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Striving for Health Equity Through Nursing Education: A Critical Examination of Non-traditional Community Health Placements

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Abstract

The use of non-traditional community health placements is common in undergraduate nursing programs; however, we know little about how these initiatives impact partner organizations or equity-denied communities. Based on our experiences as nursing faculty who facilitate these placements, we critically reflect on whether students can advance the health equity agendas of our partner organizations. Using the political economy of health inequities, we discuss how biomedicalism and neoliberalism shape and constrain our students' work and identify potential harms created by this approach. Furthermore, we link non-traditional community health placements to our current political economy to determine who benefits from this model of nursing education. Finally, we identify strategies to mitigate these harms by critically reflecting on our practice and committing to more equitable partnerships.

KEYWORDS: political economy of health inequities, non-traditional community health placements, biomedicalism, neoliberalism, health equity

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Community health nurses (CHNs) in Canada partner with individuals, families, communities, and populations to achieve health equity and social justice by working in settings outside of the traditional healthcare system of hospitals and urgent care centers (Community Health Nurses of Canada, 2019). Health equity means all people have the resources and opportunities necessary to achieve their full health potential and are "not disadvantaged by social, economic and environmental conditions" (National Collaborating Centre for Determinants of Health, 2023, p. 2). Health equity is a prerequisite for social justice, which aims to create just social, political, and economic structures that promote participation and respect and is conceptualized as a moral imperative for nurses (McGibbon & Lukeman, 2019; Yanicki et al., 2015). Of particular importance for CHNs is recognizing that equity-denied populations experience intersecting and often compounding vulnerabilities based on social class, gender, race, and other group membership statuses, resulting in their marginalization, oppression, and social exclusion (Baxter et al., 2024; Yanicki et al., 2015). To achieve health equity for these populations, CHNs must advocate for changes to the structural determinants of health while building community relationships to strengthen grassroots initiatives (Baxter et al., 2024; McGibbon & Lukeman, 2019).

Undergraduate nursing education is essential in supporting student development in the knowledge, attitudes, and skills necessary to engage in this challenging work (Schofield et al., 2022). However, the theory-to-practice gap in community health nursing education is well established, with some researchers suggesting there is a need to improve the quality of community health (CH) clinical placements to align with the Canadian Association of Schools of Nursing (CASN) *Guidelines for Quality Community Health Nursing Clinical Placements for Baccalaureate Nursing Students* (CASN, 2010; Pijl-Zieber et al., 2015; Schofield et al., 2022). Recently, we (two of the authors of this discussion paper) piloted an initiative for undergraduate nursing students enrolled in their CH placement, where we partnered with organizations that work with people who are experiencing homelessness and use substances. In these non-traditional settings, we engaged in both direct and indirect supervision of our students, moving between supporting student groups placed at three different organizations spread across our city each clinical shift.

Our reason for pursuing partnerships with these organizations was based on our belief it is necessary to work with communities that are marginalized to provide high-quality clinical experiences that allow students to engage in praxis, linking concepts such as health equity, social justice, and the structural determinants of health to their nursing practice (Cohen & Gregory, 2009; Schofield et al., 2022). Recognizing many people with lived and living experiences of substance use and homelessness report negative experiences with the healthcare system, we also hoped our partnerships with these organizations might increase student empathy, leading to better care and improved health outcomes (Rajab et al., 2023; Ramsay et al., 2019). Additionally, as nurses who have worked in our city, Lethbridge, Alberta for many years, we felt our initiative might provide additional capacity to organizations through our students' work and the specific health knowledge they bring.

From our perspective, this initiative appears to meet course outcomes, relevant provincial and national entry-to-practice competencies, and CASN criteria for CH placements, while aligning with our program pedagogy and philosophy and promoting student empathy and understanding of health inequities. However, given the relative power and privilege we and our students hold as members of the nursing profession, we worried about the impact our CH placements might have on our partner organizations and the people who access their services, given the unique vulnerabilities that exist in our community. Like other Canadian cities, ours struggles with housing availability, and the number of people experiencing homelessness has risen by over 200% in recent years (City of Lethbridge, 2022; Lethbridge Housing Authority, 2023). Additionally, the complex link between housing and substance use means 80% of people experiencing

homelessness in Lethbridge also report a substance use issue (City of Lethbridge, 2022; Milaney et al., 2021). Taken together, the people we work with in downtown Lethbridge experience intersecting and compounding vulnerabilities, often resulting in poor health outcomes.

As nurse educators dedicated to addressing health inequities within a curriculum grounded in a commitment to social justice, we must reflect upon the ethical implications of our presence and our students' practice when working with community organizations. To explore our CH placement through the lens of power, this discussion paper utilizes the political economy of health inequities as a critical theory. The political economy of health inequities establishes that public policy, programs, and initiatives shape access to the social determinants of health, and policymaking exists within the context of racist, sexist, and classist economic and political structures leading to significant health inequities that reinforce existing social relations (Harvey, 2021). As such, the political economy of health inequities is well suited to identifying power imbalances that inform programs and policies, highlighting who wins and loses from exploitive practices (Harvey, 2021; Raphael & Bryant, 2019).

This materialist understanding of the root causes of health inequities also acknowledges how the political economy shapes dominant discourses related to health, such as biomedicalism and neoliberalism (Friel et al., 2021; Raphael & Bryant, 2019). Similarly, a political economy perspective can also challenge prevailing assumptions about the nursing profession, namely that it is inherently beneficial, apolitical, or ahistorical (Foth et al., 2017). Therefore, in this discussion paper, we will challenge the notion that students in non-traditional CH placements can address health equity using a critical political economy lens before turning to strategies that may address the potentially exploitative nature of university and community partnerships. First, to understand the ethical issues that may arise from non-traditional CH placements, it is essential to contextualize trends in nursing education.

Background

CH placements have traditionally been located at public health and home care sites where students work directly with RNs (Dietrich Leurer et al., 2011). The phenomenon of non-traditional CH placements, including those without direct RN presence in settings with the capacity to advance health equity, coincided with the adoption of a baccalaureate degree as an entry-to-practice requirement for the nursing profession, leading to an influx of students required to enroll in CH clinical placements in the early 2000s (Dietrich Leurer et al., 2011; Duncan et al., 2020). Although the trend towards non-traditional CH placements is often attributed to a lack of traditional CH placements, it has also been suggested that the move represents a commitment to finding innovative clinical settings that allow students to address the social determinants of health and promote health equity by working with communities experiencing marginalization outside of the health sector (Cohen & Gregory, 2009).

The most reported measure and justification for non-traditional CH placements in the published literature is their impact on student learning. According to Snyder et al. (2022), engaging in street outreach and similar experiences has the potential to improve nursing students' perceptions of CH clinical experiences and prepare them for community and public health nursing practice. Cohen and Gregory (2009) and Reimer-Kirkham et al. (2005) suggest clinical placements in non-traditional settings can provide students with the "real world" experience necessary to bridge theory to practice. However, others have challenged this assumption, suggesting the theory-to-practice gap persists in non-traditional CH placements, with students feeling unprepared to practice as CHNs (Pijl-Zieber et al., 2015; Schofield et al., 2022). In addition to promoting knowledge development of community concepts, non-traditional CH placements can challenge students' biases and assumptions, reducing stigmatizing and discriminatory attitudes (Gardner & Emory, 2018; Laliberte et al., 2017; Richmond & Noone, 2020; Snyder et al., 2022; Zeien et al., 2021). Experiences in non-

traditional community settings are also thought to enhance the skills necessary for safe and competent nursing care, including improvements in therapeutic communication, harm reduction, and referral to community resources (Bishop et al., 2021; Doran et al., 2020; Richmond & Noone, 2020).

Despite the positive impact non-traditional CH placements are reported to have on student learning and professionalization, little is known about how these placements impact partner organizations. Research suggests non-traditional CH placements are beneficial as nursing students can complete the work organizations may be unable to do and bring knowledge and energy that may be beneficial (Doran et al., 2020; Gardner & Emory, 2018; Laliberte et al., 2017; Reimer-Kirkham et al., 2016). Despite these positive findings, Reimer-Kirkham et al. (2016) highlight the increased time and attention nursing students require from community partners in light of students' ongoing skill development, potentially creating a barrier to staff working directly with community members.

The limited literature relating to the impact of non-traditional CH placements on partner organizations is problematic. Additionally, we are unaware of any published literature that investigates how students placed in non-traditional CH placements address health inequities through their work. However, given the colonial history of nursing and nursing education that has caused significant harm to people who experience marginalization, including Indigenous communities, it is essential our profession critically reflect on our practice and take action to prevent further damage (Symenuk et al., 2020). In the following sections, we reflect on our experiences as facilitators of non-traditional CH placements through the lens of the political economy of health inequities to theorize ways in which we may cause harm.

The Political Economy of Non-Traditional Community Health Nursing Placements

Maintaining the Status Quo

The political economy of health inequities highlights the ways in which actors interact with ideologies, such as biomedicalism and neoliberalism, that work to maintain the power and influence of dominant sectors of society and contribute to health inequities and poor health outcomes (Friel et al., 2021; Raphael & Bryant, 2019). Biomedicine situates the cause of poor health within the body and, therefore, privileges individualized interventions, such as health education and pharmaceutical treatments, at the expense of actions that target our current political economy (Baum & Fisher, 2014; Harvey, 2021). This occurs despite evidence of the limited effectiveness of these approaches in addressing health inequities, as health is closely linked with the quality of material conditions (Baum & Fisher, 2014). Concerningly, the dominance of biomedical interventions obscures how political and economic structures shape the conditions in which poor health arises, potentially depoliticizing calls for social change (Friel et al., 2021). Despite these critiques, biomedical hegemony persists in nursing education and practice despite recent efforts to integrate concepts such as health equity and social justice into nursing curricula (McGibbon & Lukeman, 2019; Schofield et al., 2022).

Despite our intentions, our CH placement did not diverge from the status quo of biomedically privileged interventions. Although we understand these individualized and decontextualized strategies are largely ineffective as they fail to target the root causes of health inequities, the reality of the partnership and academic schedules prevented much of the time-consuming and difficult work needed to create structural changes. Due to the short length of the placements (16 hours a week for 12 weeks), students were primarily involved in downstream interventions, such as distributing safe substance use supplies, facilitating health education, and providing basic first aid. These interventions can be beneficial and are an essential aspect of nursing work; however, they

do little to address health inequities that arise from poor policy decisions. For example, while our students educate community members on good hand hygiene, staying hydrated in the warm weather, and preventing frostbite, public policies create conditions where people experiencing homelessness in our city have little access to the clean water, sanitation facilities, or homes necessary to adopt these behaviours consistently. In addition to the short length of student placements, it is true that despite meeting entry-to-practice competencies, our students are only beginning to form the advanced skill set necessary to facilitate the political, legal, and social action necessary to address the structural determinants of health. Unfortunately, we recognize that the nursing student's work contributes to the perception *something* is being done to support people who use substances or experience homelessness in our city while failing to advance an agenda that would support social change.

The focus on medical and behavioural approaches in our clinical experience and the nursing profession, more broadly, should also be situated in relation to neoliberalization. Neoliberalism is an ideology and practice of reducing government interference in the market, including resisting public policies that would redistribute power, resources, and opportunities to reduce health and social inequities (Baum & Fisher, 2014). A key neoliberal policy response is the reduction of government spending, making it more difficult for people experiencing marginalization to access healthcare and requiring increased self-management of health concerns (Kusdemir & Oudshoorn, 2023). Kusdemir and Oudshoorn (2023) suggest nurses have "often become the unintended champions of neoliberalism, those assigned to constrain the use of public resources, the gatekeepers of the public purse" by privileging downstream approaches to complex social problems (p. 41). As such, neoliberalism has an important impact on nurses' interactions with communities that experience marginalization and stigmatization for their "unhealthy behaviours," potentially deeming them unworthy of quality care (Hardill, 2019; Kusdemir & Oudshoorn, 2023).

Although we reinforce the importance of the material drivers of poor health in our clinical course, we echo others who have noted a significant gap between theory and practice in non-traditional CH placements, where students learn about health inequities but do not necessarily engage in activities that would address them (Pijl-Zieber et al., 2015; Schofield et al., 2022). Without acting on the structural drivers of poor health, our nursing students may hold the people we work with accountable for their failure to adopt healthier behaviours following their brief interventions. For example, our students help educate people who use substances on how to use more safely, including advice not to use alone, in a city where they now lack access to supervised inhalation services (the preferred route of consumption for people in our community) and are therefore limited in their ability to implement this harm reduction strategy. In turn, the people we work with, who are already intensely discriminated against, may feel increased feelings of shame when they receive health education from nursing students and then are unable to adopt new behaviours (Rajab et al., 2023; Reilly et al., 2022). As stigma is now understood as a key determinant of health, nursing students acting primarily through individualized approaches instead of structural ones may exacerbate existing health inequities rather than reduce them.

The Burden of Non-traditional Nursing Placements

In part due to the persistence of largely ineffective biomedical approaches in our CH placements, it is unclear, and in our opinion, unlikely, that our students address health inequities despite our best intentions. At the same time, our students require the attention, mentorship, and support of our partner organizations. Although staff were not tasked directly with the supervision, assessment, or evaluation of our students, large class sizes mean we, as faculty, often engage in both direct and indirect supervision of our students, moving between sites to provide each student group support throughout the day. The result is that staff serve as important mentors to our students, often using their own expert understanding of

key community health concepts to encourage students to make connections between theory and practice and to achieve course outcomes while we attended to our other student groups. This support represents a substantial amount of uncompensated labour, and we are concerned this additional burden might impede their work, potentially reducing their ability to meet the needs of the people they work with. For our partner organizations, the extra labour created by hosting CH placements may be particularly problematic when it is common for staff to have lived or living experiences of substance use and homelessness and be employed in precarious, poorly paid positions (Jones, 2022; Kolla et al., 2024; Olding et al., 2021). As the unregulated drug poisoning crisis has escalated, burnout, grief, and trauma responses have been increasingly reported, with harm reduction workers suggesting they lack access to essential workplace supports (Kolla et al., 2024; Olding et al., 2021).

Furthermore, the community organizations we work with are often under-resourced and face significant political resistance across governmental levels to implementing evidence-based strategies to address the harms associated with substance use and homelessness. For example, the AIDS Outreach Community Harm Reduction Education and Support Society, which operated the supervised consumption site in Lethbridge and served as an important partner for our CH clinical course, was defunded by the Government of Alberta in 2020 (Salvalaggio et al., 2023). Since then, support and funding for harm reduction services have been precarious, with our partner organizations reporting the service provision landscape related to substance use and housing is constantly evolving (Salvalaggio et al., 2023). Therefore, the additional demands placed on community organizations, which are sometimes already significantly strained, may prevent them from achieving their organizational goals (often tied to funding) as they relate to health equity.

Despite the increased workload on staff to support our students, we commonly hear from our organizations that they *want* to partner with our nursing program. Partner organizations report they want students to understand the discrimination and violence the people they work with experience in hopes the next generation of nurses might be more empathetic and inclusive and less racist, classist, sexist, and stigmatizing than those of the past. Our hope is the same, and frequently throughout the semester, students report transformative experiences. In reflective journals, students say their assumptions have been challenged, they recognize the racism many people experience, they identify the limitations of biomedical interventions, and they understand the need for redistributive policies, such as social housing, to improve health outcomes. Many speak to the ways in which the semester has changed their approach to nursing, shifting away from thinking about illness in a way that is devoid of the social, political, and economic context in which it arises. As others have noted, these are important outcomes to support nursing students' readiness to practice effectively as CHNs (Cohen & Gregory, 2009; Schofield et al., 2022).

However, we worry there may be unintentional harm to community members from our students' learning. Although our program is becoming more inclusive, the students are predominately white and most often have some degree of socioeconomic privilege, reflecting both the profession's and postsecondary institutions' colonial and racist tendencies (Stake-Doucet, 2023). At the same time, Indigenous people are disproportionately represented in the unhoused population we work with, meaning many of the interactions that challenge the assumptions and stereotypes of students and potentially improve the student's future care are with Indigenous people (City of Lethbridge, 2022). Although sharing one's story may be cathartic, we have witnessed the people we work with experience significant distress as they disclose experiences of violence, trauma, discrimination, and racism and receive little from students in return, given that students are not equipped with the tools necessary to address such disclosures. As such, the balance of benefits between students and the people they work with can be highly unequal, lending further concerns about the potentially exploitative nature of non-traditional CH placements in nursing education.

Who Benefits from Non-traditional CH Placements in Nursing Education?

In addition to interrogating the belief that student placements are inherently beneficial to our community partners, the political economy of health inequities is well suited to examine who wins and loses from non-traditional CH placements (Raphael & Bryant, 2019). As demonstrated above, the clearest beneficiaries of non-traditional CH placements, such as ours, are the nursing students who gain valuable perspectives, experience, and skills, which we hope will improve their future nursing practice. However, nursing programs and postsecondary institutions also benefit, as the reliance on community organizations to support students in non-traditional settings may allow for larger class sizes than would normally support student learning and ensure safe practice. In our program, faculty members are typically assigned 12 students in CH placements, compared to eight students in acute care settings, despite requiring the same amount of faculty labour (approximately eight hours of student supervision per shift). The ability to offer our CH clinical with fewer sections conservatively saves our program the expense of one full-time faculty member's salary each year. The cost savings of increased class sizes can help some institutions weather neoliberal austerity policies, such as in our province, where postsecondary funding has decreased by 31% in the last five years (Usher, 2023). Additionally, larger class sizes are one strategy to address the shortage of nurse academics, who commonly report job dissatisfaction due to heavy workloads and a lack of administrative support (Boamah et al., 2021). As such, some postsecondary institutions have benefitted from the exploitation of community organizations and the people who access them as they continue to offer programming with fewer and fewer resources.

The necessity for non-traditional CH placements can also be traced to policy decisions within the healthcare system. There have been reports, prior to the COVID-19 pandemic, that across Canada, public health nursing, and public health more broadly, have experienced a decline in authority, funding, and capacity for addressing structural determinants of health (Guyon & Perreault, 2016; Kirk, 2020). Although public health funding increased during the COVID-19 pandemic, the majority of health spending continues to be directed to acute care facilities (Duong & Vogel, 2022). Additionally, the overall nursing shortage in Canada, due in part to additional pressures and worsening work conditions, has, in our experience, resulted in fewer nurses and traditional CH sites willing to support our students (Baumann & Crea-Arsenio, 2023). The need for some nursing programs to utilize non-traditional CH placements as a strategy to graduate larger classes of nursing students to meet workforce demands allows provincial governments to continue austerity measures guided by neoliberal ideology in both the healthcare and postsecondary systems. Subsequently, governments can position themselves as being fiscally responsible to the general public and dominant sectors of society as they attempt to maintain power through the election cycle while failing to adopt economic policies that would equitably redistribute wealth and resources. As such, those who profit from the status quo of neoliberal governance may also benefit from non-traditional CH placements.

The continued promotion of biomedical and individualized health interventions creates significant ethical concerns with non-traditional CH placements, as provincial governments, universities, and students appear to benefit the most from these partnerships. Despite this, it seems unlikely, given our current political economy, that there will be sufficient growth in the number of traditional CH placements, meaning some programs will continue to rely on community organizations for their support of nursing students. Therefore, we believe it is imperative that nurse educators and postsecondary administrators critically reflect on non-traditional CH placements and take all actions necessary to mitigate potential harm.

Calls to Action

We suggest CASN's (2010) *Guidelines for Quality Community Health Nursing Clinical Placements for Baccalaureate Nursing Students* are a logical starting point for committing to

more equitable partnerships between nursing programs and community organizations and would supplement CASN's (2020) *Accreditation and Standards Framework* that requires evidence of a joint evaluation of clinical placements between nursing programs and community partners. The guidelines should also align with CASN's (2014*) Entry-to-Practice Public Health Nursing Competencies for Undergraduate Nursing Education*, ensuring students "promote and protect health" when collaborating with community partners (p. 13). Updated guidelines may prompt more transparent dialogue between nurse educators and community partners about the potential burdens associated with supporting nursing students and ensure that placement agreements between nursing programs and community organizations clearly outline roles, responsibilities, and the scope of nursing student work as it relates to health equity. Additionally, CASN's (2010) guidelines should provide concrete strategies for mitigating the potential harms of non-traditional CH placements, including ensuring faculty members have the time and resources necessary to provide sufficient support to students.

Nurse academics should conduct research that would fill in existing gaps in the literature by investigating the impacts of non-traditional CH placements on community partners and people who experience marginalization through a health equity lens, and we plan on contributing to this body of knowledge in the future. In the meantime, we should continue to unsettle dominant discourses in our profession through critical engagement with our nursing practices. It will be necessary for students and colleagues who witness violence and oppression in their practice to acknowledge our moral responsibility to address social injustices, recognizing our positions as social and political actors (Kusdemir & Oudshoorn, 2023; McGibbon & Lukeman, 2019). To do so, we must continue to find ways to close the theory-to-practice gap by implementing innovative teaching strategies that build student competencies that would support them in raising awareness of how the political economy creates health inequities and intervening to advance structural changes. Knowledge translation and political advocacy activities such as creating infographics or policy briefs are strategies to increase these skills in nursing education. Additionally, strengthening student skill sets in engaging with social organizing, including through our own labour movement, would support praxis (Buck-McFadyen & MacDonnell, 2017). It is also essential for educators to critically reflect on the cost student learning outcomes may have for community members and consider how other educational interventions, such as virtual simulation, may achieve similar results with less risk of harm (Plotzky et al., 2021; Schofield et al., 2023).

Nurse educators and university administrators should commit to unsettling power relations by ensuring the expertise of community members is respected and decision-making is shared equitably (McGibbon & Lukeman, 2019). Having a dedicated and knowledgeable CH clinical facilitator may be one strategy to ensure more equitable partnerships with community partners. Importantly, postsecondary institutions should provide reasonable compensation to organizations for the mentorship and support of nursing students and cover any incurred costs related to the placements. Compensation is especially important for community partners, such as many harm reduction organizations, who commonly employ people who experience marginalization, aligning with calls from advocacy groups to respect the expertise of people with lived and living experiences of substance use and homelessness (Touesnard et al., 2021). Lastly, faculty members and university administrators must be vocal about the impact reductions in postsecondary and public health funding have on their ability to support students in developing the skills necessary to address the structural determinants of health.

Conclusion

CHNs have a moral obligation to address health inequities, and nurse educators have the critical task of preparing students to do this work effectively (McGibbon & Lukeman, 2019). We must continue to support our students in

developing the skills necessary to truly engage in praxis, where reflection and dialogue can lead to concrete action that resists the status quo and addresses health inequities through structural changes. However, there is a risk that if nurse educators do not critically evaluate the burdens we may place on our communities, we will model to our students a complicity in the maintenance of our current political economy rather than a genuine commitment to health equity. The first step in engaging in more equitable partnerships is to reflect on our practice, recognizing how power and influence shape policy decisions, including those made in postsecondary and CH settings. The next step is to mitigate potential harms while continuing to draw attention to how oppressive and exploitative systems and the people who benefit from them create and sustain health inequities.

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