

Incorporating Intersectionality as a Paradigm in Nursing Education: Why don't we act on what we know?

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“One of the core functions of 21st century education is learning to learn in preparation for a lifetime of change” (David Miliband, 2003)

The practice of nursing is situated within a societal context that brings forward issues of equity as well as considerations of equality and inequality. In understanding health challenges at individual and collective levels, nurses are obligated to focus on social justice which is defined by the Canadian Nurses Association (CNA, 2010a) as “the fair distribution of society’s benefits, responsibilities, and their consequences” (p. 10). Further, the 2008 Canadian Nurses Association code of ethics emphasizes that nurses must remain cognizant of the relationship between social justice, health and well-being and therefore should “recognize that some people have limited choices because of social, economic, geographic or other factors that lead to inequities” (p.21 vii). As part of this understanding, the code suggests that registered nurses should advocate for change in systems and societal structures. Developing student knowledge of systems interaction and societal structures that influence health is complex, important and demanding for all. The inclusion of intersectionality concepts in a population health course with third year Bachelor of Science in Nursing students provides a learning opportunity toward developing diversity practice, policy awareness and potentially future action.

What we Know

Change, as discussed by Choby and Clark (2014), is an implicit, important and circular consideration in both health and illness circumstances that raises underlying questions for health care professionals seeking improved health outcomes. The provider response, however, has most often led to individual care interventions that largely focus on risk behaviours and consequently miss the importance and effects of the inter-related social world on wellness. Multiple intersecting factors encourage a focus beyond the immediate in looking at structures and systems, appreciate margins and address social and policy change (Mason, 2000).

For some time now, it has been recognized that the future of nursing depends on the ability of the discipline to address the health needs of diverse populations and marginalized groups. As a result a sustained theme in the literature is the need for health care workers to be responsive to the linguistic and cultural diversity of their patients/clients (Burgess, Reimer-Kirkham, & Astle, 2014; Hanson, 2010; Wilson, et al. 2012). In addition, the composition of the nursing work force itself in many countries has become increasingly diverse as a result of globalization (Giddings, 2005; Davis & Tschudin, 2008). Accordingly, nursing has focused on examining and promoting respect for different cultural beliefs and values (Burgess, Reimer-Kirkham, & Astle, 2014); however, perhaps this response has been insufficient.

The approaches taken include transcultural nursing which is based in anthropology, cultural competency which focuses on the acquisition of skills, and cultural safety as a relational approach that was developed by a Maori nurse in New Zealand (Nursing Council of New Zealand, 2011). Cultural safety was developed as a critical lens to identify inequities and oppressive practices and broadens the scope of diversity by including “...age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability” (Nursing Council of New Zealand, 2011, p. 7). Cultural safety requires a reflective, relational approach in which nurses seek to understand the diversity within their own cultural reality and its impact on others who differ from them in any way. The Canadian Nurses Association suggests that the promotion of cultural competence and safety is a way to address social justice (CNA, 2010b). Despite these efforts, there is a tendency within nursing pedagogy to replicate essentialist understandings of culture and diversity (Gregory, Harrowing, Lee, Doolittle, & O’Sullivan (2010). This creates a static view that does not address the social, political, and economic dynamics that influence the diversity and the construction of culture (Burgess, Reimer-Kirkham, & Astle, 2014; Gregory et al. 2010). In addition to diversity and cultural considerations exploratory, developmental and an ongoing deep understanding of the professional self, both for nursing students and educators, is an important journey within this context.

The forces of globalization have introduced changes that place us in a post-multicultural era of rapid change and unprecedented demographic complexity in both rural and urban areas; Boccagni, 2015; Meissner & Vertovec, 2015; Phillimore, 2015; Vertovec, 2010; Wessendorf, 2014) highlighting the need for health care provider inquiry and potential adaptation. What has emerged from recent global trends is “super-diversity”, referring to the fact that people are moving in unprecedented numbers and bring with them resources and experiences from multiple places in their everyday interactions with other people and social structures, but also to increasing intra-group heterogeneity (Phillimore, 2004; Vertovec 2007, 2010) Boccagni (2015) notes that a focus on diversity offers an opportunity to examine issues of social disadvantage and exclusion, such as class, age, gender, disability, sexual identity or legal status, in other words a focus on the complex relationships between people and their social worlds. There is a need for an overarching framework to assist nurses in knowledge development and to inform practice regarding issues of social injustice and health inequities. Further, “There is a need for coherent theoretical frameworks that help to explain the dynamic interrelationships among the social and biological determinants of health, including processes of human resilience and vulnerabilities, causal pathways, and cumulative effects of circumstances and risks over the life cycle” (Tudiver et al. 2004, p. 12, quoted in Hankivsky & Christoffersen, 2008, p. 274).

It has been documented that nurses are well positioned to be leaders in raising awareness about and taking leadership in reducing disparities because they operate at the intersection of “the ‘personal and political’ (Reutter & Kushner, 2010; Smith, 2007). Cathy Crowe, a Toronto street nurse who works with and advocates for the homeless stated: “Throughout our history, it has been nurses who, after witnessing injustices, spoke out. They

responded with words, with research, with action, with the development of programs, with legal action, and with new policy proposals” (Crowe, 2006, p.5).

Why Intersectionality?

An understanding of the ways in which social location affects individuals and communities can enable nursing practice to become more efficient and caring (Pauly, MacKinnon & Varcoe, 2009). Within this context, Van Herk, Smith, & Andrew (2010) emphasized the necessity for nursing as a discipline to examine its own social location with respect to power inequities within the profession and in interactions with individuals and communities as well as understanding the social locations of those clients. This is in keeping with the Canadian Nurses Association which noted that societal contexts are constantly changing and thereby influence practice (Canadian Nurses Association, 2008, 2010). As Boch (2010) stated, an intersectionality approach can shift the paradigm of being culturally competent towards an understanding of, and critical examination of, the complex social, political, economic, historical, and geographical contexts that affect the health of individuals and communities. In other words, it explicitly focuses on the complex interactions of the root causes and social determinants of health and inequity and the resulting experiences of inequality and power. (Hankivsky, 2014; McPherson & McGibbon, 2010; van Mens-Verhulst & Radtke, 2006). However, an application of intersectionality requires a conceptual shift in the way we view and understand social categories and how they impact individuals and communities (Viruell-Fuentes, Miranda, & Abdulrahim (2012).

Inquiry for Learning

Through our BScN program, students learn about intersectionality in our population health course. The introduction of an intersectionality paradigm in third year is intended to facilitate a broader understanding of the interaction of multiple determinants of health within a population health context while continuing to acknowledge the individual context.

Citizenship concepts are also introduced from a historical perspective early in our population health course providing a focus on wellness and fostering examination of responsibilities and relationships including reciprocity within and between societal structures such as family/kin, market, state/government and community. The rights and duties offered by the citizenship designation influence all societal structures including associated governance practices that define access and influence identity and belonging and hence wellness (Jenson, 2009). The inclusion, exclusion and social justice issues profiled by Jenson in her discussion of citizenship emphasize the influence of these societal structures, provide historical perspectives in enlightening our 21st century challenges and perhaps the rationale for continuing to take action on the two population health goals, improving the health of populations and decreasing health status inequities, outlined by Health Canada (2001). Hankivsky & Christoffersen (2008) discuss, in depth, the need for further exploration, connection, interrogation, and action on the determinants of health related to inequities.

Students bring a very basic understanding of the social determinants of health (SDOH) introduced in their first year. The SDOH can be understood as the social conditions which people experience over their life spans which are shaped by the distribution of power, money, and resources at global, national and local levels and are influenced by choices in policy (Srinivasan & Williams, 2014). Unfortunately, understanding tends to be focused on learning reducible categories (Hankivsky & Christoffersen, 2008). This is partly due to the predominance of lifestyle/behavioural discourses in health care and the idea that individuals are solely responsible for their health. Application of an intersectionality paradigm would enable nursing students to critically examine the ways in which the SDOH and their related policies are at the root of inequities. An understanding of the context of individual and community health situations should result in care that is more sensitive and understanding and an intersectionality paradigm offers a perspective that can enhance nurses' ability to alleviate and prevent the effects of inequities through direct care as well as through advocating for healthy public policy (Reutter & Kushner, 2010; Smith, 2007).

As yet, there is no unified, comprehensive, way to operationalize intersectionality in research or in practice (Hankivsky, et al. 2010; 2014; Hulko, 2009; Van Herk, Smith, & Andrew, 2010). With our students, we used the intersectionality wheel diagram developed by the Canadian Research Institute for the Advancement of Women (CRIAOW) as a tool to introduce a basic understanding that intersectionality includes everybody and that it opens up a multilevel, multidisciplinary space (Simpson, 2009; Van Herk, Smith & Andrew, 2010). The intersectionality wheel demonstrates that the approach takes into account the micro, meso, macro levels of analysis as it is comprised of a series of four concentric circles. The broad social categories such as gender, race and class are included along with socially constructed influences that are dynamic, flexible, and grounded in historical and geographical location (Caiola, Docherty, Relf, & Barroso, 2014). The innermost circle of the wheel represents an individual's unique circumstances of power, privilege, and identity. The second circle represents aspects of identity, such as citizenship status, housing situation, age, class, occupation. The third circle represents different types of discrimination that can impact identity such as ethnocentrism, racism, ageism, transphobia. The outer circle represents the larger forces and structures that reinforce exclusion, such as historical forces, educational system, colonization, legal system, and globalization. Students are expected to reflect on their own understanding of context or crossroads, paying attention to time and space (Hankivsky, 2014) and to discuss their findings with other students. They are expected to apply a critical reflective approach taking into account previously learned course content on equity/inequity, exclusion/inclusion, social determinants of health, and care ethics. Working with the wheel, demonstrates that people cannot be reduced into separate, distinct categories but are products of the intersections of myriad influences and it highlights the fact that privilege and oppression can be experienced simultaneously.

Student Perspectives

A community clinical practicum provided the students with an opportunity to apply and further explore the intersectionality paradigm. The practicum involved concurrent placements with a community agency and with a public health nursing unit. The students completed a project with the agency that focused on a particular population. In seminar, the students completed a questionnaire about their experiences. The following are some student responses to questions about their understanding of intersectionality.

“interactions reinforce each other; everything connects.”

“different environmental (contextual) aspects can have a “layering” effect, when considering inequity. These include social, political, economic, cultural (etc.) contexts”

“helps us study the relationships among multiple dimensions and modalities of social relationships and subject formations”

“a person’s unique circumstances, aspects of identity, larger forces and structures(e.g. globalization)”

“deals with issues of oppression and privilege and what the values and beliefs are for different socioeconomic groups and how these can influence their health determinants”

“As health care providers we have to realize that every client is going to have unique circumstances and needs. There may be differences in ability, education level, cultural safety, etc. We must be reflexive and responsive to these needs.”

“It allows a more holistic, comprehensive and meaningful nursing process. The community nurses’ role involves analysis and incorporating social determinants of health into our practice. Health is integrated within all contexts such as social, political, economic, and cultural.”

Within our nursing program it is an explicit requirement that students engage in reflective practice and reflexivity. It is expected that nurses will reflect on practice and use this information to inform future actions and behaviours and that they will question their own attitudes, habitual actions, and complex roles in relation to others (Clarke, 2014; Maestre, Szyld, del Moral, Ortiz, & Rudolph, 2014; Rolfe, 2014; Thompson & Pascal, 2012). This fits well with intersectionality for, as Hankivsky (2014) noted, intersectionality requires reflexivity.

What we noticed in the student reflections and application of intersectionality to their projects, was a shift in language use. It is clear that in taking an intersectional approach, traditional categories of language use are no longer effective (Lanehart, 2009). In their descriptions of their field placement experiences, it is evident that the students are becoming aware of power structures, structural inequities and opportunities for change. There is a shift from the ethno-focal perspective that tends to predominate in health, a move away from individual, culture-based frameworks to approaches that focus on the intersections of multiple

influences on health outcomes, as recommended by Van Mens-Verhulst & Radtke (2006). For example, the intersectionality approach creates awareness in a student that an individual's identity as a disabled person might be stronger than their identity as an immigrant and that the crossroads for individuals and groups are unique and dynamic.

Discussion

The concept of intersectionality prevails in a boundary space between observation, academic thought and political activism and can be described as essential to illuminating thinking, understanding context, and addressing the dynamics of power from a variety of perspectives including research, practice and education (Mason, 2000; Van Herk, Smith & Andrew, 2011). Fulfilling the responsibilities society allocates to professionals in policy and practice roles requires evidence informed support for change. As such, the tenets of intersectionality are continuing to evolve (Dhamoon, 2011). Dhamoon portrays this as indicating an openness to reflection and inquiry which assists in providing an active learning space for third year nursing students. An intersectionality paradigm and associated concepts reveal the complex and changing struggles of social life in a vivid way. An exploration of these struggles and challenges can enable nursing students to further appreciate the influence of the determinants of health on wellness, and may provide a place of discovery or insight into population challenges as well as opportunities for change. These insights hold promise for assisting students to reflect on, design, and evaluate population-based interventions. They also prompt them to be alert to healthy public policy opportunities that arise when the importance of an issue is sufficiently recognized for action (Raphael, 2014).

In introducing the perspectives offered by intersectionality a third space for learning seems to be created where students can further explore the determinants of health. Third space discussion denotes a location for shifting relationships, for example between learner and teacher. This is a space where transformation can occur, an opportunity to take risks in order to facilitate the development of something new and different (Stevenson, & Deasey, 2005). Van Herk, Smith, & Andrew (2011) discuss the opportunity to explore and address power relations evident in care environments and with care providers. Striving to provide better care and ultimately best care, including influencing healthy public policy, is identified in the Canadian Nurses Association, National Commission Report, A nursing call to action (2012) as a priority.

Intersectionality concepts are discussed within our policy and community themes. These are two of our four Healthy Populations course themes along with population health approaches and epidemiology in our health studies course. The intent in fostering an intersectionality discussion at two points in the course is to provide an opportunity to explore intersectionality concepts related to multilevel policy linked to inclusion and exclusion with high priority populations. In addition, discussion within the community theme considers privilege, stigma and oppression from an intersectionality perspective related to high priority, vulnerable or invisible populations through the triple jeopardy of gender, poverty, race (McGibbon & Etowa, 2012). From there, asset based community development, capacity building and

community organizing approaches in promoting wellness and change are explored. The photograph “Measure of a Woman” created by Rosea Lake (2010) is shown by permission of the author to illustrate and explore gender and race intersections related to assumptions that can quickly move to bias and on to marginalization through social views. As Hankivsky & Christoffersen stated: “Intersectionality encourages a contextual analysis that probes beneath single identities, experiences and social locations to consider a range of axes of difference to better understand any situation of disadvantage” (p. 276).

In the CNA position statement, Leadership in nursing (2009), nursing leadership is described as being about critical thinking, advocacy, and action. Critical thinking with intersectionality as the catalyst may enable advocacy for best care including healthy public policy sponsorship or profile raising in what is now being called healthy political science (Kickbush, 2013) thereby promoting action on what we know. Kickbush (2013) identifies “The challenge for health promotion at the beginning of the 21st century is to reinvent itself and address the key determinants of health requiring a new mental map and different theoretical base” (p.ii).

Exploring intersectionality in a population health course provides a critical thinking space for opening up positive relationships as well as exploring identity and context considerations in care provision. Intersectionality provides a world view that fosters inquiry and insight into practice and policy development facilitating ongoing action on what we know. Perhaps the global world demands action of us as educators, guiding critical thinking toward sustainable action in a global context. Action on diversity begins at home.

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