

Practical Strategies for Providing Culturally Sensitive, Ethical Care in Developing Nations

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Providing health care in developing nations results in cultural and ethical challenges for health care professionals. The authors' intent is to raise readers' awareness of how to maintain an ethical and culturally sensitive approach to practice in developing nations. Four practical approaches to ethical decision-making, developed from the literature and praxis, in conjunction with traditional moral theory and guidelines from professional and international organizations are discussed. Ethical multiculturalism, a view that combines universalism and multiculturalism undergirds culturally appropriate and ethically responsive decisions.

Keywords: *ethical multiculturalism; global ethics; developing nations cultural sensitivity; nursing ethics*

Nursing, as a discipline, has traditionally been a strong advocate for social justice (American Nurses Association [ANA], 2001; International Council of Nurses [ICN], 2000). In response to social justice concerns, many nurses work with people and communities that are the most marginalized in our society and in the world. Member nations of the United Nations (UN) designate themselves as a developed, developing, or undeveloped nation. The term *developing nation* describes nations with a lower income average, a relatively undeveloped infrastructure, and less industrialization than developed nations. Nurses who work in other countries, particularly developing nations, face two significant moral concerns: how to interface with established cultural norms and how to handle the novel ethical dilemmas that arise from practicing in a different culture (Lutzen, 1997; Stark, Nair, & Omi, 1999). The standard ways of making decisions, used in one's own culture, are challenged and often require greater cultural sensitivity and ethical reflection (Davis, 1999; Stark et al., 1999). But how do nurses show cultural sensitivity and ethical relevancy in other cultures?

What practical strategies help nurses make appropriate choices when caring for people in developing nations?

In this article, the authors present four *practical* reflective strategies developed through literature review and reflective experience, or *praxis*. *Praxis* originates from Aristotle and is defined by Chinn and Kramer (2004) as "value-grounded, thoughtful reflection and action that occur in synchrony" (p. 266). *Praxis* places value on what one learns by doing. The strategies presented are useful for decision making in conjunction with traditional decision-making processes of moral principles and guideline from authorities like the World Health Organization (WHO) and ICN and from the ANA Code of Ethics.

These strategies are grounded in *ethical multiculturalism* (Crigger, Holcomb, & Weiss, 2001), the belief that universalism and multiculturalism, two different philosophies that underlie ethical decision making (Berlinguer, 2004), can often be accommodated in given contextual situations. For example, parents in Honduras often keep children out of school because of the cost of uniforms and books and because the children work to make money for the family. It is common to see 7- or 8-year-old children removing large boulders from the road all day to make a small wage. From a universalist perspective, this practice is a violation of human rights; yet from a multicultural view, it is culturally acceptable. From an ethical multiculturalist view, both responses are inherently correct and both can be accommodated; for example, one solution would be to supplement the family's income so that the child could have books and uniforms for school. Several programs have been set up in developing countries across the world that do what this example suggests.

Although the authors' experiences are limited to Honduran populations, other developing nations share similar cultural characteristics, making these strategies broad enough to be potentially transferable to other contexts. For example, poverty, limited education, sexism, and lack of health care are common, to varying degrees, in all nations but are more widespread and severe in developing nations (Begum, 2001; Nussbaum, 2000).

The first section of the work discusses salient elements of global ethics. The second section is devoted to traditional ethical ideals and principles that are particularly applicable to work in developing nations. The four practical strategies are discussed in the concluding section.

ETHICS IN A GLOBAL COMMUNITY

Some ethicists claim that people and governments of wealthier nations lack a moral duty to assist people in developing nations (Singer, 1993). Funds and resources of developed nations are used for their citizens, and few resources are channeled toward needs of the poor in developing countries. Faced with little assistance and few internal government and public resources, people who are born into extreme poverty usually spend their life there; they have no way to transcend it (Benatar, 1997; Pogge, 1998; Ruger, 2004). There is evidence to suggest that the disparity between the wealth of the developed or industrialized nations and the poverty of the developing nations is growing rather than shrinking (Marshall & Koenig, 2004).

However slowly, the worldview of many people of all nations is becoming more global and recognizes an interdependence of the earth and its people (Austin, 2001). There is growing concern and progress toward global equality, reduction of suffering, and promoting and equalizing societal common good. Larger national and international institutions like the WHO, the Pan American Health Organization, The UN Children's Fund, and the World Bank have actively promoted global health care and societal justice for some time (ICN, 2000; WHO, 1978).

In 1978 a historical conference of the major international organizations and 134 participating nations was held. The goal of this conference was to develop strategies to achieve Health for All by the year 2000. The results are published in a landmark document, the declaration of Alma Ata (WHO, 1978). Further work toward defining and meeting these goals are advanced in the WHO Millennium Development Goals and Primary Health Care (WHO, 2005).

Nursing has made advances in recognition of these global issues through international groups like Sigma Theta Tau International and ICN. In addition, special sponsored work like the Arista Conferences (Dickenson-Hazard, 2004) or the Grand Challenges (Hegyvary, 2004) have also brought global health to the forefront in nursing.

Humanitarian assistance may be supported by governmental and political organizations like WHO and UNICEF; however, a large part comes from smaller national and international private secular agencies, such as universities that sponsor educational programs or faith-based organizations. Although well meaning, some of these programs are criticized as poorly coordinated with other humanitarian assistance programs and with the authorities of the communities and countries receiving the services (Drifmeyer & Llewellyn,

2003). In addition, some humanitarian assistance programs may have health care workers who are not adequately trained or who lack cultural sensitivity and/or ethical awareness and do not know how to respond to the new demands made in these novel situations (Donnelly, 2000; Drifmeyer & Llewellyn, 2003; Okeke, Lamikanra, & Edelman, 1999).

THE STARTING PLACE

In this article, the authors address only the last of these three criticisms given in the preceding paragraph. How should nurses work with the underserved populations in developing nations and remain sensitive to their ethical and cultural particulars? Are there practical strategies that help practitioners make more appropriate decisions about their service? As health care professionals who have worked for more than 8 years in Honduras, the authors have established partnerships with private organizations, a city government, and the University of Honduras and conducted four research projects, short-term clinics, educational programs, and seminars (Crigger et al., 2001; Crigger et al., 2004). Guidelines from global and professional organizations and traditional moral theory have shaped our practice.

TRADITIONAL ETHICAL THEORY

There are guiding ethical ideals or principles that can be useful when working in developing nations. These ideals or principles include (a) the common good, (b) beneficence and nonmalevolence, (c) respect for persons, and (d) universalizability.

The Common Good

According to political philosophy and ethical theory, the role and end of a just society is to work toward the common good for all within as well as for the good of each individual (D. Miller, 2003; Nussbaum, 1998). So individual and society are inextricably joined in actions that impact them both. Some actions may help the individual but be detrimental to the society or vice versa. For example, use of newer, broader-spectrum antibiotics, rather than older antibiotics, may cure an individual of a respiratory infection but also may hasten the development of antibiotic resistance in a community (Garrett, Baillie, & Garrett, 2001). Thus, the impact that working with individuals or communities has on society as a whole is an important consideration. The question one must ask is: What effect does this action have at other levels of society?

Beneficence and Nonmalevolence

Beneficence and nonmalevolence are well-established deontological principles (R. W. Miller, 2004; Volbrecht, 2002). Simply stated, nonmalevolence is to do no harm, and beneficence is to do good. For example, in clinics, the authors

are increasingly concerned about informing people of particular treatments they are given. In Honduras, as in many developing countries, large numbers of people seek care. As nurse practitioners, the authors struggle with whether or not people are sufficiently informed of proper use of the treatments or medications prescribed. For example, treating a person with a medicine for scabies may also cause an allergic reaction. In giving most any medication or treatment, there is a possibility of causing harm. Therefore, use of a particular drug or treatment should be considered in view of its benefits and possible harm. Does giving the client the medication do more harm or more potential harm than good? Does the possible allergic reaction outweigh the good that the medication will do in eradicating the scabies?

Respect for Persons and Autonomy

The phrase “respect for persons” has a long historical development and is viewed differently by bioethics and traditional ethical authorities. In bioethics and the health care setting, respect for persons typically translates into autonomy and ability to make authentic consent for treatment or research. However, the ANA (2001) Nursing Code of Ethics clearly advocates the primacy of human dignity as a much broader concept: “A fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity and human rights of every individual” (p. 7). Thus, the nursing conception of dignity and respect, as expressed by the ANA Code of Ethics, is much broader than the bioethics interpretation of dignity as autonomy and consent.

The idea of dignity and inherent worth is enriched and predated by the Kantian view of dignity afforded to human beings. Kant believed that everything in the world had either a price or was afforded dignity. Everything with a price can be brought to market and sold. Dignity, quite the opposite, is the intrinsic value placed on someone for whom no price can be set and who cannot be bought and sold. For Kant, dignity was a moral worthiness given to human beings because human beings are able to make choices (Kant, 1785/1964, II, 77-79, pages 102-103). To paraphrase the Kantian well-worn phrase: Moral value and dignity demand that one never use other human beings as means to gain an end but only as ends unto themselves. To say this in common parlance, a person does not “use” a person to get something else.

A good example of using people to meet ends is the great debate currently being waged in the global ethics arena over selling body parts (Berlinguer, 2004; Marshall & Koenig, 2004). The poor from developing nations sell various tissue or organs, such as kidneys, for money. Some authorities believe that the sale of body parts is a violation of the Kantian “ends rather than means” principle—if selling body parts is a violation of the Kantian interpretation, then selling body parts is a violation of their dignity and respect as a person. Yet others claim that this practice is an autonomous

decision and people should be allowed to sell their body parts if they so choose. In either case, this problem illustrates the desperate conditions of the poor in developing nations who are willing to be exploited by the wealthier peoples of the world. Exploitation is evident because the donors suffer the physical stress of a major surgery, potential long-term complications, and, not infrequently, death to sell a kidney for less than US\$2,000 (Berlinguer, 2004).

Universalizability

Another important element in ethical decision making relates to the categorical imperative or what more recently has been called universalizability (Sinnott-Armstrong & Timmons, 1996). Universalizability is the logical belief that a person should make laws or rules that apply to anyone given the same situation. As Kant (1785/1964) claimed, “We must be able to will that a maxim (principle) of our action should become a universal law—this is the general canon for all judgment and action” (p. 91). Nurses often use the universalizability principle to determine the ethical acceptability of choices and ultimately the care of patients. A nurse might say, “I treat my patients the way I want to be treated if I were requiring care.” With this statement, the nurse is saying that he is applying the same standard to others as he is applying to himself. In the case of working with developing nations, research on populations in developing nations has long been criticized for not using standards that are equitable with standards used for protection of human subjects in developed nations. A recent movie, *The Constant Gardener*, artistically illuminates the problem of abuse and exploitation when some people are treated as less valuable than others. In addition, participants in research are often not given fair benefits from participation (Hastings Center, 2004).

STRATEGIES FOR HEALTH CARE

Praxis in Honduras has been an unfolding process of becoming more sensitive and more ethically responsive. The strategies represent what the authors have learned through the literature and through personal experience with other nurses who are active or are considering work in developing countries.

Before the authors engaged in health care efforts in Honduras, they considered how to approach a culture in which they had little knowledge. As professional nurses, they decided that the primary goal was to promote and protect the health of communities with socially oriented strategies as well as treat individuals. The authors’ goal was to achieve a more inclusive health change. Four ways of thinking about service and the people served were condensed into four short phrases that can be easily recalled. The authors include these ways of planning along with the traditional moral theory and guidelines from organizations when making decisions. The

four strategies are (a) revealing ignorance, (b) reverencing the culture, (c) refraining from harm, and (d) reducing biomedical and cultural ethnocentricity.

Revealing Ignorance

Health care providers may lack knowledge of the culture, and this lack can lead to misunderstandings (Donnelly, 2000). Unfortunately, much of the existing literature encourages readers to become "culturally competent" as if one outside of a culture is capable of understanding another culture given study and exposure. Our experience has been quite the opposite: The beliefs that one has about becoming "competent" in another culture may oversimplify the complexities of that culture (Nussbaum, 1997). During the course of the authors' work in Honduras, their understanding of the culture continues to grow, but they do not believe that "culturally competent" is an outcome but rather a dynamic ongoing process. As outsiders, any individual is only capable of understanding parts of another culture, no matter how much exposure one has to it. It is as though one is given puzzle pieces that fit together to make a coherent understanding of another culture but, as an outsider, pieces remain missing. One is in a constant process of fitting pieces together but will never find the right fit for all the pieces. On the other hand, people who are born into a culture are able to fit the pieces into a unified and reasonable whole. In other words, the entirety of their beliefs and actions are congruent—their world and how they interface with that world makes perfect sense to those who are from that culture.

Sachs and Tomson (1992) have claimed that any culture is a complete and logical system in itself; however, to someone outside the culture, the beliefs and behaviors may appear to be irrational. This was certainly true of the Hondurans. Even now, after more than 10 years of involvement in Honduras, the authors have limited understanding of the culture. But they realize that the Honduran culture makes perfect sense to the Honduran people they encounter. The authors accept the fact that they are in a dynamic process of piecing together an understanding of the culture and who these people truly are. With their work in Honduras, each exposure to the culture brings them closer to understanding. However, in terms of revealing ignorance, the authors recognize and value the set-apart nature of the culture.

Reverencing the Culture

Failure to acknowledge and work with the existing culture and its health care system is identified as a barrier to work in other cultures (Parfitt, 1999). Reverence means to act in respect (*Webster American Heritage Dictionary*, 1981). Many of the major public health issues encountered in Honduras were beyond the abilities of the authors to change. Although health care providers can encourage changes and educate the people with whom they work, the

authors do not have the ability to implement the sweeping social changes needed to address significant public health issues such as unsanitary water, overcrowding, or waste removal. The authors had to accept the public health limitations in the country and at the same time respect the culture for the services that were provided.

The Hondurans for whom the authors provided care often value Western health care as superior to their own. This preference is a well-documented response by developing-nation populations (Okeke et al., 1999). In these situations, the cultural values and beliefs are discounted and marginalized; there is a reduced sense of empowerment and the individual becomes empowered only by realignment with the preferred values and beliefs of the developed nation. In a developing nation, empowering by adopting a Western biomedical approach presupposes that there are resources available to meet the needs of the health care recipients (Salas, 2005). Therefore, the selection of what can economically be a standard for one nation may not be a feasible standard for another. In other words, providing Western biomedical care for people in developing nations may cause people to abandon their own traditions in favor of an ideal that is not available to them.

Reverencing the culture means that one works with communities with whom they partner and respect their values and norms. In the authors' situation, the community involved as an active participant. The authors met with leaders of the community and worked to jointly bring service to a particular community. Establishing a partnership encourages the continuity of care for the people for whom service is provided. Patients who required follow-up were referred to the community leaders or health care providers in the area. For example, a case of suspected sexual abuse of several preadolescent girls in one family was referred to the community leader who knew the family and follow-up took place through the church. Obviously the standard practice of what is done in the United States was not possible in this situation. In this case, the authors sought advice from their Honduran partners, who responded to the abuse situation with interventions that were traditional and appropriate for that culture.

Refraining From Harm

An important element to providing care is to be non-malevolent or to avoid harm, as described (London, 2005). Nonmalevolence, or doing no harm, may be overshadowed by beneficence such that the nurse does not equally consider the burdens and benefits of the service provided. In other words, nurses and other providers may get so caught up in giving that they ignore the potential harm that might occur from their actions.

There are controls to help reduce the potential for harm, and nurses should be aware of the positions of international agencies who address health care in all nations. WHO is the largest international organization in international public health. WHO

has been given authority through the UN charter to serve as the “directing and coordinating authority” on international health (Taylor, 2004). In 1997, the World Bank Committee published their study of the Honduran health care system and recommended a number of ways to improve the public health care system in Honduras (World Bank, 1997). Among the recommendations were the rational use of medications and use of the essential-medications framework to assure more economical and better access to safe and efficacious medications.

In a recent WHO study, researchers found that one third of the global population does not have access to full and effective medications needed to treat pathological conditions. The Millennium Development Goals (WHO, 2004) include adaptation of essential medication. The essential drug lists for each country is limited to no more than 300 known medications that are needed to satisfy the health care needs of that particular country or population. WHO or other global agencies work in collaboration with each country to establish a list of essential medications for that country. By limiting the number of medications known to be efficacious, the cost and availability can be more assured, and there is evidence to support that essential drug lists are working in practice (Ratanawijitrasin, Soumerai, & Weerasuriya, 2001).

In the authors’ practice, the essential-medications list for Honduras is used when selecting medications for the pharmacy during short-term health care work. In addition to the essential drugs, consideration is given to the ability to provide continuity of care and avoidance of bringing drugs that have potentially harmful side effects. Another consideration is drugs that must be taken long term for chronic conditions must be available through the health services in Honduras. Regarding medication management, the authors established the following guidelines:

1. Educate the individual on nonpharmaceutical management of the condition first. Provide written information. Often there are so many people seeking care that this essential care is marginalized or omitted.
2. Limit treatment of drugs for chronic conditions and require follow-up.
3. If a condition requires follow-up, give the medication only if the individual commits to seeing a health care provider for follow-up.
4. Administer medications that will be available in that country (based on the essential-drugs list) before we give a limited supply of the medication (WHO, 2003).
5. Take no drugs that are inappropriate for the country. For example, the authors never take anti-lipid medications. Instead, information about diet based on the foods available in the community is given to the patient.
6. Use drugs that are on the essential drug list. For example, often newer antibiotics are available through the drug representatives, but because developing nations have a greater potential risk for antibiotic resistance than do developed nations, newer drugs are not appropriate to use. In addition,

there are established clinical guidelines for prudent use of antibiotics.

7. Avoid irrational prescribing. A desire to help may result in overprescribing. The strategies of “what if” or “just in case” were recognized as irrational reasoning that clouded prudent decision making about medication choices (Hogerzeil, 1995). One way to avoid harm through irrational prescribing is to consider and internalize the WHO (2002) definition of rational prescribing: “Patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community.”

Reducing the Biomedical and Cultural Ethnocentricity Threat

Western biomedical traditions are considered advanced when compared to others (Parfitt, 1999; Salas, 2005). This superior ethnocentric view might be imposed on developed country’s beliefs and attitudes about health and health care. This shift from traditions within a culture to adapt beliefs and attitudes of Westernized health care has the potential to be good and bad. Cultures can adopt external ideas too quickly, and it can be harmful. On the other hand, cultures may resist adopting and be harmed by not adopting a view quickly enough (Berlinguer, 2003; Pellegrino, 1992). Care in a developing nation is often a disservice because U.S. standards of care cannot be met in developing countries. The attempt to replace the traditional health care with Westernized health care is only temporary and at times may be more harmful than beneficial.

Antibiotic use in developing nations is a good example of both harm and good. The benefits are self-evident. Many people have been cured of diverse illnesses because of antibiotic treatment. However, antibiotics are not innocuous; there may be significant complications and side effects (Crigger et al., 2004).

In 1998, 13% of the Honduran national budget for health paid for medications and of that 13%, 3% to 4% was used to purchase antibiotics (Secretaria de Salud, 1998). The 3% to 4% reflects the public health care costs and not the private health care sector use, which is probably greater. Although the country has laws to restrict sales of prescription drugs, the laws are not enforced. Anyone in Honduras can go to a pharmacy without a prescription and purchase antibiotics. Inappropriate antibiotic use is a greater tragedy in developing nations than in other wealthier nations because it diverts the extremely limited resources of a very poor country from other much-needed areas.

The authors are conducting research to gain a better understanding of the rural communities’ view of health and illness and of their traditional treatments. The strategy is one of merging the health practices and bringing the most beneficial practices from another culture while preserving the valuable traditional treatments.

SUMMARY

Professional nurses and nurse educators are increasingly serving the underserved in developing nations. The authors have worked in Honduras and through experience, the literature, and reflection have developed a way of addressing difficult decisions to be more culturally sensitive and ethically appropriate.

First, the authors do not subscribe to multiculturalism or universalism as absolutes but rather adapt a moderate view, *ethical multiculturalism*, that accommodates both views as they apply to given situations. The established principles of ethical theory, WHO policies and statements, and the ANA Code of Ethics are essential to making decisions about service and should be balanced with ethical principles of the common good, beneficence and nonmalevolence, respect, and universalizability. The authors suggest four practical strategies to use when providing service, developed through praxis and the literature that promote cultural and ethical sensitivity.

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