddens 1979). *Routine*, on the other hand, plays a crucial function in social reproduction, even more so if it is associated with

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collectively orchestrated without being the product of the orchestrating action of a conductor" (Bourdieu 1977, p.72)

[16] The notion of class habitus will be discussed further on in relation to the conceptualisation of social class.

tradition. Nevertheless, de-routinisation can happen as well, therefore generating social change.

In this research, the notion of *institutions* is used differently in its broad and narrow senses. In its broader sense, the institutionalisation of care is analysed as a complex historical process which goes far beyond the nursing and medical professions. According to Giddens (1984), institutionalisation processes involve relations of signification, domination and legitimation. In its broader sense, therefore, the notion of institution cannot be understood as a fixed entity. Power relations happen "not just in formal institutions defined as 'political' or 'public', but in most forms of relationship, and in most contexts of interaction" (Ortner 1989, p.194). In its narrow sense, institutions like hospitals, other healthcare delivery centres and nursing institutes or colleges, are also considered. Even if the focus of this research is not placed on them, their role in the reproduction and transformation of social structures is acknowledged. Finally, Giddens' notion of *routinisation* is analysed in relation to the more critical concept of *discipline*, which has been subject to intense debate in the history of nursing and medicine.

When analysing the role of nursing education in nurses' lives, Bourdieu's (1984) contributions on the different forms of capital have been of great interest. The author based his theory on the following equation: *[(habitus) (capital)] + field = practice*. He states that practice takes place in a specific social field and includes the combination of habitus and capital. The latter can take four forms: economic, cultural, social and symbolic (Bourdieu 2001). *Economic* capital is perhaps the more straightforward and 'objective', in Bourdieu's understanding of the term. *Cultural* capital is more complex and can take three different shapes or states: interiorised or embodied (organism), objectified (cultural goods) and institutionalised (academic credentials). The first, embodied form, is represented in the *habitus*, transmitted during the process of early socialisation and followed by a period of accumulation.

The conditions of transmission and acquisition of cultural capital are a lot less evident than those of economic capital (Bourdieu 1977). Cultural capital is institutionalised in the form

of academic credentials and mainly through educational institutions, although the family and early socialisation group also play a crucial role. The relationship between early socialisation, social position and education is further explained in his joint work with Passeron (1990), where the authors extensively analysed "the sophisticated mechanisms by which the school system contributes to reproducing the structure of the distribution of cultural capital and, through it, the social structure" (1990, p.vii).

The third form of capital, *social* capital, is understood as a durable network of more or less institutionalised *relationships* of mutual knowledge (Bourdieu 2001). Social capital can never be completely separated from economic and *symbolic* capital. This last form of capital contains all the other forms of capital once perceived and legitimised. This is generally invisible through different forms of *euphemisation* and the *naturalisation* of the dominant order. Some examples of symbolic capital are the notions of 'taste' and 'pedigree' (Bourdieu & Passeron 1990) or the naturalisation of male domination (Bourdieu 2002).

Bourdieu (1984) acknowledged a degree of mobility in the social space, even though with limitations. If we analyse the trajectory of an individual, the starting point is a set of inherited capital that leads to a certain position, that is, their *field of possibilities*. Trajectories can be individual or collective, but are never random movements in the social space, even though they may seem so. Class or social mobility is possible through strategies of reconversion from one form of capital to another. Bourdieu's conceptualisation of the distribution and reproduction of social power through the different forms of capital is of great interest for this research and served as a guide in the analysis of the nurses' life stories, aiding in the identification of the economic, social, cultural and symbolic resources, or the lack of them, which affected their social and professional developments. Furthermore, it was also useful to analytically separate the 'nursing field' from the 'social field', and look at the ways in which the capital they acquired from one field influenced their position in the other.

Nevertheless, the analysis of institutions and the different forms of capital was not enough to account for the nurses' individual ability to challenge and transform broader social structures. In this sense, the conceptualisation of agency as an individual capacity was of great interest as a complement to the more 'structural' analyses.

2.2.2.3. A brief discussion of the notions of agency, intentionality and choice: The need for a historical and contextual situation of freedom

Initially, the concept of agency was used in opposition to structure, which was understood as a constraint (Giddens 1979). Later, Sewell (1992) challenged this opposition and defined the actor's agency as their knowledge of the social schemas (i.e. structures) and their ability to apply them to new contexts. Therefore, a dichotomic separation between the individual (agency) and the society (structure) misses the ways in which they constantly interact. This dichotomy is partly related to one of the biggest dilemmas in the analysis of action, that is, the relationship between individual freedom and social or structural determinism. Though this is not the place to enter into this philosophical debate, this research is based on the argument that there is no such thing as absolute free choice. In order to conduct a critical social analysis, freedom has to be situated (Chinn & Kramer 2015).

The notion of *situated freedom* was developed in the hermeneutic analysis of human agency conducted by Taylor (1979; 1985). Relying on the works of Hegel, Taylor argued strongly against naturalism and behaviourism in their denial of human consciousness and intention. For him, free activity emerged as "a response called for by a situation which is ours in virtue of our condition as natural and social beings, or in virtue of some inescapable vocation or purpose" (1979, p.160). Benner and Wrubel (1989) took Taylor's analysis and placed it in relation to Heidegger's notion of concern and participation in a meaningful world. They criticised the notion of radical freedom because it "ignores the fact that the choice of meanings is predicated on the meanings available in the person's own background, culture, and language" (Benner & Wrubel 1989, p.54)

Similarly, human action and agency need to be historically situated. According to Ortner (1989, p.193), history is crucial in the analysis of practice as it accounts for the ways in

which "social beings, with their diverse motives and intentions, make and transform the world in which they live". By adding 'history' to the analysis of human agency and understanding man as "both a product and a producer of society and history" (Ortner 1996, p.11), both 'voluntaristic' and 'constraining' versions of agency could be sidestepped.

Authors such as Giddens (1979; 1984) or the Comaroffs (1992) emphasised the role of the *unintended consequences of action* and pointed to the multiplicity of motives which lead agents to behave in a particular way. To explain this apparent contradiction, Giddens (1984) understood *intentionality* as a day-to-day process which did not necessarily point towards consciously defined goals. Nevertheless, the rationalisation of intention happens only at a discursive level. Similarly, Schutz (1972) stated that meaning is only attributed to action once the action has been completed.

History, anthropology and social sciences have been crucial in reflecting on the importance of situating human agents in a broader background. Nevertheless, the particular ways in which the broader historical and social context affects people's decisions, actions and practices is still contentious. It is clear that human action is not motivated exclusively by external determinants. However, neither do the 'inner' motives respond to a mere desire or to its opposite, a purely rational 'weighing' of different options (Taylor 1985). In summary, intentionality does not necessarily mean 'free choice' or a clearly defined goal. Action is influenced by a wide range of factors that go far beyond subjective feelings and individual 'choices'. This complexity is more clearly shown in studies about domination and resistance, which analyse situations where the subjects face strong external constraints when trying to turn their 'intentions' into actions.

2.2.3. Situating agency (III): Domination, resistance and the role of power

Broadly, there are two key factors in the individual's internalisation and transformation of social structures. The first is related to ideological discourses and the ways in which they allow and legitimise power relations between individuals and groups. The second is related

to the conditions of possibility[17] for these inequalities, which are located beyond the realm of ideas. The distinction between the realm of ideas (or discourses) and the material conditions for them was key in both Marxist and critical post-structural analyses. Regardless of the difficulties in this separation between ideological, discursive and material factors, analysis of the ways in which discourses and ideology permeate social structures, institutions and people is crucial (Berger & Luckmann 1971; Williams 1977).

2.2.3.1. The role of ideological discourses in the structural power relations

Practice theory allows greater understanding of the ways in which social structure can be reproduced and transformed. Within this process of reproduction/change, power relations are also acknowledged, even if they are not generally central (Ortner 2006). Bourdieu opened the door to the analysis of the *embodiment* of unequal social structures through his notion of *habitus*, which he further applied to the analysis of gender and class. For him, power was generally conceptualised in the domination/subordination dialectic, especially the way in which the structures of domination "escape the grasp of individual consciousness and power" (Bourdieu 1977, p.184). Central to the latter were the notions of *symbolic power* and *symbolic violence*, a "gentle, disguised form which violence takes when overt violence is impossible" (1990, p.133).

Symbolic power and its exercise through symbolic violence are better understood in the form of ideological discourses. Ideology, in its political sense, generally accounts for a complex set of ideas that usually serve to justify, legitimate or sustain a specific social order. Marx's work was a critical reworking of the concept and it gradually began to be used in a political sense (Williams 1977). Ideology was sometimes defined as a system of *illusionary* beliefs, termed by some Marxists false consciousness[18] or mystification.

[17] I borrow this expression from Foucault (1977, p.67) and his analysis of discourse, power and knowledge. He used this notion to account for "what gives rise to the aleatory series of these events, and fixes its limits"

[18] Scott (1985), who held a critical view of this theoretical argument, stated that the expression was not used by Marx himself but by some of his followers: "Marx, to my knowledge, never used the term 'false-consciousness', although 'the fetishism of commodities' may be read this way. But the fetishism of commodities mystifies, especially the bourgeoisie, not merely subordinate classes" (1985, p.39)

Nevertheless, ideology could also refer to the general process of the production of meanings and ideas. This later definition is closer to Geertz's (1973) interpretive analysis of ideology as a symbolic system.

When analysing ideology from a political perspective, it is important to consider that power is closely related to knowledge, and to the form in which it is socially produced and transmitted. Ideologies reshape experiences and produce new knowledge of social behaviour (Asad 1987). In this respect, the notion of discourse often merges with that of ideology. Broadly speaking, both terms refer to similar aspects of social life, even though they originated from different theoretical disciplines (Purvis & Hunt 1993). The use of the term 'ideology' in the social sciences is usually linked to the Marxist tradition, whereas the analysis of discourse originated in the linguistic strain of modern social theory. On the other hand, Purvis and Hunt observed that discourse is generally more oriented towards the linguistic and semiotic dimension of human experience.

The discursive trend in the social sciences questioned the previous distinction between two great realms, thought and being, with their subsequent dualities nature/culture, individual/society and mind/body (Scheper-Hughes & Lock 1987; Purvis & Hunt 1993). Later, linguistic discursive analysis was modified by Foucault and his followers, giving more relevance to the role of power in the process of discourse formation. Foucault (1977) made a clear distinction between discourse and ideology, avoiding the use of the latter term. His analysis is focused on the causes and origins of discourse, and less on its consequences or results, that is, on their ideological effects (Purvis & Hunt 1993). The origins and possible conditions for the formation of these discourses are key to understanding of the ways in which they operate. In this sense, Brah (1992) underlined the fact that excessive focus on the effects of broad ideologies such as the 'scandalous Thing of White Patriarchal Capitalism'[19] could hide the ways in which these ideological and material processes work, thus making it very difficult to understand the complex basis of inequalities. The authors

[19] Haraway (1991, p.197) used this expression to account for the broad ideology which "turns everything into a resource for appropriation, in which an object of knowledge is finally itself only matter for the seminal power, the act, of the knower".

observed that, for the analysis of the ideological effects of discourses, the work of Gramsci (1970) and post-Marxist authors, who tried to overcome the early 'materialistic' approach, are of interest, as they introduce the notion of 'ideas' as weapons in the class struggle. As most of them were political activists, their main aim was to envision the ways in which alternative ideologies could be generated. Gramsci's dialectical relationship between hegemony and subalternity is a good example of this latter view.

Hegemony is generally understood as a complex process of domination that works without the need to use explicit coercion and that "to a greater or lesser degree, comes to permeate civil society" (Baer et al. 2003, p.5). Nevertheless the Gramscian binary division between hegemony and subalternity is not always clear in society. Besides, his portrayal of the 'subaltern people' as not being able to situate their oppression falls too close to the post-Marxist notions of mystification or false consciousness. Giddens' (1979; 1984) analysis of ideology may be more useful in identifying the potential of 'subaltern agents'. He identified three main ways through which ideology operates in society: the representation of regional interests as universal; the denial of contradiction within society; and the discursive naturalisation of the present or *reification*. Berger and Luckman (1971, p.106) had defined reification processes as "the apprehension of the products of human activity *as if* they were something other than human products, such as facts of nature, results of cosmic laws, or manifestations of divine will". The notion of reification can also be assimilated to Bourdieu's (1990) descriptions of the *euphemisation* and naturalisation of the existing relations of domination.

Purvis and Hunt (1993) suggested a distinction between ideology as a process and discourse as an effect, as well as recovering the Marxist view, focusing on the effects of some discursive practices. Like Laclau and Mouffle (2001), the authors understood the processes of discourse formation as inscribed within social practices. When discourses are connected to systems of domination they become ideological. They incorporate certain forms of significance into lived experience where "sectional or specific interests are represented as universal interests" (Purvis & Hunt 1993, p.497).

Ideological discourses emerge at various times during this research. The first is related to the analysis of the historical origins of the modern nursing profession and its development in the Indian subcontinent and Bangladesh. A second emerges from the nurses' narratives; it appears in their conceptualisations of nursing care and in the challenges and contradictions which they faced when trying to apply an 'ideological' version of nursing to their lived experiences in their professional and broader social fields. In this regard, some authors pointed to "conflicts between the inherited British model of nursing and Bangladeshi societal norms" to explain the visible contradiction between what nurses do and what they say they do (Hadley et al. 2007, p.1166).

Nevertheless, even though it is true that certain ideologies help in the establishment and maintenance of unequal power relations, their hegemony is never complete. This research is aligned with Scott's (1985; 1990) critical analysis of the concepts of hegemony, mystification and false consciousness. Scott argued that linking compliant behaviour with the Parsonian idea of 'normative consensus' was too simple and overlooked other, less direct, forms of resistance. Therefore, the fact that resistance is not always overt does not mean that domination is accepted. A further examination of the relationship between agency and resistance may aid better understanding of these ideas.

2.2.3.2. Agency and social power: Potentials and limitations of understanding agency as a form of resistance

According to Giddens (1979), power and agency are understood as a human capacity. Nevertheless, none of them is equally distributed in society (Sewell 1992; Ortner 2006). Bourdieu's theory of the internalisation of unequal social structures is useful in understanding this aspect. Nevertheless, a difficulty emerges when trying to define the individual's role in the reproduction or transformation of social reality. In this regard, the concept of resources, initially developed by Giddens (1979; 1984) and reworked by Sewell (1992), has been more useful.

Giddens distinguished between two types of resources: *allocative* resources allocated their command over objects, whereas *authoritative* resources focused on people. Sewell (1992)

reworked Giddens' conceptualisation and instead suggested classifying resources as either human or nonhuman. Human resources would include "physical strength, dexterity, knowledge, and emotional commitments (…), including knowledge of the means of gaining, retaining, controlling, and propagating either human or nonhuman resources" (1992, p.9). Similarly, Van Dijk (1993) considered that social power is based on access to socially valued resources, both material and non-material. Knowledge is one of the most significant non-material resources, due to its close relationship to social power (Foucault 1977; Long 1992; Sachs 1992). In the narratives of the nurses, knowledge occupied a central position, especially in their struggles to increase their social recognition.

At this point, the re-conceptualisation of the notion of agency from both the feminist and post-colonialist viewpoints is of interest (Ortner 1996). Seeing individuals as capable agents, no matter how disadvantaged in terms of social power, allows deeper understanding of their daily struggles. Nevertheless, there are also some dangers embedded in this more 'positive' view of agency. A clear example is the appropriation of notions like agency and empowerment by right-wing political discourses, especially in the field of international development. Notions like 'local knowledge', 'empowerment' and the conceptualisation of subjects as 'actors' soon became 'buzz words' (Gardner & Lewis 1996; Cheater 1999) and, even worse, were used as instruments to justify and legitimise vertical interventions (Rahnema 2010) and/or curtail financial support and resources (Cornwall 2010).

A similar process happened with the notion of *empowerment*, which has a prominent role in both development and gender studies. The term emerged from the confluence of grassroots experiences, such as the American Black radicalism of the 1960s, community development groups in the North and South and the growth of feminist grassroots organisations (Setty 1991, cited in Kabeer 1994, p.223). The meaning changed when it was absorbed by the government discourse of "returning power to the people" of the 1980s in both the UK and US governments (James 1999). In this way, its political meaning was disfigured (Kabeer 1994; Gardner & Lewis 2015).

Another reason why the term has been criticised is because of the implicit meaning of powerlessness in opposition to empowerment. The 'disempowered view' was especially pervasive in early discourses about gender and development, which portrayed women as passive victims needing to be saved by development policies (Kabeer 1994; 2011; Cornwall et al. 2007; Gardner & Lewis 2015). A broader understanding of power that can move beyond the liberal view is necessary (Kabeer 1994; Cornwall et al. 2007). In this research, the notion of empowerment or, more specifically, *empowering*, will be mainly used to account for the circumstances, institutions, or processes that can increase the subjects' social power. Therefore, it is understood that all subjects have a certain degree of power and that they can never move from powerlessness to full empowerment.

In order to overcome the dilemma between overemphasising or ignoring individual ability to overcome structural inequalities, Ortner used the Comaroffs' (1992) distinction between *agentive* and *non-agentive* forms of power. For Ortner (2006), the *agentive* side of power implies intentionality and the pursuit of culturally-defined projects. Intentionality, in this sense, does not necessarily point towards an actual realisation of people's projects. For instance, Scott's (1985) dialogical analysis between thought and action showed how the former allows the conception of lines of action which may be impractical at the moment but plausible later. This places greater potential on the effects of daily and, apparently, uncoordinated forms of resistance.

In its negative, *non-agentive* form, power is understood as social inequality, asymmetry and force. However, even within this asymmetry and inequality, the most disadvantaged people and groups hold a certain degree of power to maintain some control over their lives. In this sense, agency could be understood as a form of resistance to domination through which people try "to sustain their own culturally constituted projects, to make or sustain a certain kind of cultural (or for that matter, personal) authenticity 'on the margins of power'" (Ortner 2006, p.147). Ortner's view of the domination/resistance tension as a clash of competing projects is useful to conceptualise the collective side of agency, or the potential for 'group agency'. The author observed that even if groups do not have agency in a psychological sense, they have common projects and power. In this regard, agency should

be considered as a social process. Nevertheless, conceptualising agency simply as a form of domination or resistance could lead to an analytical trap (Ortner 1996). The subordinate people can either be portrayed as 'compliant' with the hegemonic ideology or enacting completely different and morally better, projects.

Like Ortner (2006), Scott (1985) and Mahmood (2005), in their respective discussions of class and gender inequalities, had also warned against the dangers of 'romanticising resistance'. Mahmood took a further step and questioned the category of resistance itself, which could hide "forms of being and action that are not necessarily encapsulated by the narrative of subversion and inscription of norms" (2005, p.9). In any case, the notion of resistance can be helpful in the analysis of human agency, as long as it is not overemphasized.

According to Foucault (1977), we may say that wherever we find power, we find resistance. A key Foucaultian idea for this research is his conceptualisation of power as a capillary, which allows us to look for "the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (1977, p.39). Foucault conceptualised power as something "beyond good and evil". In this sense, his contributions were crucial in moving beyond a binary conceptions of power, that is, beyond the domination/resistance duality (Kingsolver 2010). The Foucaultian analysis of power is more focused on its *relational* aspect and the ways in which it is produced and reproduced through social interaction. Nevertheless, in certain situations a binary conception of power can be helpful in allocating structural inequalities and theorize about oppression (Kingsolver 2010).

This research is situated somewhere between a *structural* and a *relational* analysis of power. On some occasions, the structural form of power has been useful in looking at the inequalities between groups, such as in the analysis of the broad position of nurses within the health system and society. Nevertheless, when looking at nurses' experiences more closely, structural analysis was not sufficient to explain their agency. A greater focus had to be placed on the ways in which nurses constantly negotiated and redefined their position.

Foucault's notion of *strategy* has been be useful in analysing this relational process. For him, strategy points to a minimum form of rationality consisting of "mobile sets of operations, whereby a multiplicity of heterogeneous elements (forces, resources, the features of a terrain, the disposition and relation of objects in space-time) are invested" (Gordon, 1977, p. 251).

Ortner's (1999c) conceptualisation of agency is also aligned with the latter view, as she drew considerably on the Foucaultian analysis of power. Her theoretical position opens the way to analysis of the complexities of human action in a context of inequality, without ignoring the role of individual subjectivity. Similarly, Brah (1992) observed that we need conceptual frameworks that understand the processes of subjectivity formation as both social and subjective. Ortner's view and her integration of the Foucaultian analysis of power was a crucial step in this regard:

> "I view agency as a piece of both the power problematic and the meaning problematic. In the context of questions of power, agency is that which is made or denied, expanded or contracted, in the exercise of power. It is the (sense of) authority to act, or of lack of authority and lack of empowerment. It is that dimension of power that is located in the actor's subjective sense of authorization, control, and effectiveness in the world. Within the framework of questions of meaning, on the other hand, agency represents the pressures of desires and understandings and intentions on cultural constructions" (1999c, pp.146–147)

In the case of this research, writing about Bangladeshi nurses and power carries a significant risk of presenting them as either 'victims[20]' or 'heroines' within the patriarchal, postcolonial, unequal class structures of the biomedical system and the broader society. Neither of which would be helpful to analyse their situation.

[20] Feminist academics and activists, especially those working with battered women, have made an important change to their categorisation. Women, children or other subjects of violence were reconceptualised from 'victims' to 'survivors'. For a further analysis about this discursive change and its implications, see Dunn (2005) and Leisering (2006).

In summary, human agency and power are influenced by a variety of factors. Neither the motives nor the consequences of action are always conscious or easy to explain and interpret. This research aims to better understand the *agentic* capacity of the nurses, while acknowledging the complexity of the term. In this sense, a dialectical approach between history, social structure and agency "allows human action, and the social phenomena created by it, to be both determined and indeterminate, purposive and unintended, coherent and fragmentary" (Comaroff & Comaroff 1992, p.122). This perspective should be kept in mind when looking at the structural inequalities that shape people's lives.

2.3. STRUCTURAL INEQUALITIES AND THEIR INTERSECTION

This section focuses on the ways in which social inequalities are reproduced and can potentially be challenged by individuals or groups. Bourdieu's notion of capital and Giddens' classification of resources were critical in understanding the ways in which power is distributed unequally. A reworking of the notions of ideology and discourse were also necessary for a better understanding of the role of non-material resources. Now is the time to identify the most relevant forms of social inequality analysed in this research.

2.3.1. Social class and other stratification categories

Social stratification is not neutral, as it always implies an unequal distribution of power (Giddens 2009). When the focus is placed on the distribution of material resources, the stratification is usually analysed in terms of social class. Nevertheless, there are other categories such as race, ethnic group or caste that also have to be considered, notwithstanding gender, which will be analysed separately.

2.3.1.1. Social class: Between material conditions and group identity

The study of class relations can be traced back to the so-called Bourgeois theories of economic growth and their greatest opponent: Marxism. Later, post-Marxist authors began to place greater emphasis on the non-economic or cultural aspects of class relations. Gramsci's notion of *lived* class (Crehan 2002; Pizza 2005) was developed by cultural

Marxists like Willis (1977) and Williams (1977). This 'cultural' analysis of social class in relation to group identity was also used in political anthropology (Scott 1985; 1990). Social class was understood as a culturally and ideologically constructed identity (Crehan 2002; Ortner 2006).

Practice theorists also made significant contributions to the study of class relations. For Bourdieu (2001), the objectivist versus subjectivist debate about class adscription created a false opposition, given that individuals are at the same time classified and classifying agents. Without denying the material aspects of social classes, he also defined an embodied form of *class habitus*, which constituted a "subjective but not individual system of internalized structures, schemes of perception, conception and action common to all members of the same group or class (Bourdieu 1977, p.86). Lázaro (2014, p.64) observed that the notion of class moves far beyond the occupation of a particular social position, as it also relates to "subjective systems of representation, signification, behaviour and practice[21]". Similarly, Giddens (1979) understood class in a relational way, either as collectives or merely as categories which aggregate certain qualities. He adopted a broad notion of class, which can also include non-economic aspects, in the formation of collectives, such as gender or ethnicity. Ortner (2006) also concluded that race, ethnicity and class should be analysed together, as they all influence each other. This aspect is further developed through feminist intersectional theories.

2.3.1.2.Status, capital and the non-economic elements of the 'class society'

The notion of *status* is also crucial in the analysis of class relations and other forms of social stratification. Developed by Max Weber, the concept has been extensively used to refer to non-economic criteria that define the value of a group in society. Weber (1946, p.187) defined status as the "typical component of the fate of men that is determined by a specific, positive or negative, social estimation of honour". Nevertheless, the author admitted, economic factors also influence social status, as status privileges involve the monopolization of material and non-material goods.

[21] My translation.

Bourdieu's (1990) conceptualisation of the different forms of capital is of great interest to better analyse the relationship between economic and non-economic factors in social stratification. He reworked Weber's notion of status through his definition of symbolic capital: "'Status groups' based on a 'life-style' and a 'stylization of life' are not, as Weber thought, a different kind of group from classes, but dominant classes that have (…) legitimised themselves" (1990, p.139). In this way, social status works as an effective way of euphemising and legitimising economic capital.

The notion of status is closely related to the social ranking of occupations and professional groups and, despite its limitations, occupation is still used as a social class indicator (Giddens 2009). The relationship between the nursing profession and class is highly relevant, not only because of its current position in the ranking of professions, but also because of its historical role in gender and class struggles. On the Indian subcontinent, historical 'status anxiety' amongst nursing leaders was even greater, due to the association of nursing with disadvantaged groups (Nair & Healey 2009; Nair 2011).

Finally, the relationship between status and honour is especially significant in this research. As highlighted by the Indian nurses interviewed by Nair and Healey (2009), the low status of the profession is manifest in the everyday experiences of Bangladeshi nurses. The authors observed that the consideration of nursing as a 'low-status' occupation led, on some occasions, to moral questioning of the group which, when added to gender stereotypes, had very negative consequences for the nurses. These could range from difficulties in getting married to sexual harassment in and outside the workplace. In addition, status issues influenced internal nursing hierarchies.

2.3.1.3.Race, caste and religion: The reification of 'biology' and culture

Race, caste and religious groupings are closely related to the notion of class, albeit they have specific features. All share a strong identity aspect which, in many cases, has been used to naturalise, mask, or in Bourdieu's (1990) terms, *euphemise,* structural inequalities and power relations. This makes them much more pervasive than the notion of class. The

notions of race and caste were not directly mentioned by the nurses in this research. Nevertheless, they have been included in this section because of their relevance in the historical development of the nursing profession in the subcontinent.

Racial classifications point to "differences of power based on alleged physical differences" (Ortner, 1999, p.28). The category 'race' was developed by Western Europeans during their global expansion from the fifteenth century onwards, and has taken different forms throughout history (Sanjek 2010). Racial discrimination has had a crucial role in tragic episodes of human history, including slavery and genocide, and is still crucial today. Starting with an ethnocentric approach, anthropology gradually withdrew from the early forms of biologically-based racism[22]. An early step was to change the notion of 'race' to that of 'culture', especially among the most essentialist forms of culturalism (Ortner 2006). A crucial move was made in the 1960s, placing the very idea of race as the target of criticism (Montagu 1964, cited in Sanjek 2010, p.586). In any case, it is now clear that even though 'race' does not make any sense as a biological category[23], it is still relevant as a social construction. In this research, racism is analysed in conjunction with colonialism and post-colonialism.

Ethnic[24] identity only emerged implicitly in nurses' narratives, mainly in the form of religious groupings, even though it has played a crucial role in the country's history. Today, tensions are still found between 'Bengali' and 'non-Bengali' groups in some regions (Van Schendel 2009). A more significant category is religious adscription. Communalism[25] is a

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[22] The work of Franz Boas was pioneer and a key contribution to the critique against racism and evolutionist theories (Leacock 1985; Barnard & Spencer 2010a) Later, the contributions of Ruth Benedict of the Culture and Personality school continued with the elaboration of a sustained critique against biologicism and racism (Leacock 1985).

[23] For an argument on the uselessness of the category 'race' as a biological and genetic instrument, see Goodman (2000) and Krieger (2005).

[24] The term ethnicity is relatively new and, prior to the 1970s, was rarely found in anthropological literature (Sokolovsky & Tishkov 2010). The notion emerged as a response to post-colonial politics through the rise of ethnic minority activism in industrial states.

[25] According to Stein (2010, p.274), "in Indian usage, 'communalism' usually refers to political mobilizations and alignments based upon differences between Hindus and Muslims; (…) the term can also include conflicts

crucial aspect in Bangladeshi politics and religion plays a central role in people's identity. However, nursing occupies a special position in relation to religion, as the profession has traditionally been linked to Christian or disadvantaged Hindu women.

Caste classifications and adscription, as with race, are believed to be inherited by birth (Giddens 2009). The term caste was first coined as the English translation for *varna* or *jati*[26] (Béteille 2010). In spite of the considerable differences between caste and ethnic groupings, Béitelle (2010, p.112) pointed out that in many cases "caste loyalties tend to act like ethnic loyalties". Practically, caste and class stratifications intersect. For this reason, the less offensive and more inclusive notion of Dalit[27] is used throughout this research.

Dumont's (1970) work was an important contribution to the understanding of ideas like ritual purity and its consequences in social hierarchies and stratifications, and became "the most coherent and powerful theory of caste developed in the anthropology of India" (Fuller 1996, p.4). Nevertheless, it was precisely this coherence, together with the reduction of religion to static hierarchical values, which became a source of criticism. Dumont was also criticised for ignoring the role of colonialism in the reinforcement and transformation of caste-based hierarchies. During colonialism, an all-India caste system was constructed with the excuse of protecting the disadvantaged groups "from the evils of the system" (Waligora 2004, p.161). In reality, however, the colonial authorities had taken sides from the beginning, favouring the scribal castes (Brahmins) over the rest and punishing the Muslims,

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among caste and language groupings". The roots of the ideology lie in the association between religion or caste groupings and the notion of 'communities' as separated and bounded entities.

[26] *Varna* and *jati* do not have the same meaning. Roughly, the former refers to an ideal model and the latter points towards the actual social grouping and "what Indians usually mean when they speak of caste today" (Stein 2010, p.52). There are only four recognised *varnas* (Brahman, Kshatriya, Vaishya and Shudra), whereas the classification of *jatis* is much richer and more complex.

[27] The notion of Dalit, which can be translated as 'oppressed', was coined by the Indian reformer Ambedkar. The term emerged in response to the offensive connotations of the term 'Untouchable', as well as the condescendence of the Ghandian notion of Harijan. Nevertheless, it goes beyond the notion of 'caste' and " has begun to symbolize a much broader spectre of the oppressed and hitherto excluded social strata" (Kothari 1994, p.1591).

who were held responsible for the 1857 Mutiny[28] (Stein 2010). The outcome of this colonialist, Orientalist, essentialist and racist version of the caste-system was a reinforcement of communal tensions between the different groups. Beteille (1979, p.544) ironically concluded that the Indians "probably learnt more from the Western practice of inequality than from the Western theory of equality".

One of the most crucial and pervasive effects of the caste system is the association of castes with occupations. This is especially significant for nursing and midwifery, which have historically been considered as 'lower' occupations because of their 'polluting' nature. Finally, the notions of class, caste and race cannot be analysed without adding a gender component.

2.3.2. Gender inequalities: Paths to overcome patriarchal domination

Gender is a cross-sectional form of inequality and, as such, it appears in different theoretical and political debates. In this research, gender plays a prominent role, as it is crucial to the two fields analysed: the nursing profession and Bangladeshi society. The following sections analyse the main discussions on the embodiment of, reproduction and resistance to gender inequalities.

Bourdieu (1977; 1984) extensively analysed the effects of euphemisation and the naturalisation of inequality. Nevertheless, it was his later work, *Masculine Domination* (2002) which threw greater light on the issue. He understood masculine domination as a particular form of symbolic violence that produced a paradoxical submission. Like Ortner (1996), he situated the principle of division in an arbitrary misrecognition of 'nature'. As happened with racism[29], sexism reifies and naturalises differences that may be perceived as

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[28] The relationship between the rulers and the local soldiers (*sepoys*) was generally stable until the Sepoy Mutiny of 1857, which led to a civil rebellion and the first real threat to the Empire (Baxter 1997; Rahman 2010; Stein 2010). The Mutiny started in Bengal and was eventually suppressed by Punjabi soldiers, which would have significant consequences for the state's stereotyping of people from both regions.

[29] The attempted analogy between racism and sexism was soon criticised by Black feminists who considered them as different forms of intersecting oppression which cannot be equated (Kerner 2009). Brah (1992) and Kerner (2009) agreed that racism, gender and social class are neither reducible to each other nor completely

biologically or culturally constructed, turning them into common or 'natural' categories (Stolcke 2000; Kerner 2009). To avoid the naturalisation of gender inequalities, history should be taken into account (Butler 1999; Bourdieu 2002). Otherwise, we could fall into a "vicious way of ratifying domination, which consists of making women responsible for their own domination" (Bourdieu 2002, pp.39–40).

Bourdieu (2002) provided a good example within the education sector. Throughout their socialisation, girls internalise the principles of the dominant ideology, which leads them to normalise the social order and to refuse the careers from which they are implicitly excluded. Women's symbolic capital within the family is somehow transported to their jobs, which "provide the functions of presentation and representation, reception and hospitality" (2002, p.100). This aspect is relevant in relation to the notion of nursing as a 'feminine profession'.

Bourdieu's analysis is of interest, even though it still focuses on domination. Other authors like Mahmood (2005) and Ortner (1996) have placed a greater emphasis on the role of women's agency. Ortner (1996) merged practice theory with what she termed as feminist-minority-postcolonial-subaltern theorizing. By focusing on practices, she was able to centralise power relations with people's specific realities, without falling into the trap of free agency or voluntarism, thus permitting a more critical view of the interaction between forms of oppression other than gender in women's lives.

With the emergence of third wave[30] feminism in the 1970s, the early universalist views of female oppression were challenged (Narotzky 1995; Brownell & Besnier 2013). Black

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autonomous. In other words, the similarities and differences between the different categories of discrimination are equally significant. This aspect is taken up again later in this chapter.

[30] Feminist theory is broadly conceptualized into three waves. The first was the early emancipation movements of the nineteenth century. Secondly, there was a change in grassroots movements after World War II, which focused on the visualization of women's contributions through their reproductive work (Sacks 1989). Finally, the end of colonization and the anti-racist movements gave place to third wave feminism, which included Black feminists and women from the former colonies (Narotzky 1995; Brownell & Besnier 2013)

feminism, socialist feminism, 'Third World' feminism[31] and, most recently, Muslim feminism, have all challenged many of the early premises of White feminism[32]. Black and socialist feminists emphasised the need to account for racial and class oppression in the fight for women's emancipation (Davis 1983). On the other hand, the Orientalist portrayal of non-White women as 'compliant' or 'passive' was also criticised. Mohanty (1984) extensively argued against the portrayal of 'Third World Women' as a homogeneous group, usually stereotyped as religious, family-oriented, legal minors, illiterate, domestic and, only sometimes, revolutionary. Similarly, Western conceptualisations of Islam and gender were often reduced to the issues of veiling and dress as forms of oppression (MacLeod 1992, p.537). In the latter regard, the contributions of critical authors working with Muslim women in Bangladesh has been key in acknowledging the internal diversity and different forms of agency of Muslim women (Kabeer 1988; 1994; White 1992; Kotalová 1996).

There is a longstanding dilemma in feminism between the need to universalise women's oppression in order to fight against it, and the need to situate this oppression historically and locally. This apparent contradiction is due to a deeper issue, which has been raised by anthropologists since the very beginning – the study of similarities in human experience and the acknowledgement of cultural differences[33] (Moore 1988; Sacks 1989). Mahmood (2005, p.20) argued that this tension within feminism is "attributable to its dual character as both an *analytical* and a *politically prescriptive* project[34]". The difficulties emerge when trying to separate the two sides. Just like *the personal is political*[35], the theoretical is political too.

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[31] For a review of the emergence of 'Third World Feminism', see Kabeer (1994) and Oliva (2004)

[32] White and Black feminisms should not be conceptualised as opposed forms of understanding feminism, but instead they should be seen as historically situated discursive practices (Brah 2004).

[33] A pioneer in the anthropology of gender was Margaret Mead's work *Sex and Temper in Three Primitive Societies*, which set a landmark by rejecting the biological idea that women's tempers were determined by their sex (Narotzky 1995; Brownell & Besnier 2013). A further turning point in breaking the biological justification of sexism in Western thought came with Simone de Beauvoir (Ortner 1996).

[34] Author's italics

[35] This expression, also termed "the private is political", was broadly used during the Second Wave feminism and other social movements.

The notion of patriarchy is a clear example of the above-described dilemma. Critical feminists and anthropologists alike have questioned the definitions of patriarchy as a universal form of female domination[36] (Moore 1988; Butler 1999). Instead, the authors stressed, both the nature and consequences of male domination have to be specified and contextualized. In the US, the notion of women's common oppression raised by early feminism was criticized by Black feminists not as much for denying it, but to highlight the fact it was not used as a common strategy for a radical change (Hooks 1984). Critical feminists concluded that gender discrimination had to be analysed in relation to race and class oppressions (Davis 1983; Hooks 1984; Moore 1988). Central to this inclusive analysis were studies of the notion of *intersectionality*.

2.3.3. *Intersectionality*, multiple oppressions and the need to overcome the domination/resistance dichotomy

North-American Black feminists claimed from the beginning that race was not just an item to be added to the gender experience, but was central to it (Davis 1983; Hooks 1984; Moore 1988). In the UK, the notion of 'triple oppression' was initially used, although the term was later contested, arguing that each social division emerges from a different ontological basis (Yuval-Davis 2006). At an individual level, however, the ontology of discrimination is often less important than the *experience* of being oppressed. Intersectional analysis has taken a significant step in further analysis of the ways in which oppression and privilege operate at the individual and structural levels (Kelly 2009; Chinn & Kramer 2015). The term *intersectionality* was coined by Crenshaw (1989), who used a traffic analogy to account for the articulation of different forms of oppression:

[36] Butler (1999, pp.45–46) wrote: "The very notion of 'patriarchy' has threatened to become a universalizing concept that overrides or reduces distinct articulations of gender asymmetry in different cultural contexts. As feminism has sought to become integrally related to struggles against racial and colonialist oppression, it has become increasingly important to resist the colonizing epistemological strategy that would subordinate different configurations of domination under the rubric of a transcultural notion of patriarchy."

> "Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars travelling from any number of directions and, sometimes, from all of them. Similarly, if a Black woman is harmed because she is in the intersection, her injury could result from sex discrimination or race discrimination" (Crenshaw 1989, p.149)

Intersectional methodology is not just about adding variables to the analysis of oppression (MacKinnon 2013). Instead, the author observed, intersectional analysis "embodies a particular dynamic approach to the underlying laws of motion of the reality it traces and traps while remaining grounded in the experiences of classes of people within hierarchical relations" (2013, p.1020). In other words, the different structural forms of oppression intersect with each other and with the subjective experiences/identities of individuals.

The intersection of oppressions cannot be seen merely in a summative way. On the one hand, oppressions and privileges are never total and vary between contexts and situations. On the other hand, when it comes to political action against a particular form of oppression/discrimination, internal tensions between the 'oppressed groups' in terms of race, class, gender and so on, can reduce their cohesive power (Moore 1988; Brah 1992; Butler 1999). Therefore, the problem does not lie as much in the acknowledgement of the different forms of oppression, as in the 'moral authority', to use Brah's expression, attributed to them[37]. For instance, the nineteenth century women's movement in the US prioritised the fight against patriarchy over other forms of discrimination like racism or classism (Davis 1983; Hooks 1982). A similar situation occurred in India with the arrival of Euro-American feminism (Burton 1992; Ramusack 1992; Stein 2010). In the case of nursing, this bias was made evident when upper-class nurse 'ladies' concentrated their

[37] The author exemplified how in the early anti-racist female movement in the UK:
"Instead of embarking on the complex but necessary task of sifting out the specifics of particular oppressions, identifying their similarities or connections with other oppressions, and building a politics of solidarity, some women were beginning to differentiate these specificities into hierarchies of oppression. The mere act of naming oneself as a member of an oppressed group was assumed to vest one with moral authority. Multiple oppressions came to be regarded not in terms of their patterns of articulation/interconnections but rather as separate elements that could be added in a linear fashion, so that the more oppressions a woman could list the greater her claims to occupy a higher moral ground" (Brah 1992, pp.135–136)

efforts on professionalization while neglecting the fight to improve the poor working conditions of their working-class colleagues. Historical examples of elitism biases within 'professionalist' nursing movements were found in the UK (Davies 1995; Rafferty 1996), US (Hill 2006; Wolf 2006) and India (Nair & Healey 2009; Healey 2006; Healey 2008).

In any case, the need for a joint effort to fight the broad ideologies that sustain different forms of inequality does not exclude the acknowledgement of the particular ways in which the different oppressions are embodied at an individual level. In this sense, one of the key contributions of non-White feminism and intersectional analysis was the acknowledgment of the specific experiences of racialised or marginalised women. Hooks (1984) said:

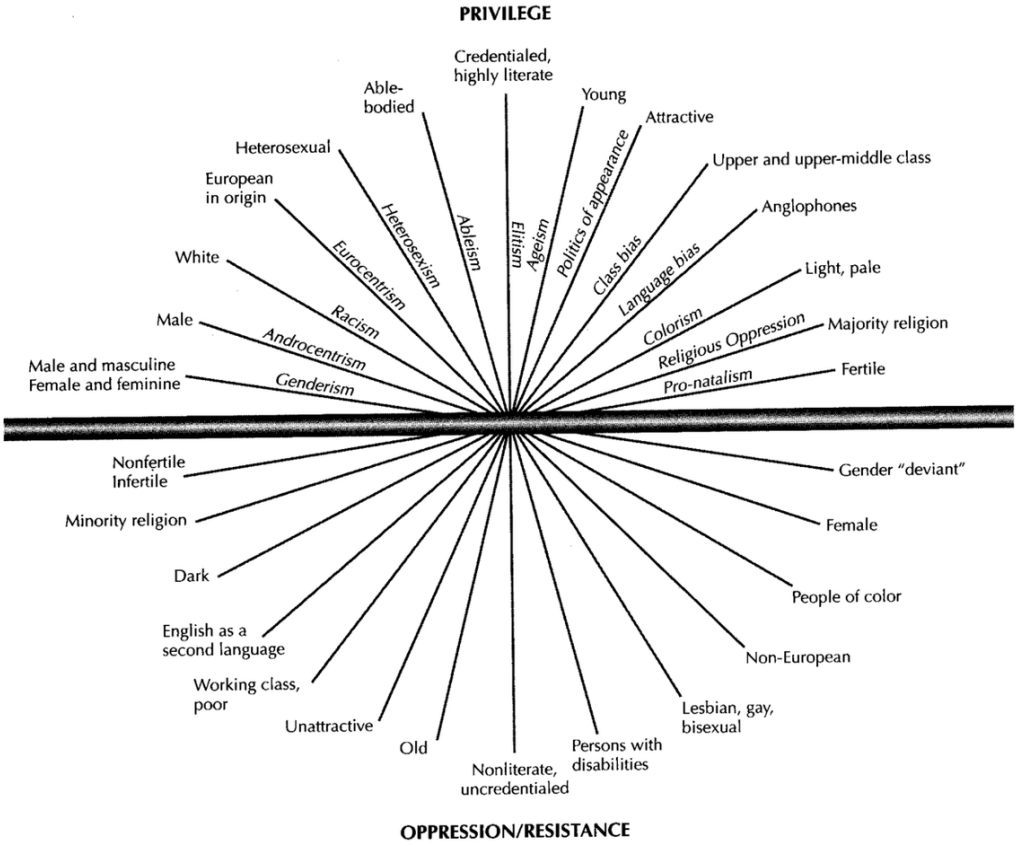
> "Black women with no institutionalized 'other' that we may discriminate against, exploit, or oppress often have a lived experience that directly challenges the prevailing classist, sexist, racist social structure and its concomitant ideology. This lived experience may shape our consciousness in such a way that our worldview differs from those who have a degree of privilege (…). It is essential (…) that black women recognize the special vantage point our marginality gives us and make use of this perspective to criticize the dominant racist, classist, sexist hegemony as well as to envision and create a counter-hegemony" (Hooks 1984, p.15).

This aspect will be taken up again late in this chapter as it refers to the specific position that working-class nurses and other caregivers occupy within the hegemonic medical model and society. What is clear is that power relations operate within feminism(s) (Brah 1992) and amongst groups of people who experience similar oppressions (Butler 1999). Nevertheless, 'provisional unities' can occur "in the context of concrete actions that have purposes other than the articulation of identity" (Butler 1999, p.21).

In summary, the oppressions or discriminations which we suffer mould us; they inhabit us outside and in and cannot be fought without relating them to each other at an individual and structural level (Lázaro 2014, p.66). In order to acknowledge the ways in which different degrees of inequality intersect at an individual level, Morgan (1996) developed what she

called the privilege/oppression wheel (see figure 1), which presents forms of social bias (i.e. racism, genderism, class bias, amongst others) in the form of a wheel, with the aim of demonstrating graphically that a single person can be oppressed in certain aspects while being privileged in others. This idea is related to the notion that everybody holds a certain degree of power. Therefore, inequalities cannot be analysed in terms of either 'having' or 'not-having' (Sen 2007).

Figure 1. Morgan's privilege-oppression wheel



Source: Morgan (1996, p.107)

An adaptation of the wheel is presented in Chapter Five in relation to the most salient forms of social stratification/discrimination amongst Bangladeshi nurses. This research will take a critical and inclusive feminist perspective, in which patriarchy, colonialism, racism and other forms of oppression are articulated at a structural and individual level. Structurally,

the ways in which inequalities are constructed (Brah 1992; Lázaro 2014) are analysed in Chapters Four and Five in relation to Bangladeshi society and nursing, respectively. Even though some of the broad causes of inequality are independent, in many cases they all feed each other (Lázaro 2014). In addition, the different forms of oppression are materialised in the form of discourses and practices that articulate more than one ideological system.

At a 'micro' or subjective level, the intersection of inequalities is analysed through the nurses' biographies. At this level, oppressions and privileges mix and intersect in different and often contradictory ways. At this point, a return to the notion of agency is necessary. As previously stated, individuals are never fully oppressed. The work of Sen (2007) can shed more light on this aspect. The author analysed the old European dichotomy between the 'Patient' and the 'Agent' and related them to the contraposition between the feminist pursue of 'welfarism' and agency, respectively. With the feminist move to the emphasis on women's active roles, the 'welfarist' approach could be ignored. Nevertheless, the author observed, agency and wellbeing should be pursued jointly. First, because greater agency has been shown to make a long-term contribution to women's wellbeing. Secondly, because women's wellbeing, in turn, increases their agency. Therefore, "it is necessary to widen the focus of attention from women's well-being, seen on its own, to women's agency (including, *inter alia*, its association with women's well-being but taking on, along with it, very many other aspects of society)" (Sen 2007, p.250)

It is important to take the notion of agency one step forward and move it beyond the domination/resistance dichotomy, and the work of Mahmood (2005) has been useful in this aspect. The author analysed the emergence of pious movements among Muslim women in Egypt and found that the religious revivalist movements posed significant challenges to both secular-liberal politics and feminism, because they reflected the following dilemma:

> "On one hand, women are seen to assert their presence in previously male-defined spheres while, on the other hand, the very idioms they use to enter these arenas are grounded in discourses that have historically secured their subordination to male authority"(Mahmood 2005, pp.5–6)

In spite of the different subject and context, similarities can be found between the above-described dilemma and that which emerged in the analysis of the professionalization of care. On the one hand, enrolling in nursing was a good way for many women to attain independence and, in some cases, to achieve a successful professional career. On the other hand, however, nurses' hegemonic ideology portrayed ideals of submission to medical authority, with nurses' working conditions being a reflection of gender and class discrimination. I agree with Mahmood that exploring this apparent contradiction through the notions of domination and resistance is not sufficient to understand the role nursing has played in many women's lives. A good way of overcoming this dilemma is further analysis of one of nurses' most central, and often problematic, experiences: taking care of other people.

2.4. CARING AS A PRIMARY EXPERIENCE AND THE INTERACTION BETWEEN NURSING KNOWLEDGE AND POWER

The term 'care' has been traditionally associated with nursing from both the lay and academic perspectives. Care and nurture are at the centre of nursing identity, although neither term is easy to define[38] (McFarlane 1979). Thus, although modern nursing can be defined as the professionalization of care of the sick (Abel-Smith 1960), this does not necessary mean that this care belongs exclusively to nurses (Skidmore & Purkis 1998; Saillant 2009), or that caring is the only feature of nursing (Olson 1997). In this research, caring experiences are significant because of the ambivalent position they occupy in nurses' lives. A distinction should be made between caring as a primary experience, nursing care as a specific activity, and the ideological discourse around the role of care in the nursing profession.

[38] Siles (2003) correlated two broad cultural and religious traditions in the West with their different terminologies for the institutionalisation of care. In the reformist, Anglo-Saxon world, the term nurse is used, deriving from the Latin term *nutrire*. In contrast, the predominantly Catholic Southern European countries adopted terms that have their root in the Latin word *infirmitas*. Whereas the former term points towards the necessity of daily survival, the latter is more limited to the care of sick people. This research is more aligned with the first epistemology of nursing and care.

Working from a hermeneutic phenomenological position, Benner and Wright (1989) understood caring as a primary activity which went far beyond the discipline of nursing. Influenced by Heidegger, the authors understood caring as "a word for being connected and having things that matter work well because it fuses thought, feeling and action – knowing and being" (1989, p.1). Care is also related to the experience of being in a meaningful world and to the notion of *concern,* which reflects a sense of project but also places human beings in a vulnerable position. The authors argued against the denial of this vulnerability in the mechanistic conceptualisations of personhood that suggested a refusal of interpersonal involvement as a form of coping.

Nursing profession and the nurses' practices take place within the broader medical system, which has often been criticised for being biologicist and mechanicist (Menéndez 1984). Slowly but surely, however, the hegemonic model of medical care began to be challenged by different disciplines and schools of thought. In many cases, these critiques were accompanied by a vindication of the role of care (Saillant 2009). From a feminist perspective, the hidden nature of care and its relegation to domesticity was analysed as a form of gender and class oppression (Saillant 2009; Pérez Orozco 2014). Medical anthropology contributed significantly to the analysis of the power relations between the hegemonic medical model and other, non-institutionalised, forms of care (Haro 2000; Menéndez 2003). The nursing profession occupies a liminal position between the patriarchal, scientific, hegemonic medical model and the subaltern, often ignored or undermined forms of care. This section introduces these discussions and concludes with an analysis of the threefold relationship between care, knowledge and power.

2.4.1. Interpretive and critical analysis of the institutionalisation of care: The contributions of medical anthropology

Within medical anthropology, the works of Eisenberg (1977) Kleinman (1988; 1980), Good (1994) and their joint works with other authors (Kleinman et al. 1978; Kleinman & Kleinman 1991) constituted a pioneer analysis of the meanings and experiences of illness. The authors suggested biomedicine should be analysed as a particular and situated biomedical system with its own assumptions and meanings (Martínez Hernáez 2008).

When their interpretive analysis was merged with a political economy approach, critical medical anthropology (CMA) emerged, with the aim of questioning the assumptions behind the hegemony of biomedicine and its role in reinforcing structural inequalities (Foster & Anderson 1978; Menéndez 1981; 1984; Baer et al. 2003; Singer & Baer 2012).

One significant aspect of CMA is the situated analysis of different medical systems (Frankenberg 1981; 1988) and care practices (Haro 2000; Menéndez 2003) through the notions of hegemony/subalternity or domination/resistance. The domination of the biomedical system over other forms of care is, according to the critical authors, a reflection of broader power relations in society (Baer et al. 2003). The analysis by Menéndez (1984; 1981; 1991; 2003) is especially significant, as he merged the analysis of peoples' knowledge and practice of care with a critical analysis of medicalization.

Inspired by Foucault and Gramsci, Menéndez (2003) extensively wrote about the medicalization of social problems and defined the hegemonic medical model (HMM) as biologicist, a-social, a-historical, a-cultural, individualist, pragmatist, curative and based on an asymmetric doctor/patient relationship. Medicalization should be understood as a long term process that received a great boost from the growth of capitalism[39] (Baer et al. 2003; Foucault 1996). Biomedical hegemony occurred through a combination of the "exclusion of the patient's knowledge, formal professionalization, ideological identification with scientific rationalism, health/disease as a merchandise, tendency to the medicalization of problems and to a separation between theory and practice" (Menéndez 2003, p.194), which had a significant impact on the way in which nursing and, more broadly, care of the sick, was understood within biomedical institutions.

[39] Comelles (1996) stated that medicalization processes are not exclusive to the modern medical system, and were documented in Antiquity. Nevertheless, with the advent of Christianity, Comelles argued, a de-medicalisation process occurred in Europe and it was not until the sixteenth century that medicine began to recover its political signification. The most significant developments in the medicalization process took place in Europe in the eighteenth and nineteenth centuries through the birth of modern and social medicine (Foucault 1996).

However, the biomedical discourse should not be understood as a single, unified whole. The process of medicalization was full of contradictions and difficulties (Menéndez, 1984) and took singular shapes according to the context. A clear example of this uneasy process was the introduction of modern medicine and nursing in India and the ways in which it gradually displaced ancient systems like the Unani or Ajurvedic[40]. Nevertheless, for the purposes of this research, there is another, more central, process. In many ways, nurses and other professionals involved in the daily care of the sick have resisted the curative emphasis of the hegemonic biomedical model. Since the nursing reform in nineteenth century Britain and throughout the professionalization of nursing, greater emphasis has been placed, at least rhetorically, on the association between nursing and care. The care/cure dichotomy, however, has had its own problems and has been contested over time.

2.4.2. Nursing identity and care: problematising their straightforward relation

This section presents a summary of the discussions on the relationship between care and nursing. The works of medical anthropologists, and especially those of nurse anthropologists, have been useful in accounting for the complex relationship between nursing and care. Dougherty and Tripp-Reimer (1985, p.220) stated that: "medicine is primarily (and properly) concerned with disease, its aetiology, pathophysiology, and treatment". Nursing, in contrast, is more focused on "actual and potential needs which emerge in response to illness or health states" (1985, p.220). The authors used the distinction between *disease* and *illness* to account for the differences between medicine and nursing[41]. In many cases, this distinction was made through a dichotomy between the notions of *cure*, associated with biomedicine, versus *care*, usually linked to nursing

[40] For a deeper analysis of class ideology and the legitimation of scientific medicine in the context of medical pluralism see Frankenberg (1980; 1981)

[41] The distinction between *disease* as a biological entity and *illness* as the personal aspects of suffering was first made by Fabrega (1972, cited in Eisenberg 1977, p.10). The distinction between disease as etic and illness as emic was soon picked up and elaborated on by interpretive authors like Eisenberg (1977) and Kleinman (1978), amongst others. Young (1982) added a third category, *sickness*, to account for the social aspects of disease, which was further analysed from the field of critical medical anthropology by Frankenberg (1986).

(Torralba 1998; Saillant 2009). This dichotomic analysis (disease/illness, cure/care), however, has to be problematized.

The terms *care* or *caring* have a very broad meaning and it is difficult to define them accurately. Chrisman (1982, p.118) observed that, within the nursing field, they symbolised "a quality of personal relationships infused with the work nurses do to aid patients cope with health-related aspects of everyday life". Nevertheless, the ideology of caring and nursing practice extends far beyond an interpersonal relationship with patients. One of the first distinctions between the different aspects of caring was made by Griffins (1980; 1983), who separated nursing care activities from the attitudes and emotions associated with them. Although, one may question whether it is possible to separate 'activities' and actions from attitudes, it is useful analytically to distinguish between nurses' reported activities and their rhetoric about care. Consistent with the gap between the 'rhetoric and reality' of nursing care in Bangladesh (Hadley & Roques 2007), I soon realised that it was very difficult to get the nurses to directly state their views on nursing care. What is more, centring the narratives on the notion of care could lead to its essentialisation.

The dichotomy *care/cure* has been used by nurses to claim their own identity in opposition to doctors and the technical side of medicine (Dougherty & Tripp-Reimer 1985; Collière 1998). Nurses have claimed a humanistic, holistic approach to the profession since their establishment as a discipline (Chrisman 1982; Dougherty & Tripp-Reimer 1985; Leininger 2007; Olson 1997; Collière 1998). This is significant because of the social power associated with the ability to cure (Comelles 1996). The ability to care, in contrast, is either devalued or assumed to be a 'natural' function of women or disadvantaged social classes (Arthur et al. 1999). The power relations between those who cure (medical doctors) and those who care (nurses, servants, family members and so on) are clear.

Nevertheless, the *care/cure* dichotomy has been contested over time, as it can further contribute to the patriarchal, classist and racist ideology that legitimises and reproduces an unequal division of labour within the health system (Gamarnikow 1978; Salvage 1985; Evans 2006). In addition, the distinction falls too close to the Victorian ideology of the

separate spheres[42] and the reification of care as 'naturally feminine' (Gamarnikow 1991), as well as to an essentialist and universalist vision of nursing (Saillant 2009). Some authors have argued that the care/cure split represents the mind/body dualism which emerged in the West during the scientific revolution of the seventeenth century (Wicks 1995). Finally, it may be questioned whether this separation between cure and care makes any sense in practice and also whether cure is possible without care (Leininger 1988; 2006).

The establishment of modern nursing led to a significant redefinition of the notion of care and to its appropriation by reformists as a natural, feminine attribute of nurses. This 'renewed' rhetoric around nursing care soon became hegemonic in the academic and institutional environments. Nevertheless, the practical ways in which nursing care was delivered took a different shape. The portrayal of care as 'motherly affection' started to be questioned in several contexts (Littlewood 1991; Somjee 1991; Olson 1997). Not only did this early ideological discourse of caring idealise the therapeutic relationship (Saillant 2009), but it also perpetrated what Pérez Orozco (2014) termed the *reactionary ethics of care*.

The reactionary ethics of care are especially significant in capitalist societies, where women's identity and recognition is subject to tasks for the maintenance of life or in other words, reproductive tasks. This ethic is reactionary because it damages its subaltern subjects through their immolation and self-sacrifice. In addition, it limits the notion of welfare to the boundaries of the family and contributes to silencing the capital-life conflict. Thus, the responsibility for sustaining the lives, which was endangered by the capitalist system, is allocated to the domestic and private spheres. Care is never socialised, but instead obeys a globally sexualised and racialised division of labour. The analysis by Pérez Orozco is significant because it places the capitalist ideology in opposition to life (both human and non-human). Considering that the hegemonic biomedical model is one of the central institutions of capitalist societies, the result is that modern nursing was born in the midst of a system that did not place caring at its heart.

[42] The ideology argues that men and women belong to separate spheres, closely related to naturalism and serve to perpetuate power relations by linking them to biology (Gamarnikow 1978).

The idealisation of care nursing and its appropriation by the nursing profession has had consequences. On one the hand, by assigning religious and 'superhuman' values to nursing care, the tensions and problems associated with its practical delivery are suspended. Notions like 'vocation' and 'self-sacrifice' have served to justify nurses' oppression and dreadful working conditions. On the other hand, this idealised portrayal of caring as a therapeutic relationship often hides the compensatory or 'practical' aspects of care, which are usually carried out independently of the professional and institutional delivery of care (Saillant 2009). The author states that most authors of this idealised version of care are nurses in search of a specialised professional identity.

Nevertheless, the reification of care should not be seen only in negative terms. In some cases, it led to broader criticisms of medicalization and the feminist claims for a less technical medicine (Samuelson 1991; Olson 1997; Saillant 2009). The care-based identity was also used by nurses in to claim greater autonomy within the medical field and served to generate a large body of knowledge and discussion. It should be emphasized that it is not the act of caring itself that leads to inequality, but the conditions under which it happens (Saillant 2009). The work of Falk Rafael (1996) and her notion of *empowered caring* throws some light on this.

Falk Rafael (1996) developed the notion of *empowered caring* emerged as an alternative to two other forms of care, which she termed *ordered caring* and *assimilated caring*. The former is usually related to the ways in which modern nursing emerged in nineteenth-century England and spread to other parts of the world. Assimilated care, on the other hand, developed later as a consequence of the liberal feminist movements within the nursing profession and led, in many cases, to a model of nursing which sought assimilation with the medical sciences and the 'masculine' role of doctors and managers. Nursing and caring activities had historically been devalued due to their 'femininity' and nurses had been dispossessed of knowledge, power and ethics. As a consequence, for nurses to acquire power, distance was needed from other nurses and their 'feminine' caring activities

(Roberts 2006). Falk Rafael (1996, p.12) expressed this using the adage "if you can't beat them, join them".

So far, it would seem that nurses have only two options within medical institutions: either they accept their submission in the form of ordered care, or they challenge it by assimilating 'masculine' aspects of medicine. However, Falk Rafael suggested an alternative form of care that could emerge from nurses' grounded experiences in the form of *empowered caring,* which is based on a feminist perspective that acknowledges women's oppression and, at the same time, values their specific experiences (Falk Rafael 1996). This form of power acknowledges the traditional and often necessary 'power over' but moves beyond it. Traditional power sources include credentials, association, research and expertise. They point towards a particular form of knowledge which separates 'rational', theoretical and technical knowledge from practical experience. Menéndez (2003) had already suggested that one key elements in the hegemonic medical model was this theory/practice dichotomy and the devaluation of lay forms of knowledge. Nursing, as an inherently practical activity, did not fully fit into the biomedical 'scientific' logic and thus nursing knowledge was often undermined or ignored.

2.4.3. Nursing, power and knowledge: care as a form of *praxis*

Beginning in the 1980s and throughout the 1990s, a rich, stimulating discussion took place about the different forms of nursing knowledge. Influenced by feminism and phenomenological hermeneutics, nurse theorists began to suggest the need for a humanistic approach to nursing care theory. The work of Carper (1978; 2006) in the late 1970s, complemented by White (2006), were crucial in conceptualising what the authors termed fundamental patterns of knowing in nursing. Carper (2006) identified four main patterns of knowing in nursing: empirics or the science of nursing; aesthetics or the art of nursing; personal knowledge; and the ethics or moral component. White (2006) added a fifth pattern, which she termed socio-political knowing.

From the 1950s onwards, the term 'nursing science' began to be used to account for the *empirical knowledge* which emerged from factual and descriptive knowledge with the aim of providing theoretical explanations (Carper 2006). Later, with the advent of critiques of the empiricist model, nursing began to be claimed as an art and more emphasis was placed on *aesthetic knowledge* and the role of emotions. Nevertheless, the notion of 'art' soon faded into oblivion, partly due to "the vigorous efforts made in the not-so-distant past to exorcise the image of the apprentice-type educational system" (Carper 2006, p.132). Closely related to the aesthetic form of knowledge is *personal knowledge* which is, according to Carper (2006), the most difficult to master and teach. In contrast to empirical knowledge, personal knowledge is keener to accept "ambiguity, vagueness, and discrepancy between oneself and others" (2006, p.133). Another specific form of personal knowledge considered relevant for this research, is encompassed by the notion of *spirituality*[43]. Finally, Carper (2006) highlighted the role of *ethical knowledge* in the choices which nurses constantly make between different actions. The behaviour of individual nurses is also situated within a certain moral framework which is, in turn, related to the society where they live, their religious communities, ethnic groups, and so on.

The different patterns of knowing in nursing have different values attached to them. Empirical knowledge is usually deemed more reliable than other, less 'scientific' forms of knowing, which has had significant consequences for nursing.

2.4.3.1. The devaluation of practical knowledge and its impact on the nursing profession

Antrobus (1997, p.447) observed that the nursing profession has the uniqueness and richness of its commitment to "drawing its knowledge base from practice". I would argue that this commitment is not exclusive to nursing, although it is true that nursing may be considered a practical, experience-based, profession. Historically, practical or embodied forms of knowing have been analysed in opposition to abstract reasoning, which is generally considered 'superior'. This idea takes us back to the early Cartesian mind/body,

[43] It is important to clarify that the notion of spirituality is a broad term which goes beyond religious values, as it also involves an existential component (McCormick et al. 2001).

objective/subjective dualities. A similar dichotomy was also made between nursing as a 'feminine' form of knowledge and medicine as a 'masculine' field (Doering 1992; Davies 1995; Antrobus 1997).

The early developments in 'nursing science' and the move towards empiricism led to the idea, which has persisted until the present, that knowledge was to be gained mainly from academic settings (Chinn & Kramer 2015). Nevertheless, empiricism was also challenged from inside the nursing profession. With the humanistic, phenomenological and feminist ascendency in nursing, other forms of knowledge also challenged the 'scientific' Cartesian worldview. Intuition and experiential, phenomena-centred knowledge began to be seen as a significant contribution to elucidating the "health-illness experience" (Doering 1992, p.31). This form of embodied knowledge, in its "rapid, non-explicit and non-conscious ways of grasping the significance of a situation", allows the self to attribute meaning to it and act accordingly (Antrobus 1997, p.450). Phenomena-centred, experiential knowledge is similar to what Giddens (1979; 1984) conceptualised in the form of *practical consciousness* and Bourdieu's (1977) notion of *habitus*.

It should be remembered that nurses' embodied knowledge is also socially constructed. The specific institutional socialisation processes of nurses; the ideological aspects of *care* (especially in relation to gender and class), and the position of the profession within the medical and social fields all intersect with nurses' individual and intersubjective experiences with patients, relatives and colleagues.

2.4.3.2. Nursing knowledge as *praxis*: Socio-political and emancipatory knowledge

The notion of *socio-political knowledge* was developed by White (2006) in a review of Carper's patterns of knowing. She identified it as a crucial pattern not only in relation to the patients' context, but also to nurses and their profession, which included both society's understanding of nursing and nurses' socio-political understanding. Chinn and Kramer (2015) based their conceptualisation of nursing knowledge mainly on the works of Carper

(2006) and White (2006), adding the notions of *praxis* and emancipatory knowing[44]. Chinn and Kramer (2015, pp.5–6), "emancipatory knowledge (…) begins with being aware of social problems such as injustices and questioning why these exist". In addition, emancipatory knowledge, as praxis, could be individual and collective, opening up an interesting area of debate about nurses' group agency. Nurses may also be seen as a community of critical reflectors and actors who "act on their insights and move toward the goal of transforming nursing and health care" (Chinn & Kramer 2015, p.6), which returns us to nurses' specific role in society:

> "Nurses provide care for people in the midst of health, pain, loss, fear, disfigurement, death, grieving, challenge, growth, birth, and transition on an intimate front-line basis. Expert nurses call this the privileged place of nursing (…). In expert nursing practice, nurses focus on the lived experience in health and in stressful situations" (Benner & Wrubel 1989, p.ix)

Nurses' experiences, therefore, move far beyond the interpersonal encounter with patients and their colleagues and are related to Schutz's notion of intersubjectivity, and especially to his conceptualisation of the 'I-Thou' relationship. Carper (1978) also applied Buber's 'I-Thou' notion to the personal pattern of knowing in nursing: "This knowing is a standing in relation to another human being and confronting that human being as a person. This 'I–Thou' encounter is unmediated by conceptual categories or particulars abstracted from complex organic wholes" (1978, p.28). In addition, the idea of witnessing and, to a greater or lesser extent, being part of a wider *social suffering*[45], places nurses in a particular position where they have the potential to observe and act upon broader structural inequalities. This idea reminds us of Hooks' (1984) conceptualisation of Black, working class women who had a particular lived experience of oppression, but also had the

[44] The authors drew on the earlier work of Jürgen Habermas (1973) who aimed to emancipate them from or, in other words, to transcend the practical and technical interests of knowing.

[45] The notion of social suffering was coined by Kleinman et al (1997) to account for a particular form of structural violence resulting from "what political, economic, and institutional power does to people and, reciprocally, from how these forms themselves influence responses to social problems" (1997, p.ix).

possibility of turning that experience into a privileged knowledge of the different forms of discrimination in order to fight against them.

The notions of emancipatory knowing and socio-political knowing are reminiscent of what Falk Rafael (1996) defined as empowered caring. The later took much from Benner's (1982) analysis of nursing expertise as a source of power which could be more enabling than the traditional 'power over'. Benner (1982, p.406) was convinced that "nurses offer avenues of understanding, increased control, acceptance, and even triumph in the midst of what, for the patient, is a foreign, uncharted experience". Therefore, experience is crucial in nursing knowledge and cannot be limited to either the mere passage of time or the uncritical application of theorems (Benner 1982). All these discussions about the triple relationship between care-knowledge-power are taken up again in Chapter Eight. For now, is should be remembered that the intersubjective experience of caring can also be empowering for nurses and the people they are caring for.

2.5. CONCLUDING REMARKS: KNOWLEDGE, AGENCY AND POWER

The aim of this chapter was to present the main theoretical discussions which have shaped this research. More than a pre-established theoretical framework or position, this is a process of discovery, research in itself, of ways through which the individual experiences of nurses can help explain, and be explained by, the broader situation of Bangladesh. If I had to choose a central idea to articulate the discussion I would still select the notion of *agency*, as well as its relationship with other categories like *knowledge* and *power*. The discussions around the notion of *caring* and the ways in which nursing knowledge is generated, transformed and reproduced are also significant to understand the role which nursing education and practice has had on the lives of the nurse teachers.

Starting from the problem of the individual versus society couplet, this research aims to provide, with a dialectic that constantly shifts between subjectivity and intersubjectivity; between representations and practices; between knowledge, ideology and power; the ways in which all these elements shape action. With respect to knowledge, ideology and power, a crucial aim of this chapter was to clarify the ideological and political position of this

research. The life stories of nurses cannot be fully understood without accounting for the different forms of social inequality and discrimination throughout history. Nursing has a particular hegemonic ideology, which is clearly based on gender and class inequalities, and which has to be contextualised within broader historical elements, like the rise of capitalism and scientific technologies.

In addition, caring is understood as a primary human experience, which, in the case of the nurses in this research, happens mainly within a post-colonial, patriarchal and classist hegemonic medical system. Nevertheless, their caring experiences move far beyond the medical institutions, as they are greatly affected by the immediate social and family networks where they occur. Finally, caring is also analysed as a particular form of knowledge that is, in Foucault's terms, both generative and representative. When caring is understood as a form of *reactionary ethics* (Pérez Orozco 2014), it can be used to perpetrate gender and class inequalities. In contrast, when caring happens in safe environments and is understood as a form of *praxis* (Chinn & Kramer 2015), it has the potential to generate social change.

3. METHODOLOGICAL ISSUES: DIALOGUES AND DIALECTICS

"That time when I was born, it was (…) 1949, after Second World War and, you see, the United Nations is established in 1948. But I am born in 1949. So what is the condition of the world is ultimately affecting my childhood" (Tuli, 03/03/12)

3.1. INTRODUCTION

This statement is taken from one of the first interviews with one of the key informants in this research. Her awareness of the global events taking place when she was born shows both her reflective nature and the influence of international organisations on her personal and professional life. Born in a poverty-stricken area of the then East Pakistan and orphaned at a very young age, she still managed to get an education and provide for herself and her family. She attended missionary schools, joined a religious congregation, which she would later leave, and managed to become a teacher. It was then when, unhappy with the way things were run in the congregation, she decided to change her life path, leave the religious life and become a nurse.

Tuli's life story, which is explored further in following chapters is, in many ways, unusual but may serve as an example of the constant tension between her individual subjectivity and the events happening around her. Throughout her narrative, which is one of the most self-reflective stories presented here, she retrospectively analysed her life on many occasions. She emphasized her constant efforts to try and help other people, 'in her own way' without breaking local social and cultural norms. This constant tension between her own personality, the decisions she took and 'external' factors shows how these enabled her on some occasions and constrained her on others.

The profoundness of Tuli's narrative would probably not have achieved if she had not been prompted to tell her life story. The analysis of experience in the form of narratives has been

crucial to this research. The following sections present a brief introduction to the main theoretical and methodological discussions on the use of personal narratives.

3.1.1. The specificities of life stories as a form of narrative and their uses in social sciences

Personal narratives are a specific representation of experience that mediates between "an inner world of thought-feeling and an outer world of observable actions and affairs" (Garro & Mattingly 2000, p.13). A personal narrative is a dual process simultaneously "born out of experience and (which) gives shape to experience" (Ochs & Capps 1996, p.20). The interpretive current in the philosophical and social sciences led to a renewed emphasis on the meaning of personal accounts. What emerged from a hermeneutic-phenomenological analysis of life stories is that the *narrated story* cannot be separated from the *lived story*[46] (Widdershoven 1993).

This research does not follow a purely hermeneutic-phenomenological approach for several reasons. First, there was the language issue; interviews were conducted in English, which was neither the nurses' nor my own mother tongue. Secondly, the central aim was not to focus on *how* the stories were told, but on their overall meaning within a broader context. Nevertheless, some of the crucial methodological and theoretical issues surrounding the analysis of narratives were also experienced and elaborated throughout the research.

Life stories as an anthropological practice allow reconciliation between observation and reflexivity (Larrea Killinger 2012). Through the analysis of the biographical events of an individual and the context in which they are narrated, a broader perspective is obtained. The personal experience is analysed "over time, as regards its development, integration with family and community, and perception of the world" (Aziz & Maloney 1985, p.4) It is precisely this enquiry about the ways in which the inner self interacts with the 'outside' world where the complexity of anthropological analysis lies.

[46] My italics

Life stories and personal narratives have been used by anthropologists and other social scientists for a long time, even though they by no means invented it (Balán 1974; Marsal 1974; Plummer 1989). The distinction between the universal awareness of the individual body-self and the social conception of the notion of personhood is important in this respect (Scheper-Hughes & Lock 1987). Individualism and humanism can be traced back to medieval times, even if the search for personal identity with respect to the outside world did not become mainstream until the nineteenth century (Plummer 1989; Betraux 1981b). Barker (1984, cited in Comaroff & Comaroff 1992, p.26) cited the use of personal diaries in the rise of the bourgeois notion of personhood in the eighteenth century; the Cartesian 'I' as an image of a self-conscious being with the capacity to gaze out and measure the world. Similarly, Bourdieu (1989) pointed to the use of biography as a modernist fantasy about society and selfhood, as a *biographical illusion*. Contemporary critics of the subject, especially from the feminist standpoint, have challenged the notion of a 'Universal Man' as the embodiment of a historical essence (Brah 1992).

Biographies were gradually 'smuggled' into the academic world (Bourdieu 1989), reaching their peak in the 1920s under the auspices of the recently created Sociology Department of the Chicago School (Plummer 1989). In anthropology, the Culture and Personality School also played a crucial role (Pujadas 1992). Most of the initial publications combined psychoanalytical insights and the link between individual actions and historical and social conflicts[47] (De Miguel 1996). Unfortunately, this initial interest gradually vanished in sociology, with a return to 'scientific' and statistical methods after the two world wars (Marsal 1974; Magrassi & Roca 1986; Plummer 1989; Pujadas 1992). A revival in the use of life histories occurred in 1960s, within a broader change in social science towards a more humanistic approach with questioning of positivist paradigms (Balán 1974; Pujadas 1992).

[47] Thomas and Znaniecki's *Polish Peasant*, published in 1920, was emblematic in this regard, marking the symbolic birth of life history as a methodological tool in social sciences, especially sociology (Plummer 1989; Pujadas 1992). Meanwhile, European and North American anthropologists were also using life histories to document 'societies' which were in danger of disappearing due to the colonial impact (Balán 1974; Magrassi & Roca 1986).

Emphasis was placed on social change, which positivist approaches could not fully comprise due to their incapacity to explain the temporal variable (Pujadas 1992). The work of the anthropologist Oscar Lewis (1961; 2012) and his 'social realism' have probably become the most widely known example of this renewed approach to life stories (Balán 1974). Concurrently, developments in the field of discourse analysis, especially the critical works of Foucault, influenced the way in which biographies were used (Linde 1993). The contributions of hermeneutics and phenomenology and their incorporation into anthropology were also significant (De Miguel 1996; Larrea Killinger 2012).

The movement towards the "rights of the disenfranchised", prompted social scientists to use the life stories of women, minorities and poverty-stricken people to share their accounts of "suffering and redemption" (Rosenwald & Ochberg 1992, p.2). Life *stories* started to be used in feminist and postcolonial studies[48]. Greater emphasis was placed on the narrated story, moving away from the notion of life *history* and pointing to the thin line between objectivity and subjectivity and advocating a less andro- and ethnocentric analysis of reality (De Miguel 1996). The use of the terms *history* or *story* suggest different theoretical and methodological approaches (Behar 1990; 1993; Linde 1993; Rosenthal 1993). In broad terms, in *life stories* the emphasis is placed on personal narration, that is, on the way the events are recounted. *Life histories,* on the other hand, highlight the broader historical and social events surrounding the narrated story. In addition, Larrea Killinger (2012) identified two theoretical approaches to the use of life stories in social science, which treat biographies as either information or meaning units. In the former, a biography is a synthesis between the individual and the collective (society), thus allowing comparison between different biographies. In the latter, meaning-based approach, biographies are analysed as a form of narration. The focus is placed on the story and the interaction between the narrator and researcher.

[48] Ruth Behar's (1993), *Translated Woman. Crossing the Border with Esperanza's Story*, includes both views and clearly exemplifies the attempt to analyse individual stories from a politically critical perspective.

The distinction between life *stories* and life *histories* is not an easy one and may sometimes be artificial and misleading. First, it only makes sense within Anglo-Saxon literature[49]. Secondly, the terms are often used interchangeably even in English. Notions of *history* and *story* cannot be considered as pure categories. As fluid notions (Behar 1993), they allow a dual focus on both the *narrated story* and the *experienced history*, with a stronger emphasis on one or the other depending on the aims and methodological approach.

Life *histories* involve a great deal of biographical material, usually contrasted or supplemented by other documental and oral sources (Marsal 1974; Betraux 1981a). In this research, the fact that several women were included limited the depth of each account and their treatment as *histories*. Furthermore, even though it is clear that life stories are never fully exhaustive (Magrassi & Roca 1986), the narratives presented focus strongly on the professional field. Nevertheless, an effort was made to move between the *narrated* experience and the *lived* experience; to reconstruct the 'factual' part of their stories and relate it to broader social and structural factors. The positivist idea that narratives represent an external reality 'outside' has been widely abandoned by social scientists (Rosenwald & Ochberg 1992). Riessman (1993) and Stivers (1993) prefer to use the term *alternative truths* in narrative analysis, which aims at "believability, not certitude, for enlargement of understanding rather than control" (Riessman 1993, p.21), and state that historical truth is not the primary issue and the omissions are as important as the inclusions. Moreover, the analysis of alternative truths can also help "in developing a nuanced understanding of structures and processes of domination" (Stivers 1993, p.423). Similarly, Clifford (1986, p.7) used the term *ethnographic truths*, defining them as "inherently *partial*, committed and incomplete", although in spite of this partial nature they may still be a source of what he termed 'representational tact'.

[49] In Spanish, for example, such a distinction is not possible and the term *historias de vida* usually includes both approaches. Interestingly, when Behar (1993) was wondering whether she should call her informant's biographical account a life story or life history, she eventually decided to use the Spanish term *historia*. "Esperanza [the protagonist of her book] certainly understood that the border between history and story, and reality and fiction, is a fluid one" (1993, p.16).

For the purpose of this research, the notion of *life stories* initially seemed more accurate than that of *life histories,* due to both theoretical and methodological reasons. Theoretically, the emphasis on *history* carries an assumption of 'truth' or 'fact' behind the story, which is treated as a 'mirror' or 'window' to an objective, external reality (Peacock & Holland 1993). This research is more concerned with *meaningful acts* and with their intersubjectivity, than with the veracity of the accounts.

3.1.2. Outline of the research design and timeframe

The initial design for this research was made throughout 2011, culminating in the submission and subsequent approval of the research protocol by ICDDR,B at the beginning of 2012. The fieldwork was conducted in Dhaka, in two main periods: February-May and September-December, 2012, and lasted for seven months. In the three months from June to August, 2012, an initial analysis of the first interviews was made, together with a further literature search. I left Bangladesh in December, 2012 and started to make a deeper analysis of the interviews. During a further two-month work-related visit to the country (April to June, 2013), I took the opportunity to interview three additional informants and I also visited the key informants again, even though I did not interview them further. For the past three years I have been working on the theoretical analysis and writing up.

The wide scope of the initial aim, to analyse nurses' personal and professional experiences, has been a double-edged sword. On the one hand, it allowed me to start with an open approach to the nurses' narratives, with the intention of letting them move towards what the nurses considered most important in their experience. On the other hand, it soon became evident that this initial approach was highly impractical and, perhaps, too ambitious. Trying not only to capture and comprehend their individual narratives, but also construct a dialogical and relational narrative, has been the biggest methodological and theoretical challenge. In this chapter I present the main methodological aspects, decisions and discussions that emerged from the research.

3.2. RESEARCH PARTICIPANTS

Twenty-two nurses were initially included as participants, but only twenty met the research requirements[50]. Initially, six key informants were purposely selected and subsequently thirteen more nurses were interviewed using the snowball technique.

3.2.1. Selecting the first six key informants

Key informants have traditionally been used in anthropology as a way of gaining an in-depth access to their setting (Poggie 1972). In more recent works, key informants are also defined as 'culturally competent informants' (Romney et al. 1986) or 'focused informants' (Bernard 2006). Romney et al (1986) developed the *Cultural Consensus Model* to identify informants, assuming that people from the same 'culture' would share a common understanding. While acknowledging that, while the notion of 'common culture' is problematic, the initial assumption was that the key informants would share some common pattern in their discourses on nursing in Bangladesh.

Key informants are people who not only have a substantial knowledge of their 'culture', but are also willing to share this knowledge (Bernard 2006). My involvement in the academic side of nursing made me start by interviewing some of the teachers I already knew, who then led me to interview other teachers. The informants' inclusion criteria considered their professional and academic expertise, their availability and English fluency[51]. According to Bernard's (2006, p.199) recommendation, I tried to find "trustworthy informants who were observant, reflective, and articulate, who know how to tell good stories, and stay with them".

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[50] Two of the nurses who had originally signed the consent form and fulfilled the initial background questionnaire have not been included. The first was too busy to carry on with the interviews and the second was interviewed once, but the quality of the sound was not good and the interview was too short to be considered.

[51] For a detailed description of the inclusion criteria, see Appendix B.1

I initially interviewed seven nurses, six women and one man, who were working in institutions accessible to me. None were currently working in the government sector, although three had done so. The initial aim was to obtain a heterogeneous group of nurses, including men and women, married and unmarried, from different religious backgrounds, who had been studying and/or working in both government and non-government institutions[52]. Unfortunately, this heterogeneity could not be achieved in all aspects.

Gender wise, the only male nurse included as a key informant left the country in the middle of the data collection period. Other male nurses were interviewed but not as key informants. This constitutes a limitation in terms of gender diversity. The final outcome regarding their marital status was interesting. Two had joined religious congregations at a young age: one decided to stay and the other left the congregation but remained unmarried. There was also another unmarried nurse who was interviewed towards the end of the research.

The religious profile of the key informants was also unbalanced. Four nurses were Christian, two Muslim and none Hindu or Buddhist. This distribution does not correspond to the current religious background of Bangladeshi nurses, with more Muslim nurses joining the profession each day. It resembles the initial recruitment pattern in the subcontinent, where Christian nurses dominated nursing educational institutions. In order to compensate for the lack of Hindu key informants, the views of the Hindu nurses interviewed in the later fieldwork phase are also included in different parts of this thesis.

A wide range of experiences were gathered in relation to the educational and work settings. Even though the age range differed, all had undertaken their nursing education in a similar time period, and most had either worked or studied in both government and non-government institutions, allowing them to compare their experiences in the two sectors.

[52] See Appendix B.2

3.2.2. Adding more informants from different settings and selecting one more key informant

During the second fieldwork phase, I tried to interview clinical nurses in the government sector. This was very challenging and I could only talk to three nurse supervisors from government hospitals and another supervisor from a private institution. The interviews were not as smooth as those with the first nurses. They were not fluent in English and so I worked with a research assistant acting as an interpreter. The interview setting did not allow privacy, as we had to meet in the nurses' common office, with a constant flow of people coming and going. Moreover, they were very busy and could not allocate enough time for an in-depth interview. These interviews, in spite of their limitations, gave me an insight into their working environment and a brief contextualization of how they had become nurses.

After this initial (and somewhat frustrating) attempt to interview clinical nurses, I decided to move away from the hospital and continue interviewing nursing teachers. Thanks to one of the key informants, I gained access to experienced teachers working in the government sector and for international organizations. They were leaders and generally well known amongst the teaching community. One nurse teacher was especially significant because of her reflective and critical analysis of the nursing situation in Bangladesh. Unfortunately, I met her towards the end of the fieldwork and I could not obtain such an in-depth biography but, even so, decided to include her as a key informant.

Forty-four interviews were finally conducted with twenty-two nurses, of whom seven were considered key informants. In-depth interviews, however, were not the only source of information, as shown in the following section.

3.3. FIELDWORK AND DATA COLLECTION TOOLS

The fieldwork was initially planned as two phases separated by three months of analysis in between. The first phase lasted four months and the second three months. I also travelled

back to Bangladesh afterwards, where I took the opportunity to interview nurses who I had contacted previously but had not been able to interview.

3.3.1. First data collection phase: from obtaining a 'biographical background' from the key informants to the reconstruction of their life stories

The aim of the first research phase was to reconstruct the key informants' life stories, focusing on what being a nurse meant to them, using in-depth, open-ended interviews. According to Riessman (1993), I started by asking broad questions about general topics related to biographical events. The interview guidelines[53] initially developed involved broad questions, or what Spradley (1979) called descriptive questions. The guidelines were based on the literature review of nursing in Bangladesh and comprised four main areas: demographic background; biographical introduction; nursing education; working experience. As I began asking questions about their background, I realised that it was easier to have them complete a questionnaire with basic questions about their family, education and working experience[54]. The aims of this initial survey were to make sure that detailed information was given with respect to dates and places and get a general picture of their backgrounds.

When I began asking questions, I had to make an important methodological decision. As I did not want to start with questions about their experiences and views about nursing, I asked about their personal background. This somehow led me to an initial reconstruction of their life events. I reflected on this during the first fieldwork period:

> I discovered that with 'rich informants' (…) who tend to give long, detailed explanations of their lives, for the second and third interview it may be OK to prepare them roughly (…). But after the third interview, I had already gathered a lot of information and, if not careful, I would make them repeat things they had already said (…). I have decided to reconstruct the life stories of the informants with whom I have done more than two interviews. (Interview notes, March 2012)

[53] See Appendix C.1 for the full guidelines

[54] See Appendix C.2

I had to modify the initial interview guidelines in order to obtain better understanding of their life events before their nursing education; I ended up obtaining the life stories of the key informants. I realised that this was a very good way of looking at the intersection between their personal and professional experiences. In some cases, however, I needed to clarify why I was asking so many questions about, for example, their childhood. Undertaking an initial chronological analysis of the 'factual' narrated events allowed me to get not only an idea of their lives but also to begin relating one biography to another and to wider historical events.

3.3.2. Second data collection phase: Focusing on nurse teachers

When I travelled back to Bangladesh in September, 2012, I had two clear aims: to continue working on the key informants' biographies and to add a wider range of informants. This led me to modify the interview approach.

3.3.2.1. In-depth interviews with the key informants and focused interviews with new informants

First, I revisited the key informants initially selected for at least one further interview, in order to work on parts of their biography that needed more clarification or deeper understanding. Unfortunately, one of them was preparing to migrate to another country with her family and it was impossible to schedule an interview. Some informants were very busy and could only be interviewed once for a short time. Other informants, in contrast, were keen to be interviewed twice and 'tell their story'.

3.3.2.2. A circumstantial tool: Group interviews

Group interviews had not been planned initially. However, I had to conduct them twice in order to interview all the nurses at once, as they were short of time. I was aware that it would lessen the depth and duration of the individual accounts, but I did not want to miss the opportunity to interview them. Moreover, it was interesting to see how they interacted

with one another and gave their opinions of each other's experiences. However, these cannot be considered as focus group discussions because of their 'improvised' nature.

3.3.3. Third data collection phase: Adding more informants and visiting nursing institutions

I returned to Bangladesh in 2013 for a work-related visit. However, as I got ICDDR,B approval for an extension of the fieldwork period[55], I decided to take the opportunity to go back to two of the later informants. On one of these visits, I talked to a new informant who was also keen to be interviewed. During this period, I also made several visits to different hospitals where former students, whom I had previously taught, were working as staff nurses; I was also able to talk informally to them about their first experiences. Even though these conversations are not formally included, they contributed to my background knowledge of the clinical area.

3.3.4. Summary of the characteristics of the interviews: Transcribing experience

I conducted forty-four interviews, two of which were in groups[56]. Most interviews were conducted at the informants' offices and the degree of privacy and interruptions varied. They generally agreed to be tape-recorded although four refused, prompting me to take notes instead. The interviews lasted between thirty minutes and two and a half hours, with an average of one to one and a half hours. The interviews were mainly conducted in English, even though, on many occasions, the informants were using Bengali expressions. As I had an intermediate level of Bengali at the time, I understood most expressions and asked for clarification when I did not.

I personally transcribed the interviews as soon as possible, in order to have a 'fresh' recall of the situation. Verbatim transcription was used, according to a modified version of Jefferson and Godam's transcription convention (Manzo 1996, cited in Bernard 2006). In

[55] See Appendix D

[56] The characteristics of the interviews have been summarised in Appendix E

this way I accounted for non-textual elements of the interview, such as pauses, inflections, emphasis, unfinished sentences or short periods as far as possible (Riessman 1993; Bernard 2006).

Nevertheless, a further modification was made for the presentation of the interview quotations in the final text, according to what Riessman (1993, p.43) called a "systematic method of reduction". Garro and Mattingly (2000, p.29) highlighted the role of anthropologists in "selecting, juxtaposing, and summarizing material, often from interviews, to represent an individual's 'story'". In summary, there is a significant degree of interpretation of the stories to meet the aim of this research and the circumstances in which the fieldwork took place. The nurses' own interpretations and the *meanings* they attached to their life events are preserved as far as possible. Nevertheless, the sentences are often been modified to make them easier to read. In the following table, examples can be found of the modifications made for the presentation of the interview quotations in the final text:

Table 1. Final editing of the informants' speech

	Original transcript	Edited transcript for the final text
Pauses or silences	(.) Short pause ( ) Long silence	All have been removed from the final text.
Utterances	Transcribed Ex: hum, eh, yeah	Left in only if relevant for the overall meaning of the quotation.
Emphasised expressions	CAPITAL LETTERS	The capitalisation of emphasised words has been left in to preserve the nurses' original expressions.
Contextual comments	(( ))	Generally left in unless they provided no useful information.
Further edition	Verbatim, no text edition done.	The original text has been edited, using square brackets to add words and ellipsis to reduce parts of the original text. When more contextual information was needed, it has been added between square brackets. 'Spelling mistakes' related to verb conjugations; prepositions; the gender of the pronouns; and other elements, are corrected in the final text as long as they do not alter the overall meaning of the phrase.
Examples	"That time when I born, it was the, eh, year of for—1949"	Ex: "That time, when I [was] born, it was (…) 1949"
	"Boyfriend couldn't come, and without information from the ho— he, hospital or all their duty dress they were just pull out and that eh, keep one bag and then lay dress"	"[Their] boyfriend couldn't come, and without [informing the hospital authorities they changed] (…) their duty dress (…), [kept it in] one bag and then [put on a] lay dress"

A transcript, no matter how rich, will never be a complete reproduction of the interview and involves a good deal of 'contamination' (1989) or, to use a more positive term, interpretation (Riessman 1993). In this regard, I agree with Scott (1985) in that neither events nor human subjects speak entirely for themselves. If they did, Scott observed, "it would suffice merely to turn on the tape recorder and offer a complete transcript to the reader" (1985, p.138). The objective of the transcription was not to make an in-depth linguistic analysis of the narrative but to understand the way the informants recalled and organized their experiences.

3.3.5. Obtaining more background information: Observations, personal records and written reports

Throughout the fieldwork, and in order to obtain more background information, I tried to meet the nurses in their daily contexts as far as possible. I also participated with them in a wide range of social events (religious celebrations, nursing cultural programmes and educational conferences) and, on some occasions, I was invited to their homes, thus being able to meet their families. Attending nursing programmes was crucial to grasp the 'official' rhetoric about nursing in Bangladesh. I also tried to gather as many documents and reports as I could.

I observed the nurses working in the clinical area on several occasions. Even if this was not planned as a data collection tool, it became a useful tool when trying to contextualise the nurses' accounts and the literature about the current situation of nurses. Finally, I had several chances to share my work with other health professionals, mainly doctors and nurses, who were involved in either nursing education or practice. Even though their narratives were not directly related to the objectives of the study, their views and opinions were invaluable in order to analyse the complexities and challenges faced by the 'Western' professionals when trying to implement international nursing care standards in Bangladesh.

All this background information was crucial to analyse and contextualise the nurses' narratives. In the following section, a brief description of the different analytical questions, tools, challenges and decisions can be found.

3.6. DATA ANALYSIS AND INTERPRETATION: THE ROAD FROM THE INDIVIDUAL LIFE STORIES TO THE STRUCTURAL FACTORS

De Miguel (1996) discussed the uneasy relationship between life as *lived* and life as *narrated* and pointed to the limited power of words and to the importance of the interpretive process throughout the reconstruction of an (auto)biography. Chronological reconstruction is needed, at some point, to understand the present narration and meaning of the life story (Magrassi & Roca 1986; De Miguel 1996; Rosenthal 1993; 2006).

Nevertheless, inconsistencies and incoherencies, as well as the ideology and cultural presuppositions of both the narrator and the author have to be acknowledged in the final written work, as they are a reflection of the complexity of social life (De Miguel 1996).

Narrative analysis implies, to a greater or lesser extent, some form of interpretation; it is important to systematize and make clear how this interpretation has been done (Plummer 1989; Riessman 1993). Riessman identified four different phases in the analysis of narratives: attending experience; telling about experience; transcribing experience; analysing experience. All of them started during the first fieldwork period, and the last one, the analysis of experience, continued until the production of the final text. The former three phases, attending, telling about experience and transcribing it, were carried out in the form of interviews and have already been discussed in the previous section.

The analysis and reconstruction of the nurses' narratives was done in three main phases. The first step was to organise the interview materials following a biographic and thematic order. Once the biographies had been individually reconstructed, a *dialogical* approach was used to relate them to one another and to the broader background of nursing in Bangladesh. Finally, a *relational* approach was taken to relate the nurses' narratives to broader theoretical discussions around the relationship between agency and structure in a context of power relations.

3.6.1. First individual reconstruction of the life stories: Reflections on time, identity and context

3.6.1.1. The importance of time: Past, present and future enacted and reconstructed

As previously discussed, personal narratives do not occur in a void but rather in a specific moment in time and space. In this sense, the same event will never be narrated twice in the same way, as "narratives are apprehended by *partial* selves, and these so apprehended

narratives access only fragments of experience[57]" (Ochs & Capps 1996, p.22). Past and possible future experiences are narrated from the present perspective, which is in turn is shaped by an interpersonal and broader historical and social context.

There is a clear relation between time and causality in personal narratives. Chronological order gives them a sense of internal coherence (De Miguel 1996) and helps organise "otherwise disconnected experiences" (Ochs & Capps 1996, p.22) Narratives not only give meaning to past experiences but also point to future actions (De Miguel 1996). In summary, they direct "toward imagined ends or forms of experience which our lives or particular activities are intended to fulfil" (Good 1994, p.139).

Temporality is a complex aspect of life stories, which are not necessarily lineal and are not presented in continuously and chronologically (Linde 1993; De Miguel 1996; Ochs & Capps 1996). According to Bourdieu (1989), chronology is part of the 'biographical illusion' and is due to a common sense of belief that describes life as a route with its own crossroads and intersections. Nevertheless, Rosenthal's (1993; 2002) distinction between the analysis of the *experienced life history* and the analysis of the *narrated life story* was useful as an analytical tool. The author suggested using a chronological perspective first, without looking at the narrator's self-interpretations of their life events. After this, thematic fields could be identified, and finally the life history could be reconstructed by analysing the meaning of past events from a present perspective.

Within this chronological order, what de Miguel (1996) termed 'markers', which include social landmarks like marriage or graduation, and individual events that had particular significance for that person or group, are important. In this research, they included mainstream academic, professional and social rites of passage, and other specific particular experiences that shaped nurses' narratives. There were also wider themes, which emerged several times throughout their life stories. An initial template[58] for the first analysis of the interviews was developed comprising of the following sections: genogram; map with the

[57] Author's italics

[58] See Appendix F

places they had lived; past biographical events; current situation. Other categories were added to each biographical structure according to the particularities of their individual life stories.

After finishing the initial analysis of the first set of interviews I obtained a general perspective on the biographies and started to identify commonalities and differences. This helped me plan the subsequent fieldwork phases and to get a broad picture of the narrative of each nurse and the way they were trying to give meaning to them.

3.6.1.2.Writing up individual biographies first: a necessary exercise

On completion of the fieldwork period, I was faced with the task of trying to reconstruct the life stories, relate them to each other, and carry out the necessary interpretation and transformation of the text. The interpretive process was more difficult than I had initially thought. I realised some parts were not clear and I needed to double-check some events. I reviewed different narratives of events from the same informant and, on some occasions, had to check factual information. I managed to get a more accurate account of the biographies but, as expected, there were always gaps and parts of their life that could not be fully understood.

3.6.1.3.Personal identities in context: Identifying *meaningful* experiences

A further aspect is the role of the life stories in shaping personal identities within a wider social context (Widdershoven 1993). A clear example is Frigole's (1992) work on the life story of a Spanish labourer born at the beginning of the twentieth century. By reconstructing the peasant's narrative, the author was able to reflect on the meaning of being a man during that time and compare this with subsequent generations.

Hence, life stories not only give meaning to personal identities, but are also a reconstruction of social processes (Frigolé 1992; De Miguel 1996; Larrea Killinger 2012). The act of narrating a story is an act of giving meaning to experience. In this regard, the notions of point of view, narrative plot and the definition of *self* acquire crucial importance (Ochs &

Capps 1996). Without ignoring individual subjectivities, this research is more interested in the notion of a *collective meaning* (De Miguel 1996). To access this, it is important to contextualise the individual life story in a particular social 'group' or category (gender, class, ethnic group, profession, for example). Following de Miguel (1996), life stories are, in a certain way, 'group stories'. In this case, the stories of the nurses, when analysed dialogically, show common patterns concerning their identity as nurses and the *meanings* they attach to nursing care. This became evident when the narratives were dialogically related to each other. Even though not all shared the same level of social criticism, in many cases, sometimes spontaneously, other times prompted by myself, they used their life experiences to denounce the unfair treatment received, mainly in their specific identities as nurses, women, or members of a minority group.

In this sense, Larrea Killinger (2012) points to the role of personal accounts as an act of denouncing and sees her informant's narration as, using Gramsci's term, subaltern. Frigole (1992) had a similar approach, using informants' life stories to reflect on power relations and social exploitation and injustice at that time. Terradas (1992) took a completely different perspective and created the idea of 'antibiography' to reflect how society, in the case of his main character, the rise of capitalism, makes some peoples' lives insignificant and even invisible. He reconstructed the life of a nineteenth-century working-class woman that would otherwise have gone unnoticed.

Some authors suggest that the analysis of the family and immediate social networks is a crucial link between individual experience and social structure (Aziz & Maloney 1985; Pujadas 1992; De Miguel 1996). Pujadas pointed to the contextualisation of individual accounts within their primary social grouping as an intermediate position between extreme humanist or positivist approaches. Frigole (1992) used what he termed the 'ethnographic context', which included the broader social and cultural background. According to Wright Mills (1950, cited in De Miguel 1996, p.21), considering a life as isolated from its background leads to what he called "Robinson Crusoe syndrome".

It should be remembered that narratives are not just 'mirrors' of experience, because "telling a story, enacting one, or listening to one is a constructive process, grounded in a specific cultural setting, interaction, and history" (Mattingly & Garro 2000, p.22). This meaningful context or biographical construct emerge and takes coherent shape during interviews (Rosenthal 1993). Interview notes, together with the field diary, are crucial tools in contextualising stories and their interpretation. Therefore, the interview context includes not only the broader social, historical and structural background, but also the intersubjective interaction that takes place during the interviews.

3.6.2. The role of intersubjectivity in the analysis of personal narratives and their interpretation

We now return to the notion of intersubjectivity and the comprehension of other people's experiences. Having made it clear that this exercise of understanding departs from our own individual experiences, it is useful to look at the different 'voices' which are found in the actions of telling, listening to, and writing about personal narratives. The multiple authorship of this process points to the inter-subjective experience between informants and anthropologists and to the temporal-spatial context in which the interaction takes place.

The interview context should be considered in its historical moment and the constant interaction between interviewer and interviewee (Behar 1992; Riessman 1993). Acknowledgement of the multiplicity of voices in the text was a crucial factor in the interpretive current in anthropology and social sciences. Initiatives such as including the informants as co-authors (Behar 1992) and acknowledgement of the anthropologist's own 'voice' or 'biases' (Clifford 1986; Geertz 1988) marked a turning point in the way ethnographies and other anthropological accounts were written.

As stated in the previous chapter, ethnographic authority began to be questioned by feminist and post-colonial studies that highlighted the position of anthropologists within a world of unequal power relations and their role in essentialising their research subjects. The roots of this unequal relationship lie in the politics of knowledge and the fact that "anthropologists have classically studied populations marginal to the centres of Western

power, those who were unable, until recently, to answer back" (Comaroff & Comaroff 1992, p.12). Generally, it is the dominant party who writes about the encounter with other groups. If we acknowledge that anthropologists working with subaltern groups have, in many ways, the power to write about them, two opposite outcomes can occur:

> "Either the less powerful parties are not heard at all, as the writer focuses largely on the dominant representations, or the less powerful appear only as the Other, defined wholly by their oppression, their only agency being expressed through 'resistance'" (Ortner 1999b, p.18)

In any case, life stories partly challenge the most positivist scientific thinking (Pujadas 1992; Larrea Killinger 2012), allowing social scientists to take a middle position between subjective testimony and the representation of a life, which is also a reflection of specific historical and social moments. Behar (1992) reflected on the constant dilemma which anthropologists face concerning the authorship of life sorties, oscillating between leaving the account in the native voice and placing it in a theoretical and cultural context.

A partial solution to this dilemma is to acknowledge the researcher's role in selecting and organising materials, that is, in their interpretation (Balán 1974; Frigolé 1992; Behar 1993; De Miguel 1996). A crucial aspect of the life story is that there is generally a very close relationship between researcher and informant (Magrassi & Roca 1986; Plummer 1989) which, according to Lewis (2012) allows 'emotional understanding' and a subsequent commitment by the researcher to the people study. Another action that may highlight informants' authorship is to give informants as much time as possible to talk freely during interviews (Betraux 1981b; Chase 1995).

In this case, my position as a foreigner, woman, nurse, teacher and anthropologist has undoubtedly affected the way in which the interviews were conducted and analysed and the final narrative written. In some regards, being a nurse and a woman placed me closer to the nurses, but in some others, such as being a foreigner and a 'researcher', it distanced me from them. I could never experience 'being a nurse in Bangladesh' in the same way as my

informants did. Nevertheless, I did at least give it a try: I tried to go to clinical areas as much as possible; I accompanied some nurses in their hospital work and spent as much time as possible, not only with them, but also with patients and their relatives. Even if I was not a 'Bangladeshi nurse', I was still a nurse working in Bangladesh.

Finally, intersubjectivity cannot be reduced to the interaction between researcher and informant. The Comaroffs (1992) warned against the risks embedded in an excessive emphasis on subjectivity. For this reason, a further level of intersubjectivity, termed by Schutz (1972) as the 'I-Thou' relationship, has been searched for through the contextualisation of the nurses' experiences within a broader structure and history.

3.6.3. Further analysis of the life stories: Relating one to another and placing them in a broader context

Historical and structural analysis has been crucial in this research. Going back to the quotation presented at the beginning of this chapter shows how Tuli referred to the Second World War and the creation of the United Nations as crucial events at the time she was born. This detail is relevant, not only because it reflects her awareness of her individual position within the broader and global world, but also because the end of the 1940s marked a new era for the former colonies. India and Pakistan became independent from British rule and were partitioned in 1947. Yet the colonial legacy was not over; as has been widely acknowledged, colonialism did not end immediately.

In 1949 President Truman, in his inaugural discourse as the US president, also announced his commitment towards improving 'under-developed' areas of the world. His discourse was considered as a landmark in the birth of the then-incipient development discourse (Gardner & Lewis 1996; 2015). This is especially relevant to all Bangladeshi society, and health system and nursing at the time when the nurses joined the profession.

Before moving on to structural and theoretical analyses, a further analytical step was necessary. After editing each individual story, a 'common story' had to be constructed, by creating a dialogue between the nurses and the literature about nursing in Bangladesh.

While it was relatively straightforward to relate the stories to one another, a big challenge emerged when trying to relate the individual, subjective accounts with the broader structural factors. The aim was "to theorise about what is shared across histories without disregarding the uniqueness of individual accounts" (Mattingly & Garro 2000, p.14).

It was during this theoretical analysis that the work of practice theorists and their conceptualisation of the tensions between individual agency and structure became crucial. Dual analysis of the nursing field and Bangladeshi society pushed the theoretical discussion towards the role of power relations throughout history, especially in relation to post-colonialism and gender. Looking at theoretical approaches to the subject within the social sciences and their historical evolution over time was very helpful in answering some of the questions that emerged from the analysis of individual stories.

Having presented this theoretical-methodological discussion, a final analysis is now presented of the ethical aspects and limitations of this research.

3.7. ETHICAL CONSIDERATIONS

The basic principle of any research is that the expected benefits should overcome the expected risks. Due to the nature of their work and research interests, many anthropologists have long worked side-by-side with vulnerable people (Gardner & Lewis 1996; IUAES 2009; AAA 2012; FAAEE 2014). Power differentials must be acknowledged and addressed while Human Rights must be ensured (IUAES 2009). Furthermore, anthropologists have an ethical responsibility in their portrayal and must condemn any form of oppression.

Throughout this research I have followed Spradley's (1979) principles[59] as a starting point. After reviewing more recent ethical statements by anthropologists (IUAES 2009; AAA 2012; FAAEE 2014), I find that Spradley's principles are still applicable. These mainly

[59] They were based on the *Principles of Professional Responsibility* by the American Anthropological Association (AAA 1971, cited in Spradley 1979, p.34)

relate to protecting informants, asking for consent, sharing research aims and findings, and protecting records.

3.7.1. Protecting the informants and asking for consent

The first principle in any ethical statement is to do no harm (IUAES, 2009). Even though asking questions may be thought to be harmless, the potential damage to the informants' dignity has to be considered when collecting, storing and disseminating the information (AAA 2012). In addition, sharing personal experiences through long interviews also has some risks that have been considered, including, as McCracken (1988) highlighted, time consumption, intellectual or emotional demands, and privacy dangers.

To minimise the effects of time consumption, interviews were conducted at a place and time that was most convenient to the informants, causing them minimal disturbance. Generally, the interviews took place in the workplace, although some preferred to be interviewed at home. The intellectual and emotional demands related to sharing personal experiences are mainly linked with recalling painful memories (Frigolé 1992). In spite of the emotional demands, the act of story-telling may be 'therapeutic' in itself and has been used by artists and healers alike (Ochs & Capps 1996). In the specific case of nurses, Spouse (2003) found out that it was indeed very positive and even therapeutic for nursing students to 'tell her their story' and talk about their clinical practice. In this research, there were moments when nurses became emotional or tired. Nevertheless, they generally agreed to carry on with the interview and some acknowledged it had been a positive reflective experience.

Privacy has been maintained as far as possible by protecting the informants' identities and secure data storage. Pseudonyms have been used in the transcripts and field notes from the very beginning, and sensitive information was written in a way only I could understand. In the final text, I tried to preserve nurses' pseudonyms in order that readers could follow the thread of the personal narratives. On some occasions, however, the generic term 'nurse' has been used, especially when they were talking about sensitive issues. In these cases, it was

considered that their right to be protected surpassed the need to put the background into context.

Written consent was sought from interviewees and the form also included the possibility of not being recorded[60]. Informed consent goes beyond the signature of a document and should be considered as a constant dialogue and negotiation from the first to the last interaction with the informants (AAA 2012). For example, some informants did not want to be recorded at all and others asked to stop the recorder at certain moments. Their decisions were always respected, even if it meant, in many cases, an incomplete record of their statements.

3.7.2. Sharing the research aims and findings and protecting the records

The research aims and objectives were always shared with the informants during the first interview and then clarified if necessary. I only faced suspicion and initial reluctance on one occasion and this was mainly due to the misunderstanding and negative reaction caused by a previous research paper about nursing in the country[61]. However, after clarifying my position and my respect towards Bangladeshi nurses, she agreed to be interviewed. Later, I would discover that part of her reluctance to share certain views was also due to her political position. By the end of the interview, she ended up clearly disclosing her opinions and even laughed while saying she could lose her job if some people heard them. This is just an example of how vulnerable Bangladeshi nurses are in many regards and may also explain the reluctance of some nurses to be recorded. In this case, it also shows their courage and commitment to their professional struggle for the betterment of nursing in Bangladesh.

[60] See consent forms in Appendix G
[61] I decided not to disclose either the authors or the content of the mentioned research for confidentiality reasons

With respect to sharing of findings, I decided not to send the full biographies back to the informants unless they asked for them[62]. I did this for two reasons: first, they were so detailed and extended that it would have led to misunderstanding and confusion about my interpretations of their narratives. Secondly, and most importantly, my notes often contained references to other people and I wanted to preserve their privacy as well. I tried to maintain the confidentiality and privacy of this data collection and storage to protect the informants. I was aware that there is always a risk of data leakage, especially with the use of digital records (AAA 2012). I kept hard copies of the documents only when strictly necessary. Field notes were transformed into soft copies as soon as possible. All electronic documents were coded and password-protected, and pseudonyms have been used in all documents, including field notes.

3.8. LIMITATIONS OF THIS RESEARCH AND ATTEMPTS TO OVERCOME THEM

Some limitations have been mentioned throughout this chapter. I will now summarise them in three main groups: time constraints and funding; access, language and the informants' profile; and, my role as a foreign nurse teacher, which in itself is not a limitation and may even be an advantage, but nevertheless has potential risks.

Time is one of the most common limitations in qualitative research. In my case, as I was conducting the fieldwork far from my country and only had funding for a limited period, I had to work on a part-time basis during the first months. This limited my availability to meet the informants and left me less time to conduct an on-going analysis of the interviews. *Language* was a key aspect as well. As stated previously, my Bengali level is not enough to maintain an in-depth conversation and analyse its contents. This made me select as key informants only nurses able to speak English. When I tried to interview nurses not fluent in English, the interviews did not flow in the same way. Furthermore, when analysing the transcripts after some time, I realized some words were completely unintelligible. In addition, the low sound quality resulted in some sentences being incomplete.

[62] Only on one occasion did a nurse ask for the return of the interview notes, which I complied with as soon as I completed them

My *identity* as a female, foreign nurse and educator working for a non-government institute clearly influenced access to the research informants and their descriptions of the situation of nursing in Bangladesh. In some cases, my 'white privilege' was beneficial, while on a few other occasions it led to suspicion. I am aware that, sometimes, the fact that I was somebody 'from outside' could have stopped them talking freely about some topics. Nevertheless, the fact that I could speak and understand Bengali to a certain level and that I had been in the country for three years made them feel more relaxed during the interviews. My gender was generally an advantage, considering that most nurses are women. Finally, intersubjectivity and my influence on the interviews and the narratives should be acknowledged. At some moments it was a substantial limitation when, for example, I interfered in their narratives to spontaneously give my own opinions on certain topics. This undoubtedly affected their responses, but also made the conversation more natural. I tried to acknowledge these situations by adding my own comments or questions to the informants' quotations when I considered that they prompted the informants to change the direction of their discourse.

In summary, the researchers' own experience, insights and theoretical/ideological positions do not have to be a limitation. In many cases, it was my experience as a nurse, both in Bangladesh and in Spain, which helped me understand and contextualise many of the situations the nurses were describing. In certain ways, we all had a *shared experience* as nurses and nurse teachers.

3.9. CONCLUDING REMARKS: THE USE OF LIFE STORIES: A DIALOGICAL AND RELATIONAL APPROACH

The theoretical analysis merged *dialogical* and *relational* approaches. It is dialogical because it creates an 'interaction' between the six life stories of the nurse teachers. It is not until the biographies of different individuals are analysed together that certain common causal principles can be found (Angell 1974). Amongst the most common themes analysed through this joint approach are the problems related to the individual or familial life cycle and the analysis of the way in which broad social changes affect the life of individuals and

entire generations (Balán 1974; Plummer 1989; Pujadas 1992). Notwithstanding, in order to reflect broad social change processes, a significant number of individual cases have to be analysed (Langness 1974).

The use of more than one life story, together with a broader socioeconomic and historical analysis allows a move away from individual subjectivity to a sociological, and therefore collective, experience. Sociologically, "this contributes to solving the problem of truthfulness as these life stories may be 'checked ' against each other, as far as matters of sociological interest are concerned" (Betraux 1981a, pp.8–9). This does not solve, however, the longstanding tension between an individual subject and the wider society, one of the main facets of sociology and the more 'social' approaches to anthropology (Plummer 1989). A crucial effort to overcome this dichotomy was found in the work of practice theorists, whose contributions have been key to this research.

The initial, and indeed, ambitious question of "what it is like to be a nurse (teacher) in Bangladesh?" can never be completely answered, even if we interviewed every nurse teacher in the country. Therefore, this research is only an initial attempt to further contextualise the life experiences of a number of nurse teachers within a wider historical and socioeconomic context.

PART II: SITUATING THE NARRATIVES. BEYOND 'THE CONTEXT'

"[Ethnographers] must always give texts contexts and assign values to the equations of power and meaning they express. Nor are contexts just there. They, too, have to be constructed analytically in light of our assumptions about the social world" (Comaroff & Comaroff 1992, p.11).

The objective of the next two chapters is to provide the reader with an understanding of the main contextual and conceptual categories discussed throughout the research. The first chapter contains an introduction to Bangladesh, starting with its geographic setting, continuing with the main historical events that have made it what it is today, and concluding with a presentation of its current socioeconomic situation.

Once the setting has been described, the subject of study, the nursing profession in Bangladesh, is contextualised. The history of modern nursing is presented first, to reflect on how the profession was created at a specific time and under a specific ideology. This will help to contextualise the image of modern nursing that was transported and re-configured by the British during their rule in India. Having done this, the political economy of nursing in relation to the medical system and the Bangladeshi society is presented.

A critical analysis of both nursing profession and Bangladeshi society becomes essential to understand how the two fields articulate in the lives of the nurse teachers. In this sense, they are presented not a as context that is 'just there' but as a set of ideologies, practices, institutions and social structures that constantly intersect with each other and with nurses' specific experiences.

4. BANGLADESH: HISTORICAL AND SOCIOECONOMIC BACKGROUND

"Bangladesh is a country that has for centuries been politically, and consequentially economically, a colony of foreign countries. To emerge from servility after such a long period is not easy" (Begum 1998, p.535)

4.1. INTRODUCTION

Bangladesh is a fairly new country. The less than fifty years that have passed since independence has been marked by a series of challenges that started before its birth in 1971. Its colonial past, Pakistani rule for over twenty years and its struggle for independence have influenced the economy, society and the very complex and unstable political situation. In spite of recent improvements, poverty and inequality are still endemic; social protection and public services are very limited and the overall wellbeing of Bangladeshis is affected by these socioeconomic disparities. This chapter provides an introduction to the main historical, political and economic aspects of Bangladeshi society. A special emphasis has been placed on the country's political and social institutions, and on their role in the reproduction of religious, class, and gender-based social stratifications and inequalities.

4.2. BRIEF INTRODUCTION TO THE HISTORY OF BANGLADESH

The geographical location of the country in the middle of a delta, together with its climatic particularities, have shaped the country's history and development[63] (Baxter 1997; Van Schendel 2009). Flooding in Bangladesh has both positive and negative consequences; it provides the country with a uniquely rich cultivable land, while at the same time, the uncontrollable nature of the floods have severe consequences on peoples' lives every year (Van Schendel 2009). The delta has experienced important transformations over the

[63] See Appendix H.1 for further geographical information and a country map

centuries, from a rich and fertile area to becoming, directly after its independence, one of the poorest countries in the world. This progress cannot be understood without looking at the centuries of foreign domination the country has suffered (Zaman 2005), starting from the Mughal Empire and continuing with British rule and East Pakistani domination (Van Schendel 2009).

Bangladesh is a relatively young country; it was constituted at the end of 1971 after a nine-month long Liberation War. The history of Bangladesh is complex and goes back to the first millennium BCE, when the first Indo-Aryan groups began to settle in the area[64] (Baxter 1997; Van Schendel 2009; Rahman 2010; Stein 2010). The first empire in the area was the Mauryan, followed by a series of feudal kingdoms which alternated between Brahmanism and Buddhism (Rahman 2010). Islam arrived through the establishment of the Delhi sultanate in 1206, yet it was not until the arrival of the Mughals[65] in 1610 when the population began to convert to the conquerors' religion (Baxter 1997). In spite of the migration of upper-class Muslims from other parts of India, land continued to be mainly in the hands of the Hindu landlords, who were known as *zamindars* (Chakrabarti & Chakrabarti 2013).

4.2.1. British rule in Bengal

The end of Mughal rule in Bengal came with their defeat in the battle of Polashi (Plassey) in 1757 and the introduction of the East Indian Company (Robinson 1989; Van Schendel 2009; Stein 2010), even though European trade and influence had started long before

[64] A chronology of the country can be found in Appendix H.2

[65] According to the Chakrabartis (2013), the most important factors in the large-scale conversion of Bengalis were the influence of Sufism and the ideal of equality in Islam, which attracted lower-caste Hindus. The Sufis arrived in Bengal in the fifteen century form West and Central Asia and their veneration of saints, together with their system of religious leaders easily merged with the ideas of the Hindu gurus (religious preceptors). The authors suggest that conversion to Islam was also linked to the expansion of the agrarian frontier in East Bengal.

then[66]. British rule in India lasted for 190 years; it had a great impact on the politics, economy and society of Bengal. Economically, the arrival of the Europeans and the establishment of the East Indian Company meant an opening to international markets and large scale productions of crops like opium, indigo, tea or jute (Van Schendel 2009). This, together with land reform and later the transfer of power, led to significant changes in social organization. The colony reinforced the existing caste and religious divisions and contributed to an increasing socioeconomic inequality, which has persisted until now.

The arrival of the British saw the introduction of two measures disastrous to the majority of the Bengali population: a rigid tax collection system and the Permanent Settlement Act of 1793, which upgraded the Hindu *zamindars* from tax collectors to landlords (Baxter 1997; Van Schendel 2009; Lewis 2011). Socially, the most important reforms came under the rule of Governor Lord William Bentinck (1828-36), who began introducing Indians in the lower levels of the administration (Robinson 1989). Under his rule, the practice of widow-burning (*sati*) was also abolished (Abraham 1996; Van Schendel 2009; Stein 2010; Chakrabarti & Chakrabarti 2013). Major changes also took place in education. English replaced Persian as the state's official language in the 1830s (Van Schendel 2009) and Western education began to be promoted amongst Indians, with the missionaries being pioneers in this regard (Chakrabarti & Chakrabarti 2013).

The promotion of literacy and education was closely related to the Western ideology of personhood associated with classic liberalism. The debates taking place in nineteenth century Britain were transported to the colonies. Education was a crucial means of instructing 'the poor' in the bourgeois doctrine of self-improvement. Discipline was presented as a necessary tool for self-betterment, which would eventually lead to "upward mobility for men, upward nobility for women. In this respect, the outer shell of the individual was a gauze of inner essence" (Comaroff & Comaroff 1992, p.188).

[66] The Portuguese arrived at the port of Chittagong in 1517 and their missionary and trading activity prospered until 1632, when the Mughal Emperor drove them out (Baxter 1997). They were followed by the Dutch, the English and the French (Van Schendel 2009).

Even though Islamic madrasahs were present in Bengal before the arrival of the Europeans, it was not until the later period of British rule when a formal education system began to emerge (Rahman et al. 2009). The establishment of schools, colleges and universities had a huge impact in the propagation of European and British values (Stein 2010). Nevertheless, the system was urban and elite based and mainly addressed to men. There were also important differences between Hindus' and Muslims' access to education in favour of the former (Baxter 1997; Rahman 2010; Stein 2010).

Little-by-little a highly educated elite began to develop humanist and liberal ideas from the West (Rahman 2010). Eventually, these ideas of science, rationalism and freedom of thought influenced Indian reformers, who were mainly Hindus at first[67] (Baxter 1997; Prakash 1999; Chakrabarti & Chakrabarti 2013). Later, Muslim social reformers played a crucial role as well, especially in relation to peasants' rights (Van Schendel 2009; Chakrabarti & Chakrabarti 2013). Some limitations were that the elite groups often had little or no practical skills and they were totally alienated from the masses who had little or no access to the new education system (Rahman et al. 2009; Zaman 2005). These inequalities especially affected the rural population, the poorest sections of society and of course, women, whose education was exclusive to wealthy families who could pay for home tuition (Stein 2010). For a long time, the provision of female education rested mainly in private hands, philanthropic organizations (Stein 2010) and missionaries (Fitzgerald 1997). General education was not opened to women until the second half of the nineteenth (Rahman et al. 2009).

In spite of the above described social reforms, British rule preserved the military structure developed by the Mughals, employing Indian soldiers (*sepoys*) from the beginning (Stein 2010). As time went by, the tensions between the local soldiers and the Company increased, which would lead to the 1857 Mutiny. The subsequent distrust towards Muslim

[67] The delay in the creation of a 'Muslim elite' was mainly due to the easier adaptation of Hindus to the British system (Baxter 1997; Zaman 2005), the preferential treatment of the British towards the Hindus, the better socioeconomic position of the Bengali Hindus (Zaman 2005; Stein 2010). It is important to consider that the Crown had favoured the Hindu scribal castes (Brahmin) and therefore, it was easier for them, already being literate, to incorporate Western education (Stein 2010).

Bengalis and the preference for the 'loyal' Hindus also increased after the Mutiny. After the Mutiny, the second period of British colonization was characterized by a change of approach; India became part of the Crown and was therefore ruled by the British government. Growing concern for the Indian population started after the administration began to be heavily criticised by influential Englishmen (Stein 2010). The Indian elites started to become involved in the political arena, a process which ended in the foundation of the Indian National Congress in 1885 (Rahman 2010) and the All India Muslim League in Dhaka (Robinson 1989; Van Schendel 2009; Rahman 2010). In many cases, nationalism was related to the ideology of communalism. Communal riots would be especially important from the beginning of the twentieth century (Van Schendel 2009).

Parallel to the growing nationalist movement in India, the World Wars and the 1930s economic crisis evidenced the "costs of colonial dependency" (Stein 2010, p.318). Economic deprivation led to urban and rural revolts in Bengal (Van Schendel 2009; Chakrabarti & Chakrabarti 2013) which intensified after the 1943 famine. These revolts favoured the victory of the Muslim League in the 1945 election in Bengal (Van Schendel 2009; Rahman 2010; Chakrabarti & Chakrabarti 2013). In the following year a growing movement began to create a single independent state of Pakistan instead of two separate Muslim states (Baxter 1997; Rahman 2010). After World War II the British Government was forced to take a decision about ending British rule in India, which terminated in partition in 1947 (Robinson 1989; Van Schendel 2009).

4.2.2. Partition and Pakistani rule

The Partition of India was a very complicated and contentious process, which led to violent conflict on the Punjabi border and a massive population exchange on the Bengal border (Van Schendel 2009; Stein 2010). Eastern Bengal became a province of Pakistan, the two 'wings' being separated by more than 1,000 miles of Indian territory (Mascarenhas 1971; Van Schendel 2009). Eastern Bengal would soon become a colony of the Western wing (Baxter 1997; Van Schendel 2009). Eastern Bengal had inherited, from the British period a weaker political, military and civil organization (Rahman 2010; Chakrabarti & Chakrabarti

2013). The ruling elite was largely non-local and unaware of the population's needs, with power being mainly held by two non-Bengali groups: the *Muhajirs* and the Punjabi Muslims (Van Schendel 2009; Lewis 2011).

President Jinnah proclaimed during 1948 that Urdu would become Pakistan's official language (Baxter 1997; Van Schendel 2009; Rahman 2010). The reaction was immediate and a language movement, known as *Bhasha Andolon,* was formed in East Pakistan (Van Schendel 2009). The movement provoked a violent repression by the government, which ended up with killings in Dhaka University in 1953[68]. Demonstrations and protests continued until 1954, when Bengali was declared an official language together with Urdu (Rahman & Islam 2009; Chakrabarti & Chakrabarti 2013). Slowly but surely the Bengali 'vernacular elite' began to become politically organised. The All-Pakistan Awami (People) Muslim[69] League was formed in 1949. Unfortunately, elections could not be conducted because of the Pakistani Army coup d'état, which brought the dictator Ayub Khan to power (Rahman 2010). In the 1960s, the Bengali nationalist movement resurfaced under the leadership of Shehikh Mujibur Rahman of the Awami League (AL) (Van Schendel 2009; Rahman 2010).

In 1970, the floods were devastating, a cyclone killed more than 300,000 people[70], and the Pakistani regime appeared to be unable to deal with the catastrophe. When elections were eventually held in December, they showed an overwhelming victory for the AL (Baxter 1997; Van Schendel 2009; Rahman 2010). Violent demonstrations started and Mujib was pressed to declare independence (Mascarenhas 1971; Rahman 2010). He eventually called for a general strike and a non-cooperation movement, both strictly followed by most of the

[68] On the 21st of February, thousands of students from different parts of Dhaka, including children, had gathered in the city to demand equal status for Bengali. The police started charging against them when they tried to enter the university and after the students' reaction, the police did eventually fire at them. Many students were injured and five died, including a five-year old boy (Van Schendel 2009). Later, the 21st of February was declared International Mother Tongue Day.

[69] In 1955 the adjective 'Muslim' was removed in order to include Hindus and other minorities (Baxter, 1997).

[70] The official death toll was 500,000 people, even though other sources suggest 350,000 (Van Schendel 2009).

population (Mascarenhas 1971). Finally, on the 25th of March, West Pakistani troops made an extremely violent armed assault on Dhaka[71] and Mujib was jailed (Mascarenhas 1971; Van Schendel 2009; Chakrabarti & Chakrabarti 2013). The Liberation War lasted from March to December of 1971, becoming one of the worst armed conflicts in the subcontinent.

India played a crucial role in the Liberation War by supporting the guerrilla, known as Freedom Fighters (*Mukti Bajini* or *Mukti Jodda*), and by eventually pushing the final battle, which led to the surrender of the Pakistani army, which had important consequences for the future of Bangladesh, leading to two narratives about independence and nationalism: the *Bengaliness*[72] and the *Bangladeshiness* (Baxter 1997; Van Schendel 2009). Other countries were involved as well, reflecting the geopolitics of the Cold War times (Van Schendel 2009).

4.2.3. Independent Bangladesh

Bangladesh, officially the People's Republic of Bangladesh, was born on the 21st of December, 1971 in the midst of significant international disapproval (Van Schendel 2009). The country had been left in a very bad condition, with a loss of about ten million people[73] who had sought refuge in India and an estimated death toll of three million (Rahman 2010). Poverty was widespread after more than twenty years of economic dispute (Van Schendel 2009). Moreover, the first government of Bangladesh experienced a series of political and economic problems that ended up with the assassination of Sheikh Mujib and his family in 1975.

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[71] The killings of March have been considered one of the worst genocides of the century. The army carefully targeted the symbols of Bengali nationalism (Van Schendel 2009) and focused their attacks on specific population groups like the armed corps (police, Bengali army), the intellectual elite (journalists, students, professors, politicians), and Hindus (they were considered a threat to Pakistan) (Mascarenhas 1971).

[72] Even though, initially, the relationship between India and Bangladesh was cordial, the progressive militarisation on Islamisation during the dictatorships increased the distance between the two countries. A paradigmatic example was General Zia's proclamation in the late 1970s that the citizens of Bangladesh would be Bangladeshis and not Bengalis (Mascarenhas 1986; Van Schendel 2009).

[73] This is an estimated figure because, as Van Schendel (2009) states, it is impossible to verify it.

Once Mujib was killed, the then chief of the army General Ziaur soon displaced the then president. Zia amended the constitution in 1977 changing two of its main pillars: secularism and socialism (Mascarenhas 1971). In a symbolic ideological step, he proclaimed that the citizens of Bangladesh would become Bangladeshis instead of Bengalis (Mascarenhas 1986; Van Schendel 2009). In 1979, parliamentary elections were held and Zia contested and won with his recently founded Bangladesh Nationalist Party (BNP) (Baxter 1997; Rahman 2010). During the Zia regime, Bangladesh made important socioeconomic developments, although the economic situation of the country gradually worsened. Social violence, political murders and 'secret killings' became more frequent. Zia was eventually killed in 1981 in the midst of a military coup (Robinson 1989; Baxter 1997; Van Schendel 2009). The coup was constrained by General Hussain Muhammad Ershad, who would later declare martial law again (Mascarenhas 1986; Robinson 1989; Baxter 1997; Van Schendel 2009). His regime was characterized by progressive militarization of all aspects of political and civil life and a stronger emphasis on Islam (Robinson 1989).

From 1991, a democratic but unstable period began where the two main parties, BNP and AL alternated power in coalition with smaller parties like the Islamist Jamaat-i-Islam (aligned with BNP) or Jatya Party (alternating between AL and BNP) (Rahman 2010). Political tensions increased and a state of emergency was declared again in 2007. Eventually, parliamentary elections took place in 2008 under a caretaker government, which were easily won by AL. The 2014 elections were boycotted by the opposition, which led to "a virtual abdication of the opposition's role as the people's representative" (Jahan 2014, p.255).

Street violence is endemic; in 2013 at least 507 people were killed according to human rights groups (Riaz 2014). Two main sources of discontent and violence have meant the abolition of the caretaker government system and trials for the 1971 Liberation War crimes (Jahan 2014). The rupture of the interaction between the two leaders of the main political parties has persisted, challenging the normal functioning of the country (Zaman 2005; Van

Schendel 2009; Jahan 2014). In spite of this instability, the Bangladeshi political system is currently a parliamentary democracy, with the president as Head of State and the Prime Minister as Chief Executive (Zaman 2009). However, there is still a long way to go in terms of actual representativeness in Parliament (Jahan 2014). In addition, as long as the elites continue to pursue their own interests, real democracy will not be achieved (Lewis 2011). The next section analyses socioeconomic inequalities.

4.3. THE POLITICAL ECONOMY OF BANGLADESH: PERSISTING INEQUALITIES

Bangladesh today is one of the most densely populated countries in the world, with more than 1000 people per square kilometre (Van Schendel 2009; United Nations Data 2015). However, population growth started to slow down from the 1980s, with the promotion of birth control[74] (Chakrabarti & Chakrabarti 2013). The country is overwhelmingly rural, with 80 per cent of the population living in villages (Chakrabarti & Chakrabarti 2013). In recent centuries, however, Bangladesh has experienced increasingly rapid urban growth (Van Schendel 2009; Lewis 2011). Not only has rural-urban migration increased in recent decades, but international emigration has also grown without precedent since independence. The main type of migration is economic (Van Schendel 2009), and remittances are a crucial source of currency (Rahman 2010; Lewis 2011; Chakrabarti & Chakrabarti 2013). The migration of nurses has been significant as well, especially since the mid-1980s (Aminuzzaman 2007).

In spite of developments in the industrial sector and increasing overseas migration of Bangladeshis, the country's economy is mainly based on agriculture, with rice and jute as its main crops (Van Schendel 2009; Rahman 2010; Lewis 2011; Chakrabarti & Chakrabarti 2013). Bengal was a great example of the effects of the 'Green Revolution' during the 1960s. While it introduced improvements in the cultivation of rice and wheat, it also exacerbated social tensions and class differences (Stein 2010). Landholding and access to

[74] I prefer not to use the term 'population control' in a positive way, as it reminds us of the post-colonial, Malthusian Eugenicist ideology (Wilson 1994). This is especially relevant in Bangladesh, a country which had historically been portrayed as 'overpopulated'. For demographic statistics, see Appendix H.3.

market is extremely unequal in Bangladesh, which leaves very limited access to work activities for the majority of landless labourers (Kabeer 2011).

After the 1980s, the textile industry began to grow considerably, mainly because of its cheap labour (Baxter 1997; Lewis 2011; Chakrabarti & Chakrabarti 2013; Riaz 2014). It provides jobs to millions of people, especially women (Lewis 2011), although the working conditions in the textile industry have become a source of international concern (Van Schendel 2009). The service sector has also been experiencing substantial expansion in recent years, being the biggest contributor to the country's gross domestic product (GDP) in 2011 (Chakrabarti & Chakrabarti 2013).

The Bangladeshi economy and social development have remained highly dependent on foreign aid since the beginning (Perry 2000; Robson 2005). The source of aid has changed over the years and has been greatly influenced by the country's international relations. An important consequence of the dependence on foreign aid is the emergence of what Blanchet (1996, p.195) termed 'poverty rhetoric', where "'women', 'the poor' and, increasingly, 'poor children' are used to attract sympathy and funds".

Bangladesh has lately been highlighted as an example of a 'success story' in development, especially in relation to its improved education policy and NGO-led microfinance programmes (Lewis 2011; Riaz 2014). A significant increase in GDP, together with a significant reduction in population growth, are positive outcomes of changes in the Bangladeshi economy and society (Van Schendel 2009; Lewis 2011). It has to be said, however, that despite all the governmental and non-governmental development efforts, poverty in Bangladesh is still widespread, especially in rural areas, where almost half the households are landless (Rahman 2010). The evolution of the basic economic indicators is shown in Appendix 8.3.

4.4. BANGLADESHI IDENTITY AND POLITICS

Identity is a contentious issue in Bangladesh. Directly after independence, there was the distinction between *Bengaliness* and *Bangladeshiness*. The country's official language is Bengali, which is spoken by 95% of the population (Government of Bangladesh 2015). Even though Bengalis form the vast majority of the population (up to 98%) (Chakrabarti & Chakrabarti 2013), other minority ethnic groups have experienced problems since independence, mainly non-Bengali Muslims[75] and other indigenous groups who are also called *Adivasis* or 'tribals'[76], often pejoratively. Both Urdu-speaking and indigenous groups have experienced different forms of segregation and persecution over time (Van Schendel 2009). The former experienced substantial repression after independence, whereas the latter have been facing longstanding land problems, especially in the Chittagong Hill Tracts (CHT) area[77].

The main religion is Islam (86.6%), followed by Hinduism (12.1%), Buddhism (0.6%), Christianity (0.4%) and others (0.3%) (Government of Bangladesh 2015). Bangladeshi Muslims are mainly Sunnis, mostly converted through the Sufis who arrived during the fifteenth century (Rahman 2010; Chakrabarti & Chakrabarti 2013). There are also non-Bengali Muslims, mainly descendants of Urdu-speaking migrants (Baxter 1997) and Rohingya refugees from Myanmar (Lewis 2011). Hindus in Bangladesh form the second religious group in terms of population, even though their number has progressively fallen (Van Schendel 2009). There has been a constant relationship between Hinduism and Islam in Bangladesh and they have influenced each other. Christianity and Buddhism in Bangladesh are less important in proportion but are still large in terms of population

[75] The *Muhajirs* or Urdu-speaking communities are usually called 'Biharis' by the Bangladeshi population, regardless of their original precedence (Van Schendel 2009)

[76] *Adivasi* is the Sanskritic term for indigenous or autochthonous. It began being used in colonial times, together with the term 'tribal', to designate people who could not be classified under the British-simplified caste system. It had, however, a political connotation: "If the forest and hill people were organized 'tribally', they were deemed to have no historic rights in the lands they had long exploited" (Stein 2010, p.269).

[77] A civil war started between the indigenous population and the Bengali Government, lasting from 1975 to 1997 (Baxter 1997; Van Schendel 2009; Lewis 2011). The agreement did not manage to eliminate the conflict and nowadays CHT is the only area of Bangladesh which remains under military control.

numbers. The role of Christian missions in education and health is remarkable (Baxter 1997), and it is not uncommon for Muslim families to send their children to Christian mission schools.

The role of religion in the construction of Bengali identity has varied over time, and so has the relationship between the two main religious groups, Hindus and Muslims. On the surface and in the daily life of most Bangladeshis, religious and ethnic groups seem to peacefully coexist. Politically, however, there are tensions, which can be brought up at any time, generating fear and violence. Islamic terrorism has recently increased in Bangladesh, backed by international groups like Al-Qaeda or the Islamic State, who have claimed several attacks against minority groups, liberal intellectuals and foreigners, and have created significant fear and a sense of instability in the daily lives of Bangladeshis.

4.5. BANGLADESHI SOCIETY

Although one cannot speak of 'Bangladeshi society' or 'Bangladeshi social structure' as a closed and universal system, there are certain patterns of kinship and social organisation shared between groups.

4.5.1. Kinship in Bangladesh: An introduction

Most authors agree that family is a central social institution in Bangladesh (Aziz 1979; Chowdhury 1995; Kotalová 1996; Rozario 2001a; Inden & Nicholas 2005). The extended family plays a crucial role in communication and the diffusion of ideas and acts as a decision-making or consultation group (Aziz 1979; Zaman 2009). Family and 'fictive kin' relationships play a central role in the economic sphere as well. They constitute the basic unit of economic endeavour and landholding and, in the villages, "the family works as a unit of production, income and consumption until today" (Quasem 2002, p.193). Industrialization and post-colonialism have brought important changes. The traditional joint and extended families are being replaced by smaller family units and a higher life expectancy is producing an aging population, especially in rural areas. Moreover, women

are gradually entering the paid labour market and subsequently changing their role in society.

The Bengali[78] kinship system is patrilineal and patrilocal and uses highly complex and descriptive terminology (Inden & Nicholas 2005). In addition to the variety of the designations according to the kin's position in relation to ego (maternal/paternal side, older/younger position, and so on), there are also differences between Hindus and Muslims[79].

4.5.2. Lineage, honour, shame and their relation to social and gender norms

Patrilineage is usually defined as *gusthi* and is based on a blood relationship with a common ancestor (Chowdhury 1995; Kotalová 1996; Rozario 2001a). The concept of shared blood (*rokto*) is central to indicate brotherhood and its symbolism is related to the ideas of purity and pollution (Kotalová 1996), and to the couplet of honour (*ijjat*) and shame (*lojja*) (Rozario 2001a). As happens in many societies, the two concepts form a dyadic relationship that greatly influences and reinforces social control[80]. While honour (*ijjat)* is generally ascribed to men, women can also damage it through their behaviour, especially in relation to sexual modesty (*lojja*) (Blanchet 1996; Kotalová 1996). The term *lojja* can be positively praised as the virtue of shyness (Aziz 1979; Rozario 2001a) or negatively seen as shame. The main instrument to maintain female purity is the institution of *purdah*[81] or female seclusion. Some of these behavioural norms are: avoiding contract with unrelated men; talking softly; covering their body; or restricting their spatial mobility.

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[78] The term Bengali will be used instead of Bangladeshi to describe the broad regional kinship system, as the main structure and most terms are common to both Bangladesh and Indian Bengal. See Appendix I for more details.

[79] Most differences between Muslim and Hindu kin terms lie in the fact that Muslims borrowed Urdu terminology (i.e. *amma*, *abba*), which in turn derives either from Arabic, Persian or a modification of the original Sanskrit form (Inden & Nicholas 2005).

[80] "Codes of honour and shame are reported to be found in both northern and southern Mediterranean, that is, in both Christian and Muslim parts, and also with variations in northern and southern Europe" (Pitt-Rivers 1977 and Peistiany 1965, cited in Rozario 2001a, p.85).

[81] The term *purdah* means, literally, curtain (Chowdhury 1995). As a social institution, it is linked to the idea of female sexual modesty (Kotalová 1996), which in practice means female seclusion (Rozario 2001a). How

In practice, female seclusion affects women from all religious backgrounds, though in different ways. It varies enormously depending on the age and socioeconomic background of the women (Huq 1979; Islam 1979; Aziz & Maloney 1985; Begum 1987; White 1992; Chowdhury 1995; Kotalová 1996; Rozario 2001a). Women from economically deprived families have always worked outside the house, although this does not necessarily mean that they do not follow *purdah* ideology (Islam et al. 2010). Furthermore, the profile of women working outside the house has changed in recent decades, with more women from middle and upper classes joining paid work (White 1992; Rozario 2001a).

The notion of *purdah* is closely related to the ideal of purity and the polluting potential of women through their bodily substances (Rozario 2001a). This aspect also affects women who work in potentially polluting situations, mainly traditional midwives (*dais*) and nurses. Moreover, modern nursing breaks other social norms related to female seclusion: it means working outside, often in the evening and night shifts, and surrounded by unknown men. Nevertheless, the situation has changed over the years and it is by no means the same in all contexts.

4.5.3. Affinal connections: The importance of marriage in Bangladesh

Marriage is almost universal in Bangladesh (Aziz 1979; Kotalová 1996; Amin 1998). Women are expected to get married and become mothers and their identity is defined according to her bond to her husband and children (Kotalová 1996). Singleness is generally unusual and is looked at in different ways for men and women, even though in both cases it often leads to a questioning of "their nature, particularly their sexual, physical and mental capacities" (1996, pp.190–191). As Kabeer (2011) observed, the centrality of marriage in women's lives cannot be explained only in terms of economic dependence. It pointed to "the vulnerability of being on their own, bereft of protection and status in a society where a

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and when it started to be applied as a social norm is not clear (Islam 1979). It is usually linked to Islam, but there is evidence that other religious groups like high-caste Hindus have practised *purdah* for many years (Jeffery 1979, cited in Rozario 2001b, p.88).

woman without an adult male guardian is subject to individual and social harassment" (2011, p.522).

Sometimes marriages occur between people from different religious groups, which are popularly known as mixed-marriages. Muslim men could marry a woman from another 'revealed' religion, whereas Muslim women should only marry Muslim men (Ahmad & Chowdhury 1979; Aziz 1979). The marriage of Christian women to Muslim men is relatively frequent in certain areas and is a matter of concern for the Christian community (Rozario 2001a). Hindus have stricter rules in relation to endogamous and exogamous marriages and marriage usually occurs between couples from similar castes or classes (Aziz 1979).

4.5.4. Hierarchy within the broader society: The polysemic concepts of society (*samaj*), religion (*dhormo*) and caste (*jati*)

The Bangladeshi society is visibly hierarchical: "indication of rank is displayed in casual conversations and official inquiries, whereby persons are specified by references to skin colour, size of salary, academic degrees, and birth order within the family" (Kotalová 1996, p.148). Similarly, Zaman (2005, p.50) identified the following indices: "income, academic degree, skin colour and birth order within the family". Through the above-described notions of purity, honour and shame, the boundaries between the social groups (religion, caste, class, gender) are maintained and reinforced. These boundaries, however, are not always fixed and certain permeability is allowed between them.

The concept of society is usually translated in Bengali as the polysemic term *samaj* (Blanchet 1996). Its meaning ranges from a locally defined kinship or territorial group (*para*, village) to the broad notion of nation (Rozario 2001a). Generally, being part of the *samaj* is often more important than being part of the state, since "the *samaj* is associated with proper living as Bengali, as Muslim, as Hindus, as a civilized people" (Blanchet 1996, p.27). When the concept of *samaj* is applied to a territorial unit, it involves social organisation and control and solidarity (Kotalová 1996). *Samaj* members are involved in all

community rituals (Chowdhury 1995; Rozario 2001a), and the authorities of the *samaj* have the power to sanction deviant behaviour (Chowdhury 1995).

Being part of the *samaj* carries a range of moral and religious values, which can be grouped in the notion of *dhormo*[82]. Broadly, *dhormo* is related to moral order in society, including both "commonsensical truths" (Kotalová 1996) and a sense of "duty in life" (Blanchet 1996). Distinctions are made between the practical or behavioural implications of *dhormo* according to social classification categories like gender, caste, class and religion. According to Devine and White (2013), there are two forms of *dhormo*. The first is generally translated as religion or a set of specific beliefs and practices. The second is broader and refers to a "moral order that informs the proper way of being and relating in the world" (2013, p.144).

The concept of *dhormo* is related to this research in different ways. On the one hand, it helps to explain the role which religion plays in the construction of the moral values attached to nursing. A clear example of this is a nursing song that is analysed in Chapter Five. The song makes the distinction between the concepts of *dhormo* (roughly translated as devotion in this context) and the concept of duty (*khormo*), even they are related.

Mention should be made about the concepts of caste and class as well. As a mostly Muslim country, it might be assumed that the idea of caste would not be as present in Bangladesh as it is in India. Nevertheless, the concept of *jati*, which is the way in which caste is usually translated, can also be used to designate the different religious groups or Muslim classes and sects (Aziz 1979). There are important differences, however, between the idea of caste amongst Hindus and the class classification amongst Muslims (Rozario 2001a). The notion of *jati* is also related to *dhormo*: "the universe is divided into a variety of classes – *jats*, which are distinguished by their substance and behaviour – *dhormo*" (Kotalová 1996, p.46). The two terms are related to the idea of a shared substance, which is exemplified in blood (*rokto*) (Blanchet 1996). The notion of *jati*, in its hierarchical sense, can be applied to castes, social and religious groups, and even gender (Blanchet 1996; Kotalová 1996).

[82] Etymologically, the term comes from the Sanskrit *dhr*, meaning "to sustain, to support" (Inden & Nicholas 2005, p.14).

The notion of class is also used from a more practical or material perspective. A dichotomist distinction between rich and poor people is often found in the Bangladeshi narratives (Kotalová 1996; Hartmann & Boyce 1998; Zaman 2005). Kotalová observed how people from disadvantaged backgrounds could present themselves as *gorib* (poor), *choto lok* (lesser people) or *murkhu* (ignorant). At the other end of the classification, rich people can be presented as *dhoni* (opulently rich), *maharjon* (money lenders), *boro lok* (big shots) or *bhodrolok* (gentlemen)[83]. The relationship between illiteracy, rural background and low social status is crucial in Bangladeshi society and emerged in the narratives of the nurses, on more than one occasion. Education is often seen as a crucial contributor to upwards-social mobility, even though it has its limitations.

Patron-client relations, inter-class solidarity and charity impregnate Bangladeshi society (Aziz 1979; Gustavsson 1991; Lewis 2011). A clear example of this can be found in the use of 'fictive kinship terms'. These terms are not only used in patron-client relations but are also employed in daily conversations to address both known and unknown people (Aziz 1979; Maloney 1979). For example, a person of similar age who is in a higher hierarchical position would be designated as 'sister' or 'brother' (*apa*/*didi*[84] for a female, *bhai*/*dada* for a male). An unknown older person would usually be called 'uncle' (*chacha*/*mama*) or 'aunt' (*khala*/*pishi*).

The way in which people are addressed in Bengali clearly exemplifies the country's social hierarchies. The distinction between the three forms of addressing the subject 'you' – formal (*apni*), informal (*tumi*), highly informal or intimate (*tui*) – is a complex classification according to age, familiarity and social position, which is learnt from childhood (Blanchet 1996). A clear example is the ways in which the address form *'tui'* is used, ranging from an expression of intimate closeness to a way of marking social distance,

[83] There is an important difference between *boro lok* and *bhodrolok*; whereas the former indicates economic wealth, the latter is related to title and family name (Kotalová, 1996).

[84] The former term for Muslims and the latter for Hindus, Christians or Buddhists.

calling '*tui*' a servant or a staff worker, for example. Whereas it is accepted in the former situations and considered normal, at other moments it can also be degrading and even disrespectful.

Nurses are usually addressed either in the English term 'sister' or 'brother,' or in the Bengali equivalent (Leppard 2000; Akhter et al. 2003; Zaman 2005). Doctors sometimes address them using the English term 'nurse' (Khatun 1998, cited in Akhter et al. 2003, p.235), while expecting the title of 'sir/madam' or 'professor'. Afsana (2005), in her analysis of social interaction in an obstetric hospital, observed how nurses were sometimes treated as junior, despite being older and much more experienced than doctors. The following quotation from a nurse, extracted from Afsana's work, exemplifies the power relation between the two professions:

> The doctor told me, not to call him *bhai* (brother) but 'Sir'. I said, you are not a professor. He said, I will be one day. Can you imagine how I felt then? I saw him as a young student (Nurse, quoted in Afsana 2005, p.153)

However, that this status distinction is not exclusive to Bangladesh. In addition, female doctors can also be treated as minors in many regards.

4.5.5. Bengali life stages: The importance of seniority

As in many other contexts, life stages in Bangladesh are influenced by the biological transformation of the body, the gender differences and, because of its Sanskritic influence, the lineage or caste (Aziz & Maloney 1985). Nevertheless, life stages in Bengal do not necessarily correspond to specific age. Overall, it can be said that age, like gender, religion or other social stratification strategies, determine a person's role within society or *samaj*. It is, again, related to the idea of *dhormo* as social duty.

As happens elsewhere, a person's status increases with their age. Aziz and Maloney (1985, p.85) placed the 40s and 50s as the "time of life marked by respectability". A sharp distance can be found between the 'seniors' and the 'juniors' in any social interaction. For example, senior nurses should be treated with respect and obeyed by junior students or staff nurses.

They should not be corrected or challenged, as it may seem disrespectful. This is obviously not exclusive to Bangladeshi society, even though it is probably more visible than in other contexts.

4.6. GENDER AND THE POSITION OF WOMEN WITHIN THE *SAMAJ*

The position of women in Bangladeshi society has been extensively analysed from different perspectives. In the case of the women in this research, gender plays a crucial role, not only in relation to nursing, but also in relation to their broader social identity. From their early childhood, boys and girls are socialised in a different and, in many regards, unequal way (Aziz & Maloney 1985; Blanchet 1996). According to Blanchet, whereas boys represent wealth, girls are seen as a big responsibility for the family, as they have to be given in marriage and the corresponding dowry paid. A preference for son still prevails in Bangladesh, especially in rural areas where their labour will be needed in the future (Kabir et al. 1994). This preference is not exclusive to Bangladesh or South Asia. Moreover, a preference for son does not mean that girls are not wanted or that their birth is not celebrated. It rather means that families aim to have a balanced number of sons and daughters, albeit with a preference for a larger number of sons (Blanchet 1996).

Another important aspect in relation to gender differentials is that of women's social and legal dependence, as they continue to be under male guardianship, even in their adult life (White 1992; Chowdhury 1995; Rozario 2001b). After getting married, their guardianship is transferred from fathers to husbands and, in the case of widowhood, to their sons (White 2013). If a woman gets divorced, it would usually be her eldest brother's responsibility to get her remarried (Kotalová 1996). This does not mean, however, that women have no authority in the house. As they become older, their role in both their natal home and their in-law's is modified.

Two significant changes have taken place in the situation of women within the *samaj*: growing integration in the formal (and paid) workforce and the impressive increase in female education. Both need to be critically analysed as they are often used as part of the 'success story' of developmentalist discourse. As discussed in relation to nursing, access to

education and paid jobs does not necessarily lead to a straightforward improvement in women's social position, at least collectively.

4.6.1. Women, gender, aid and research in Bangladesh

White (1992) critically observed that almost all studies of women and gender relations in Bangladesh have been funded by foreign aid. This has important consequences in the broad institutional narrative about gender. Blanchet (1996) observed how the roots of these discourses can be traced back to the Colonial and Orientalist[85] discussions on 'the status of Indian women'. Later, with the growth of feminism in the West and the more participatory approach to development, women began to attract the attention of social researchers and development planners (Rozario 2001b). Towards the end of the 1970s the main focus was on women's work and fertility, thus reproducing the Victorian 'separate spheres' ideology (White 1992). Later still, and greatly influenced by the publication of Boserup's (1986) study, an 'economistic' approach was added to the focus on status under the following assumption: "The idea is that as women's status rises (typically with greater economic participation) they will have increasing decision-making power especially in relation to economic matters" (White 1992, p.23).

The 'economistic' stream was formally led by the United Nations through the Decade for Women (1975-85) and extended to other development organisations (Gardner & Lewis 1996). The approach was known as Women in Development (WID) and had an important impact in Bangladesh as well, where the then Ministry of Women's Affairs and a National Women's Organisation were established in 1975 (White 1992; Zaman 1979). A great number of political actions took place which focused on female education ('vocational training'), agriculture-based development programs, and hostels for career women, amongst others (Zaman 1979). Interestingly, an extensive study about nursing was published by

[85] Orientalism was defined in the classical work of Edward Said (Said 1978, p.3) as a "Western style of dominating, restructuring and having authority over the Orient —dealing with it by making statements about it, authorizing views of it, describing it, by teaching it, settling it, ruling over it". Following a Foucaultian analysis, the author extensively criticized the role of the pervading dichotomic and essentialist division between East and West and the power relations established between them.

Alam (1975) in an edited book called *Women for Women. Bangladesh 1975*[86]. The chapter has been of great interest to this research.

With the broader changes in feminism, WID's approach was soon criticised for focusing on women in isolation, that way obscuring other forms of inequality (White 1992; Gardner & Lewis 1996; Rozario 2001a). WID evolved to Gender and Development (GAD) in an attempt to provide a more inclusive approach. Nevertheless, as Gardner and Lewis observed, both approaches were often used interchangeably. In addition, GAD could also be used as a top-down approach (Cornwall 2003), and as happened with other participatory approaches, its theory and actual implementation varied considerably.

The contradictory relationship between the donors and the State was clearly exemplified in the gender field. As White (1992) observed, the 'Western aid community' was generally critical towards Bangladeshi social gender norms and aimed to changed them in many ways. In other cases, the author observed that, gender was used in an instrumental way. Nevertheless, it has to be admitted that significant contributions have occurred within the third sector, in terms of women's mobilisation and increasing power both in 'public' and 'private' areas (White 1992; Kabeer 2011).

The contributions of Marxist feminism were also relevant in the development field, as they contextualised gender differentials within broader inequalities and other forms of oppression (Kabeer 1994). Crucial in the latter regard was the emergence of Third World feminism; White's (1992) study could fit in this stream. The author criticised the replacement of domestic patriarchy by development patriarchy. She identified three contrasting images in the portrayal of Bangladeshi women within gender literature where they were either pictured as 'in urgent need', burdened by submission or, from another perspective, 'poor but militant'. White's work focused on gender as a contested image in the public discourse of Bangladesh, analysing the ways in which the 'gendered' image

[86] *Women for Women: A Research and Study Group* is a Bangladeshi-based feminist organisation which was established in 1973 by "a group of committed woman professionals" who shared the aim of "a sound information base for identifying the issues relating to the disadvantaged status of women in Bangladesh and for creating public awareness with a view to ameliorating the existing situation" (Halim 1999)

influenced the identification of problems and their possible solutions. Without denying the role of patriarchy, she focused on the degrees of informal power and the effects of ideological and economic change in different groups of women.

White's analysis has been crucial to add a critical perspective on the literature and discourses about gender. Another crucial contribution to the study of women from minority groups was Rozario's (2001a) study of gender relations within a Christian community. The author argued that "Christian women, while enjoying greater physical mobility than their Muslim counterparts, are constrained by Christian and Muslim men's politics" (2001, p. 1). Her work has been useful to contextualize the gender, social and religious discourses of the Christian nurses in this research.

Finally, Kabeer's work, either alone (1994; 2000; 2011) or with other authors (Kabeer et al. 2011; Kabeer & Natali 2013) has also been used to reflect about the concept of empowerment and the role of women in the economic sphere. The author understands empowerment "in terms of multidimensional processes of change rather than [as] some final destination" (2011, p.500). She uses a hermeneutical approach, where the sense of self and identity are fluid rather than fixed by cultural norms, being constructed and reconstructed through everyday social interactions.

4.6.2. Women in the labour market

Begum's (1987) work is probably the most representative study within WID approach. The author explored the relationship between paid work and gender in three ways: by identifying the factors which affect the employment (or lack of it) of women in the rural areas; the problems faced by working women; the economic and social impact of income earning in the specific lives of women. Her study was criticised (White 1992), but it still had an important effect in making the crucial contribution of rural women in the economic development of the country visible.

Important changes have taken place in the latest decades. Women from all socioeconomic strata are now joining paid labour outside their houses in different areas. A paradigmatic example of women's labour is their predominance in the garment industry (Rozario 2001a), even though other opportunities are also opening for women in the service sector. In addition, local and international NGOs, especially those focused on micro-finance, have historically targeted rural poor women as their main agents (Kabeer 2011). It has to be highlighted, however, that the integration of women in the labour market does not necessarily lead to an increase in their status (White 1992). This early developmentalist assumption has been challenged over time from both the feminist and development literature, even though it still prevails in many discourses. White (1992) alerted the risks associated with this discourse, which in the worst of cases could lead to the perverse assumption that poverty was good for women as it drew them outside their houses.

There is no doubt that economic independence is a crucial aspect of anybody's agency and social power. Nevertheless, simply working outside the house does not automatically lead women to 'stand on their own feet'. In many cases, it leads to exploitation, as in the case of women working in the garment industry. The situation described by Rozario (2001a, p.xvi), is reminiscent of the patriarchal and classist treatment of women during the capitalist expansion in Europe. The author wrote that "women who work in the garment factories submit to a highly restrictive discipline which is supposedly aimed at preserving their dignity and reputation as 'good' women, but they are nevertheless heavily stigmatised by many Bangladeshis, male and female" (2001a, p.xvi). A similar contradiction is found amongst female waged labourers in the rural areas of the country, as it can be viewed as either a sign of dependence on their patrons, or a sense of pride in contributing to the family income (Kabeer 2011).

In summary, if the broader structures of oppression and inequality are not challenged, women could continue to be vulnerable to abuse and exploitation, either inside or outside their households. As some authors have argued, the development establishment is often not interested in challenging the established structures of power (White 1992; Rozario 2001a), however, greater effort needs to be made in this regard.

4.6.3. Education as an 'empowerment' tool and its limitations

The education delivery system in Bangladesh has made important achievements since independence, especially in reducing the illiteracy rate through primary education and in gender parity (Rahman & Islam 2009; Government of Bangladesh 2011; Khan et al. 2014). Nevertheless, overall literacy remains low[87] and the education system is still highly male-oriented (Baxter 1997). Even though the enrolment rate has greatly increased (BANBEIS 2014; United Nations Educational Scientific and Cultural Organisation 2015), the dropout rate is still alarmingly high (Campaign for Popular Education 2007; Khan et al. 2014). Moreover, the enrolment rate falls radically after secondary level (Government of Bangladesh 2011; Khan et al. 2014).

The current education system is a centralized one, administered by the Ministry of Primary and Mass Education (MOPME) and the Ministry of Education (MOE)[88] (Campaign for Popular Education 2007; BANBEIS 2014). The system is divided into three branches: English Medium schools, which are mainly private; Bengali Medium schools, which are generally offered by the government through a minimal tuition fee; and religious schools (madrasahs), which may be publicly or privately funded (Zaman 2005). There are three government-funded streams: general stream; technical and vocational education; and madrasah stream (Khan et al. 2014), whose numbers and social influence have increased greatly over time (Devine & White 2013).

Apart from inequalities in access to education, there are also significant concerns about its quality (Rahman & Islam 2009), especially at primary level (Government of Bangladesh 2011). With high teacher-student rates[89] and under-resourced centres, learning becomes

[87] More details on education indicators can be found in Appendix H.3

[88] The current structure of the education system in Bangladesh can be found in Appendix J

[89] According to the latest available information, teacher-student ratio was 1:40 in primary education in 2011 (World Bank 2016). Similar numbers were found for secondary education, with a rate of 1:39 and at university level (BANBEIS 2014).

difficult for many students. The teaching and learning methodology is very limited and rote learning is common at all levels (Islam 2011; Khan et al. 2014), especially in the over-crowded, age-heterogeneous primary classrooms (Gustavsson 1991). In addition, the secondary education structure, reproducing the British-inherited pattern of generating an educated civil service, does not help students prepare to enter the labour market (Ilon 2000). The mushrooming of private universities is controversial, especially in relation to the quality of the education they offer and the negative impact that the commercialization of education has on society (Islam 2011; Sarkar et al. 2013).

The education system in Bangladesh is unequal and depends on private funding, especially for secondary and tertiary education (BANBEIS 2014). There is also a big gap between rural and urban areas in terms of resource allocation, which gets wider as the education level increases (Rahman et al. 2009). Gender wise, early marriage and lack of support from families to educate female children is still high, especially in rural areas (GoB, 2011a). In spite of this, the number of female students accessing primary and secondary education has increased significantly[90]. According to Lewis (2011, p.37), this has produced "a positive and coherent policy narrative that has found widespread support among both elites and masses".

Rote learning is also related to a cultural association of memory with intelligence. Blanchet (1996) observed how the school system in Bangladesh generally "sanctions the memorization of a finite knowledge contained in books", therefore dismissing the knowledge "gained from the children's own experiences in their own environment" (1996, p.151). Young children are made to memorise an important amount of information that they are often unable to understand. The situation is even worse if information is provided in English and not properly translated to Bengali.

Finally, it is important to acknowledge not only the inequalities and limitations in the education system, but also the *uses* of literacy (Gardner & Lewis 1996). As the authors

[90] An important contribution to the increase in young women's access to secondary education was the female education stipend program (FSP) introduced in the 1990s (Rahman & Islam 2009).

pointed out, literacy can be an 'ambivalent servant' which has to be analysed in conjunction with other variables. On the one hand, universal education can act as a "powerful social equalizer" (Blanchet 1996, p.181). On the other hand, it can serve to reinforce social inequalities, becoming an instrument of domination and political influence (Bourdieu & Passeron 1990; Foucault 1977). Educational systems are crucial ideological apparatuses and this becomes especially important in post-colonial contexts. As Hobart (1993, p.20) pointed out, modern education and the hegemony of 'scientific knowledge', carried the view of its recipients as "passive objects to be developed".

Moving back to the Bangladeshi context, Blanchet (1996) wondered to what extent the Bangladeshi Government and society desires the development of a 'Western' sense of citizenship. Instead of pursuing an 'equalising' goal, education is often used by the elites to pursue their own interests. Gardner and Lewis (1996, p.117) observed how in rural Bangladesh, "people use the skill of literacy for their own and perceived interests (…), such skills can sometimes be used to further the interests of the literate at the expense of the illiterate".

Female literacy and education has been one of the central strategies to increase women's agency and power in society and has undoubtedly benefited them in many regards. Nevertheless, as has been conveyed so far, the relationship between education and power is not straightforward. First, female education has focused for many years on 'feminine' professions such as nursing, teaching and so on, an important constraint in terms of women's career choices. Second, it reinforces the 'separate spheres' ideology, which assumes that care-related responsibilities are 'naturally' feminine. This idea is explored in Chapter Five.

In summary, while access to education is undoubtedly a crucial and basic right, a straightforward line cannot be drawn between literacy and socioeconomic improvement, at least at an individual level. From a more structural perspective, it is important to maintain a critical view of the dual role of education in relation to social inequalities. Literacy and

schooling can either be 'social equalisers' or an instrument for the reproduction of structures and ideologies of domination.

4.7. CONCLUDING REMARKS. THE INTERSECTION OF INEQUALITIES

As shown so far, the role of colonialism in the construction of contemporary Bangladesh is undeniable. After independence from British and Pakistani rule, it is interesting to analyse to what extent certain colonial patterns have persisted. Foreign donors play an important role in the development of Bangladeshi economic and population policies (Perry 2000; Lewis 2011). This can be clearly seen in the health and education sectors. This chapter has focused on the latter, as the former is jointly analysed with the situation of nursing in Chapter Six.

Bangladeshi society is unequal in terms of the distribution of social and economic power. The main areas of inequality in relation to this research are the rural-urban imbalanced resource allocation, and socioeconomic and gender differentials in terms of social position. Although it is necessary to analyse socioeconomic inequalities from an intersectional perspective, gender wise it is important to move beyond a monolithic analysis of 'women in Bangladesh'. Focusing on their individual and collective agency avoids portraying them as passive victims of the system:

> "In Bangladesh, the term 'women' very often includes adolescent girls who are lumped together with older women (…). Differences among 'women' according to age and class are regularly overlooked. The result is a relief category which together with 'the poor' exemplify the perfect victims" (Blanchet 1996, pp.3–4).

In summary, women in Bangladesh, as elsewhere, have multiple identities and positions which vary in relation to their socioeconomic status, age, position in the family, geographic area, religious group, and so on. Their identity as nurses must be added to this complex equation. In some sense, being a nurse and 'caring' for other people can be seen as a 'noble profession', while in other cases it can be a source of low social status. The next chapter explores this longstanding dilemma.

5. HISTORY AND THE POLITICAL ECONOMY OF NURSING IN BANGLADESH

"Nursing history, as a piece of women's history, has faced the paradox of being women's work – invisible, devalued, underpaid – and yet a critical necessity to society" (Andrist 2006, p.5)

5.1. INTRODUCTION: GENALOGY ON IDEOLOGICAL DISCOURSES AND PRACTICES AROUND MODERN NURSING

Care of the sick has never been exclusive to nurses, even though it has been claimed as the essence of the profession (Leininger 1988; 1996; 2002; McFarland 2001; Sitzman & Eichelberger 2010). This fact hinders not only the drawing of boundaries between nurses and other professionals (Dingwall et al. 1988), but also the placement of its origins in history. When understood and defined as the caring of sick individuals, nursing has existed since the beginning of mankind[91]. Nevertheless, the birth of modern nursing and its movement towards professionalization is usually attributed to a specific moment in history. Starting in Europe between the end of the eighteenth century and the beginning of the nineteenth century, it rapidly spread and developed worldwide. Modern nursing is therefore a "Western professional construct, which developed within specific historical circumstances, and has been variously understood and interpreted in different societies" (Littlewood 1991, p.3).

In reviewing the nurses' narratives and the way in which they explained the role of nursing education in their lives, broad discourses emerged in relation to nursing. A further analysis with regards to nursing history and the origins of the profession led to the identification of two official or hegemonic ideologies about nursing in Bangladesh. These were the 'Nightingale' discourse, which placed a central focus on care and the values of the nineteenth century nursing reform, and the 'professionalist' discourse, with a stronger

[91] The existence of people who were taking care of the sick out with the family is also well known from Ancient Civilisation (Kelly & Joel 1999). Rafferty (1996) pointed out the oral "culture" of nursing work to explain the lack of written information previous to the nursing reform.

emphasis on the nurses' educational and social status. Many of the contradictions of the nursing profession in Bangladesh emerge from the distance between these hegemonic rhetorics and the practices or experiences of the nurses.

Foucault's (1977) notions of genealogy and archaeology of knowledge have been found to be very useful to analyse the ways in which the above described discourses emerged and evolved over time. The *genealogy* focuses on the enquiry of the past in order to make intelligible "the 'objective conditions' of our social present" (1977, p.233). The notion of *archaeology* goes beyond a historical analysis and looks at the ways in which sanctioned discourses emerge "according to their material, historical conditions of possibility and their governing systems of order, appropriation and exclusion" (Foucault 1977, p.233). Even though Foucault's methodology for discourse analysis has not been strictly followed, his theoretical conceptualisation of the relationship of power, knowledge and the historical conditions in which dominant narratives are born and reproduced over time has been of great interest.

This chapter has four main sections. The first explores the emergence of modern nursing, in order to analyse both the historical and material conditions, and the ideological discourses behind the first nursing reform. Having done this, the transportation of the nursing reform to colonial India is then be critically analysed. This historical contextualisation allows a better understanding of the present situation and dilemmas of nursing profession in Bangladesh. The analysis of the latter has been divided in two parts. The first includes a summary of the history and political economy of nursing in the country. The second analyses the apparent gap between nursing care rhetorics and practices in relation to the ideological discourses and structural inequalities presented throughout the chapter.

5.2. THE BIRTH OF MODERN NURSING: POWER AND IDENTITY STRUGGLES IN THE PROFESSIONALISATION OF CARE

At the beginning of the nineteenth century, significant socioeconomic, political and scientific transformations were happening worldwide. Broadly speaking, the changes experienced by the English nurses during the nineteenth century were a result of the

industrial revolution, scientific and technological advances, movement towards a welfare system[92], changes in the nature of medicine (mainly the establishment of hospitals as training and experimental centres), and the integration of women into the labour force. It was in this context where the nursing reform took place, which led to a transformation in the categorisation of nursing activities from domestic service into health care (Gamarnikow 1991).

5.2.1. The nursing reform in context: Nineteenth century hegemonic ideologies of gender and class in Britain

The establishment of nursing as a profession is usually linked to the figure of Florence Nightingale, a British nurse who has been widely acknowledged as the founder of modern nursing (Kelly & Joel 1999; Beck 2006; Chinn & Kramer 2015). From a more critical perspective, she has also been considered as the prime exponent of 'character' training for nurses (Rafferty 1996). Imbued in the Victorian ideologies of gender and class, she became a defender of the theory of 'separate spheres' (Salvage 1985) and that of 'health as a civilising mission' (Dingwall et al. 1988). She conceptualised health and disease under an environmentalist paradigm (Pfettscher et al. 1998), which clearly influenced her insistence on hygiene and order.

Born in 1820 to a wealthy English Victorian family, Nightingale was educated in an exceptional way compared with other women from her background and time (Pfettscher et al. 1998; Kelly & Joel 1999; Rosdahl & Towalski 2003; Bostridge 2008). Despite strong opposition from her family, she managed to obtain practical training as a nurse with the Deaconess School in Kaiserswerth, Germany, and to visit the Sisters of Charity in Paris (Kelly & Joel 1999; Bostridge 2008). Upon her return to England, she became the superintendent of a charity hospital in London (Kelly & Joel 1999). Shortly after that, the Crimean War began and, after negotiations, she was asked to lead a group of nurses and

[92] The movement towards social welfare can be found in the work of well-connected philanthropists. Dingwall et al. (1988) named two main influences in this philanthropic work: the reforming spirit of evangelical Christianity and the concern about social order, which was threatened by the sudden changes which occurred during the Industrial Revolution.

take them to the battlefields (Dingwall et al. 1988; Kelly & Joel 1999; Bostridge 2008). Her main achievement was a reduction in hospital mortality from 60% to 1% by the end of the war (Kelly & Joel 1999). These improvements, together with the image of Nightingale and her nurses carrying a lamp during their rounds, which led to her representation as 'the lady with the lamp', made her famous on her return to England, becoming an icon of nursing and one of the visible leaders of nursing reform. Upon her return from Crimea, Nightingale began focusing her attention on the reform of hospital nursing and was able to start a nursing school at St. Thomas Hospital (Baly 1987; Kelly & Joel 1999). One of the biggest innovations of the program was that it targeted both 'ladies' and working class women together, even though they worked under different conditions.

Until the end of the nineteenth century, most care was provided at home, especially amongst the wealthier families (Dingwall et al. 1988; Rafferty 1996). The institutionalised care of the sick was greatly undertaken either by religious orders[93] or 'uncommon' women such as prisoners and prostitutes (Kelly & Joel 1999). This, together with a broader ideology where disease, poverty and crime were related (Dean & Bolton 1980; Rafferty 1996), led to significant stigmatisation of working class nurses. Hospital nurses were therefore associated with the chaotic environments where they worked (Wolf 2006), often with a rhetoric exaggeration of their 'character'[94].

On the other hand, the growth of capitalism had created increasing division amongst upper-class and proletarian women, who were becoming more involved in paid work outside their homes (Gamarnikow 1978). Nursing reform was strongly influenced by the Victorian ideology of the 'separate spheres', which accepted the employment of women for domestic-like activities, as it was in their 'nature' (Reverby 1987). Nursing reform emerged from the

[93] The situation in England differed from that in the European mainland with respect to the role and power of religious orders in the hospitals. In Britain, hospitals "were never completely church controlled, although they were founded on Christian principles and accepted responsibility for the sick and the injured" (Kelly & Joel 1999, p.17).

[94] It has been demonstrated that "in articles, reports and commissioners' investigations these 'pauper nurses' are spoken of in singularly disparaging terms: the inferiority of their characters, their agedness, their uncleanliness, their intoxication, their illiteracy and their promiscuity are all that the documentation will allow us to acknowledge " (Dean & Bolton 1980, p.85).

need to 'civilise' and 'discipline' the working class, which included both patients and nurses. The latter could become, through nursing education, 'respectable' working class women (Dingwall et al. 1988). The notion of "respectable working class" appeared in opposition to criminality, which was rhetorically associated with poverty and substance abuse (Rafferty 1996). Within this broader ideology, the Nightingale programme and nursing reform aimed to achieve "the morality and spiritual devotion of religious orders, the education of the middle classes, combined with the hardiness of working-class girls" (Baly 1987, p.37).

The intersection of the scientific paradigm and the technological boom, with the reinforcement of religious and moral values during the nineteenth century, led to significant conflicts in nursing identity, which in many ways have persisted until the present. On the one hand, changes in medicine and science, and the sudden growth of hospitals as highly technical spaces required more experienced and trained nurses. On the other hand, nursing maintained a moral and frequently religious character (Dingwall et al. 1988). The 'reformed' nurse, "embodied the ideal attributes of the emerging order of health care: enlightenment, rationality, science, Christian purity, innocence, virtue, youth, freshness, gentleness, hygiene, sobriety, gentility, and intelligent obedience" (Rafferty 1996, p.20). Towards the end of the nineteenth century, however, the reformist discourse began to be challenged by other nursing leaders who focused their efforts to the improvement of nurses' education and practice standards.

5.2.2. The 'Professional rhetoric': Divergences and convergences with the 'Nightingale discourse'

A profession is generally understood in relation to the "payment for special skills, in contrast to the amateur" and to "proficiency and concentration on the task in hand" (Salvage 1985, p.89). Salvage observed how in many regards, the professional discourse emerged in opposition to the notion of 'vocation' or 'calling', which was fiercely defended by Nightingale and her followers. In addition, the notion of profession carries a status connotation that places it above the notion of a job. By raising the nursing status to that of a profession, it was argued that highly educated nurses would be produced and, therefore,

better nursing care delivered. The firsts step was to improve nursing education and service standards through registration.

Initially, a group of nurse leaders[95] began pushing for the establishment of a central examination and registration centre in Britain. For Nightingale and some other reformers who opposed this new rhetoric, nursing training was essentially practical and based on discipline (Abel-Smith 1960). They believed that examination alone could not assess the personal qualities of the nurses. Opposition also came from hospital managers and general medical practitioners (Dingwall et al. 1988). In contrast to the latter, elite practitioners were indifferent or even supportive, as they felt less threatened by registered nurses. Eventually, the Registration Act was passed in 1919.

A critical look at the consequences of professionalization showed that it could lead to elitism and hierarchies within the health system through the distinction between 'professional' and 'unprofessional' professionals or behaviour (Salvage 1985). The latter, Savage observed, could be used to discipline nurses, pointing to aspects of their personal behaviour as 'unprofessional'. In addition, professionalist rhetoric often ignores the role trade unions had in nursing organisations and the improvement of their working conditions.

The 'professionalist fight' has been criticised for being elitist, as it set its priorities on aspects not necessarily shared by all nurses. For instance, placing all the efforts on upgrading the academic standards for nursing without improving their salaries or providing them with financial support for their education would inevitably exclude a great number of nurses who could not afford it.

[95] Amongst them, Ms Bedford-Fenwick should be highlighted. She played a role, not only in the "battle for registration" but also in the instauration of a professional view of nursing education. She "rejected the essentialist emphasis on personal qualities of the nurse throughout the registration debate", arguing instead for "technical competence" (Rafferty 1996, p.60)

5.2.4. The institutionalisation of nursing: Roots and effects of the nursing dilemma

Following Gidden's (1979) analysis of institutions and society, the institutionalisation of nursing was both enabling and constraining. It was enabling because it allowed many women to develop themselves in this specific area, and to obtaining financial support. At the same time, the institutional ideology was in many ways a reflection of broader social and gender inequalities. In many ways, the reformists' ideological discourse has acted as both the cause and effect of nurses' subordinate position within the health system. The association of nursing with the ideology of separate spheres led to negative outcomes for nurses. Cohen (1981, p.9) ironically pointed out how "Nightingale established and promulgated an educational system that does not produce professionals like herself: staunchly independent women who discard female stereotypes and refuse to accept the convention of traditional health care". Her ideals of self-sacrifice contributed, in many ways, to the subordinate position of nurses within the health system (Reverby 1987; Wolf 2006).

The 'professional' rhetoric had significant ideological differences in respect to early nursing reform, although it was still led by 'ladies' who were not necessarily involved in direct nursing care. Neither were they sympathisers with the working-class movement (Abel-Smith 1960). Class divisions amongst nurses were often stronger than their shared struggles as women (Reverby 1987). Even more, the professionalist discourse of nurse leaders in the UK and US was often used to temper and restrain other forms of protest and industrialist action (Bellaby & Oribabor 1980; Wolf 2006). The notion of nursing as 'vocation' or 'calling' and its gender ideology hindered the attempts of nurses to claim better working conditions (Bellaby & Oribabor 1980). With the exceptions of nursing leaders like Lavinia Dock or Eliza Mahoney[96], who had a more radical approach to nurses' rights in terms of gender, class and race, 'professional' leadership was generally distant from nurses' daily struggles.

[96] Lavinia Dock fought for a greater involvement of nurse leaders in the wider women's movements arguing that "nursing represented women's first emancipated step after a century and a half of subjugation" (Baer 1992, cited in Andrist 2006, p.5). Mahoney, on the other hand, became the first Black woman to graduate from a nursing school. She pioneered civil rights in nursing and fought against racial discrimination in the profession.

The nursing duality and dilemmas took a special form in India, where inequalities were added in terms of race and caste. Imperial ideologies merged with the theory of separate spheres and to broader ideological discourses related to gender and class. Brahmanism and notions of ritual pollution, together with the prominent role of missions in the development of the profession, shaped a specific structure and status of nursing institutions in the subcontinent. The following section explores this further.

5.3. MEANWHILE IN INDIA … A RECONFIGURATION OF DISCOURSES AND PRACTICES

The history of nursing in the Indian subcontinent is complex and reflects the various medical, religious and social systems that have coexisted throughout history. From ancient times, the continent has suffered invasions and the domination of foreign rulers, each bringing their own medical system and developing it with more or less acceptance by the local population. With the arrival of European traders and the subsequent instauration of the East Indian Company and British Crown, Western[97] medicine displaced other forms of care and slowly but surely led to the current hegemonic medical system.

The birth of modern nursing in India was contemporary with the birth of modern nursing in the UK and US and was clearly influenced by the developments taking place in both countries. Nightingale was involved in the Indian health reform herself and her presence (and sometimes myth) is still alive in the professional and academic rhetoric of Indian and Bangladeshi nurses. The arrival of British and American female doctors and nurses through missionary or philanthropic organisations brought with them a mixture of 'Nightingale' and professional discourses, which clashed in some aspects and converged in others. The relationship of British traders, officials, missionaries and philanthropists with the local population varied from place to place and evolved over time. What is undeniable, however, is that the birth of modern nursing was tied to the Empire and embedded in gender, race, class and caste power relations.

[97] Western medicine will be used to refer to biomedical, European-imported medicine.

5.3.1. Arrival of Western medicine to India and early developments

In the pre-colonial period and during most of British rule, indigenous forms of medicine were the main health facility[98] (Osman 2004; Healey 2007). These forms of medicine and care varied enormously between regions and social groups. Nevertheless, Brahminical notions of ritual pollution and the subsequent delegation of certain 'polluting' tasks to the Dalit gradually acquired a central role. The paradigmatic figure of the low status, associated with the contact with bodily fluids, was the *dai* or traditional midwife. The historical low status of *dais* has been widely studied in India (Mavalankar et al. 2016) and Bangladesh (Blanchet 1984; Rozario 1998; 2002; Afsana 2005). Similarly, institutionalised care of the sick became a task of the disadvantaged (Robson 2005).

Generally speaking, Western medicine arrived in India through three main areas, which grew in relation to changes in the colonial ideology and circumstances: the army, missionary and philanthropic organisations, and what Harrison and Pati (2011) termed State medicine[99]. The creation of the Indian Medical Service (IMS) in 1714 is usually considered a landmark (Osman 2004). Nevertheless, it was not until 1888 that nurses were sent by the British government to organize the military hospitals and the Indian Nursing Service (INS) was established (Wilkinson 1958; Somjee 1991; Healey 2011).

5.3.3. The role of missions and philanthropic organisations in the 'civilising mission': Explicit and implicit forms of racial discrimination

The Victorian imperialist idea of 'moral responsibility' towards the Indian population, especially women and children, acquired special relevance after the mutiny (Burton 1992; Arnold 1993). Western female philanthropists were one of the main proponents of a "custodial, classist, ageist, and hierarchical" notion of responsibility (Burton, 1992, p. 139). This specific intertwining between Christian, Victorian and scientific values in the

[98] For a further historical review of medical systems in India, see Basavanthappa (2009a), Leslie and Wujastyk (1991), Mehta (1965), Rao (1968), Somjee (1991) and Wilkinson (1958).

[99] See Appendix K for a chronology of modern medicine and nursing in India

provision of health to the Indian population has been critically analysed as the spread of the 'sanitary gospel' (Harrison 1994), civilising mission[100] (Harrison & Pati 2011) or medical imperialism (Ramusack 1992; Witz 2001).

With the turn of the century, health provision started to be used by missionaries and philanthropists as a tool to access the local population, especially to the so far restricted female world (Fitzgerald 1997; Forbes 1986; 2006). The claimed superiority of Western medicine allowed the missionaries to "heal body and soul" (Abraham 1996; Fitzgerald 2001). Medical missionaries from Britain and the United States were in many places the first to provide women and children with education (Gourlay 2003) and health care (Lal 1994; Forbes 2006).

Missionaries and local philanthropic organisations had traditionally focused on the Dalits (Harnar 1975, cited in Simon 2009, p.89), many of whom converted to Christianity. It was from these communities that many women would later become nurses (Abraham 1996; Robson 2005). In contrast, government-aligned philanthropic organisations focused their efforts on upper class Hindu and Muslim women, who were generally more secluded (Witz 2001). In many ways, the imperialist discourse and practices merged local seclusion and class hierarchies with Victorian ideologies of gender and class. The outcome was a new, reinforced form of race, class, caste and gender discrimination.

5.3.4. The slow march towards public healthcare provision

The first Western-style hospitals in India were set up by the army and were for the soldiers, even though they progressively began to admit civilian patients as well (Wilkinson 1958; Nandi & Loomis 1974). Dispensaries began to be built later, playing a crucial role in the provision of health services to women (Wilkinson 1958). As with many parts of Europe,

[100] The expression 'civilising mission' has been used by some historians as a translation from of the French notion of *mission civilisatrice*, which could be compared to "what the English initially called improvement or 'betterment' and, later, 'moral and material progress'" (Mann 2004, p.4). The notion of 'civilising' is rooted in the notions of *civis* and *civitas*, and the adjective 'civil' points to the notion of order, education and politeness (Williams 1977). When the notion was extended to 'civilisation', it was understood as "an achieved state of development, which implied historical process and progress" (1977, p.13).

the provision of health services in India was urban and hospital-centred (Ramasubban 1984; Harrison & Pati 2011). Furthermore, the conditions in a lot of these hospitals were deplorable and many patients suffered hospital-related diseases (Kumar 1998). The association of caregiving with the status of the ones being cared for has been widely recognised (Benner & Wrubel 1989). This had significant consequences for Indian nurses as well.

With decentralisation of the colonial administration at the end of the nineteenth century, Indian officers could enjoy a greater role through the municipalities (Harrison & Pati, 2011). Meanwhile, an important move towards the professionalization and systematization of Western medicine education and services began to take place in the civil branch of the IMS (Mehta 1965; Rao 1968). Nevertheless, the recruitment pattern followed the racial segregation policies of the colonial administration until the early twentieth century (Harrison & Pati, 2011; Kumar, 1998). In spite of the growth of professional medicine, access to health services, water and sanitation continued to be limited for most people (Gourlay 2003). India had, by 1937, one of the highest death rates in the world (Rao 1968). A significant development in terms of public health was the constitution of the Health Survey and Development Committee in 1943, which would eventually produce what was known as the Bhore Report of 1946 (Wilkinson 1958; Rao 1968; Osman 2004). Unfortunately, the report soon faded into oblivion after partition and Pakistani rule carried on with the curative, urban- and elite-centred health system that the Raj had left (Zaidi 1985; Somjee 1991; Osman 2004). These setbacks and constraints greatly affected the development of the nursing profession (Healey, 2006, 2007).

5.3.5. The establishment of professional nursing in the Raj: A tortuous road

If moves to the 'Indianisation' of IMS were slow and difficult, they were even worse in the case of female doctors and nurses. Nursing and medical education of women began in the hands of either missionaries or philanthropists (Wilkinson 1958; Witz 2001). According to the missionary ideology, teaching, medicine and nursing-midwifery were considered suitable professions for women. The British administration, however, did not initially share

their view. Using *purdah* as an excuse, State and British-led philanthropic organisations continued to stop Indian women from getting medical training at the same level as their Indian male and European female counterparts (Lal 1994; Burton 1996; Forbes 2006).

Nursing education programmes were gradually introduced in missionary, philanthropic and government hospitals during the 1890s-1900s (Wilkinson 1958; Basavanthappa 2009a). In the area that now constitutes Bangladesh, then East Bengal, three missionary hospitals started training nurses during the first half of the twentieth century, and were followed by civilian and government hospitals (Haider & Shah, 1992; Wilkinson, 1958). Generally, missionaries were more keen to offer training to Indians in the vernacular languages, whereas the government and municipal hospitals retained the English language as they had been targeting mainly European and Anglo-Indian students (Wilkinson 1958; Abraham 1996). In this way, racial, class and caste discrimination took a specific part in nursing education and service.

The fight for registration took place in India as well and was viewed as essential to the growth of the nursing profession (Wilkinson 1958). As had happened elsewhere, a leading elite was formed who were far from the reality and needs of the majority of Indian nurses (Robson 2005). On the one hand, Western nurse leaders' emphasis on professional standards excluded Indian nurses from positions of authority (Healey 2007). On the other hand, the efforts of formal associations did little to improve nurses' working conditions. By appealing to their obedience, service and 'nobility', nurses were discouraged from joining open protests and industrial-type actions.

Nursing was rhetorically related to the Christian ideals of service, self-sacrifice and devotion (Fitzgerald 1997; Simon 2009). Even though the values are also shared by Muslims (Bryant 2003), Hindus and Buddhists (Sondgrass 1999), their rhetorical association with nursing was mainly due to Western Christian women. Paradoxically, however, Western nurses tended to occupy leadership posts which were far from the 'hands-on' and intimate care they were meant to promote (Robson 2005). Missionaries continued to play a crucial role in the provision of nursing services and education well into

the twentieth century (Healey 2011). Fitzgerald (1997) noted that, by the time of India's Independence, 90% of the nurses were Christian and 80% had received their education in missionary hospitals, a fact also explained by the State's neglect of the profession over time (Ramasubban 1984; Nair & Healey 2009; Healey 2007).

The last years of Colonial India witnessed what Healey (2007) called a "rush to reform the profession", especially when its underdevelopment became evident and embarrassing after the world wars. The number of trained nurses was still very low, at one nurse to every 50-60,000 people (Wilkinson 1958). However, if the situation was bad in India, it was even worse in what was then East Pakistan. What would later become Bangladesh was left with only fifty nurses (Alam 1975; Begum 1993).

5.3.6. Developments after partition: overcoming the nursing shortage in east Pakistan

The colonial rule and subsequent Partition had left Pakistan with a poorly staffed, underdeveloped, urban-biased and highly centralised healthcare system (Banerji 1974; Hemani 1996; Ahmed et al. 2015). Health planning did not start until 1955 and was overwhelmingly focused on birth control (Osman 2004). During the 1960s, the first real initiatives to improve the health of the rural population were taken by the Government (Ahmed et al. 2015), and these provided employment opportunities for young women, who could become family planning workers within their villages (Robson 2005).

Independent Pakistan suffered from a severe nursing shortage; most non-Muslim nurses had migrated to India and many British nursing sisters went back to their country[101] (Haider & Shah 1992; Hemani 1996). The already meagre number of nurses was concentrated in West Pakistan (Wilkinson 1958; Haider & Shah 1992). Indian nurses had to be sent to the Eastern wing (current Bangladesh) to resume the organisation of nursing education and services (Alam 1975; Directorate of Nursing Services 2011). Prior to that, nurses were educated in hospitals on an on-the-job basis and only three junior nursing schools were

[101] There seems to be a discrepancy about the exact number of senior nurses who were present at that time, the number oscillating between around 100 and 350 (Hemani 1996).

functioning (Wilkinson 1958; Directorate of Nursing Services 2011). The first senior nursing school was established in 1947, attached to Dhaka Medical College and Hospital (Alam 1975; Begum 1993; Robson 2005). The School was run by a British nurse, who was also the Superintendent of Nursing Services and acted as Registrar of the Pakistan Nursing Council (Karmakar 1993; Directorate of Nursing Services 1994a).

As happened in the Western wing, it was difficult to attract young Muslim women to the nursing institutes (Begum 1993; Directorate of Nursing Services 1994a). This difficulty made educational requirements more relaxed, meaning only seven to eight years of schooling was enough to become a nurse (Alam 1975). During the 1960s, a sustained effort was made by nurse leaders to increase the number of students, and initiatives were implemented, such as the celebration of 'nursing weeks' among schoolgirls (Karmakar 1993; Directorate of Nursing Services 2011).

In 1952, the East Pakistan Nursing Council was created and a Nursing Act was passed to bring uniformity to nursing education (R. Khatun 1999). A College of Nursing was established in 1956 in Karachi to offer courses in nursing education and administration (Robson 2005; Directorate of Nursing Services 1994a). To upgrade the nursing profession in the East, junior nursing schools were abolished in 1960 (Begum 1993; R. Khatun 1999). Nevertheless, and due to the limited numbers of senior nurses[102], expanding the profession was an "up-hill struggle" (Robson 2005, p.34). Eventually, a College was established in Dhaka in 1970 and Senior Training Schools were established in the five remaining medical colleges and district hospitals. As a result, the number of nurses trained rose from 50 in 1947 to 600 in 1970 (Begum 1993). In the same year, a common category of nurse-midwife was established, as the former had been educated separately until then (Minca 2011).

[102] Eight women had been sent to London for nursing education in 1949 and in the 1960s more nurses were sent to the United States under a USAID fellowship (Karmakar 1993; Directorate of Nursing Services 1994a; Begum & Shresta 1999).

5.4. HEALTH AND NURSING DEVELOPMENTS AFTER INDEPENDENCE

By the time of independence in 1971, the health of the population was far from good. The Liberation War had had a terrible effect on a country that was already suffering from over-population, malnutrition and a high incidence of preventable diseases (Osman 2004). Pakistani rule had left a very weak health care system, especially in the rural areas (Osman 2004; Zaman 2005). However, within a decade, Bangladesh managed to develop "an extensive, multi-tiered public health care infrastructure" (Zaman 2005, p.51). Nevertheless, for the first few decades, most of the health planning effort was focused on birth control, which left other areas underdeveloped (Osman 2004; Sabina & Barkat 2012).

5.4.1. The health system in independent Bangladesh: Persisting inequalities

The relationship between health and social inequalities has been widely analysed from both medical and social science perspectives (Benach 1997; Farmer 2004; World Health Organisation 2016). Bangladesh has made great achievements in some health indicators[103], especially in life expectancy and the reduction in maternal and child mortality. Nevertheless, the progress has been much slower in other areas like nutrition, sanitation and access to health care services. This has led to a double burden, where the population suffers from infectious and preventable diseases (Zaman 2005), and from an increasing prevalence of non-communicable diseases (Ahmed et al. 2015).

The Bangladeshi Health System comprises a mixture of public and private initiatives (Osman 2004). The supervisory body is the Bangladeshi Government through the Ministry of Health and Family Welfare (MOHFW) (Osman 2004; Lewis 2011). Even though the country has a well-established structure of public health service delivery[104], it remains largely underused by the population (World Health Organisation 2010). The system is

[103] Detailed information on health indicators can be found in Appendix H.3

[104] A diagram of the health service delivery structure can be found in Appendix H.4. According to the latest information available (Bangladesh Bureau of Statistics 2014), the public health care system in Bangladesh is delivered through 593 Government hospitals. At a primary care level, 1469 Union Health and Family Welfare Centres, and 12,248 community clinics at ward level (Ahmed et al. 2015).

highly centralised and under-resourced (Ahmed et al. 2015). There is widespread and chronic policy implementation failure due to accountability problems, high centralisation and a strong influence of donors (Osmani 1990; Lewis 2011; Sabina & Barkat 2012).

Health centres are generally understaffed and underequipped, especially in the rural areas. The health workforce shortage is particularly bad for nurses and health technologists[105] (Bangladesh Health Watch 2007; World Health Organisation 2010). Many posts have been left vacant, especially in remote areas (Khan 2012). Dual place holding and absenteeism amongst doctors in Bangladesh has been widely described (Gruen et al. 2002; Chaudhury & Hammer 2004; Zaman 2005; Sida 2012; Ahmed et al. 2015). A recent report by the Swedish International Development Agency (2012) also observed that patients' advice and treatment were still influenced by nepotism and by health workers' possibility of making personal gains. Even though dual job holding is less common amongst nurses, it has also been reported (Leppard 2000).

On top of staff shortages, there is a significant lack of equipment and supplies (Zaman 2005; Lewis 2011; Chowdhury et al. 2012; Ahmed et al. 2015). As a result, in the rural areas, informal and often untrained health providers of Western, homeopathic and traditional (*kobiraj*) medicine continue to be the principal resource (Zaman 2005; Ahmed et al. 2015). There is a lack of extensive studies about private and non-Governmental health care provision in Bangladesh, even though all highlight the increasing growth of the sector[106] and its lack of regulation (World Bank 2003; Ahmed et al. 2009; Ahmed et al. 2015). The growth of NGOs and the private sector also responds to the role of development agencies and external donors, and to the more recent establishment of private-public partnerships (Osman 2004). The underuse of the existing public health services and the growth of the private sector are an important limitation in terms of geographical

[105] The doctor-nurse-technologist ratio is 1:0.4:0.24, which is in sharp contrast with the WHO recommended ratio of 1:3:5 (Ahmed et al. 2015). In terms of absolute numbers, there are 41,894 Diploma and 1571 BSc nurses registered, as well as 660 midwives, for the population (BNMC 2016b). Many, however, are still unemployed.

[106] For instance, Lewis (2011, p.192) notes that "in 1980 there were 510 Government hospitals and 39 private, and by 1998 there were 626 private hospitals and clinics and 647 Government ones"

accessibility. Even though Government hospital distribution is geographically balanced (BHW 2012), its per capita expenditure (Huque et al. 2012) and the concentration of equipment and manpower are much higher in urban areas (Directorate of Nursing Services 2011; Ahmed et al. 2015). Moreover, public health expenditure tends to favour the richest districts and the wealthiest quintiles of society (Huque et al. 2012).

The neglect of healthcare investment by the Government has been especially bad for nurses. According to the former Director of the Directorate of Nursing Services (DNS), Minati Sarma (1999, p.7), one of the overriding characteristics of nursing in Bangladesh is the "low value society and decision-makers place on nursing care". Several studies have also pointed out the State's neglect of nurses' involvement at policy and decision-making levels as a leading cause of the profession's problems (Youssef et al. 1997; Akhter et al. 2003; Directorate of Nursing Services 2011).

5.4.2. Developing the nursing and midwifery professions after independence

At the time of Liberation there were around 600 registered nurses, of whom 350 were working in Government services (Directorate of Nursing Services 2011). The nurse-doctor ratio was about one nurse for every ten doctors (Alam 1975). Consistent with the country's reliance on foreign aid, developments in nursing have been strongly influenced by international and bilateral agencies, of whom the WHO and the Department for International Development, UK (DfID) have taken prominent roles. But, in spite of its undeniable contributions, foreign aid has often lead to problems of sustainability and the bolstering of local elites, prioritising the donors' areas of interest (Robson 2005).

The recently-formed Bangladeshi Government took several steps to increase the number of nurses, increasing agreed places in nursing institutes and posts in hospitals (Karmakar 1993; Directorate of Nursing Services 1994a). Male students started to be admitted, as the number of female candidates had decreased due to the war (Alam 1975). In 1972, two important professional bodies were established: the Bangladesh Nurses Association (BNA) and the Bangladesh Nursing Council (BNC) (Directorate of Nursing Services 2011). In the

same year, the BNC developed the first curriculum for senior registered nurses. The Directorate of Nursing Services (DNS) was created as a separate directorate under the Ministry of Health and Family Planning, Health Wing.

The DNS faced several challenges, mainly with respect to the tensions with the Directorate of Medical Services and their lack of relationship with the Directorate of Family Planning (Robson 2005). This had two significant consequences for nursing. First, it left nurses with no control over maternal and child health activities in the community (Begum 1997; Robson 2005). Secondly, the thousands of village health workers and medical assistants who were trained in the 1970s further restricted "the pool of young women from which nurses could be drawn" (Robson 2005, p.139).

In 1980, coinciding with the beginning of the Second FYP, the government issued a 'crash programme' for nursing education (Robson 2005). All the key informants in this research joined nursing at that time. The programme, which led to a significant expansion in nurse training institutes[107], was conducted with the help of international organisations and donors. The expansion was, however, too rapid and under-funded (Youssef et al. 1997; Robson 2005). There was no accreditation system carried out by the BNC, nor were there clearly defined standards of practice (R. Khatun 1999). This led to a lack of coordination between theory and practice, that is, between teachers and health administrators.

As a result of the overproduction of nurses during the 1980s, a bulk of unemployed professionals was generated[108]. They could not join Government posts "unless those already in employment took up opportunities to work abroad" (Robson 2005, p.36). It was in this context where the promotion of overseas educational and professional experiences began as a joint effort between the Government and international agencies. Nurses were

[107] Eighteen Nursing Training Centres (NTCs), later known as Nursing Training Institutes (NTIs) were opened, attached to 50-bed general hospitals in the sub-districts (Begum 1993; R. Khatun 1999; Robson 2005; Directorate of Nursing Services 2011).

[108] An assessment conducted in the 1990s estimated that 3189 nurses (25%) out of 12680 were unemployed, 6491 (61%) worked in the Government sector, 1000 (8%) worked in the private sector and 2000 (16%) worked abroad (Directorate of Nursing Services 1995).

sent to the UK, the US and other Asian countries such as Saudi Arabia and India. Many of these nurses, including some of the key informants in this research, returned to Bangladesh and took leadership positions.

During the first decades after independence, nursing services were hospital-oriented and it was not until the 1990s that a significant move towards community health was made (Begum 1993; Karmakar 1993). Another step to strengthen the nursing service came in the form of a WHO-supported National Plan of Action for Nursing Development in Bangladesh (Directorate of Nursing Services 1994a). A situational analysis was conducted, which identified quantitative and qualitative setbacks[109] in both service and education services. Following the situational analysis, a joint project between GoB, WHO and DfID was started under the name of the Strengthening Nursing Education and Services (SNES) Project (Sarma 1999; Robson 2005). Its interventions included the provision of professional education for senior nurses, courses for middle-level managers and educators, and Masters education in the UK for twenty selected nurses.

After completion of SNES, a similar project was started under the name of Strengthening the Role of Nurses (SRN), this time focusing on three main areas: BNC; DNS; and CoN (Robson 2005). An important outcome of the SRN project was the publication of an extensive observational study which evidenced nurses' lack of involvement in direct patient care (Hadley & Roques 2007). Overseas education of Bangladeshi nurses continued through the WHO in several locations, mainly Australia and Thailand. The post-basic education (BSc Degree) offers increased within the private sector and more Government colleges were also opened outside Dhaka (Directorate of Nursing Services 2011).

In 2002, the 1990 basic curriculum was reviewed and it became evident that it was still not fully implemented (Robson 2005; Aminuzzaman 2007). In addition, WHO provided technical support to conduct a review of the Diploma curriculum in order to reach

[109] These were mainly due to high teacher-student ratios, a significant nursing shortage and high unemployment rates, poor environment and working conditions, and political conflicts within different nursing groups. The poor image of the nursing profession was also identified as a significant source of concern.

international standards (Directorate of Nursing Services 2011). Significant changes were made, such as increasing the entry requirement from SSC (class 10) to HSC (class 12), reducing the four-year Diploma to a three-year programme and adding new subjects, amongst others (Bangladesh Nursing Council 2006). Currently, four curricula coexist in Bangladesh for the following programmes: a three-year Diploma in Nursing Science and Midwifery; a two-year Post-Basic BSc; a four-year Direct BSc; and a three year Midwifery Diploma[110] (BNMC 2013a).

The increase in the number of private institutes and colleges should also be mentioned. At present, they greatly outnumber the Government places in both the Nursing Diploma and Degree[111]. This growth has been encouraged by the Government as a measure to overcome the nursing shortage (Directorate of Nursing Services 2011). Nevertheless, Government posts for these newly graduated nurses are not ensured and nurses often join the private sector for some time (Directorate of Nursing Services 2002). There is a significant lack of regulation and reliable data on nurses' working conditions in non-Government centres. Bigger private hospitals are usually better resourced and tend to pursue higher nursing standards (Andaleeb et al. 2007) and better conditions in terms of pay, workload and continuous education (Oulton & Hickey 2009). Smaller clinics are generally worse in this regard (Directorate of Nursing Services 2011).

Public service is generally preferred by nurses as it offers more security (Directorate of Nursing Services 2011). As soon as posts are opened, tend to move to the Government sector. In addition, a symbolic achievement came in 2011 when the Prime Minister

[110] The current Diploma curriculum began to be implemented in 2006 and one year later, a direct-BSc curriculum was also published (BNMC 2013). For the first time, a midwifery curriculum started to be developed in 2011 with WHO's support (Directorate of Nursing Services 2011) and was finally issued in 2012 (BNMC 2012).

[111] According to the latest information available from the BNMC (2016a), the three-year Nursing Diploma is offered in 151 different institutes (43 governmental; 108 private), the four-year Direct BSc in 52 colleges (14 governmental; 38 private) and finally, the two-year Post-Basic BSc can be found in 39 colleges (4 governmental; 35 private). If we compare these numbers with those of 2013 (BNMC 2013), the number of governmental educational institutions has remained exactly the same, whereas privately offered places have increased significantly for the three courses.

declared that all Diploma nurses would hold Class II positions[112] for government posts (DNS 2011). This had significant consequences for Bangladeshi nurses, who had been traditionally concerned about their status as civil servants (Robson 2005). The class upgrading was also accompanied by a revision of the DNS recruitment rules. The Government issued a circular in 2015 for the appointment of 3,616 senior staff nurses, which was thoroughly protested by many unemployed nurses "who were hoping to be recruited on the basis of their year of graduation, merit, and seniority instead" (*The Daily Star, 31st May 2016*).

Mention should be made of the current situation of midwives. Considering the country's high fertility rate and the fact that most deliveries being conducted at home[113], the role of midwives is clearly crucial (Minca 2011). However, the profession has been affected by the low status associated with traditional midwives and by the nursing shortage. Nurse-midwives are mainly located in hospitals, where deliveries are mostly conducted by doctors or medical students (HPNSDP 2011). Community based skilled-birth attendants (CBAs), who started to be trained by the Government in 2004, are now the main midwifery service providers at domiciliary and union level. Seeing the dire condition in which delivery care had been left over time, recent initiatives[114] have been taken by the Government in collaboration with UNPFA and WHO (Minca 2011). In 2012, a separate curriculum was issued for midwives with the double aim of 'weaning' nurses from midwifery (Robson 2005) and "increasing the cadre of specialised and highly-educated midwifes" (HPNSDP 2011, p.6). There is hope that the newly educated midwives will upgrade Government maternal and child services, especially in the rural areas.

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[112] They had been considered as Class III employees so far

[113] 90% of the deliveries take place at home and amongst them, 64% are assisted by untrained Traditional Birth Assistants (TBAs) (Minca 2011)

[114] These initiatives were mainly focused on emergency obstetric care. Investments were made in the training of community-based Skilled Birth Attendants (SBAs) and in the improvement of accessibility to the Upazila Health Centres (Minca 2011).

In summary, nursing in Bangladesh is overwhelmingly hospital-centred[115] and clearly insufficient in numbers to meet the demands of the country's population. Working conditions are still far from being good. This subsequently affects the nursing care received by patients and contributes to the already negative image of nursing work. Professional bodies and nursing associations have made strong efforts to improve the situation. Their work, however, has been hindered by significant structural limitations.

5.4.4. Professional bodies and nursing associations: Limited leadership

The official Government institution in charge of regulating nursing services and education is the Directorate of Nursing Services (DNS), which belongs to the Ministry of Health and Family Planning (DNS 1994b). The Bangladesh Nursing and Midwifery Council (BNMC) [116] is specifically focused on nursing education and also monitors nurse registration. There are different nursing professional associations, mainly the Bangladesh Nurses Association (BNA) and the Bangladesh Diploma Nurses Association (BDNA), which are actively involved in the battle for nurses' rights as health workers.

When looking at the organisational structure of the Government Health System in Bangladesh, one soon realises that the DNS occupies an unusual position. The Directorate is supposed to be an independent institution directly reporting to the Ministry of Health and Family Welfare. In reality, however, it occupies a lower position in relation to the other directorates[117] (DNS 1994a). This leads to practical management problems and a clear power imbalance between nurses and doctor officers. In addition, the DNS is a highly-centralised institution (DNS 1994b; 2002; Robson 2005). DNS officers are mainly selected on the basis of their seniority and tend to be posted in an acting position[118] (DNS 1994b).

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[115] A report by the World Bank (2003) showed how 95% of the nurses in Bangladesh worked in urban hospitals and clinics. A more recent study by Hadley and Roques (2007) stated that 99% of nurses worked in hospitals.

[116] Previously known as the Bangladesh Nursing Council (BNC)

[117] The organogram of the health system in Appendix H.4 clearly shows the peculiar position of the DNS

[118] Since 1993, no regular Director of Nursing has been appointed (HPNSDP 2011)

This, together with the fact that they are usually close to retirement age, makes it difficult to take radical decisions.

The DNS has consistently been denouncing its insufficient physical facilities, human and material resources (DNS 1994a; Robson 2005; Oulton & Hickey 2009). Robson (2005, p.70) described how the rooms were dark and crowded with visitors who were "mainly recently qualified nurses, usually with a male relative, desperately seeking employment", and I had a similar impression when I visited the office in 2012. Oulton and Hickey (2009), in a review of the nursing crisis in Bangladesh, Nepal and India, identified analogous challenges.

The BNMC is the regulatory body for nursing education and practice and is mainly funded through the fees charged to nurses and nursing institutions for registration, accreditation, examination and licensing (DNS 1994a). Among the limitations of the BNC, DNS situational analysis highlighted a lack of quality control of nursing education and practice. This is partly explained by the inadequate incomes of the Council, and structural factors such as the teachers' shortage or the inadequate clinical learning and assessment of students, who are often 'used' as staff nurses. More recent studies have stressed similar problems, pointing out the Council's ill-defined and limited legal responsibility over nursing education and the regulation of service (Robson 2005; Oulton & Hickey 2009). The BNMC office is also under-resourced and suffers from lack of permanent positions (Robson 2005; Oulton & Hickey 2009). Moreover, as members are selected by the Government, they are not necessarily nurses (Oulton & Hickey 2009).

In spite of the setbacks, regular registration examinations were finally introduced in 2012, even though they did not necessarily ensure acceptable levels of competency (Berland 2014). A code of ethics was published by the BNC under the name of *Act and rules* (BNC 2011) and quality assurance has started in some institutes (Oulton & Hickey 2009). More recently, a document with entry to practice competencies for nurse-midwives has been elaborated under the Canadian government-funded Human Resources for Health Project (BNC 2014).

In addition to government organisations, other professional bodies can be found, such as the Bangladesh Nurses' Association (BNA), Bangladesh Midwifery Society (BMS), the Bangladesh Diploma Nurses' Association (BDNA),[119] the Bangladesh Diploma Nurses Welfare Association (BDNWA), the Diploma Nurses Association (DNA) (DNS 2011) and the Masters Nurses' Forum (Sarma 1999). Nursing associations often act as labour unions even though not officially considered as such. Tensions between some of these associations have been highlighted as limiting factors in the advancement of the profession (Begum 1997; Sarma 1999; Robson 2005).

In summary, nursing leadership in Bangladesh faces significant challenges. Not only do nurses occupy a liminal position within the health system and its institutions, but they also suffer from internal tensions and what is locally known as 'politics'. In this sense, the political economy of nursing in Bangladesh is closely related to significant problems faced in nursing care delivery, especially in the Government hospitals. The following section will explore this further.

5.5. NURSING CARE PROVISION IN BANGLADESH: BEYOND A THEORY-PRACTICE GAP

The Bengali word for nurse is *shebika*, derived from the verb *sheba kora*[120], which can either mean 'to care', 'to nurse' or 'to serve'. When I asked one of my Bangladeshi friends from Barcelona about the notion of care, she told me that it could be expressed in different ways. The most common ones were '*dekha-shona kora'* (literally, to 'look and listen' and figuratively, 'to look after'), '*sheba kora'* or more recently, the Anglicism 'take care *kora'*. She also stated that the word '*shebika*' is rarely used, as the English term 'nurse' is preferred.

[119] They recently changed their name to Bangladesh Diploma Bekar Nurses Association (BDBNA), *bekar* meaning unemployed in Bengali.

[120] *Kor* is the verb root which is added to certain nouns to indicate action

It seems that the way in which nursing care is delivered in Bangladesh does not always fit with the notion of 'service', or at least not in the way in which it is rhetorically taught. Even though it is difficult to say where this contradiction started, the one thing that is clear is the significant influence of colonialism and post-colonialism. Nursing education in Bangladesh still follows a British-inherited curriculum with a strong emphasis on hands-on care (Hadley & Roques 2007). To explore this gap between rhetoric and practice, official documents and current research works are analysed in conjunction with my own observations during the fieldwork period.

5.5.1. Nursing rhetorics: Reminiscences and re-conceptualisations of the 'Nightingale' discourse

The definition of nursing by the Bangladesh Nursing Council (BNC 2011) may resemble contemporary Western definitions of nursing, which highlight holistic care and health promotion activities. Nursing is defined as encompassing "the promotion of health and prevention of illness across all health care, including the community". Nevertheless, on several occasions I witnessed a portrayal of nursing which reminded in many ways to the nineteenth century, colonial, 'Nightingale rhetoric'. The 'lady with the lamp' was constantly praised in academic and official activities.

The International Nurses' Day celebration was a clear example of the 'Nightingale' narrative. Speeches were made about her contributions in Crimea and in nursing education and her picture was usually in the background. Similar displays were described by Salvage (1985) in the UK, where the commemoration of nurses' day was more focused on tradition than on the reality of nurses' work. I had a similar impression in Bangladesh. A clear example of this narrative was a song written by a nurse-midwife from a philanthropic institution. Its chorus repeats *"shebai to amar dhormo; rugno manusher, shebai to amar khormo",* which could be translated as "serving people is my foremost devotion; serving ailing people is my ultimate duty". *Dhormo*, as previously explained, has a polysemic meaning which goes beyond religion and can also mean commitment or devotion. The songs continues by stating how close nurses are to the sick people and the ways in which people addresses them as either 'sisters' or even 'daughters'. It concludes that "serving

humanity is like serving God". Unfortunately, there is not enough space here to conduct a detailed linguistic and semiotic analysis of the whole song[121]. Nevertheless, its broad connotations of 'devotion', 'service' and religious duty are worth consideration. The song highlights the 'loving' attributes of nurses, especially as it shows how patients address them as 'ma'[122]. This is in sharp contrast to Somjee's (1991) analysis, which shows that the 'motherly' images of nurses do not usually make sense in the Indian context.

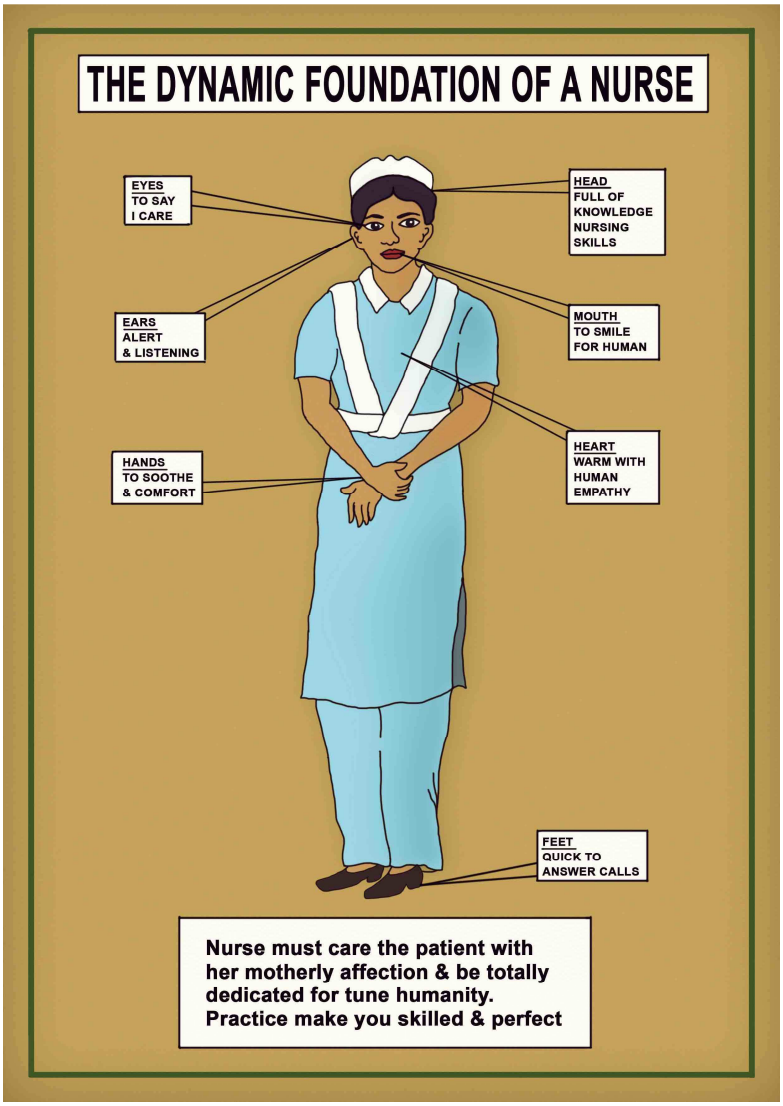
Another example of the 'caring nurse' image is the following picture,[123] used for the cover of this thesis:

[121] The full lyrics of the song can be found in Appendix M, as well as a small description of the polysemic terms.

[122] 'Ma' is the affectionate term for 'mother', even though it can also be used to warmly address daughters.

[123] The picture was handed to me by a nurse on one occasion. Permission has been obtained to use it in this work.

Figure 2. The dynamic foundation of a nurse



The comments of the picture deserve attention, as they clearly show a mixture of servility and 'knowledge and skills'. This relationship between service, knowledge and skills is key and appeared on occasions in the narratives of the nurses and is summarized throughout this work. For now, what is more interesting is the contrast between the 'Nightingale' images presented so far and definitions of nursing and descriptions of nurses' performance in Bangladesh (Begum 1998; Leppard 2000; Akhter et al. 2003; Afsana 2005; Uddin et al.

2006; Andaleeb et al. 2007; Hadley & Roques 2007; Hadley et al. 2007; Zaman 2009; Hassan et al. 2010).

5.5.2. Observational studies: Nurses' limited involvement in direct patient care

Bangladeshi nurses are often described as avoiding contact with their patients (Hadley & Roques 2007; Zaman 2009). A recent study (Hadley & Roques 2007) found that Bangladeshi nurses working in Government hospitals spent only 5.3% of their time beside their patients and allocate a great deal of time and energy to 'unproductive activities'. This is consistent with other observational studies and ethnographies[124]. Nevertheless, when asked about their functions, nurses emphasized the delivery of bedside care to patients (Begum 1993) and tend to 'recite' activities extracted from their curriculum (Hadley & Roques 2007).

Nurses generally allocate a considerable amount of time to paperwork and other non-nursing activities. This has been identified by Begum (1993), Rema (1999) and Khanam (1999) in the 1990s and continues to be a significant problem, especially in the Government sector. Nurses' excessive involvement in paperwork has been observed in other countries like the UK (Dingwall et al. 1988) and the US (Reverby 1987). Nevertheless, it poses a problem in Bangladesh because of lack of understanding of the contents of records (Zaman 2005; Hadley & Roques 2007). Keeping inventories and counting material is another responsibility usually placed on nurses, consuming time and creating pressure, as they are often held responsible if any item is missing (Zaman 2005; Leppard 2000; Hadley & Roques 2007).

Basic nursing activities, such as bed making or performing patients' hygiene are usually left to either young student nurses or to other workers like ayahs, ward boys or sweepers (Hadley & Roques 2007; Zaman 2005). In addition, as Government hospitals do not regularly provide bed linen, bed making is usually limited to keeping it neat and clean (Rema 1999; Zaman 2009). Patient positioning is often carried out by relatives (Rema

[124] A summary of the characteristics and results of the studies can be found in Appendix L

1999) and overall patient monitoring and supervision seems to be the responsibility of their attendants, at least in Government hospitals (Hadley & Roques 2007, p.1156). Health education is generally provided in the form of specific instructions or orders to patients' attendants in order to take care of the patient (Karmakar 1993; Rema 1999; Akter 1999). Oulton and Hickey (2009) observed that due to the nursing shortage and the overwhelming number of doctors, the latter often performed activities which could be done by nurses. According to the authors, this was "partly as a job preservation strategy and partly because they do not believe nurses are capable" (2009, p.12). Nevertheless, when the ward is busy, 'doctor' tasks like dressings are delegated to nurses, assistant nurses, ayahs (Leppard 2000) and ward boys (Zaman 2005). With respect to the administration of medicine, Rema (1999) found that the nurses' performance was better than in other areas, albeit still limited. According to Zaman (2005, p. 143), nurses proudly manage intravenous lines because "at least this is a task that the relatives are not able to perform". In the case of oral medication, nurses would handle the medicines for patients (Karmakar 1993) and instruct them and their relatives about the appropriate doses, occasionally asking ask if they had taken them (Zaman 2005; 2009). In most Government hospitals, patients have to purchase the medicines themselves (Ahmed et al. 2015; Perry 2000; Nilsson et al. 2005). Similar restrictions also apply to the provision of food (Zaman 2005).

The situation described above is different in non-Government institutions, where patients' expectations are generally greater. Generally, private health care provision is better resourced and makes greater efforts to promote higher nursing standards (Andaleeb et al. 2007). Furthermore, non-Government institutions enjoy higher levels of freedom to implement innovative approaches (Hadley & Roques 2007; DNS 2011). Private hospitals also tend to place more restrictions on visiting hours, which stops relatives from getting involved in patients' care (Hadley & Roques 2007).

Overall, the available research shows persistent inconsistencies between what nurses say they do and what they are observed doing. These descriptions, even though based on empirical observations, need to be contextualised and critically analysed. First, the avoidance of 'basic' nursing activities is not exclusive to Bangladeshi nurses (Stein 1969;

Salvage 1985). Second, nurses' involvement in patient care varies greatly according to the institution where they work, and is greater in private or NGO institutions (Hadley & Roques 2007). Finally, the reason for the apparent reluctance of nurses to engage with patients is due to various structural, institutional and social reasons, which have to be carefully explored. Amongst them, institutional discrimination and the low social status of nursing activities have been highlighted.

5.5.3. Institutional discrimination: Hierarchies and a longstanding neglect

The working conditions of nurses in Bangladesh are far from good, especially in big Government hospitals. Nursing shortages, lack of equipment, overcrowded wards and institutional neglect account for nurses' potential 'burnout'. The latest available nurse-bed ratio was 1:13[125] for the morning shift (HPNSDP 2011). The rate is much higher in Government than in private hospitals, and significantly increases during the evening and night shifts (Zaman 2005). According to the DNS (2002), in most Government hospitals, it is usual to find one or two nurses handling 60 to 80 patients.

The already-meagre number of nurses is further diminished through overseas migration of fully educated nurses, mainly to the Middle East, Italy, Libya and the UK (Directorate of Nursing Services 2011). Some authors have compared the situation in India and Bangladesh to that of the Philippines, a paradigmatic examples of the risks of an 'export-based' approach in nursing (Nair 2007; Berland 2014). The risks of 'brain drain' and exacerbation of the nursing shortage are obvious. Nevertheless, the DNS maintains that nursing migration does not hamper the delivery of nursing care. This is because the number of migrant nurses is low nowadays[126] and they tend to move for a limited amount of time.

Undoubtedly, the severe shortage of nurses greatly contributes to poor patient care in Bangladesh. Nevertheless, Hadley et al (2007, p.1167) concluded that "conflicts

[125] This ratio would not look that bad, if it was not because in many hospitals, the bed occupancy rate is underestimated due to patients being based on the floors and corridors (Directorate of Nursing Services 2002).

[126] According to the DNS (2011), in 2011 the total number of nurse-midwives migrating from public sectors was only 200-250.

experienced by nurses are not due to an overtaxing workload, as elsewhere". Rema's (1999) study also showed that some nurses admitted that if they wished to perform a task, they were able to do so. This does not mean, however, that nurses systematically escape from their duties. There are other factors, which need to be taken into consideration, such as the poor health system infrastructure, nurses' vulnerability to other staff members and unknown patients, especially males, and a severe lack of resources and infrastructure to provide minimum standards of care.

Nurses do not generally feel sufficiently valued by the institutions where they work. Poor salaries, lack of educational facilities for their families and accommodation problems have been raised as important challenges for nurses (Uddin et al. 2006). Also, nurses' salaries are much lower than those of other professionals with the same level of education (Leppard 2000; Zaman 2009). Taking into account the fact that salary plays an important role in terms of social value (Akhter et al. 2003), the low salaries of nurses affect both their economic and social capital. Accommodation can become a significant issue for young, unmarried women (Leppard 2000) and personal safety is also a source of concern, especially at night (Oulton & Hickey 2009; Hassan et al. 2010; DNS 2011). This is one reason why evening and night duty are disliked by nurses (Begum 1993; Uddin et al. 2006). Apart from safety issues and the socially negative connotation, evening and night shifts clearly affect nurses' family and personal life (Begum 1998; Hadley et al. 2007).

The nurses' liminal position in the hospital hierarchy and their situation as women makes them subject to misbehaviour from both their co-workers and patients and relatives (Directorate of Nursing Services 2011). Nurses have been historically undermined by doctors at a structural or broader political level[127], and 'locally' in the hospital wards (Leppard 2000; Zaman 2005). A further aspect in the doctor-nurse relationship in Bangladesh is the contention around the 'romantic' relationships between nurses and

[127] The greatest example of this structural subordination is the lower position that the DNS occupies in the Ministry of Health compared to its medical counterpart (Directorate of Nursing Services 1994a). Nevertheless, nurses' subordination happens in middle-level institutional bodies, like hospital medical boards, colleges, universities and so on.

doctors (Zaman 2005; Hadley et al. 2007). This latter aspect can significantly affect the way in which both groups interact within the hospital.

Seniority-based promotion, a common practice, is a further challenge. Still claimed by one sector of nurses (Begum 1993), it is also seen as problematic (Oulton & Hickey 2009; Directorate of Nursing Services 2011). This can create leadership problems when nurses are placed in positions of authority without having the necessary abilities. Deficient leadership has also been pointed out as one of the causes of nurses' job dissatisfaction (Latif 2010), poor performance (Rema 1999; DNS 2011) and poor bargaining influence within the health system (Oulton & Hickey 2009).

Overall, poor working conditions greatly affect nurses' motivation and job satisfaction. Several studies, which were carried out in government hospitals, showed that the latter varied depending on the size of the hospital (Uddin et al. 2006; Hassan et al. 2010; Latif 2010). Interestingly, earlier studies conducted by nurses showed, that despite the several challenges they had to face, nurses were overall satisfied (Begum 1993; Karmakar 1993; Rema 1999). Even though the available information is not enough to conclude that there has been a decrease in levels of satisfaction, there seems to be a rhetoric amongst the nurses which point to the 'good old days' when hospitals were less crowded and nurses more involved in hands-on care.

5.5.4. Nurses' social status: A critical look at the role of female seclusion norms and the notion of ritual pollution

In an article about gender and health in Bangladesh, Gonsalves (1999), a nurse, reflected on how women's low status and its association with domestic duties influenced the nursing profession:

> "Nurses in the hospitals perform tasks similar to the role of women in the home: caring for the sick and housekeeping duties (...). The members of the nursing profession also internalize this concept since they are part of society and they are socialized into thinking as people in general think" (1999, p.127-128)

Nurses' interaction with what nurses termed 'the public[128]' is somehow a reflection of their position in society (Leppard 2000). The association of nurses' social status with that of the people to whom they take care of has been a longstanding issue in the profession (Benner & Wrubel 1989). In the Indian subcontinent, 'status anxiety' of nurses has been a historical and longstanding issue (Nair & Healey 2009; Nair 2011), and the same could be said about Bangladesh (Alam 1975; Directorate of Nursing Services 1994a; Hadley & Roques 2007). Several factors have been highlighted to account for the nurses' poor social status, such as sociocultural factors, low status of women[129], low pay and lack of employment opportunities, poor performance of nurses, domination by other professionals, and internal group tendencies (DNS 1994a).

Amongst the sociocultural factors influencing their social status, a group of nurses interviewed in the 1990s felt that there was a lack of general knowledge about the nursing profession, which was explained partly by people's 'illiteracy and superstition' (Begum 1993). Nurses also stated that there were also religious barriers and a general disregard for night duty. Finally, poor nursing care was also mentioned as influencing the nurses' low status, even though only by a small percentage of nurses. More recently, nurses still pointed towards night duty, contact with strangers (especially males), and the performance of low-status tasks (Hadley & Roques 2007).

The attribution of nursing profession's low status to local gender norms and to the Brahmanic notion of ritual pollution should be critically analysed. Historically, both aspects have been used to account for the reluctance of women from the 'mainstream society' to become a nurse. The influence of India's colonial past on the status differences between doctors and nurses should be underlined. The administration clearly targeted Brahmins and

[128] Both Leppard (2000) Zaman (2009) found, in their hospital ethnographies, that the nurses used the English word to refer to patients and their relatives. In Bengali, the use of this English usually expresses the idea of an "undisciplined crowd" (Zaman 2009, p.369).

[129] At the time of the study, 87.33% of nurses in Bangladesh were female. Later, Sarma (1999) stated that nurses comprised of about 95% of the nursing workforce.

other advantaged castes when it came to male medical education and public posts (Kumar 1998). Their higher position in the social hierarchy and their acquisition of British education somehow saved them from the potential 'pollution' attached to their work (Somjee 1991). The situation was different for Indian nurses, as they were mainly recruited from "a stigmatised and socially marginalised section of the population" (Robson 2005, p.30).

Similar to the reformists England, nursing leadership in late colonial India worked hard to raise its status by attracting 'suitable girls' (Wilkinson 1958) or 'a better class' of candidates (Healey 2007). Without questioning the idea of nursing work as a 'polluting' activity, reformists and missionaries alike called upon the notions of service, self-sacrifice and devotion to motivate young women to perform low-status tasks. Littlewood (1991) argued that, in the UK, the portrayal of nurses as 'angels' somehow saved them from being considered 'dirty' themselves. Unconditional love[130] could, therefore, break the barriers of ritual contamination. This became one of the pillars of the 'Nightingale' rhetoric and the reformists' efforts to 'dignify' the profession. Even though the strategy proved to be effective for the UK middle- and upper-class 'ladies', it did not seem to work as well in colonial India.

Female seclusion was also used to explain women's reluctance to work in the hospitals, often without considering their dreadful working conditions. Again, a closer look at the colonial legacy in nursing is useful to critically question this rhetoric. Imperialist ideology and institutions reproduced and reinforced female seclusion, especially amongst the elites (Lal 1994; Burton 1996; Forbes 2006). In this way, they contributed to the gender and class discrimination of Dalit nurses in India. The 'dignifying' of their work should not come from their own agency or from measures to improve their social and economic capital.

[130] Dunlop (1986, cited in Littlewood 1991, p.177) pointed out the breaking of these polluting barriers as an act of love, as in the case of taking care of relatives or friends: "sharing dirt depends on knowledge and friendship with a person. The more intimate one is the greater the sharing. To share or care for another's pollution is a restatement of humility and love". Even though this idea is significantly present in the ideal of Christian charity, it is not exclusive to it.

Instead, their individual status would be upgraded through the entry of 'ladies' in the profession.

Returning to contemporary Bangladesh, the fear of ritual pollution has also been presented as one of the factors influencing nurses' avoidance of direct patient care (Hadley et al. 2007). According to that logic, one would expect nurses to perform hand washing as a way of avoiding pollution. Nevertheless, the majority of the observational studies showed it was not usually performed (Karmakar 1993; Rema 1999; Hadley & Roques 2007). In addition, Leppard (2000, p.19) observed when hand washing was conducted in the hospital canteen, it followed "the world view that separates clean and unclean (…), where the left hand is used for 'dirty' functions (…) and the right hand reserved for 'clean' functions".

Most nurses interviewed by Leppard (2000) believed that it was the visitors and attendants who brought it from outside the hospital. This is interesting because it takes us back to the idea of the hospital as a place where hygiene and social discipline norms are merged. In some cases, the notion of contamination seems to be more related to a lack of social order than to the scientific principles of infection control. This is consistent with the analysis made by Mary Douglas (1966) in relation to Western ideals of purity and danger, and the hygienist theories of nineteenth century Europe. Again, Nightingale's and the nurse reformists' ideological legacy should be highlighted, as it resulted in the creation of "a unified nursing structure dedicated to 'cleansing' patients and their environment, both physically and morally" (Bellaby & Oribabor 1980, p.163).

The available resources and knowledge of infection control measures should be considered. Khatun (1999) showed that even though the nurses were fully aware of how to prevent nosocomial infections, they would not be able to fully follow the recommendations. Surgical gloves are not readily available in Government institutions (Hadley & Roques 2007) and even soap and sinks are often difficult to find. Khatun's (1999) study showed that there were no sharp bins in the hospital, albeit most nurses referred to using them. Leppard (2000) observed a lack of awareness of the potential dangers of blood-borne

diseases amongst the health team, which was consistent with a recent study on HIV/AIDS awareness amongst young people in Bangladesh (Azim et al. 2009).

Robson (2005) argued that the reasons for nurses' avoidance of basic care activities went far beyond those related to ritual pollution. She observed that "female nurses, in particular, feel their gender leaves them physically unprotected when engaged in close contact with patients and their relatives" (2005, p.121). Finally, the author highlighted the particular situation of Bangladesh in terms of its 'overproduction' of doctors, which clearly affected the development potential for nurses in the clinical and community areas.

In summary, the practices of nurses in relation to their intimate contact with patients, and especially, to the management of bodily fluids, embody a complex interaction of several factors. Amongst them, scientific ideals of infection; the legacy of hygienist ideologies related to social control; religious conceptualisations of ritual pollution and their relation to gender and class hierarchies can be highlighted. In addition, the available resources and the physical environment in which care practices take place should be considered as well. Regardless of its causes, what is clear is that having intimate contact with patients can be challenging for nurses in many regards. Nevertheless, to what extent this leads to an avoidance of patient care must be carefully analysed.

5.5.5. 'Care avoidance' as cause and consequence of nurses' low social and institutional status

Hadley and Roques (2007), concluded that nurses felt constrained between their nursing care duty and social norms, according to which their family's reputation and their own social status were linked to their activities. Delegating 'polluting' or 'low status' activities to surrogates was, therefore, a strategy to avoid this contradiction. Furthermore, relatives began getting more involved in patients' care in Government hospitals during the 1980s, partly as a consequence of rapid and often unplanned hospital expansion (Hadley & Roques 2007). In Bangladesh, unlike neighbouring countries like India, there is no provision of auxiliary nurses in the Government sector. As a result, the role of auxiliary nurses is often undertaken by the so-called 'special ayahs' (Afsana 2005). They are termed 'special'

because the institution does not formally employ them.

The image of nurses avoiding their duty and being detached from patients does not aid their social recognition. Institutional and social neglect affects the practical working conditions of the nurses and leads to a vicious circle. Nurses' low job satisfaction negatively influences performance which, in turn, generates a bad social image. Patients have generally been reported to be dissatisfied with nurses' performance, especially in the rural areas of the country (Rahman et al. 2002; Andaleeb et al. 2007). Khatun (1998) highlighted the role of nurses as agents of change, who have the duty of engaging the prestige of the profession through their practice. Nevertheless, without denying nurses' capacity to enhance their social image, their scope is limited. Therefore, it would be easy narrow to blame them for their low social status.

5.5.6. A final remark on nursing education: Beyond an inherent theory-practice gap

The difficulties associated with the transfer of theoretical knowledge to clinical settings have been widely discussed elsewhere (Ajani & Moez 2011; Corlett et al. 2003; Chan et al. 2012). McCaugherty (1991) argued that the theory-practice gap would always exist in nursing because it was inherent to the characteristics of the profession. Haigh (2009) concluded that the gap was not necessarily a negative feature. In the case of Bangladesh, however, the distance between nurse education and practice is so wide that it becomes detrimental to the profession, in many ways.

To the 'natural' gap between nursing education and practice, the colonial history of the country has to be added. Even though the current curriculum is supposed to be more aligned with the background of the country, it is not always correctly implemented (Robson 2005; Hadley & Roques 2007). In contrast to holistically-oriented nursing care of the curriculum, the Bangladeshi Health System is still highly hospital-centred and nursing work is very much task-oriented (Youssef et al. 1997; Hadley & Roques 2007). English is used as a medium of instruction in educational institutions and hospitals, regardless of teachers' and students' poor language proficiency (Leppard 2000; Robson 2005; Hadley & Roques 2007). This has been identified as one of the main reasons for poor curriculum

implementation (Aminuzzaman 2007). Attempts were made to introduce Bengali as a medium of instruction, but were strongly opposed by senior nurses (Robson 2005). Most students have been schooled in Bengali (Robson 2005), and lack basic science skills and the capacity for critical thinking (Berland 2014). Students, and frequently teachers, often end up memorising texts from books or class notes.

The rapid growth of nursing institutes in the 1980s and 1990s created a disproportionately high teacher-student ratio (DNS 1995). The situation is not much better today, especially in big urban institutions (Aminuzzaman 2007). There has been an improvement in the number of teachers, and their educational background, but their working conditions are far from ideal. The schools' facilities and equipment are limited and there is a limited number of permanent staff (HPNSDP 2011). These problems also affect the clinical supervision of students (DNS 1995). Also, classroom teaching is generally considered more prestigious than bedside teaching (R. Khatun 1999). Moreover, even though teachers are motivated to conduct practical demonstrations in the ward, they are not always well received by the staff nurses (Robson 2005). A solution, even though partial, to the difficulties in clinical teaching on the wards has been the setting up of demonstration laboratories (DNS 2011). Nevertheless, the latest available report stated that, even in the biggest Government institution, the labs were "in pitiable shape" (HPNSDP 2011, p.5).

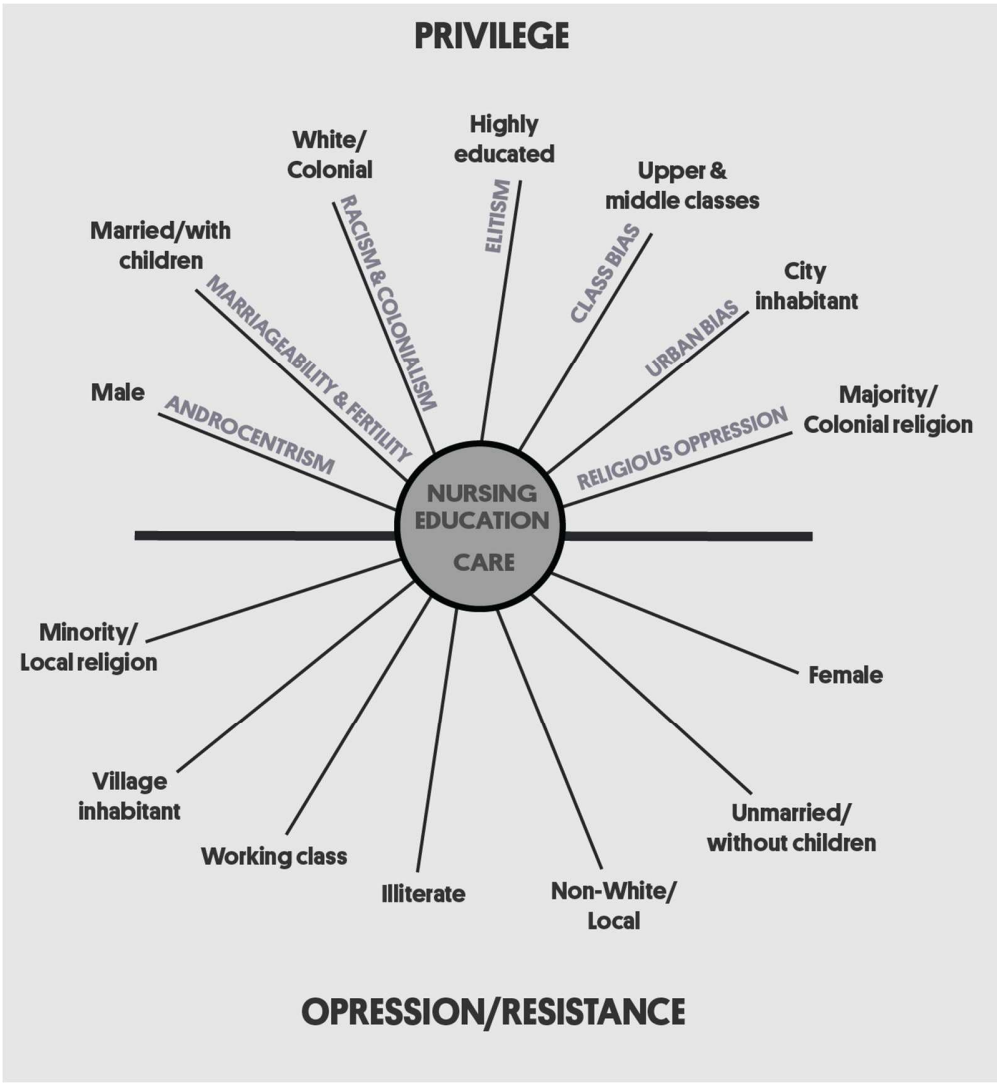
Karmakar (1993) found that the nurses themselves were aware of the dissociation between theory and practice. Later, Leppard (2000, p.166) observed that while nurses praised the theory-practice integration during their training, "what was learned in training was always expressed in terms of what was known (*jana*) rather than in terms of skills or competence". Finally, students have traditionally been used as a means of obtaining cheap labour. Initially, long duty hours at the hospital left very little time for students to study and rest (Alam 1975, p.146). This is shown through the narratives of the nurses in Chapter Seven. The 1990s curriculum reform was an important step, as students were meant to have a more gradual involvement in clinical activities. These changes, however, are not always well received by senior nurses (Leppard 2000).

5.6. CONCLUDING REMARKS: OVERCOMING THE APPARENT CONTRADICTION

In many ways, it seems that the distance between the 'Nightingale', British-inherited model of care and nurses' working conditions seems to be widening. The theory-practice gap in Bangladesh is related to structural factors, which affect not only nursing education and service, but also nurses' daily lives. Overcoming this gap would need broader changes, which are beyond the scope of nursing leaders, and rather have their roots in national and global socioeconomic inequalities. A good way of summarising these inequalities is through analysis of the ways in which domination and resistance, like privilege and oppression, usually happen at the same time. An adaptation of Morgan's (1996) wheel has been developed to account for the main privileges/oppressions that intersect in nurses' lives.

The idea is not to analyse each category separately but to look at their ideological basis and the ways they are articulated in nurses' lives. The fact that some elements have been removed from the original wheel does not mean that they are not significant. Ideologies like ableism, heterosexism, colourism or language bias surely play a significant role in the daily experiences of many Bangladeshi women. Nevertheless, they were not central in the nurses' narratives.

Figure 3. Adaptation of the privilege-oppression wheel to this research



Source: Adapted from Morgan (1996, p.107)

Caste and social class have been situated together. The reason for this is that the nurses did not separately identify them. Only two nurses in this research, one Muslim and one Hindu, pointed to their family names or caste. Also, as already discussed, caste in Bangladesh operates in more implicit ways and is closely associated with religion, kinship and wealth. The urban-rural inequalities are significant and somewhat related to wealth and class, as there is a concentration of economic and cultural resources in the cities. Nevertheless, they

have been situated separately because they also point towards an identity question: rural people are often stereotyped as less knowledgeable and 'cultured' than urban people.

Racism and colonialism have also been jointly situated. The reason for this is their role in the lives of the nurses emerged in an indirect form through the history and institutions of the country. Racist ideologies and practices played a significant role in Bangladesh during the colony and greatly shaped the country's medical and educational institutions. Religion is another aspect in which colonialism and post-colonialism have had a significant impact. For instance, if we look at the broad Bangladeshi society, we will see that Muslims are the majority group in terms of religion. Nevertheless, within nursing, Christian and Hindu nurses are found in greater numbers. This aspect is a 'tricky' one because even though Islam is the majority religion, Christianity was the religion of the Empire and clearly influenced its modern institutions.

Historically, the British colony played an ambivalent role regarding religion. On the one hand, the administration favoured the Brahmins and other wealthy Hindus over Muslims and Dalits. On the other hand, the missionaries and some other philanthropic organisations focused on the provision of education (even though generally at a lower standard) of disadvantaged Hindus and Christian converts. This makes it difficult to see religion as a dichotomic (privilege/oppression) factor. Furthermore, religion has had a significant impact in the ideological discourses of the nursing profession around the notion of care.

Closely related to androcentrism, a separated axis has been drawn to account for the role of marriage in Bangladesh. Marriage occupies a middle position between androcentrism and pro-natalism. Many women from Bangladesh experience significant social pressures to get married and, probably to a lesser extent, to have children. Marriage has also played a significant role in the history of nursing profession and particularly, in the lives of Indian and Bangladeshi nurses. The fact that nursing or midwifery activities were often for widows or unmarried women has been given as one reason for 'mainstream' women's reluctance to become nurses. Also, marriage has traditionally been discouraged amongst nursing students.

Finally, nursing education and care are located in the middle of the wheel. As shown in the following chapters, nursing has played an ambivalent role in the lives of the nurses. This chapter has shown how, at a structural level, nursing has traditionally been allocated a low status in Bangladesh. Nevertheless, the ethnographic data discussed in Chapters Six to Eight pose a significant challenge to the notion of nursing as low-status, at least in the lives of the nurses.

PART III: BIOGRAPHICAL ANALYSIS

In this section, the life stories of the seven key informants are analysed from a dialogical perspective. Before doing so, the nurses are briefly introduced from the present, providing only key aspects of their biographies. Following Hertz-Lazarowitz (2005), a key statement from each nurse has been selected to illustrate their identities. Further information about all informants is shown in Appendix N.1, and a more detailed grid with the key informants is available in Appendix N.2.

SUMITA, 39 years old[131], Christian, married, one child.
Key statement: "Nursing was my last and least option to stand on my own two feet"
Sumita is currently working as teacher in a non-Government nursing institute. She was orphaned as a child and spent some time in missionary boarding schools outside Dhaka. Thanks to this, she had an English Medium education. She was led into nursing by her aunt, also a nurse, who recommended studying in a Hindu philanthropic institution. Her academic performance has always been outstanding, although she has not enjoyed the same opportunities as the nurses who studied in Government institutes.
She spent some time working overseas, in Saudi Arabia and the UK. Upon her return to Bangladesh, she joined a small philanthropic nursing school and has been working as a teacher since then. She stressed on several occasions that she has worked hard to reach her current position. Being responsible is very important for her.

RABEYA, 47 years old, Muslim, married, children
Key statement: "Ultimately liked nursing, and once I loved it"
Rabeya is currently working as a teacher in a non-Government nursing institute. She spent her childhood shifting between district capitals due to her father's job as a railway officer. She defined him as liberal and highlighted his commitment towards her mother's and sisters' education. Her becoming a nurse was somewhat circumstantial. She had not obtained good marks in her Secondary School Certificate (SSC) examinations and her father was disappointed. When her brother submitted her application to study nursing in a Government institute, she agreed without really knowing what nursing was about. She struggled at first, but ended up enjoying her profession.
On several occasions she had to confront her husband, who did not want her to work as a nurse. When her children were little, she worked in teaching and social work on an ad-hoc basis until she resumed her career. She did some management work in nursing as matron and supervisor, and at some point she decided to move to the education sector. Today, her husband does not try to stop her working anymore, and her sons support her in her profession. Nevertheless, she often struggles to manage work and family life. She is very

[131] Age in 2012, when the interviews took place

proud of her achievements, especially in the academic area, as she sometimes feels that her family did not think that she would go such a long way.

AGNES, 65 years old, Christian, nun
Key statement: "I was a teacher but I had obedience vow, I had to accept it [becoming a nurse]"
After her retirement from clinical work, she helped found a nursing institute in the philanthropic institute where she currently works. Her mother died when she was a child and her father lived in India, so she spent her childhood with her extended family. She joined a religious order when she was in her teens against the will of her father and brothers. At first she was confused and did not know that they had been trying to contact her, so she remained in the order. Agnes worked as a teacher for some time until the mother superior asked her to become a nurse. She was surprised and again confused, because she did not want to quit her job as a teacher. Nevertheless, she accepted her vow of obedience and joined a Government nursing institute. She ended up enjoying her work as a nurse and she saw it as a way of teaching others.
She has always combined her nursing activities with her religious and social work commitments in the community. She has felt valued and recognized by the doctors and other colleagues. She believes that Christian values are very important in nursing.

FARHANA, 55 years old, Muslim, married, one child
Key statement: "I managed the ward"
Farhana is currently working as a teacher in a non-Government nursing institute. She was born in Dhaka, where she spent most of her childhood, except from the Liberation War period. During her childhood, she was very sick and spent months at the hospital. She decided to join the nursing institute of the Government hospital where she had been admitted. Her father was a schoolteacher and always insisted she should study further. Her mother was also educated, and she did not want her to become a nurse. She had to go sit for the admission exams secretly. Nevertheless, when her father died, her mother agreed that it would be good for her to finish her Diploma and work as a nurse. She was involved in nursing 'politics' during her student life.
After completing her BSc in nursing, she began working as a nurse instructor in the government sector straight away. She was then awarded a scholarship for higher education in the UK, where she returned after some time and worked as an aid nurse. She had worked as a nurse in Saudi Arabia as well. Upon her return to Bangladesh, she quit her Government post and moved to the private sector, where she worked in supervisory posts at first.
She believes that nursing care delivery has deteriorated from the time when she was a student. She highlighted on several occasions that they learnt by doing and that she acquired a high level of responsibility from the beginning.

TULI, 63 years old, Christian, unmarried
Key statement: "If we pay attention to everyone who is suffering, God will be with us"
Tuli spent most of her life working in the Government sector, first as a Staff Nurse, and later as a teacher. After retiring from public service, she joined a non-government hospital, where she is involved in nursing management and educational activities. She was born in a small village in a 'remote area' and was orphaned at a young age. Her mother struggled

financially and started working when her father died. She spent part of her childhood in missionary boarding schools, thanks to her mother's work at the church. During her teenage, she decided to become a nun as an act of gratefulness towards God and the religious people who had helped her. She worked as a teacher and social worker but after some time, she left the order and decided to join a Government nursing institute.
At first she found it difficult to study with younger women, but gradually adjusted to the life in the institute. She performed very well and was soon posted as a teacher. Later, she was also awarded a scholarship to study in the UK. Upon her return, she resumed her work as a nursing teacher. She collaborated with the nursing bodies in nursing education planning.
From the beginning, she dedicated her time to the suffering and she easily empathised with people from disadvantaged backgrounds. She has a strong sense of vocation and sees nursing and teaching as her mission in life. She has acted as a role model and resource person for many people and has led other young women to join the nursing profession.

TERESA, 44 years, Christian, married, children
Key statement: "Working without limitations"
Teresa is currently living abroad. When I met her, she was working as a teacher in a non-Government institute. She was born to a big family and was looked after by them, as her father migrated to the Middle East when she was a teenager. During her secondary education, she moved to a district capital and stayed in the convent near a missionary hospital where her aunts were working. One was a doctor and the other a nurse. Her family wanted her to be a doctor but she decided instead to become a nun. At first, her doctor aunt opposed, but eventually another aunt found a 'suitable' philanthropic nursing institute for her to study. One of the biggest fears of her family was that she would marry a Muslim man and abandon her Christian community.
She was enthusiastic about nursing from the beginning and soon began to stand out in her class. After completing her diploma, she moved to Dhaka in search for a job as a Staff Nurse. Nevertheless, she soon moved to an NGO-run community project. She was asked to join the project during a visit to a relative who was very close friends with the NGO director.
She returned to Dhaka to study for her BSc in nursing and, after graduating, joined one of the women's health institutes where she had done her placements. Thanks to an international breastfeeding programme, she managed to travel overseas on more than one occasion. At some point she moved to the education sector and worked as a nursing teacher for some years until she finally migrated overseas with her family.
She highlighted on several occasions that she enjoyed it when she was able to work freely, 'without limitations'. In certain moments, she struggled because she was not always able to share her knowledge and experience with her colleagues.

AMENA, 55 years old, Muslim, married
Key statement "When I am caring for patients I feel a different sort of power"
Amena has been working as a nursing teacher in the government sector for a long time and also as a consultant for a multilateral organisation. She has been involved in nursing planning at a decision-making level and has a broad perspective about the situation of nursing. She spent her childhood between two capital cities, following her father's destinations as a railway officer. Her mother was also highly-educated because she spent

part of her childhood in a boarding school. Amena stressed her father's liberal views on religion and women's status. Her becoming a nurse was circumstantial. She had not obtained very good results in her secondary examinations because she had been sick. Her father was disappointed and she did not know what to study. She went to her uncle's home to look after him because he was sick and they needed some support. A relative told her about nursing. She decided to join a Government institute.
She was awarded a scholarship to study in the UK. Upon her return, she worked in the clinical area for some time and later, she was posted as a nursing teacher. She remembers how from the beginning, she was very dedicated and she performed well. She was also very nonconformist and got involved in student politics from the beginning. Her views about nursing show a deep analysis of its political economy. She studied sociology and her husband was involved in Marxist politics. Furthermore, her father's views about gender equality may have influenced her as well. She managed to merge her vindications for social justice with an outstanding performance in the practical field. According to her, she was strong in fighting for the nurses' rights, but looking after the sick patients also gave her 'a different sort of power'.

When one looks at the life stories of the key informants as a whole, important similarities between some emerge. A number arise from the way in which they were selected for this research and these are discussed in the methodology chapter (i.e. they are all women, are mainly Christian, and all are nursing teachers). There are other biographic similarities, however, which should be considered. The main common feature is that all have been professionally successful. Out of seven nurses, six have travelled abroad on several occasions, for work-related purposes, and all are involved in nursing education, which in Bangladesh is considered much more prestigious than doing clinical work.

Personal and professional development has not been easy and they have faced important challenges from different sources: their families; their colleagues; the nursing and medical institutions; amongst others. Their life stories exude self-determination and a strong sense of purpose. There are significant differences in their socioeconomic and family backgrounds, personalities and life events, which make their comparisons interesting. How can women from such different backgrounds reach similar and, indeed, successful working positions in a country with marked socioeconomic inequalities? A closer look at their life events is necessary to answer this question.

6. JOINING NURSING: BETWEEN CIRCUMSTANCES AND 'VOCATION'

"I got one Principal from America so, you see, my life discipline and practice was in an accurate way. That's why today I am like this (…). I am working ANY, ANY, anywhere, I have no problem. But what I made the foundation in my life, that is guiding me (…). I understand that (…) our basic learning in life it is very important" (Tuli, 02/12/2012)

6.1. INTRODUCTION

Tuli's acknowledged role of foreign missionaries in her early education is significant because it is not exclusive to her. Other Christian nurses pointed to their experiences in mission schools as giving them a strong 'foundation' for their future education. In the case of the Muslim nurses, their emphasis was placed on the role their parents played in encouraging them to study. This chapter analyses the ways in which the seven protagonists entered the nursing field. First, a brief contextualisation of their childhood and teenage years is presented. Following Bourdieu's approach, the focus of this first part is placed on the nurses' social, economic and cultural capital. Having done this, a dialogical account of the factors that influenced their decision to become a nurse is presented. The broader image of nursing, their own preconceptions and other circumstantial events has been taken into consideration, and the role of their relatives and other influential people.

6.2. CHILDHOOD AND TEENAGE: THE ROLE OF THEIR FAMILY AND EARY LIFE EVENTS

The role of early life events in their future experiences is undeniable and has to be considered in perspective when analysing biographies. It becomes even more important in a society where the family background is so crucial. Furthermore, in South Asia, nurses' socioeconomic position and family origins have historically been raised as one of the main factors influencing the status of the nursing profession.

Significant similarities can be found between the nurses in this research. Four could not stay with their father's all the time during most of their childhood. Amongst the remaining three nurses who grew up with them, one lost her father when she was a teenager. This could have been a contributory factor for some in joining nursing, although they were far from the often-stereotyped image of 'destitute orphans'. Another crucial aspect, which is shared by all, is their education, as they all attended good schools. Religion wise, Sumita, Teresa, Agnes and Tuli come from Christian families. The latter two nurses joined religious orders during their teenage years, even though Tuli left after some time. Farhana, Rabeya and Amena are Muslims and interestingly, all described their fathers as 'open-minded'.

6.2.1. Early life experiences: Missing parents, extended families and liberal fathers

Probably the most significant commonality amongst the nurses is that, in most cases, one of their parents was missing during their childhood or teenage years. Four nurses became orphans before finishing their nursing education. Sumita and Agnes lost their mothers and Tuli lost her father, all at an early age. Farhana's father died when she was already studying nursing. Tuli and Sumita spent some time in boarding mission schools and Agnes stayed with her extended family. Teresa's father worked abroad for most of her teenage years and she was taken under the wing of a big family. Rabeya was the only nurse who followed her father's work-related destinations.

6.2.1.1. Boarding schools and 'orphanages': Discipline and independence

Sumita and Tuli had to spend some time in boarding schools from an early age, which Sumita termed 'hostel' and Tuli 'orphanage'. In Bangladesh, it is not unusual to see institutionalised children whose parents are still alive[132]. Children are generally considered orphans when they have lost their father, that is, the economic provider of the family

[132] A study conducted in the 1990s showed that more than 85% of children in orphanages had mothers who were still alive (Haque 1991, cited in Blanchet 1996, p.240). The institutionalisation of children goes back to Colonial times when missionaries and philanthropic organizations began setting up hospitals, schools and orphanages in remote and poverty-stricken areas of the subcontinent (Khair & Khan 2004; Haider 2011).

(Blanchet 1996). When this happens, children are usually taken care of by their extended family (Blanchet 1996; Islam 2013), as happened in Agnes' case. If this is not possible, they may be sent to wealthier houses as servants (Blanchet 1996). Only in some cases are children admitted to orphanages.

Sumita was born in a town outside the capital. Her father worked in a cotton mill and her mother died from an infectious disease when she was only three months old, leaving two children behind. She made it clear that her family was not 'poor' and that it was only because of the tragic incident of her mother's death that she struggled:

"My family, they are not poor, but because of my mother, no? That's why I was in that condition. Otherwise OK, middle class" (Sumita, 11/03/2012)

Sumita's father remarried and her stepmother began to mistreat her and her brother. From then on, her grandmother became, in Blanchet's (1996) terms, her 'mother substitute'. In spite of being generally good to children, the author observed that grandmothers were often "too poor and too dependent on their own sons to take the responsibility alone" (1996, p.239). This was exactly what happened in the case of Sumita. At some point, her grandmother could not take care of them and she was sent to boarding school. She managed to get admitted thanks to her grandmother's negotiations[133] and to the financial support of two Christian organisations.

Tuli's father, who was a farmer, also died when she was young and her mother was left with six children. She had to start working in churches and missions, making an effort to educate her children and settle them down. Tuli also spent some time in a missionary school where her mother was working. Sumita and Tuli share similar memories of their early childhood, when they were compelled to work and study hard, being very careful about their expenditure:

[133] Haque (1991, cited in Blanchet 1996, p.240) observed in his study that in order to get 'orphans' admitted, the institutions usually required patronage and in some cases, bribes. Sumita did not mention any bribe being involved, even though her grandmother's intervention must have been crucial.

> "We need to work for two and a half hours every day as students, and Friday half day. So during the weekdays, after finishing the class then we need to go for work, no? I worked in the garden. And what I did, you know? Always I wrote my study in a piece of paper and I went with that piece of paper (…). I worked and at the same time I studied ((We laugh))" (Sumita, 18/03/2012)

> "How I can give my school fees? I started to work in school, like washing and everything else; taking water from the pond and bringing it to the house (…), the latrine and washing the school rooms, stairs and school field (…). Mean the time when I have some [time], when the teacher is not coming, also that time I am sewing (…). Humbly I am getting something from them [she means that she was selling her handicrafts]. I am collecting these things [money] for my brother and sister and for my mother. When I am going on holiday I am giving them something" (Tuli, 03/03/2012)

Sumita and Tuli were fortunate because they were still protected by the institution and some family members. As Blanchet (1996, p.240) observed, "children without parents or patronage are more likely to be found as child labourers outside orphanages". The fact that their families were Christian may have helped in this regard. Their early experiences in the missionary schools would undoubtedly shape their later developments and the way they described them. They displayed, on occasions, a similar rhetoric of personal effort and self-sacrifice, together with recognition of the support received from their teachers. As a result, both performed very well at school. Furthermore, their early experiences in boarding schools increased their sense of independence and their personal and social resources. By the time they became nurses, they were more mature than other young women of their age and, most importantly, they had developed what Goffman (1966) termed 'adaptive techniques' to institutional life.

6.2.1.2. The extended family as a crucial source of support

Teresa's and Agnes' fathers were cooks and they were living away from their families. Nevertheless, their family support was greater than in the cases of Tuli and Sumita:

> "We had a big family, a joint family. So, we were grown up so nicely, in a dramatical way [drama means theatre, cultural activities in this context]. (…) My father, brothers, all together we make drama in the village, no? Always we are happy, no? Big family, rich family" (Agnes, 18/02/2016)

> "We were big family (…). Three families joint together (…). Twenty-one fixed and other labour [workers] (…). EVERYDAY at lunchtime some relatives were coming and going and eating, like a station, bus stop ((I laugh)) (…). My grandpa always liked that, to serve the people" (Teresa, 01/06/2012)

Families tended to be big at this time, especially in the rural areas. In Agnes' case it was her paternal aunt, a widow with two children, who took care of her and her siblings when her mother died of eclampsia. Her father was working in Kolkata and did not settle back in Bangladesh until she was in her teens. Teresa was born and grew up in a town in the north of Bangladesh. Initially, her father worked in Dhaka, but later he migrated to the Middle East and worked there for some time. Her mother was a housewife who had managed to attend school up to class seven. Teresa is the oldest of seven siblings, whom she has financially supported on many occasions.

6.2.1.3. Emphasis on education: The role of the missionary schools and their parents' 'open-minded' views

It is interesting to note that all the Christian nurses and one Muslim nurse attended missionary schools at some point. In the cases of Tuli and Sumita, the significance of school support was even greater. If it had not been for the school's financial support, their families would probably not have been able to afford their education at that level. Agnes and Teresa provided interesting accounts of their perceptions of the superiority of the missionary schools, when compared to the government ones:

> "In mission schools everybody is very alert and very strong to give (…) teaching. They are not avoiding teaching; they cannot give up that class (…). [In other schools, teachers] will give the work, the homework, or class work and they will go to another school, like this, no? But in mission school nobody can do that (…). Everybody gets (…) high marks" (Agnes, 26/02/2012)

> "The Government was a very lengthy process, it always [involved] dowry, *jowtuk* and the Government is always asking for money, and the Government's people are not working very hard. They are always hiding something, they are just coming and going like this" (Teresa, 01/06/2012).

Teresa's statements about mismanagement in the Government education sector are not exclusive to her. Lack of supervision, teacher absenteeism, internal politics and corruption

are not uncommon in Government education institutions (Blanchet 1996). Agnes and Teresa were also doing well at school; even though not all praise their schools to the same extent, they usually acknowledge that the teachers motivated them to study further. Interestingly, Rabeya studied in a mission school run by Italian nuns. The students were mainly Christians, although there were also other Muslims. According to her, the conditions of Muslim children in the missionary schools varied according to the wealth of their families. There were some disadvantaged Muslim families who, in her words, 'gave' their children to the nuns, which meant the children subsequently converted. There were also wealthier Muslim families, like Rabeya's, who sent their children to mission schools because they considered that the education system was better.

In the case of the Muslim nurses, their parents seem to have had a crucial role in their motivation to study further. Farhana's father was a schoolteacher, and both Rabeya's and Amena's parents were railway officers. Their mothers had managed to access education, which was even more exceptional at that time. Farhana and Rabeya stressed that their mothers were also involved in social and educational activities. All emphasised the fact that their mothers were educated and that their fathers were 'open-minded'. Farhana described him as 'liberal' and Rabeya as a religious, pious man with 'modern' ideas. She highlighted the influence of British education on her father's views:

> "Because my father worked with British people so his attitude (…) he adapted to ALL culture. He always (…) tried to educate my mother. My mother was educated maybe up to class nine level, then she completed a degree. All three sisters we are working because of my father. He told: 'Please, you establish yourself and do something'. THAT TIME his mentality (…) his ideology is modern" (Rabeya, 19/12/2012)

Amena's case is interesting, because she explicitly mentioned that her father had an egalitarian approach to gender. For this reason, he always insisted that they had to study and he was not that much bothered about his daughters being involved in the household tasks. On the other hand, he also taught them to share their goods with people who needed them. For example, he refused to give them new clothes during the Eid festival[134], arguing

[134] There is a tradition where children usually get new clothes during the Muslim celebration of Eid-Al-Fitr.

that there were many people around them who could not even eat. The following quotations show Amena's reflections about the influence that her parents, and especially her father, had on her and her siblings:

> "I was in Class eight, in our time, being in Class eight means that the girls should know every home duties. They usually assisted their mothers. But my father said: 'No, she can do it later. She cannot do any housework; she will study. She will play, she will enjoy her life. I don't want my daughter to [be] busy with the [housework] (…). Not only me, my other sister also" (Amena, 18/11/2012).

> "He always preferred women's dignity in society. That is very important because his father was also a teacher (…). My father was involved in politics, maybe he is very much enthusiast about the egalitarian approach of male and female and other things and he (…) was brought up in such a way. [My parents have seen that] verbal violence is not good. We have never found it in my father's life or my mother's life. It is a good practice that we have learnt from the family" (Amena, 29/05/2013).

The three Muslim nurses in were brought up with liberal or progressive ideas. When they later decided to become a nurse, it generated ambiguous reactions within their families. They seemed to respect their wishes, even though there was some reluctance, especially from their mothers.

In spite of the different ways in which the six nurses were raised, they were generally supported to study further and develop themselves. Considering that many came from rural areas, where women's access to education was limited at that time, they all stood out in this regard. With more effort or, for some, less, they managed to complete their secondary education on time and they were able to sit for their SSC exams.

6.2.2. Secondary school certificate (SSC): Deciding about their future

There are two common examinations within secondary education in Bangladesh: the SSC, which was previously known as *matriculation*, shortened to *matric*, and the Higher Secondary Certificate (HSC), which was previously known as *intermediate*. The former is carried out at the end of class 10 (around 15 years of age) and the latter is performed upon completion of class 12 (around 17 years of age) (MoEDU 2008). The number of students, especially female, appearing in the SSC examination has gradually increased (BANBEIS

2014; Khan et al. 2014). Nevertheless, not many women continue with their education after obtaining their SSC, and it was even less in the period when the nurses of this research studied. The results obtained from the SSC exam and the group in which students were placed would later influence their future choices. As happens elsewhere, there is a general belief in Bangladesh that the science stream is more demanding and offers better quality education than the humanities or arts.

Studying science was also not common for women at that time, especially in the villages. Farhana decided to shift from science to humanities for this reason. Most nurses had passed their SSCs from the humanities group and only Teresa had completed her HSC before joining the institute. Sumita was in the science group and she obtained a first division, which would have given her greater opportunities for higher education. Nevertheless, her family situation and economic problems did not allow her to continue on the science scheme. Tuli and Agnes did not become nurses straight after passing their SSCs, as they both joined religious orders.

6.2.3. Joining religious congregations and working as teachers: The experiences of Tuli and Agnes

Tuli and Agnes followed similar biographical paths in many regards. They were both orphans, they studied in missionary schools, joined religious orders at a young age, and both worked as teachers before becoming nurses. The main difference is that Tuli decided to leave the order after a period of time. Their reasons for becoming nuns were also different. Agnes had never thought about becoming a nun; it was, in her own words, a 'sudden onset'. Her father, uncle and brothers were planning to have her marry in Dhaka and she was happy about this. Things changed when she received a letter from the Mother Superior of the order her nun aunt belonged, asking her to go and visit them. Once she was there, they did not let her go back home. There were disputes between her family and the nuns for some time. They tried to visit her but the Mother Superior would not let them do so. She was unaware of the whole situation and it is questionable to what extent she 'willingly' joined the order. In any case, she did not seem to place great emphasis on this in her narrative, on her own position or thoughts.

Tuli, on the other hand, recalled wanting to be a nun since she was thirteen. She was very close to a foreigner teacher from the order and shared her desire with her. The nun's niece had helped her pay her school fees and Tuli felt grateful to them. Another significant reason was because being a nun was a way to get higher education, which would allow her to support her family.

Regardless of their reasons for becoming nuns, they shared similar experiences after joining the order, as they both obtained teaching certificates and worked in the education sector for some time. In addition, they lead several social and community projects, like sewing centres for women, hostels, and so on. This aspect reminds me of Ortner's (1996) reflections about the Nepali Sherpa women who joined the Buddhist nunneries, where, she concluded, by taking vows, women were 'breaking out' of most disadvantages of the female state. This is not to say that religious life has given them absolute freedom from a rigid patriarchal society as, in many ways, nunneries and other religious institutions can be greatly constraining. The point is that even *within* their limitations, they still managed to achieve personal gains, such as access to education, status, and personal and economic safety.

Both Agnes and Tuli had to interrupt their teaching activities when the Liberation War started. They had to help in the missions' dispensaries, which became their first nursing experience. Rabeya and Farhana were younger and did not experience the war in the same way, although they all have vivid memories of it. Sumita was the only nurse who was not born by 1971 and Teresa was too young to recall anything about the war.

6.2.4. A break in their childhood and youth: The interruption of the liberation war

Tuli and Agnes were both nuns and teachers when the war began. As normal schooling had been interrupted, they were asked to help attend war victims in the mission dispensaries. Agnes recalled how, even though she did not think of becoming a nurse at that time, she felt happy to be able to help other people:

> "I have good feelings that I can do something. When the sister is absent, that time I can help to father (…). He wrote the prescription and I could give the medicines. That time I felt my, I fulfil that I am a, REALLY I can do something. I am a teacher but I can do something" (Agnes, 26/02/2012)

Tuli started working in the mission's dispensary as well. She had undertaken first aid training from when she was a Girl Guide and was ready to help. She also protected and sheltered young girls and helped them to move from one place to another. As she wore religious dress, her figure was more 'respected' and she used this to protect the young women. She highlighted how she had to look after the soldiers from both sides, following the principles of providing care to everyone. She obtained the Freedom Fighter award later. In this way, Tuli and Agnes learnt how to give first aid and nursing care. Nevertheless, they still did not imagine they would become nurses one day.

6.3. JOINING NURSING EUCATION: CIRCUMSTANCES AND IDEALS

From the beginning of its professionalism in the West, nursing was portrayed as a 'suitable' profession for women. It has been an important way for women from working-class backgrounds to access education and a 'decent' way to earn a living. This posed a historical contradiction in the Indian subcontinent, where nurses tended to be portrayed as poor and 'destitute' women. An important effort was made by nurse leaders to increase the status of the profession by attracting women from 'respectable' families (Begum 1993). This section will explore the reasons for nurses joining the Nursing Diploma programme, and a broader picture of the nursing students' background at that time. A summary of the nurses' experiences when they first joined is contained in Appendix N.3.

Maggs' (1980) highlighted the importance of looking at the origins, social and educational backgrounds of nurses[135]. The author pointed to a feedback process where the ways in which nurses were educated influenced the type of recruitment of nursing schools. At the same time, it was precisely the nurses' origins and background which determined "the way

[135] In this case, the author was looking at the recruitment patterns of provincial hospitals in late nineteenth century Britain. Nevertheless, his observations can be applied to other contexts and epochs.

in which the image of the nurse was produced and used to enhance the status of those who remained in the occupation" (1980, p.19).

In Bangladesh and the wider Indian subcontinent, status anxiety has accompanied not only nursing rhetoric, but also the lives of specific nurses. In relation to the former, it generated a model similar to that which Maggs (1980, p.35) observed in nineteenth century Britain, "concerned itself primarily with what sort of women became nurses". Initially, it portrayed nursing as a 'vocation' that carried with it a rejection of material considerations and marriage. Later, and with more Muslim and 'mainstream' women becoming nurses, the popular image evolved to one where nurses were thought of having 'no money', 'no brain' or neither. This latter aspect is explored further through the nurses' narratives.

Before moving forward, it is important to consider the age differences between the nurses. Agnes and Tuli were born in the mid-and late-1940s, Amena in the late-1950s, Farhana, Teresa and Rabeya in the early and late 1960s and Sumita in the early 1970s, meaning that broad historical events affected them in different ways. Nevertheless, all studied for their Diploma in similar time spans, between the early 1980s and the early 1990s. This was the decade of rapid, and often unplanned, growth of nursing in Bangladesh.

6.3.1. The intersection of gender, religion and class: Nursing as a 'non-Muslim' and 'low-status' job

Religion plays a crucial role in Bangladeshi society and in the image of the nursing profession in the subcontinent. As stated previously, nurses historically came from Christian or lower-caste Hindu families. This was traditionally explained in terms of gender and the ideals of pollution and purity. All nurses became nurses at a time when prejudices against the profession were still very strong. Some faced initial disapproval from their families, even though they eventually managed to gain acceptance. This was either because of their good academic performance and motivation, or for practical reasons of income and social safety.

Nursing students in Bangladesh are overwhelmingly female, and were even more so when the nurses studied joined the profession. Only Farhana referred to having male students in her class. Interestingly, a study conducted by Gonsalves (1999) showed that the main reason for young women to enter the profession was because it was considered as 'suitable' for women, an idea also highlighted in campaigns to attract nursing students (Hadley et al. 2007). However, Farhana stated how part of her family's opposition was because nursing was considered 'non-Muslim', which indeed meant 'not-for-Muslim-women':

> Hindu students were also not coming too much; they were restricted like the Muslims. Before, people thought that this is a non-Muslim job. Because the Muslim they are religiously restricted, they will not do the night duty, did not touch the male patients, like that (…). But slowly, you know, the requirement of job, your life, you need the money, so Muslim girls are coming to nursing (Farhana, 04/03/2012)

With respect to the religious background of the nurses' class-mates, there were differences between the big Government and non-Government institutes where they studied. In the latter, students were mostly Christians, followed by Hindus, with a minority of Muslims. This was one reason why Teresa's family finally accepted her decision, as they were afraid of her marrying a Muslim man if she went to a Government hospital. Rabeya and Farhana studied in a big medical college in the capital, where most students were Muslim. Agnes' institution was governmental as well, but located in a smaller city, and contained a large number of Christian and Hindu students. This was probably because it was located outside the capital and there was a Christian mission nearby. Information was not provided by Tuli on her classmates' religious background.

According to Bryan (2003), several factors stopped Muslim women from entering the profession, some related to their general status as women (i.e. education, cultural and traditional constraints on their activities), and others related to the nursing profession itself (i.e. its low status or image, low pay, poor working conditions and concerns about security). Two studies conducted in the biggest Government nursing institute in Bangladesh in different periods showed an increase in the number of Muslim students (Alam 1975; Begum 1993). This could be for different reasons. First, the broader changes related to women's social status may have eased the prejudices against young women studying or

working outside (Raynor et al. 2006). Second, the security offered by nursing in terms of stipend, accommodation and job opportunities, both in Bangladesh and overseas, was another important motivation (Alam 1975). Finally, the lower entry requirements applied to nursing in the past also increased its attractiveness to a wider range of students.

6.3.2. Family and socioeconomic background of the nurses and the effects of the crash programme: The 'no money/no brain' stereotype

The literature on nurses' backgrounds in Bangladesh shows a diverse and changing pattern yet, as already mentioned, nurses generally come from middle-lower socioeconomic backgrounds (Andaleeb et al. 2007; Oulton & Hickey 2009; Zaman 2005; 2009). Alam's (1975) study showed the majority of nurses' fathers were, in order, farmers, Government service holders, businessmen or teachers. More than ten years later, Begum (1993) found a similar pattern, as did this research. One key aspect, in relation to this, is the consequences that students' family backgrounds have on their social status.

Family size and nurses' positions with respect to their siblings are other significant factors in their decision to become nurses. Alam (1975) and Begum (1993) observed that nurses generally came from large families. Alam signalled that about half were either the first or second child as a significant factor. Both characteristics, coming from large families and having younger siblings, were found in five of the nurses. Furthermore, two nurses specifically referred to how this latter aspect influenced their decision of either joining or continuing with their nursing education.

Finally, the role which family members, especially parents and relatives, had in the nurses' decision (or acceptance) to become nurses should be highlighted, especially because, in Bangladesh, parents and relatives play a crucial role in their children's career 'choice' (Blanchet 1996; Leppard 2000). Nursing is not generally the first choice for bright and wealthy students for several reasons. First, the apparent contradiction between nursing activities and local gender, religious and social norms makes it a less desirable profession for women. The poor working conditions and low salaries contribute to make it less

attractive. Secondly, nursing did not enjoy a high educational status in the past. Directly after independence and due to the severe shortage of nurses, entry requirements were relaxed and important efforts were made to attract young women:

"A campaign targeted high school girls, emphasizing the benefits of a high salary, including a stipend during training, secure accommodation, a vocation suitable for girls with lower academic achievements and the opportunity to earn a living abroad. This campaign was successful in attracting young girls" (Hadley & Roques 2007, p.1167)

At the time when the nurses in this research undertook their admission tests, the process was relatively easy. The only requirement was to hold their SSC[136], pass the admissions test and, in some cases, a signature from their guardians. Tuli and Agnes admitted that some students had been admitted without having passed their SSC examinations. Nevertheless, the lowering of the entry standards became a double-edged sword. On the one hand, it proved to be effective in attracting a greater number of students from wider backgrounds. On the other hand, however, it often evolved into a negative perception of nursing students, seeing them as having 'no brain', 'no money', or neither. This was clearly exemplified in Farhana's family reaction; being a middle-class family, with options for her to get higher education, they initially disagreed. She pointed out three reasons for her parents to oppose. First, nursing was considered a hard job and she was physically weak at that time. Second, the profession was considered as not suitable for Muslim women. Finally, its low educational status was also highlighted:

> "My mother scolded me (…) because I had a very big surgery and before (…) people were not coming nursing. They felt that nursing was a very low job, and it was people who were very poor and not good students who would go to nursing. But if you were a good student, you would go to university (…). That time those who were not getting chance to join anywhere ((she laughs)) they were coming to nursing. Like, if you have no money, you would give you daughter to nursing. That's why nursing was neglected by society, you know? People thought: 'You don't have money, you don't have brain; you'll go to nursing'" (Farhana, 04/03/2012)

[136] With the new curriculum and in an attempt to increase the educational background of the students, they are currently required to hold HSC certificates (Bangladesh Nursing Council 2006).

Rabeya also pointed to low SSC scores as a reason for her joining as well. In her case, she also came from a middle-class background and could have studied further. She had already been admitted to college for her BA by the time her brother pushed her into becoming a nurse. Her aunt, who was a matron in the hospital, talked to Rabeya's father and he agreed to send her to the nursing institute because of her bad academic results:

> "Eh, my brother collected the [form] and, because I am not more intelligent amongst my other brothers and sisters, so my father was angry and [told]: 'What will you do in the future? You better go nursing, and do it'. Then, my brother wrote the application, EVERYHTING. Because I am not interested to come here ((She laughs))" (Rabeya, 01/04/2012)

"Because in our culture people are always thinking that those girls who are fool, those who have no knowledge, they would go to nursing" (Rabeya, 09/04/2012)

Initially she 'was not interested' but she decided to give it a try. She ended up enjoying her education to a point where she had to confront her family to let her carry on. Nevertheless, the rhetoric of nursing education as easy and non-meritorious remained in her narrative, even to the point where she undermined the fact that she obtained the first place in the whole of Bangladesh for the Nursing Diploma:

> "Because at that time, in our batch (…) [we were] not good students. Good students had the opportunity to go to medical, engineering or like this. So we are same, same together, that's why [I became first] ((She laughs))" (Rabeya, 18/04/2012)

Amena had also obtained a low score in her HSC exam because she had been sick. Her father was angry and she did not know what to do. She was sent to her uncle's house to take care of him because he was sick. A relative came to visit and saw that she was 'just sitting' and insisted on her joining nursing. Interestingly, a similar account was provided by Dipali, one of the nurses interviewed on one occasion towards the end of the fieldwork. After passing her SSC, she went to visit her aunt. One of her aunt's friends came and asked her to join the nursing institute where she worked as Principal:

> "That time my aunt was the nursing matron [from a district institute]. I went to visit her house with my father. After going there, my auntie's colleague, who was the principal (…) of the Nursing Training Centre, came to visit our house (…). I served her tea and she saw me, then she told: 'Who is she?' Then my auntie said: 'She is my

> nephew (…)'. She asked me: 'What are you doing here?' (…). I said: 'Nothing' [she was just waiting for her SSC results]. Then she said: 'Then join my, my institution, tomorrow morning' (…). No application, no interview[137]" (Dipali, 27/11/2012)

When she told her parents that she wanted to study nursing they were not very supportive, even though they let her do so. The strongest opposition came from her maternal uncle, who was very conservative and did not want her to join. She had to run away from her uncle's house and move to her father's:

> "That time I wrote my brother, who was in Russia Study for his higher education, I mentioned that (…) I am getting chance to study nursing and nobody likes it except my father (…). My MAMA [maternal uncle] just caught me: 'No, you cannot go out from this room' So I just ran away to my father's house (…). Mama doesn't, still doesn't like it. Still: 'OK, go to hell', (…) he is like that, he is very conservative" (Amena, 29/05/2013)

Tuli's and Sumita's situations were opposite to Rabeya's and Amena's in this regard. They had obtained very good academic results, yet their families could not support their education. Nursing became a good opportunity to 'stand on their own two feet'. Sumita had obtained very good SSC results from the science group. She made it very clear that if not for her economic conditions and lack of family support, she could have studied further. She wanted to gain admission into college to become a doctor. When I asked about her reasons for becoming a nurse, she replied, literally: 'this is very *tragedic*[138] in my life'. At first her aunt told her that she should get a first division[139] if she wanted her to continue supporting her education, and so she did. Nevertheless, she seemed to change her mind and told her that college education in the science background was too expensive. A long quotation is provided here as it illustrates her emotional narration of the situation:

> "My aunt came before writing my SSC exam. Then she said: 'If you get first division, then you inform me (…)'. Then I got first division but I didn't inform because (…) it was my sorrow inside, that if I don't get first division, then my aunt would not support me (…). Then some of her friends said: 'Your niece has got a good result,

[137] My translation. The original text is in Bengali and English

[138] She meant tragic. The original quotation has been used to preserve her expression

[139] The highest score

> you know?' Then she came in our house full armed with sweets. In the evening, she gave me three options: 'Number one option ((she clears her throat)) if you like to study further, you cannot'. Then I asked: 'Why?' 'Because you don't have anybody'. Because my brother was in India, he studied in India, my granny is old. Nobody was there to take care of me, to take me to Dhaka or to take me for admission in any other college. I was really upset because I liked to study, other (…). Then second option was: 'If you like to get married, OK, you just tell me', then she would see a boy for me. Then I said 'No, I don't want to get married'. Because that time I was only fifteen years old. Then the last option was: 'If you like to do training on diploma, then you just go early in the morning to [the nursing institute] with your stepmother'. I don't know where it was but I agreed (…) because this was the way to (…) study more, I thought inside (…)
> But when I went to nursing, at that time it was my last and least option to stand on my feet. That's why I felt anyhow I need to complete this nursing education. I feel a little bit, not afraid, just I was little bit, how I will tell [I ask her to speak in Bengali] Bangla means *ami kichuta ie chilam, amar* economical support *keu dibe na khub bhitu chilam* [I was afraid that nobody was going support me financially] In the other side [they were supportive], but not for study, not for education matters" (Sumita, 11/03/2012)

There is an interesting aspect in Sumita's narrative. When she first told it to me, I did not fully understand. She mentioned three options (studying further, marriage or nursing), but it was clear that the first was not possible. Thus, she was eventually left with two options: marriage or nursing. The latter was a middle solution, for her to be able to continue her education in an independent way. She would not need anybody to pay her fees and she would be able to work and establish herself. Moreover, she already had some contact with the profession, as she had an older neighbour who was a nurse and she lived in what she termed a nursing "production area".

Tuli's narrative stands somewhere between 'standing on her own two feet' and her wish to work for other people outside the order. She had started to question her life in the order and the way the nuns were treating the 'needy people':

> "Two things are giving me little bit thinking: 'Is it correct?' What way I can work freely? Or I can serve the needy people? Because in the order (…) we are giving importance for the RULE, but sometimes [we are] not [considering] the human beings, [we are not] not understanding the people (…). Why I am here if I am not giving accurate service to the women, to the people? (…) That time I thought, I left the order" (Tuli, 13/03/2012)

Leaving the order was not easy. Tuli was almost by herself, as her brother was not initially supportive of her idea to become a nurse. Luckily, a friend hosted her in her house at this time. She faced important financial struggles until she managed to get admitted to the institute, which was the best way for her to become independent:

> "I had no money for (...), my wealth, for anything else. It was a tough day in my life. I had no proper bedding also, at night I needed to sleep on the floor. Anyway, then I thought that if I wanted to (stay) myself, I had to stand in my own feet, I needed to struggle up to the end. I started [nursing] in this way" (Tuli, 03/03/2012)

Sumita also used the same expression, 'standing on her own two feet'. Amena did not have the same economic need, even though her father had always encouraged her to be financially independent. Interestingly, the three nurses described the teachers' reactions of surprise after their good performance during the admission tests. They wondered why they joined nursing in spite of being bright students. Tuli's narrative points to their economic reasons for joining, whereas Amena focused on the reasons for the teachers' reluctance to admit 'good' students:

> "The interview paper was very easy (…) then I got first [position]. When I needed to stand for my viva interview, then [the teacher asked] 'Why you are not coming for studying MBBS [Bachelor in medicine]? Why you are just for nursing? Because you are a talented girl' Then I told that 'I lost my father I have not this kind of study or facilities anywhere, so what is possible for me, that I just now came here'" (Tuli, 03/03/2012)

> "Then I filled up the forms and joined (…) I stood first and they don't want me I, I can remember that they mentioned: 'You cannot stay, your result is not too bad, after a few days you will just go and enter higher education, then one seat will be vacant. So how do you ensure that you will be here?' So I just mentioned: 'OK, you just give me the chance, I will show you that I will stay in nursing ((she laughs)). So there is a bargain" (Amena, 12/12/2012)

Nursing was a good opportunity for students who had either low academic scores in their SSC or a lack of economic support. A good way to avoid the negative image of nursing associated with either 'poor' or 'weak' students was the Victorian narrative of service and the image of nurses as 'angels'.

6.3.3. Christian families: the fear and reality of mixed marriages

When she became a nurse, Teresa's parents were worried about her marrying a Muslim man. Their concern was based on both her character and the fact that many nurses in the community had actually married Muslim men:

> "Because that time I was SO ah, like, *ki boli* [how can I say] not like silent girl, (…) I like to go here and there, do everything. So my parents and my doctor auntie was scared about me, what I will do if I go for nursing (…). There are many examples from our village, our mission, our church. There are lot of Christian girls [who marry Muslim men] (…). EVERYBODY converted (…). When some girl wants to be a nurse (…) her parents are worried: 'What will happen during that course?' (…). They changed they religion, they got married with a Muslim boy (…). Because they are separate from the parents, they are separated from the Christianity. In the Government Nursing Institute, Government hospitals (…), they meet with the Muslim boy or some affair or love affairs (…) and after coming back from the nursing hostel there were married with a Muslim boy" (Teresa, 26/03/2012)

Interestingly, Teresa pointed out that even though mixed marriages could be accepted in other countries, they are less desirable in the 'Bengali culture':

> "Is a very big shock for that parents, village parents because this is not a culture of our country, the foreign country culture. Maybe they got, they get marry different religion, like this. In our Bengali culture they want to preserve their religion" (Teresa, 26/03/2012)

Nevertheless, Agnes observed that even though Christian nurses married Muslim men, they preserved their original religious values. Two more nurses, who were not key informants, but were also interviewed for this research, were also married to Muslim men. Rehena never thought that she was going to do so. She had had previous proposals from Muslim doctors, but she did not trust the way they were acting with other women. Even though people began telling her that she was becoming 'old' and she should get married, she persisted with her wish to marry a Christian man. Nevertheless, the war erupted and, after Liberation, she decided to marry a Muslim doctor. As mentioned previously, it was common for parents to have their daughters married at this time (Alam 1975), even though, in her case, it was on her own initiative.

Rozario (2001b), in her study of Christian women as markers of "communal boundaries", pointed out the strategies which the local community used to prevent mixed marriages, especially amongst nurses. The creation of the Christian Nurses Guild, to which both Teresa and Sumita belonged, was a clear example of this:

> "Most Christian nurses were employed in the metropolitan city of Dhaka. They came into more direct and frequent contact with non-Christians in their daily activities. Many of the Christian women who married Muslim men were nurses and the guild was formed in response to this state of affairs. The meetings and conferences were marked by religious authorities (bishop, priests and nuns) giving speeches about how to be 'a good Christian nurse'. The problems of Christian nurses deserting the Church by marrying Muslims were always discussed" (2001b, p.158)

For the Christian nurses, the values of their profession and their religious community often merged in the form of cultural nursing programmes. These moments were good examples of the ways in which the 'Nightingale rhetoric' is still alive in Bangladesh.

6.3.4. Sidestepping status issues through the notion of nursing as a 'noble profession': Reminiscences of the Nightingale discourse

There was also a more positive narrative associated with the nursing profession, which was historically promoted by its leaders, beginning with the missionaries and continuing throughout time with certain local adaptations. The identification of nursing as a suitable profession for women and its association with the ideals of 'purity', 'goodness' and 'service' was a powerful tool in attracting young students. However, it should be noted that the persuasiveness of the discourse was reinforced by other factors, like free accommodation, stipend-endorsed education and job security.

Teresa and Farhana are the two nurses who could be presented as examples of 'vocational' discourse. Both had had previous experiences with nurses and had created an idealised picture of what nursing care was. Farhana was admitted to hospital when she was fifteen

years old and spent a long time there. She became very close to some nurses and felt a sense of admiration for their work:

> "That time I just saw nurses' activity, they looked after me, they liked me, so that time I decided that I would study nursing (…). I spent a long time, nearly two months in the hospital [and] that time I interacted with nurses and I thought I will come to nursing, that is my reason" (Farhana, 26/02/2012)

According to Farhana, nurses and doctors were more caring at that time. She also realised that nurses spent more time with patients than doctors and this finally convinced her to become a nurse:

> "That was a very big ward, a surgery ward. But I think that patients were less then. The doctors and nurses were giving more care than today. That brought me to nursing, because the nurses were always giving attention to me" (Farhana, 04/03/2012)

One of the student nurses who was interviewed by Spouse (2003) in the UK provided a very similar account, describing "how friendly the nurses and doctors were and how clearly she can remember their names and the way they made her feel like a member of their own family" (2003, p.49).

In Teresa's case, she got to know the nurses through two of her aunts, who were a nurse and doctor respectively. When she was getting ready for her HSC exam, she stayed in a convent with them, which was next to the hospital where they worked. She would often visit the wards and observe nurses' and doctors' activities. Her family, especially her doctor aunt, wanted her to be a doctor as well. However, she was more interested in nursing because, like Farhana, she thought that nurses spent more time with patients. Moreover, she felt attracted by their look and their image 'like angels' in their white uniform:

> "When I have seen the nurses uniform there, white and (…) their innocent figure, like angels. I have seen the group of doctors and nurses; they are going, during their patients' round, that trolley they are pushing (…). I was observing HOW nicely they are going. And they are touching patients, and doctors they are not touching patients but they are writing on the paper (…). They are providing care but doctors only they are prescribing. This is the difference between doctor and nurse.
> So that when the hospital staffs and doctors, nun sisters, they were trying a lot to motivate me to be a doctor, not a nurse (…): 'You will be a doctor and people will

> call you 'lady doctor, madam'. So you have to study like a doctor'. But I was decided, I don't know how: 'No, no, no! I don't want to be a doctor. I want to make me a nurse'. That time I didn't know about Florence Nightingale but I know about Mother Teresa (…) I first myself I don't know, but I decided for this dress and trolley, the two symbols motivated me ((I laugh))" (Teresa, 26/03/2012)

According to Teresa, she was pressured by her relatives to become a doctor, even though she ignored them. She implicitly says that she rejected the higher status associated with doctors and opted for the ideal of selfless service to humanity.

The idealised image of nurses wearing white dresses has been consistently highlighted as a source of attraction for young students in Bangladesh (Alam 1975; Begum 1993; Leppard 2000). The images that the white uniform invokes are worth analysing, as it is probably one of the most emblematic symbols of nursing:

> "The nursing uniform is instantly recognisable, and even very small children draw pictures of a nurse in a white cap and apron. Uniforms themselves exert a kind of fascination and it's not surprising that the combination of uniformed women, high drama, illness and death would have made the nurse such a popular figure in the media" (Salvage 1985, p.18)

The author continues with a critical analysis of the often-stereotypical image of nurses in the media and books, and their association with 'white young women'. White is generally associated with 'purity' in the West as is the idealised images of nurses as 'angels'. In the Indian subcontinent, however, white is also associated with widowhood. For this reason, nurses' uniforms have historically been a source of contempt. Healey (2007) described how, in India, the Western uniform was opposed for two main reasons: its colour and shape. Similarly, nurses from a Government hospital in Bangladesh asked for changes in their uniforms in order to improve nursing care (Karmakar 1993).

Nurses can be found wearing either white saris or Western pants and shirts, depending on whether they are staff nurses or students. Saris are generally worn in Government institutions, whereas nurses from private international hospitals tend to wear shirts and

pants. During the time I was conducting fieldwork, I repeatedly heard complaints from nursing students of a non-Government institution because they were mocked by other nurses about their uniform. It consisted of a shirt and pants and they were not allowed to wear the usual scarf (*unna*), which women wear in Bangladesh to cover their breasts. Moreover, they were not wearing caps, an historical identity symbol for nurses. They and male nurses are usually dressed in Western shirts and pants, and Muslim nurses are also seen wearing hijabs (see Figure 4).

Figure 4. Student nurses and staff nurses' uniform in the Government sector

Source: DNS (2007)

In contrast to the general preference for saris and caps, I found two nurse supervisors, one from a Government institution and one from a non-Government one, who thought that wearing shirts and pants with no cap on their heads was a better option in terms of infection control.

Nurses' appearance, including their dress and figure, has traditionally been stated as one reason for young women to join. As Tuli pointed out, they were not mature enough at that time to fully realise what being a nurse actually meant:

> "When I was in high school (…) every year one nurse is going to the schools and telling about nursing, about Florence Nightingale works and her life, what way she dedicated her life and it is a noble profession. They are saying the positive things and we observed that with nice uniform, it looks nice ((She starts laughing)) [wearing] white uniform. That time we are not very mature but we liked it" (Tuli, 13/03/2012)

Finally, Amena made an interesting observation that could also be understood as a reflection on her early vocation. Even though she had no previous knowledge of what being a nurse was, she was looking after her uncle when a relative mentioned the possibility of becoming a nurse to her. According to her, that relative 'identified' something in her. I asked her about that:

> Susana: And why were you staying there? Because you were taking care of him
> Amena: Just, not much taking caring but there is no female candidate, because his daughters had got married very early. They need one girl's support. Like, if he wanted something to eat, some glasses of water, these sort of things (…). My relatives told: 'OK, go and take care of your [uncle] ' I don't know that is nursing but (…) that man who come, he identified that I have very much keen to
> Susana: Yeah, to care
> Amena: Take care
> Susana: Care of the, of the other person, that's very interesting
> Amena: He identified, I didn't identify ((She laughs)) (Amena, 29/05/2013)

In summary, even though the 'Nightingale' or vocational discourse seems to be stronger amongst Christian nurses, it is not exclusive to them. In addition, their previous contact with hospitals or having nurse relatives were also strong influences on some.

6.3.5. The influence of relatives: From 'being pushed' to having to 'manage' them

Most nurses in this research had contact with nurses before joining the institute. Some had nurse relatives; others had visited the hospitals themselves and two had helped in dispensaries during the war. The relevance of having nurse relatives as a factor in becoming a nurse was also observed by Alam (1975) and Leppard (2000) in Bangladesh and by Spouse (2003) in the UK, who pointed to students having previous experience in hospitals, either as patients or attending sick relatives.

Alam's (1975) study analysed the most influential people in students' decisions to become a nurse. Parents, other relatives and teachers were the main influences, albeit from different positions. Parents and relatives generally opposed students' decisions to become a nurse,

whereas teachers generally played a supportive role. Mothers were generally the ones who opposed the most, except in the case of Christian nurses, where the level of disagreement was similar between both parents. Differences were found according to the students' religious group, and Muslim students were those who received the greatest opposition from their families. The narratives of the nurses in this research show a similar pattern.

Amongst the Muslim nurses' parents and close relatives, different reactions were found. All of their fathers were generally supportive, or at least, they let them do what they wanted. In the case of Rabeya and Farhana, the strongest opposition came from their mothers. Amena did not mention anything about her mother but she said that she was strongly criticised by her uncle.

> "During my first life in nursing (…) [my paternal aunt and uncle], they just told my father: 'Oh, you want your daughter's income for livelihood? This is not good, this is not fair'. My father mentioned: 'No, I have seen my nieces, what's happening in their life, everybody gets married and have three to five, seven children and (…) either they get lost [abandoned] by their husband, or somebody just divorces (…). I don't want [this for] my daughter. I want that social security is there, an economic base (…). So from the beginning of our life we know that (…) there is no alternative, we have to work. My father is always preparing us in such a way because he has seen it in [his family]. Because the, my (…) uncle, he is very good teacher (…), he graduated from Kolkata in English and he is not much aware about the economic matters, or he doesn't bother. He is very much educationalist (…). My uncle has seven daughters and two sons (…). Their life is like get married, have children and then quickly their husbands died, or this sort of things happened. [But my father] thinks in a different way" (Amena, 29/05/2013)

Farhana had to sit the admissions exam in secret. She was already studying at college when she saw the nursing advertisement. Her mother was strongly opposed and she had to 'steal' her father's signature for the application form. Later, she had to sit for the examinations in secret too:

> "[I needed his] signature in the application form (…). Because like, the form, I keep like this ((She grabs a paper and shows me how she folded so that her father could not see what was written on it)) and I said: 'Father I need your signature here', and he asked: 'Why?' I said: 'For my exam paper, this one I need your signature', so my father signed, my father didn't look also ((I laugh)), I cheated" (Farhana, 18/03/2012)

> "And then I submitted the application and then did the written test in the morning so I told my, my mother lie. I said I am going to college and then I came to give the written test. But unfortunately the test shifted the time, twelve. So: 'Where I will go?' And then, I, because of my age was very young ((she laughs)) And didn't have the thinking, like, critically thinking so one girl, she came from Chittagong, she said: 'Now where I will go this time, how?' I said: 'Ah, we are living in Dhaka, come with me' ((She laughs again)) (…). So I took that girl to my house and my mother asked 'Who is she?' And then she said 'I came to give interview for nursing with her'. Oh, my God! My mother scold, scold, scolded me and then [it was already] eleven. So I think 'I need to go there' but my mother said: 'You just take the rickshaw and give her to go'. And my mother didn't like (…) [me to go]. I said: 'No, she is, don't know anything in Dhaka (…), I need to take her (…)' Like this way I went there" (Farhana, 03/04/2012)

Rabeya was initially motivated by her brother and even though her father agreed at first, when she first returned from her nursing institute during an Eid vacation, they did not want her to go back. She cried and begged them to let her and eventually they did. Teresa also 'plotted' to be able to become a nurse. She passed her SSC in humanities, but her aunt, who was a medical doctor, changed her group to sciences for her HSC because she wanted Teresa to become a doctor. She decided, at that point, not to study hard for her HSC so she would not be able to become a doctor and, therefore, could become a nurse:

> "I didn't want to make me a doctor, I always like to make me a nurse. That was the conflict (…). So I didn't study hard, like this ((we laugh)) *Dusto* [naughty] (…). Now I understand what I did ((laughs))" (Teresa, 01/06/2012)

Farhana's expression, 'managing' her parents, is representative of the more subtle forms of resistance which some nurses in this research used to pursue their goals. Scott (1985; 1990) showed how, even under extreme coercion, there is always room for what he termed 'hidden transcripts' or the 'weapons of the weak'. In this case, it was a matter of persistence. The idea that they were only 'trying' and that their decision to become a nurse was not definitive may have given them room to overcome their parents' resistance. Once the course had started, it was more difficult for their parents to oppose.

Ortner (1999b) showed a similar strategy was used by Sherpa women in different situations. This happened when they ran away to work in Darjeeling or to join a nunnery. It

was also used to climb further when male co-expeditors or husbands did not allow them to do so:

> "She did not argue or talk back; she simply pushed the limits with her behaviour (…) and hoped to create a fait accompli. This is perhaps another variant of running away to a nunnery or to Darjeeling, and hoping or assuming that others would go along with the act after the fact" (Ortner, 1999, p.240)

Ortner provided another example of a Sherpani who challenged her husband's opposition by asking for smaller goals: "Each time he said 'go down', she said 'just a little more'" (1999b, p.241). This 'just a little bit' strategy is often found when a long-term decision is found as problematic. As shown in Chapter Eight, many nurses had to demonstrate, throughout their student and professional lives, that 'in spite of being nurses' they were still good students and capable professionals.

Sumita was led by her aunt and encountered no family opposition. Furthermore, her grandmother, her closest relative at the time, felt relieved because, according to her, becoming a nurse was better than becoming a nun, which had been Sumita's earlier idea. Teresa did not face strong opposition from her parents either. Nursing was generally well regarded within her local community; their only concerns were related to the possibility of her marrying a Muslim man:

> "Because that time I was SO, like, *ki bolbo* [how can I say] not like a silent girl, you know, I like to go here and there, do everything. So my parents and my doctor auntie was scared about me, what I will do if I go for nursing" (Teresa, 26/03/2012)

> "My doctor auntie's part was negative to be a nurse because she wanted me to be a doctor in our family, traditional. But my family: my father, my mother, my grandfather, they were happy and they said: 'Whatever she likes she can do. Don't put pressure' (…). But one thing they were very worried because I was VERY unstable, very 'here and there'. So they were very worried about my life: 'What will happen? We don't know maybe something will happen' ((laughs)) (…). Because previously, from our church, EVERYBODY got married with Muslim boys, those who became nurses" (Teresa, 01/06/2012)

Tuli's and Agnes' cases were a bit different because they were older and more independent from their families by the time they joined, plus they were already working as teachers. Even so, they were not happy at first because of nursing's low status:

> "They are thinking that maximum time the nurses are going here and there (...) They thought that with my life [would get] spoiled [and] that blame will come to the family. That's why they are not happy" (Agnes, 09/05/2012)

The expression 'here and there' is significant in the case of women as it often has the connotation of being out of control. It does not necessarily point towards socially sanctioned behaviours, but it is a way of expressing that they are 'all over the place' or in danger of getting 'spoiled'. Tuli had to negotiate with her brother, who had become her guardian after her father died. He initially refused to provide his signature but she managed to convince him:

> "OH! When I joined for nursing nobody likes it. Even my brother is not talking with me. He was telling me that: 'What you like you can do', but he would not like to sign my paper also, because he was my guardian (…). Everybody is thinking that I will be a teacher" (Tuli, 13/03/2012)

In summary, most nurses found both support and opposition in their families. The discourse of nursing not being a suitable profession was found, regardless of the religious background and, in many cases, had to do with the association between nursing education and students who were either not bright or who came from very poor socioeconomic backgrounds.

6.4. DIFFERENT REASONS AND NARRATIVES. REVISITING THE NOTIONS OF 'VOCATION' AND 'CHOICE'

Two apparently-different discourses can be identified within the nurses' narratives. The first reproduces the idea of vocation and service to humanity, whereas the second describes a more a circumstantial or practical decision. The two narratives are by no means opposed or incompatible. Most joined the profession without being fully aware of what being a nurse meant, and thus not all had the ideals of devotion and care of the sick. The ideas of 'vocation' and 'service' need to be critically analysed as they point to a connotation of individual 'choice'.

Chapter Two discussed the idea that making a free, rational choice can be seen as a Western construct (Comaroff & Comaroff 1992). White (1992), in her ethnography of Bangladesh, criticised the stress on decision making as free choice. According to her, the idea of choice "does not fit with perceptions of fate which are so widely found in peasant societies" (1992, p.24). Therefore, it is important to consider other factors, which are external to the individual and influence their 'decisions'. A clear example of how problematic the idea of 'choice' can be in conceptualising their decisions is an example from Agnes. Her narrative is different from the other five, as she was just following her vow of obedience. Her life story questions the notion of vocation twice. First, when she was persuaded to become a nun, which was explained earlier. Second, when her Mother Superior asked her to become a nurse. Agnes was disappointed and confused because being a nurse was not in her plans and she was very happy with her work as a teacher. The Mother Superior gave Agnes one day to think about it, but she could not calmly analyse the situation:

> "I couldn't analyse. She gave me time, the whole day, no? Now, 8 pm I was called again: 'You give me the answer yes or no'. (…). There is NO room to think anything because after about eleven years I taught in the school. ALL the students' face is coming out (…) and tears are coming but how can I say no? I couldn't imagine. In the evening time when again the mother told me: 'Come, what do you think?' I said 'I couldn't imagine and I didn't think anything. I have no room to say yes or no'. Mother said: 'This is God wish, that if you, because you cannot decide, I decide you will do' (…). This way I am a nurse. Because that time I was thinking, because the mother would say: 'You have obedience vow, how can you say no? (…) 'If you say no, I will not give you time to for teaching next'. What to do ((We laugh)) (…) You are thinking that I will be a nurse, OK" (Agnes, 18/02/2012)

Again, her narrative shows a contradiction between her inner will and her fear of challenging the authority of the order. More than her 'choosing to obey', her narrative shows she just felt unable to take the decision at that time.

The 'vocational' and often idealised narratives of the reasons for entering the nursing profession are not free from ideological influence. Different campaigns have been conducted over time to attract young applicants, portraying nursing as a "an exciting and

glamorous profession, that will allow them to serve humanity" (Cohen 1981, p.12). Bourdieu (1984; 2002) critically analysed the use of the concept of 'vocation' to maintain and reinforce the subordinate position of certain groups, especially of women. According to him, it has the effect of "producing these kinds of harmonious encounters between dispositions and positions in which the victims of symbolic domination can felicitously (…) perform the subaltern or subordinate tasks assigned to their virtues of submission, gentleness, docility, devotion and self-denial" (2002, p.57). This 'vocational' education also helps reproduce class inequalities, as it channels individuals towards certain positions "because they feel 'made' for jobs that are 'made' for them" (1984, p.110).

Robson (2005, p.26) concluded that even though the Nightingale definition of nursing as a vocation is still present in the hegemonic 'Western' discourse, "it has little relevance in many of the world's poorer countries, although lip service is often paid to it". Many students who were admitted to nursing schools did so, either in search of economic independence and security, or, more recently, were attracted by the possibility of overseas employment. The author's argument is consistent with other studies that suggest that many nurses decided to become so for economic and social safety reasons (Leppard 2000; Zaman 2009). Nevertheless, two issues should be clarified. First, people choose nursing as a career for economic or other practical reasons in Western countries as well (Miers et al. 2007). Second, other studies in Bangladesh which directly asked nurses about their reasons for joining had shown reasons other than economic motivations (Alam 1975; Begum 1993; Gonsalves 1999b). The search for economic security does not by any means exclude other more 'humanitarian' reasons.

When asked about their reasons for becoming nurses, in retrospect, nurses tended to provide a complex account of the different circumstances that led them to join the institute. Articulating the specific reasons for a decision was taken a long time ago is not always easy. Past decisions tend to be rationalised in an effort to provide coherence (Linde 1993; De Miguel 1996). Thus, it is interesting to look at the way in which the nurses construct their narratives from their current position as nurse teachers. In some cases, they acknowledge their 'lack of choice', whereas in other cases, like Farhana's and especially

Teresa's, they construct a fully coherent narrative, which is further enriched with idealised images of the nursing profession. Nevertheless, in most cases there seems to be a combination of circumstantial events, romantic images of nurses, and the option to obtain higher education and financial independence.

6.5. A FINAL NOTE ON THE NURSES' SEARCH FOR INDEPENDENCE: BEYOND ECONOMIC SAFETY

Tuli and Sumita, both used the expression 'standing on their own two feet' to account for their wish for independence. This was something common to all the nurses, although it took different connotations. For some nurses like Tuli, Sumita and, later, Farhana, it was clear that becoming a nurse was the best option to ensure economic security while at the same time being able to continue with their education. For other nurses like Teresa, Rabeya or Amena, their appreciation for independence and the possibility of self-development would become more evident later, once they had left their family's home. It is clear from the nurses' narratives that nursing education had played a significant role in relation to their social and economic self-reliance. However, the independence that nursing education gave them went far beyond the economic sphere, as the next chapters show.

7. BECOMING NURSES: LEARNING BY DOING AND MAKING THE MOST OF THEIR EDUCATION

"In the course of time the outlook of the people has changed with the expectation of the profession and they started to think that *nurses are also human beings*. Nurses always deal with the life and death of a man[140]" (Begum 1993, p.11)

7.1. INTRODUCTION

When I first looked at Begum's (1993) statement "nurses are also human beings", it made me think to what extent nurses' low status has affected their narratives. The author pointed to a gradual improvement in nurses' social image, which other authors and some nurses in this research acknowledged as well. Many nurses faced strong opposition from their families in order to be able to study and work, although they finally managed to overcome their relatives' early reluctance.

Chapter Six analysed nurses' primary socialisation in their families and subsequent socialisations in the educational institutions they attended prior to nursing. A further socialisation process came when they became trainee nurses. Following Berger and Luckman (1971), any form of socialisation involves significant internalisation processes and are related to the subjects' identity. In the case of nursing education, their young age, the intensity of their educational and first clinical experiences, strong discipline, the relevance of the 'Nightingale' rhetoric and the fact that nursing institutes followed a boarding system, all contributed to a strong internalisation of nursing values and identity. There seems to be a general perception amongst nurses that they were more involved in practical care in the past. This aspect is crucial because it points towards a longstanding dilemma in nursing between the 'apprenticeship' and 'professional' models of nursing education. This aspect is analysed in the first part of the chapter.

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[140] My emphasis

The second part of this chapter analyses the consequences of being nurses on personal, social and family life. As nursing was not socially valued at that time, they had to demonstrate to their families and also to doctors and hospital authorities, that in spite of being nurses, they were knowledgeable responsible. Nurses' emphasis on the importance of their knowledge leads us to the last part of the chapter, where their performance is analysed as a form of agency.

7.2. NURSING EDUCATION AND 'OLD' REPRESENTATIONS AND PRACTICES AROUND CARE: STRENGTHS AND LIMITATIONS OF THE APPRENTICESHIP MODEL

Nursing education in the 1980s and early 1990s was still facing significant challenges, as was shown in the situational analysis conducted by DNS (1994a). Teacher-student ratios in both Governmental and non-Governmental institutions were still very high[141] and many teachers were still inexperienced at that time. Essential shortages were also faced in the service sector, which undoubtedly affected students' clinical experiences. Other issues included an inadequate evaluation of teachers and students, insufficient facilities, unsatisfactory English skills (teachers and students) and a lack of clinical supervision. This, together with the generalised nursing shortage, made students act more as service providers than as undergraduate learners (DNS 1995; Chowdhury 1999).

Nursing education has undergone significant changes since the time when they were students. Critical in this regard was the changes in the nursing curriculum that took place in the early 2000s. A move was made from the former 'apprenticeship system' to a more 'professional' approach. The educational background of aspirants was increased and more emphasis was placed on their critical thinking and theoretical grounds. This, together with broader changes in the health system and society, made the nurses in this research acquire a nostalgic narrative in some regards. The 'good old days' were often praised, portraying a situation where nurses were much more involved in direct patients' care from the very beginning of their diploma education.

[141] 1:36.6 in Government institutions and 1:25 in private institutions (Directorate of Nursing Services 1994a)

The socialisation process of nurses is analysed from two perspectives. The first looks at the institutional daily routine of nursing students, whereas the second one is more concerned with the ways in which nursing and care were taught and learnt. Finally, the reflections of the nurses around the forms of nursing knowledge is analysed, understanding the latter as a form of *praxis* (Chinn & Kramer 2015).

7.2.1. Life at the institute: Discipline, independence and protection

Most nurses obtained their Nursing Diploma from big Government institutes. Only Teresa and Sumita studied in a non-Government philanthropic institution. In spite of being a Hindu institution, it has attracted many Christian students and it is well known amongst their community. According to Teresa, this was because they were supportive towards Christians for also being a minority group. Both she and Sumita stated several times that nurses from that hospital were well known for their good performance.

Perhaps even more important than the difference between Government and private institutes were the disparities in terms of learning opportunities between the bigger institutes attached to medical colleges and the smaller ones, which were usually attached to 50-bedded district hospitals (Robson 2005, p.76). Farhana referred to this issue once:

> "Our institute was very big, we had a good teachers and a good environment and everything was available. But in the small institutes there is teachers' shortage, books' shortage, instruments' shortage; in the hospital there is no practice scope. Because there are limited patients, and also the environment. The nurses [are] young women and the people doesn't like these things" (Farhana, 03/10/2012)

On their admission, there was an initial three-month period when they were Preliminary Training Students (PTS). This consisted of mainly theoretical training, even though in some cases, they also had to undertake clinical work. Most of the students were in their teens and were away from home for the first time; and many struggled at first, especially when they began clinical work. Not only did they have to adjust to their new physical environment, accommodation, food, etc., but they also had to follow a strict routine, which often included long duty hours combined with their study. Sumita recalled other reasons for students to

leave, such as getting admission in Government institutions, securing other jobs or getting married.

Their socialisation reminded in many ways to Goffman's (1961) *total institutions*, and to Foucault's (1996) analysis of the role of boarding institutions in disciplining their residents. Within nursing, the strict discipline to which nurses were subjected, especially after the nineteenth century reform, has been widely described (Reverby 1987; Dingwall et al. 1988; Nair & Healey 2009). Discipline has often been combined with long hours of work (Reverby 1987), which were used to socialise 'obedient' nurses (Stein 1969). Nevertheless, there are some particularities that need to be considered regarding discipline in nurses' experiences in this research.

7.2.1.1. Boarding and sponsored education as a way of gaining independence

Staying away from their families was a significant change for the students, and some left due to homesickness. Nevertheless, the ones who stayed seemed to share good memories of their experiences at the hostel. Rabeya was an example of this adaptation process:

> "Food was so difficult that time. I don't know how we loved this hostel (…). In addition, from early in the morning I saw that there was nobody, I had no relations, how I will stay there. Sometimes (…) I am crying, like this. But ultimately I thought: 'No, this is good' ((I laugh)) Because [I have my] own place, personal space. That time maybe I developed personal care, because in the school years we were together brothers and sisters, we did not have personal space" (Rabeya, 01/04/2012)

Accommodation and safety has been a common complaint of Bangladeshi nurses over time (Alam 1975; Akhter et al. 2003; DNS 2011). Nevertheless, the nurses in this research seemed to generally be happy about the arrangements in their institutes. Farhana was even more privileged because the hostel superintendent was her relative and gave her the keys of her private room so she could rest after work. Food, however, was raised as a problem by some nurses, both from government and non-government institutes. Their narratives were consistent with those provided by Alam (1975) from a big government hospital in the capital.

Nursing education has historically been sponsored in Bangladesh, at least in the philanthropic and Government institutes. The nurses in this research all got a similar amount, which ranged between 140-165 BDT (after deducting their food and board), and was increased annually. This was clearly not a big amount, even at that time. In Alam's (1975) study, some students mentioned that they had to bring money from home, while others reported helping their families with that money. In any case, the living conditions of the students could be very different depending on the economic capital of their families.

Most nurses had contact with their families, even though the degree and frequency of their visits, and the material support they received varied. Sumita and Tuli, who did not get that much financial support from their families, were struggling and trying to save money in any possible way. Sumita received support from the Principal of the institute, who sympathised with her economic condition. Tuli tried to supplement her stipend by sewing and selling handicrafts, that way being able to save money for her mother and siblings. In Agnes' case, her stipend went straight to her mother superior and if she needed to buy anything, she had to ask her. In contrast, Teresa, Rabeya and Farhana had greater social and economic capital at that time. Farhana could get money from her relatives and Rabeya admitted that on some occasions they would bring her cooked food. Teresa stated that her relatives were sometimes sending money or goods as well.

7.2.1.2. Social activities at the institute: Restrictions and enjoyable moments

Leisure activities and social relationships form an important part of their experience at the institute. Arranging cultural events is an important aspect of Bangladeshi education institutions and they often require great preparation and effort, by both students and staff. They are, indeed, a great source of entertainment and distraction from their hard study and work. Amena, Sumita and Teresa actively participated and led this type kind of events (i.e. celebration of religious festivities, international nursing day, etc). The former two nurses were also involved in the Catholic Nurses Guild[142] and local church. Agnes collaborated in

[142] Rozario (2001b) pointed out the role of the Christian Nurses' Guild in the reinforcement of Christian women's communal boundaries. This issue will be picked up in Chapter Seven.

a missionary maternity and sick shelter next to the hospital and Tuli was also undertaking other voluntary activities along with her nursing education.

Nevertheless, when it came to move out of the institute or hospital premises, the students' mobility was highly controlled. Young, unmarried women who live away from their families are more vulnerable and clearly susceptible to being 'mixed up' with men, one of the most commonly-penalized forms of 'misbehaviour'. Pre-marital relationships are socially castigated in Bangladesh, especially those of women. This is related to the previously mentioned concepts of honour (*ijjat*) and shame (*lojja*). Even though premarital relationships were not explicitly mentioned in nurses' narratives, references were made to the sanctions applied to students who 'misbehaved' with 'boyfriends'. As shown in their narratives, social control is exercised in nursing institutes, either by the 'authorities' (principal, teachers and other staff members) or by students themselves.

Agnes mentioned that her relatives thought that nurses were at risk of getting 'spoiled'. The notion of teenagers and youngsters getting 'spoiled' (*nosto*) has different meanings according to their gender (Blanchet 1996). For girls, it mostly refers to them having initiated sexual activity, consented or not, before their marriage. Being 'spoiled' the author continues, has a moral connotation and is related to the concepts of *samaj* and *dhormo*. Therefore, socially disapproved behaviour in young women can have significant consequences on their future social life. For this reason, some teachers and even some students themselves, try to protect vulnerable students from social outrage.

When Agnes was asked about the main reasons for students dropping out, she mentioned marriage and misbehaviour, the latter usually being associated with having 'boyfriends' and sneaking out of the hospital. In theory, marriage was not allowed while undertaking nursing diploma at that time[143]. Nevertheless, some nurses admitted that even though the authorities knew that some students were married, they did not say anything. Alam (1975) found that

[143] Alam (1975) stated that marriage was not allowed in the 1970s. When I asked one of the current leaders in nursing education about the current situation, she replied that even though there was no written rule currently, the prohibition is strictly maintained in some institutions nowadays.

the authorities were more relaxed after the Liberation War, when some parents had their daughters married in order to ensure their safety.

7.2.1.3. The ambivalent role of discipline: Between control and 'protection'

The Victorian gender and class ideology was reproduced in the nursing institutes outside Britain and persisted until the twentieth century. In the US, for instance, nursing schools were seen as places where " innocent young women would be nurtured, they hoped, through a combination of moral uplift and hard work" (Reverby 1987, p.41). Similarly, Falk Rafael (1996) highlighted that nurses had historically been controlled not only in their education and practice, but also in their dress, residence and even in their freedom to marry. In colonial India, the narrative of nursing as a noble profession further reinforced notions of service and obedience (Healey 2007; Nair 2012). In Bangladesh, not much has been discussed about the particular disciplinary strategies in nursing institutions. Nevertheless, remarkable work like those of Leppard (2000), Afsana (2005) and Zaman (2005), have deeply analysed the uneasy position of nurses within the power relations in the hospitals.

Interestingly, the nurses in this research did not necessarily see discipline and hard work as a negative feature of nursing education. The 'disciplining' of nurses was often legitimised by their vulnerability, 'innocence', and their subsequent need for protection. The notion of 'innocence' can point to the concept of immaturity, but also to that of purity. Loss of innocence is often conceptualised as 'getting spoiled' (Blanchet 1996). Young, inexperienced female students from disadvantaged socioeconomic backgrounds or with a limited social network were considered the most vulnerable.

In the case of nursing students, it was their teachers who played that double function of protecting and disciplining them, as they were living away from their families. Being 'friendly but strict' was seen as a good quality of some teachers. Mina, who was one of the

oldest teachers from a Government hospital,[144] described this aspect. Mina explained what it was like in the mid-1960s, when the number of students was smaller:

> Mina: At that time they [the teachers] were nourishing us.
> Susana: Yeah, they were taking care of you ((giggle))
> Mina: Every day we wrote our resignation letter ((giggles)) because of the hospital duty. But the food, accommodation and the affection, love, everything we got.
> Susana: They were taking good care of you.
> Mina: Yeah, because of our sustainability in nursing education, they are SO caring.
> (Group interview, 08/12/2012)

Mina pointed out, however, that 'nourishing' included discipline as well. This vision was shared by other nurses, who understood discipline as a way of being protected from 'misbehaviour'. Tuli stated that in the past, not only nursing teachers, but also students' parents' were more involved in their education:

> "Nowadays we can observe what way the education is not [provided] in an accurate way because of the society problem (…), ALSO the technology and this way everything is misguiding (…). But when we were in the education field, that time we have principles, we have discipline; the teachers were giving concentration for her their students. In addition the mothers and fathers, and the society were not like this crazy. That time there was SO simple life" (Tuli, 02/11/2012)

Therefore, the line between 'discipline', caring and protection is not always neat. What seems to be clear is that because they were female and young, teachers then acted in a somewhat 'parenting' role. This need for protection, however, did not justify the long hours of work and menial duties that nurses had to undertake during their education period. The latter are more related to a pedagogic model that greatly drew from the 'learning by doing' or 'practice makes perfect' premises.

7.2.2. Theoretical knowledge: Learning about nursing

All the nurses in this study had had a certain amount of contact with either nurses or hospitals before entering the profession. Nevertheless, as noted by Spouse (2003) in the

[144] Unfortunately, Mina could not be added as a key informant as only two interviews could be conducted with her, the first being in a group

UK, having previous experiences in health institutions, or seeing nurse relatives does not necessarily help students to get an accurate idea of what nursing is. The following quotations illustrate the nurses' 'reality check':

> "We never see that it is so tough profession, so tough, hard job and they are doing night duty (…). But when I come [to nursing], it was so tough" (Rabeya, 01/04/2012)

> "I didn't know actually the nursing. I saw many times nurses and I thought that they are giving only the injection, only the medicine. But this much study that they are doing, I didn't have any idea ((She laughs))" (Farhana, 04/03/2012)

> "Actually I had been introduced about nursing a little bit, that nurses they have to clean the patients' wound and giving injection, giving medicine, like this. But I didn't know about the study course curriculum (…) ((We both laugh)) I have to study lot and English, oh my goodness! It was embarrassing for me" (Teresa, 26/03/2012)

Two key issues arise in the ways which nurses narrated their theoretical learning in nursing. The first is related to the idealisation of care as service in what I termed the 'Nightingale rhetoric'. The second one looks at particular ways in which knowledge was transmitted, and the strategies nurses used to make the most of it. It is assumed that they were following the 1972 nursing curriculum, as its first revision was made in 1989 (Directorate of Nursing Services 2011). Farhana described the distribution of the subjects in this way[145]:

Table 2. Distribution of subjects according to Farhana

Course	Subjects
First Year	• Nursing Arts: Bandaging, Bed Making, Nursing Care, First Aid, Nursing Ethics and History Of Nursing • Anatomy and Physiology • Hygiene • Nutrition • Microbiology
Second Year	• Pharmacology • Paediatric Nursing
Third Year	• Medical Nursing • Surgical Nursing • Gynaecological Nursing • General Nursing
Fourth Year	• Midwifery and Obstetric Nursing

[145] Even though her description may not be exhaustive, it provides with a general idea of how the course looked like

The British influence was strong at the time they studied. According to Tuli, they were initially following the materials that had been used in India:

> "In 1970 it was East Pakistan period. Some old UK nursing books were in some libraries of the Schools of Nursing. Some typewritten nursing paper was used, e.g. nursing arts. It was from West Bengal, India" (Tuli, personal communication, 2016)

Similar to what happened in the West, subjects like 'Nursing Arts' were changed into more 'scientific' orientations, partly in an effort to overcome the old apprenticeship system (Carper 2006). The equivalent subject in the current curriculum would be 'Fundamentals of Nursing' (BNC 2006). Unfortunately, I could not access the previous curriculum although on one occasion, a nurse asked me to type the notes she used in the late 1970s from a Government institution. Amongst them, some fragments from the History of Nursing, is be presented to illustrate how the 'Nightingale discourse' of nursing as service and 'art' was reproduced. The paper began with introductory praise for the contributions of missionaries and religious orders to nursing, followed by an overtly idealised narration of Nightingale's life:

> "Florence Nightingale – the founder and Mother of modern nursing. In addition, called the lady with the lamp. Her greatest contribution to nursing was in the field of nursing education. With her great powers of organization and administration, she improved the health of the British Army in Scutari and later in India. Under the direction, St. Thomas Hospital in London was founded, which became a model for nursing schools all over the world" (Notes on 'The History of Nursing')

The text goes on to explain Nightingale's call to serve the 'poor' and the initial opposition she faced from her family. This aspect is significant, considering that many Bangladeshi and Indian nurses faced a similar rejection. The text highlighted Nightingale's strong vocation of service as key in her determination not to get married. The way in which Nightingale started working at the hospital was also praised and narrated with an important degree of emotion, presenting her almost as a heroine:

> "In 1845, hospitals were places of wretchedness, degradation and squalor and the nurses were of very low character and morals. In 1853, after much heartache and defying her family, she began nursing in an institution (…). Life was Spartan, work rigorously hard and food scarce, but Florence was at last happy and felt that life was worthwhile" (Notes on "The History of Nursing")

Regarding the history of nursing in the subcontinent, the narrative about the hindering of the profession and 'scientific development', due to local customs was also reproduced, together with more structural factors:

> "The Muslim system of *purdah* which prevented women from leaving their homes and having a public voice, the Hindu caste system which prevented contact with the lower classes of people (…), illiteracy, poverty, political unrest, and language differences" (Notes on 'The history of nursing')

Finally, the document stated that nursing was "looked down on as servants' work". In contrast, the notes continued, progress in nursing was helped first by European traders, adventurers and discoverers who set up dispensaries. Armies and colonizers were also praised for introducing military nursing and mission hospitals were considered as crucial institutions for nursing education in India. The role of technical advancements was recognised, even though it was also associated with a risk for nursing drifting away from the patients' bedside. The notes help provide a general idea of the model of care and nursing taught at that time. The combination of an ideology of devotion and self-sacrifice, long hours of duty and a strong discipline in their daily activities, led to a narrative which in many ways resembles the accounts of their predecessors in the UK and later, in the US.

English was used as a medium of instruction and as many students were not proficient in the language, teachers ended up dictating or writing the lectures, which would later be memorised. Their teachers were both nurses and doctors, the latter being generally involved in non-nursing subjects. Teaching and learning resources were inadequate at that time. Most hospitals had libraries, even though they were not always available for students. More recently, even the College of Nursing (CoN) library was found to be insufficient for students' educational requirements (Prakasamma 1999; Robson 2005; Kabir Talukder et al. 2010).

Some students had study rooms and others used their classrooms or bedrooms or the corridor. If the ward was quiet, they also studied during night duty. Sumita explained that they studied together in groups at the hostel. I could also observe that group study was also

common in the institute where I worked. This was partly because there were not enough books for all students and partly because joint study seems to be common practice in the country. Robson (2005, p.105) found a similar strategy amongst nurses who were sent to the UK: "by working in groups the Bangladeshis were able to memorise whole sections of English text through constant recitation and copious note taking".

Most nurses stated that having to study in English was challenging, especially for those who were coming from Bangla Medium Schools. In order to help them understand the subjects, teachers would often provide them with Bengali explanations. The latter scenario was also found by Robson (2005), on her visit to the College of Nursing, not long ago. Rabeya stressed how they were, using her own words, 'fed' English and Maths and Sumita pointed out how students were 'spoon-fed'. The expression 'to feed', together with their descriptions of how most students learnt, points to a predominance of rote learning. In contrast, some nurses stated that they tried to move beyond that in several ways. Rabeya explained how they approached senior or 'good' students, doctors or medical students for further explanations. Farhana noted that some students like her, who wanted to get higher marks, complemented their notes with medical books.

As had happened in the case of libraries, the equipment available in practice laboratories varied from one institute to another. Usually, teachers did the demonstrating, but sometimes students took the initiative and went to the lab by themselves. Overall, they had to use different and often imaginative techniques, to compensate for the scarcity of human and material resources. On top of that, they had to combine their theoretical learning with a considerable amount of clinical work.

7.2.3. Integration of theoretical and practical knowledge: 'Learning by doing'

Apart from their theoretical learning, students had to work clinically right from the beginning. Examples of Sumita's and Farhana's daily routine are provided to illustrate their tight schedule:

> "In the morning duty, suppose we come to duty at 7, then until 9 we were in the hospital ward. Then 9 to 12 we had class, then again we come to duty, then we take lunch, then we leave, like this, morning shift. Evening also like this, from 2 o'clock start duty, we come to dining with [clinical] dress then we eat and we go, we went to the ward, then 4 o'clock class, then again we come to the ward, then maybe after finishing the duty we took our dinner then we go to the hostel" (Sumita, Philanthropic Institution, 11/03/2012)

> "We have like one-hour theory class, then we went to the hospital and again two hours of work, again come back, and again class. If we had evening duty, we did morning class then go to evening duty (…). When we did the night duty, we came and then did the class ((she laughs)). Just two, three hours of sleep, this way we learn that work" (Farhana, Government Medical College, 26/02/2012).

The other nurses described similar situations, where they were rushing between the hospital and classroom. They used to work clinically at least six days per week and according to Rabeya and Agnes, they often had to attend class on their free day. The combination of duty and class was often found excruciating by the students and it was one reason for leaving (Alam 1975). In spite of acknowledging that they often felt exhausted, they saw the old system and long hours of duty positively. Teresa and Sumita saw it as a good way of integrating theory and practice. Interestingly, they both used the notion of 'creation'. Amena, on the other hand, portrayed a threefold relationship between knowledge, skills and attitude:

> "That time the doctors were taking classes (…) and they were giving notes about medicine and surgery diseases (…). We continuously went to the hospital and we just correlated the nursing care with that disease. We created the nursing care. Nobody gave us the nursing care [theory][146]" (Teresa, 01/06/2012)

> "When I was third year [student], (…), we were supporting the second year, first year [students]. That time I saw that the students were only memorizing everything; they didn't CREATE anything" (Sumita, 18/03/2012)

> "Knowledge is our basis, clinical is your next. Clinical skill and professional SKILL and behaviour, is important for taking care of the patient. The same motto is for nursing and for medical, orthopedicians, is for everybody, there is no excuse" (Amena, 29/05/2012)

[146] My emphasis

Overall, the nurses show in their narratives a good capacity to integrate theoretical notions with practical examples. It has to be remembered, however, that they are all nursing educators. In addition, the tendency to attribute meaning to past experiences should be considered as well (Schutz 1972; De Miguel 1996). In any case, what seems clear is that, by stating their interpretation of nursing care, nurses were able to narrow the gap between the British-inherited curriculum and the realities of the wards. In this sense, these nurses managed to conceptualise nursing care as a form of *praxis*, that is, "a practice informed by various forms of knowledge" (Falk Rafael 1996, p.15). Their analyses and conceptualisations of care show a highly reflective and elaborate narrative that moves far beyond classical notions of 'ordered care' (Reverby 1987). Nevertheless, when it came to translate the 'Nightingale' rhetoric of service into practice, several challenges emerged.

7.2.3.1. First encounters with patients: Getting past their shyness and becoming 'strong'

The move from the classroom to the clinical areas is always an important moment for nursing students and is closely related to their gender and age (Spouse 2003). For many, it is the first time they are exposed to patients' suffering, and in many cases, their death. This can be emotionally draining if students are not mature enough, or if they are left without supervision and support. Rabeya laughed when she recalled how embarrassed she felt when she had to insert a urinary catheter to a male patient for first time. For Rabeya and her classmates, talking to patients and their families was initially difficult and they had to be pushed by the nurse in charge to go to the patients' side:

> "[The nurse in charge would tell us]: 'Why are you standing here?' [There was] no sitting arrangement there, always standing. If we came in front of the table [the nurse in charge would say]: 'Go, why are you here? Go, do, go'. Very hard (…) It was the male ward, you know, that time we fell shy because we had never met like this, our home environment was not like that. ALL were male person, adult. When I went, they told things (…), sometimes (…) their language is not proper. We felt shy" (Rabeya, 19/12/2012)

For many students, working on the wards was their first experience of dealing with what Leppard (2000) termed, using the nurses' words, 'the public'. Interestingly, Sumita, Farhana, Amena and Tuli highlighted that they were 'stronger' than other students. Amena

and Tuli explained that they often had to reassure other students who were more sensitive. Tuli reflected on the difficulties young students had to overcome:

> "That time I understood the situation of the student nurses, those who are coming newly and with this kind of environment. In our country the father is earning money, the mother is cooking, they [girls] are going to the school. After that, they are coming to the nursing and this is their work. For everything in the medical situation they need to adjust" (Tuli, 13/03/2012).

Nevertheless, Amena admitted that at the time, the students' relationship with patients and carers was good, and the formers' coping was better than today:

> "[They were] so empathetic. So this way we learnt, and the coping was good. But nowadays the BSc group think: 'OK, I am not a nurse, I will not be the nurse, I will be the nurses' teacher. Diploma nurses said: 'OK, if I can give a government job nobody said me anything (…) 'If I have a strong voice, the nursing superintendent or nursing supervisor doesn't say single word to me because I am shouting them'. See the differences?" (Amena, 18/12/2012)

Benner and Wrubel (1989) extensively reflected, from a phenomenological perspective, about the importance of finding a balance between detachment and over-involvement. Emotional detachment from patients is used as a coping mechanism for formal and informal caregivers (Carmack 1997). Furthermore, nurses often undergo "an unofficial socialisation process where it is considered unprofessional to become too close to patients" (Dowling 2006, p.50). Authors like Benner and Wrubel (1989) were critical of mechanistic models of stress management that sidestepped the emotions involved in the intersubjective experience of caring. Even though they acknowledged that distancing strategies were useful, they rejected the idea that "detachment and control are always preferred modes of coping" (1989, p.3). Pretending to be completely detached would be not only useless, but also impossible, as we live in a world where all of us "are permanently mortal, that is, not in 'final' control" (Haraway 1991, p.201). In any case, carers seem to eventually find a balance between detachment and involvement (Dowling 2006). Farhana reflected on this:

> "I remember that when the first patient died in my ward I cried with the relatives because I felt so sorry for them (…). Then gradually I was ((she laughs)) strong, I didn't cry (…). That time I cried, cried, cried. Some students couldn't cope with these things and they gave up" (Farhana, 18/03/2012)

From a gender perspective, Davies (1995) wondered why should being close to patients should be termed as 'risky'. For her, becoming close meant " crossing boundary between the rational action appropriate for the public domain and the intimacy which our gendered thinking reserves for the private and domestic one" (1995, p.146). Similarly, for Bangladeshi nurses, gender and social norms may be more significant than 'professional' detachment. Rabeya provided an example of the tension between providing intimate care and being 'modest':

> "One patient I had. Her name was Sazia and she was maybe fourteen years old and she had a tumour. She was a nice girl; she and her mum, they liked me (…). But then I saw that her brother is interested (…). He is doing engineering in a good university. But I thought (…) that it would be better to detach [myself from them]. The next time [that the girl was] admitted, [the boy] called me [at the hostel] and then I told my roommate to tell him that I was on leave ((We laugh)) (…). Because in our culture [it would be] a little bit problematic if you (…) [become] close. Then, from ANY AGE they would come and stand in the hostel gate and your prestige would be concerned. [People] think in another way; this is difficult" (Rabeya, 18/04/2012)

In some cases, however, nurses challenged the hegemonic gender and class ideologies. Their eagerness to learn and in some cases, their compassion for other people, pushed them to provide intimate care not only to male patients, but also to patients who had been ostracised for 'being poor', having 'smelly wounds', and other stigmatising conditions. Sumita and Tuli reflected this mixture of being 'strong' and 'compassionate':

> "Actually I was thirty kilo and I was strong (…). One of my colleagues saw blood then she fainted, then she left (…). I was a little bit strong, I was never afraid or never fainted (…). I was interested to know more: 'What is that? Why blood? From where is this blood coming? How can we stop it? What is the doctor doing? Like this (…). There are SO [many] bad cases (…): infection cases, bad smelling, no? Nobody liked that, but I said: 'You just supply me the materials'. Then I did it in this way and I enjoyed with that. Because it was in my mind that if I learn now, then it will be in my mind, any type of cases that come I can overcome them. That's why I always tried to work with the serious cases" (Sumita, 18/03/2012)

> "One day seven patients came (…) There was a robbery in one village and [one] was wounded seriously (…) He needed seven blood bags. He would not survive but the doctors wanted to see the end of the patient, what way it is happening, because in medical college that time doctors want to learn something (…) They called me because I was always interested to learn something (…). That time I had no duty,

> what way I will go? Because my Sister Tutors will see that I am going but, why? Then I used my brain a little bit. I uniformed myself. They wouldn't know if it is my duty or not (…). So I passed this way because I wanted to help the sick people and also I wanted to learn" (Tuli, 02/11/2012)

This initial eagerness was also reported by Spouse (2003, p.189) in the UK: "when students first commenced their clinical placements, they were excited and enthusiastic at encountering the real world of nursing". All nurses in this study provided emotional and rich accounts of their first encounters with patients. They tended to emphasize that at the time they 'did not understand' (meaning they were innocent) and were getting too close to patients. Gradually, however, they managed to acquire a balance.

7.2.3.2. Nursing care as service: Spirituality and the rewards of helping other people

Chapter Five showed that the birth of the nursing profession in the Indian subcontinent carried a strong religious and gendered ideology of 'service' and self-sacrifice. Somjee (1991) observed that in India, a generational difference could be found between older nurses, who tended to reproduce 'service' and 'grateful' narratives, and younger nurses. According to the author, older nurses did not forget the their "social ostracism, indignity, and wretchedness in general, prior to joining the profession" (1991, p.45). Nursing, Somjee continued, had given them a 'second chance' in life, which also implied a sense of being useful to other people. In spite of acknowledging and supporting younger nurses' higher qualification and assertiveness, they were often seen as too demanding and less involved in 'human' care. In Bangladesh, even though senior nurses shared the view of young nurses as less involved in basic nursing care, I found that the situation was different from that in India.

Some nurses emphasised their religious commitment, although religion did not always occupy a central place in their narratives. Furthermore, their spiritual commitment did not necessarily lead to a denial of the material side of their lives. This section presents some statements by Christian and Muslim nurses about their conceptualisation of nursing as service. Their narratives show that even though Christian nurses tend to explicitly mention their religious values, the spiritual experience of care as service to humanity is by no means

exclusive to them. In the end, the *caring* experiences of the nurses were similar regardless of their religion.

Before moving forward to discussion of the notion of nursing as service and the religious and gendered ideologies behind it, three aspects of religion should be distinguished: the ideological, experienced and social. The first is related to the influence of a particular set of religious or moral values, greatly linked to the Judeo-Christian tradition, in the birth and further development of modern nursing. The relationship between religious orders and nursing and to the Victorian ideology and nursing reform were historically situated in Chapter Five. Many of these values have persisted in hegemonic definitions of nursing care, including notions of service, self-sacrifice, devotion, self-denial, etc. Undoubtedly, nurses' socialisation and their process of identity formation are greatly influenced by this particular ideology. Nevertheless, there is another element which has to be considered when analysing the role of religion and spirituality in nursing which is more existential and is related to nurses' lived experiences when taking care of other people. Finally, religion also works as a form of social grouping and identity marker, which has a significant relevance in the context of Bangladesh. Similar to what happens with ethnic adscription, belonging to a particular religious group affects people in different ways depending on whether it is the religion of the majority or not.

For instance, one nurse stated that she was discriminated for being Muslim in a context where Hindu nurses were the majority, whereas other Hindu and Christian nurses also acknowledged that their belonging to 'minority groups' had affected them in some occasions. The severest incident I heard in this regard was the experience of a Hindu nurse who was also interviewed in this research, although she was not a key informant. Apparently she had been prosecuted for being involved in 'nursing politics' and protests. On one occasion she was accused of anti-State activities and blasphemy. She was suspended from her job and expelled from a scholarship program to study overseas. She referred to the fact that she was a woman who belonged to a minority group as key aspects in her prosecution. Nevertheless, I interviewed other Hindu nurses who did not have such

problems. The above-described case seemed to be more related to her involvement in industrial action and protests than to the fact that she was Hindu.

It is important to consider that apart from these unfortunate incidents and from occasional comments of Christian nurses about their condition as a minority group, religion did not generally emerge as an explicit form of oppression. The key aspect about religion and nursing was more related to the historical association between the profession and minority religious groups. The paradox in Bangladesh and other Muslim countries like Pakistan is that the 'majority groups' in nursing have traditionally been 'minority groups' in society. Therefore, it is possible that some Christian nurses may have felt their position threatened in one of the few social spaces where they had a significant social and cultural capital. In addition, as Muslim nurses constitute in many contexts the majority group, some nurses feel that it more difficult to challenge them. One Christian supervisor commented that Muslim nurses do not always behave well and when she tells them off, she has to do it in a soft way because she is afraid that they will leave. In contrast, she had met a Christian nurse who was 'less knowledgeable' but a harder worker. According to the supervisor, the nurse was afraid of losing her job, as she was not fully qualified to work as a Senior Staff Nurse in other hospitals. Therefore, it is not just a matter of numbers, but also of social and educational capital.

I did not usually ask nurses directly about their religious feelings, although in some occasions it came up. When this happened, I let them know my position, telling them that even though my family was Christian by tradition, I did not follow any religion. Two nurses, one Hindu and one Muslim, portrayed themselves as liberal, even though they did not use this term. One said that she was not 'mad on religion' and the other said she was 'not very religious'. In general, however, the nurses' views on religion were diverse. Some had a strong religious rhetoric, especially those who had been nuns. One presented a deep 'existential' or spiritual narrative, constantly reflecting on her position in the world.

Sumita, a Christian nurse, provided an elaborate reflection of how by being responsible and providing good nursing care to her patients, she was rewarded by their prayers. This was one factor that made her successful:

> "Suppose one patient (…), nobody likes to give bed bath, arranging everything, and giving dressing. But I did that and I feel satisfied. Because when the patient is discharged (…) she will be waiting for me (…), she will say 'thank you'. Her carers will also be happy (…). She will go back to her relatives and say something about our hospital, not ME. Then so many patients will come. That means hospital's benefit, not my benefits. My benefits is, is that when the patient will pray, she will tell something to God (…): 'That nurse has taken care of me you just help her'. That's why I am, I am here, you know? Only for, I think that the patients prayed for me" (Sumita, 11/03/2012)

Tuli, Christian as well, made a similar reflection when she was narrating how she helped other people during the War and also through her service as a nurse. In the second interview, a strong sense of 'calling' or vocation emerged:

> "I thought that IF we are in right way and paying attention to EVERYONE who is suffering, God will be with us" (Tuli, 13/03/2012)

> "I was SO happy because I gave especial care two patients and they survived. Amongst seven, three of them are survived (…). So I thank to God for that. In the 11th hour, who is with me? This is something, this is the call of God, otherwise nobody can do it. There are so many people in this world, but they are not being used by God (…) Sometimes I have the painful thing [experiences] but (…) all these things are encouraging me (Tuli, 02/11/2012)

Tuli also believes that the suffering she had to go through, especially during her childhood, has helped her to sympathise with other people who are also suffering. She concluded that all this was God's wish. Teresa pointed to God as well when she reflected on her nursing experiences. Talking about her future plans to look for a job overseas, she was confident that the 'authorities' would consider her commitment to nursing service:

> "I will get the certificate and before going. I will take my good professional standing certificate from my BNC and from my nursing director some recommendations about me, also from some other institutes where I am working as a volunteer (…). Then I will submit there [overseas] (…) because they will think that I am Christian and I am

serving the people, I've been serving the people so they can guess what type of lady am I" (Teresa, 06/06/2012)

Amongst Christian nurses, only one directly linked the 'deterioration' of nursing care to a loss of Christian values. Similar to the Indian nurses described by Somjee (1991), she highlighted that nowadays nurses who join from mainstream religion, i.e. Muslim nurses, are more interested in getting a salary than in serving people. After hearing this narrative and getting to know more about the 'Nightingale rhetoric', I decided to ask Farhana, a Muslim nurse, her opinion on this particular issue. She agreed that in the past, women from Muslim families did not want to join the nursing profession, and that nowadays more women are coming because they need money. Nevertheless, she did not think that there was a difference between nurses and religious groups in the way they worked:

Susana: Do you think there was a difference between Christian, Muslims and Hindu in the way they touched the patients, or they approached to nursing profession?
Farhana: No, I didn't think anything because (…) similar way we work there
Susana: OK. Because I know that sometimes people understand nursing as a religious duty, like to care for the sick persons, or care for the poor people, I know that Christian religion says that but I don't know
Farhana: Muslim also say, like, if you care the poor people you will get the Allah (…).I am Muslim but always I think (…) I am a nurse, I don't have any male or female, or Muslim, or Hindu, anything, all patients are same for me (…), that's why if you feel like that you are a nurse and all patients same for you (…). This way you will work, I know since the student [life] I worked very hard and ALL doctors and everyone liked me (Farhana, 04/03/2012)

Two other Muslim nurses also shared good memories of working on the wards. Amena narrated how emotional she felt when a lady who had been paralysed for a long time began walking. She and her students had been closely involved in the care and she felt proud of them. When the lady called Amena to tell her she was walking, she said she "was feeling different and automatically tears came" (Amena, 29/05/2013). She referred to the reward for caring for other people as a different sort of power. Nevertheless, caring for others did not stop her from protesting when there was any kind of mismanagement:

"After joining in nursing, I have done well in the performance and in the practical side (…). I also enjoyed nursing, because when people are satisfied with their care, then I feel satisfaction (…). But I was very strong in support of, you know, any

> mismanagement or anything: 'Why it is happening, what?' As [I was] young so everything [I was] protesting" (Amena, 18/12/2012)

Therefore, the rewards of helping other people emerged from the caring experience itself. The Judeo-Christian rhetoric of self-sacrifice and Victorian ideologies of gender and class that imbued modern nursing have all had a significant influence on the 'Nightingale rhetoric' of service. Somjee (1991) argued that in India, the association of nursing with motherly affection was problematic as it did not adjust to local behavioural patterns for interpersonal relations. Similarly, the rhetoric of service was not always followed by all nurses. Most importantly, it did not necessarily translate into self-denial or oppression. The nurses in this research managed to gain respect within institutions thanks to their performance, which often fell closer to the idea of 'managing' or 'handling' patients, relatives, and the overall functioning of the ward.

7.2.3.3. Acquisition of responsibilities: 'Managing' the wards and 'doing everything'

Olson (1997) observed that in the files of the nursing students of early twentieth-century US schools, their activities fell closer to the notion of 'handling' than to that of 'caring'. Indeed, control and order were often applied to nurses themselves. From the time of the nineteenth century reform and throughout the twentieth century, nurses were in many contexts *trained*[147] under a strong discipline system. Their involvement in repetitive, often meaningless tasks left very little room for creativity (Stein 1969; Reverby 1987; Doering 1992). Furthermore, it could also be a way of imposing discipline on nurses. For instance, Tuli and Amena explained that keeping inventories was sometimes stressful, because they were blamed if anything was missing. Teresa, on the other hand, saw 'cleaning' and 'order' positively. She laughed while recalling that when she first joined as staff nurse in a small clinic, she immediately started "to clean the hospital like Florence Nightingale".

In any case, it seems clear that the link of certain activities with domesticity and 'femininity', dispossessed them from any value in terms of scientific knowledge, which was for a long time a 'masculine' domain (Doering 1992). Gonsalves (1999a, p.127)

[147] It has to be remembered that from the beginning of modern nursing, "nurses were to be 'trained', while physicians were to be educated" (Doering 1992, p.28).

observed that the concept of nursing in Bangladesh was associated "with the tasks that nurses perform i.e. physical care, material management in the ward, housekeeping and maintenance of cleanliness". According to the author, the fact that these activities were not highly valued by the public was a significant influence on the low status of the profession.

Interestingly, however, some nurses in this research seemed to regard these activities as a way of gaining recognition in the institution. Their pride lies more in their sense of 'managing' and getting responsibilities than in a sense of fulfilment when realising activities related to 'order' and 'cleaning'. Agnes stated how she was usually placed on the morning shift because she could manage the ward. Teresa and Rabeya were preferred for working at nights because, contrary to what other nurses did, they never slept. Rabeya stated how they normally placed her in the 'heavy' wards. Farhana was probably the nurse who emphasised the managerial aspects of care to the greatest extent. For her, *managing* the wards and the patients implied being accountable and therefore, respected:

> "I worked very hard and the, ALL doctors and everyone liked me because (…) I managed the ward (…) I worked myself, so [I got] everything organized (…) I managed the patients, if any patient came I managed them, since my student life" (Farhana, 04/03/2012)

This understanding of 'management' goes beyond its material or organisational aspect, as it also meant ensuring that patients were properly taken care of. Therefore, the notions of management and service were not necessarily antagonists. The distinction made by Saillant (2009) between the *compensatory* and *relational* aspects of care may be useful in this regard. According to the author, both forms of care are intimately connected when the former is understood as a social activity.

Nurses from both Government and non-Government hospitals stressed how student nurses were indispensable on the wards. Moreover, during the evening and night shifts, there were many fewer nurses and students were often left by themselves. Early in their student life they were asked to undertake significant responsibilities. Some were in charge of the wards before completing their Diploma. The Philanthropic Hospital where Teresa and Sumita

studied was almost entirely run by nurse students. The following account exemplifies their gradual acquisition of responsibilities:

> "From the first year we know how to give injection, how to make beds, [attend] the round with the doctor, carry orders from the doctors, everything. Because there is no staff nurse; we are the ones. Third year *apu* [sisters], they are the seniors. We learnt from the students ((We laugh)) (…) Because at that time, after completing fourth year we had a bond for two more years. That time we were the staff in charge of the ward" (Sumita, 06/12/2012)

At that time their teachers were not regularly supervising them clinically. Therefore, it was normally the nurse in charge, staff nurses, brothers (male nurses) and doctors who helped them learn practical skills. There are reasons to believe that leaving a hospital in the hands of students is not the best way to ensure accurate nursing care.

7.2.3.4. Praising the old apprenticeship system: Social change and nostalgia for the 'good old days'

So far, it is clear that nurses share a certain nostalgia for the 'good old days', especially in relation to the ways in which nursing care was delivered. Recent decades have witnessed rapid social and technological changes that have had a significant impact on nursing. Somjee (1991) analysed nurses' narratives in India and found a 'generational gap' between nurses in their conceptualisation of nursing service. As in many other contexts, senior Indian nurses complained about younger nurses' excessive focus on the 'technological' aspects of their work, and their 'materialistic' or 'practical' motivations to join and stay in the profession.

Schulman (1958; 1972) complained, in the late 1950s in the US context, that with the event of technology, nurses were less interested in acting like 'mother surrogates'. Salvage (1985) found the rhetoric of service and of nursing as a 'vocation' and nurses as 'born, not made' was still present, especially amongst senior nurses. In Bangladesh, current students were generally seen as more 'knowledgeable', better educated and more assertive. This aspect was viewed with certain ambivalence. On the one hand it was clearly a sign of the improvement in women's access to education. On the other hand, however, young nurses

were less experienced practically. In some cases, their higher academic background was seen as a barrier in providing direct nursing care.

Two further aspects should be highlighted regarding tensions between the apprenticeship and professionalist models. First, the rhetoric about the general 'deterioration' of care should be considered. Secondly, it is important to remember that students are currently meant to be supernumerary[148] clinically. This is related to historical efforts taken by nursing reformers to move away from the old apprenticeship model (Basavanthappa 2009b). In this way, students would be able to work jointly with their mentors while being in a "safe position to make mistakes" (Spouse 2003, p.205). Nevertheless, the nurses in this research are not always that positive about the current education system when they compare it to their experiences as students.

As happened with nurses' idealisations of their 'vocation', their portrayals of their educational period can also carry a certain reification of care. Nevertheless, more than thirty years have passed since nurses were admitted in nursing and the social change and generational gap are undeniable. One of the most relevant and positively-regarded aspects of the current system is that it has managed to attract a wider and highly-educated range of candidates to the profession. Nevertheless, there also a general feeling amongst nurses was that current students are less experienced practically. In contrast, they are more knowledgeable in technical aspects ('computer') and in English. With the new Curriculum, students are now required to hold HSC certificates and, according to Rabeya, preference is given to students with a science background. These changes in nursing education have been accompanied by broader changes in Bangladeshi society that are especially significant with respect to access to technology, both in the educational and medical fields, and to women's position in society.

Rabeya observed that current students are more mature and able to 'understand' things better, whereas in her times, they just did what they were told to. In this context, the idea of

[148] The UK Nursing and Midwifery Council defined the students' supernumerary status as the prohibition of being employed, as part of their preparation, "by any person or body under a contract to provide nursing/midwifery care'" (NMC 2004, cited in Allan et al. 2011, p.848)

'understanding' is more related to the previously described notion of maturity than to an academic or knowledge-related understanding capacity. It also implies that students are more assertive; they have now more bargaining capacity and they are able to challenge and question what other people tell them to do:

> Rabeya: Now students [are] more clever, more meritorious (…). They can understand. REALLY this is the fact. That time we never realized why we did things, because somebody ordered us: 'Do this one'. We did, we never asked: 'Why I do this thing?' Because the senior person told me 'Do' (…). Day by day it will change; when we are more aged and more experienced, then we can realize why it is essential.
> Susana: Because when you were studying nursing you were young, you were like fifteen, or sixteen
> Rabeya: Sixteen years, that time we can't [understand] (Rabeya, 18/04/2012)

Tuli was also positive in relation to the uplift of the entry requirements for nursing students and highlighted how significant was for the nurse leaders to upgrade the educational background of their students:

> "That time those who prepared the curriculum, we are telling that [nursing] is a pure science, so with SSC people are not capable for this kind of standard curriculum. We need intermediate [students] and we also need to improve a little bit their English (…). We had to fight with this and finally we sanctioned intermediate [level for the applicants], so we are very pleased for that" (Tuli, 11/05/2012)

In Bangladesh, where the status associated with higher education is especially important, professional discourse has the potential to fall into an elitist narrative. The stereotypical belief of 'no money, no brain equals getting admitted in nursing' was discussed in Chapter Six. This historical devaluation of the nursing profession has clearly influenced nurses' focus on the educational upgrading of nursing education, leading to an increase in entry demands for nursing candidates. Some nurses seemed to be caught in the dilemma described by Reberby (1985) between care as service and professionalism. The more recent analysis of Davies (1995) in the UK showed that nurses were still facing a similar situation. According to her, this was mainly because "the vocabulary of professionalism and the strategies of knowledge creation leave no place to discuss the contradiction of care, and the paradox of daily experience" (1995, p.145). Davies attributed this tension to the fact that

the professional discourse was based on a patriarchal managerial ideology, which gave little room for 'feminised' experiences of care.

Three main issues emerged from Davies' analysis, which have been also found in this research. First, professional caring maintains a complex relation with scientific knowledge. Second, professional carers integrate emotions as a necessary aspect of their work. Besides, the interpersonal relationship between carers and cared for is not only one-to-one, as Daniels (1987) observed. In a way, this aspect reminds us of Schutz's (1972) various levels of subjectivity. Finally, the process of caring is by nature uncertain and therefore, learning to be flexible is part of care-related knowledge.

The nurses in this research were aware that increasing educational standards was a necessary step to take. Nevertheless, they soon realised that if it is not accompanied by improvements in nurses' performance on the ward, their efforts are worthless. Interestingly, their views break with the old dichotomy between nursing 'science' and nursing 'arts'. The former, greatly defended by the early professionalist discourse, undermined the aesthetic pattern of knowledge in nursing in an attempt to overcome past apprenticeship models (Carper 2006). The following quotations from Amena point to this articulation between the apprenticeship and professional models. She was referring to the current students from a direct BSc programme, who had asked for an extension of their placements in the form of a post-graduation internship:

> "Previously what we say, student nurses are like fair star, they are always taking care of the patient, and internee doctors are like fair star (…). Fair star means like angels. They are doing all their hard work in their internship and during their studentship. So people are looking and [thinking] 'Oh, that small students [who are] coming, they are very good, very gentle, very polite, taking care of me (…). Because they come and everyday look at me and ask me how I am. So I feel good that at least somebody is there to take care. She didn't give me medicine (…) but everyday she came and ask'" (Amena, 18/12/2012)

> "Students now are getting afraid (…) because they don't know any clinical life [before] going to join in any places [as staff nurses] (…) [One teacher] also said: 'Because of their computer knowledge and English knowledge they will be well accepted', I said 'No, maybe for few nurses it may be possible BUT the hospital requires clinical skills. Professional skill is not English or (…) computer skills.

> Computer, anybody can lean within (…) three to four days (…) [But] how the nursing service or medical system works, that is in the program" (Amena, 29/05/2013)

Two nurse teachers, who had been involved in high-level planning throughout their professional lives, shared a critical view on the ways in which changes in nursing education were implemented at a political and local level. One observed how many nurses enthusiastically applied a model from Thailand as a way of overcoming the past 'apprenticeship' model. One nurse made two critical points in this regard. First, it was not true that all Thai hospitals were following international standards. Second, as the situation in Bangladesh was very different, the new model was misunderstood and led to an unexpected outcome: students began getting less involved in patients' care. Furthermore, according to the nurse, many teachers and nurse leaders accept these changes uncritically. That makes it very difficult to implement changes because the models are decontextualized.

As in many other areas, there have been significant implementation issues in relation to implementation of the new curriculum. First, not all teachers are familiar with the new system. Second, in spite of changes in the curriculum, the gap between theory and practice is still unresolved and students' clinical role models are not always accurate, as one teacher observed. Overall, the narratives of the nurses provide a general feeling that things have changed and that for several reasons, nurses are less involved in direct patient care.

> "We did everything for patient (…) But nowadays I saw the students they are not taking this responsibility" (Farhana, 04/03/2012)

> "[We did] all kinds of work, no? (…). In the morning also bed, bed making and in the evening time, those who will join in the evening at two after taking handover everybody should go to the bed to make bed again, but nowadays never" (Agnes, 26/02/2012).

> "At time we don't know the activity of daily living. We didn't know but we did everything" (Teresa, 26/03/2012)

> "Morning time we ALL together we worked with the patient: changing bed, dusting, and giving bath, then EVERYTHING finishing then we start our other activities" (Sumita, 03/11/2012)

This historical devaluation of nursing knowledge, especially the practical side, has clearly influenced nurses' focus on the upgrading of nurses' educational level, although the 'old apprenticeship system' had its strengths as well. Some nurses seemed to be caught in a dilemma. They were aware that increasing educational standards was a necessary step to take. Nevertheless, they soon realised that if it was not accompanied by improvements in nurses' performance on the ward, their efforts would be worthless. On one occasion, Tuli provided a clear example of this ambivalence. She was explaining that when she was studying her BSc, in the 1980s, a nurse leader came from Pakistan to conduct a seminar about nursing. They discussed the changes that the nursing profession was facing in Asia:

> "This lady asked: 'What do you think, my children, why the Asian countries are destroying the nursing care of the patient?' That time, so many people are telling: 'We are not highly educated, we are not getting in-service education'. But I stood up and said: 'We are keeping ourselves away from real nursing care, we need to improve it. Then we will meet our status; we will get the value from the society, by the people'. And then this lady is telling: 'Yes, my child, you are correct. We need to come back to give the proper nursing care to the patient" (Tuli, 11/05/2012)

Tuli acknowledged that the way in which nursing care was delivered to the patients had to consider the 'culture' as well. Therefore, 'professional' and 'service' discourses do not necessarily have to be antagonists. Most of nurses in this research managed to find a balance between both ends of the 'professional versus service/apprenticeship' dilemma. They were highly educated and strong defenders of the importance of nurses' access to technical and formal knowledge. At the same time, however, they were also advocating for an 'embodied' form of knowledge (Benner & Wrubel 1989). The latter emerged mostly from their intersubjective experience with the patients and their efforts to integrate theoretical and practical knowledge.

Drawing from the nurses' narratives about their encounters with patients, a third conceptualisation of care emerges as a form of praxis. The emphasis on the structural transformative capacity of caring was not found in all nurses. Interestingly, those who most clearly reflected on it were Tuli, from a more 'service-oriented' perspective, and Amena, from a position that was more close to political economy and social justice.

7.2.4. Nursing care as *praxis* and socio-political knowledge: 'A different sort of power'

Falk Rafael (1996, p.14) stated that socio-political knowledge in nursing "has a revolutionary component that involves an awareness of and commitment to change problematic social and cultural contexts". Just as the intimate relation with people from different backgrounds helps in breaking stereotyped assumptions, nurses' encounters with people who are suffering could provide them with a greater sense of social justice. This latter aspect is related to what the author termed "empowered caring ontology" where both patients and nurses were "transformed during the caring relationship" (1996, p.15). *Empowered caring* can also be related to what White (2006) had identified as socio-political knowledge in nursing and to Chinn and Kramer's (2015) *emancipatory knowing* and *praxis,* which are related to awareness of injustices and their questioning in practice. Instead of terming it *empowered* caring, my proposal is a slight modification into *empowering* care. With the modification from a past participle into a gerund form, I imply that it is the action of caring itself that can be empowering for both carers and those cared for.

In the lives of the nurses presented so far, a constant tension emerges between nursing and power, which is greatly articulated around the notion of knowledge. Nevertheless, not all explicitly reflected on this three-way relationship between nursing care/power/knowledge and their narratives are unbalanced. Some nurses, especially Tuli and Amena, provided articulated reflections about the ways in which they experienced the effects of social inequalities when caring for disadvantaged people. Their positions against social inequalities could range from denouncing the disadvantaged position of young women, to describing the discrimination many patients suffered within the health system. Interestingly, they started from apparently different perspectives on nursing care.

Tuli portrayed a more 'service' ideology, whereas Amena took a 'political economy' approach. Yet both shared a common experience of witnessing social injustices and reacted to them. This is not to say that other nurses were not critical towards social inequality. In many occasions, they reacted against gender violence or their discrimination within the

medical system and society. Nevertheless, the narratives of Tuli and Amena were more explicit in relation to their socio-political knowledge. Not only they acknowledged injustice, but they often suggested or conducted actions to fight against it. The following account exemplifies one of these actions, in this case related to the redistribution of resources:

> "I have SO MANY stories through my nursing life. What way I offer my idea, my experience and my help to people (…). When I was in third year (…) I was in the surgery ward and it was postoperative room. I am giving night duty, that time I observed that there was one patient who was maybe 35 years old, had three children and a young wife. Another patient was the mosque's imam. He suffered from abdominal obstruction and had got surgery. He had five saline bag there but these poor people had only two and he needed another one, but had no money. That time I thought I could take one from them [the imam]. But I am student, I need to take care for myself also. If I am taking this bag and giving it to him, then [they will say that] the nurse is the thief, stealing these things. So I went to the imam and talked with him" (Tuli, 03/03/2012)

Tuli's conversation with the imam is an example about the ways in which nurses can advocate for other people's needs. The following quotation is presented in the way in which she reproduced the conversation with the imam:

> Tuli: You are now OK, you have no need, so you have three bags. If you give two bags to this people, it will be very helpful for him. When you will get to your house, what you will do?
> Imam: I will go and I will make *Milad*[149] and I will give food for the poor people
> Tuli: So you can help also with this, this one and it will be more effective to Allah

Interestingly, Tuli managed to 'protect herself' also in this situation, so she decided to ask for a written permission from the imam. She concluded that after this incident, the doctors were surprised and it was through this kind of situations that they managed to know her.

> "I took writing [permission] because otherwise it will not be effective, so I noted and he signed and I managed it in this way. The day after, in the morning I talked with the doctor. Oh, the doctor was getting a big surprise. So this way some of the doctors also know me" (Tuli, 03/03/2012)

[149] Muslim celebration of the birth of Prophet Muhammad (PBUH)

Tuli's experience may sound familiar to many nurses. Unfortunately, however, these kinds of actions where nurses act as key agents in patients' recovery are not always publicly recognised. Davies (1995) remembered a comment from a nurse in the UK who had been participating in the RCN project who clearly showed this lack of visibility. The nurse's contribution had been crucial for the patient to survive, but when a friend asked the patient about his stay in hospital, he only praised the work of the doctors who had operated on him. This points again to the greater value that cure receives over care (Comelles 1996). This was termed by Salvage (1985, p.7) as the 'tyranny' of the healthcare system where "doctors, the active curers, are seen as scientists – logical thinkers who can be relied on to make tough decisions based on hard fact – while passive nurses give tender loving care". Needless to say that in Bangladesh a similar situation could be found. The nurses in this research had repeatedly stated that they did not feel sufficiently valued by 'society'.

In spite of their lack of recognition, working side by side with patients and easing their suffering provided nurses with an inner strength that was also related to a sense of social justice. Interestingly, Amena, a Muslim nurse, compared the 'power' that she felt when getting involved in 'nursing politics' and protests, with that she felt when taking care of patients:

> "From my student life actually. When I am caring for the patients I feel different, you know? The power, I feel a different sort of power: 'Oh, I can do the good things for the patient'. This is a very inherent thing that I learnt from patient caring and I enjoyed that (…). I never thing about [getting] promotion or anything I think about people's love, patients' love is different, the feelings are different, it is satisfaction (…). (Amena, 29/05/2013)

It has to be highlighted that Amena came from a family with a strong sense of social justice. Furthermore, her father had always taught her about the importance of gender equality, pushing her to study and get financial independence. Their views remind of the ways in which Davies (1995) portrayed new practitioners as engaged; interdependent; accepting of an embodied use of the self as part of the therapeutic encounter; creators of a community where solutions are negotiated and reflective users of their expertise.

In summary, the reward for caring for other people cannot only be linked to the Christian ideology, even though rhetorically it could sometimes seem so. A significant aspect here is that the (rhetorically) 'Christianised' notion of service has been seen as a further contribution to nurses' oppression. Low salaries, poor working conditions and low investment in education have been historically justified thanks to the notions of vocation and service. Nevertheless, nursing service does not necessarily have to lead to self-denial. Therefore, the 'disempowering' of caring activities has more to do with the low social value attributed to them than with the experience of caring itself. This opens up a new conceptualisation of nursing care in Bangladesh that breaks with the previous views of nursing as a 'low status profession'. It also challenges the idea that nurses in Bangladesh 'do not nurse' or that they avoid patients' care in order to protect their status. Some nurses have shown that it is possible to maintain ethical practice while at the same time fighting for their rights and those of the patients, and most significantly, to produce and transmit a locally meaningful form of nursing knowledge. Last but not least, they seem to have managed to gain social recognition and to overcome the initial reluctance of their relatives and social networks regarding their profession. This aspect is explored as follows.

7.3. BEING A NURSE IN THIS SOCIETY: FROM STUDENTS TO STAFF NURSES

Most studies highlight the consequences which being a nurse in Bangladesh has had on their family and social relations (Alam 1975; Leppard 2000; Hadley et al. 2007; Zaman 2009). Considering that most nurses were very young when they were admitted into the nursing institutes, receiving support from their families was crucial. Their relatives' initial reactions varied from leading them to join to strongly opposing their decision. The nurses had to 'manage' their family members in several ways, which ranged from direct confrontation to more subtle resistance strategies.

By the time that the nurses completed their diploma, they were on a 'marriageable' age. In the case of nurses, their profession can be both a limitation and an advantage in regard to their marriage arrangements. Even though working within a clinical area is believed to decrease their possibilities in the 'Bride market' (Alam 1975; Nair & Healey 2009; Hadley

et al. 2007; Zaman 2009), their higher education and financial independence can also be an advantage (Somjee 1991). Finally, their role as 'knowledgeable' caregivers can also help to increase their social recognition within their families and closest social networks.

7.3.1. Moving away from the 'safety' of the institutes: First working experiences of the nurses

The transition from nurse student to staff nurse is usually a crucial moment, as it involves a significant change of role. In the case of the nurses in this research, however, it did not mean that much in terms of practical work as they had already taking great responsibilities as students. The biggest difference was that they were now employed by the hospital. Amena, Farhana, Agnes, Rabeya and Tuli all joined Government positions directly after finishing their Diploma. Back in the day, the students with the best academic results from the Government institutes were offered positions as staff nurses straight away. Sumita thought that this was an unfair system, as she could not join a Government post in spite of having stood first within her batch. This was because her institute belonged to a philanthropic institution. She and Teresa had to move to Dhaka in search of better job opportunities. They worked in small private clinics at first, but did not last long, mainly because of the working conditions. Sumita joined a big paediatric hospital in the capital and Teresa moved after some time to a district capital and worked in an NGO-led community project. Her joining was almost accidental, as she was just visiting a relative from that area when she was asked to join the project.

Accommodation and workplace safety as significant issues, especially when they were unmarried and had to move to the capital in search of a job:

> "That was very tough, seeking a job, because we knew NOTHING about Dhaka city at that time (…). We were going to different clinics with our papers, and then just meeting with the directors and board, chairman (…) [We told them]: 'We passed our diploma nursing (…) ((laughs)) if you need then you can interview us' (Teresa, 21/04/2012)

Sumita complained that in the first private clinic where she worked, the nurses were sleeping in a place that was like 'a tin shield'. Teresa, on the other hand, narrated how she

had to implement significant arrangements in terms of accommodation to ensure that nurses were not disturbed during their resting time. Salary was also a source of concern for young nurses, especially for those who had family duties. Teresa, for instance, was the eldest sister and on many occasions she had to support her younger siblings. Sumita, on the other hand, was left almost by herself in Dhaka and had to ensure a monthly income in order to stay safe.

Even though accommodation and safety was generally better for nurses who studied and worked for the Government, the situation was not much better in the small institutes outside the big cities. One nurse stated how unsafe they felt when she and another group of young nurses were placed in a small Thana Health Complex outside Dhaka. They were afraid because they were aware that nurses were vulnerable to physical attacks, especially at night. They protested and the hospital administrator eventually supported their claim to be transferred to a safer place:

> "That time (…), not many, some nurses have (…) [had their] full dress removed by the elite people's (…) son, those who are very much in power. [They] take [the nurse] and get married without consent (…). They are telling that 'Delivery is there, please come' and when she will go with them then [she got] raped. Not much cases but is happening (…)
> Thana Health administrator, doctor said [to the DNS director]: 'They are not safe here, many occurrences are going on (…). Because some young men are coming around and some things are going to happen. Please, take these girls who are not married' (…). That time, our age is like 22, very young" (Nurse, May 2013)

Again, being single was highlighted as a factor further contributing to their vulnerability. Tuli reflected on the vulnerable position of young students in this way:

> "The first time, when they are coming in the hostel, they are exposed to a different world, Dhaka. They can't keep the balance (…). They wanted to survive; they are searching one boy so they can survive (…). We are authority, we need to understand these girls and we need to find out the way [in which] we can manage them by ourselves, by their colleague, by our office rules and with communication with their guardians (…), this is the solution" (Nurse, May 2012)

Gender-based violence was explained and understood in different ways by nurses. They generally admitted the problem was structural, although some nurses also pointed to nurses'

individual behaviour as a 'cause' of their harassment. When I told one nurse that some nurses had complained about their personal safety in their workplaces, she said that it was not true that nurses were in danger. In her view, it was nurses who put themselves in risky situations:

> "It is not true [that the working environment is unsafe]. If you are not interested, it is not possible [to be harassed] (…). Sometimes the nurses' behaviour is so bad; this is one reason. When one time you misbehave with them, they remember this (…) and then they come to harass you" (Nurse, April 2012)

Nevertheless, later in the interview, she acknowledged that there were certain places, like the emergency services, where nurses were more exposed to aggressive behaviour from patients or relatives. Interestingly, she also mentioned that sometimes it was doctors who misbehaved. Finally, she admitted that it was safer for nurses to always wear uniform and avoid 'risky zones'. Cleary, being surrounded by 'the public' (patients and relatives, inhabitants of the cities) was perceived as a threat. Nurses could also be mistreated by doctors and other staff members, although they did not seem to be seen as 'dangerous' as 'the public'.

Regarding nurses' strategies to stay safe, their narratives initially ambivalent. On the one hand they acknowledged the need for 'protecting' themselves from the dangers of the 'outside world'. On the other hand, however, they sometimes 'blamed' the nurses for the consequences of their 'misbehaviour'. Marriage could help young women to acquire economic safety and a greater social status, although the link between marriage and safety is by no means straightforward.

7.3.2. Marriage: The ambiguous role of nursing education

Even though marriage is almost universal in Bangladesh, Rozario (2001a) found an increasing number of unmarried Christian women within the community where she conducted the fieldwork. Amongst the student and staff nurses interviewed in Alam's (1975) study, almost half of the Muslims were married, yet the number decreased significantly amongst the Hindu and Christian nurses. In this research, the two unmarried

nurses were also Christian and Hindu. The other key informants are married and all but one has children. Contrary to most nurses from their generation, their marriages were not arranged by their families.

Another significant particular of the nurses in this research is their residence pattern after marriage. Bangladeshi kinship system is patrilocal, and traditionally, the new couple move to the husband's house, at least for the first years of marriage (Islam 1979; White 2013). However, the nurses in this study followed a different pattern as they were all working in the capital and tended to stay in nuclear families. In some cases, like when Farhana and Sumita migrated overseas, they spent some time separated from their husbands and, in Farhana's case, from her son.

Religion did also play a significant role in the nurses' marriage patterns. Amongst the Christian nurses, Agnes is a nun, Tuli remained single and both Teresa and Sumita married at a relatively older age. Teresa was determined not to get married when her husband contacted her through her relatives and it took a while for her to accept his proposal. Similarly, Sumita did not want to get married at first, albeit for different reasons. Sumita's early reluctance was mainly because he was Muslim. Nevertheless, like Teresa, she eventually agreed:

> "Anyhow I get married, because that time I was like floating. Nobody was supporting from back, nobody was supporting from up [she makes the gesture], in this situation. And my age also going, you know? Bengali girls, if they are twenty plus, that means nobody will marry them. I don't have any family member, nobody, so where will I go? So better, I thought, I should just take a step to get marry him. Anyway, now I am happy" (Sumita, 11/03/2012)

When I asked her if she had to convert to Islam in order to get married, she told me that she had married him on the condition that she could maintain her faith. I once asked her if her in-laws had protested when they found out that she was a nurse. Her answer pointed to her education and income as a way of increasing her bargaining power:

> "My husband's family, they are not that much educated (…) and I am from Dhaka and I am also established, that means that I am stable, no? I work, I have a good job. I

> sometimes helped him, his mother heard that (…). Then my husband said: 'Even if I marry one blind girl, my family will accept' Then I said: 'I am, I am better than a blind girl'. They accepted me nicely, you saw my mother-in-law" (Sumita, 06/12/2012)

Interestingly, Sumita's case came up in a conversation with a younger woman who was also Christian and unmarried. She said that mixed marriages were unusual and that Sumita could do it because she was intelligent and strong. The association between intelligence and strength is interesting because it points to a particular form of agency that was constantly raised by the nurses.

The remaining nurses, Farhana, Amena and Rabeya, also met their future husbands without the intervention of their families. Farhana's future husband was studying at a Government university in Dhaka, next to the hospital where she was working as a Staff Nurse. Her family agreed because at that time he had completed a Masters and she was already working. Similarly, Rabeya became acquainted with her husband at the medical college where she was working. He was a pharmaceutical representative and would sometimes come to the hospital. He wished to marry her, but he disliked her profession, and he proposed to her on the condition that she would quit her job at the hospital. He did not let her work at first, but she ignored his advice and returned to work anyway:

> "He didn't like this profession. Before [getting married] (…) he told that he was not going to give me permission to work. That time I thought that it would be possible to work ((I laugh)). But after marriage, when my leave is finished then there was a horrible condition. He went out for work and I was alone in the room, so I felt bored. One day, without his consent, I went to the hospital and wrote my joining letter. When I returned from the hospital, my sari [was in the] *armary* [wardrobe]. Then he told: 'Why this is here?' Then I told: 'I feel bored'. That's why then he gave permission" (Rabeya, 03/06/2012)

According to Rabeya, her husband's views were due to the fact that he came from an area where people were very traditional and religious and they followed the 'previous concepts'. After having struggled to balance her work and family life, she held a critical view on gender discrimination:

> "Men they have all opportunities. They have girlfriends, they enjoy life, they are thinking like this. This is the difference with my husband. Because he thinks that I am female person so I [have to] work in the house, not go outside" (Rabeya, 03/06/2012)

Amena had also met her husband before getting married and they had to convince their families. Her husband's family were reluctant at first because of the fact that she was a nurse. Her family, on the other hand, did not like the fact that he was involved in politics. She compared her involvement in nursing with his involvement in politics. Their families appreciated both kind of activities, but they did not want their children to be involved in them:

> Susana: So [your marriage] was not arranged by the family
> Amena: No, not arranged (…) we convinced both families to get things done (…)
> Susana: So your families agreed
> Amena: At the last moment they agreed (…). I tried to convince my father and he was convinced, but the other family members didn't like his politics (…). My brothers thought: 'She needs to get married with a secured job man' (…). In his family, as I am a nurse, there was another problem: 'NURSE? No' (…). We needed to convince them (…)
> Susana: So eventually his family accepted the fact that you were a nurse
> Amena: Accepted like: 'OK if we do not accept maybe my son wouldn't get married'. So they, they accepted it in such a way. After my marriage, my father-in-law mentioned: 'OK, (…) could you just erase [his politics] from his head?' ((we laugh)). 'It is your task (…). If you could do it I will be very happy' (…). Because [my husband] was so KEEN with Marxist politics. [But my husband said]: 'No If you don't like it, then go (…) I don't mind you to make my father happy (…).
> Susana: So you couldn't convince him (…)
> Amena: No, I never wanted because I have seen that his father is very good man as a general people but (…) [he thought that] 'OK, politics, maybe done by other people, but not by my son'. In my family they thought the same thing: 'Politics? Maybe done by other people, not my son-in-law' (…). But my father was different, he mentioned 'OK, if he likes, what's wrong? (…) So it's OK, let them do their own thing'. My father is actually different" (Amena, 29/05/2017)

Mina was a Hindu nurse teacher whom I met towards the end of the fieldwork period. Unfortunately, I could only interview her once and for this reason, she could not be included as key informant. On one occasion, we were talking informally about her 'singleness' and she discussed about it without any regret, highlighting the fact that many

married women are unhappy. Like Mina, Tuli decided to remain single at a certain point. She had left the religious congregation at a young age and she would still have been able to get married after that. She received a marriage proposal from a Hindu man and although she considered marrying him at first, she eventually refused because of the way in which he behaved. She feels grateful that she did not marry that man, even though she acknowledges that she is now more vulnerable because of her single status:

> "When I came out from congregation my relatives, especially my elder sister was thinking: 'If you are not married, who will see[150] you? (…) In our culture this is the practice. Children will take care of their mother or father; husbands also take care of their wives (…). But who will take care of me?" (Tuli, 02/11/2012)

Sometimes people question her because she is earning money and they assume that she is keeping it for herself, even though she is not. Since the beginning of her independent life, she has financially helped many people and she is indeed living a very Spartan life. Besides, Tuli is now facing a dilemma regarding where she will stay, after her retirement. She has many friends who have offered for her to stay with them, but she prefers to stay with her family, which is better regarded in Bangladeshi society.

Mina moved to a friend's house when she got retired from her government post. She had always had a very close relationship with that family. Her friend was also a nurse who used to be her student. She was a Christian nurse, married with one child. Mina had always looked after the child as if he was her nephew. Nevertheless, not all the single nurses in Bangladesh could stay with other families. According to Tuli, some of the old unmarried nurses stay in nursing homes.

7.3.3. The role of nurses as caregivers: Beyond the professional sphere

Working as a nurse offers a great experience about taking care of sick and vulnerable people. Furthermore, the fact that most nurses work in medical institutions provides them with connections to health services. Nevertheless, considering that most nurses are women,

[150] 'To see' probably means, in this context, 'to look after' (in Bengali, *dekha-shona kora*)

their role as caregivers extends far beyond their professional obligations. This section focuses on the intersection between the different fields where the nurses are expected to act as carers, and the ways in which they articulate their multiple roles.

Teresa had her first child while she was studying for her MPH. This was hard, but she managed to finish her studies. By the time the interviews for this research took place, she had one son and one daughter. We talked about their education on several occasions; she was not very happy about the system in Bangladesh and that became one major reason for her family to move overseas. Sumita's only son is still young and not attending school. He stays in the house and when she is at the office, he is looked after either by her mother-in-law, her husband, or their young maid. Sometimes it becomes difficult for her to combine her professional development and her parental commitment. On one occasion she got the opportunity to travel overseas for a three-month research internship and she had to leave her young son behind.

Rabeya was working as a Staff Nurse in a Government medical college in the capital when her first son was born. Her husband was working in another city and she was in Dhaka by herself. Eventually, she decided to follow her husband to the destinations where he was working. She did some casual non-nursing work, like teaching or collaborating in local NGOs on an ad-hoc basis. It was not until they returned to Dhaka that she was able to resume her nursing career and start working in a consistent way. She would quarrel with her husband on several occasions, in a constant negotiation to be able to pursue her career as a nurse. Nowadays, her children support her in her decision to work as a nurse, and her husband has changed his attitude as well. According to her, the fact that she managed to continue studying made her husband regard her and her profession in a more positive way.

Farhana's son was born a long time after she first got married. For this reason, he was very special to her and her husband. She had to leave him behind when she migrated to Saudi Arabia and she would only see him every ten months. When she later moved to the UK, her husband and son went with her. Nevertheless, after some time, they returned to Bangladesh. She then moved to the private sector because she believed that the Government's posting

system could interfere with her family life. Rabeya had a similar opinion in the latter regard. In her case, she highlighted how difficult it was for nurses to access to government seats for BSc or post-graduate education next to the place where they lived. Rabeya concluded that this clearly hampered their opportunities for continuous learning, because 'in their culture', nurses were concerned about their children's care.

One big challenge for women, in Bangladesh and elsewhere, is carrying the double responsibility of doing all the housework and working outside the house (Islam 1979). Rabeya's narration of her daily routine also exemplifies the amount of household work that she has to undertake along with her work in the college:

> "Before going to the office all [household work] is completed. After [finishing at the] office I go home. Then I (…) open the fridge and I take meat, fish, everything put in the water. Then I take *roti* [homemade bread] and sometimes I go to the roof for walking[151] (…). I took a *bua* [domestic worker] this month and she is cleaning (…). Otherwise I clean the house, everything (…). At seven o'clock I sit for cooking (…), I have limited time. At that time my sons come, my husband comes and they sit (…). I prepare the *nasta* [snack] (…). They are not moving or not doing anything, so this is difficult (…). [For dinner] I have to prepare] meat for my son and fish for my husband. *Dhal* is compulsory, *baji* [fried vegetables] compulsory and *bhaat* [rice] is compulsory. So it is very difficult (…). But nobody will come and ask if I need help, never. Until twelve o'clock I work, work, work" (Rabeya, 03/06/2012)

Urban middle and upper class women from Bangladesh can reduce their workload by hiring domestic help, but their role as mothers and housewives is still predominant. I could observe that with the exception of Tuli, most nurses in this research had hired domestic helpers. Pérez Orozco (2014) made an interesting analysis of the way in which middle- or upper-class women delegate domestic activities to other women from more disadvantaged backgrounds. The author highlighted that in contemporary high-income countries, domestic and caring activities have not been socialised. Instead, they have been transformed in a

[151] Due to the perceived lack of 'safe spaces' for women in the big cities, walking over the rooftop was the only alternative for those who wanted to exercise without leaving their homes. Other middle-class women who had more free time would take a rickshaw to the nearest park and start walking around it in circles. Nevertheless, parks were not safe places either, especially when it got dark.

"new, sexualised and racialised international division of labour[152]" (2014, p.219). This aspect is closely related to what Pérez Orozco termed the *reactionary ethics of care*.

Some authors have denounced the extreme vulnerability of domestic servants, who are usually female and either underpaid or not paid at all (Enayet 1979; Begum 1987; White 1992). Unfortunately, this subject could not be addressed in the interviews, as it did not emerge as a central issue. I considered that it was a sensitive topic. In any case, I could see some nurses interacting with their helpers and I could see how they were always respectful to them.

Returning to the analysis of the nurses' role as care providers, it was not only children who were taken care by them. Most nurses referred to occasions in which they had to look after elderly or sick relatives, either in their homes or at the hospital. Rabeya stated how in more than one occasion she was in charge to speak to the doctors and manage the medical information. Agnes and Farhana provided with two examples where they had to be in charge of complex medical treatments of their relatives at home. On one occasion, I could observe that Sumita was also asked for medical advice by her neighbours. I asked her about this:

> "If anybody calls me, then I go there and I give whatever they need. Sometimes they want to push injection. Then I give it and say: 'This is free service (…). Sometimes they call me at midnight, even though I try to go and attend. It is actually for the pregnant mother when they call me during the night. I give advice and they take it (….) I always try to explain that I am a nurse, even though I am not working in the hospital but I am teaching" (Sumita, 06/12/2012)

Her narrative reminded me to Teresa's description of the time when she was a nursing student. Whenever she visited her village, she would be asked to conduct check-ups or administer treatments to her relatives and neighbours.

Drawing from the narratives of the nurses, it is clear by now that their education and working experience has provided them with a great source of social capital. Nevertheless,

[152] My translation

the combination of work and family life is not always easy to balance. This is a common issue elsewhere, and there is not enough space here to discuss it with the level of depth that it deserves. It must be highlighted, however, that in the case of these nurses, their role as caregivers was empowering in many ways. Even though some nurses were expected to undertake a significant amount of domestic work and other caring activities inside of the family, they still managed to pursue a successful professional career. This was achieved, however, thanks to significant efforts and personal investments.

7.4. THE NURSES' OUTSTANDING PERFORMANCE: COMPLIANCE AND RESISTANCE AS DIFFERENT FORMS OF AGENCY

The nurses all have in common their outstanding performance in all aspects of their nursing education, including academic results, clinical practice and overall behaviour in the institute. Several times they noted how in general teachers and doctors liked them. The staff nurses were generally supportive towards them, yet in some cases they faced opposition if they were too proactive. Socially, they managed to break significant conventions, although they managed to do so in a way that did not place them in risk of being ostracised.

Throughout their nursing education, being well behaved and not mixing too much with the 'naughty' students was significant for the nurses. Rabeya explained how some students used to go back to the hostel during their breaks from the clinical work and they sometimes received visitors from outside. In contrast, she usually stayed at the hospital attending to her duty:

> After the round then we leave for tea, sometime student come to the hostel and sometimes they [got] visits. Some are, you know, naughty (…). But I never liked [these situations]. Because if somebody [stands] in front of the gate and visits [you], this is very bad. So I never do these things. When I worked in the hospital, really I worked (Rabeya, 18/03/2012).

Middle-class parents showed a similar concern about their children having friends who behave and are good students (Blanchet 1996). They would often tell their children to remember who they were, "meaning don't do anything which could dishonour the family or lower its prestige" (1996, p.160). In the case of the nurses in this research, their relationship

with the other students was generally good. Most nurses highlighted their roles in helping other students who were not performing well, either academically or in their broad behaviour:

> "One colleague was so poor and no more *medha* [intellect], she was a little bit [in the] middle. She can't understand but she can memorise it. I told her: 'You will study with me'. And then she passed, she likes me" (Tuli, 13/03/2016)

> "Because [my friend] was not that good student, I helped her a lot, everybody knows (…) I supported her, ALWAYS. Not with the money but my brain, that I shared with her. That's why she passed at a time" (Sumita, 18/03/2012)

> "From our first year batch two students disappeared for that cause [getting married]. Because they didn't do [anything for] themselves, but our senior staff nurse, she took them to her house at night and held them. Then the next day they were discharged from the batch, [it was] very strict. Because students they were not allowed [to go out] without a night pass, gate pass. The senior staff, she was Christian and she got married with a Muslim ward boy, very disgusting, very nasty thing. The two girls, in between two girls, one was very desperate, like this. We could have managed her if she [would not have] mixed with that senior staff, but we were very innocent" (Teresa, 01/06/2012)

> "I was first year student and my roommate fell in love with one boy and everyone said that the boy was very bad. One day, again the Principal called me and said: 'You will look after this girl'. And then I checked her every time and that boy was angry with me. ((She laughs)). One day I was coming from the hospital, the boy caught me and said: 'You are doing this things, you know who am I'. I said: 'I don't need to know who are you, but she is in the institute eh, if you love her, you need also [to wait until] she will qualify' (…). After that, that boy never did anything with me and when he saw me just '*Asalaam aleikum*, how are you' like that ((She laughs)) (Farhana, 04/03/2012)

In spite of the difficulties, they all appeared to have good memories of their times at the institute. Sharing their clinical experiences with other students in a friendly and 'safe' atmosphere was a significant part of their learning.

Interestingly, Tuli enjoyed spending time and helping to support staff workers, commonly known as Fourth Class Employees. Her narrative in many ways carries the ideals of Christian compassion and service to, in her words, 'the needy people'. Besides, she stated that she always felt comfortable among the 'humble' and 'innocent' people. This could also

be due to her socioeconomic origins. In spite of this, she distinguished the Fourth Class Employees from the 'educated' people:

> "EVERYBODY liked me (…). Fourth Class employee (…) they liked me very much. I feel them because they are getting little money (…). When I am coming from my home I am taking some fruit I am sharing with them. ALSO when they are going to for the holiday (…) they give me (…). I feel SO relaxed with them. (They are) innocent people but we are the educated people, we are the people we are a little bit, not like them" (Tuli, 13/03/2012)

Finally, Amena and Farhana provided an interesting account of their experiences at the institute. Even though they performed very well academically and clinically, they were also actively involved in students' protests. The Government universities in Bangladesh, especially the big ones, are highly politicised, and nursing education did not escape from this. Nevertheless, 'nursing politics' took a particular shape, as they were more related to the students' fight for the betterment of their working and living conditions. In some cases, their protests went beyond that, like when some students protested because they could not afford to pay for the gifts for the official visitors. On another occasion, the nurses had to organise a strike because they wanted to build a hostel for medical students inside of their campus.

Amena explained that the students involved in the protests, 'did not bother anything'. For this reason, the 'authorities' were initially suspicious about them. They had to demonstrate, through their behaviour on the wards, that in spite of being 'revolutionary', they were also responsible at work. She narrated two episodes where her job commitment was critical to allow her to gain respect. In the first situation, she and her colleagues had been critical towards the administration of the nursing services for not protecting them. The DNS director listened to their protests and after observing that they were performing well and had a great support from the doctors and administrators, she accepted their claims.

> "When we are doing the protest, that time when she [the director of the DNS] come. We just, just collapsed the collapsible gate (…). At the beginning she get angry, but then she, when everybody mentioned that 'Oh, they have very good nurses there'. Particularly the doctors and Thana Health, administrator say that 'I have the very good girls. I think they are the heart of this centre'. So she just convinced herself" (Amena, 29/05/2013)

Farhana explained how the nurse that cared for her when she was sick was also involved in student politics. Thus, the nurses seemed to find a balance between 'compliance' and good performance in their daily activities, and resistance to the situations they considered unbearable. Even Rabeya, who did not seem to get involved in students' protests and had stated 'she hated politics', admitted it was thanks to the nurses' struggle that their situation had improved.

Nevertheless, as shown in the next chapters, the students' scope to protest and resist was conditioned by their vulnerable position within the institutions. Joining industrial action or leading open confrontation towards the 'authorities' had significant consequences on the professional and personal lives of some of the nurses. The one thing that 'saved' them was their good performance both academically and clinically. Eventually, they all stood out in one way or another. Sumita and Rabeya attained first position in midwifery, in Bangladesh, at the end of their fourth year. Unfortunately, Agnes and Tuli did not specify their final marks during their Diploma, even though I assume that they must have been good as they both gained easy access to the BSc programme.

Some of the nurses combined their nursing education with other courses. Even though they were not meant to do so, some students joined other colleges towards the end of their Diploma. Sumita was admitted into a private college near the nursing institute and prepared for her HSC there. Teresa had passed her HSC when she became a nurse and was admitted directly to a BA Degree course after finishing her Nursing Diploma. Rabeya also passed her HSC after completing fourth year of her Nursing Diploma and completed a BA Degree. Amena began studying a degree in Sociology right after finishing their nursing diploma. Even though she could not attend the final exams, her sociology education did undoubtedly give her a broader view about the certain aspects of the nursing profession and society in Bangladesh.

The nurses' outstanding academic results had two significant outcomes. On the one hand, they were allowed greater opportunities throughout their professional career. On the other

hand, they could demonstrate to their relatives that 'in spite of being nurses', they were still knowledgeable. This was highlighted by Farhana, Agnes and Rabeya. Farhana's case exemplifies the process of 'gradual acceptance'. When she started studying nursing her mother was very annoyed. Her father was more 'liberal', but would not give his open support either. Her mother was a little happier when she saw that Farhana's results for the PTS were good, but she was still worried about her health. Later, Farhana received further opposition from her uncle, who had become her guardian after her father's death. There was a wedding proposal for her cousin but the groom's family wanted him to marry Farhana instead because she was older. Nevertheless, when they got to know that she was a nurse, they refused:

> "They don't want to marry me because I am a nurse. That time I think there was a very strong social stigma. Now the society is changing but at that time there was a strong [stigma]" (Farhana, 03/10/2012)

In any case, even her uncle eventually accepted her decision in the end, especially after she settled and married a 'good boy'. Her sisters had also asked several times why she did not pursue them to study nursing.

Finally, obtaining good results was also a source of pride and satisfaction for the nurses. The following quotations, which include also other nurses apart from the key informants[153], illustrate this aspect:

> "Ultimately liked it [nursing] and once I loved it" (Rabeya, 18/04/2012)

> "After joining in nursing, I have done well in the [theoretical] performance, and in the practical side (…). For this reason as I have done the good I also enjoyed nursing, because when people have satisfaction with their care, then I feel satisfaction" (Amena, 18/12/2012)

> "I really enjoyed and the, when we just finished the three months preliminary training time, we joined in the hospital. I don't know, still I enjoy the hospital work. If I go, I enjoy" (Jackeline, 18/12/2012)

[153] Cathreen and Ishrat were local consultant in joint projects between the Government and WHO. Jackeline is the principal of a government nursing institute

Cathreen: We didn't feel difficult [to work clinically] because we accepted it from our heart that we have to do it. We didn't think (…) that it is difficult, we haven't got any time, so we didn't feel [the] difficulties, we enjoyed
Ishrat: We enjoyed, yes
Cathreen: We enjoyed with friends all day, even in the hospital we enjoyed (Group interview, 17/12/2012)

"When I came to nursing there is hard work and I had a very big surgery so every time I had high temperature, I thought that I could not, I would go back home. So suddenly, and first year in PTS (…) I stood first place and all subjects honours mark, so it created me interest to study this subject more" (Farhana, 26/02/2012)

"[When I passed the admission tests] I was really, that situation, that moment I cannot express how I was happy because if I FAILED maybe I, I don't have any shelter to leave or the further life" (Sumita, 06/12/2012)

For some it was a matter of personal fulfilment, whereas for others, the sense of personal satisfaction was accompanied by necessity. In Tuli's case, a sense of 'mission' or 'vocation' motivated her to continue in spite of the difficulties:

"The Principal and the matron (…), they called me: 'What's happening, Tuli? Do you have any problem here? (…). Then I kept silence. That time these two ladies gave me a nice lesson. They told me: 'You are an educated girl, you came from a different situation in your life, and the training period is always a little bit painful. You need to follow the sister tutors, (…) matron and supervisors, and ward in charge, doctors, so many people. So, and at that time also you need to concentrate for your study. It is not easy, but we can see that if you work (…) with your training, you will be a good future asset for nursing profession (…). So many girls want to be a nurse but they can't, but you are getting chance (…). They are counselling me very nicely and that time I got a big encouragement that I have to stay there. From that day I was working in a NEW way" (Tuli, 03/03/2012)

Tuli's narrative, which shows how her wish to "set an example" or "be an asset" helped her to overcome many of the challenges that she would face throughout her professional and personal life. We could say that in this sense, Tuli was closer to the 'service' narrative about nursing care. Thus, service could also be empowering.

7.5. CONCLUDING REMARKS: BACK TO THE NURSING DILEMMA

This chapter clearly reflects the 'nursing dilemma' that was described in Chapter Five in two ways. If we intersect the 'managerial' and *compensatory* view with the notion of care as 'service' or its *relational* form, a more complex view emerges which avoids falling in the trap of 'service as self-denial'. Reberby (1987) and, later, Benner and Wrubel (1989) were critical towards the association of caring with altruism. For the authors, the roots of the word altruism, and the ways in which it was applied to nursing, have shaped the longstanding dilemma of nurses, who are artificially made to choose between them or the people they care for. Reberby observed that:

> "Caring is not just a subjective and material experience; it is a historically created hone (…). Nursing was organized under the expectation that its practitioners would accept a duty to care rather than demand a right to determine how they would satisfy this duty (…). Because nurses have been given the duty to care, they are caught in a secondary dilemma: forced to act as if altruism (assumed to be the basis for caring) and autonomy (assumed to be the basis for rights) are separate ways of being" (1987, p.5)

Benner and Wrubel suggested a reversal of this logic, where instead of basing altruism on caring, the latter was made the basis for altruism. This aspect is of great significance in nurses' lives. This section has shown that nurses struggled to find a balance between providing personal patient care and keeping a 'safe' distance from them. By concentrating on ward management, nurses acquired a higher level of authority and respect with respect to patients and other staff members. Nevertheless, this did not necessary lead to total detachment from or dismissal of 'basic' nursing care activities.

On another level, the dilemma is also related to the ambivalent role of nursing education as a form of capital in the lives of young women. This dilemma is related to the embodiment of gender and class inequalities in nursing and more broadly, in care-related activities. As Bourdieu says (2001), overall, nursing education increased their economic, social and cultural capital. The financial independence they gained after starting work provided them

with more room for making future decisions. This clearly affected their marriage patterns, which were different from the average women of their generation. Some remained single, others delayed their marriage age considerable and all married nurses 'chose' their partners before getting married.

Nevertheless, the improvement in their capital was by no means a straightforward process. First, the nurses were highly 'disciplined' and had to overcome significant challenges during their diploma education. Second, the social status of nurses was still low when they studied and their educational achievements were not always socially recognised. For some, it was not until they passed their BSc or Masters, that their relatives considered them well-educated. Third, hospital work was often badly regarded, and in some cases, they had to challenge their family's wishes in order to continue working. Finally, they did not always feel valued within medical institutions and in some cases, they felt that they could not fully 'utilise their knowledge'. This, together with the limited scope for career development on the clinical side, pushed them towards the educational sector. The following chapter focuses on these aspects.

8. MOVING TO THE EDUCATIONAL SECTOR AND FURTHER CAREER DEVELOPMENT: 'UTILISING THEIR KNOWLEDGE'

"[For] those who want to learn something, if I know it, I ALWAYS try to teach and always I want to share that" (Teresa, 26/03/2012)

"Whatever I learn, I always share it with the different categories, this is my motto and constitution" (Teresa, 21/04/2012)

8.1. INTRODUCTION

Teresa's narrative shows in different moments her eagerness to learn and to share her knowledge with other people. I could see her working and observed how enthusiastic she was about her job. Another key feature in Teresa's narrative was her wish to work 'without limitations'. She recalled her sense of freedom and innovative capacity when she was working in an NGO-led community health project:

> "Riding bicycle and motorbike, I enjoyed a lot there also. I had no limitations and people know how much work I can do (…) with the available resources. I just changed a little the design but (…) there is nothing impossible (…). My director was giving [me as an] example: 'How she is working'" (Teresa, 21/04/2012).

She found that, in certain Bangladeshi institutions, however, it was sometimes difficult for her to work freely and share her experience with other people. I asked once about her experience working as a teacher in a big Government-like nursing college. She was overall happy about her work with students, although she missed having more opportunities to 'share' with her colleagues.

The previous chapter analysed nurses' first experiences during their education and early clinical practice, and the consequences which entering the nursing field had on their personal, family and social lives. Joining nursing education provided them with both opportunities and limitations in terms of economic, social and cultural capital. A similar ambiguity can be observed if we look at nurses' professional development *within* nursing.

Most could access overseas experiences, higher education and relatively well-paid and well-regarded jobs as teachers. Nevertheless, reaching their current position was not straightforward for many. In spite of their outstanding performance, their enthusiasm and pro-activeness were not always valued or well regarded. However, is should be remembered that only a small amount of Bangladeshi nurse graduates can access these kinds of opportunities.

This chapter begins with an analysis of the nurses' transition from the clinical areas to the educational field, and their further professional development. Afterwards, a broad analysis is conducted of structural constraints faced by the nurses and the individual and collective strategies used to overcome them. As was done in Chapter Six in the analysis of their obtaining the nursing diploma, I discuss this second transition to the educational field. Finally, a concluding discussion is presented on the interaction between the nurses' socioeconomic background, life events, and the consequences of becoming nurse teachers in their personal and professional lives.

8.2. BECOMING NURSE TEACHERS AND FURTHER CAREER DEVELOPMENT: BRIEF SUMMARY OF THE NURSES' PATHS

Generally, the nurse teachers seemed to be happy with their decision to move to education. They sometimes had to face tensions with colleagues or their students, although they also appreciated the scope for self-development and independence. Interestingly, when looking at the ways in which nurses made the transition from the clinical to the educational field, their development seem like a 'natural' escalation in the nursing hierarchy. It has been mentioned that in Bangladesh, teaching is considered as more prestigious than working in hospital (R. Khatun 1999). Therefore, moving to the educational sector could be seen as a way of gaining status and avoiding the 'polluting' nature or lower status of clinical work. Nevertheless, as stated later, this argument is not enough to explain why the nurses in this research became teachers.

In many cases, their move seems to have more to do with their aims to pursue a career while escaping from the institutional limitations of the hospital work. The working

conditions on the wards were, and still are, challenging. Nurses often have to face internal hierarchies and tensions between staff members, safety issues, low salaries, lack of accommodation and difficulties in combining changing duty schedules with their family responsibilities. Furthermore, there is limited scope for professional innovation and independence and the resources for patient care are very limited, especially in the Government sector and in small non-Government clinics. Teaching, on the other hand, is seen as an area where nurses can continue their self-development and 'utilise their knowledge' more creatively. Nonetheless, nursing education institutions also have their own problems and, therefore, becoming teachers has not necessarily led to an end of their professional struggles.

8.2.1. Taking the leap into nursing education

To become nurse teachers, the first step to take was to gain clinical experience and complete their BSc in nursing. In addition, obtaining a BSc was a way of accessing higher education and continuing their career development. Most nurses obtained their degrees from the Government College of Nursing. Farhana, Tuli and Agnes studied during the 1980s and Sumita and Teresa joined later in the 1990s. Sumita highlighted the disadvantages faced by nurses from non-Government institutes. First, they were not always aware of the possibility of studying further. Second, they could not enjoy the security of a paid lien[154] and finally, it was more difficult to get admitted. Sumita and Teresa could join because of their high marks. Rabeya could have also applied, as she had studied in a government institute and obtained very good result. Nevertheless, she did not do so, mainly because of her husband's opposition. Eventually, more than twenty years after obtaining her Diploma, she got admitted in a private college and managed to successfully complete her BSc.

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[154] It is important to clarify at this point the differences between the concepts of 'lien' and 'deputation'. When a nurse is on *lien*, she gets her salary from the organisation where she is working or studying during that period. She must, therefore, give her original salary to the Government during that period. A lien can be extended to a maximum of five consecutive years. On the other hand, when a nurse is *deputed*, she is transferred to another post within the Government sector. She maintains the same salary regardless of the level of the position which she is occupying. For example, if a Staff Nurse is deputed as a Supervisor, she will still get her salary as a Staff Nurse, even though she is occupying a higher post.

At that time, students' overall performance at the College was not as good as expected (Banu 1999; Prakasamma 1999). Similar to what had happened during their Diploma, the nurses in this research stood out in this regard. Farhana, Tuli and Amena were amongst the first students in their BSc batch. For this reason, they were soon posted as teachers in government institutes, all outside the capital. Farhana and Tuli highlighted that their working conditions were challenging in some regards. There was a significant teachers' shortage and in Tuli's case, the equipment and building were inadequate and there were significant political tensions in the institute. They did not even have running water or a regular access to electricity. Amena's early experience as a teacher did not last long. She was first placed in an institute outside Dhaka and then transferred to the College of Nursing. After less than one year, however, she had to return to her previous post as Staff Nurse. The main reason was that other teachers considered that she was too junior.

The experiences of Teresa, Agnes and Sumita were different because they were working in non-Government institutions and their move into education was more gradual. Rabeya followed a different path. She had gained educational experience as a primary school teacher and social worker during a period when she had to stop hospital work. When she resumed nursing, she mainly worked in supervision-related posts until she completed her BSc. After graduating, she began working in a small philanthropic nursing institute, where she had an opportunity to join a bigger non-Government college.

In any case, all had been working as staff nurses and ward-in-charge for some time before becoming teachers. At that time, getting a BSc and moving into education was a very lengthy process which could take at least nine years: four years for the Diploma, three years of required experience and two more years to get the BSc (DNS 1994). Nowadays the situation has changed and the students have more straightforward access to the BSc. They can either join the direct-BSc Programme, which is offered in both private and Government institutions, or move straight to the BSc post-basic degree right after finishing their Diploma. One nurse, who was currently working in a non-Government institution, stated

that the previous system was better, as it ensured that nurses had obtained a sound clinical experience before becoming teachers:

> "[The young teachers] can (…) [prepare] nice power-points, but I think that our job is, you know, nursing is not only in the literature; it is practical work with the human beings' body (…). You go to the library and there are lots of books. You can easily learn many things and you have many knowledge in your head but if you don't know how to implement it (…)" (Nurse teacher, non-Government sector, June 2012).

Interestingly, some nurses from a Government College, where the first batches of the direct-BSc Programme were starting to graduate, found a similar problem. Apparently, students asked for a further internship after graduation in order to increase their practical expertise because they were 'afraid' to work on the wards. Furthermore, some students who had entered the programme were not interested in working as clinical nurses. They knew that once they graduated, they could directly move into teaching.

8.2.2. Overseas experiences

All but one key informant had either educational or working experiences overseas. Farhana, Tuli and Amena were selected for a public scholarship for higher education in the UK. Teresa attended short courses in Japan and later moved to North America with her family. Farhana and Sumita also managed to work in Saudi Arabia first, and later in the UK.

8.2.2.1. Educational programmes in the UK: the experiences of Farhana, Tuli and Amena

During the 1990s, scholarships were open through the Overseas Development Agency (ODA) for nurses to study in UK institutions. This was part of the wider Strengthening Nursing Education and Services (SNES) project. Amena had great expectations before travelling to the UK and she recounted how her father had encouraged her to study abroad:

> "[My father told me]: 'You know that outside study is different (…). As your line is different in nursing you have to (…) get the good opportunity and show your courage (…). People are coming in the world you do something for the people, not that just passing their life in livelihood, this is not the way. So think in such a way and do your business when you return" (Amena, 29/05/2013)

According to Robson (2005), UK-based scholarships meant a great investment and nurses' experiences were not always satisfactory. Some struggled with English and the more participatory educational approach. Others felt lonely and homesick and suffered racism and many faced economic difficulties, which were. In this research, racism was not stated as a problem, although money and accommodation problems were common. Amena and Farhana were married and did not seem to face financial problems during their educational stays. Nevertheless, Farhana struggled later, when she returned to the UK to work. Tuli was unmarried during her educational stay and had decided to stay in institutional accommodation with the international students. She had to develop several saving strategies:

> "I am going to the Asian shop (…) to buy something. One week they had fresh things, but after that they need to change it and they wanted to sell it. Some of the people will not like to buy it, but we are going there because we are getting it a little bit less expensive (…). For fish, maybe the lower portion that they are not using (…), we are taking it" (Tuli, 10/11/2012)

The Diploma in Advanced Nursing included clinical placements, which Farhana described as very interesting. According to her, they learnt to provide 'whole care', in contrast with the task-oriented approach that predominated in Bangladesh. On their return to Bangladesh, the nurses tried to implement their new knowledge and experience. In spite of the setbacks, however, the experience proved satisfactory for most nurses, who ended up either occupying leadership positions in the government sector or acting as local consultants to the project offices of international donors (Robson 2005). Nevertheless, many, Robson observed, remained 'stuck' as senior staff nurses. The nurses in this research were amongst the successful ones, as they all managed to improve their posts.

8.2.2.2. Working overseas: Expectations and reality

Both Farhana and Sumita worked in Saudi Arabia as Staff Nurses, and later, in the UK as care assistants. They both went to Saudi Arabia from 2000 to 2003 and worked in the same paediatric unit of a general hospital. Later, they both moved to the UK, even though they followed different paths. In addition, their personal situation and their working experiences

were different in certain aspects. For both it was a significant economic and personal investment.

Somjee (1991) and Nair (2007) observed in India that younger nurses placed more emphasis on career development, including overseas employment. Begum (1993) also showed in Bangladesh that most nurses were willing to accept a job abroad. The motivations to migrate were similar for Indian and Bangladeshi nurses, and included job dissatisfaction, especially in relation to salary and career development, and a low image of nursing in the country (Aminuzzaman 2007; Nair 2007). Generally, Western countries were seen as places where nurses were respected and valued (Aminuzzaman 2007). Three nurses in this research shared this view, especially in relation to the doctor-nurse relationship:

> "You know our country's policy. If we are nurses, we cannot work freely. The doctors are always jealous with us. In foreign countries [also], but there is policy and strategy [to systematically regulate in which way we should] work. But in Bangladesh (…), [wherever] I go, I am always pressed by the people (…). Even in Bangladesh we are working for the WHOLE day but [we only get] fifty, sixty thousand taka [per month]" (Nurse, June 2012)

Previous research has shown that some nurses were reluctant to migrate because of either homesickness, a need to look after their family, or the desire to serve people in their country (Begum 1993). Aminuzzaman (2007) found similar responses and added the fear of racial discrimination to the list of potential challenges. He concluded that some nurses admitted that they were willing to take the risk, as that would be better than "living in a country where their profession was not treated with dignity and was socially looked down on " (2007, p.17). Most nurses were willing to return to Bangladesh in order to serve their country and also because of emotional, cultural and religious motives. Nevertheless, some nurses, like Teresa, contemplated long-term migration in order to provide better education opportunities and a safer environment for their children.

The government has maintained a contradictory position in relation to migration policies for health workers. On the one hand, it initially promoted nurses' migration as a proof of its "commitment to the safe migration of women" (Aminuzzaman 2007, p.3). On the other hand, in an attempt to retain physicians and nurses in the country, the government began

implementing disincentives, which were finally stopped as ineffective (Rahman & Khan 2007). In spite of the restrictions, many professionals managed to migrate on their own initiative (Aminuzzaman 2007). This was the case of Farhana and Sumita.

A large number of nurses began migrating during the 1980s, which was followed by a continuous flow until the 2000s and a gradual decrease until the present (Aminuzzaman 2007). No specific studies have been identified describing the reasons for this decline, although Aminuzzaman pointed to nurses' experiences as a potential explaination. Other health professionals described Bangladeshi nurses as "'shy', 'culturally insensitive' 'inward looking' but 'sincere' and 'hard working'", and lacking in "specialized nursing service skills and interpersonal and communication skills" (2007, pp.14–15). Aminuzzaman concluded that in spite of the Government-provided English courses, the candidates were often too 'old' to learn a new language, as the nominations were based on political pressure and tended to favour the most senior nurses.

Saudi Arabia was not the preferred destination of Bangladeshi nurses[155], although many were keen to give it a try. The working environment in the Middle East was perceived as hostile, unfriendly and a place where Bangladehsi migrants were looked down on (Aminuzzaman 2007). This did not seem to be an issue for neither Sumita nor Farhana. The restrictions placed on women were stricter than in Bangladesh, albeit the city where they worked was seen as less conservative and more 'touristic'. Furthermore, most nurses were foreigners and the working atmosphere was good. They communicated in English. Even though Farhana said the hospital followed 'USA standards', Sumita acknowledged standards were more 'flexible' in SA compared to European hospitals. It was in Saudi Arabia where both nurses found out about the possibility of moving to the UK.

The working experiences of Farhana and Sumita in the UK were somewhat similar. They both applied with the intention of studying there and ended up working as care assistants. Farhana could not obtain a lien because she had not renewed her contract in SA. She

[155] In the study by Aminuzzaman (2007), US emerged as the favourite destination because of a perceived higher nursing demand, followed by Canada, Australia and the UK.

worked as a care assistant for the National Health Service (NHS). She stayed at first with a Bangladeshi family, but soon after, her husband and son joined her and they moved to a separate house. After some time, it became difficult to stay in the UK. Life was very expensive and both she and her husband were working uneven shifts, making it difficult to look after their son. Furthermore, she faced trouble when she had to renew her National Midwifery Council permit. Eventually her husband told her that there was no need to struggle anymore and that the best thing to do would be to move back to Bangladesh.

Sumita also struggled, as she was there by herself. She had applied for a placement from SA, but by the time she went back to Bangladesh and passed the English test, the remaining documents had expired. Her husband encouraged her to try and move to the UK even without her placements sorted. This placed her in a vulnerable situation, especially in terms of securing accommodation and pay. After a series of misadventures, she was finally able to get a job as a senior care assistant in a nursing home. It was difficult at first because she had always worked with children but she enjoyed it. She worked as many shifts as she could in order to recover from the financial investment she had made:

> "Twelve hours duty (…) day and night (…). I spent lot of money for UK purposes, for the processing, so always I tried to balance that (…). Because [for working on] holiday there is more [pay] (…) and they provide food" (Sumita, 29/05/2012)

Eventually, she had to leave because she could not get a work permit from the nursing home where she was working. She returned to Bangladesh and tried to apply to work overseas again. Nevertheless, she witnessed some irregularities in the agency preparing her documents and gave up.

Broadly, nurses are believed to increase their professional status after gaining overseas experience (Begum 1993; Aminuzzaman 2007). Nair (2007) observed that in India, in spite of being individually better-regarded, this did not improve their overall status as a collective, especially for hospital nurses. In the case of the nurses in this research, their stays abroad undoubtedly helped them to get a broader perspective of nursing and increase their social and cultural capital. Nevertheless, this same open-mindedness, once transformed into an attempt to change the work place back home, could become

problematic. There seems to be an ambiguous reaction towards nurses who had worked or studied overseas. On the one hand, their status increases both in their professional and social spheres. Nevertheless, they can also be seen as arrogant or even detached from the struggles of their colleagues who had stayed in the country.

8.2.3. Access to higher education: Limited opportunities and, again, outstanding performance

Farhana was clear, from the very beginning of her nursing education, in that she wanted to study further. Not only that, she was told by her mother that she should occupy an 'upper position', and so she did in the end:

> "My mother always insisted me: 'You will not be a simple nurse, you should study and you will be a upper position nurse', so that's why it interested me to take higher [education]" (Farhana, 26/02/2012)

Farhana's mother's advice is may sound familiar to some nurses from other contexts. It could be rephrased as 'you're smart, why should you be *just* a nurse?' These kinds of comments indicate the low social value of the nursing profession. In Bangladesh, it takes a further connotation, as it was not until recently that nurses could access Masters and PhD education.

One nurse highlighted that, in the past, it was difficult for nurses to access higher education. She experienced difficulties when she tried to complete a Degree while working as a Staff Nurse. She admitted that in her case, the supervisors' opposition was probably related to their fears that she would fail in her hospital duties. In any case, it seemed to be hard for her to continue studying while working as a Staff Nurse:

> Nurse: Now the senior nurses are encouraging the [young] nurses for study, but that time I feel myself that they are not encouraging us. If we wanted to study, then they gave us trauma or make the situation in such a way that we don't complete or finish.
> Susana: Why would they do that?
> Nurse: Maybe that time their thinking is OK, because if you are in the Government, you should take permission. But I was not taking permission; it was in the evening course. If I need to get permission they would not allow me (…), as

> I was ward in charge. But it did not hamper my working life. The mind set was different from now (Nurse teacher, December, 2012)

In spite of their difficulties, all but one key informant holds a Masters Degree. Sumita, Teresa and Amena obtained a Masters in Public Health (MPH) from a Government institution, whereas Rabeya attended a private college. Amena and Farhana had also obtained a Masters in International Health from the UK. Back in the day, it was unusual for nurses to join Masters Programmes. In Sumita's batch, there were only eleven nurses on the course amongst 250 students from other disciplines. She explained that the nurses worked very hard and all managed to pass, unlike some doctors:

> "Doctor, community medicine doctor, nutritionist, dentist, general physician and nurse, epidemiologist, biostatistics, everybody was together, 250 students (…). We were eleven nurses. Always we studied together and always we forced teach other: 'You have to study, no cheating, no gossiping', then we all eleven nurses passed but so many doctors failed ((she laughs))" (Sumita, 06/12/2012)

Teresa obtained her MPH from the same institute. She got pregnant in that period, but carried on with her studies. After giving birth, she decided not to interrupt the course and continued with the placements. Rabeya obtained her MPH from a private university after joining her current work position at the College. She wanted to do it to improve her position and salary, as she thought that she was not as valued as the teachers who had less teaching experience but held MPHs. She struggled at first because she was working at the same time plus she also had to manage her household work. Nevertheless, she stated proudly that she got higher marks than the doctors in one subject. That became a crucial landmark, as she wanted to demonstrate to her family that she was not, in her words, 'fool'.

In spite of the increase in their academic credentials, nurses are still not equally valued compared to other professionals at the same educational level (Leppard 2000). Furthermore, opportunities for nurses to 'utilise' all the knowledge that they accumulated through their educational and working experiences were still limited in the clinical side.

8.3. STRUCTURAL CONSTRAINTS WHEN TRYING TO DELIVER CLINICAL NURSING CARE

Chapter Five showed that nurses in Bangladesh occupy an uneasy position in society and within the health and education institutions. The experiences and opinions of the nurses in this research confirmed previous reports. Acute nursing shortages, corruption, mismanagement, 'weakened' nursing leadership and poor working conditions were the most commonly cited factors. Less frequently, some nurses pointed to personal safety issues, including extreme cases of physical violence, not against themselves, but against other nurses they knew. Only one nurse, who was not a key informant but was interviewed in a couple of occasions, acknowledged having been 'tortured[156]' because of her involvement on 'nursing politics'.

Considering the challenging environment in which the nurses work and contrasting this with the nurses' narratives of their encounters with the patients, the contrast is evident. One possible explanation points towards the tendency to idealise past experiences. This, together with a 'Nightingale rhetoric' that portrays a reified picture of nursing care, leads to a nostalgic narrative of the 'good old days' and a strong critique of the current 'deterioration' in nursing care. Even though this may be a crucial factor for those nurses who have left the clinical environments, the rhetoric is also present in nurse teachers and supervisors still involved in patient care. Therefore, their narratives about the 'deterioration' of care cannot be explained exclusively in terms of idealisation or reification of care.

Apart from two particular cases of institutional persecution, the nurses' narratives seemed to point to a more general state of institutional and social neglect of the nursing profession. Two apparently opposite narratives have been identified amongst the nurses, according to their allocation of the roots of nurses' oppression and the subsequent deterioration in nursing care. On some occasions, nurses pointed to structural inequalities, whereas at other moments, and often at the same time, they signalled nurses' attitudes as a key aspect. It is

[156] She used the word 'torture', although she did not specify what type of violence was she experiencing. For obvious reasons, I did not ask.

important to clarify that none of these two 'poles' is entirely or clearly found in individual nurses' narratives. Instead, they mainly oscillated between blaming the (health) system or society; the doctors or the hospital authorities. Nurses themselves did not escape criticism and often nurse leaders and the nurses who were avoiding their duty were also signalled as a significant cause in their collective lack of power.

8.3.1. Institutional limitations on delivery of care

In spite of the efforts of the Government, non-Government, national and international agencies and institutions, nursing care provision in Bangladesh is still far from universal. This is better understood when looking at the broader situation of the country's health system and general welfare provision. A significant tendency towards the privatisation of healthcare services in terms of coverage has been widely reported (Osman 2004; Andaleeb et al. 2007). This is more evident in the case of curative services (Ahmed et al. 2015); in urban areas (Osman 2004) and in the medical and nursing education sectors (Khan 2012; Ahmed et al. 2015).

One nurse pointed to the privatisation of the healthcare delivery as one of the main structural reasons for the deterioration of nursing care service. The expansion of private clinics and a lack of regulation have contributed to an increasing dual job holding of many professionals, especially doctors. A chain of corruption was established where the patients were eventually referred to doctors' private practices thanks to the cooperation of other health workers:

> "Because of some unfair means or corruptions (…) doctors have a good relation with the ayah, ward boys and peons. Because they can bring their patient to the chamber. Nurses are now doing the same thing" (Nurse Teacher, Government sector, December 2012)

> "EVERYBODY wants to be rich quickly. This motto makes people and things and [affects] the service provider's attitude (…). Good doctors (…) [are nowadays] visiting patients in their private [chambers]. If you call them, you cannot see them in hospital. But in our time, if we called them in case of emergency, they would come and see the patient. (…) If something happens in the brain, you cannot

> survive your other parts. It is also rotten" (Nurse Teacher, Government sector, May 2013)

At first, she seemed to allocate responsibility for the deterioration in healthcare provision to the doctors, although she later pointed to 'the system'. She was also critical of nurses who sent patients to private clinics, arguing that they should try to persuade the doctors to treat them in the public hospitals:

> "You know that [the patient] is selling his land for this treatment (…). So you have to convince [the doctor], we have to protest: 'Sir, these are the cases, if you could look at them'. We can do a study about the reasons why patients are not being addressed by the doctors or by the system. Maybe we cannot say doctors; by the system" (Nurse teacher, Government sector, December 2012)

This same nurse observed that doctors' attitudes towards nurses have also changed. They are not as keen to teach nurses as in the past. This further lessens nurses' confidence and 'authority':

> "[Nurses] are not in such a position, due to the hierarchy of the disciplinary team [where they could ask]: 'OK, doctor, I have seen many times that we are using, previously we are using one antibiotic, now we are using three antibiotics (…) 'Why is happening sir? (…) Please, tell me, because I am in front of the patient, I have to give answer' (…) [Doctor may reply]: 'Why do you need it? You are asking question from me, on my prescriptions? How dare you?' (…) But previously when we ask question they are very happy to (…) give the answer and prepare us because everybody knew that nurses were in front of the patient all the time (…). But nobody from the hospital side is thinking that nurses need to have updated education from time to time" (Nurse teacher, Government sector, December 2012)

Apart from nurses' positions in the hospital hierarchy, their working conditions are worsening as well in some regards. There seems to be a general feeling that big Government hospitals are nowadays more crowded with patients, who are often placed in the corridors. This situation clearly affects the general care received, making patients angry. On many occasions, it is the nurses and other staff members who are also visible on the wards, who become the receivers of the patients' and carers' frustration. Afsana (2005) observed this vicious cycle in her hospital ethnography, where some nurses were seen to criticise patients when they asked for medicines or the administration or intravenous saline. The following quotation, from one nurse interviewed by Afsana, illustrates this aspect:

> "The situation of nurses is similar to *shakher korat* [proverb: object whose presence or absence is equally painful]. There is nowhere for them to go. Nursing care to the patient is based in giving medicine, food and personal care. But the supply of medicine and food is scarce in the hospital and the shortage of staff is quite evident. Nurses deal with patients directly. Because of this shortage, they cannot provide roper patient care. So, they start to behave badly with patients and carers when they are asked simple questions" (Nurse, cited in Afsana 2005, p.151)

Another significant consequence of the overcrowding and lack of resources was an increase in the use of 'nursing surrogates', especially in Government hospitals or poorly-staffed private institutions. They consist mainly of relatives and other visitors; 'special ayahs'; junior nurses, or nursing students. This aspect was highlighted Hadley and Roques (2007) and similar statements were found in the narratives of some nurses:

> "In my time, nursing care was very good, better than now [she listed all the activities which they did]. But this time I heard (…) that the catheter is given by the ayah, and feeding is giving by the carers or the ayah. But, in our time, the visitors were not allowed, only during the visiting [hours]" (Farhana, 18/03/2012)

Not long ago, Rabeya went to see her uncle in hospital. She recalled a situation when she had to quarrel with the nurses about their lack of involvement:

> Rabeya: He has headache, please give him some medicines, he has the suppository
> Nurse: Where is your visitor?
> Rabeya: Why?
> Nurse: You will give him the suppository
> Rabeya: No, come here
> Rabeya's aunt: Do you know who is she [Rabeya]? Come here
> Rabeya: Where did you pass [your Nursing Diploma from]?
> Nurse: Dhaka Medical College
> Rabeya: Do you know that a suppository is one kind of medicine?
> [The nurse remained silent]
> Rabeya: You must know that this is one kind of medicine. Why should a visitor give this [medicine]? You must give this one

Nursing students and junior nurses are also delegated to 'basic nursing activities'. Even though junior nursing schools were abolished in the 1960s (Begum 1993; R. Khatun 1999), junior nurses are still employed by some non-Government institutions. One nurse explained that when they first opened the nursing institute where she was working, they created a

'special batch' of nurses. They were recruited in spite of not having passed their HSC and therefore could not ask for registration. This first batch was created when the hospital was founded in order to ensure their bonding to the institution. Besides, another nurse observed, the salary of junior nurses is lower than that of Staff Nurses. In spite of this, she found they worked harder than Senior Staff Nurses because they were afraid of losing their job. In any case, junior nurses, carers and students seem to be covering the bulk of care.

The trend to privatisation has also affected nursing and medical education. In spite of the outstanding development during the last decades, the Government institutes and colleges are still outnumbered by the private ones. This has hindered the access of many nurses to higher education at an affordable price. One nurse observed this situation when she decided to join the BSc programme ten years ago:

> "There is only one nursing college [in Dhaka]. How can nurses learn? (…) There are only 200 seats (...). Then there was first established a private university, Open University" (Nurse teacher, non-Government sector, April 2012)

In addition to being more difficult to gain admittance to Government institutes and colleges, one nurse stated that standards are higher in some private institutions. There is a general belief that non-Government institutions are better in terms of learning resources and access to technology, but their opportunities for clinical practice are more limited. As part of another research project[157], we asked a group of nursing teachers and students about the differences between the clinical placements in Government and non-Government institutions. There seemed to be a general feeling that in the Government hospitals, the wards were more crowded, less equipped and less staffed. This environment provided the students with more opportunities to perform hands-on-care and improve their communication skills. Nevertheless, the standards of practice were generally lower and the students found it difficult to deliver individualised nursing care. Non-Government institutions, especially international hospitals, offered a greater learning environment in terms of nursing standards and resources. In return, the number of patients was lower and the students faced more restrictions when trying to engage in hands-on care.

[157] The research was conducted in a non-government institution. The results have not been published yet.

Unfortunately, this subject could not be further explored in this research. There is not enough empirical data to explore to what extent the deterioration of nursing care can be explained by the privatisation process. Furthermore, there have been recent improvements in terms of Government posting and salary. More research is needed to analyse the ways in which the recent changes in nursing education and services translate to improved standards of care. What seems clear, however, is that poor working conditions in Government institutions are not only hindering the care received by the patients, but also the social image of nurses.

8.3.2. Institutional discrimination of nurses within the health system

Broadly, the nurses attributed their subordinate position in the institutions and their lack of 'voice' to their gender and also to the low value that society placed on nursing care activities. This aspect is related to what Van Dijk (1993, p.255) termed "the privileged access to discourse and communication". Nurses in Bangladesh have a limited access to the spheres where structural decisions are taken. This limited access extends to their opportunities to obtain higher education, and even to be informed about their rights, as, this information is often not communicated and hindered by more powerful groups.

Some nurses, both from Government and non-Government sectors, witnessed mismanagement and corruption. Sometimes it affected them personally, and most significantly, it made them believe that they were not valued sufficiently. Some nurses had their salaries 'cut off', delayed or even, in the case of the nurse who was most actively involved in politics, suspended. Two nurses clearly expressed that the institution, in their case, the Government, was 'utilising' them without valuing their contribution.

> "You see, they use me in EVERY sector but with my designation, with my salary they deprived me every time up to the retirement" (Nurse, March 2012)

> "The Government is using us, but not using appropriately. [They are] not giving us the appropriate recognition" (Nurse, May 2013).

The second nurse also observed that, as they could not fully 'utilise their knowledge' in their workplaces, their capacities were somewhat wasted. Most nurses admitted that as a collective, they occupied a subordinate position, especially in relation to doctors. One of the most critical reflections about the power relations between doctors and nurses came from one nurse who had a longstanding experience in multilateral nursing projects and had a strong political background:

> "But in the class hierarchy, you know? When one becomes doctor, [they] shift in the top (…) of the citizen (…) [whereas nurses], whatever the family he or she is coming from, they are dropped down as a nurse. This (…) is a great issue, so working in Bangladesh, looking it in such a way 'Oh, *chotokaj*, *borokaj*, (…) prestigious work, non prestigious work'. But the work is needed, nobody bothers it (…) and that's why in the hierarchical system you can see the reflection of that" (Nurse, May 2013)

There was another nurse who observed a similar contradiction. People accepted being looked after by nurse relatives or by unknown nurses but they did not want to admit them in their families. Similarly, the institutions acknowledged that the nurses' work was needed but they did not want to improve their working conditions. According to some nurses, it was precisely this lack of promotion opportunities and their low salaries that made nurses prone to frustration. Nurses working in the Government sector pointed their lack of promotion and their 'deputation' and 'acting' positions as a considerable hindrance to their collective development:

> Nurse: You can see how nurses are fed up with nursing. After 27 years I got promotion (…). This is, this is one reason why nurses are frustrated (…)
> Susana: Just one thing. (…) If, suppose that my post is as a senior staff nurse but I am doing, I am deputed as a teacher (…) The salary is
> Nurse: No, same salary with the senior staff nurse. No benefit, nothing else (Nurse, May 2013)

On top of their meagre salaries, the latter were further reduced due to several forms of malpractice. Two nurses explained that they had spent months without getting their allowance for either bureaucratic or political reasons, respectively. Furthermore, another nurse observed that in some occasions, the nurses' salaries got 'cut down':

> "With ALL of these allowances, [the salary] is 15000 [BDT] but real salary is maybe 6000 (…). What is happening? When is going to take salary form accounts they will cut this one (…) with revenue stamp they will cut something, with other things they will cut something. And then when the annual bonus is coming they will keep something, always (…). If we say something they will create another issue for you" (Nurse, March 2012)

This kind of mismanagement posed a significant burden for the nurses. First, it made it very difficult to cover basic needs like housing, medical care, children's education. Second, these practices are hidden, whilst the official narrative emphasises that nurses had been upgraded to Second Class level and paid accordingly. This situation clearly hindered their options for an open confrontation with the 'authorities'. The following quotation exemplifies the case of a nurse who had to pay some bills not belonging to her. She showed that she had no choice but to 'comply':

> "One day eh, evening time I came to my room and SCOLD me (…) and I am crying ((She cries while talking)) (…). Because if we are not paying so we need to suffer in another way for this reason I pay. SO many things are happening in this, this kind of discrimination also (…). I am giving money but I need to keep my service book OK. Otherwise (…) it will be bad [for the] future in my pension (…). So I am giving them WHAT they are asking (Nurse, March 2012)

The most significant aspect of this experience is that it illustrates the nurses' lack of choice under certain circumstances. In this case, 'compliance' emerges again as the safest strategy to follow. In any case, what is clear is that even in the worst of the situations, the nurses' still show a certain degree of agency.

8.4. STRATEGIES TO OVERCOME THEIR LIMITATIONS: NURSES' AGENCY WITHIN THE MEDICAL INSTITUTIONS

Nursing has often been portrayed as an oppressed group within the health system (Wicks 1995; Lee & Saeed 2001; Roberts 2006). According to the theories of oppression[158], Oppressed Group Behaviour (OGB) implies an "internalization of inferiority, a lack of

[158] Greatly developed by the Brazilian educationist Paulo Freire (1993), the Pedagogy of the Oppressed meant a significant step in reconceptualising the roots of the reproduction of inequality and alternative ways of breaking it.

pride in one's culture or group, and powerlessness create certain characteristics that continue the cycle of subordination" (Roberts 2006, p.24). The analysis of the roots of oppression is useful to analyse the position of nursing as a subordinate group within the health system and their limited scope for open confrontation. Nevertheless, the model often assumes that the belonging to an oppressed group results in reactive, rather than rational, behaviours (Lee & Saeed 2001).

The Marxist idea of nurses having a *false consciousness* and being trapped in a 'vicious cycle of subordination' is too constraining to explain the complexity of the nurses' experiences. On the one hand, if taken to an extreme, it could lead to blaming the nurses for their oppression. This was observed by Bourdieu's (2002) analysis of the masculine domination. On the other hand, it carries the risk of portraying the nurses as passive victims in need of being 'enlightened' to escape from the vicious circle of oppression. This latter idea falls too close with some *developmentalist* discourses around the notion of 'empowerment'.

For the above reasons, and in order to better understand their strategies to overcome subordination, the focus is placed not only on the causes of oppression, but also on nurses' individual and collective agency. By agency, I imply a sense of *intentionality* in nurses' actions. This does not mean, however, that their intention is always rational or the fruit of a meditated decision. It points to a more general attitude in some situations, and to the value attached to it. Ortner (2006) developed a gradient between 'soft' and 'hard' definitions of agency according to the weight they lent to intentionality and aligned herself with the latter. In order to avoid falling into the 'individualist' trap which the Comaroffs (1992) had criticised, she conceptualised intentionality as including "'highly conscious plots and plans and schemes; somewhat more nebulous aims, goals, and ideals; and finally desires, wants, and needs that may range from being deeply buried to quite consciously felt" (Ortner 2006, p.134).

Furthermore, anthropologically, the notion of 'agency' moves beyond the subject. Ortner (2006, p.152) concluded that "the anthropology of 'agency' is not only about social

subjects, as empowered or disempowered actors, play the games of their culture, but about laying bare what those cultural games are, about their ideological underpinnings, and about how the rules of the game reproduce or transform these underpinnings". Nurses' agency is analysed relationally. By relating their subjective experiences to one another, common strategies are found which could be seen as collective 'patterns of resistance'. Nevertheless, the distinction between nurses' individual and collective agency is somewhat artificial and has only been done for analytical reasons.

Bearing in mind that human agency goes far beyond the use of strategies to resist domination and involves the pursuit of "culturally meaningful goals" (Ortner 2006), Foucault's (1977) notion of strategies and his *relational* conception of power is of interest. In addition, intersectional analysis and discussions on the 'common but particular' oppression of women are also pertinent in relation to the situation of nurses. On the one hand, the undermining or devaluing of care activities can be identified as a broad aspect of Western, patriarchal, capitalist societies (Pérez Orozco 2014) and their hegemonic biomedical system (Gamarnikow 1978; Menéndez 1984; Dougherty & Tripp-Reimer 1985; Salvage 1985; Rafferty 1996; Doering 1992). Therefore, it is expected that nurses and other caregivers would share certain commonalities in their socialisation and experience. On the other hand, however, the experiences of nurses and caregivers differ greatly according to their particular position in terms of gender (Davies 1995; Evans 2006), class (Dingwall et al. 1988; Gamarnikow 1978; 1991; Wolf 2006) and race (Hill 2006).

Butler (1999) concluded that in spite of the difficulties in the articulation of a single category of 'women', at some point it can be strategically useful to highlight the 'universality' of gender oppression in order to fight against it. Not only this, but looking at the roots of oppressive ideologies is a key aspect when looking at the particular ways in which they operate (Moore 1988; Brah 1992; Butler 1999). In other words, the analysis of individual and collective strategies to overcome oppression or discrimination can also be related to broader 'emancipatory' movements and to the drawing up of routes through which a common or joint path could be established. The same can be said in relation to the situation of nurses within the health system and society.

Nurses' collective agency is analysed first, to provide a broad picture of their joint strategies to increase their power as a group. At some point in their narratives, however, their collective action blurred with individual behaviour. Nurses acknowledged that the actions of individual nurses could have a significant influence on their collective image. This idea points not only to professional identity issues, but also to the significance of group status and honour in the Bangladeshi context. This blurred individual-collective terrain is explored in this section, before concluding with a relational analysis of nurses' individual strategies.

8.4.1. Getting organised: Nurses' collective agency

Bourdieu's (2001) notion of *class habitus* is useful to analyse how group identity is formed and also to point to the idea of a shared experience. Willis' (1977) notion of *class culture* could work in a similar way, as it points to "experiences, relationships, and ensembles of systematic types of relationship which not only set particular 'choices' and 'decisions' at particular times, but also structure, in reality and experientially, how these 'choices' come about and are defined in the first place" (1977, p.1). Nevertheless, neither *class habitus* nor *class culture* include the notions of *intentionality* or *project* which are embedded in the notion of agency. Even though we cannot speak of 'collective agency' in a psychological sense, groups can also have common projects (Ortner 2006). On certain occasions, people work together in the pursuit of collective goals.

Tuli admitted at some point, that nurses needed to 'get organised' in order to improve their situation. This does not always mean that they need to be formally united, but instead it points towards the need for an improvement in inter-group relationships, a good leadership and representation system and in some cases, a joint opposition against certain people or measures which work against them. The 'critical nurses' sometimes get frustrated because they feel isolated. They notice certain problems or situations within their profession that other people would not see, or at least not in the same way. They also feel they cannot change everything by themselves:

> "Nobody is thinking in my way. I am, I feel pain and sorrow (…). I can see the things and I could also change the things if I was there. But is not possible for me to go everywhere and do everything by myself (…). One or two people cannot make any changes. We just, when we are still in the patient's side we do good, when we are in student teaching we do good but not all [of us are] doing the same" (Nurse, May, 2013)

In many other cases, however, inter-group solidarity is also demonstrated amongst the nurses, especially as a reaction to open violence against any of them. Nevertheless, the capacity of formal leaders and what they term as 'nursing politics', that is, union-type industrial action, is also limited. Wicks (1995) argued that placing too much emphasis on the nurses' oppression neglected the acknowledgment of this apparent contradiction. Nurses are often stereotyped "as victims or as complainers, or as structurally 'caught' between competing masculinist strategies of professionalization and trade unionism" (1995, pp.122–123). The further sections show a much more complex situation.

8.4.3.1. Relationship amongst nurses: Reactions of support and opposition from their colleagues

Generational differences and tensions also occur amongst clinical level and can become a source of discontent (Leppard 2000; Akhter et al. 2003). Hadley and Roques (2007) found that nurses willing to perform nursing care according to their curriculum were discouraged by other nurses. It is questionable, however, to what extent this is due to the type of horizontal violence described in the theories of oppressed group behaviour (Roberts 2006; Lee & Saeed 2001). The nurses in this research provided ambivalent accounts. On the one hand, they sometimes acted as role models and were seen as an inspiration for their colleagues, whereas on other occasions their proactive attitude was perceived as a threat.

Some nurses were asked at certain point in their careers to act as agents of change on the wards. Agnes was asked by the hospital director to become, in her words, 'a symbol'. When I asked her about the reaction of the other nurses, she replied that even though they did not like to be corrected, they would not argue in front of her. Amena and Farhana had

similar experiences when they returned from the UK. Farhana narrated how some of the nurses began calling her *Londoni*[159] when they saw that she was strict with them:

> "When I went back again (…) I saw that some staff nurses were only [performing the] tasks, not as holistic care. They came late and they said: 'Oh, my children went to school and I went with them' (…). [When I told them how to behave] they didn't like me. They gave me the name *Londoni* nurse because I was always strict (…). They didn't like me ((She laughs)) (Farhana, 18/03/2012)

Amena and her friends who had returned from the UK experienced a similar situation. The hospital 'management' supported them as agents of change, but the senior nurses did not always accept their advice. She reflected on the importance of seniority and generational issues:

> "Imposing ideas sometimes doesn't work. The older generation doesn't accept the [way in which the] younger generation behaves, that is another important [aspect] (…) which is also responsible for deterioration of nursing in Bangladesh (…). We are very supported (…) by the management people. The senior managers [tell the other nurses] how they can do well in their work, organise their work in a planned way and (…) act as change leaders. But if the change leader is not coming from their side, you cannot impose (…) your feeling" (Amena, 29/05/2013)

On more than one occasion, the nurses expressed the importance of respecting seniority. Sumita mentioned that when she began working as a staff nurse, she told the senior nurses that she would do their job. On other occasions, and as the nurses became more senior, they experienced the inverse situation. Seniority in this context is not only related to age or working experience, but also to their position within the institutional hierarchy. Nevertheless, some challenged the 'seniority rules' and got involved in clinical work anyway:

> "I was very senior and they didn't allow me to do work but I said 'No. I will work because I like to work' and then I joined in the recovery room (…) [as] a supervisor" (Farhana, 10/10/2012)

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[159] *Londoni* is the designation given in Bangladesh for people who had migrated to the UK or, more broadly, to Western countries. It was widely used for the Sylheti migrants who went to the UK and on return to Bangladesh were perceived as wealthy (Gardner 1995).

Tuli had a similar experience when she joined a government hospital right before retirement. She decided to work anyway, although she was more involved in 'paperwork'. Today, Tuli is still very much in direct patient care in spite of being the hospital superintendent.

Seniority issues have often been raised as a problem, especially in relation to promotion (Oulton & Hickey 2009; Directorate of Nursing Services 2011) and generational tensions between nurses (Somjee 1991; Leppard 2000; Akhter et al. 2003). Considering the role that age and seniority play in Bangladeshi society, these tensions are unavoidable. Nevertheless, there is a crucial aspect that may have consequences for the provision of nursing care. As happens elsewhere, basic nursing care activities are considered as 'menial'. Therefore, it is believed that, as one rises up the professional and social hierarchy, it would be inappropriate to continue performing them. This has three significant consequences. First, it restricts the role of senior nurses as role models for younger nurses. Secondly, it deprives patients from being looked after by experienced nursing teams. In this regard, Wolf (2006, p.315) concluded, from the US, that "keeping experienced nurses at the bedside improves the quality of patient care and reduces recruitment and orientation costs". Finally, as happens in many places, conflicts between junior and senior nurses emerge when the former try to implement change.

Nevertheless, clinical work can be physically and emotionally exhausting, especially in big Government hospitals. Working on shifts, particularly at night, can also be difficult for older nurses and it is understandable that nurses prefer to work in less demanding services as they become older. Furthermore, as one nurse had highlighted on many occasions, many staff nurses who have been working for two or three decades have not received continuous education. Therefore, their knowledge is not updated and they can feel threatened by young students. She noticed the gap and advised the teachers:

> "Please prepare the hospital nurses for taking care, for that supervision role for the students, otherwise then maybe conflict arises (…). Nurses must be aware that this people [students] are coming, who are like your kids or sons, or daughters (…). So when they are coming [they can] accept them well (…). [Another important] thing is

> that the new knowledge is always in confrontation with the old knowledge" (Nurse, May 2013)

According to the nurses' narratives, age and working position are the main factors influencing the power relations amongst nurses. Gender and class were mentioned as significant issues in their relationship with doctors, albeit they did not seem to be a key issue amongst clinical areas. Religion could also be significant when nurses felt that they were underrepresented, although it did not seem to be a big problem on the ground. Nevertheless, as nurses escalated their political bargaining, these issues became significant.

8.4.3.2. Limitations in nurses' professional leadership: Cause or effect of institutional discrimination?

Two of the nurses studied have achieved high-level decision making levels in the Government sector, and with international organisations. They provided a very critical and detailed account on how things work politically, highlighting significant limitations in official nursing leadership, similar to those described in Chapter Five:

> "Why we can't develop? Because this chairperson, this senior person are guiding by office staff, not with tutor. If we sit together tutors, if we have good relation, so we can do something. But (…) [they are] busy with other things, official work, with family things, with relatives and local people is there, paying attention to local place, local relatives (…), so they are not interested (…). Maybe they are interested, but something is happening, something is gap there, we need to search it" (Nurse, May 2012)

One nurse observed how, locally, nurse supervisors and matron had very limited authority over the budget. Sometimes, international agencies allocated resources to nursing, but the 'local authorities' soon diverted the greatest share. By 'local authorities' she meant the civil surgeon, that is, the medical 'authority'. According to her, there was a gender component to the situation:

> "Maybe this system is going on, but who will monitoring? Because we are women, we have no voice, we are not that accurate people, you see? (…) DNS no voice, BNC no voice, nurses are going to the street for their right but who will hear it? Because of this culture nurse who are they? They are like housemaid, so who will give them importance? (Nurse, May 2012)

This same nurse provided examples from her own experience, through which she had witnessed resources diverted from nursing to the medical side. At a higher decision-making level, the nurses' bargaining capacity was still low, as the two nurses observed. One attributed this to the whole structure of the Ministry of Health, whereas the other focused on their leaders' lack of involvement in the protests. Both agreed that nursing representatives tended to have a 'soft voice' with respect to the government and official authorities:

> "[The authorities] are asking [to the nurse leaders]: 'Can you say something?' 'No, no, no, I am not telling'. But we need to take this opportunity, we need to present ourselves and (…) we need to tell our opinion (…). But always we are keeping away (…). Even when the health ministry is inviting the DNS or BNC people they are going to the corner and keeping silence (…). Why will not they give their opinion or ask questions?" (Nurse, May 2012)

> "That time the college principal liked me very much. But she doesn't, you know, compromise with this sort of things [industrial action] (…) From the very beginning of the student life I was involved in BNA, Bangladesh Nurses' Association. But they [formal bodies like DNS or BNC] see it in a different way (…). They want to talk to people in a sober way (…). So [they were more] submissive, more soft and submissive" (Nurse, May 2013)

There is also a limited scope for monitoring and accountability of nurses' performance. One nurse observed that as a result of their low decision-making capacity, the nurse supervisors at the hospital are becoming less involved in direct management. Their work is pretty much limited to monitoring the 'present and absent' nurses. When I once visited a Government hospital, I got a similar impression about the supervisors' work. They spent a considerable amount of time sitting on their room and filling registers. Meanwhile, several nurses would interrupt them to apply for leave. If any nurse arrived late, the supervisor would call their attention. They would provide different reasons for their delay, such as having to cook for their children, accompanying them to exams, facing traffic jams, etc.

Overall, the limited formal nursing leadership in Bangladesh seems to be trapped in a vicious circle that starts from the historical institutional discrimination of nurses within the health system and society. This neglect, together with the internal age and status hierarchies amongst the nurses, has led to a situation where nurse leaders are often unable to raise their

voice. Even if they do so, their protests will not necessarily be heard. Nevertheless, lobbying of official bodies has obtained significant achievements. Improvements in the nursing curriculum and the upgrading of nurses from Third to Second Class Employees in the Government Service are good examples.

8.4.3.3. An alternative to 'official' leadership: Industrial action

Some nurses in this research were involved in 'nursing politics' and industrial action. In some cases, this has had negative consequences for their professional careers. Farhana experienced it positively, as she could join an official association and get international support. After getting her Diploma, she joined the Bangladesh Nurses Association (BNA) and witnessed the tensions and final split of the Bangladesh Diploma Nurses Association (BDNA). She decided to stay at the latter and worked actively as the general secretary for three years. They undertook several activities and arranged educational programmes inside and outside the country. Other nurses were not as fortunate and they were persecuted for their involvement in protests. For confidentiality reasons, their detailed accounts are not provided here, although it is significant to note that both had their salaries curtailed for some time. One received a 'punishment transfer' and the other suffered a personal persecution and serious threats.

The following narrative summarises the consequences that their involvement in 'politics' could have. The protagonist had been involved in several 'agitations' in favour of nurses. She had just been recently transferred to the hospital and the director asked her to stop her political activities, which she refused. She sustained this apparent 'contradiction' of being committed to her job and at the same time involved in the agitations:

> "I joined but (…) the director of the hospital mentioned 'OK. Nobody wants you (…), you have to give a written consent that you cannot do this sort of work, or this sort of involvement [in politics] (…). That time I just mentioned that 'No (…) don't believe others' words, you see my work'. I was always good in the clinical side, students' teaching, in patients' care (…) and I got that time my masters and everything. He [the hospital director] identified that whoever said bad things, it was not true; during my work I was totally different. But when there is [political] movement I was again different (…). He always preferred me (…). That time I just communicated in English (...) and I could explain what I was doing (…), so every

> time any missions came from outside (…), every time that there was a new opening, new ward, new professors and new people were coming they know me very well. Because I have that courage and I can do, so in this way I get popularity within the campus. So, you know, [popular] people also get the strong voice in the movement" (Nurse, May 2013)

Overall, nurses' involvement in politics and industrial action was effective in many cases, although sometimes there was a high personal and professional price to pay. Nevertheless, the nurses still managed to progress thanks to their clinical and academic performance, in spite of the institutional discrimination in terms of salary, transfers, lack of promotion, etc. This leads us to the significance of the nurses' individual actions in their collective agency.

8.3.4.4. Muddy waters: The effects of nurses' 'individual' attitudes on their collective image

This section could be situated somewhere between the individual and collective agency of the nurses. Any collective with a strong group identity would be affected by its members' behaviours, although in the case of the nurses this seems especially significant. In the case of nurses from Bangladesh, Rema (1999) observed:

> "It is a fact that very often patients are not getting proper nursing care due to the sheer disinterest, negative attitude and negligence of nurses. As a result the public is gradually losing faith and trust in the nursing profession leading to a deterioration in the image of nursing" (1999, p.29)

This idea is shared by the nurses interviewed. As stated in Chapter Seven, nurses' behaviour moves beyond their professional performance. For nurses to be respected by 'the public' and for their status to be raised, they must follow socially-sanctioned behaviour.

Teresa found, when working in a small clinic, that some nurses had 'stealing habits'. Furthermore, their salaries were very low and, probably due to this, they were not valued enough. Doctors would call them at any time, without respecting their rest. Her solution combined a request for better working conditions and the reinforcement of 'discipline':

> "I said: 'At five o'clock the chairman can call the nurses. This is a discipline, because we did in [my former institute] (…). Because you know, in Dhaka city clinic only a few amount of money [they are paying to nurses] and the people maybe think: 'The nurses are not very valuable here and any time we can call'. (…) I was very strong for my profession from the beginning (Teresa, 21/04/2012)

The nurses' constant need to set boundaries and gain respect is especially visible in their interaction with patients and relatives. Chapter Five showed that, in some contexts, there is a vicious circle where the more nurses try to protect their status by avoiding providing basic care, the worse treatment they receive. Therefore, even though a certain 'safe distance' was needed, especially for young female nurses, their complete detachment from the patients was not desirable, as it portrayed a negative image of nurses as a group. One male nurse, who was initially interviewed, recognised that their behaviour with the patients helped to improve their social status:

> "By dint of my service, or by dint of my care, actually people had a good impression about me. I found that sometimes they told about me to other person: 'He is a very good nurse. He takes care nicely and he behaves very well with the patients'. This type of positive impression" (Ahmed, 09/05/2012)

On one occasion, Rabeya mentioned that her brother had said that nurses never smiled. She provided a full argument about nurses' attitudes to patients: nurses could smile but never laugh loudly, especially where patients were in a severe condition. She also highlighted that in 'their culture', patients do not always behave politely to nurses. Nevertheless, according to her, the situation is changing nowadays, especially in the case of educated patients, who tend to be nicer to nurses. Amena's views on the interaction between 'educated' patients and nurses were not so positive. She observed that if nurses' knowledge is not updated, they could feel embarrassed by more assertive and knowledgeable patients. Her entire argument is included as it clearly illustrates the relationship between nurses' knowledge and their agency or social power:

> "Another important thing is, the nurses who passed in 1998 or 1977, they don't get a SINGLE training (…). When lay people are there, nurses don't feel anything because they know that they are not asking them critical questions. But when educated people are there, when in the newspaper you can see there is a weekly supplement about many diseases and issues, doctors are describing things, so people read and learn. If nurses don't learn the up-to-date things, what happens? She [the nurse] gets afraid of

> the, touch the people (…). The hospital authority should ensure that nurses keep up their knowledge. When new people, new diseases, new things are coming, nurses aren't much involved in that process of knowing. Few nurses are very talented, very enthusiastic and they would get articles here and there, or share with the families and friends, but most are lacking. So when somebody tells them: 'Sister I have this drug, why?' They say: 'Yes, doctor's given it to you and that's why I am giving it to you' You see the answer? It is a lay answer, not the professional answer. They are not in such a position, due to the hierarchy of the disciplinary team [and if they ask the doctor] 'OK, doctor, I have seen that previously we are using one antibiotic, but now we are using three antibiotics, why?' (…) Please, tell me because I am in front of the patient, I have to give answer' [The doctor may reply]: 'Why do you need it? You are asking question from me, on my prescriptions? How dare you?' (…) Nobody of the hospital side is thinking that nurses need to have updated education (…). [The nurses] who are arrogant, they avoid it [going to the patients' side], they cannot touch. Those nurses who are simple [are told] 'You should go and do it', and after going there they get afraid because they don't know anything and then when the patients' carers are asking any question: '*Apa* [sister], what is the patient conditions?' [The nurse replies] 'Doctor said is OK' See the answer? Not even her own word (…), or 'your patient is not much good, you should accept it because, you know, people will die, so please, don't ask me any question. When doctor comes, please ask him questions'" (Amena, 18/12/2012)

Leppard (2000) provided a similar analysis in her hospital ethnography, in which nurses and ayahs who systematically avoided conducting deliveries or practical work were side-lined by their colleagues and considered to be less competent. Her impression was that these nurses "avoided going 'close to the beds' and as a result, were less experienced and therefore less competent clinically and in interpersonal skills than the others" (2000, p.203).

Amena observed that, apart from providing nurses with updated knowledge and encouraging them to get more involved in patients' care, it was also crucial that the media portray a positive image of the profession. She gave a real example of nurses involved in an emergency situation during their BSc course. There was a fire and they began rescuing people without thinking about their safety. Amena concluded that these types of situations, together with nurses' continuous involvement in their communities and with the disadvantaged people, could help to improve their social image. Similarly, Tuli provided with a comprehensive analysis of the interaction between individual, institutional and broader sociocultural factors:

> "We need to come back to give the proper nursing care to the patient (…). On the other hand we need to pay attention for our culture. Because in this country most of the people are coming from the majority culture, so it is with their society they will not touch this way, they will not be exposed. This is one thing. But within mass media (…) [they need to give] importance to this profession (…) by educated person: doctors (…), lawyers (…), journalists, need to give importance by Government (…). It is two things, one depends on individual attitudes, another thing is the need to pay attention by the authority" (Tuli, 11/05/2012).

Two of the nurses interviewed towards the end of this research had been awarded a Gold Medal[160] for performance. Rahman (1996), in a *Nursing Newsletter* article, reflected on other strategies to recognise nurses' performance and increase status. He concluded that even though rewards like the Gold Medal were helpful, placing the nurses in a position where they could fully 'utilise their knowledge' was also crucial. Similar narratives were found in this research. Unless the authorities and the public treated nurses better and provided them with better education and working conditions, their social status would not improve. Nurses can individually improve their image and 'gain respect', as has the following section shows, but they need a greater support from the institutions and society.

8.4.2. Potentials and limitations of the nurses' individual agency

Chapter Seven showed that the nurses utilized several strategies to increase their agency from the beginning of their nursing education. These strategies were at that time greatly based on their outstanding academic and clinical performance. Nevertheless, under certain circumstances, some nurses openly opposed the 'authorities' when they their rights or safety in danger. This alternation between compliance, ethical behaviour and protest against injustices seemed to be followed by the nurses throughout their professional careers.

8.4.2.1. Good performance as a weapon: 'My work has woken myself up in front of everyone'

Even though the nurses were aware that they had several opportunities to expand their knowledge and experience, some tended to emphasise that they had earned them through

[160] The Gold Medal is a national award given by the Prime Minster of Bangladesh in recognition to somebody's service to the country (Barnamala 2015). Many nurses have received it over the years.

their own efforts and good performance. Sumita had highlighted that she travelled to the UK and learned English at her own expense. There was another nurse who observed that after returning from the UK, she did not enjoy many opportunities for continuous education:

> "No opportunity for any training or anything else. For this study [scholarship] I have to sit for exam and get competition and then I was allowed, otherwise no such [opportunity] (…). I got this because of my (…) ability" (Nurse, May 2013)

Therefore, 'earning' their merits by themselves was a key feature in a context where corruption, mismanagement and nepotism are relatively frequent. Being honest and hard worker merged as part of a single quality, which was constantly highlighted in the nurses' narratives. Rabeya considered copying during the examinations as a severe fault. She gave an example of the time when she was studying her Masters. Unlike other students, she accepted that if she did not perform well, it was fair to get low marks:

> "Because many girls get A, but they have not enough knowledge because they are always (…) cheating, everybody knows that this is the reason (…) If I cheat I [could] never [have] told my son: 'Do not do these things'. This is not fair. Because if I am cheater, how can I tell?" (Rabeya, 01/04/2012)

For Amena, students' dishonesty went beyond copying during their exams. She used the term *phakibas*, which could be translated as 'the one who eludes responsibilities', to illustrate a more general attitude of taking advantage of other people's efforts:

> "Within the group (…) I have seen one is (…) copying, another one is preparing, other is just presenting (…). Within the class I have seen that 10% student learn (…) [and] 90% student doesn't learn (…). When they are returning back to the hospital or anywhere else they cannot do the same practice, they cannot, they didn't know how to do it." (Amena, 29/05/2013)

Nevertheless, being honest could also have some negative consequences for the nurses. Apart from leading them to lower scores at a higher effort, their honesty could also be seen as a threat by the 'authorities' and their colleagues. Key in their position within the institution was the nurses' relationship with the doctors. This particular relationship has been widely explored elsewhere, being Stein (1969) pioneer in his analysis of the 'doctor-

nurse game'. The author evidenced the presence of a set of unwritten rules that allowed nurses to make recommendations to the doctors as long as they did it in a subtle way. Significant changes have occurred since Stein wrote his classical analysis and in many ways the gap between nurses and doctors has narrowed. According to a further analysis conducted by Stein and others (1990), the main vehicles for change had been nurses' education and the growing spaces for collaboration between both professions. Similar reasons have also been stated by other authors (Svensson 1996; Hojat et al. 2001).

In Bangladesh, doctors have been historically powerful and politically influential at a level which goes far beyond the health institutions (Osman 2004). Having a greater social, economic, cultural and educational capital than nurses, their dominant position in the hospitals and other health institutions is expected. One nurse narrated an incident that shows the nurses' vulnerable position within the health institutions:

> "That time one nurse was beaten by a doctor (…). She was also a student, six months previous from me. One kidney tray or something she has given to the doctor in left hand (…). So he slapped her, and then everybody got anxious: 'Hand is hand, whether if is left or right it doesn't matter. She was just assisting him' (…). Everybody got angry, there was a great movement to cancel the registration of that doctor (…). But later (…) I have identified that one or two doctors [who were] in that occurrences, one joined the army and another one is a parliament member, you see? Promotion" (Nurse, May, 2013)

In a higher political level, doctors were even more powerful. For instance, when nurse leaders began claiming for changes in the curriculum and for an upgrading of the students' background, a strong resistance came from the Doctors' Guild:

> "[When] our new curriculum is implemented in 2008, that time the objection is coming from the Doctors' Guild: 'Why [should] the nurses be [holding] (…) intermediate [certificates]?' Because of doctors also [hold] intermediate [certificates]" (Nurse, May 2012)

Nevertheless, the nurses underlined that although nurses were not always well treated by doctors they were respected. Respect was 'earned' through a combination of knowledge, good performance and sensitive behaviour. Amena made an interesting observation which clearly related 'knowledge and skills' with power:

> "If nursing superintendent, nurses, supervisors have the knowledge, knowledge is the power. Of course we have to recognise that things; knowledge and skills both are our power, and [also] if we practice in a good way" (Amena, 18/12/2012)

Agnes, for example, explained that she was often asked for help from the doctors, especially from the young ones. It is clear that without the help and experience of the nurses, many young doctors could not learn in the same way. Similarly, Tuli clearly stated that her work had 'woken herself up' before everyone and Agnes concluded that 'by giving hard work' the authorities had 'defended' her. Farhana stated that if the nurses delegated their tasks to the ayah, nobody would respect them. She wondered:

> "Why will the doctors and public respect me? For my job. But if you give up your job, who will respect you? No one" (Farhana, 18/03/2012)

Maintaining a good relationship not only with the doctors but also with the other staff members was also crucial for nurses to be respected in the institution. Even one nurse who was more critical towards the doctor-nurse power imbalance admitted that open confrontation with the doctors was not the solution:

> "Quarrelling with the internee doctors (…) [may] worsen the situation. They [nurses] have to acknowledge that this is a hierarchy-based society and nursing position is not good in the society (…). Of course medical students feel superior and we have to accept that things and with that acceptance we need to change it (…). But is a long-term business. But in this, this time we have to accept, acknowledge and then cope and work" (Nurse, May 2013)

Within the hospital hierarchy, it seems that other factors like seniority can sometimes be more important than being a doctor or a nurse. Therefore, in Agnes case, it was the internee doctors who asked for help and who probably addressed her with respect. The situation may be different, however, for young nurses or for those of them who are less assertive or 'knowledgeable'. In any case, the nurses' performance and their commitment to their job were crucial to gain a good reputation in the institution.

8.4.2.2. Strategies used to improve nurses' working conditions and income

The nurses had to use several strategies to either increase their income, their status, and their possibilities of developing their capacities. The nurses' career paths show how they changed jobs if working conditions were not good, or there was not sufficient scope for self-development. I also saw how other nurses interviewed combined work in Government posts with other activities inside or outside the Government. Regarding the former, it could range from getting involved in the preparation of official exams, to acting as an external examiner in other institutions. Nevertheless, not all the nurses in this research agreed with this system of being involved complementary income-generating activities. One observed that this could lead to malpractice, as some nurses, who were more senior and powerful in the institution, would allocate too much time on these 'income-earning tasks', thus neglecting their daily responsibilities.

During my fieldwork, I also spoke to one nurse teacher who occasionally conducted circumcisions out of his office hours, but I did not get the impression of this being usual practice. One thing that I managed to observe was that some nurse teachers joined the private sector after their Government retirement[161]. In addition, some key informants in this research had decided to shift to the private sector at some point. Working for the Government is generally perceived as more secure in terms of ensuring a long-term salary, and housing and retirement benefits. In spite of this, some nurses find that they have more flexibility and greater opportunities to pursue a career outside the Government. Farhana and Rabeya decided to quit their Government posts after some time. Their reasons were different, although they both agreed in that the posting system at the Government was a source of instability. Furthermore, they saw opportunities coming from the private sector, especially in Dhaka:

> "There is good job (…) and I thought whatever I learnt, I can utilize fully in the private sector (…). In the Government sector, there are many restrictions, and there is no equipment. That's why I decided that I would stay in Dhaka. For my family and to utilize all my experience" (Farhana, 26/02/2012)

[161] The retirement age for Government officials used to be set at 57 years of age (Miyan 2008), although a more recent document indicates that it has been extended to 59 years (Government of Bangladesh 2013).

Their drift away from the clinical posts was also greatly conditioned by their working conditions in terms of pay, promotion, transfers, etc. Furthermore, they felt that it was difficult to utilise their expertise clinically.

8.4.3. Shifting to the educational field as a way of 'utilising their knowledge': Between a vocation and an expected move

Similar to their 'vocational' narratives about their joining in nursing, some nurses portrayed their role as teachers as a way of extending their nursing care while sharing their knowledge. In some ways, this narrative carried a sense of 'mission' in life.

8.4.3.1. The connection between teaching and nursing… or nursing and teaching

When her mother superior told Agnes that she had to become a nurse, she was initially confused because she enjoyed being a teacher. Later, she rationalized the situation and thought that she could also 'teach' her patients:

> "I was teacher, no? But that time I am practically nurse and I can teach also patients, carers (…) all kinds of advice, no? That time also I think that I am a teacher (…) REALLY, those nurses who work like this, they can think (…) that this is also a kind of [teaching], no? Practically" (Agnes, 18/02/2012)

Sumita recalled thinking of herself as a teacher since her childhood, and further developing this wish when she was helping other students during her Diploma. It was interesting that both she and Tuli emphasized that other members of their family were also teachers and they would therefore follow their tradition:

> "Even when I was [a primary school] student I observed how teachers were teaching me (…). From that dream I am now teacher. In my family, my grandfather was the teacher and (…) that things maybe I got, no? My brother, he also tried to (…) act as a teacher (…). That means this is my (…) grandfather's (…) designation ((she laughs))" (Sumita, 18/03/2012)

> "When I went to the congregation I never thought I will be a nurse, by that time I thought that I will be teacher. That's why I am getting the teachers training and then I develop myself in this way. In our [family], generation to generation we are ALL are

> teachers, professionally teachers. That's why, by born we are teachers and then we are getting that training"(Tuli, 13/03/2012)

It is worth noting that except from Teresa, the other nurses also had key persons in their families who were teachers. Farhana's father was a schoolteacher and her uncle, who became her guardian after her father's death, was a headmaster. Her mother, like Rabeya's, was involved in social work and giving private tuitions from their house. Agnes' aunt, who took care of her when her mother died, had a sister who was the teacher of the school she attended during her childhood. Undoubtedly, education emerged as a key element in the lives of the nurses in many ways. Becoming nursing teachers seemed a good way of continuing to be linked to the academic field.

Teaching is clearly a good way of learning by sharing one's knowledge with other people. Almost all nurses, in one way or the other, expressed their eagerness to incorporate new knowledge and experiences throughout their student and professional life. Teresa stated on more than one occasion that sharing her knowledge with 'the different categories' was 'her motto and constitution'. Nevertheless, she felt that 'sharing' was difficult for her due to the working environment in Bangladesh.

8.4.3.2. Difficulties and rewards when sharing their knowledge with the students and patients

Most teachers seemed to enjoy their work with the students. They seemed to drift between being strict and looking after them. Sumita exemplified this ambivalence. On another occasion, she was disappointed because she observed that one teacher was giving the answers to the students during an exam. She thought that this was a malpractice as it was very important to maintain certain rules to reinforce the students' honesty. Nevertheless, on another occasion, she was concerned because somebody from the college had told her that she was too strict and some students were 'scared' of her.

Tuli's descriptions of her relationship with the students show a mixture of 'looking after them' and trying to understand their concerns. Undoubtedly, her teaching went beyond the academic sphere. Sometimes she would sit with the students at the dining table and teach

them ‘manners’, and the importance of being honest and maintaining their religious duties. In spite of being Christian, Tuli arranged for the Muslim students to get private lessons to be able to read the Quran. The two batches with whom she worked more closely were very happy with her. She sees that as a compensation for all her struggles in the institute:

> “These girls when they left the institute, they told me: ‘You can believe us. Wherever we will be in our life, we will give nursing care’. This is my contribution (…). When I hear this kind of remark from my students, I feel proud for ALL my suffering” (Tuli, 13/03/2012)

Amena was also greatly involved in the students’ placements, although her innovations were more related to assessing them individually and showing them different aspects of community work. She had studied sociology in the past and that helped her to get a broader notion of the students’ involvement in the community. She introduced visits and programs in places where students have not gone before like a juvenile delinquency centre or a destitute women centre. Nevertheless, the visits were discontinued after her retirement:

> “The teachers don’t want to give efforts to their teaching, that’s the important things. That’s why I am feeling different (…) I took the students to the school (…) and the students enjoyed very much and they learnt also, and they know that they have power to see the changes. But it is not existed now (…). Teachers are still there (…) but they are not [doing it] (…). So it was so painful (…). Nobody wants to arrange it” (Amena, 29/05/2013)

Implementing the new system was challenging and needed a lot of preparation and work. In addition, the other teachers did not always value her efforts. Similarly, Tuli recalled facing some difficulties that when she began working as a nursing instructor, especially when she got involved in the students’ placements. ‘Her’ batch of students were pleased to have her so closely involved, but she faced opposition from some staff nurses, her teacher colleagues, and even some students who thought that she would fail them.

In many cases, the nurses acted as role models and reference people, especially for their students and for other young women. Teresa’s younger sister is a nurse, and both Agnes and Tuli had also helped some of their nieces to get admitted in nursing institutes. Nevertheless, Tuli is probably the nurse who better exemplifies the idea of becoming an

'inspiration' to other young women. The paradigmatic example of Tuli's role in helping other people to become agents of change was her bond with Selina. They met when Selina was a young girl from a disadvantaged family, and Tuli supported her throughout her education until she became a nurse. She stated proudly that some people called Selina 'the second Tuli'. I met Selina once and she was very fond of Tuli. Not only Selina, but also her former students were grateful to Tuli. There was a poem on the shelves of her office written by one where he compared Tuli to figures like Nightingale, Mother Theresa, Lady Diana and Rokeya Begum[162]. Interestingly, Sumita, who had struggled during her childhood like Tuli, also 'used' her life experience as an example to the current students:

> "Sometimes I give the example to the students also, then I think they would be encouraged. Sometimes I am telling, not personal matters (…) I don't say my name, I just say: 'I know one girl, she did like this. So, can you imagine how you are studying here? You are getting ALL opportunities very well but that student, that she didn't get, but she is in a very good position now'" (Sumita, 11/03/2012)

In some cases, acting as role-models, being an 'inspiration' through their own experience and helping other people can also be crucial aspect of the nurses' social capital. It provides them with a strong sense of professional fulfilment, and also creates strong bonds with the people they support. If taken collectively, it can also help to improve their collective image as nurses in the society.

8.4.3.3. Final remarks: Nursing education and *caring*

At the beginning of this chapter, the question emerged about whether some nurses move to the educational sector in order to avoid getting involved in patients' care. In the case of the nurses in Bangladesh, there is no easy answer to that question. From a superficial analysis, it can seem that nursing education being more prestigious than clinical work (R. Khatun 1999), becoming teacher is an expected move for those nurses who want to progress in their career. This could lead to the assumption that the nurses in Bangladesh move to the education sector as a strategy to avoid the 'low status' nature of clinical work.

[162] Roquiah Sakhawat Hossain (1880-1932) was a Bengali writer, educationist and social reformer. Apart from setting up schools and focusing on female education, she also wrote extensively against the strict seclusion of women and founded a Muslim women's society in order to make women aware of their rights (Banglapedia 2012)

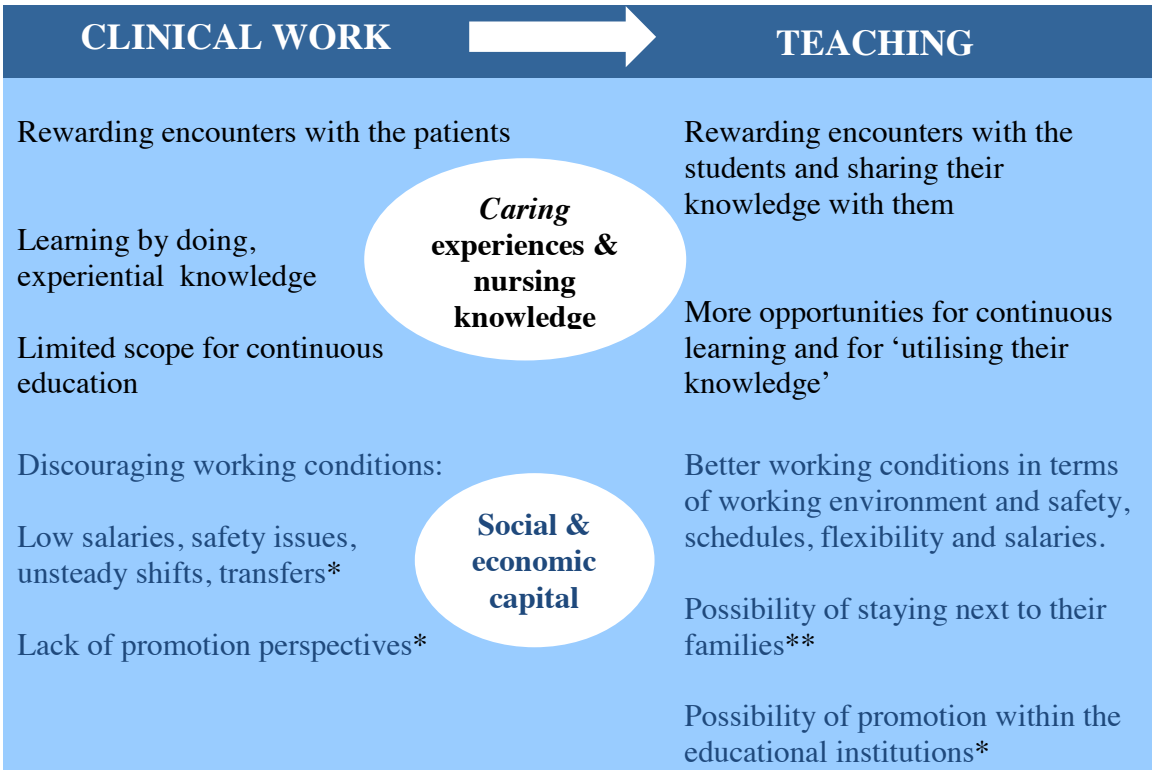
Nevertheless, this issue is far more complex than that and some aspects should be taken into consideration. First, it has been shown that 'care avoidance' obeys to a combination of gender, social and structural factors (Robson 2005; Hadley et al. 2007). Second, the pressure exerted on nurses to express overt signs of warmth towards the patients is not exclusive to Bangladeshi nurses (Benner & Wrubel 1989; Robson 2005). Third, the wards are often considered as unsafe places for the nurses, where "violence against the female nurses by male relatives and by male doctors was not uncommon" (Robson 2005, p.37). Last but not least, the limited scope for professional development for nurses working clinically should also be considered (Aminuzzaman 2007; Oulton & Hickey 2009; Akter et al. 2010). Again, this latter aspect is not exclusive to Bangladeshi nurses and has been reported in other countries like the UK (Davies 1995; Antrobus & Kitson 1999) or US (Roberts 2006; Wolf 2006).

In any case, and without exception, the nurses provided with vivid accounts of their experiences with the patients and the satisfaction that they obtained when looking after other people. Even though some of the accounts may be elaborated from the distance and with a significant degree of idealization, the situations that they described were typical of truly engaged encounters between the nurses and their patients. Besides, I could see some of these nurses interacting with the patients and their practices were consistent with their accounts. This does not mean, however, that nurses' identity is always placed in relation to the nurse-patient relationship. For the nurses, it was also important to be able to work in an independent and creative way, trying to implement all the new knowledge and experience that they incorporated with the years.

Throughout their education and indeed, their personal lives, it became clear that the nurses were constantly looking for new learning experiences. They reached a point in their professional careers where the best way to continue their development was on the teaching side. Hospital working environments seemed to be worsening; they felt that their innovations were not always welcomed by colleagues; and their broader conditions in terms of salary and promotion perspectives were also limited. Furthermore, the ways in which higher education was designed for nurses at that time seemed to 'push' them to the

education sector and in many cases, to look for jobs outside the Government sector. Even though there were significant differences from the nurses working in Government and non-Government institutions, their experiences have been analysed jointly. The following figure attempts to illustrate these issues:

Figure 5. Becoming teachers



(*) The fear of transfers and their lack of promotion were especially raised as problems within the Government sector.
(**) The opening of private educational institutes in the big cities allowed the nurses a greater choice when looking for jobs as nurse teachers.

In summary, their move to the education sector was influenced by a series of structural, personal and circumstantial factors. My argument is that for some nurses, working as teachers is a good way of fulfilling their desire to be useful in the society. Therefore, teaching could also be seen as a form of *caring*, understanding caring from a phenomenological perspective, as a primary human activity. It should be remembered at this point that nursing students in Bangladesh are generally female, young and unmarried. Besides, most nursing institutions are placed in the capitals and follow a boarding system.

Many students come from distant places and some are separated from their families for the first time. Therefore, the role of teachers often goes beyond the academic support of students and involves also taking care of their personal wellbeing. In many ways, taking care of the students in the academic setting and sharing their knowledge with them can be less more rewarding and less challenging for nurse teachers than delivering nursing care in big, crowded, understaffed and under-resourced hospital wards.

8.5. SUMMING-UP: THE ROLE OF NURSING EDUCATION IN THE NURSES' LIVES

This section expands on the previous discussion about the nurses' agency within their professional field. This final analysis explores the role that their social and family background, and their personal life events, had on their broader social capital. Their position within the hospital hierarchies, and their difficult working conditions, were both a cause and a consequence of the nurses' collective social image and status. First, a summary of the interaction between the nurses' social and professional fields can be found in Table 3. Of course, this is not an exhaustive list and, most likely, there would be many other factors that could also have been considered.

Table 3. Enabling and constraining elements in the nurses' professional and social fields

	Family background and pre-nursing experiences	Becoming nurses: professional opportunities and limitations	Being a nurse in this society
Enabling elements	Family support, 'open-minded' parents Favourable socioeconomic position of the family* Access to education, English as a medium of instruction	Access to education and paid jobs Overseas experiences Moving to higher education and teaching posts	Independency Knowledge and education Acting as role-models and 'guiding' other people Health-related knowledge and resources, caregivers in their family and community Spirituality, service to humanity, sense of personal fulfilment
Constraining elements	Economic disadvantage Death of their parents Poor performance in secondary education	Low pay and poor working conditions Instability (transfers) Low institutional recognition Power relations amongst nurses and with doctors, hospital administrators Corruption	Low status of nursing profession Gender and class inequalities, nurses being mistreated by 'the public'

(*) This is a broad term which can include several aspects ranging from their economic capital to the family structure and size, their connections and status in the wider society, etc.

Following the previous analytical table, the constraints which the nurses faced throughout their lives are contrasted with strategies to overcome them in Table 4. The former included their individual efforts and the collective actions and sources of support, such as their families or their colleagues.

Table 4. Strategies used by the nurses and other social agents to improve their situation

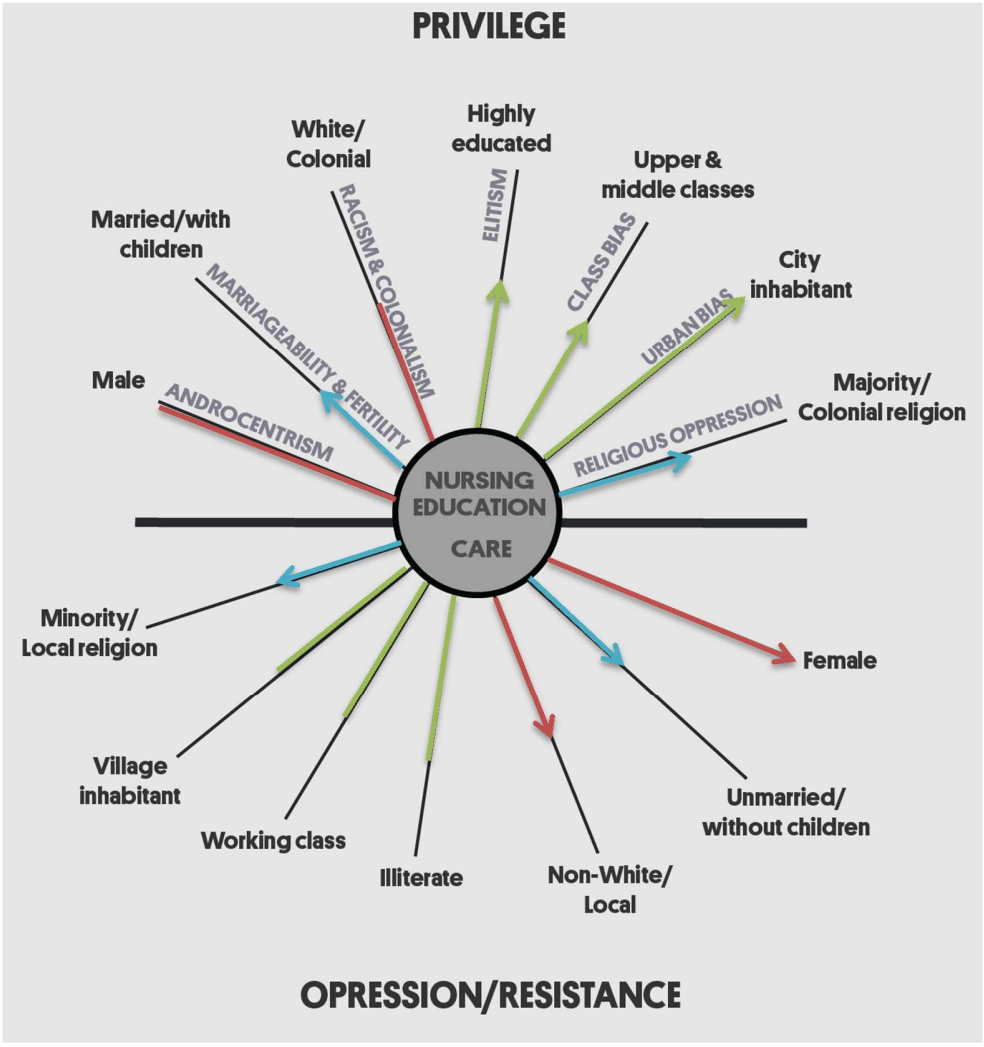
	Constraints	Individual strategies	Collective strategies
Pre-nursing experiences	Economic disadvantage Death of their parents Poor performance in secondary education	**Joining nursing education** Studying and working hard Earning/saving money	Extended family support Community support, especially in the case of Christian nurses Financial and educational support by NGOs, religious institutions
Professional field	Low pay Poor working conditions Instability (transfers) Limitations to 'utilise their knowledge'	Individual bargaining (in the private sector) Studying further **Moving to the teaching field** or to senior posts	Nursing politics, industrial action Professional bodies: bargaining with the official institutions
	Power relations in the institution, lack of bargaining power Corruption Internal tensions between nurses	Good performance – gaining respect (especially of doctors) 'Utilising their knowledge' Being honest, denouncing injustices Changing job Acting as role-models	Giving more autonomy to the nurses in their working environment Positive leadership Supporting role-models
Being a nurse in this society	Nursing as 'low status job'	Good academic performance **Moving to the teaching field** or to senior posts	Improving the students' educational background Nursing as a 'noble profession': media campaigns + setting example by the nurses' good behaviour
	Nurses' social 'misbehaviour'	Adjusting to the social and institutional norms Keeping a 'safe' distance from the patients and their male colleagues	Reinforcing discipline in the nursing institutes Ensuring nurses' personal safety
	Nurses seen as irresponsible, detached	Setting an example of good nursing care delivery Looking after and being health promoters in their family/community	Media campaigns Greater involvement of the political authorities

Two crucial moments or transitions in relation to the subject of this thesis were the nurses' admission in the nursing education programme and their move from the clinical to the

educational fields. In some ways, both processes followed a similar intersection between their personal agency and the structural and circumstantial elements that were influencing them. Yet another way of analysing how the structural, institutional, social and personal factors interact is by trying to put them all together through ain intersectional analysis. Having the *privilege/oppression wheel* in mind, the role that nursing education has had in the lives of the nurses can be better understood. Without denying the individual variation between the nurses, common patterns emerge when analysing the strategies that they used to overcome their oppressions and 'make the most' of their opportunities and (limited) privileges. Before moving forward, however, it is important to remember that the protagonists of this thesis are not representative of all the nurses in Bangladesh. In addition, being nurses is not their only project in life. For many nurses, or at certain moments, it may not even be a central project. Nevertheless, it seems that, at least for the nurses in this research, becoming nurses has been 'more than a job', in the sense that it has provided them with personal and social resources that go far beyond the earning of a living.

In summary, their current socioeconomic position is not only related to the fact that they are nurses, but also to other personal and professional factors. Amongst them, their outstanding personal capacities; the support that they received from their families and teachers for their education; the opening opportunities for good students at the time when they passed their diploma; they all led them to a successful professional career and an overall increased social capital. Nevertheless, their improvements were not straightforward and they did not happen in all areas of discrimination or oppression. The following modification of the oppression/privilege wheel shows the nurses movements from the beginning of their educational life until their current position:

Figure 6. Wheel of privilege-oppression. The role of nursing education and care



Source: Adapted from Morgan (1996, p.107)

Overall 'upward mobility[163]'
Differences amongst the nurses
Indirect influence on the low status of the nursing profession

[163] I agree with Bourdieu (1984) in that the term 'upward mobility' is problematic because it does not account for the complexity of the movements in the social space. Even so, I decided to use it in this context to point towards the broad improvement in the nurses' position in the society, not only in terms of socioeconomic class, but also in their prestige or cultural capital.

Broadly, entering in the nursing field has been socially empowering for most women in this research, although it has been even more so for those coming from disadvantaged backgrounds and minority groups. Women who came from remote or rural areas, low-income, working class, Christian families underwent 'upward movement' in terms of their socioeconomic situation. This is consistent with the study by Somjee (1991) in India, which concluded that, for Christian and Dalit nurses, nursing education had meant an overall improvement in their social position. It had given them a greater economic advancement, higher status and in many cases, 'vertical mobility' through marriage.

For nurses who belonged to wealthier backgrounds, the profession also meant economic independence, a wider choice in terms of marriage, and the possibility of working and settling abroad. Nevertheless, in a more recent study, Nair and Healey (2009, p.15) observed that "increased mobility costs them their respectability, because they are seen as deviants from an ideal womanhood". In this research, the situation of the nurses who belonged to wealthier Muslim[164] families seemed to go through an initial 'lowering' of their social status when they became trainee nurses. For this reason, they had to demonstrate that they were still able to succeed economically, professionally and in terms of settlement and marriage.

Therefore, there seems to be a common pattern amongst the nurses where, in spite of the early challenges that they had to overcome when they became a nurse, they all ended up earning social recognition in the form of cultural capital. Nevertheless, their cultural capital as nurses embodies a significant dilemma. On the one hand, it gives them access to educational credentials, whereas on the other hand, these credentials and they knowledge that they represent are not always valued. This aspect is better understood when looking at Bourdieu's (2001) analysis of cultural capital in three forms: institutionalised, objectified and interiorised/embodied. The institutional form is presented in a relatively straightforward way: nursing education has provided the nurses with academic credentials. Education has without doubt an 'equalising' effect (Blanchet 1996), even considering that

[164] At this point, it is important to clarify that, as the wheel shows, religion itself is not as influential in their oppression as it is its condition of majority or minority

the value of nursing Diploma and BSc Degree were lower than those of similar degrees in other subjects. Nevertheless, the nurses achieved a higher educational level, including Masters Degrees compared with other women of their generation and socioeconomic background.

The second form of cultural capital, which is shown in the objectification of cultural goods, is less evident in the narratives of the nurses. Nevertheless, it is the latter, interiorised form, which becomes most interesting. Nursing can be considered as an embodied form of capital in its most paradigmatic practice: the provision of care. The low value that society puts on caring activities and care-related knowledge has significantly influenced the recognition of nurses' embodied cultural capital and institutional credentials.

The ambivalent social value that has been historically attributed to nursing in the Indian Subcontinent is partly explained by its colonial past and the intersection between the Victorian ideologies of gender and class, a patriarchal hegemonic medical model, and the local religious, cultural and gender ideologies in relation to the care of the sick. In addition related to the latter is the role of nursing education in the 'marriageability' of young women. Nursing has been portrayed as having a negative impact in the latter (Hadley et al. 2007). Nevertheless, this was not the case of the nurses in this research. Amongst them, only Amena stated that her in-laws initially disregarded the fact that she was a nurse, and their opposition was eventually overcome. Similarly, Rabeya's husband had initially tried to stop her working as a nurse but eventually gave up. The nurses used different strategies to 'manage' those who opposed them, which mainly consisted of working and studying hard; using 'fact accompli' strategies and in some cases, direct confrontation.

Furthermore, having financial security and education reduced their pressure to get married quickly and, in some ways, it gave them more room for refusing marriage proposals. Some of the nurses in this research were unmarried, which is also unusual in Bangladesh. Remaining single, however, does not directly lead to 'freedom' or empowerment, as in many ways it places nurses in a situation of vulnerability. In some cases, marriage can be used as a strategy to ensure financial and social security. Sumita admitted that one factor

that pushed her to get married was her lack of family network and the fact that she was getting 'aged'. There was also another Christian nurse who was interviewed towards the end of this research, who had married a Muslim doctor at the time of the Liberation War. She admitted that many women got married during the war in order to protect their physical integrity.

Nursing has played a problematic role in relation to women's 'emancipation' or 'empowerment'. Structurally, being a nurse and/or greatly involved in care activities is not valued in a patriarchal, capitalist society. For this reason, the arrow is placed towards the 'feminine' side. In certain contexts, and especially if the nurses continue working in the clinical side, their activities are also considered as 'low-status' and are usually linked to working class women. The nurses had to demonstrate to their families and society, that in spite of being nurses, they were still 'knowledgeable', 'honest' and well behaved. Nevertheless, joining the profession has also allowed them financial independence and access to higher education through a 'suitable profession for women'. Their outstanding academic performance, together with their efforts in taking good care of their patients and students, became crucial ways of increasing their social capital and gaining people's respect.

In summary, nursing education has been broadly empowering for nurses because they have managed to 'make the most of it', not only professionally, but also personally. Nursing has been empowering because of the *caring* experience itself. This research shows that working as a nurse and taking care of sick people is not an a priori 'disempowering' activity. Nevertheless, when it happens in a context of inequality, and especially under certain ideologies, it can legitimise and reproduce gender and other forms of social discrimination. Therefore, creating safe environments for both patients and those who take care of them is essential for their *caring* experience to be *empowering*. In addition, a critical and contextualised analysis of the representations and practices of care is crucial to ensure that nursing and other professions involved in the caring of human beings are developed in a way that places, in Pérez Orozco's (2014) terms, 'life in the centre'.

9. CONCLUSIONS

This research started from the gap between the academic or institutional definitions of nursing care and nursing practices in Bangladesh (Leppard 2000; Hadley & Roques 2007; Zaman 2009). Nursing was generally defined as the provision of intimate, hands-on care to the patients, whereas nurses were seen as avoiding these practices, especially in the government sector. This was explained by a combination of structural and sociocultural factors (Hadley et al. 2007). The latter pointed to a conflict between the British-inherited curriculum, with a strong emphasis on basic care activities, and the local social and gender norms, which discouraged intimate contact between women and unknown people. The historical targeting of women from disadvantaged sections of the population and the low institutional value given to the profession since colonial time have further contributed to the low status of nursing. The initial research question was therefore to analyse the particular ways in which this gap between discourses and practices was explained in the lives of the nurses.

As the research progressed, it was decided not to address the first objective, which was *to analyse the nurses' views about nursing care and their profession,* until the end. Questions about nursing care were not initially asked to the nurses in order to avoid them providing ready-made definitions of 'nursing care activities'. In this way, Griffins' (1980; 1983) distinction between nursing care activities and the attitudes and emotions associated to them was followed. At first, when asked about their first experiences with the patients, the nurses tended to 'list' activities. When further probed, however, they were also able to provide with a deeper and more embodied understanding of care. Interestingly, the latter emerged mostly through their analysis about the 'deterioration' of nursing care throughout the latest decades.

The next objectives *discussing to what extent nursing education had been an empowerment tool for the nurses* and *analysing the ways in which their socioeconomic background, personal experiences and life events have influenced their professional careers and their conceptualisation of nursing and care,* were in reality two outcomes of the same analytical

process. These objectives were addressed in Chapters Six to Eight by relating nurse's narratives to the broader historical and socioeconomic background. The conclusions of this research are presented according to the initial order of the objectives. Nurses' conceptualisations and experiences of care are presented first. The extent to which nursing education was an empowering tool is analysed subsequently. Linked to the previous analysis, the role of their family background and personal experiences is considered.

According to the nurses' accounts, nursing service and education in Bangladesh has changed considerably since the period when they were students. On the one hand, nursing care delivery has 'deteriorated' in many contexts. An increasing tendency towards the privatisation of the health services; chronic mismanagement and corruption in both Government and non-Government sectors; and overall, the longstanding socioeconomic inequalities in the country; all pose significant barriers to the improvement in nursing care provision to the population of Bangladesh. On the other hand, much progress has been made within education, inside and outside the profession. Both aspects reflect the broader social changes that have affected the healthcare delivery system, and the overall status of nurses and women in society.

The nurses in this research were socialised into the nursing field through a British-inherited curriculum with a strong emphasis on the 'Nightingale narrative' of service, self-sacrifice and devotion. In addition, they had to overcome strong social prejudices against their profession inside and outside the health institutions. They soon realised that delivering nursing care to the patients was not easy. They had to be very careful in their interactions, as being 'too close' could not only affect their personal and family reputation, but also their physical safety. Furthermore, they had to 'become strong' to cope with the difficult and sometimes life-or-death situations they faced at a very young age.

The nurses elaborated a conceptualisation of care that fell closer to the notion of 'management'. Apart from one nurse who had a strong 'service' narrative, the emphasis was placed not so much on providing 'mother-like' intimate care but on ensuring a smooth functioning of the wards. By ensuring medicine were given promptly, that beds were 'neat

and clean' and that patients were ready (for the round or other procedures), they 'managed' crucial aspects of nursing care. This is partly related to what Foucault (1996) would see as 'disciplining' the patients. In many ways it carries the nineteenth century hygienist ideology, which was also present in the Nightingale discourse. Nevertheless, it seemed to be more related to the nurses' pursuit of respect and recognition by both 'the public' (patients and carers) and the 'authorities' (doctors, hospital administrators, nurse leaders).

There is a further aspect in relation to the concept of 'management' that is worth noting. Some nurses used the same expression to refer to them overcoming several obstacles in their personal lives, like their relatives' opposition to them working as nurses. They 'managed' their husbands, fathers, etc, by using a wide range of strategies which ranged from subtle forms of resistance (Scott 1985) to open confrontation. Either on the wards or in their personal lives, the nurses were able to demonstrate not only that they had enough knowledge and skills to 'manage' the situations, but also that were respected and obeyed by the people. Their conceptualisation of 'management' could be a seen as a form of agency.

For these nurses, their profession has, overall, been empowering. Nevertheless, it has not been so *by itself*. My assumption is that, considering their trajectories, they would probably have been able to pursue successful careers in other fields given the opportunity. Therefore, a more specific question arises, namely, *what is the added value of nursing education?* which was partly answered in Chapter Six. Accessing the Nursing Diploma allowed women, either with low SSC results or whose families could not afford the costs of College education, the opportunity to study further. This was noticed by other authors in Bangladesh (Hadley et al. 2007), although it may well happen in other contexts where nursing education is also funded. I would argue, however, that the value of nursing goes beyond access to higher education and/or paid jobs. For these women, nursing has also been a significant opportunity for self-realisation and a crucial channel for the pursuance of broader *projects* like helping other people in their families or communities, fighting for social justice, women's rights, etc.

Some nurses managed to achieve a particular form of *empowering care* closely related to the notion of *praxis*. Through their interpersonal interaction with the patients, the nurses experienced a sense of self-satisfaction. Not only that, this particular form of experiential or embodied learning provided them with a highly valued knowledge. They could then 'utilise' this knowledge in many other fields, mainly in their communities and in the nursing education institutions.

Nonetheless, nursing and care are not always empowering. Broadly, care happens in a context of inequality. The ways in which patriarchal-capitalist societies place labour force and relations of production in their centre have been discussed (Gamarnikow 1978; 1991; Narotzky 1995). According to this logic, dependency and sickness are considered as undesirable weaknesses. Nevertheless, life is indeed "vulnerable and finite; it is precarious and needs to be cared for in order to be viable[165]"(Pérez Orozco 2014, p.209). This ideological devaluation adds a greater burden to the inherent vulnerability of being sick or in need for help. The carer, whether nurse, health professional or other person from the patient's close network, plays an ambiguous position. Traditionally, care has been related to service and domesticity, which the hegemonic ideological discourse has portrayed a 'natural' functions of women (Benner & Wrubel 1989). The biomedical hegemonic model reproduces and reinforces in many ways the patriarchal and capitalist ideological system (Gamarnikow 1978; Frankenberg 1981; Menéndez 1984; Baer et al. 2003).

For many nurses their profession and institutional discrimination made them feel disempowered, frustrated, looked down on and even at risk of physical violence. On some occasions, carers tried to reverse their oppression by reproducing patterns of domination over more vulnerable colleagues or the people they are caring for. Examples of the former include nursing leaders reproducing an elitist and/or managerialist policy that undervalues and excludes the majority of the nurses who are involved in hands-on care (Roberts 2006); horizontal violence and rivalries amongst nurses (Lee & Saeed 2001); amongst others. Examples nurses mistreating the patients may be less evident, and hopefully less frequent, but it is obvious that nurses and other carers could use their knowledge and position to

[165] My translation

exert power (Falk Rafael 1996). In this regard, I agree with Saillant (2009) in that it is not *caring* that is disempowering, but the context of inequality and violence where it takes place. This also points to the relationship between agency and wellbeing shown by Sen (2007).

Nevertheless, resistances to this hegemony and the pursue of 'emancipatory' knowledge by nurses can be found since the times of the nineteenth century nursing reform (Chinn & Kramer 2015). Nurses, if given the chance, can show that they are able not only to 'manage' the patients and provide good-quality care, but also develop professionally. The life stories of the nurse teachers are a good example of the potential of human beings to resist and overcome inequality. Nursing can be a good way to help in this regard. On the one hand, nurses showed several forms of resistance to discrimination as women, nurses, minorities, etc. On the other hand, by taking care of suffering human beings, nurses have the potential to witness the effects of structural inequalities and work against them. Nurses in Bangladesh are closer to the 'public', that is, to the general population, in terms of social class. Unlike many doctors, nurses do not usually come from the elites. Hooks' (1984) reflection about on the 'special vantage point' of Black, working class women is relevant in this regard. According to the author, Black women from disadvantaged backgrounds can use their lived experiences to criticize the dominant racist, classist, sexist hegemonic structures that oppress them. Even though the nurses in this research may not be as disadvantaged as the women described by Hooks, some had overcome significant struggles throughout their life and professional careers.

Caring and the nursing profession can be empowering and a substantial source of agency. Nevertheless, if nurses' wellbeing is not ensured, or if the conditions of possibility are not created to empower nursing care, it must be nurses themselves who bear the burden and negative consequences of trying to become agents of change. The nurses in this research were able to overcome the different forms of social and institutional discrimination in one way or the other. By using collective and individual strategies they were able to pursue a more or less successful career and achieve a better social position. They made the most of their opportunities inside and outside their professional fields and transformed what was

initially seen as a 'low status profession' into something they and their previously-reluctant relatives felt pride in. In this regard, the key informants are not representative of the profession, as they stood out in many ways. Nonetheless, their backgrounds did not necessarily differ from those of other nurses. Thus, further questions emerge: what made them stand out? Was it only their individual potential?

Without ignoring the fact that all showed outstanding intellectual, social and personal capacity, there was also another shared characteristic. The key to their educational success was not so much the socioeconomic background of their families but the fact that they all had people, inside or outside the family, who pushed and supported them to study. Either a parent, teacher or both had stimulated their eagerness to learn. Furthermore, their admission to the Nursing Diploma programme was a subsequent opportunity to continue learning in a 'safe' environment without being an economic burden on families, as observed by Hadley et al (2007). In this case, a safe environment involved both physical safety and economic security. Both were achieved in the Nursing Diploma, which had a subsidised boarding system. At that time, most nurses were female and discipline was strict, and their honour was protected from being 'spoiled'.

Therefore, it was not *only* their socioeconomic background that helped them achieve a successful career. After becoming nurse teachers, the nurses quickly adjusted and achieved outstanding academic and clinical performances. This was made possible by a mixture of self-determination, their previous social and cultural capital, and the opening-up of new opportunities in nursing. Studying or working overseas, obtaining a Master's degree, and accessing leadership and teaching posts were opportunities not all nurses could enjoy or were interested in taking up. Clinical working conditions and the limited scope for progress made most change to the educational field to 'utilise their knowledge'. This suggests a significant challenge for the nursing profession in Bangladesh. If nurses' wishes, ideas and 'knowledge' are ignored, nursing care provision will remain hindered and nurses will be poorly regarded by 'the public'. The profession nowadays is experiencing significant changes and current nursing students are believed to hold greater educational capital. It will

be interesting to see the new *nursing knowledge* that emerges and whether these changes will improve the delivery of nursing care.

In any case, this thesis shows that the act of *caring* itself and the knowledge that it produces can be a source of personal and collective agency. Nevertheless, the conditions of possibility have to be created and maintained for a safe and empowering form of care to occur. This responsibility falls beyond the nursing field, as it involves structural changes, especially in terms of gender and class inequalities.

10. BIBLIOGRAPHY

AAA, American Anthropological Association, 2012. Principles of Responsibility. Available at: http://ethics.aaanet.org/category/statement/ [Accessed June 30, 2015].

Abel-Smith, B., 1960. *A history of the nursing profession*, London: Butler and Tanner Ltd.

Abraham, M., 1996. *Religion, Caste and Gender: Missionaries and Nursing History in South India*, Bangalore: BI Publications Pvt. Limited.

Afsana, K., 2005. *Disciplining Birth. Power, Knowledge and Childbirth Practices in Bangladesh*, Dhaka: The University Press.

Ahearn, L.M., 2001. Language and agency. *Annual Review of Anthropology*, 30, pp.109–137.

Ahmad, S. & Chowdhury, J., 1979. Women's legal status in Bangladesh. In Women for Women, ed. *The situation of women in Bangladesh*. Dhaka: Women for Women Research and Study Group, pp. 285–331.

Ahmed, S.M. et al., 2015. *Bangladesh Health System Review*, Geneva: World Health Organisation. Available at: http://www.wpro.who.int/asia_pacific_observatory/hits/series/bgd_health_system_review.pdf [Accessed April 17, 2017].

Ahmed, S.M., Hossain, M.A. & Chowdhury, M.R., 2009. Informal sector providers in Bangladesh: How equipped are they to provide rational health care? *Health Policy Plan*, 24, pp.467–478.

Ajani, K. & Moez, S., 2011. Gap between knowledge and practice in nursing. *Procedia - Social and Behavioral Sciences*, 15, pp.3927–3931.

Akhter, R.J. et al., 2003. Reporting from Bangladesh. In N. H. Bryant, ed. *Women in nursing in Islamic societies*. Oxford: Oxford University Press, p. 232–254; 10.

Akter, B., Chaowalit, A. & Nasae, T., 2010. Moral behaviours of nurse supervisors expected and perceived by nurses in Bangladesh. In *2nd International Conference on Humanities and Social Sciences*. Bangkok: Faculty of Liberal Arts, Prince of Songkla University, pp. 1–13.

Akter, S., 1999. An assessment of health education on self-care provided by nurses as expressed by patients in Asthma Centre of Infectious Diseases and Chest Hospital, Dhaka. In *National Conference on Nursing Research*. pp. 94–101.

Alam, B.A., 1975. Women in Nursing. A study of the nurses of Dacca Medical College. In Women for Women, ed. *Women for Women. Bangladesh 1975*. Dhaka: The University Press, pp. 121–153.

Allan, H.T., Smith, P. & O'Driscoll, M., 2011. Experiences of supernumerary status and the hidden curriculum in nursing: a new twist in the theory-practice gap? *Journal of clinical nursing*, 20(5–6), pp.847–55.

Amin, S., 1998. Family structure and change in rural Bangladesh. *Population Studies*, 52(2), pp.201–213.

Amin, Z. et al., 2008. Medical education in Bangladesh. *Medical Teacher*, 30(3), pp.243–247.

Aminuzzaman, S.M., 2007. Migration of skilled nurses from Bangladesh: An exploratory study.

Andaleeb, S.S., 2000. Public and private hospitals in Bangladesh: service quality and predictors of hospital choice. *Health Policy and Planning*, 15(1), pp.95–102.

Andaleeb, S.S., Siddiqui, N. & Khandakar, S., 2007. Patient satisfaction with health services in Bangladesh. *Health Policy and Planning*, 22(4), pp.263–273.

Andrist, L.C., 2006. The history of the relationship between feminism and nursing. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Sudbury: Jones and Bartlett Publishers, p. 5–33; 1.

Angell, R., 1974. El uso de documentos personales en sociología: una revisión crítica de la literatura, 1920-1940. In J. Balán et al., eds. *Las historias de vida en ciencias sociales. Teoría y técnica*. Buenos Aires: Ediciones Nueva Visión, pp. 19–26.

Annells, M., 1996. Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, 23(4), pp.705–713.

Antrobus, S., 1997. An analysis of nursing in context: the effects of current health policy. *Journal of Advanced Nursing*, 25(3), pp.447–453.

Antrobus, S. & Kitson, A., 1999. Nursing leadership: influencing and shaping health policy and nursing practice. *Journal of advanced nursing*, 29(3), pp.746–753.

Arnold, D., 1993. *Colonizing the Body. State Medicine and Epidemic Disease in Ninteenth-Century India*, Berkeley: University of California Press.

Arthur, D. et al., 1999. Caring attributes, professional self concept and technological

influences in a sample of Registered Nurses in eleven countries. *International Journal of Nursing Studies*, 36(5), pp.387–396.

Asad, T., 1987. Are There Histories of Peoples Without Europe? A Review Article. *Comparative Studies in Society and History*, 29(3), pp.594–607.

Asad, T., 1973. Introduction. In T. Asad, ed. *Anthropology and the colonial encounter*. London: Ithaca Press, pp. 9–20.

Azim, T. et al., 2009. *20 years of HIV in Bangladesh: Experiences and way forward*, Washington: The World Bank, UNAIDS.

Aziz, K.M.A., 1979. *Kinship in Bangladesh*, Dhaka: International Centre for Diarrhoeal Disease Research.

Aziz, K.M.A. & Maloney, C., 1985. *Life stages, gender and fertility in Bangladesh*, Dhaka: International Centre for Diarrhoeal Disease Research Bangladesh.

Baer, H.A., Singer, M. & Susser, I., 2003. *Medical Anthropology and the World System*, London: Praeger.

Balán, J., 1974. Introducción. In J. Balán et al., eds. *Las historias de vida en ciencias sociales. Teoría y técnica*. Buenos Aires: Ediciones Nueva Visión, pp. 7–16.

Baly, M.E., 1987. The Nightingale nurses: The myth and the reality. In C. Maggs, ed. *Nursing history: The state of the art*. Kent: Aspen Publications, pp. 33–59.

BANBEIS, 2014. *Bangladesh Education Statistics 2014*, Dhaka. Available at: http://banbeis.gov.bd/data/index.php [Accessed September 4, 2015].

Banerji, D., 1974. Social and Cultural Foundations of Health Services Systems. *Economic and Political Weekly*, 9(32/34), pp.1333–1346.

Bangladesh Bureau of Statistics, 2011. *Population and housing census. Socioeconomic and demographic report*, Dhaka: Ministry of Planning Government of Bangladesh.

Bangladesh Bureau of Statistics, 2014. *Statistical Pocketbook of Bangladesh 2013*, Dhaka.

Bangladesh Health Watch, 2007. *Health Workforce in Bangladesh. Who constitutes the Healthcare System?*, Dhaka.

Bangladesh Nursing Council, 2011. *Act and Rules*, Dhaka: Bangladesh Nursing and Midwifery Council. Available at: http://www.bnmcbd.com/actandrules.php [Accessed April 14, 2017].

Bangladesh Nursing Council, 2006. *Diploma in Nursing Science and Midwifery*

Curriculum, Dhaka: Directorate of Nursing Services, Ministry of Health and Family Welfare; WHO.

Bangladesh Nursing Council, 2014. *Entry to practice competencies for nurse-midwives in Bangladesh*, Dhaka: Bangladesh Nursing Council and Human Resources for Health.

Banglapedia, 2012. Roquiah Sakhawat Hossain S. Islam & S. Miah, eds. *Banglapedia. National Encyclopaedia of Bangladesh*. Available at: http://en.banglapedia.org/index.php?title=Hossain,_Roquiah_Sakhawat [Accessed April 17, 2017].

Banu, M., 1999. A study to assess factors for failure of students in examinations at the College of Nursing, Dhaka during 1993-97. In *National Conference on Nursing Research*. Research Cell College of Nursing, pp. 57–65.

Barnamala, M.T., 2015. Status, Issues and Prospects of Quality Higher Education in Bangladesh: in the Contest of Global World. *Bangladesh Research Publications Journal*, 11(1), pp.79–86.

Barnard, A. & Spencer, J., 2010a. Culture A. Barnard & J. Spencer, eds. *The Routledge encyclopedia of social and cultural anthropology*, pp.168–176.

Barnard, A. & Spencer, J., 2010b. *The Routledge encyclopedia of social and cultural anthropology*, London: Routledge.

Basavanthappa, B.C., 2009a. Brief history of medicine and nursing in india. In B. C. Basabanthappa, ed. *Medical Surgical Nursing*. New Delhi: Jaypee Brothers, p. 1–10; 1.

Basavanthappa, B.C., 2009b. Concepts of Nursing and its Profession. In B. C. Basabanthappa, ed. *Fundamentals of Nursing*. New Delhi: Jaypee Brothers, p. 31–62; 2.

Baxter, C., 1997. *Bangladesh: From a Nation to a State*, Oxford: Westview Press.

Beck, D.-M., 2006. Nightingale's passion for advocacy: local to global. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Sudbury: Jones and Bartlett Publishers, p. 473–487; 40.

Begum, C.S., 1993. *A study on nurses opinion about their own profession*. Dhaka: University of Dhaka.

Begum, H., 1998. Health care, ethics and nursing in Bangladesh: a personal perspective.

Nurs Ethics, 5(6), pp.535–541.

Begum, J., 1997. Management of nursing services. *Nursing Newsletter of the Directorate of Nursing Services Bangladesh*, 2(1), p.3.

Begum, N.N., 1987. *Pay or purdah. Women and income earning in rural Bangladesh* B. A. Ponter, ed., Dhaka: Winrock International Institute for Agricultural Development.

Begum, T. & Shresta, K.M., 1999. Educational status of nursing in Nepal, Myanmar and Bangladesh. *Nursing Newsletter of the Directorate of Nursing Services Bangladesh*, 4(1&2), pp.34–35.

Behar, R., 1992. A life story to take across the border: notes on an exchange. In G. C. Rosenwald & R. L. Ochberg, eds. *Storied Lives. The Cultural Politics of Self-Understanding*. London: Yale University Press, p. 108–123; 6.

Behar, R., 1990. Rage and redemption. Reading the life story of a Mexican marketing woman. *Feminist Studies*, 16(2), pp.223–258.

Behar, R., 1993. *Translated Woman. Crossing the Border with Esperanza's Story* Beacon Pre., Boston.

Bellaby, P. & Oribabor, P., 1980. "The history of the present" - Contradiction and struggle in nursing. In C. Davies, ed. *Rewriting nursing history*. London: Croom Helm, pp. 147–174.

Benach, J., 1997. La desigualdad social perjudica seriamente la salud. *Gaceta Sanitaria*, 11(6), pp.255–258.

Benner, P., 1982. From Novice To Expert. *AJN The American Journal of Nursing*, 82(3).

Benner, P. & Wrubel, J., 1989. *The Primacy of Caring. Stress and Coping in Health and Illness*, California: Addison-Wesley Publishing Company.

Berger, P.L. & Luckmann, T., 1971. *The social construction of reality*, London: Penguin Books.

Berland, A., 2014. *Advancing nursing education in Bangladesh*, Dhaka. Available at: http://cpr.twoinc.ca/files/5914/0960/6581/cc10-spring-2014.pdf [Accessed March 14, 2017].

Bernard, H.R., 2006. *Research methods in anthropology: qualitative and quantitative approaches*., Lanham: Altamira Press.

Beteille, A., 1979. Homo hierarchicus, homo equalis. *Modern Asian Studies*, 13(4),

pp.529–548.

Béteille, A., 2010. Caste A. Barnard & J. Spencer, eds. *The Routledge encyclopedia of social and cultural anthropology*, pp.112–113.

Betraux, D., 1981a. From the Life-History approach to the transformacion of sociological practice. In Betraux, ed. *Biography and Society. The Life History Approach in the Social Sciences*. California: SAGE Publications, pp. 29–45.

Betraux, D., 1981b. Introduction. In D. Betraux, ed. *Biography and Society. The Life History Approach in the Social Sciences*. California: SAGE Publications, pp. 5–15.

BHW, 2012. *Bangladesh Health Watch Report 2011. Moving Towards Universal Health Coverage* Bangladesh Health Watch, ed., Dhaka: Bangladesh Rural Advancement Committee.

Blackburn, S., 2016. Epistemology Oxford, ed. *The Oxford Dictionary of Philosophy*.

Blanchet, T., 1996. *Lost innocence, stolen childhoods*, Dhaka: The University Press.

Blanchet, T., 1984. *Women, pollution and marginality. Meanings and rituals of birth in rural Bangladesh*, Dhaka: The University Press.

BNMC, 2013. Bangladesh Nursing and Midwifery Council: Background. Available at: http://www.bnmc.gov.bd/Background.html [Accessed April 12, 2016].

BNMC, 2012. *Diploma in Midwifery Curriculum Document*, Dhaka: Bangladesh Nursing and Midwifery Council. Available at: http://bnmc.gov.bd/cmsfiles/files/CURRICULUM OF DIPLOMA IN MIDWIFERY.pdf [Accessed April 14, 2017].

BNMC, 2016a. Institutions with seat capacity.

BNMC, 2016b. Total registered nurse-midwives. Update August 2016. Available at: http://bnmc.gov.bd/cmsfiles/files/Total Registred Nurse-Midwife 31 August 2016.pdf [Accessed April 12, 2016].

Boserup, E., 1986. *Woman's role in economic development*, Hants: Gower Publishing.

Bostridge, M., 2008. *Florence Nightingale. The woman and her legend*, London: Penguin Books.

Bourdieu, P., 1984. *Distinction. A social critique of the judgement of taste*, Cambridge: Harvard University Press.

Bourdieu, P., 1989. La ilusión biográfica. *Historia y Fuente Oral*, (2), p.27–33 CR–

Copyright © 1989 Historia, antrop.

Bourdieu, P., 2002. *Masculine domination*, Standford: Standford University Press.

Bourdieu, P., 1977. *Outline of a theory of practice*, Cambridge: Cambridge University Press.

Bourdieu, P., 2001. *Poder, derecho y clases sociales* 2nd ed., Buenos Aires: Editorial Desclée de Brouwer.

Bourdieu, P., 1990. *The logic of practice*, Cambridge: Polity Press.

Bourdieu, P. & Passeron, J.-C., 1990. *Reproduction in education, society and culture*, London: SAGE Publications.

Brah, A., 2004. ¿Feminismo blanco, feminismo negro? In B. Hooks et al., eds. *Otras inapropiables. Feminismos desde las fronteras*. Madrid: Traficantes de Sueños, pp. 107–136.

Brah, A., 1992. Difference, Diversity and Differenciation. In J. Donald & A. Rattansi, eds. *"Race", Culture and Diference*. California: SAGE Publications, pp. 126–145.

Brownell, S. & Besnier, N., 2013. Gender and sexuality. In J. Carrier & D. B. Gewertz, eds. *The handbook of sociocultural anthropology*. New York: Bloomsbury, pp. 239–279.

Bryant, N.H., 2003. Introduction. In N. H. Bryant, ed. *Women in nursing in Islamic Societies*. Oxford: Oxford University Press, pp. 1–13.

Burton, A., 1996. Contesting the Zenana: The Mission to Make "Lady Doctors for India," 1874-1885. *Journal of British Studies*, 35(3), pp.368–397.

Burton, A., 1992. The white woman's burden. British feminists and "The Indian woman" 1865-1915. In N. Chawdhuri & M. Strobel, eds. *Western women and imperialism: complicity and resistance*. Bloomington: Indiana University Press, pp. 137–157.

Butler, J., 1999. *Gender Trouble*, New York: Routledge.

Campaign for Popular Education, 2007. *Education Watch 2006. Financing Primary and Secondary Education in Bangladesh*, Dhaka: Campaign for Popular Education.

Carmack, B.J., 1997. Balancing Engagement and Detachment in Caregiving. *Image: the Journal of Nursing Scholarship*, 29(2), pp.139–143.

Carper, B.A., 2006. Fundamental patterns of knowing in nursing. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Sudbury: Jones and Bartlett Publishers, p. 129–138; 11.

Carper, B.A., 1978. Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science*, 1(1).

Casadó, L., 2009. Antropología y enfermería: revisión teórica. In M. A. Martorell, J. M. Comelles, & M. Bernal, eds. *Enfermería y antropología: padeceres, cuidadores y cuidados*. Barcelona: ICARIA, Institut Català d'Antropologia, pp. 235–245.

Chakrabarti, K. & Chakrabarti, S., 2013. *Historical Dictionary of the Bengalis*, Plymouth: The Scarecrow Press.

Chan, E.A., Chan, K. & Liu, Y.W.J., 2012. A triadic interplay between academics, practitioners and students in the nursing theory and practice dialectic. *Journal of Advanced Nursing*, 68(5), pp.1038–1049.

Chase, S.E., 1995. Taking narrative seriously: consequences for method and theory in interview studies. In R. Josselson & A. Lieblich, eds. *Interpreting experience. The narrative study of lives*. California: SAGE Publications, pp. 1–26.

Chaudhury, N. & Hammer, J.S., 2004. Ghost doctors: Absenteeism in rural Bangladeshi health facilities. *The World Bank Economic Review*, 18(3), pp.423–441.

Cheater, A., 1999. Power in the postmodern era. In A. Cheater, ed. *The anthropology of power. Empowerment and disempowerment in changing structures*. London: Routledge, pp. 1–12.

Chinn, P.L. & Kramer, M.K., 2015. *Knowledge Development in Nursing. Theory and Process* 9th ed., St. Louis: ElSevier.

Chowdhury, A., 1995. Families in Bangladesh. *Journal of Comparative Family Studies*, 26(1), pp.27–41.

Chowdhury, A.M.R. et al., 2012. Universal Health Coverage: The Next Frontier. In Bangladesh Health Watch, ed. *Bangladesh Health Watch Report 2011. Moving Towards Universal Health Coverage*. Dhaka: Bangladesh Rural Advancement Committee, pp. 1–16.

Chowdhury, S., 1999. A study of the role of charge nurses in clinical learning of nursing students as perceived by the charge nurses and nursing instructors, DMCH. In *National Conference on Nursing Research*. Research Cell College of Nursing, pp. 102–109.

Chrisman, N.J., 1982. Anthropology in nursing: an exploration of adaptation. In N. J.

Chrisman & T. W. Maretzki, eds. *Clinically applied anthropology: anthropologists in health science*. Dordrecht: Reidel, pp. 117–140.

Clifford, J., 1986. Introduction: Partial Truths. In *Writing culture. The poetics and politics of ethnography*. Berkeley: University of California Press, pp. 1–26.

Cohen, H.A., 1981. *The nurses' quest for a professional identity*, California: Addison-Wesley Publishing Company.

Collière, M.-F., 1998. Using anthropology to analyse healthcare situations. *Nursing Inquiry*, 5(3), pp.126–139.

Comaroff, J. & Comaroff, J., 1992. *Ethnography and the historical imagination*, Oxford: Westview Press.

Comelles, J.M., 1996. Fe, carisma y milagros. El poder de curar y la sacralización de la práctica médica contemporánea. In J. A. González Alcantud & S. Rodríguez Becerra, eds. *Creer y curar: la medicina popular*. Granada: Diputación Provincial de Granada, pp. 301–336.

Corlett, J. et al., 2003. Factors influencing theoretical knowledge and practical skill acquisition in student nurses: an empirical experiment. *Nurse Education Today*, 23(3), pp.183–190.

Cornwall, A., 2010. Introductory overview – buzzwords and fuzzwords: deconstructing development discourse. In A. Cornwall & D. Eade, eds. *Deconstructing development discourse. Buzzwords and fuzzwords*. Warwickshire: Practical Action Publishing, pp. 1–18.

Cornwall, A., 2003. Whose Voices? Whose Choices? Reflections on Gender and Participatory Development. *World Development*, 31(8), pp.1325–1342.

Cornwall, A., Harrison, E. & Whitehead, A., 2007. Introduction: feminisms in development: contradictions, contestations and challenges. In A. Cornwall, E. Harrison, & A. Whitehead, eds. *Feminisms in development. Contradictions, contestations and challenges*. London: Zed Books, pp. 1–20.

Crehan, K., 2002. *Gramsci, culture and anthropology*, London: Pluto Press.

Crenshaw, K., 1989. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *U. Chi. Legal F.*, p.139.

Daniels, A.K., 1987. Invisible Work. *Social Problems*, 34(5), pp.403–415.

Davies, C., 1995. *Gender and the Professional Predicament in Nursing*, Buckingham: Open University Press.

Davis, A.Y., 1983. *Women, Race and Class*, New York: Vintage Books.

Dean, M. & Bolton, G., 1980. The administration of poverty and the development of nursing practice in nineteenth-century England. In C. Davies, ed. *Rewriting nursing history*. London: Croom Helm, pp. 76–101.

Desjarlais, R. & Jason Throop, C., 2011. Phenomenological Approaches in Anthropology. *Annual Review of Anthropology*, 40(1), pp.87–102.

Devine, J. & White, S.C., 2013. Religion, Politics and the Everyday Moral Order in Bangladesh. *Journal of Contemporary Asia*, 43(1), pp.127–147.

Van Dijk, T.A., 1993. Principles of Critical Discourse Analysis. *Discourse and Society*, 4(2), pp.249–283.

Dingwall, R., Rafferty, A.M. & Webster, C., 1988. *An introduction to the social history of nursing*, London: Routledge.

Directorate of Nursing Services, 1995. *Assessment of shortage of nurses in education and service sectors in government institutions*, Dhaka: Directorate of Nursing Services, Ministry of Health and Family Welfare.

Directorate of Nursing Services, 2011. *In-Depth Country Assessment on Nursing and Midwifery in Bangladesh*, Dhaka: Directorate of Nursing Services, Ministry of Health and Family Welfare.

Directorate of Nursing Services, 1994a. *National Plan of Action for Nursing Development in Bangladesh*, Dhaka: MoHFW and WHO.

Directorate of Nursing Services, 2002. *The Nursing Contribution to Future Health Care Delivery. A policy paper. Executive Summary*, Dhaka: Directorate of Nursing Services, Ministry of Health and Family Welfare.

Directorate of Nursing Services, 1994b. The Purpose, Phylosophy and Functions of the Directorate of Nursing Education and Services MOF&FW.

Doering, L., 1992. Power and knowledge in nursing: A feminist poststructuralist view. *Advances in Nursing Science*, 14(4), pp.24–33.

Dougherty, M.C. & Tripp-Reimer, T., 1985. The Interface of Nursing and Anthropology.

Annual Review of Anthropology, 14, pp.219–241.

Douglas, M., 1966. *Purity and danger. An analysis of concepts of pollution and taboo*, London: Routledge.

Dowling, M., 2006. The sociology of intimacy in the nurse-patient relationship. *Nursing Standard (through 2013)*, 20(23), pp.48–54.

Dumont, L., 1970. *Homo hierachicus. The caste system and its implications*, Oxford: Oxford University Press.

Dunn, J.L., 2005. "Victims" and "Survivors": Emerging Vocabularies of Motive for "Battered Women Who Stay"*. *Sociological Inquiry*, 75(1), pp.1–30.

Eisenberg, L., 1977. Disease and illness. Distinction between professional and popular ideas of sickness. *Culture, Medicine and Psychiatry*, 1, pp.9–23.

Enayet, F., 1979. Economic activities and employment opportunities. The urban situation. In WFW, ed. *The situation of women in Bangladesh*. Dhaka: Women for Women Research and Study Group, pp. 183–224.

Ericsson, K.A., Prietula, M.J. & Cokely, E.T., 2007. The making of an expert. *Harvard Business Review. Managing for a long term*, July-Augus, p.1–8; 1.

Escobar, A., 1995. *Encountering development*, New Jersey: Princeton University Press.

Evans, J., 2006. Men nurses and women physicians: exploring masculinities and gendered and sexed relations in nursing and medicine. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Boston: Jones and Bartlett Publishers, pp. 35–44.

Falk Rafael, A.R., 1996. Power and Caring: A Dialectic in Nursing. *Advances in Nursing Science*, 19(1).

Farmer, P., 2004. An Anthropology of Structural Violence. *Current Anthropology*, 45(3), pp.305–325.

Farmer, P., 1997. On Suffering and Structural Violence: A View from Below. In A. Kleinman, V. Das, & M. Lock, eds. *Social Suffering*. Berkeley: University of California Press, pp. 261–284.

Federación de Asociaciones de Antropología del Estado Español, 2014. Orientaciones deontológicas para la práctica de la antropología profesional. Available at: http://faaeeantrapologia.com/acerca-de/orientaciones-deontologicas/ [Accessed July

30, 2015].

Fitzgerald, R., 2001. “Clinical Christianity”: The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914. In B. Bati & M. Harrison, eds. *Health, Medicine and Empire. Perspectives on Colonial India*. Hyderabad: Orient Longman, pp. 88–136.

Fitzgerald, R., 1997. Rescue and redemption. The rise of female medical missions in colonial India during the late nineteenth and early twentieth centuries. In A. M. Rafferty, J. Robinson, & R. Elkan, eds. *Nursing history and the politics of welfare*. London: Routledge, p. 64–79; 4.

Forbes, G.H., 1986. In Search of the “Pure Heathen”: Missionary Women in Nineteenth Century India. *Economic and Political Weekly*, 21(17), p.WS2-WS8.

Forbes, G.H., 2006. Medical careers and health care for Indian women: patterns of control. *Women’s History Review*, 3(4), pp.515–530.

Foster, G.M. & Anderson, B.G., 1978. *Medical Anthropology* Newbery Aw., New York.

Foucault, M., 1996. *La vida de los hombres infames. Ensayos sobre desviación y dominación*, Buenos Aires: Altamira.

Foucault, M., 1977. *Power/Knowledge. Selected interviews and other writings 1972-1977, by Michel Foucault* C. Gordon, ed., New York: Pantheon Books.

Frankenberg, R., 1981. Allopathic medicine, profession, and capitalist ideology in India. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, 15(2), pp.115–125.

Frankenberg, R., 1988. Gramsci, Culture, and Medical Anthropology: Kundry and Parsifal? Or Rat’s Tail to Sea Serpent? *Medical Anthropology Quarterly*, 2(4), pp.324–337.

Frankenberg, R., 1980. Medical anthropology and development. A theoretical perspective. *Social Science & Medicine*, 14B, pp.197–207.

Frankenberg, R., 1986. Sickness as Cultural Performance: Drama, Trajectory, and Pilgrimage Root Metaphors and the Making Social of Disease. *International Journal of Health Services*, 16(4), pp.603–626.

Freire, P., 1993. *Pedgogy of the oppressed* 2nd ed., New York: The Continuum International Publishing Group.

Frigolé, J., 1992. *Un hombre*, Barcelona: Muchnik Editores.

Fuller, C.J., 1996. Introduction. In C. J. Fuller, ed. *Caste Today*. Delhi: Oxford University Press, pp. 1–31.

Gamarnikow, E., 1991. Nurse or woman: gender and professionalism in reformed nursing 1860-1923. In P. Holden & J. Littlewood, eds. *Anthropology and nursing*. New York: Routledge, pp. 110–129.

Gamarnikow, E., 1978. Sexual division of labour: the case of nursing. In A. Kuhn & A. Wolpe, eds. *Feminism and materialism: women and modes of production*. London: Routledge and Kegan Paul, pp. 96–123.

Gardner, K., 1995. *Global migrants, local lives. Travel and transformation in rural Bangladesh*, Oxford: Clarendon Press.

Gardner, K. & Lewis, D., 1996. *Anthropology, development and the postmodern challenge*, London: Pluto Press.

Gardner, K. & Lewis, D., 2015. *Anthropology and Development. Challenges for the Twenty-First Century*, London: Pluto Press.

Garro, L.C. & Mattingly, C., 2000. Narrative as construct and construction. In C. Mattingly & L. C. Garro, eds. *Narrative and the cultural construction of illness and healing*. London: University of California Press, pp. 1–49.

Geertz, C., 1983. *Local knowledge. Further essays in interpretive anthropology*, New York: Basic Books.

Geertz, C., 1973. Thick Description: Toward an Interpretive Theory of Culture. In *The interpretation of cultures*. New York: Basic Books, pp. 3–30.

Geertz, C., 1988. *Works and lives. The anthropologist as author*, Cambridge: Polity Press.

Giddens, A., 1979. *Central problems in social theory. Action, structure and contradiction in socical analysis*, London: The Macmillan Press Limited.

Giddens, A., 2009. Stratification and social class. In *Sociology*. Cambridge: Polity Press, pp. 429–474.

Giddens, A., 1984. *The constitution of society. Outline of the theory of structuration*, Oxford: Polity Press.

Goffman, E., 1961. On the characteristics of total institutions. In *Asylums. Essays on the social situation of mental patients and other inmates*. New York: Anchor Books, pp. 1–124.

Gonsalves, D.M., 1999a. An assessment of the concept and image of nursing in Bangladesh as perceived by a selected group of nurses in Dhaka. In *National Conference on Nursing Research*. pp. 127–134.

Gonsalves, D.M., 1999b. Impact of gender inequity on women's health in Bangladesh. *Nursing Newsletter of the Directorate of Nursing Services Bangladesh*, 3(1&2), p.23.

Good, B.J., 1994. *Medicine, rationality and experience*, Cambridge: Cambridge University Press.

Good, B.J. & DelVeccio Good, M.-J., 2000. "Fiction" and "Historicity" in doctors' stories: social and narrative dimensions of learning medicine. In C. Mattingly & L. C. Garro, eds. *Narrative and the cultural construction of illness and healing*. London: University of California Press.

Goodman, A.H., 2000. Why genes don't count (for racial differences in health). *Americal Journal of Public Health*, 90(1), pp.1699–1702.

Gordon, C., 1977. Afterword. In C. Gordon, ed. *Power/Knowledge. Selected interviews and other writings 1972-1977, by Michel Foucault*. New York: Pantheon Books, pp. 229–259.

Gourlay, J., 2003. *Florence Nightingale and the Health of the Raj*, Hants: Ashgate.

Government of Bangladesh, 2015. Know Bangladesh. Available at: http://www.bangladesh.gov.bd/site/page/812d94a8-0376-4579-a8f1-a1f66fa5df5d/Know--Bangladesh [Accessed July 23, 2015].

Government of Bangladesh, 2013. Public Servants Retirement Amendment Act, 2013. *Bangladesh Parliament*. Available at: http://www.parliament.gov.bd/index.php/en/acts-of-16th-session/1868-public-servants-retirement-amendment-act-2013 [Accessed December 29, 2015].

Government of Bangladesh, 2011. *Sixth Five Year Plan. FY2011-FY2015. Accelerating Growth and Reducing Poverty, Strategic Directions and Policy Framework*, Dhaka. Available at: http://www.plancomm.gov.bd/sixth-five-year-plan/ [Accessed September 27, 2015].

Gramsci, A., 1970. *Selections from the prison notebooks* Q. Hoare & G. N. O. Smith, eds., London: International Publishers.

Griffin, A.P., 1983. A philosophical analysis of caring in nursing. *Journal of Advanced*

Nursing, 8, pp.289–295.

Griffin, A.P., 1980. Philosophy in nursing. *Journal of Advanced Nursing*, 5, pp.261–272.

Gruen, R. et al., 2002. Dual job holding practitioners in Bangladesh: an exploration. *Social Science & Medicine*, 54(2), pp.267–279.

Gustavsson, S., 1991. *Primary Education in Bangladesh. Review, Analysis and Recommendations*, Stockholm.

Habermas, J., 1973. Introduction. Some Attempts to Link Theory and Praxis. In *Theory and Practice*. Boston: Beacon Press, pp. 1–40.

Hadley, M.B. et al., 2007. Why Bangladeshi nurses avoid `nursing': Social and structural factors on hospital wards in Bangladesh. *Social Science & Medicine*, 64(6), pp.1166–1177.

Hadley, M.B. & Roques, A., 2007. Nursing in Bangladesh: Rhetoric and reality. *Social Science & Medicine*, 64(6), pp.1153–1165.

Haider, S. & Shah, S.Z., 1992. *History of nursing in Pakistan* S. Haider & S. Z. Shah, eds., Islamabad: Pakistan Nursing Council.

Haider, S.K.U., 2011. Genesis and growth of the NGOs: Issues in Bangladesh perspective. *International NGO Journal*, 6(11), pp.240–247.

Haigh, C., 2009. Editorial: Embracing the theory/practice gap. *Journal of Clinical Nursing*, 18(1), pp.1–2.

Halim, M., 1999. Feminism in Bangladesh. *Center for Digital Discourse and Culture*. Available at: http://www.cddc.vt.edu/feminism/ban.html [Accessed December 5, 2016].

Haraway, D.J., 1991. Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. In *Simians, Cyborgs and Women. The Reinvention of Science*. London: Routledge, pp. 183–202.

Haro, J.A., 2000. Cuidados profanos: una dimensión ambigua en la atención de la salud. In E. Perdigueiro & J. M. Comelles, eds. *Medicina y cultura. Estudios entre la antropología y la medicina*. Barcelona: Edicions Bellaterra, pp. 101–161.

Harrison, M., 1994. *Public Health in British India. Anglo-Indian Preventive Medicine 1859-1914*, Melbourne: Cambridge University Press.

Harrison, M. & Pati, B., 2011. Social history of health and medicine: Colonial India. In M.

Harrison & B. Pati, eds. *The social history of health and medicine in Colonial India*. Oxfordshire: Routledge, pp. 1–14.

Hartmann, B. & Boyce, J.K., 1998. *A quiet violence. Views from a Bangladeshi village*, London: Zed Books.

Hassan, F. et al., 2010. Working environment of nurses in two district hospitals. *Bangladesh Journal of Anatomy*, 8(2), p.81–84; 81.

Healey, M., 2007. *Indian Sisters: A History of Nursing Leadership and the State, 1907-2007* . La Trobe University Bundoora, Victoria.

Healey, M., 2006. "I"m the gal that can do it if they let me': International Nurse Advisers and Notions of Professionalism in Indian Nursing, 1947-1965. In *16th Biennial Conference of the Asian Studies Association of Australia*. ASAA, pp. 1–28. Available at: http://coombs.anu.edu.au/SpecialProj/ASAA/biennial-conference/2006/Healey-Madelaine-ASAA2006.pdf [Accessed April 21, 2017].

Healey, M., 2011. "Regarded, paid and housed as menials": Nursing in colonial India, 1900–1948. *South Asian History and Culture*, 2(1), pp.55–75.

Healey, M., 2008. "Seeds That May Have Been Planted May Take Root": International Aid Nurses and Projects of Professionalism in Postindependence India, 1947-65. *Nursing History Review*, 16, pp.58–90.

Hemani, H., 1996. *The History of Nursing in Pakistan: A Struggle for Professional Recognition*. University of Alberta, Edmonton.

Hertz-Lazarowitz, R. & Shapira, T., 2005. Muslim Women's Life Stories: Building Leadership. *Anthropology & Education Quarterly*, 36(2), pp.165–181.

Hill, P. St., 2006. Race, race relations, and the emergence of professional nursing, 1870-2004. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Sudbury: Jones and Bartlett Publishers, p. 57–66; 5.

Hobart, M., 1993. Introduction: the growth of ignorance? In M. Hobart, ed. *An anthropological critique of development. The growth of ignorance*. London: Routledge, pp. 1–30.

Hojat, M. et al., 2001. Attitudes Toward Physician-Nurse Collaboration: A Cross-Cultural Study of Male and Female Physicians and Nurses in the United States and Mexico. *Nursing Research*, 50(2).

Holden, P. & Littlewood, J., 1991. Introduction. In P. Holden & J. Littlewood, eds. *Anthropology and nursing*. London: Routledge, pp. 1–6.

Hooks, B., 1982. *Ain't I a Woman? Black Women and Feminism*, London: Pluto Press.

Hooks, B., 1984. Black Women: Shaping Feminist Theory. In *Feminist Theory. From Margin to Center*. Boston: South End Press, pp. 1–15.

HPNSDP, 2011. *Operational Plan Nursing Education and Services*, Dhaka: Health Population and Nutritiuon Sector Development Programme.

Huq, J., 1979. Women in the economic sphere: rural. In *Economic activities fo women in Bangladesh. The rural situation*. Dhaka: Women for Women Research and Study Group, pp. 139–182.

Huque, R., Barkat, A. & Sabina, N., 2012. Public Health Expenditure: Equity, Efficacy and Universal Helth Coverage. In Bangladesh Health Watch, ed. *Bangladesh Health Watch Report 2011. Moving Towards Universal Health Coverage*. Dhaka: Bangladesh Rural Advancement Committee, pp. 25–32.

Ilon, L., 2000. Colonial secondary education in a global age: Economic distortions in Bangladesh. *Asia Pacific Education Review*, 1(1), pp.91–99.

Inden, R.B. & Nicholas, R.W., 2005. *Kinship in Bengali Culture* 2nd ed., New Delhi: Chronicle Books.

International Union of Anthropological and Ethnological Sciences, 2009. IUAES Statement on Human Rights. Available at: https://www.iuaes.org/statement/human.html [Accessed June 30, 2015].

Islam, M., 1979. Social norms, institutions and status of women. In WFW, ed. *Situation of women in Bangladesh*. Dhaka: Women for Women Research and Study Group, pp. 225–264.

Islam, M.T., 2013. *Residential Childcare: The Experiences of Young People in Bangladesh*. The University of Edinburgh.

Islam, S., Sae-Sia, W. & Khupantavee, N., 2010. Knowledge, attitude and practice on pressure ulcer prevention among nurses in Bangladesh. In *2nd International Conference on Humanities and Social Sciences*. Bangkok: Faculty of Liberal Arts, Prince of Songkla University, pp. 1–10.

Islam, Y., 2011. Tertiary Education in Bangladesh. Brief History, Problems and Prospects.

International Journal for the Scholarship of Teaching and Learning, 5(2), pp.1–6.

Jahan, R., 2014. The Parliament of Bangladesh: Representation and Accountability. *The Journal of Legislative Studies*, 21(2), pp.250–269.

James, W., 1999. Empowering ambiguities. In A. Cheater, ed. *The anthropology of power. Empowerment and disempowerment in changing structures*. London: Routledge, pp. 13–26.

Jaramillo Marín, J., 2011. Bourdieu y Giddens. La superación de los dualismos y la ontología relacional de las prácticas sociales. *CS Revista*, 7, pp.409–428.

Josselson, R. & Lieblich, A., 1993. *The Narrative Study of Lives*, Towson: Sage.

Kabeer, N., 2000. *Bangladeshi Women Workers and Labour Market Decisions. The Power to Choose* Vistaar Pu., New Delhi.

Kabeer, N., 2011. Between Affiliation and Autonomy: Navigating Pathways of Women's Empowerment and Gender Justice in Rural Bangladesh. *Development and Change*, 42(2), pp.499–528.

Kabeer, N., 1994. *Reversed realities. Gender hierarchies in development thought*, London: Verso.

Kabeer, N., 1988. Subordination and struggle: women in Bangladesh. *New Left Review*, 169, pp.95–121.

Kabeer, N., Mahmud, S. & Tasneem, S., 2011. *Does Paid Work Provide a Pathway to Women's Empowerment? Empirical Findings from Bangladesh*, Dhaka.

Kabeer, N. & Natali, L., 2013. Gender Equality and Economic Growth: Is there a Win-Win? *IDS Working Papers*, 2013(417), pp.1–58.

Kabir, M. et al., 1994. Factors affecting desired family size in Bangladesh. *Journal of Biosocial Science*, 26(3), pp.369–375.

Kabir Talukder, M.H. et al., 2010. Evaluation of implementing status of Diploma Nursing Curriculum in Bangladesh. *Bangladesh Journal of Medical Education*, 1(1), pp.25–28.

Karmakar, R., 1993. *An assessment of nursing care provided by nursing staff personnel in a selected hospital*. Dhaka: University of Dhaka.

Kelly, L.Y. & Joel, L.A., 1999. *Dimensions of professional nursing*, New York: Mc Graw - Hill.

Kelly, U.A., 2009. Integrating Intersectionality and Biomedicine in Health Disparities

Research. *Advances in Nursing Science*, 32(2).

Kerner, I., 2009. Más allá de la unidimensionalidad: Conceptualizando la relación entre el racismo y el sexismo . *Signos filosóficos* , 11, pp.187–205.

Khair, S. & Khan, S.R., 2004. Philanthropy and law in Bangladesh. In M. Sidel & I. Zaman, eds. *Philanthropy and law in South Asia*. Manila: Asia Pacific Philanthropy Consortium, pp. 48–114.

Khan, J.A., 2012. Inpatient Healthcare in Bangladesh: Current Status and Future Prospects towards Achieving Universal Health Coverage. In Bangladesh Health Watch, ed. *Bangladesh Health Watch Report 2011. Moving Towards Universal Health Coverage*. Dhaka: Bangladesh Rural Advancement Committee, pp. 35–49.

Khan, M.N.U., Rana, E.A. & Haque, M.R., 2014. Reforming the Education System in Bangladesh: Reckoning a Knowledge-based Society. *World Journal of Education*, 4(4), p.p1.

Khanam, N., 1999. Assessment of staff nurses' awareness regarding pre operative preparation for laparotomy patients in selected surgical wards in Dhaka Medical College Hospital. In *National Conference on Nursing Research*. Research Cell College of Nursing, pp. 48–56.

Khatun, R., 1999. Analysis of changes in nursing and midwifery education in Bangladesh in the decade of the 1990s. In *National Conference on Nursing Research*. Research Cell College of Nursing, pp. 20–27.

Khatun, S., 1999. An assessment of knowledge related to nosocomial infections among senior staff nurses working in Institute of Diseases of Chest and Hospital, Dhaka. In *National Conference on Nursing Research*. Research Cell College of Nursing, pp. 118–126.

Khatun, S., 1998. Nurse-'giri' or nurse-'ing': Fair attention is required. In N. H. Bryant, ed. *Women in nursing in Islamic Societies*. Oxford: Oxford University Press, pp. 235–236.

Kingsolver, A.E., 2010. Power A. Barnard & Spencer, eds. *The Routledge encyclopedia of social and cultural anthropology*, pp.565–568.

Kleinman, A., 1978. Concepts and a model for the comparison of medical systems as cultural systems. *Social Science & Medicine. Part B: Medical Anthropology*, 12, pp.85–93.

Kleinman, A., 1980. *Patients and healers in the context of culture. An exploration of the borderland between anthropology, medicine, and psychiatry*, London: University of California Press.

Kleinman, A., 1988. *The illness narratives. Suffering, healing and the human condition*, New York: Basic Books.

Kleinman, A., Das, V. & Lock, M., 1997. Introduction. In A. Kleinman, V. Das, & M. Lock, eds. *Social Suffering*. Berkeley: University of California Press, pp. ix–xxvii.

Kleinman, A., Eisenberg, L. & Good, B., 1978. Culture, illness, and care. *Annals of Internal Medicine*, 88(2), pp.251–258.

Kleinman, A. & Kleinman, J., 1991. Suffering and its professional transformation: toward an ethnography of interpersonal experience. *Culture, Medicine and Psychiatry*, 15(3), p.275.

Kotalová, J., 1996. *Belonging to Others. Cultural Construction of Womenhood in a Village in Bangladesh*, Dhaka: The University Press.

Kothari, R., 1994. Rise of the Dalits and the Renewed Debate on Caste. *Economic and Political Weekly*, 29(26), pp.1589–1594.

Krieger, N., 2005. Stormy weather: Race, gene expression, and the science of health disparities. *American Journal of Public Health*, 95(12), pp.2155–2160.

Kumar, A., 1998. *Medicine and the Raj. British Medical Policy in India, 1835-1911*, New Delhi: SAGE Publications.

Laclau, E. & Mouffe, C., 2001. *Hegemony and Socialist Strategy. Towards a Radical Democratic Politics* 2nd ed., London: Verso.

Lal, M., 1994. The politics of gender and medicine in colonial India: The countess of Dufferin's Fund, 1885-1888. *Bulletin of the History of Medicine*, 68(1), p.29.

Langness, L.L., 1974. Usos potenciales de la historia de vida en antropología. In J. Balán et al., eds. *Las historias de vida en ciencias sociales. Teoría y técnica*. Buenos Aires: Ediciones Nueva Visión, pp. 153–154.

Larrea Killinger, C., 2012. *Nasci na família errada Ser mãe e dona de casa no subúrbio ferroviário de Salvador de Bahia*, Tarragona: Universitat Rovira i Virgili.

Latif, A., 2010. *Relationship between organizational climate and nurses' job satisfaction in Bangladesh*. Prince Songkla University, Thailand.

Lázaro, R., 2014. *Interseccionalidad de género e identidades múltiples*. Barcelona: Universitat de Barcelona.

Leacock, E., 1985. Individuals and Society in Anthropological Theory. *Dialectical Anthropology*, 10(1/2), pp.69–91.

Lee, M.B. & Saeed, I., 2001. Oppression and Horizontal Violence: The Case of Nurses in Pakistan. *Nursing Forum*, 36(1), pp.15–24.

Leininger, M., 2006. Culture Care Diversity and Universality Theory and Evolution of the Ethnonursing Method. In M. Leininger & M. R. McFarland, eds. *Culture Care Diversity and Universality. A Worldwide Nursing Theory*. Sudbury: Jones and Bartlett Publishers, pp. 1–41.

Leininger, M., 1996. Culture Care Theory, Research, and Practice. *Nursing Science Quarterly*, 9(2), pp.71–78.

Leininger, M., 2002. Culture Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices. *Journal of Transcultural Nursing*, 13(3), pp.189–192.

Leininger, M., 1988. Leininger's Theory of Nursing: Cultural Care Diversity and Universality. *Nursing Science Quarterly*, 1(4), pp.152–160.

Leininger, M., 2007. Theoretical questions and concerns: response from the theory of culture care civersity and universality perspective. *Nursing Science Quarterly*, 20(1), pp.9–13.

Leisenring, A., 2006. Confronting "victim" discourses: The identity work of battered women. *Symbolic interaction*, 29(3), pp.307–330.

Leppard, M., 2000. *Obstetric Care in a Bangladeshi District Hospital: an Organizational Ethnography*. London: University of London.

Leslie, J. & Wujastyk, D., 1991. The Doctor's Assistant: Nursing in Ancient Indian Medical Texts. In P. Holden & J. Littlewood, eds. *Anthropology and Nursing*. New York: Routledge, pp. 25–30.

Lewis, D., 2011. *Bangladesh: Politics, Economy and Civil Society*, New York: Cambridge University Press.

Lewis, O., 1961. *Antropología de la pobreza. Cinco famílias*, México: Fondo de Cultura Económica.

Lewis, O., 2012. *Los hijos de Sánchez. Autobiografía de una familia Mexicana*, México: Fondo de Cultura Económica.

Linde, C., 1993. *Life stories. The creation of coherence*, Oxford: Oxford University Press.

Littlewood, J., 1991. Care and ambiguity: towards a concept of nursing. In P. Holden & J. Littlewood, eds. *Anthropology and nursing*. New York: Routledge, pp. 170–189.

Long, N., 1992. Introduction. In N. Long & A. Long, eds. *Battlefields of knowledge. The interlocking of theory and practice in social research and development*. New York: Routledge, pp. 3–15.

Long, N. & Arce, A., 1992. The dynamics of knowledge. Interfaces between bureaucratics and peasants. In *Battlefields of knowledge. The interlocking of theory and practice in social research and development*. London: Routledge, pp. 211–246.

MacKinnon, C.A., 2013. Intersectionality as Method: A Note. *Signs: Journal of Women in Culture and Society*, 38(4), pp.1019–1030.

MacLeod, A.E., 1992. Hegemonic Relations and Gender Resistance: The New Veiling as Accommodating Protest in Cairo. *Signs*, 17(3), pp.533–557.

Maggs, C., 1980. Nurse recruitment to four provincial hospitals 1881-1921. In C. Davies, ed. *Rewriting nursing history*. London: Croom Helm, pp. 18–40.

Magrassi, G. & Roca, M.M., 1986. *Introducción* G. Magrassi & M. M. Roca, eds., Buenos Aires: Centro Editor de América Latina.

Mahmood, S., 2005. *Politics of piety. The Islamic revisal and the feminist subject*, Princenton: Princenton University Press.

Maloney, C., 1979. Foreword. In K. M. A. Aziz, ed. *Kinship in Bangladesh*. Dhaka: International Centre for Diarrhoeal Disease Research Bangladesh, pp. ix–xiii.

Mann, M., 2004. "Torchbearers Upon the Path of Progress": Britain's Ideology of a "Moral and Material Progress" in India. An Introductory Essay. In H. Fischer-Tiné & M. Mann, eds. *Colonialism as Civilizing Misison. Cultural Ideology in British India*. London: Anthem Press, pp. 1–26.

Marsal, J.F., 1974. Historias de vida y ciencias sociales. In J. Balán et al., eds. *Las historias de vida en ciencias sociales. Teoría y técnica*. Buenos Aires: Ediciones Nueva Visión, pp. 43–63.

Martínez Hernáez, Á., 2008. *Antropología médica. Teorías sobre la cultura, el poder y la*

enfermedad, Barcelona: Anthropos.

Mascarenhas, A., 1986. *Bangladesh. A Legacy of Blood*, Kent: Hodder and Stoughton Educational.

Mascarenhas, A., 1971. *The Rape of Bangladesh*, Delhi: Vikas Publications.

Mattingly, C. & Garro, L.C., 2000. *Narrative and the cultural construction of illness and healing*, London: University of California Press.

Mavalankar, D., Sankara Raman, P. & Vora, K., 2016. Midwives of India: Missing in action. *Midwifery*, 27(5), pp.700–706.

McAdams, D.P., Josselson, R. & Lieblich, A., 2006. *Identity and story. Creating self in narrative*, Washington DC: American Psychological Association.

McCaugherty, D., 1991. The theory-practice gap in nurse education: its causes and possible solutions. Findings from an action research study. *Journal of Advanced Nursing*, 16(9), pp.1055–1061.

McCormick, D.P. et al., 2001. Spiritualty and HIV Disease: An Integrated Perspective. *Journal of the Association of Nurses in AIDS Care*, 12(3), pp.58–65.

McCracken, G., 1988. *The long interview*, California: SAGE University.

McFarland, M., 2001. Teoría de la diversidad y de la universalidad de los cuidados culturales. In M. R. Alligood & A. M. Torney, eds. *Modelos y Teorías de Enfermería*. Barcelona: ElSevier España, p. 472–498; 22.

McFarlane, J.K., 1979. A charter for caring. *Journal of Advanced Nursing*, 1, pp.187–196.

Mehta, J.N., 1965. Medical Services in India (The Sir George Birdwood Memorial Lecture). *Journal of the Royal Society of Arts*, 113(5112), pp.995–1019.

Menéndez, E.L., 1990. *Antropología médica: orientaciones, desigualdades y transacciones*, México: CIESAS.

Menéndez, E.L., 1991. Definiciones, indefiniciones y pequeños saberes. *Alteridades*, 1(1), pp.23–32.

Menéndez, E.L., 1984. El modelo médico hegemónico: transacciones y alternativas hacia una fundamentación teórica del modelo de autoatención en salud. *Arxiu d'Etnografia de Catalunya*, 3, pp.85–119.

Menéndez, E.L., 2003. Modelos de atención de los padecimientos: de exclusiones teóricas y articulaciones prácticas. *Ciencia & Saúde Coletiva*, 8(1), p.185–207; 185.

Menéndez, E.L., 1981. *Poder, estratificación y salud. Análisis de las condiciones sociales y económicas de la enfermedad en Yucatán*, México D.F.: Ediciones de La Casa Chata.

Miers, M.E., Rickaby, C.E. & Pollard, K.C., 2007. Career choices in health care: Is nursing a special case? A content analysis of survey data. *International Journal of Nursing Studies*, 44(7), pp.1196–1209.

De Miguel, J., 1996. *Auto/biografías*, Madrid: Centro de Investigaciones Sociológicas.

Mills, C.W., 1959. *The Sociological Imagination*, New York: Oxford University Press.

Minca, M., 2011. Midwifery in Bangladesh in-depth country analysis. , Background.

Miyan, M.A., 2008. *Retirement and Pension System in Bangladesh*, Amsterdam.

MoEDU, 2008. Education structure of Bangladesh. Available at: http://www.moedu.gov.bd/index.php?option=com_content&task=view&id=339&Itemid=354 [Accessed September 30, 2015].

Mohanty, C.T., 1984. Under Western Eyes. Feminist Scholarship and Colonial Discourses. *Boundary*, 2(3), p.333–358; 333.

Moore, H.L., 1988. *Feminism and anthropology*, Cambridge: Polity Press.

Morgan, K.P., 1996. Describing the emperor's new clothes: Three myths of educational (in)equity. In A. Diller et al., eds. *The gender question in education: Theory, pedagogy, & politics*. Boulder: Westview Press, pp. 105–122.

Nair, S., 2012. *Moving with the times. Gender, status and migration of nurses in India*, New Delhi: Routledge.

Nair, S., 2011. Report on the National Seminar on "Indian Nursing in the New Era of Healthcare." *Indian Journal of Gender Studies*, 18(2), pp.237–240.

Nair, S., 2007. Rethinking Citizenship, Community and Rights: The Case of Nurses from Kerala in Delhi. *Indian Journal of Gender Studies*, 14(1), pp.137–156.

Nair, S. & Healey, M., 2009. *A Profession on the Margins: Status Issues in Indian Nursing*, Delhi: Centre for Women's development Studies. Available at: http://www.cwds.ac.in/wp-content/uploads/2016/09/A-Profession-on-the-margins.pdf [Accessed April 14, 2017].

Nandi, P.K. & Loomis, C.P., 1974. Professionalization of Nursing in India: Deterring and Facilitating Aspects of the Culture. *Journal of Asian and African Studies*, 9(1–2), pp.43–59.

Narotzky, S., 1995. *Mujer, mujeres, género. Una investigación crítica al estudio de las mujeres en las Ciencias Sociales*, Madrid: Consejo Superior de Investigaciones Científicas.

Nath, S.R. et al., 2014. *New Vision Old Challenges. The State of Pre-primary Education in Bangladesh*, Dhaka.

Nilsson, J. et al., 2005. Role and function: Aspects of quality of life of older people in rural Bangladesh. *Journal of Aging Studies*, 19(3), pp.363–374.

Ochs, E. & Capps, L., 1996. Narrating the self. *Annual review of anthropology*, pp.19–43.

Oliva, A., 2004. *eminismo postcolonial: la crítica al eurocentrismo del feminismo occidental*,

Olson, T., 1997. Ordered to care?: professionalization, gender and the language of training, 1915-37. In A. M. Rafferty, J. Robinson, & R. Elkan, eds. *Nursing history and the politics of welfare*. London: Routledge, p. 150–163; 8.

Organisation, U.N.E.S. and C., 2006. Country Basic Information: Bangladesh. Available at: http://www.ibe.unesco.org/fileadmin/user_upload/archive/Countries/WDE/2006/ASIA_and_the_PACIFIC/Bangladesh/Bangladesh.htm [Accessed June 13, 2015].

Ortner, S.B., 2006. *Anthropology and social theory. Culture, power and the acting subject*, London.

Ortner, S.B., 1989. *High religion. A cultural and political history of Sherpa Buddhism*, New Jersey: Princeton University Press.

Ortner, S.B., 1999a. Introduction. In S. B. Ortner, ed. *The fate of "culture". Geertz and beyond*. Berkeley: University of California Press, pp. 1–13.

Ortner, S.B., 1999b. *Life and death on Mt. Everest. Sherpas and Himalayan mountaineering*, New Jersey: Princeton University Press.

Ortner, S.B., 1996. *Making gender. The politics and erotics of culture*, Boston: Beacon Press.

Ortner, S.B., 1991. *Narrativity in history, culture and lives*, Ann Arbor.

Ortner, S.B., 1984. Theory in Anthropology since the Sixties. *Comparative Studies in Society and History*, 26(1), pp.126–166.

Ortner, S.B., 1999c. Thick resistance: Death and the cultural construction of agency in Himalayan mountaineering. In S. B. Ortner, ed. *The fate of "culture". Geertz and*

beyond. Berkeley: The University of California Press, pp. 136–164.

Osman, F.A., 2004. *Policy making in Bangladesh. A study of the health policy process*, Dhaka: AH Development Publishing House.

Osmani, S.R., 1990. Structural Change and Poverty in Bangladesh: The Case of a False Turning Point. *The Bangladesh Development Studies*, 18(3), pp.55–74.

Oulton, J. & Hickey, B., 2009. *Review of the nursing crisis in Bangladesh, India, Nepal and Pakistan*, Geneva: Department for International Development. Available at: http://www.unfpa.org/sowmy/resources/docs/library/R155_OultonHickey_2009_SouthAsiaReview_Nursing_Crisis22Feb09.pdf [Accessed April 14, 2017].

Peacock, J.L. & Holland, D.C., 1993. The narrated self: life stories in process. *Ethos*, 21(4), pp.367–383.

Pérez Orozco, A., 2014. *Subversión feminista de la economía. Aportes para un debate sobre el conflicto capital-vida*, Madrid: Traficantes de Sueños.

Perry, H.B., 2000. *Health for all in Bangladesh. Lessons in Primary Health Care for the Twenty-First Century*, Dhaka: The University Press.

Pfettscher, K.R. et al., 1998. Modern nursing. Florence Nightingale. In A. M. Tomey & M. R. Alligood, eds. *Nursing theorists and their work*. St. Louis: Mosby, p. 69–85; 7.

Pizza, G., 2005. Antonio Gramsci y la antropología médica contemporánea. Hegemonía, "capacidad de actuar" (agency) y transformaciones de la persona. *Revista de Antropología Social*, 14, pp.15–32.

Plummer, K., 1989. *Los documentos personales. Introducción a los problemas y bibliografía del método humanista*, Madrid: Siglo XXI.

Poggie, J., 1972. Toward Quality Control in Key Informant Data. *Human Organization*, 31(1), pp.23–30.

Prakasamma, M., 1999. Development of nursing research in Bangladesh. In *National Conference on Nursing Research*. Research Cell College of Nursing, pp. 1–6.

Prakash, G., 1999. *Another reason. Science and the imagination of Modern India*, New Jersey: Princeton University Press.

Pujadas, J.J., 1992. *El método biográfico: El uso de las historias de vida en ciencias sociales*, Madrid: Centro de Investigaciones Sociológicas.

Purvis, T. & Hunt, A., 1993. Discourse, ideology, discourse, ideology, discourse,

ideology... *British Journal of Sociology*, 44(3), pp.473–499.

Quasem, M.A., 2002. *Bangladesh. A land of beautiful traditions and culture*, Chittagong: Chattagram Sangskriti Kendra.

Rafferty, A.M., 1996. *The politics of nursing knowledge*, London: Routledge.

Rahman, M.M. et al., 2009. Secondary Education in Bangladesh: History and Contextual Perspectives. *Journal of Bangladesh Studies*, 11(2), pp.57–68.

Rahman, M.M. et al., 2002. The Quality of Health Care from Patient Perspectives. *Bangladesh Medical Research Council Bulletin*, 28(3), pp.87–96.

Rahman, M.O. & Islam, M.T., 2009. Universal Primary Education for All Towards Millennium Development Goal 2: Bangladesh Perspective. *Journal of Health Management*, 11(2), pp.405–418.

Rahman, M.O. & Khan, R., 2007. Out-Migration of Health Professionals in Bangladesh. Prospects of diaspora formation for homeland development. *Asian Population Studies*, 3(2), pp.135–151.

Rahman, M.S., 1996. Reward for nurses. *Nursing Newsletter of the Directorate of Nursing Services Bangladesh*, 1(3), p.12.

Rahman, S., 2010. *Historical dictionary of Bangladesh* 4th ed., Maryland: Scarecrow Press.

Rahnema, M., 2010. Participation. In W. Sachs, ed. *The development dictionary. A guide to knowledge as power*. London: Zed Books.

Ramasubban, R., 1984. The development of health policy in India. In T. Dyson & N. Crook, eds. *India's demography: essays on the contemporary population*. New Jersey: Humanities Press, pp. 97–116.

Ramusack, B.N., 1992. Cultural missionaries, maternal imperialists, feminist allies. British women activists in India, 1865-1945. In N. Chawdhuri & M. Strobel, eds. *Western women and imperialism: complicity and resistance*. Bloomington: Indiana University Press, pp. 119–136.

Rao, M.S., 1968. The history of medicine in India and Burma. *Medical history*, 12(1), p.52.

Raynor, J., Wesson, K. & Keynes, M., 2006. The Girls' Stipend Program in Bangladesh. *Journal of Education for International Development*, 2.2, pp.1–12.

Rema, A., 1999. Basic nursing care activities performed by the senior staff nurses in selected wards of Dhaka Medical College Hospital. In *National Conference on*

Nursing Research. Research Cell College of Nursing, pp. 28–38.

Reverby, S.M., 1987. *Ordered to care. The dilemma of American nursing, 1850-1945*, Cambridge: Cambridge University Press.

Riaz, A., 2014. A Crisis of Democracy in Bangladesh. *Current History*, 113(762), pp.150–156.

Riessman, C.K., 1993. *Narrative Analysis*, California: SAGE University.

Roberts, S.J., 2006. Oppressed group behavior and nursing. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Sudbury: Jones & Bartlett Learning, pp. 23–31.

Robinson, F., 1989. *The Cambridge Encyclopedia of India: Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan and the Maldives*, Cambridge: Cambridge University Press.

Robson, P., 2005. *Nursing education, foreign aid and development: a case study from Bangladesh*. Durham: Durham University. Available at: http://etheses.dur.ac.uk/2201/1/2201_210.PDF?UkUDh:CyT [Accessed April 14, 2017].

Romney, A.K., Weller, S.C. & Batchelder, W.H., 1986. Culture as Consensus: A Theory of Culture and Informant Accuracy. *American Anthropologist*, 88(2), pp.313–338.

Rosdahl, C.B. & Towalski, M.T., 2003. The nature of nursing. In C. B. Rosdahl & M. T. Towalski, eds. *Textbook of basic nursing*. Philadelphia: Lipincott - Williams, pp. 4–11.

Rosenthal, G., 2002. Family history: Life stories. *The History of the Family*, 7(2), pp.175–182.

Rosenthal, G., 1993. Reconstruction of life stories: principles of selection in generating stories for narrative biographical interviews. In R. Josselson & A. Lieblich, eds. *The narrative study of lives*. California: SAGE Publications, pp. 59–91.

Rosenthal, G., 2006. The narrated life story: on the interrelation between experience, memory and narration. In G. Rosenthal, ed. *Narrative, Memory & Knowledge: Representations, Aesthetics, Contexts*. Huddersfield: University of Huddersfield, pp. 1–16.

Rosenwald, G.C. & Ochberg, R.L., 1992. Introduction: life stories, cultural politics, and self-understanding. In G. C. Rosenwald & R. L. Ochberg, eds. *Storied lives. The*

cultural politics of self-understanding. London: Yale University Press, pp. 1–18.

Rozario, S., 2001a. *Purity and communal boundaries. Women and social change in a Bangladeshi village* 2nd ed., Dhaka: Dhaka University Press.

Rozario, S., 2001b. *Purity and Communal Boundaries. Women and social change in a Bangladeshi village* 2nd ed., Dhaka: Dhaka University Press.

Rozario, S., 1998. The dai and the doctor: discourses on women's reproductive health in rural Bangladesh. In K. Ram & M. Jolly, eds. *Maternities and Modernities. Colonial and Postcolonial experiences in Asia and the Pacific*. Cambridge: Cambridge University Press, p. 144–176; 5.

Rozario, S. & Samuel, G., 2002. *The Daughters of Hāritī. Childbirth and female healers in South and Southeast Asia*, London: Routledge.

Sabina, N. & Barkat, A., 2012. Dynamics of Health Sector Policy and Reforms. In Bangladesh Health Watch, ed. *Bangladesh Health Watch Report 2011. Moving Towards Universal Health Coverage*. Dhaka: Bangladesh Rural Advancement Committee, pp. 17–23.

Sachs, W., 1992. Introduction. In W. Sachs, ed. *The development dictionary. A guide to knowledge as power*. London: Zed Books, pp. xv–xx.

Sacks, K.B., 1989. Toward a Unified Theory of Class, Race, and Gender. *American Ethnologist*, 16(3), pp.534–550.

Said, E., 1978. *Orientalism*, New York: Vintage Books.

Saillant, F., 2009. Cuidados, deseos vinculares y utopías terapéuticas: un análisis del concepto de caring. In M. A. Martorell, J. M. Comelles, & M. Bernal, eds. *Enfermería y Antropología. Padeceres, cuidadores y cuidados*. Barcelona: ICARIA, Institut Català d'Antropologia, pp. 189–218.

Salvage, J., 1985. *The politics of nursing*, London: William Heinemann Medical Books.

Samuelson, H., 1991. Nurses between disease and illness. In P. Holden & J. Littlewood, eds. *Anthropology and nursing*. New York: Routledge, pp. 190–201.

Sanjek, R., 2010. Race A. Barnard & J. Spencer, eds. *The Routledge encyclopedia of social and cultural anthropology*, pp.584–588.

Sarkar, S.H., Rana, S. & Zitu, R.A., 2013. Challenges of Quality Higher Education in Bangladesh: A Study on Public Universities. *Jounal of Education and Practice*, 4(8),

pp.151–160.

Sarma, M., 1999. Analysis of changes in nursing and midwifery service in Bangladesh in support of National Health for All goals and health care reforms of the Country in the 1990s. In *National Conference on Nursing Research*. Research Cell College of Nursing, pp. 7–19.

Van Schendel, W., 2009. *A History of Bangladesh*, Cambridge: Cambridge University Press.

Scheper-Hughes, N. & Lock, M.M., 1987. The mindful body: A prolegomenon to future work in medical anthropology. *Medical anthropology quarterly*, 1(1), pp.6–41.

Schulman, S., 1958. Basic functional roles in nursing: Mother surrogate and healer. In E. G. Jaco, ed. *Patients, physicians and illness*. Illinois: The Free Press, pp. 528–37.

Schulman, S., 1972. Mother surrogate - after a decade. In E. G. Jaco, ed. *Patients, physicians and illness. A sourcebook in behavioural science and health*. New York: The Free Press, pp. 223–229.

Schultz, P.R. & Meleis, A.I., 1988. Nursing epistemology: Traditions, insights, questions. *Journal of Nursing Scholarship*, 20(4), pp.217–221.

Schutz, A., 1972. *The phenomenology of the social world* Heinemann., London.

Scott, J.C., 1990. *Domination and the arts of resistance. Hidden transcripts*, New Haven: Yale University Press.

Scott, J.C., 1985. *Weapons of the weak*, New Haven: Yale University Press.

Sen, A., 2007. Women and Men. In *The Argumentative Indian. Writings on Indian History, Culture and Identity*. New York: Penguin Books, pp. 220–250.

Sewell, W.H., 1992. A Theory of Structure: Duality, Agency, and Transformation. *American Journal of Sociology*, 98(1), pp.1–29.

Sida, 2012. *Reality Check Bangladesh 2011. Listening to People's Realities about Primary Healthcare and Primary Education - Year 5*, Stockholm.

Siles González, J., 2003. Antropología y enfermería. La necesaria simbiosis entre dos disciplinas para vertebrar culturalmente la teoría y la praxis de los cuidados. *Índex de Enfermería*, 12(43), pp.28–32.

Simon, E.B., 2009. Christianity and nursing in India: a remarkable impact. *Journal of Christian nursing : a quarterly publication of Nurses Christian Fellowship*, 26(2),

pp.88–94.

Singer, M. & Baer, H., 2012. *Introducing Medical Anthropology. A discipline in Action* 2nd ed., Maryland: Altamira Press.

Singer, M. & Erickson, P.I., 2011. Introduction. In M. Singer & P. I. Erickson, eds. *A Companion to Medical Anthropology*. Sussex: Wiley-Blackwell, pp. 1–5.

Sitzman, K. & Eichelberger, L.W., 2010. *Understanding the work of nurse theorists: a creative beginning*, Sudbury: Jones & Bartlett Learning.

Skidmore, M. & Purkis, M.E., 1998. Response to Marie-Françoise Collière: using anthropology to analyse healthcare situations. *Nursing Inquiry*, 5(4), pp.279–281.

Smith, R.G., 1937. Translator's introduction. In M. Buber, ed. *I and Thou*. Edinburgh: T. & T. Clark, pp. v–xii.

Sokolovsky, S. & Tishkov, V., 2010. Ethnicity A. Barnard & J. Spender, eds. *The Routledge encyclopedia of social and cultural anthropology*, pp.240–243.

Somjee, G., 1991. Social Change in the Nursing Profession in India. In P. Holden & J. Littlewood, eds. *Anthropology and Nursing*. New York: Routledge, pp. 31–55.

Sondgrass, M.E., 1999. *Historical encyclopedia of nursing*, California: ABC-CLIO.

Spouse, J., 2003. *Professional learning in nursing*, Oxford: Blackwell Publishers Ltd.

Spradley, J.P., 1979. *The ethnographic interview*, Orlando: Holt, Rinehart and Winston, Inc.

Stein, B., 2010. *A history of India* 2nd ed. D. Arnold, ed., Sussex: Wiley-Blackwell.

Stein, L.I., 1969. The doctor-nurse game. *ETC: A Review of General Semantics*, 26(2), pp.205–216.

Stein, L.I., Watts, D.T. & Howell, T., 1990. The doctor–nurse game revisited. *New England Journal of Medicine*, 322(8), pp.546–549.

Stivers, C., 1993. Reflections on the Role of Personal Narrative in Social Science. *Signs*, 18(2), pp.408–425.

Stolcke, V., 2000. ¿Es el sexo para el género lo que la raza para la etnicidad... y la naturaleza para la sociedad? *Politica y Cultura*, 14, pp.25–60.

Stolcke, V., 1996. Antropología del género. El cómo y el por qué de las mujeres. In J. Prat & Á. Martínez Hernáez, eds. *Ensayos de antropología cultural. Homenaje a Claudio Esteva-Fabregat*. Barcelona: Ariel, pp. 335–343.

Svensson, R., 1996. The interplay between doctors and nurses—a negotiated order perspective. *Sociology of Health & Illness*, 18(3), pp.379–398.

Tanaka, S., 2013. The notion of embodied knowledge and its range. *encyclopaideia*, 17(37), pp.47–66.

Taylor, C., 1985. *Human agency and language. Philosophical papers I*, Cambridge: Cambridge University Press.

Taylor, C., 1979. The issue of freedom. In *Hegel and modern society*. Cambridge: Cambridge University Press, pp. 135–169.

Terradas, I., 1992. *Eliza Kendall. Reflexiones sobre una antibiografía*, Barcelona: Universitat Autònoma de Barcelona.

Toren, C., 2010. Socialisation A. Barnard & J. Spencer, eds. *The Routledge encyclopedia of social and cultural anthropology*, pp.646–649.

Torralba, F., 1998. *Antropología del Cuidar*, Barcelona: Institut Borja de Bioètica y Fundación MAPFRE Medicina.

Uddin, M.T., Islam, M.T. & Ullah, M.O., 2006. A study on the quality of nurses of the government hospitals in Bangladesh. *Pakistan Academy of Sciences*, 43(2), p.121–129;

United Nations, 2004. Map of Bangladesh. *Map No. 3711 Rev. 2*. Available at: http://www.un.org/Depts/Cartographic/map/profile/banglade.pdf [Accessed August 26, 2015].

United Nations Data, 2015. Country Profile: Bangladesh. , 2015(08/21). Available at: http://data.un.org/CountryProfile.aspx?crName=Bangladesh [Accessed December 26, 2014].

United Nations Educational Scientific and Cultural Organisation, 2015. Gross enrolment ratio by level of education. Available at: http://data.uis.unesco.org/?queryid=142 [Accessed October 2, 2015].

United Nations International Children's Emergency Fund, 2015. Bangladesh. Statistics. Available at: http://www.unicef.org/infobycountry/bangladesh_bangladesh_statistics.html [Accessed August 30, 2015].

United Nations Population Division, 2002. Fertility Levels and Trends in Countries with

Intermediate Levels of Fertility.

Vincent, J., 1978. Political anthropology: manipulative strategies. *Annual Review of Anthropology*, 7(1), pp.175–194.

Wagner, H.R., 1977. The Bergsonian Period of Alfred Schutz. *Philosophy and Phenomenological Research*, 38(2), pp.187–199.

Waligora, M., 2004. What is your "Caste"? The Classification of Indian Society as Part of the British Civilizing Misison. In H. Fischer-Tiné & M. Mann, eds. *Colonialism as Civilizing Misison. Cultural Ideology in British India*. London: Anthem Press, pp. 141–162.

Weber, M., 1946. Class, status, party. In *Essays in sociology*. Oxford: Oxford University Press, pp. 180–196.

White, J., 2006. Patterns of knowing: review, critique, and update. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Sudbury: Jones and Bartlett Publishers, p. 139–150; 12.

White, S., 1992. *Arguing with the crocodile. Gender and class in Bangladesh*, London: Zed Books.

White, S.C., 2013. *Patriarchal investments: Marriage, dowry and economic change in rural Bangladesh*, Bath.

Wicks, D., 1995. Nurses and doctors and discourses of healing. *Journal of Sociology*, 31(2), pp.122–139.

Widdershoven, G.A.M., 1993. The story of life: hermeneutic perspectives on the relationship between narrative and life history. In R. Josselson & A. Lieblich, eds. *The narrative study of lives*. California: SAGE Publications, pp. 1–20.

Wilkinson, A., 1958. *A brief history of nursing in India and Pakistan*, Madras: The Trained Nurses' Association of India.

Williams, R., 1977. *Marxism and literature*, Oxford: Oxford University Press.

Willis, P., 1977. *Learning to labor. How working class kids get working class jobs*, New York: Columbia University Press.

Wilson, A., 1994. New World Order and West's War on Population. *Economic and Political Weekly*, 29(34), pp.2201–2204.

Witz, A., 2001. "Colonising Women": Female Medical Practice in Colonial India, 1880-

1890. In A. Hardy & L. Conrad, eds. *Women and Modern Medicine*. Amsterdam: Editions Rodopi, pp. 23–52.

Wolf, E.R., 1982. *Europe and the people without history*, Berkeley: University of California Press.

Wolf, K., 2006. A slow march to professional practice. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf, eds. *A history of nursing ideas*. Sudbury: Jones and Bartlett Publishers, pp. 305–320.

World Bank, 2003. *Private sector assessment for Health, Nutrition and Population (HNP) in Bangladesh*, Washington DC: World Bank. Available at: http://siteresources.worldbank.org/INTBANGLADESH/Data and Reference/20206318/Bangladesh_PSA_for_HNP-Full report.pdf [Accessed April 14, 2017].

World Bank, 2016. Pupil-teacher ratio in primary education (headcount basis). *World Bank Data*. Available at: http://data.worldbank.org/indicator/SE.PRM.ENRL.TC.ZS [Accessed April 17, 2017].

World Health Organisation, 2016. 10 facts on health inequalities and their causes. *Health Topics*. Available at: http://www.who.int/features/factfiles/health_inequities/en/ [Accessed September 7, 2016].

World Health Organisation, 2010. Strengthened health system: Nursing and midwifery. Available at: http://www.ban.searo.who.int/en/Section3/Section41/Section98.htm [Accessed August 21, 2013].

World Health Organisation, 2015. WHO Country Profile: Bangladesh. Available at: http://www.who.int/gho/countries/bgd/country_profiles/en/ [Accessed July 23, 2015].

Wright Mills, C., 2000. *The sociological imagination*, Oxford: Oxford University Press.

Young, A., 1982. The Anthropologies of Illness and Sickness. *Annual Review of Anthropology*, 11, pp.257–285.

Youssef, E.Y.A. et al., 1997. *Nursing Practice Around the World*, Geneva.

Yuval-Davis, N., 2006. Intersectionality and Feminist Politics. *European Journal of Women's Studies*, 13(3), pp.193–209.

Zaidi, S.A., 1985. The urban bias in health facilities in Pakistan. *Social Science & Medicine*, 20(5), pp.473–482.

Zaman, N., 1979. National policies and women. In WFW, ed. *The situation of women in Bangladesh*. Dhaka: Women for Women Research and Study Group, pp. 332–351.

Zaman, S., 2005. *Broken Limbs, Broken Lives. Ethnography of a Hospital Ward in Bangladesh*, Amsterdam: Het Spinhuis.

Zaman, S., 2009. Ladies without lamps: nurses in Bangladesh. *Qual Health Res*, 19(3), pp.366–374.