A Black Feminist Study of African Nova Scotian Nurses and Their Leadership in Healthcare

By

Keisha Jefferies

Submitted in partial fulfilment of the requirements
for the degree of Doctor of Philosophy

At

Dalhousie University
Halifax, Nova Scotia
April, 2022

Dedication

For my daughter, Tatiana.

Table of Contents

List of Tables

List of Figures

Abstract

Introduction: African Nova Scotians (ANSs) are a culturally distinct and resilient people who have endured historical and contemporary hardships yet have persisted and succeeded in exceptional ways. Currently, little is known about African Nova Scotian (ANS) nurses; however, available literature suggests that ANSs are underrepresented as health practitioners, particularly in nursing. Addressing this knowledge gap warranted an examination of ANS nurses and their leadership experiences. This dissertation includes a series of manuscripts that situate Black nurses in Canada before presenting the focal qualitative study that critically examined the leadership experiences of ANS nurses in healthcare practice.

Methods: This study was guided by the theoretical underpinnings of Black feminist theory. Data collection involved one-on-one semi-structured telephone interviews with eighteen ANS nurses. Eligibility criteria required participants to be a regulated nurse and to identify as ANS. Data, in the form of interview transcripts, were analyzed using the analytical framework of Critical Discourse Studies. Specifically, the analysis involved the interrogation of three structure levels – namely the discursive, social, and cognitive.

Findings: Study findings are presented in three overarching sections: 1) African Nova Scotians as a Distinct People 2) Institution of Care and 3) Leadership Philosophy and Practice. Each section contains conceptual themes and subthemes, which together, provide a comprehensive understanding of factors that influence the leadership of ANS nurses. Section 1 revealed how formative aspects of ANS identity influenced leadership philosophy and practice. Section 2 involved the interrogation of the nursing profession and the healthcare system as social structures, which are implicated in the [re]production of power dynamics. Finally, Section 3 presents the conceptualization of the leadership philosophy and practice for ANS nurses.

Conclusion: This study presents insight into the ways in which ANS nurses perceive and practice leadership. Leadership, which was deeply rooted in a community-oriented approach to care, was regarded as an integral component of nursing practice. Understanding and integrating ANS nurses and their knowledge into practice has implications that extend beyond nursing. These findings include significant considerations for the advancement of community health and healthcare. Finally, this study contributes to the ongoing work of reclaiming ANS identity.

Glossary and Definitions

ANS	African Nova Scotian
APN	Advanced Practice Nurse
BFT	Black Feminist Theory
CAN	Canadian Nurses Association
CRC	Combahee River Collective
IB&M	Indigenous Black and Mi'Kmaq Initiative
LPN	Licensed Practical Nurse
NP	Nurse Practitioner
NSH	Nova Scotia Health
PLANS	Promoting Leadership in health for African Nova Scotians
PTSS	Post Traumatic Slave Syndrome
RN	Registered Nurse
SON	School of Nursing
TYP	Transition Year Program
UN	United Nations
US	United States

African Nova Scotians (who also self-identify as Indigenous Black, Africadian, Afri-Scotian or Scotian) are descendants of free and enslaved Black Loyalists, Black Refugees, Maroons and other Black people who were settled across 52 indigenous (original) land-based Black communities.

Ancestry refers to the ethnic background or lineage of a person.

Identity is a socially constructed concept that refers to how people perceive themselves, independent of their ancestry.

Anti-Black Racism is the specific form of prejudice and discrimination that manifests in the policies, practices and decisions that knowingly or unknowingly reinforce discriminatory beliefs and attitudes towards Black people.

Black Tax is a socially constructed concept that refers to the mental, physical, emotional and spiritual burden that Black people are forced to negotiate as they navigate institutional and spaces or interact with people.

Class is a socially constructed concept that refers to the system of ordering of a society whereby people or groups are divided based on perceived or actual social or economic status.

Ethnicity is a multidimensional dynamic concept that includes aspects such as race, ancestry, identity, language and religion. Ethnicity also includes more subtle elements including culture, customs, beliefs and practices, which are subject to change over time. Statistics Canada described three fundamental approaches to measuring ethnicity, which include: ancestry; race; identity.

Gender (Expression & Identity) is a socially constructed concept that includes expressions such as behaviors, roles and identities. Gender expression and identity influences perceptions of selves and others, their acts and interactions, and the distribution of power and resources. Gender identity traditionally included girls, boys, women and men however, gender has expanded to include trans, non-binary and gender queer.

Institutions are stable, esteemed, recurring patterns of behaviors. Integrated systems of rules that structure social interactions. It includes informal institutions such as customs, behaviors or patterns that are valued or esteemed in a society as well as the formal institutions have a mandated permanence in controlling social behaviours.

Nurse includes largest group of regulated health professionals in Canada. Nurses include four recognized designations which are licensed practical nurses, registered nurses, registered psychiatric nurses, and nurse practitioners. Nurses practice is the areas of clinical care, research, education, and administration.

Nursing Leadership encompasses the action, advocacy, and critical thinking that is required to promote change and improve the health of individuals, families, and communities as well as the overall healthcare system. It includes both formal and informal leadership roles since all nurses have capacity to be a nurse leader.

Power is the socially constructed concept that accounts for the capacity of specific groups to control and benefit from the unequal access to resources.

Power Dynamic is a social construct that describes how power affects a relationship between people, groups and structures.

Race is a socially constructed concept that is based largely on genetically or biologically imparted features such as skin color.

Racism is the prejudice, discrimination directed towards a person or group of people based on their membership in a particular marginalized racial or ethnic group.

Sex is the biological attributes found in humans and animal. It is associated with the physical and physiological features related to genetic or biological components. Sex is used to assign female or male however, variation also exist in this classification.

Sexism is the prejudice or discrimination directed at a person or group of people based on their sex or gender.

Sexual Orientation is a socially constructed concept that refers to a person's pattern of emotional, romantic and sexual attraction to other people.

Social Construct refers to the idea that was created and advanced by people in society or particular contexts.

Socioeconomic Status is a socially constructed concept that refers to the social ordering of people or groups based on measuring a combination of factors such as wealth, education, income, and occupation.

Acknowledgements

This dissertation, and my academic journey overall, would not have been possible without the timely, inspiring, and unconditional support of extremely important people in my life.

First, I offer a special thank you to my ancestors, who endured exceptional hardship and courageously forged a path for me to tread. I owe a sincere thank you to my home community and the extraordinary members that raised me. From my basketball and track-and-field coaches, who instilled the value of discipline, structure and hard work, from a young age. To the very few but unforgettable elementary and secondary school teachers, staff and administrators, who guided me through an education system that was not designed for me to be successful. More thanks go to key organizations including the Black Educators Association (BEA) and the Black Business Initiative (BBI), where I developed important life skills including the drive towards professional development and excellence. To the amazing nurses who participated in this study, thank you for trusting me with your experiences, each of you has inspired my own understanding and practice of nursing and leadership.

To my PhD co-supervisors, Dr. Ruth Martin-Misener and Dr. Gail Tomblin Murphy, I cannot thank you enough. Both of these transformational nurse leaders were essential guides in seeing me through the doctoral program. The unwavering encouragement and consistently inspiring words were needed and utilized on a continuous basis.

Dr. Jacquie Gahagan and Senator (Dr.) Wanda Thomas Bernard, my committee members, you have helped me in so many ways. From navigating turbulent circumstances, to offering the most constructive yet challenging insight, as well as simply being available and eager to support me. Thank you.

I would be terribly remiss if I did not acknowledge and thank the three truly brilliant exceptional women, with whom I began my PhD journey. Sydney Breneol, Brianna Hughes and Martha Paynter, I cannot express how grateful I am to have shared such an experience with you. Our time together – both physically and in the heart – is beyond appreciated.

Another truly phenomenal group of women, who came to my rescue in many times of need, include my tribe; my sistas – Crystal Watson, Michelle Patrick and Dr. Barb Hamilton-Hinch. Each of these women has showed up for me in ways that a community does. The personal and professional support paired with endless laughs, good food and even better conversation will always be appreciated.

A special thank you is necessary to my Masters supervisors, Dr. Megan Aston and Dr. Thecla Kohi, who set the foundation for me to excel in the doctoral program. Notably, Dr. Aston was instrumental in my transition and success in the doctoral program. Another thank you is due to Said Msabaha, who gave new meaning to the

word family. Additional people at Dalhousie who encouraged my inner passion for advocacy, policy and institutional-wide thinking include Dr. Kevin Hewitt, Dr. Marty Leonard, and supportive professors in the Dalhousie School of Nursing.

A special thank you to Erin Seatter, who entered my doctoral journey at the best time and provided a type and level of support that brought me to the finish line. And deep appreciation to Jackie Gilby, who supported me – and countless other graduate students – with exceptional coordination and guidance throughout my graduate studies.

Finally, to my family and friends, my sincerest and deepest gratitude to you all for everything over the years. Dr. Amanda Cook, one of my biggest cheerleaders and best friends, thank you from the bottom of my heart. Crystal and Sadie States, your love and kindness over the years cannot be appreciated or recognized enough. To my grandmother, Alice, I thank you immensely for caring for me and making the important decisions that brought me to where I am today. And lastly, I must thank my beautiful daughter, Tatiana, who brought so much joy and balance to my life throughout my doctoral journey.

Chapter 1: Introduction

This introductory chapter provides a succinct overview of this qualitative study, examining the leadership experiences of African Nova Scotian (ANS) nurses, as well as an outline for the format and structure of the dissertation. ANSs are a distinct group of people, within the greater Black population in Nova Scotia, whose experiences in nursing are not well understood. There is a paucity of evidence regarding ANS nurses in healthcare and more specifically, their experiences in relation to leadership. To this end, this qualitative study sought to critically examine the leadership experiences of ANS nurses in healthcare practice. This study was focused on answering the following two questions: 1) What are the leadership experiences of ANS nurses and; 2) How do ANS nurses perceive leadership? Using Black feminist theory (BFT) to guide this study, which involved semi-structured interviews with ANS nurses, data were analyzed using the analytical framework of critical discourse studies (CDS) to generated conceptual themes. In the sections that follow, this chapter outlines the background for this study, the research problem, research purpose and guiding questions, followed by the significance of this research and finally the scope of this study. The chapter concludes with an outline of the format and layout of the remaining dissertation.

1.1 Study Background

African Nova Scotians (ANSs) are a culturally distinct group within the larger Black population in Nova Scotia. ANS heritage and the context of their arrival in Nova Scotia, dating back to the 1600s, as enslaved or "free" people, resulted in a unique experience of Blackness. With approximately 22,000 ANSs comprising approximately 2.4% of the Nova Scotian population, ANSs represent one of the largest racially visible groups in Nova Scotia (African Nova Scotian Affairs [ANSA], 2016). Nearly 72% of ANSs identify as third generation or greater (ANSA, 2016). This is significant, especially considering that ANS communities are understood as one of the oldest, and at one time, the largest congregation of Black people in Canada. Many of the approximately 50 ANS communities located across Nova Scotia served as early settlements, some of which are designated as historic sites and many others remaining populated and active today. The myriad socioeconomic issues encountered by ANSs are the direct result of centuries of colonialism and anti-Black racism in Nova Scotia. For example, high rates of chronic illness have contributed to a notably worse health status for ANSs compared to that of the general population of Nova Scotia. Further, the United Nations [UN] (2017) concluded that racism remains rampant in Canada, particularly in Nova Scotia, and that significant disparities persist in areas of education, health, employment, and housing. Anti-Black racism, which is a term credited to Dr. Akua Benjamin, is defined as the policies, practices, decision making and systemic processes, embedded throughout the fabric of Canadian institutions, which result in discriminatory treatment towards Black people. As anti-

Black racism is known to permeate multiple sectors of society – from education, labor, justice, and health, growing research indicates how anti-Black racism compromises health.

Addressing anti-Black racism in healthcare – and the successive harms that ensue – requires practitioners who are competent, invested in change and are in positions to instigate systemic reform. Nursing is one of the most populous and regarded as one of the most trusted professions, and nursing is one of the more prevalent health practitioner groups in healthcare. Leadership is a basic entry-level competency and standard of practice in nursing practice. It is understood that all nurses, despite their level of training, have the capacity to be a nurse leader. Whether through formal or informal leadership practices, nurses have the ability to effect widespread advancement in healthcare. Nurse leaders are capable of challenging health inequities and disparities through their knowledge and skills, by influencing health policy, shifting practices, and contributing to the transformation of the larger healthcare system. Despite progressive advancement by nurses in healthcare, there is a historical legacy within the profession that has limited expansion to its full scope. By restricting access to the nursing profession, to only those who embodied the Victorian ideals of "true womanhood" Black women were effectively prohibited from entering the nursing profession (Flynn, 2011). Flynn (2011) found that Black women were deliberately excluded from entering and practicing nursing in Canada (Flynn, 2011). Black women in Canada, who wanted to pursue a career in nursing, were prohibited from doing so until the 1940s (Flynn, 2011). Instead, Black women who desired to pursue a career in nursing were instructed to train in the United States (US), where Black women were permitted to attend nursing training facilities in the 1870s. Myself and other scholars who conduct critical social research in nursing, recognize the insidious implications and present-day impacts that this anti-Black legacy holds. Acknowledging these historical transgressions, actively addressing anti-Black racism is current practice, and ensuring the representation and inclusion of individuals [and voices] who have been historically excluded from nursing and leadership is vital in order to advance towards enhanced health and wellbeing for ANSs as well as the larger population.

1.2 Knowledge Gap

The limited existing evidence indicates that there is an underrepresentation of ANSs in the nursing profession, specifically in leadership roles. Beyond this, the current body of literature does not adequately capture the significance of ANS ancestry for ANS nurses and their leadership experiences. Unsurprisingly, much of the literature pertaining to a general understanding of Black nurses emerges out of the US, which has an extensive history of Black scholarship and social programs directed towards the advancement of the Black population. The acknowledgement and consensus regarding the existence of slavery in the US has enabled successful attempts to address past transgressions, through strategies including the establishment of institutions

of higher learning to foster and grow Black scholarship, such as Historically Black Colleges and Universities (HBCUs) as well as widespread Black-centric organizations. Unfortunately, a similar understanding of the deeply engrained nature of anti-Black racism in the fabric of Canadian society remains an issue of contention. Blatant denial and failure to acknowledge Canada's own historical transgressions has led to extensive gaps in literature and in our collective knowledge regarding Blackness in Canada – not to mention considerable disparities in socioeconomic and health outcomes.

Though evidence regarding Black nurses in Canada is being uncovered and generated, there are still large gaps in understanding that persist. As is revealed in the literature review chapter, existing Canadian literature focuses largely on the experiences of Black immigrant nurses, in larger more diverse metropolitan regions such as Ontario, Canada. This literature is extremely insightful and necessary to complete our full understanding of Black nurses in Canada. However much of the existing literature fails to account for the diversity and heterogeneity that exists within the Black population in Canada. The literature review chapter also shows gaps in the methodological approach within this body of literature as there is currently no qualitative or quantitative studies that examine the historically situated group of ANS nurses. Yet, there are three foundational studies, each of which included participants who identified as ANS. However, these brilliant works did not focus exclusively on the ancestral component of Blackness. To this end, this qualitative study attempts to begin to fill this gap.

1.3 Research Purpose and Questions

The purpose of this qualitative study was to critically examine the leadership experiences of ANS nurses in healthcare practice. Guiding questions in qualitative research help to narrow the focus of the study and offer additional direction for the inquiry in question. Thus, the guiding questions for this qualitative study were:

1. What are the leadership experiences of ANS nurses?
2. How do ANS nurses perceive leadership?

1.4 Research Significance

This research offers insight into how ANS nurses are instrumental in addressing health inequities and disparities to improve health outcomes for individuals, families and communities. Beyond the significance of this work in nursing and healthcare, this study holds tremendous significance for ANSs. By serving as a historical record of sorts, this dissertation adds to the growing information that validates and situates ANSs as a distinct people. To this end, not only is this research significant as it begins to address a knowledge gap in nursing, leadership and Canadian history, this research contributes to ongoing work to reclaim aspects pf ANS identity.

1.5 Study Scope

The scope of this study is restricted to a critical social investigation of the leadership experiences of ANS nurses. This study employs BFT and CDS to interrogate power dynamics within nursing and healthcare. This study had minimal budget and any costs were covered through scholarship funding, internal departmental awards, and supervisory support. Finally, a significant portion of this study occurred during the first two years of the COVID-19 pandemic, which had an impact on several components of the study.

1.6 Dissertation Layout

This dissertation is a compilation of manuscripts and short excerpts. The manuscripts included in this dissertation have either been published in or submitted to peer-reviewed journals. They include a combination of theoretical, discursive, commentary and research manuscripts. To facilitate navigating this dissertation, there are several sections throughout this dissertation that provide information introducing and situating the manuscripts. This dissertation begins with the *Personal Location* (Chapter 2), which includes one manuscript. Next, the *Background* (Chapter 3), which provides context for the study, contains two manuscripts. Following this, the *Literature Review* (Chapter 4) contains two manuscripts. The theoretical and conceptual frameworks are situated in the *Philosophical Underpinnings* (Chapter 5), which includes three manuscripts. Thereafter, the *Methods* (Chapter 6) provides a comprehensive overview of the process used to conduct the qualitative study that constitutes the crux of the dissertation. This then leads into the *Findings* (Chapter 7), which contains one umbrella manuscript and three overarching conceptual sections. Rounding out the dissertation and giving meaning to the findings, the *Discussion* (Chapter 8) contains one manuscript and several important subsections that tie together the findings. Finally, a *Conclusion* (Chapter 9) summarizes the dissertation in entirety.

Chapter 2: Personal Location

As a doctoral student conducting qualitative research, it is essential to position myself – as the researcher – by presenting a brief account of my personal and professional values and experiences in an attempt to reconcile how these experiences shape my perspective and worldview. Situating oneself is necessary in research as it allows readers to further understand how the researcher, as a tool, impacts the research (Creswell, 2013). Additionally, this locating of self will guide the reader and facilitate an understanding as to where my ideas, experiences and interpretations originate as well as understanding the motivation for the research. The action of situating oneself, through a personal location, extends beyond a simple description of our theoretical and conceptual frameworks. Situating ourselves usually includes information that reveals how the researcher came to invest themselves in a particular topic or phenomenon in addition to offering insight into all aspects of the research process including selecting the paradigm in which we conduct research, identifying and constructing research questions, and the choice of methods. This chapter begins with a sharing of contextual aspects to help situate an understanding of my approach to research as well as myself as the researcher. This is followed by a manuscript that builds upon this description. The manuscript, which is a scholarly personal narrative, offers additional insight into my worldview and how I operate as a researcher.

2.1 Situating the Self

I was born and raised in New Glasgow, Nova Scotia, which is a town located 160 kilometers outside of the provincial capital, Halifax. New Glasgow is one of the more-than 50 ANS communities located across Nova Scotia. I was raised in a single-parent home by my maternal grandmother, from infancy. I am the first in my family to complete high school, pursue post-secondary education, go on to pursue graduate education and a professional career. Throughout my early years, I did not see many Black people in affluent sectors of society. In my town, it was rare to see Black teachers, healthcare providers, lawyers among other professional careers. For example, growing up, there was one Black physician, who was well-known and greatly admired by the community. There were few, if any, Black nurses.

In addition to my ANS heritage, I have been a registered nurse in Nova Scotia since 2013. After completing high school, I moved to Halifax, where I obtained a Bachelors of Science (Biology) degree from Mount Saint Vincent University. I then completed the Baccalaureate nursing degree at Dalhousie University in 2013, after which I obtained a permanent full-time staff nurse position in the neonatal intensive care unit (NICU) at the IWK Health Centre. After practicing for two years, where I developed a keen interest and passion for research and health policy, I decided to pursue graduate education. In 2015, I enrolled in the Masters of Nursing – Health Policy Practicum at Dalhousie, where I completed a health policy analysis of breastfeeding

practices in Tanzania. I gained a tremendous amount of experience in research, health policy and nursing practice throughout my Masters degree, under the supervision of Dr. Megan Aston (Halifax) and Dr. Thecla Kohi (Dar es Salaam) while working in Tanzania, as a research assistant. Following the completion of my Masters degree in 2017, I enrolled in the doctoral program in the School of Nursing (SON) at Dalhousie. Finally, adding a bit more excitement to my doctoral studies, I welcomed my beautiful daughter, Tatiana in October, 2017, during the first semester of the first year of my PhD.

In addition to my academic work, I have been involved in extensive extra-curricular activities at Dalhousie and in the SON. Some of these activities include committees, working groups, and consultation. Notably, in 2017, I co-founded the *Community of Black Students in Nursing (CBSN)*, which is a peer-led student mentorship group for Black students in nursing. CBSN inspired the launch of similar student-led groups as well as a student equity coalition. CBSN remains active today, under the leadership and direction of a transformative nursing students. I maintain a supportive role with CBSN.

Outside of academia, I am engaged at both the provincial and national level to advance conversations and initiatives, to address anti-Black racism in nursing. Highlights from this advocacy work include serving as a member of the Black Nurses Task Force with the Registered Nurses Association of Ontario (RNAO). In my role as a Task Force member with RNAO, I co-authored two peer-reviewed manuscripts, which describe the mobilization of Black nurses in Canada as well as a descriptive account of the ways in which the Task Force is tackling anti-Black racism in Ontario. I also work collaboratively with the Canadian Nurses Association, researchers and academics.

The following section includes a published scholarly personal narrative that sought to generate meaning from my journey to becoming a nurse leader. The narrative is a self-examination that employed Narrative Inquiry and BFT as guiding methodologies to answer a salient question: *What is the experience of an ANS woman in becoming a nurse leader?* This personal narrative was conducted under the supervision and mentorship of Dr. Sheri Price, who is a Narrative Inquiry researcher. Dr. Price provided mentorship and support through the Nova Scotia Health Research Foundation Scotia Scholars Trainee program.

2.2 African Nova Scotian Grit: A Scholarly Personal Narrative About Nursing Leadership

This work in section 2.2 also appears in: Jefferies, K., and Price, S. (2021). African Nova Scotian Grit: A Scholarly Personal Narrative About Nursing Leadership. *Health Populations Journal, 1*(1), 34-42.

2.2.1 Statement of Manuscript Contribution

KJ conceived and develop this manuscript with guidance and mentorship from SP. KJ drafted the manuscript and SP contributed to the methodological and analytical components of this work. SP approved the

final version of the manuscript and KJ submitted the manuscript for review. Copyright details are located in Appendix A.

2.2.2 Background

Nursing leadership, which involves critical thinking, action, and advocacy, exists within all roles and domains of nursing (Canadian Nurses Association [CNA], 2018). Nurse leaders possess knowledge and skills to inspire and influence both people and systems (CNA, 2018). My journey to becoming a nurse leader is a mosaic of challenge and triumph. As a first-generation African Nova Scotian (ANS) university student, I encountered a series of obstacles in my journey to becoming a nurse leader. From an early age, I was reminded that my race, being Black, was undesirable. I did not realize to what extent this would impact how I understood the world. Moreover, I could not have anticipated how influential race would be in my life, especially in relation to my nursing education. As I continue to grow as a nurse leader, I further understand the significance of racism as a social determinant of health. Anti-Black racism, which includes policies and decisions that oppress Black people, is deeply embedded in economic, political, educational, and health institutions (Carruthers, 2018), including nursing. Additionally, anti-Black racism does not exist in isolation and is thus impacted by ableism and heteronormativity, as well as class and gendered oppression (Carruthers, 2018). My experience in nursing has been shaped by oppression. This article is a reflective exercise that analyzes and shares salient aspects of my journey to becoming a nurse leader.

At this moment, I am a registered nurse, full-time doctoral candidate, activist, and mother. I elected to share my story through a scholarly personal narrative (SPN), which is an approach to writing narratives that emphasizes the significance our lives hold (Nash, 2004). SPNs can tell a thoughtful story offering insight into personal and social realities that are often omitted in conventional research (Nash, 2004). My SPN provides a reflective analysis on my experience as an emerging nurse leader by sharing pivotal moments in my nursing education. I believe that sharing my story serves three purposes: expanding the knowledge base by adding stories that have historically been excluded; sharing narratives that resonate with others; and informing policies to promote recruitment, retention, and representation in nursing and post-secondary institutions. While my SPN emerges from a place of vulnerability, there is healing in speaking one's truth. Thus, I use my privilege as an educated Black woman to speak my truth, generating meaning from my experience, through an SPN. The guiding question for this work is What is the experience of an ANS woman in becoming a nurse leader?

2.2.3 Theoretical Underpinning

The theoretical tenets guiding this SPN are those of narrative inquiry and Black feminist theory (BFT). Narrative inquiry uses stories or narratives to describe how individuals make sense of their experience by

centring the narrative as the fundamental unit of interest (Clandinin, 2007; Polkinghorne, 1988). Narratives describe human experience and provide an account of a sequence of events with intention to provide meaning (Clandinin, 2007). Similarly, storytelling and oral histories are central to BFT, which is a theoretical perspective that encourages an intentional and unapologetic examination of how intersections such as race, class, sexuality, ability, and gender impact people and groups (Collins, 2000; Lorde, 1984). BFT posits that knowledge is contained within lived experience; thus, to know requires [un]learning about the experience of another (Collins, 2000; Lorde, 1984). [Un]learning about experience involves listening to others as they speak their truth. Speaking one's truth is both an act of resistance and an act of healing. hooks (1993) encourages Black women to be courageous and speak their truth through open and honest sharing that goes beyond simply naming "bad" things or exposing horrors. A commitment to this self-work is essential because "there is no healing in silence" (hooks, 1993, p. 16).

2.2.4 Methods

This SPN employs the Ten Tentative Guidelines for Writing SPNs (see Table 1) described by Nash (2004). This approach goes beyond simply recounting a personal story that offers little or no meaning by incorporating methods that are personal and social; practical and theoretical; reflective and public; local and political; narrative and proposing; and self-revealing and self-examining (Nash, 2004). I employed the ten guidelines iteratively throughout the writing process to develop and refine my narrative. Further, I received mentorship from a narrative researcher, Dr. Sheri Price, to conceptualize and create this work.

2.2.5 Findings

The iterative nature of this narrative resulted in an SPN that encapsulates salient moments of my academic experience and development as a nurse leader. The findings of this reflective exercise are presented under two overarching themes with related subthemes. The two main themes are Developing Personal and Professional Identity and Potential vs. Power.

2.2.5.1 Developing Personal and Professional Identity. Porter (2017) explains that identity development for Black women is based on specific interactions that are connected to and influenced by socialization. Dissecting and examining aspects of my identity has proven useful in understanding how I view issues, problem-solve, and advocate for change. The aspects of my identity that will be discussed below include being ANS, a first-generation university student, and a registered nurse.

Table 1

Ten Tentative Guidelines for Writing Scholarly Personal Narratives (SPNs)

1	Establish clear constructs, hooks, and questions
2	Move from the particular to the general and back again… often
3	Try to draw larger implications from your personal stories
4	Draw from your vast store of formal background knowledge
5	Always try to tell a good story
6	Show some passion
7	Tell your story in an open-ended way
8	Remember that writing is both a craft and an art
9	Use citations whenever appropriate
10	Love and respect eloquent (i.e., clear) language

2.2.5.2 ANS Identity. A core aspect of my identity includes being an ANS woman. My ANS identity embodies significant elements of my ancestry in Nova Scotia, which has a profound impact on my nurse leadership and activism. ANSs comprise a community of people within the larger Black community in Nova Scotia, Canada who are descendants of peoples dating back to the 1600s (Whitfield, 2018). Being socialized in a predominantly White environment means that many ANSs were born, raised, worked, and played in spaces that did not welcome or support Black people but rather problematized Blackness. A combination of factors results in an identity, for ANSs, that is both layered and complex and is beyond the focus of this paper. However, despite socialization in an environment that problematizes Blackness, there is deep-seated resiliency, strength, and determination that pushes ANSs to rise against the odds. My ANS identity is further enhanced by my identification as a Black woman. “Being Black” encompasses more than physical features and appearance. Blackness encompasses biological and socio-cultural components as well as a distinct mindset and world view (Carruthers, 2018). This is why many Black scholars, activists, and writers capitalize the word Black when writing about Blackness. Refining this core element of my identity serves as a solid foundation in my nursing leadership. For example, an act as seemingly simple as deciding when to use the term ANS vs. Black is an important decision dependent on contextual factors.

2.2.5.3 First-Generation University Student. Another significant component of my identity that has influenced my nursing leadership is being a first-generation university student. As the first person in my family to complete high school, attend post-secondary education, and pursue a professional career, it would be an understatement to say that I was not prepared for university. The complexity of being an ANS woman and a first-generation student meant that life beyond high school was a mystery. I was unfamiliar with standard university expectations including reading a course syllabus, academic etiquette, and on-campus student services

and supports. Campus orientations were helpful; however, these orientations better served students who had existing knowledge of university processes.

Knowledge gaps about university were compounded by living in an ANS community, where post-secondary education was not the norm. Similar to many ANSs, I was not raised in an affluent community where attending college or university was the norm. Instead, many people in my rural community worked menial jobs or lived paycheque to paycheque. Additionally, I did not have dinner conversations that centred around education or career aspirations. I certainly was not discouraged in these pursuits; rather, conversations tended to focus on more immediate, present-day issues. A lack of career guidance and not seeing myself reflected in higher ranks of society extended into my schooling, where there were few Black teachers or counsellors and even fewer discussions with Black students about future aspirations. Many teachers and staff had low academic expectations for Black students. The absence of early educational advising was countered in large part by Black community members who went above and beyond. Community members, including educators, coaches, and mentors, encouraged us (Black students) and affirmed that we had potential and that we were destined for greatness. Recognizing the implications of first-generation students from ANS communities provides insight for facilitating access and fostering success in post-secondary education.

2.2.5.4 Registered Nurse. Nursing was not a profession that I considered from a young age. As described, growing up in a small rural community, I did not see any Black folks working in health care unless it was in the cleaning or cooking sector. It never occurred to me that I could be a nurse because I did not see Black nurses. You cannot be what you cannot see. And despite not seeing Black health-care providers, I saw a lot of sickness, disease, and caregiving in my family and community. Chronic illnesses including diabetes and heart disease claimed the lives of too many family and community members. The women in my family cared for sick loved ones, both as they aged and when they died. As a child, I saw home care first-hand: bed pans, bed baths, feeding, and other forms of care. I also saw the ways in which my grandmother, great-grandmother, and great-aunts provided care to loved ones. It was competent, intentional, selfless, and loving. Watching these phenomenal women care for loved ones helped me to truly appreciate what it means to care for another. They were not licensed care providers; however, I witnessed core aspects of nursing care from the women in my family.

My interest in science led me to complete a biology degree after high school. Uncertain about career options with a biology degree, I applied to several community college health-focused programs including a medical laboratory technology program before eventually deciding upon nursing. I was drawn to nursing because the program incorporated a robust scientific curriculum in addition to an accelerated program option for

students with science prerequisites. Additionally, my institution of interest offered an entrance scholarship to facilitate access for ANS and Mi'kmaw students. Ultimately, I chose to enrol in nursing for the emphasis on science, the accelerated program, and the renewable entrance scholarship. Becoming a nurse is a culmination of my early childhood experience and interest in science. Witnessing home care first-hand and expanding this knowledge through formal nursing education positioned me to truly embrace the art and science of nursing; I wanted to be a nurse!

2.2.5.5 Potential vs. Power. The theme of potential vs. power expands upon the systemic barriers that exist in post-secondary education. Specifically, this theme depicts the struggle between personal abilities and capabilities with rigid institutional processes. The subthemes of rising to the challenge, twice as good, self-determination, and contributors to success all further describe the work of countering institutional oppressive standards with tailored initiatives and targeted supports that enhance self-confidence, determination, and eventual success.

2.2.5.6 Rising to the Challenge. My undergraduate nursing experience was enjoyable, which I attribute to certain key factors. First, as an accelerated student, I had "university experience," which facilitated organization, balance, and overall success as a student. Second, the accelerated program included a de facto cohort of university-prepared students, which made navigating the program easier. Finally, I completed the program with another cohort of more than ten Black students who, together, built a solid community of support. My undergraduate experience is in contrast to that of my Master of Nursing (MN) program. The ease, confidence, and comfort with which I entered the undergraduate program did not exist at the graduate level. As the only Black student in the graduate program, entering from a position of implied inferiority, I regularly questioned my belonging.

I began the MN program after working at a tertiary maternal, pediatric, and newborn centre. During my clinical practice, I became involved in health policy and research, where I developed a deep appreciation for the ways in which evidence was created and used. My interest to pursue graduate education was supported and strongly encouraged by the research supervisor, who was also faculty within the School of Nursing. With enthusiasm, I began the application process; however, before the submission of my application, I was explicitly told that I did not qualify for the thesis program and that I would only be considered for the course-based or nurse practitioner program. Despite working as a research assistant and showing potential in research, I was told that I could not apply for the thesis-based MN program because my GPA of 3.64 did not meet the 3.7 admission GPA requirement. I did not dwell on this rejection because I was simply excited to be continuing my education.

Months later, I was granted admissions to the course-based program: the program to which I was instructed to apply. I was overwhelmed with excitement to embark on this new chapter of my career.

Admissions to the graduate program would not be my only hurdle in graduate school. After time, I realized that my experience and growing potential was no match for the rigid institutional policies that reinforced the exclusion of Black students. Equally disturbing was the discovery that exceptions, through formal and informal processes, are often made. However, this was not an option for me. Instead, the default to rigid and discriminatory policies were prioritized over my personal attributes, experience, and ultimate potential.

2.2.5.7 Twice as Good. Entering a graduate program as an ANS woman and first-generation university student was no easy feat. Post-secondary education, specifically graduate education, is a privilege that is posited in a way that reinforces inequity. Those who are able to knowingly or unknowingly leverage privilege are more likely to be admitted and succeed. I witnessed and experienced how institutions unfairly place additional burdens on already marginalized students by forcing them into a vicious cycle of needing to be twice as good in order to achieve a fraction of success. To succeed, I had to overcome obstacles that were designed to prevent me from being successful, including restricted admissions, a lack of representative mentors, oppressive curriculum content, stigma, and overt or subtle criticisms of my abilities. The battle to belong goes beyond the default excuse of imposter syndrome. Experiencing institutional racism reinforced by anti-Black policies and decision-making is not the same as doubting whether you arrived at a place by sheer luck. Rather, belonging arises from a belief that you are welcome in a space. Rising to the challenge, time after time, does build character and a supreme level of resiliency. However, it is also an unnecessary stressor that may cause physical and psychological exhaustion. Navigating a space that repeatedly diminishes and dismisses potential and actively attempts to curb success is an all too common experience for many Black students.

An example of this is illustrated by my experience of trying to advocate for equal opportunity. As a course-based MN student, I was not required to take research courses, yet I enrolled in the required thesis courses because I had become passionate about research and was committed to expanding my research knowledge and skills. Toward the end of my first year, I completed the required research thesis courses with a stellar GPA. Recognizing both my interest and potential in research, my supervisor encouraged me to draft a letter to self-advocate for transfer into the thesis program. This inspired me because I felt not only as though my supervisor saw how passionate I was but also that she saw promise in me. So I submitted my request, which was denied. I was told that the program no longer permitted students to transfer into the thesis program. This was disappointing but equally confusing, since the program was normalizing the practice of bridging students from the MN to PhD program. I struggled to understand why non-Black students were identified, selected, and

essentially groomed for success, while Black students were being denied admissions into the program or prohibited from doing a thesis-based MN. Again, despite my potential and experience, I was not permitted to enroll in the thesis program. At the time, I believed that there was a valid reason for why I was being denied this opportunity a second time, despite going beyond my program's expectations. I began to believe that I was inferior and that I did not belong. I have since come to understand that my potential was overlooked and dismissed because of factors beyond GPA and outside of my control. My potential was dismissed ultimately because I did not fit the traditional image of a thesis student.

2.2.5.8 Self-Determination. The struggle to belong as a graduate student regularly challenged my confidence. Despite my effort to "fit in," I felt out of place. I was excelling academically but I still felt as though I did not belong. Ultimately, my perspective began to shift after two pivotal moments: discovering BFT and working in Tanzania. Each of these critical moments enhanced my self-understanding and confidence as an ANS woman. After years of trying to make sense of how I fit into the world, I was suddenly presented with information to which I could relate. Prior to my introduction to BFT, I did not question the status quo; I accepted societal practices, including my own experiences of racism as normal. My Eurocentric education had instilled within me notions of colour-blindness, including the avoidance or dismissal of race and racism. Reading literature by and about Black women was transformative, as it enabled a deeper reflection on my experiences as an ANS woman in education and nursing, while also equipping me with language to articulate and question my experiences.

Travelling to Tanzania and spending three months working at a local university reinforced my growing knowledge from Black feminist literature. After attending a global health conference in 2015, which was made possible by a travel bursary through the Dalhousie Global Health Office (GHO), my passion for global health research was ignited. The GHO was instrumental in my growth as a scholar and this relationship constituted what would become one of the most formative relationships in my graduate education. Accessible travel bursaries and resources for conferences, opportunities in global health work, mentorship, and finally lasting friendships were all elements that accelerated my personal and professional growth. My relationship with the GHO led me to apply for the Queen Elizabeth II Diamond Jubilee Scholarship, which is a federally-funded program that increases the skills of global citizens through international exchange opportunities. This scholarship enabled me to complete my research internship at Muhimbili University of Health and Allied Sciences in Dar es Salaam, Tanzania with a team of Canadian and Tanzanian researchers.

2.2.5.9 Contributors to Success. Completing my master's degree would not have been possible without specific targeted initiatives and supportive individuals. As a first generation ANS university student, I

experienced many of the financial constraints that limit post-secondary education for Black learners including minimal or absent generational wealth, student debt, family obligations, and precarious employment. I was fortunate to receive a scholarship created to support ANS and Mi'kmaw students in graduate studies in conjunction with two named scholarships through the School to cover my tuition and living expenses. Financial assistance in the form of bursaries and scholarships available through dedicated programs was vital. I had accumulated significant student debt from my undergraduate degrees; thus, scholarships alleviated my financial burden and ensured that I could begin and ultimately complete the program.

Financial resources were complemented by supportive individuals and key opportunities for development. For example, the opportunity to strengthen my academic profile through a research internship in Tanzania remains invaluable. Working closely with the team to disseminate research findings through presentations and publications strengthened my research expertise, which continues to inform my nursing leadership. Moreover, working collaboratively and learning from an international research team, with researchers who looked like me, remains unmatched.

2.2.6 Discussion

2.2.6.1 Representation and Visibility in Nursing. Ensuring representation and visibility of historically marginalized groups in nursing is essential. A legacy of assumptions and restrictions in nursing has reinforced the oppression and exclusion of Black folks (Flynn, 2011). These assumptions include the fundamental image of a nurse, nursing education, and the curriculum, as well as the profession in general. Historical imagery of nurses as angels and handmaidens (Price & McGillis Hall, 2014) combined with restrictions based on race, gender, class, ability, and sexuality are in opposition to how Black people were and continue to be viewed (Collins, 2000; Flynn, 2011). For example, the refusal to admit Black students into early nursing training programs (Flynn, 2011) has congealed norms that continue to perpetuate discrimination throughout nursing. Moreover, nursing education has been described as being oppressive to non-White folks by not attending to intersectionality and attempting to maintain an apolitical position (Bell, 2021). These aspects, among others, have contributed to Black nurses feeling disconnected or marginalized within the profession (Etowa et al., 2009).

2.2.6.2 Pipeline to Success. Addressing issues of representation and visibility in nursing is connected to larger educational barriers that inadvertently push Black students to be twice as good to simply be considered. Profound barriers are detected in elementary school, with the school-to-prison pipeline. Increased suspensions, excessive detentions, and implicit bias reinforce the disproportionate streamlining of Black students into programs below their capabilities (Bernard & Smith, 2018; James & Turner, 2017). Too many Black students

are dismissed as lacking potential, subjected to heightened surveillance and unnecessary scrutinization. These actions have long-term consequences as they reduce the likelihood of high school success, thereby limiting options for continued education and career choice (James & Turner, 2017). Likewise, streamlining Black students into course-based graduate programs has lasting academic and employment implications including decreased funding opportunities, stigma, and career stagnation. Thus, anti-racist frameworks in institution policies and decision-making are necessary to create a pipeline to success.

2.2.6.3 The Ivory Tower. Entering and navigating academia, popularly referred to as the "ivory tower," has mental health implications, which are exacerbated by egos, competitiveness, and an elusive work–life balance, among other challenges (Rawlins, 2019). The ivory tower is known to pose unique challenges for Black and Indigenous people and people of colour, whether as students, staff, or faculty. For example, Henry et al. (2017) describe how the under-representation of Black and Indigenous faculty in academia is further strained by work environments that are not equitable, diverse, or inclusive. Growing issues including microaggressions and layered oppression have prompted several institutions to commit to anti-racist initiatives to reduce and attempt to eliminate institutional oppression.

2.2.7 Conclusion

By sharing salient moments from my academic journey to becoming a nurse leader, my SPN offers insight for students, administrators, and decision-makers in nursing and advanced education. As described, I share my story with the intention of normalizing the sharing and inclusion of stories from people who have historically been silenced or restricted within nursing; inspiring others through shared experience; and highlighting persistent barriers in education. Specifically, my SPN elucidates opportunities to address anti-Black racism in academia. For example, challenging restrictive and oppressive admissions processes, improving resource allocation, and committing to positive representation and visibility, are all plausible solutions to position students from marginalized groups for success. The mandate of higher learning institutions should be to cultivate a sense of belonging and create opportunities for the intellectual growth of all students regardless of their circumstance or background.

Finally, this reflective exercise is beneficial in my ongoing nursing practice and activism work. By analyzing pivotal moments loaded with challenges, triumph, self-doubt, and self-determination, I learn more about myself and about the ways in which society works for and against people. Navigating the ivory tower continues to present challenges; however, collaborative efforts with like-minded individuals provide the building blocks to challenge issues, develop sustainable solutions, and transform oppressive norms. My passion

for research, commitment to excellence, and desire to see change is what drives me. As an ANS woman, Black feminist, mother, and nurse leader, I will continue to speak my truth and contribute to change.

Chapter 3: Background

The objective of this chapter is to provide additional context for understanding the research study. The chapter begins with situating Blackness in a global context. It then presents a succinct excerpt regarding People of African Descent in Canada. The chapter then briefly describes literature pertaining to ANSs, including the description of the historical and contemporary socioeconomic factors that impacts ANSs. Following this section, a note about ANS nurses provides a foundation upon which the remaining sections of this chapter rest. The chapter concludes with two manuscripts, which present content on Blackness in nursing. To note, this chapter is structured as such – including content regarding ANSs as well as Black nurses in Canada – for two important reasons. The first is to provide a basic foundation to situate ANSs as a distinct people, especially in relation to the larger Black population of Canada. The second is due to the paucity of literature regarding ANS nurses.

3.1 International Recognition and Situatedness

In 2014, the UN officially declared the years 2015-2024 as the International Decade for People of African Descent, recognizing people of African descent as a distinct group whose human rights must be promoted and protected (ANSA, 2019; UN, 2019). The theme of the 2015-2024 International Decade is Recognition, Justice and Development. The UN estimates that nearly 200 million people, living in the Americas, identify as being of African descent. Building upon this declaration, the UN commissioned a UN Working Group to conduct an investigation into the experience of people of African descent in Canada. In 2016, the UN Working Group visited key cities across Canada, including Ottawa, Toronto, Montreal and Halifax to meet with individuals from multiple sectors, such as community and government (UN, 2017). The Working Group determined that anti-Black racism continues to be rampant in Canada, particularly in Nova Scotia. Additionally, these national consultations unveiled that significant disparities persist in critical sectors including education, health, employment, and housing. In alignment with the International Declaration and the recommendations from the UN Working Group Report, the federal government of Canada – under the leadership of Justin Trudeau – officially recognized The International Decade for People of African Descent in 2018.

3.2 People of African Descent in Canada

In 2016, the number of Black people in Canada was estimated to be approximately 1.2 million people or 3.5% of the total Canadian population (Statistics Canada, 2019). According to Statistics Canada, the Black population was noted to double over a 20-year period, between the years 1996 and 2016. Ontario, the most populous and racially/ ethnically diverse province in Canada, had the large Black-identifying population, at

roughly 627,700 people or 52% (Statistics Canada, 2019). To facilitate understanding the heterogeneity that exists within the Black population in Canada, discussing the generational or ancestry effect is helpful. Statistics Canada provides a comprehensive description of first, second and third generation Black people in Canada. First generation includes those who were born outside of Canada. Second generation refers to those who were born in Canada, who have at least one parent born outside of Canada. Finally, third generation include those who were born in Canada and have both parents who were also born in Canada. At 56.4%, first generation Black people in Canada are the most numerous, followed by second generation at 35% and the third generation group at 8.6% of Canada's Black population. This final group, the third generation, who include the population of focus for this study comprise nearly 72% of the Black population in Nova Scotia. Finally, the composition of the Black population in Canada includes those who immigrated from predominantly Black countries such as Jamaica, Haiti, Cameroon, the Democratic Republic of the Congo and Nigeria (Statistics Canada, 2019).

3.3 African Nova Scotians

ANSs are a distinct group within the larger population of Black people in Canada (Pachai, 1997). The Black population in Nova Scotia is comprised of two main groups within the larger Black community, namely recent Black immigrants and Indigenous Black people – not to be confused with Indigenous Peoples who inhabited turtle island precolonial times (Pachai, 1997; 1991). Black immigrants in Nova Scotia include those who arrived in Canada, as far back as 1981 and who do not necessarily have a significant ancestral connection to the historic land based ANS communities across Nova Scotia (Pachai, 1997; 1991; James et al., 2010). Recent migrants arrive from various places around the world, including but not limited to continental Africa, the Caribbean and the United States (Pachai, 1991; Whitfield, 2018). Whereas Indigenous Black people are understood to be those who arrived in various parts of Canada either enslaved or to escape slavery in the United States (Pachai, 1991; Whitfield, 2018). Notably, Nova Scotia is not the only province with Indigenous Black populations who settled in various historic communities, as historical records indicate numerous settlement sites throughout New Brunswick, Quebec, Ontario and Alberta (Whitfield, 2018). Finally, it is important to note that while there are evolving and continued attempts to distinguish, identify and define Canadians according to their ethnicity and race, this task is highly variable, complex, dynamic and nuanced therefore, discussions of this nature should maintain flexibility.

Nova Scotia is understood as one of the oldest, and at one point the largest, congregations of early Black people in Canada. African Nova Scotian Affairs [ANSA] (2016) states that there are more than 50 ANS land-based communities located across the province of Nova Scotia, some of which served as settlement sites between the 1600 and 1800s. While some of these ANS communities are designated historical sites, others as

contemporary dwellings (ANSA, 2016; Pachai, 1991). Some of the more well-known ANS communities include the Preston township, Guysborough, Digby, Shelburne, Whitney Pier and Windsor. Table 2 depicts the five major metropolitan areas within Nova Scotia and the population of ANSs associated with each (ANSA, 2016).

Table 2

ANS Population in the Nova Scotia Metropolises

Metropolitan Area	Population
Halifax	15,090
Cape Breton	1,105
Truro	855
New Glasgow	665
Kentville	440

There are approximately 22,000 individuals who identify as ANS or as Black in Nova Scotia, comprising approximately 2.4% of the Nova Scotian population (ANSA, 2016). Currently, ANSs represent the largest racially visible group in Nova Scotia, at 37% with 72% of ANSs being three generations or greater (ANSA, 2016). ANSA (2016) explains that ANSs are a culturally distinct groups of Black people in Nova Scotia and this is related directly to their ancestry and the historical context in which they arrived in Nova Scotia. ANSs have ancestral linkages to Nova Scotia dating back to the 1600s when they arrived as slaves or "free" people (Pachai, 1997; Whitfield, 2018). This historical connection is significant as it has resulted in a unique culture, experience and way of understanding and interacting with the world (ANSA, 2016; UN Report, 2017; Pachai, 1997). Additionally, this historical context has contemporary implications, especially in relation to ancestral trauma.

Given the lingering effects of slavery and the contemporary racism that is rampant in social and institutional structures, available data shows that ANSs experience significant challenges and barriers due to discrimination. Oppressive and discriminatory practices are evident in the healthcare, education, judicial and social systems (Pachai, 1991; Thomas Bernard & Smith, 2018). Poorer health outcomes, high unemployment, increased demand for social assistance and lower education only begin to highlight the ways in which ANSs have been and continue to be marginalized in Nova Scotia (Walsh, 2017). Health disparities and inequities are issues that stem from the organization and operation of social and structural determinants of health (World Health Organization [WHO], 2017). Social determinants of health (SDH) are not biological or genetic factors that make accessing and obtaining equitable health and services difficult but rather they are socially constructed

dynamics that systematically oppress and marginalize specific groups (WHO, 2017). The World Health Organization [WHO], (2017) explains that the SDHs, which include income, education, employment, transportation, housing, food security, access to quality healthcare, race, gender and social support, are shaped and exacerbated in large part by the unequal distribution of power, money and resources at various levels of governance.

Regarding the demographics of ANSs, ANSA (2016) describes key indicators related to the status of the ANS community, which include income, age distribution and employment. The distribution of income shows a stark difference between income and employment for ANSs compared to the general Nova Scotia population. For example, the average total income for ANS males is $33,500, while for ANS females it is $29,600 (ANSA, 2016). This is compared to the average total income for the general Nova Scotian population of $41,500 (ANSA, 2016). The prevalence of low income, after taxes, for ANS males and females is 18.7% and 18.5% respectively, compared to the general Nova Scotian population at 6.7% (ANSA, 2016). While the prevalence of low-income households for ANS males and females is 21.9% and 21.7% respectively, with the rest of Nova Scotia at 7.9% (ANSA, 2016). Lastly, there is a notable difference in the age distribution of ANSs. Almost 45% of the ANS population is below the age of 25 years, with the median age being 28 years compared to the median age of the general Nova Scotia population at 45 years (ANSA, 2016). These figures introduce the notion of intersectionality by highlighting how gender and race interact to produce variations in privilege and marginalization.

3.4 African Nova Scotian Nurses

To date, very little is known about ANS nurses. Research involving this group is limited and underexplored. Additionally, there is currently no database that disaggregates demographic nursing workforce data according to race or ethnicity. However, as will be highlighted in the literature review chapter, there have been qualitative studies conducted in Canada with Black nurses, which have included ANS nurses in the sample.

The remaining two sections of this chapter contain two published manuscripts, which help to situate and provide context for the study in question. While these published manuscripts do not focus explicitly on ANS nurses, they examine two critical concepts, regarding Black nurses in Canada. The first published manuscript (3.5) is a commentary, titled *Black nurse leaders in the Canadian healthcare system,* which highlights a growing gap in the Canadian nursing workforce, specifically in nursing leadership. This commentary was successful in advancing the exploration of important consideration regarding representation in nursing and in leadership. The second published manuscript (3.6), titled *The strong Black woman: Insights and implications*

for nursing, is a discursive paper that described the intricacies of the strong Black woman archetype and how the construct is significant and relevant in nursing. The SBW archetype is one yet pervasive controlling racial image that is consciously and unconsciously ascribed to Black women. As will be presented in the following manuscript and findings chapter, the SBW archetype and other controlling or racial images, are extremely prevalent in nursing. Finally, given the highly gendered nature of nursing; combined with the historical legacy of exclusion, discrimination and anti-Blackness in nursing, a study of Blackness in nursing cannot exist without exploration or mention of this construct.

Together, these published manuscripts couch the ANS context alongside the larger context of Black nurses in Canada. Again, as was highlighted in the SPN, it is not uncommon for peoples of African descent to identify both racially and/or ethnically with a particular group. Thus, while many ANSs claim ANS as their ethnic identity, there is a notable portion who identify themselves as Black (with or without ANS ethnicity).

3.5 Black Nurse Leaders in Canadian Healthcare

This work in section 3.5 also appears in: Jefferies, K., Aston, M. & Tomblin Murphy, G. (2018). Black Nurse Leaders in the Canadian Healthcare System. *Canadian Journal of Nursing Leadership*, *31*(4), 50-56.

3.5.1 Statement of Manuscript Contribution

KJ conceived and develop this manuscript with guidance and mentorship from MA and GTM. KJ drafted the manuscript while MA and GTM provided feedback on each draft. MA and GTM approved the final version of the manuscript and KJ submitted the manuscript for review. Copyright details are located in Appendix A.

3.5.2 Background

Black nurse leaders are nurses of African descent who embody nursing leadership competencies and practice in formal and informal leadership roles. In Canada, individuals of African descent typically include those who have ancestral linkages to continental Africa but may have immigrated to Canada by way of the Caribbean, Africa or the United States (Maddalena et al. 2013; Pachai 1997). Several terms are used to describe Black people in Canada such as African, Black or Caribbean Canadian; however, this discussion will use the term *Black* in reference to individuals who identify as such. The common African origin has resulted in Black people sharing similarities in culture, practice, belief and way of life. However, the manner, time and circumstances of the arrival of Black people in North America (i.e., transatlantic slave trade from the fourteenth to nineteenth centuries) have resulted in stark differences among Black people (Pachai 1997). As a result, the experience of Blackness can be similar yet vary greatly within the Black community.

Nursing leadership is required for and integral to health policy, practice and system reform (Downey et al. 2011; Ferguson 2015; Huston 2008). Nursing leadership encompasses the formal and informal leadership roles in nursing, which are practiced by licensed practical nurses, registered nurses as well as advanced practice nurses (CNA 2009; Downey et al. 2011; Ferguson 2015; Huston 2008). Examples of formal leadership roles include managers and charge nurses, whereas informal roles include coaching and mentoring (Downey et al. 2011). Each level of nursing has a distinct scope, which influences opportunities for how, where and when nursing leadership is practiced (CNA 2009; CLPNNS 2013). In addition, as nursing leadership competencies are embedded within nursing programs, all nurses upon graduation have the foundation required to serve as formal and informal leaders (CNA 2009; CLPNNS 2013). Similarly, many nurses have access to training throughout their career, which aims to enhance leadership competencies, including conflict management and team building. Yet, to truly address gaps in care provision and offer services that are relevant and inclusive of diverse needs, nursing leadership must also develop and support Black nurse leaders who reflect the values of the Black community.

3.5.3 Visibility and Representation of Black Nurse Leaders

A multitude of factors acting as barriers has resulted in a lack of visibility and the underrepresentation of Black nurse leaders in the Canadian healthcare system (Jefferies et al. 2018a). Visibility refers to recognizing and acknowledging Black nurses in practice whereas representation refers to the number of Black nurses in practice in relation to the population of Black people in Canada. Unfortunately, Black nurses encounter numerous barriers along their journey to becoming a nurse as well as in the workforce (Etowa et al. 2009; Vukic et al. 2016). Examples of barriers include the historical admission restriction of Black students to nursing schools and the contemporary policies and structures that were developed during a time when racism and segregation were acceptable (Flynn 2009). The impact of these substantial barriers perpetuates an oppressive system that favours the advancement of White nurses while simultaneously restricting the progression of Black nurses (Flynn 2009). Thus, supporting Black nurse leaders goes beyond maintaining a diversity quota and having a token Black nurse as part of the care team (Vukic et al. 2012). Intentional action on an individual, team, organizational and systemic level must be used to achieve representation and visibility (Vukic et al. 2012; Jefferies et al. 2018b). The underrepresentation of Black nurse leaders can be linked directly to the underrepresentation of Black students in nursing programs (Etowa et al. 2005; Vukic et al. 2016). Although more Black students are gaining admission to the nursing program, particularly beyond the baccalaureate level, the rates of attrition among Black students remains high, as traditional recruitment and retention initiatives have

been unsuccessful in considerably increasing enrolment and promoting retention within programs (Vukic et al. 2016).

Black nurses are overrepresented in entry-level and non-specialty areas such as continuing care assistants and underrepresented in specialty, advanced practice and upper-level roles such as intensive care units and managers (Calliste 1996; Flynn 2009; Hagey et al. 2001; Premji & Etowa 2014; Vukic et al. 2016). Moreover, systemic barriers and ideologies make transitioning to advanced practice roles and specialty areas, such as nurse practitioners, managers and intensive care units, difficult for Black nurses (Calliste 1996; Flynn 2009; Hagey et al. 2001; Premji & Etowa 2014). Moreover, the underrepresentation and invisibility of Black nurse leaders is compounded by the dearth of race-based consideration found within traditional leadership models, theories and frameworks (McLane-Davison 2015). As a result, influential Black nurse leaders are often omitted from discussions in nursing (Jefferies et al. 2018). This is problematic, as the theories and frameworks developed to be used with diverse groups of people are not developed in an inclusive manner. This lack of racial consideration in leadership has led to Black scholars and allies exploring and developing more Africana approaches to leadership (McLane-Davison 2015; Shockley 2008). Thus, as society continues to diversify in relation to patient populations, work environments and colleagues, Black nurse leaders are pivotal in ensuring that Black voices are heard and included in decision-making.

3.5.4 Significance of Black Nurse Leaders in Canada

Phillips and Malone (2014) explain that increasing diversity in nursing has significant implications for addressing the health disparities experienced by non-White communities. Canada is in dire need for Black nurses to be visible and represented in leadership to address the unique and diverse health needs within the Black community. There are approximately 1.2 million Black people in Canada, which accounts for approximately 3.5% of the Canadian population (Statistics Canada 2018). Black communities across Canada experience health issues at higher rates than the general Canadian population. For instance, Kisely et al. (2008) found that African Nova Scotians experience high blood pressure, diabetes and mental illness at a rate of 13–45% higher than non-Black Nova Scotians. Evidence also shows that Black people often receive a later disease diagnosis and worse disease prognosis. This later disease diagnosis is particularly concerning in the case of prostate cancer, which is shown to be higher among Black men (Prostate Cancer Canada 2018).

Black patients describe ease and reassurance when they see and receive care from a nurse who looks like them (Etowa et al. 2007). This is due in part to the fact that there is a plethora of nuances that practitioners are unaware of, which result in misunderstandings and insensitive care. An example of this is related to the maintenance required for Black skin and hair. These misunderstandings then lead to a lack of trust in the

healthcare system and the providers, which reduces the inclination to seek care (Etowa et al. 2007). Too often, stereotypes, assumptions, unconscious bias and ignorance cloud the ability of practitioners to provide competent care to Black patients (Edge 2010). Edge (2010) found that harmful stereotypes held by practitioners affected the manner in which they provided care to Black patients. Edge (2010) also found that practitioners would adopt a "colour-blind" approach, stating that they did not take a patient's race into consideration. Despite this being a common traditional approach to working with patients of a different race or ethnicity, evidence shows that the "colour-blind" approach is more detrimental to a patient, as they are not regarded as an individual and their unique circumstance is not considered (Bonilla-Silva 2014).

Race is listed as a social determinant of health, which significantly influences health service utilization and access (Maddalena et al. 2013). Race is also just one of the many factors that severely impact the health of the Black community. Many Black people in Canada experience the pressures of multiple social determinants of health, such as unemployment, inadequate housing, food insecurity and hazardous/harmful environments (UN Report 2017). Moreover, within the Black community, there are hyper-marginalized individuals who experience social constructs or multiple factors impacting and influencing their health status resulting in profound inequities (Collins 2000; Crenshaw 1991). Black women and Black trans folks are examples of groups who experience hyper-marginalization. Not only do Black women experience oppression in the form of racism because of their Black identity, but they also experience oppression as the result of sexism from their female identification (Collins 2000; Crenshaw 1991).

Black nurse leaders are essential in addressing the unique needs of the Black community in multiple ways. These include informing policies impacting the health of Black individuals, families and communities; addressing harmful stereotypes rampant in healthcare; informing culturally competent care; and fostering an inviting and safe work environment. Black nurse leaders are needed to facilitate this process to incorporate key considerations from their lived experience. Without incorporating this perspective, the gap in service provision will continue to grow and the Black community will continue to be underserved and suffer injustices (UN Report 2017).

3.5.5 Facilitating Black Nurse Leaders in Practice

To address the absence and invisibility of Black nurse leaders, it is necessary to be intentional in supporting Black nurses throughout their nursing journey. Black nurse leaders are essential to ensuring relevant care provision to the Black community and ultimately improving their health outcomes. Thus, supporting Black nurse leaders in education and the workforce is vital (Jefferies et al. 2018). As described, Black students encounter increased challenges and barriers when applying to nursing programs. Therefore, examining the

admission process is an essential initial step (Vukic et al. 2012). In addition, the nursing education curriculum must be inclusive, relevant and reflective of Black values and experiences (Jefferies et al. 2018). Finally, recruitment and retention initiatives need to be redesigned in a manner that dismantles hegemonic and narrow views of what nursing entails and who is able to be a nurse (Price & McGillis Hall 2014; Vukic et al. 2016). An example of a progressive initiative is seen with the recently launched initiative in the School of Nursing at Dalhousie University. This initiative, which was conceptualized by the first author and colleagues, offers peer-mentoring for Black students in the nursing program at Dalhousie. The *Community of Black Students in Nursing* is designed to provide guidance navigating the undergraduate and graduate programs, expose students to research, offer opportunities for community engagement and provide a safe space to share and discuss experiences as a Black student nurse.

Addressing the drawbacks of nursing education must happen in unison with addressing drawbacks and gaps in the nursing workforce. Empowering Black nurse leaders cannot be achieved in a system that holds on to oppressive, hegemonic ideologies. The nursing workforce and health systems must review, amend and create policies in collaboration with Black nurses to ensure that their voices are heard and included (Etowa et al. 2011; Vukic et al. 2012). There are several jurisdictions across Canada, which have initiated progressive approaches to nursing diversity and inclusion through their strategic plans and guidelines. Finally, prioritizing the collection of race-based data is necessary to adequately assess and address health issues in the Black community. Without race-based data, there is inadequate understanding of the current issues and ways to move forward.

3.5.6 Conclusion

Representation and visibility of Black nurses is necessary if health policies and practices are intended to serve all Canadians from diverse communities. Black nurse leaders are capable of using their experiential knowledge and training to inform their practice when working with patients from culturally and racially diverse backgrounds. Specifically, Black nurse leaders are able to use their subjectivity and lived experience to address the challenges of race, class and gender as well as the profound influence of race on health. Drawing on their experiential knowledge, Black nurse leaders are able to assist in the development of policies, practice standards and health system reform to better serve the Black community. Without the insider perspective of Black nurses, it becomes increasingly difficult to recognize and challenge the oppressive privilege within the Canadian healthcare system. Thus, this commentary is calling for a paradigm shift across practice areas and at multiple levels to improve the health outcomes of the Black community and to strengthen the reputation of nursing leadership in Canadian healthcare by truly being inclusive.

3.6 The Strong Black Woman

This work in section 3.6 also appears in: Jefferies, K (2020). The Strong Black Woman: Insights and Implications for Nursing. *The Journal of the American Psychiatric Nurses Association*. doi:10.1177/1078390320983900

3.6.1 Statement of Manuscript Contribution

KJ conceived and develop this manuscript with input from SP (acknowledged in full publication). KJ drafted and submitted the manuscript for review. Copyright details are located in Appendix A.

3.6.2 Background

The strong Black woman (SBW) is recognized from a mile away. She is strong, capable, and resilient and appears to succeed despite all odds. Laverne Cox, Serena Williams, Michelle Obama, Oprah Winfrey, and Beyoncé are a few of the contemporary names associated with Black women who are endearing, transformational, and *strong*. They *are* strong Black women. But what does it mean to be an SBW? Where did this concept originate from? And is this a title that all Black women should aspire for? The label SBW is a social construct or controlling image that is used to describe Black women who display a particular set of character traits that make them appear "superhuman" (Collins, 2000). The SBW construct generally encompasses five main components centered on independence, caring, and strength, which include the obligation to (1) maintain and present an unwavering image of strength, (2) suppress all emotion, (3) be self-reliant, (4) succeed despite all odds, and (5) always place the needs of others before those of oneself.

There are several well-known racial constructs that emerged during the enslavement era and gained popularity through minstrel shows and continue to be associated with Black folks (Amuchie, 2016; Collins, 2000; Hill, 2009). Notable examples include the mammy (think aunt Jemima), the welfare queen, the angry Black woman [or matriarch], and the Jezebel (Ashley, 2014; Collins, 2000; Dow, 2015; C. M. West, 2008). Modern depictions of trans women in films have largely been of comedic nature with critics illuminating how these offensive portrayals of trans women have been used in an attempt to either emasculate Black men or portray trans individuals as psychologically unstable—which is false and highly offensive (Feder, 2020). Last, the mandingo, Sambo, and Uncle Tom are constructs that are used to hypersexualize, emasculate (Mobley & Johnson, 2019), or present Black men as self-hating. Each of these depictions carries with it its own set of assumptions. However, the common thread that binds each of these together is their historical origin and the intention to control Black folks (Collins, 2000; Feder, 2020). While these constructs are easily recognizable and remain prevalent in pop culture and media, their understanding and use in health care is not widely discussed.

To this end, it is necessary to elucidate how one of the more prevalent constructs manifests and the implications for health care—specifically, nursing. Enter, the strong Black woman.

3.6.3 At the Intersection of Race and Gender

The SBW construct—also referred to as the superwoman schema—is assigned to Black women and is regarded as the admirable yet destructive manifestation of intersectional pressure that is encountered by Black women (Collins, 2000; Watson & Hunter, 2016; Woods- Giscombe et al., 2016). Since time immemorial, Black women have been situated as pillars within families and communities (Etowa et al., 2017; L. M. West et al., 2016) and carry the burden of a multitude of societal forces including sexism, racism, and class exploitation (Collins, 2000; Collins & Bilge, 2020; Crenshaw, 1991; Davis, 1981; hooks, 1984; Lorde, 1984). During this current climate, which continues to expose racial injustice, Black women remain at the helm leading change first and foremost within families and also in communities as activists, scholars, and health care professionals. This undeniable display of independence, caring, and strength constitute the central tenets of the SBW construct. These central tenets then serve as the foundation for the five general components of the SBW construct, which include an obligation to (1) always maintain and present an image of strength, (2) suppress emotion, (3) be self-reliant, (4) succeed despite all odds, and (5) always place the needs of others above those of oneself.

Traditionally, the SBW construct has received positive regard, with Black women being applauded for demonstrating this combination of traits. Yet, despite the appealing nature, there is an aspect of the construct that is less discussed. The harmful aspects of the SBW construct have proven to be highly detrimental to the mental, physical, and spiritual well-being of Black women (Etowa et al., 2017). Thus, the purpose of this discussion paper is to present a succinct description of the SBW construct, the associated components, and examples of how this construct may manifest in the lives of Black women. The article concludes with implications of the SBW construct for nursing by discussing how knowledge of this issue can be used to better understand and address the needs of Black women as providers and consumers of care.

3.6.4 Black Don't Crack

The inspiration for this article arose from a podcast titled *Therapy for Black Girls*, which is a podcast founded by a psychologist based in Atlanta, Georgia (Harden-Bradford, 2018). The podcast, which has more than 150 episodes, offers a weekly conversation for Black women "about all things mental health, personal development, and all the small decisions we can make to become the best possible version of ourselves" (Harden-Bradford, 2018). Each week, the host invites a well-known Black woman health care provider to discuss a topic. The episode inspiring this article is called *Shedding Your Superwoman Status* (Episode 54), in

which the conversation centered on a well-known phrase in the Black community. This phrase "Black don't crack" refers to the youthful physical appearance that many Black people carry into their older years. It quite literally refers to the minimal—and in some cases absence of—wrinkles, fine lines, and other visible signs of aging. There is a paucity of empirical evidence on this phenomenon; yet the concept is well-known and widely understood among Black folk in North America (Morgan, 2019).

The intriguing aspect of the discussion on the topic of "Black don't crack" was the acknowledgement that metaphorically Black does in fact crack and that Black cracks quite extensively. However, this cracking happens from the inside out (Harden-Bradford, 2018). This metaphor is deeply layered and intertwined with aspects of respectability politics (Higginbotham, 1993), weathering (Geronimus 1992, 2001; Geronimus et al., 2006), intergenerational trauma (DeGruy, 2005), as well as elements of everyday racism (Essed, 1991) or microaggressions, each having a direct and significant impact on the mental, physical, and spiritual well-being of Black folks, and thereby accelerating this metaphorical cracking. "Cracking from the inside out" symbolizes the substantial physical and mental strain arising from the internalization of socioeconomic problems (DeGruy, 2005; Geronimus, 1992, 2001; Geronimus et al., 2006; Harden-Bradford, 2018).

The entire premise of the SBW construct, which will be described in the following section, is built on the notion that Black women can [and should] be able to overcome challenges on their own and not show weakness. These unrealistic and subconscious expectations create societal misconceptions while simultaneously reinforcing the pressure to raise to such expectations. As a result, the SBW construct is shown to have a profound impact on health, with Black women having poorer outcomes than White folks and Black men (Etowa et al., 2017; Geronimus, 1992, 2001; Geronimus et al., 2006; Kisely et al., 2008). Additionally, subscribing to the SBW construct is linked to mental health issues including increased depression and suicidality (Green, 2019). Thus, the interconnectedness between the SBW construct and health necessitates careful consideration regarding how this phenomenon affects Black women's well-being.

3.6.5 Have You Met a Strong Black Woman?

The SBW is a social construct, stereotype, or controlling image assigned to Black women that emerged during the enslavement era (Collins, 2000). The SBW is viewed as strong, independent, and successful in every facet of her life (Watson & Hunter, 2016). She ". . . depicts a strong, self-reliant, independent, yet nurturing woman who denies her own wellbeing to meet the expectations of others" (Etowa et al., 2017). The central tenets of the SBW construct include notions of strength, independence, and caring (Donovan & West, 2015; L. M. West et al., 2016). Displays of strength include perceived natural resilience and the ability to overcome any challenge with a level of ease while working tirelessly without complaint (Donovan & West, 2015).

Independence for the SBW means that assistance or support cannot be accessed, and if this occurs, the individual is perceived as weak, needy, dependent, or unqualified. Finally, caring requires that the SBW place the needs of others before those of her own, that she be self-sacrificing, and that she willingly gives her time, resources, and energy (Donovan & West, 2015). The five components of the SBW construct include (Harden-Bradford, 2018)

1. The obligation to present an image of strength
2. The obligation to suppress any emotion
3. The obligation to maintain independence and not be dependent on others
4. The obligation to succeed against and despite all odds
5. The obligation to always place the needs (and comfort) of others before those of oneself.

With most Black women understanding what it means to be an SBW, the general consensus is that this image encapsulates strength, spirituality, determination, care, and expertise (Abrams et al., 2014; L. M. West et al., 2016). Embracing the SBW construct has notable benefits including the potential to improve self-efficacy and perceived invincibility, leading some to use it as a coping mechanism (Green, 2019; Watson & Hunter, 2016). However, the SBW is also understood to be emotionally contained, selfless, and "every woman" (Abrams et al., 2014). As a result, Black women express mixed feelings about whether or not the SBW construct should be embraced (Dow, 2015), with some feeling obligated to be an SBW (Etowa et al., 2017). For example, embracing the SBW construct can be used as a survival mechanism particularly in sociopolitical environments that oppress Black women (Etowa et al., 2017). Etowa et al. (2017, p. 386) found that Black women felt compelled to embrace the SBW construct to ". . . get through the racist education system . . ." and be a pillar of support for their family and community. Dow (2015) expounds on the notion that Black women are conflicted by the construct, with some viewing it as a goal to strive toward, while others consider it inevitable, and still others seeing it as something to be avoided. These conflicted responses veil the cavernous harms of embracing the SBW construct and the consequences of using it as a survival or coping mechanism (Etowa et al., 2017; Green, 2019; Watson & Hunter, 2016).

3.6.6 Harms of Advancing the SBW Construct

The harms of advancing the SBW construct are greatly minimized or even normalized throughout society. As eluded to, these harms affect all facets of Black women's health, cross-cutting physical, mental, and spiritual well-being. The SBW construct is associated with poorer health, increased substance use (Jerald, Cole, et al., 2017), and decreased mental health service use or other self-care activities (Hunter & Watson, 2015; Woods-Giscombe et al., 2016). Moreover, there is a significant reduction in self-care including help-seeking

(Etowa et al., 2017; Woods-Giscombe et al., 2016). Unsurprisingly, Black women have expressed concern related to the mental and physical toll of being an SBW (Etowa et al., 2017).

Specifically, psychological distress results from feelings of failure for not being able to attain and sustain expectations in addition to the obligation to manifest strength, reject assistance, succeed in all aspects of life, and take care of others (Dow, 2015; Hunter & Watson, 2015; Liao et al., 2020; Watson-Singleton, 2017). Moreover, increased levels of stress, anxiety, depression, and loneliness are associated with the SBW construct (Donovan & West, 2015; Green, 2019; Liao et al., 2020). Additionally, Black women who embraced the SBW construct had an increased likelihood of suicidality (Green, 2019). The mental health implications of the SBW construct are further aggravated by the notion that accessing mental health services is viewed as a weakness (Woods- Giscombe et al., 2016), especially since emotional support has the potential to act as a mediator between the pressures of the SBW construct and psychological distress (Watson-Singleton, 2017).

In terms of physical harm, the threat of fatigue and illness is heightened. The socioeconomic climate does not permit Black women to be ill or take time off. Instead, it is expected that Black women forgo their own health needs and self-care (Etowa et al., 2017). The SBW construct depicts a strong, self-reliant, independent Black woman who is giving, to the detriment of herself, which may serve as a buffer against stress (Etowa et al., 2017) or be a cause. Being everything to everyone all the time is an impossible task, which has led some Black women to believe that they must be strong and made of steel (Etowa et al., 2017). Last, decreased health service utilization has implications that extend to families and communities.

3.6.7 Nursing Implications and the Strong Black Woman

The SBW construct has resounding implications for Black women, the community, and nursing. Nursing, which has a history of racial, classist, and gender tensions (Flynn, 2009) as well as power dynamics, would benefit greatly from examining how the profession reinforces and perpetuates harm through the SBW construct. The SBW construct prescribes not only how Black women are treated as patients but also how this image affects Black women who practice nursing. Black women nurses battle issues of systemic and institutional racism as well as issues of representation, in the profession and in leadership roles. Anti-Black racism includes the intentional or unintentional language, policies, decisions, and practices that work to oppress Black folks. Examples in nursing that extend beyond the well-known racial slurs also include missed promotions and heightened surveillance (Jefferies, 2020; Modibo, 2004). Exploring, naming, and then challenging the views of health care providers and the racial imaging used in practice—across disciplines—are essential to avoid assumption-based care (Andrews et al., 2017; Jerald, Ward, et al., 2017). Therefore, this

section initiates a conversation toward a deeper understanding of how nursing may advance through practice, education, research, and policy.

3.6.7.1 Practice. Non-Black nurses equipped with knowledge about the SBW construct have an opportunity to be an informed colleague and provider. Reducing and ultimately eliminating the inappropriate use of this requires deep reflexivity. Labeling Black women as an SBW reduces the quality of health care, while forcing Black women to advocate for better care. Thus, resisting the urge to use the SBW construct in relation to Black nurse colleagues and patients is absolutely critical. Nursing must work to create an environment that provides appropriate care and a space where Black folks, particularly women, are able to provide and receive quality care.

Specifically, defaulting to this construct in the care setting has the potential to alter therapeutic interactions between patients and providers, which may further exacerbate existing health inequities (Andrews et al., 2017). For example, Hoffman et al. (2016) explain that health care providers hold beliefs that biological differences exist between White and Black patients, with the false assumption that Black patients experience less pain. These beliefs, paired with the SBW construct, have created life-threatening circumstances surrounding childbirth for Black women. Black women are thought to have a higher pain tolerance and experience less pain during childbirth, which leads to inadequate pain management and an increased likelihood of maternal death (Edge, 2010; Kasprzak, 2019).

3.6.7.2 Education. SBW are learners and educators. The past 20 years have exposed deep knowledge related to Black learners. Jefferies (2020) published an analysis piece outlining a gap in Canadian nursing education—critiquing a nursing curriculum that reinforces oppressive stereotypes and is void of content acknowledging the historically significant contributions of Black nurse pioneers. Segregation and systemic racism have greatly influenced nursing education, with many effects still felt today (Flynn, 2009; Hine, 1982). Meaning, receiving an antiracist perspective and approach to nursing education is highly dependent and variable based on the academic institution and location. Evidence shows that the SBW construct is present for Black postsecondary students, causing increased levels of stress, depression, and hypervigilance (Corbin et al., 2018; Donovan & West, 2015). Additionally, Mirza (1995, 2006) describes the oppression experienced by Black women in academia. High attrition, self-reports of feeling isolated, and stark underrepresentation necessitate examination at the institutional level.

3.6.7.3 Research. The implications for research related to the mental and physical health of Black women as well as the SBW construct are extensive. As evidence about Black women's health mounts, it is necessary to employ a variety of methodologies to investigate the SBW construct in order to inform appropriate

interventions to address various health needs. Deepening understanding, through qualitative, quantitative, and mixed approaches, about how the SBW construct affects Black women's health is beneficial. Moreover, ensuring that data collection and analysis occur in a manner that challenge (rather than reinforcing) systems of oppression such as racism, ableism, sexism, heteronormativity, and class exploitation is necessary. For example, research that employs an intersectional analysis (Collins & Bilge, 2020) to investigate the SBW construct as related to queer and trans Black women is vital. Finally, the growing body of evidence pertaining to the SBW construct warrants synthesis of this work in the form of a systematic or scoping review.

3.6.7.4 Policy. Health policy refers to the decisions, plans, and actions that are designed to achieve specific health outcomes/ goals within a particular setting (World Health Organization, 2020). While policies offer guidance, structure, and directive, they are often the products of dominant discursive frameworks that are not only reflective of but also the result of social, structural, and historical influences (Cheek & Gibon, 1997). Thus, Cheek and Gibson (1997) suggest applying a critical approach to policy that challenges what is and is not written as well as the language used and the associated ideology that is being promoted. The SBW construct along with other racially charged assumptions have extensive historical roots that have been woven into the fabric of policy and institutional discourse. Policy that relies on outdated and harmful assumptions widens health inequities experienced by Black women. Thus, policy makers must be intentional in attending to racial, ethnic, and cultural diversity to enhance health care (Amuchie, 2016). As the notion of strength in relation to Black women evolves (Green, 2019), reliance on the SBW construct must continue to be challenged on a local, national, and global level (Etowa et al., 2017). Likewise, as more becomes known about the helpful and harmful aspects of the SBW construct (Nelson et al., 2016), this knowledge can be used to redefine what it means to be strong, interdependent, vulnerable, and deeply connected (Nelson et al., 2016).

3.6.8 Conclusion

Black women continue to impress the world with their capabilities by leading change. As health care strives toward equity, it is vital that the amour that Black women [are perceived to] don is not used to justify or reinforce assumption-based behavior. The SBW construct is empowering for many Black women; however, it is also proven to greatly affect physical, mental, and spiritual health. The superhuman portrayal leads to unrealistic expectations, increased demands, and added stress. Nursing is central to this discussion as it is one of the most trusted and accessible health professions, largely due to holistic practice, therapeutic skills, as well as knowledge. Nurses, across all sectors, have the responsibility to not only be knowledgeable about this construct and the assumptions therein but also similarly engage in ways to not perpetuate harm. Providers must expand their understanding of strength to go beyond a singular concept regarding Black women in order to permit deep

reflexivity in practice, education, research, and policy to inform care and ensure that nursing is not only supportive but also antiracist.

Chapter 4: Literature Review

This chapter, which constitutes the literature review for this qualitative study, includes two manuscripts. Together, these manuscripts provide a comprehensive, systematic charting of the available literature regarding Black nurses in Canada. The undertaking of a scoping review was a calculated decision as this type of review provides an informative layout of existing literature. The chapter begins with a short introduction to scoping review methodology and the inherent benefits for research and knowledge generation. This section is followed by the published a priori protocol and then the scoping review report, which is currently under review.

4.1 Scoping Review Methodology

According to JBI, scoping reviews are an effective approach to map or chart a particular area of research, particularly if that area is unclear or poorly defined (Peters et al., 2017). These reviews use the mnemonic, *PCC*, which represents the *participants, concept,* and *context* of interest. Scoping reviews are an excellent starting point in evidence syntheses (and research in general) as they help to identify the types of available evidence in a given field, they facilitate the identification and analysis of knowledge gaps, they allow for the clarification of key concepts and definitions in literature, they provide an understanding of how research is conducted in relation to a specific topic or field, and they enable the identification of key characteristics or factors related to a concept (Peters et al., 2017). Finally, by clarifying working definitions or conceptual boundaries related to topics or fields, scoping reviews serve as excellent precursors to qualitative, quantitative or mixed methods systematic reviews (Peters et al., 2017).

After undertaking a traditional narrative approach for the initial literature review at the beginning of my dissertation, I decided it would be more appropriate to conduct a systematic mapping of the existing body of literature related to Black nurses in Canada. As will be described in the a priori protocol, this was a strategic decision to undertake a scoping review for three key reasons. First, at the time of protocol development, there was no existing systematic review or synthesis of this body of evidence. Second, given the nature of the phenomenon of interest, charting the existing evidence regarding Black nurses in Canada, was a timely project that was long overdue. Third, this scoping review offered an opportunity for research mentorship. As the lead author, I applied for and received an Operating Grant through the Research and Development Fund in the Dalhousie SON, where I hired two ANS nursing students as research assistants to support the development and conducting of the review.

As will be outlined in each of the following two manuscripts, this scoping review included a scan and charting of peer-reviewed and grey literature regarding Black nurses in Canada. The first published manuscript (4.2), which is the a priori scoping review protocol, published through the JBI Evidence Synthesis System,

provided the systematic strategy for the review. The second manuscript (4.3), is the final consolidation of the full scoping review report, which is currently under review.

Finally, an important point to note regarding the included manuscripts is concerning the terminology used to describe the participants of interest. The first published manuscript, which is the a priori protocol that was published in the JBI Evidence Synthesis, uses the term *African Canadian* in reference to participants of interest. However, after conducting a scoping review charting food security amongst African Canadian communities, and careful examination of the gathered sources, an informed decision was made to use the term *Black,* which was justified as being more inclusive and in alignment with the wider social and academic language (Jefferies et al., 2021). This note of a change in language is further explained in the second manuscript (4.3).

4.2 African Canadian Nurses in the Nursing Profession in Canada: A Scoping Review Protocol

This work in section 4.2 also appears in: Jefferies, K., Martin-Misener, R., Tomblin Murphy, G., Helwig, M, Thomas Bernard, W., Gahagan, J. (2021). African Canadian nurses in the nursing profession in Canada: A scoping review protocol. *Joanna Briggs Institute Database of Systematic Reviews and Implementation Reports (JBISRIR), 19*(4), 883-890. doi: 10.11124/JBISRIR-D-19-00376.

4.2.1 Statement of Manuscript Contribution

KJ conceived and develop this manuscript with methodological guidance and mentorship from RMM, GTM, MH, WTB, and JG. MH developed and ran the preliminary search after consultation with KJ. KJ drafted the manuscript while RMM, GTM, MH, WTB, and JG provided feedback on each draft. RMM, GTM, MH, WTB, and JG approved the final version of the manuscript and KJ submitted the manuscript for review. Copyright details are located in Appendix A.

4.2.2 Background

Nursing is a health profession that encompasses both an artistic and scientific approach to care (Henry, 2018). Florence Nightingale, who was a British nurse, social reformer, and statistician, is regarded as the founding philosopher of modern nursing (Encyclopedia Britannica, 2021). In 1860, Nightingale established the first scientifically based, professional nursing school located in London, England (Encyclopedia Britannica, 2021). Nursing has since transformed into a profession with influence in clinical practice, education, research, and policy (Henry, 2018). In addition to changes within the profession, nursing is undergoing an image transformation (Flynn, 2009; Price & McGillis Hall, 2013). The image of nursing reflects who is viewed as a nurse and who is able to become a nurse (Flynn, 2009; Price & McGillis Hall, 2013). Historically, a nurse was depicted as an image of purity, dignity, and gentleness (ie, the Victorian ideals of “true womanhood”), which

was associated with white women and not with people of African descent (Flynn, 2009). Within Canada, the nursing profession is of interest because Canadian nursing schools did not admit African Canadians into their programs until the late 1940s (Flynn, 2009). Racism in Canada prevented African Canadians from entering nursing and practicing in a safe, inclusive environment, and this continues today (Bernard & Smith, 2018; Boyer, 2017; Jefferies et al., 2018; Patterson & Veenstra, 2016).

The legacy of African Canadian nurses illuminates years of racism, discrimination, and struggle, but also profound resilience and success (Flynn, 2009; Jefferies et al., 2018). The purpose of this scoping review is to synthesize the existing evidence related to African Canadian nurses practicing the nursing profession in Canada. By definition, nursing encompass clinical care, policy, education, administration, and research (CNA, 2015). This review is both timely and necessary as diversity in Canadian nursing is gaining national interest; there is no published synthesis of this evidence; and there is a need to determine the magnitude and type of available evidence. Lastly, this review may hold international relevance by offering insights for racialized people in nursing while simultaneously addressing the international call-to-action declared by the United Nations (UN).

4.2.2.1 People of African Descent in Canada. In 2014, the UN declared 2015–2024 as the International Decade for People of African Descent in order to address the ongoing human rights violations and social injustices experienced by people of African descent worldwide (UN, 2021). The decade's theme, "People of African Descent: Recognition, Justice and Development," has been recognized by several countries, including Canada (UN, 2021). In addition to this international call-to-action, a 2017 UN report raised a nationwide alarm in Canada, calling for immediate action to improve the social welfare of African Canadians by addressing the pervasive anti-Black racism that is rampant across all sectors of Canadian society (UN, 2017).

In Canada, there are approximately 1.2 million people who identify as Black or of African descent (Statistics Canada, 2016). Throughout the literature and in everyday communication, several terms are used in reference to African Canadians or people of African descent who reside in Canada. Terms commonly used in research include "Black," "immigrant," "African," and "visible minority" (James et al., 2010; Jefferies, Tomblin Murphy & Helwig, 2020). The authors acknowledge that African Canadians are not a monolith and that there are differences that exist within this group. However, to provide clarity for this review and to facilitate understanding by an international audience, the term "African Canadian" will be used (Jefferies, Tomblin Murphy & Helwig, 2020).

African Canadians have a hidden history in Canada, which dates back to their arrival as enslaved or freed people in the 17th century (James et al., 2010; Pachai, 1997). Jefferies et al. (2020) provide a more

comprehensive explanation of the historical context surrounding African Canadians, particularly involving the arrival of African Canadians; their contributions in war efforts; as well as health issues affecting this group, including high rates of chronic illnesses, such as hypertension, diabetes, and mental illness Jefferies et al., 2020; Kisley, Terashima & Langille, 2008). Additionally, Jefferies et al. (2020) expand on the human rights violations and social injustices that remain pervasive throughout multiple sectors of society including, but not limited to, housing, labor, education, and health.

4.2.2.2 Diversity in Nursing. Within the nursing profession, diversity has a positive impact on patients and the function of the health care system (Etowa, Price & Debs-Ivall, 2011; Phillips & Malone, 2014). Diversity is a term used in reference to the biological, genetic, cultural, and sociological variations of individuals and group Jefferies, 2019). Specifically, diversity is often thought of in terms of sex, race, sexual orientation, and ability. Ensuring diversity in nursing has numerous benefits, including a culturally inclusive and competent approach to care, the integration of experiential knowledge from professionals, as well as a holistic understanding of diverse individuals, families, and communities (Etowa, Price & Debs-Ivall, 2011; Phillips & Malone, 2014). There is a need to understand the multiple and intersecting layers of diversity in nursing related to race, sex, sexual orientation, ability, and class while simultaneously understanding how each of these components interacts with one another. The authors recognize the need to examine multiple facets of diversity in nursing. However, based on national and international proclamations to address human rights violations and discrimination encountered by African Canadians (UN, 2021; 2017), the authors have prioritized synthesizing the evidence pertaining to African Canadians in the nursing profession in Canada.

4.2.2.3 African Canadian Nurses in Canada. The first nursing school in Canada opened in 1874, with the number of nursing schools increasing to 70 by 1909 and more than 200 by the 1920s (McPherson, 2005). However, Canadian nursing schools did not admit African Canadians until the late 1940s (Flynn, 2009). Institutional racial segregation displayed by nursing schools in Canada is often contrasted to that of the United States, which admitted Black students to nursing schools in the 1870s (Flynn, 2009; Hine, 1982). Until the 1940s, African Canadians interested in pursuing nursing were instructed to travel to and train in the United States (Flynn, 2009).

At present, African Canadians continue to experience challenges entering the nursing profession. For example, the under-representation of African Canadian nurses has been linked to institutional racism, which prevents African Canadians from entering or advancing in nursing (Jefferies et al., 2018; Vukic et al., 2016). Vukic et al. (2016) explained that despite initiatives put in place by institutions, there are systemic barriers that impede recruitment, admission, and retention of African Canadians in nursing. When present, African Canadian

nurses are concentrated in entry-level and non-specialty areas while being under-represented in specialty areas, advanced practice positions, and leadership roles (Jefferies et al., 2018; Premji & Etowa, 2014). Lastly, African Canadian nurses feel as though they are practicing on the margins of the nursing profession due to racism perpetrated by patients, colleagues, and superiors, as well as the systemic hurdles (Etowa, Sethi & Thompson-Isherwood, 2009).

A preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews, and the JBI Database of Systematic Reviews and Implementation Reports revealed no published or in-progress systematic reviews on this topic.

To date, the only record of a synthesis of this evidence is a literature review conducted by Etowa et al. (2009). The review by Etowa et al. (2009) was published as a section of a manuscript; however, i) it was a literature review embedded within a manuscript and thus was not published as a systematic review; ii) the review was described as a literature review, which did not describe a systematic process for searching, screening, or analyzing the literature; and iii) at least 10 years have passed since this manuscript was published. To this end, the authors deem it necessary to build on the literature review by Etowa et al. (2009) by conducting a scoping review to determine the extent of available peer-reviewed and non-peer-reviewed evidence regarding African Canadian nurses in the nursing profession in Canada. Thus, the purpose of this review is to synthesize the existing evidence by illuminating areas that have been investigated as well as describing ways in which African Canadian nurses have been represented. Identifying and mapping all existing evidence will inform knowledge gaps and priorities for future research. Finally, this review informs a larger qualitative study that examines leadership in the nursing profession among a historically distinct group of African Canadian nurses.

4.2.3 Review Question

What evidence exists regarding African Canadian nurses in the nursing profession in Canada? Specifically to: i) describe how African Canadian nurses have been represented in the literature. ii) map existing evidence to inform knowledge gaps and priorities for future research.

4.2.4 Inclusion Criteria

4.2.4.1 Participants. This scoping review includes sources focused on African Canadian nurses, with African Canadians encompassing various groups of people who identify as Black or as being of African descent in Canada (James et al., 2010; Jefferies et al., 2020). Literature about African Canadians includes those who identify as African Canadian, Black, immigrant, African Nova Scotian, or a newcomer from continental Africa, the Caribbean, South America, or the United States (James et al., 2010; Jefferies et al., 2020).

4.2.4.2 Concept. The concept of interest is the nursing profession, which encompasses five domains of nursing practice including clinical care, education, administration, policy, and research (CNA, 2015). All levels of professional nursing practice will be included, ranging from nurses who received training at the diploma, baccalaureate, or graduate level. Respectively, in Canada these regulated roles refer to practical nurses, registered nurses, and advanced practice nurses, including nurse practitioners and clinical nurse specialists (CNA, 2015). Non-licensed, clinical practice roles, such as personal care workers and continuing care assistants, will be excluded as these are unregulated, unlicensed professions that are not classified as nursing in Canada (CNA, 2015).

4.2.4.3 Context. This review focuses exclusively on the Canadian context. Despite similarities throughout the Black experience that transcend international borders, there are highly influential contextual elements, including historical racism, segregation, and socialization, which result in stark differences between Canada and other countries. These differences require a country-level examination prior to a global comparison. The Canadian context is of particular interest because African Canadians are identified as a highly vulnerable group globally (UN, 2021; 2017), yet literature regarding this group remains hidden as Canada continues to lag in collecting race-disaggregated data (UN, 2017).

4.2.4.4 Types of Sources. This scoping review will consider experimental and quasi-experimental study designs including randomized controlled trials, non-randomized controlled trials, before and after studies, and interrupted time-series studies. In addition, analytical observational studies including prospective and retrospective cohort studies, case-control studies, and analytical cross-sectional studies will be considered. This review will also consider descriptive observational study designs including case series, individual case reports, and descriptive cross-sectional studies for inclusion. Qualitative study designs including, but not limited to, phenomenological, grounded theory, ethnographic, qualitative description, action research, and feminist research will be considered. Additionally, systematic reviews, dissertations, and gray literature, as well as text and opinion papers, will be considered for inclusion. Research that includes a subgroup analysis, related to the context, concept, or population, will also be considered for inclusion.

4.2.5 Methods

This scoping review will be conducted in accordance with JBI methodology (Peters et al., 2017).

4.2.5.1 Search Strategy. The search strategy was developed in collaboration with a librarian, and the final search strategy will undergo peer review by a second librarian. The search aims to locate published studies and gray literature. An initial limited search of CINAHL (Appendix B) was undertaken to identify articles on the topic. The words contained in the titles and abstracts of relevant articles, and the index terms used to

describe the articles were used to develop a full search strategy for CINAHL and MEDLINE. The search strategy, including all identified keywords and index terms, will be adapted for each included information source. Search terms related to the population of interest include “African Canadian,” “Black,” “African Nova Scotia,” “immigrant,” and “minority,” as these terms are used in Canada. Other keywords include “nurse” and “Canada.” Ancestry searching will be performed to identify relevant sources. Literature published in English and French will be included, and databases will be searched from inception to present.

Information database sources include CINAHL (EBSCO), MEDLINE (Ovid), Embase (Elsevier), Sociological Abstracts (ProQuest), Gender Studies Database (EBSCO), America: History and Life (EBSCO), PsycINFO (EBSCO), Academic Search Premier (EBSCO), and Scopus (Elsevier). Sources of unpublished studies and gray literature to be searched include Canadian Nurses Association, Registered Nurses Association of Ontario, College and Association of Registered Nurses of Alberta, Nova Scotia College of Nursing, and ProQuest Dissertations and Theses Global (ProQuest).

4.2.5.2 Study Selection. Following the search, all identified citations will be collated and uploaded into Covidence (Veritas Health Innovation, Melbourne, Australia) and duplicates removed. Titles and abstracts will then be screened by two independent reviewers against the inclusion criteria for the review. Potentially relevant studies will be retrieved in full and their citation details imported into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI; JBI, Adelaide, Australia). The full text of selected citations will be assessed in detail against the inclusion criteria by two independent reviewers. Reasons for exclusion of full-text studies that do not meet the inclusion criteria will be recorded and reported in the systematic review. Any disagreements that arise between the reviewers at each stage of the study selection process will be resolved through discussion or with a third reviewer. The results of the search will be reported in full in the final report and presented in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (PRISMA-ScR) flow diagram Tricco et al., 2018).

4.2.5.3 Data Extraction. Data will be extracted from included articles by two independent reviewers using the data extraction tool developed by JBI, which has been modified for a scoping review by the reviewers (Peters et al., 2017). A preliminary customary data extraction tool has been included in Appendix C. The tool will be tested with two reviewers completing extractions independently followed by comparisons before continuing with the extraction process. The data to be extracted will include details about the article, purpose of the article, population, concept, context of the study, study methods, and key findings relevant to the review objective. A detailed description of the data extraction process, the data extraction tool, and tool modifications will be included in the full scoping review report. Any disagreements that arise between the reviewers will be

resolved through discussion or with a third reviewer. Authors of sources will be contacted to request missing or additional data, where required.

4.2.5.4 Data Analysis and Presentation. Data will be presented in diagrammatic or tabular form in a manner that aligns with the objective of this scoping review. A narrative summary will accompany the tabulated or charted results to describe the characteristics of the literature and how the results relate to the objective and question. The categories used for data presentation include those within the extraction tool; however, these may be modified based on the review findings.

4.3 Black Nurses in the Canadian Nursing Profession: A Scoping Review

This work in section 4.3 is currently under review with International Journal for Equity in Health - revisions have been requested as of March, 2022. Jefferies, K., States, C., MacLennan, V., Helwig, M., Gahagan, J., Thomas Bernard, W., Macdonald, M., Tomblin Murphy, G. & Martin-Misener, R. Black nurses in the nursing profession in Canada: A scoping review. *International Journal for Equity in Health*.

4.3.1 Statement of Manuscript Contribution

KJ conceived and developed this manuscript with methodological guidance and mentorship from RMM, GTM, MH, WTB, and JG. MH developed and ran the comprehensive search after consultation with KJ. KJ, CS and VM performed all stages of the review of literature including abstract and title screening, full-text review and data extraction. KJ drafted the manuscript while each author provided feedback on each draft. All authors approved the final version of the manuscript and KJ submitted the manuscript for review. Copyright details are located in Appendix A.

4.3.2 Background

The health and human rights of people of African descent have been brought to the forefront in the wake of the COVID-19 pandemic, which has exposed the most vulnerable, marginalized and oppressed sectors of society (Tuyisenge & Goldenberg, 2021). The televised mistreatment of people of African descent has led to mounting calls for action to end anti-Black racism, particularly through research and the collection of race-disaggregated data (Rizvic, 2020). Anti-Black racism is defined as the specific processes, decisions and policies that intentionally or unintentionally discriminate against Black people (BHA, 2018). The impact of anti-Black racism permeates a multitude of sectors in Canadian society including education, healthcare and nursing specifically. Addressing anti-Black racism and discrimination in the nursing profession warrants research that investigates how social constructs including heteronormativity, gender identity/ expression, class and disability interact with race to influence health (Bowleg, 2020). As one of the largest and most trusted health care professions, the nursing profession is in an optimal position to address the lingering effects of historic

oppression in healthcare and throughout society more broadly. Precisely, promoting diversity and inclusivity within the profession is suggested as one approach to address issues of belonging as well as care delivery for patients (Phillips & Malone, 2014). Ergo, in light of the increasing focus on the implication of racism in Canada and various countries, it is necessary to begin to chart existing evidence about Black nurses to illuminate insights for future research and practice. Finally, the title of this report, and the language used throughout to describe the participants, differs from the published protocol (Jefferies et al., 2020). The published protocol describes the participants as *African Canadian nurses*, however, after careful review of the existing and emerging literature in this area, it was deemed necessary to modify the terminology from *African Canadian nurses* to *Black nurses*. The term *Black* has gained global recognition as a term that extends beyond biology or genetics to include a more politicized and widely understood meaning that is "based on the historical, social and structural location inhabited by" people of African descent (Flynn, 2004 p. 16; Jefferies & Price, 2021).

4.3.2.1 Black Nurse Trailblazers: A Launchpad for Black Nurses. Understanding the historical context of nursing is an important first step in situating a review regarding Black nurses in the nursing profession in Canada. Historically, in the global west, people of African descent struggled to enter, practice and have their contributions recognized in the nursing profession (Flynn, 2021). For example, Mary Seacole (1850s), a Jamaican-born nurse who was based in London, England provided care to British soldiers during the Crimean War (Mary Seacole Trust, 2016). Seacole, who was as active and innovative as other prominent historical nurse figures, was all but erased from the historical nursing record until recently (Mary Seacole Trust, 2016). Similarly, in the United States, African Americans were banned from entering nursing training facilities until the 1870s, with Mary Mahoney (1879) being the first African American to become a nurse (Hine, 1989; 1982).

In Canada, the historical nursing record reveals a legacy of segregation and discrimination, which scholars argue remains relevant today. The first nursing school in Canada opened in 1874, with the first Baccalaureate program offered in 1919 (McPherson, 1998; Wong, 1980). However, in the female-dominated profession, Black women were not permitted to train as nurses until the late 1940's (Chaplan, 2020; Flynn, 2011). At the time, Black women, who aspired to be a nurse, were instead instructed to travel and train in the United States (Chaplan, 2020; Flynn, 2011). Notwithstanding, Black women in Canada, who were committed to care provision despite being denied the opportunity to train formally, eventually formed the Black Cross Nurses in Canada. This auxiliary group was established in the 1920s and modelled after the Red Cross. The Black Cross Nurses comprised a network that enabled Black women, who were not formally trained nurses, to provide health-related care service to various communities (Canadian Encyclopedia, 2021). Examples of services

provided by the Black Cross nurses included answering sick calls, assistance to new mothers and children as well as domestic duties (Canadian Encyclopedia, 2021). In addition to informal care practices by Black women, community-level activism was the catalyst that ignited the process of challenging the systemic barriers encountered by Black women entering nursing. Early activism was led in large part by Pearleen Oliver, who despite not being a nurse, had a pivotal role in shifting the overt discriminatory admissions policies in nursing training facilities in Canada (Chaplan, 2020). Oliver, in collaboration with community-based groups and organizations, including the Nova Scotia Association for the Advancement of Colored People (NSAACP) and the Canadian Negro Citizenship, publicly challenged the exclusion of Black women from nursing schools, which is marked as a pivotal moment for Black history in Canadian nursing (Chaplan, 2020; Flynn, 2011).

4.3.2.2 The Nursing Workforce in Canada. Canada recognizes four nursing designations, which include licensed practical nurses (LPNs) [or registered practical nurses (RPNs) in Ontario]; registered nurses (RNs), registered psychiatric nurses and; nurse practitioners (NPs) (CIHI, 2019). Of the 448,044 regulated nurses with an active license in Canada, approximately 130,710 are licensed practical nurses, 6,115 are registered psychiatric nurses, 304,558 are registered nurses and 6,661 are nurse practitioners (CIHI, 2019). In terms of demographics, the Canadian Institute for Health Information (CIHI) disaggregates data regarding the nursing workforce according to gender as binary and age however, critical demographic indicators including race/ ethnicity, sexual orientation, gender identity/ expression, class as well as disability are missing. In the absence of these data to advance knowledge and inform policy development in a comprehensive and evidence-based manner, there is a growing call for the collection of race-disaggregated data (Rizvic, 2020). One of the main crises impacting the nursing workforce in Canada is related to the nursing shortage. The nursing shortage has been described as an ongoing health system issue that has been further exacerbated by multifaceted population health issues, including the COVID-19 pandemic. Strategies to address the shortage include considerations in three critical areas – RN production; RN retention; RN deployment, with emphasis on the in-migration of internationally educated nurses (IENs), attrition in nursing education programs and workforce productivity (Tomblin Murphy et al., 2012).

4.3.2.3 Considerations in Nursing Education. Another area of concern that directly impacts the Canadian nursing workforce is nursing education. Nursing education encompasses salient aspects of nursing training including curriculum and program admissions. Canadian nursing curricula has been criticized as relying too heavily on a Eurocentric ideological foundation that effectively reinforces prejudice, stereotypes and discrimination towards specific groups (Bell, 2020; Blanchet et al., 2018; Flynn, 2021; Lane & Waldron, 2021). It has also been criticized for failing to incorporate content that would enhance competency related to care

delivery for historically marginalized populations (Bell, 2020; Blanchet et al., 2018; Flynn, 2021; Lane & Waldron, 2021). Nursing curricula tends to omit content that incorporates the experience, contributions or basic existence of Black nurses in Canada (Flynn, 2021). To address these gaps in nursing curricula, researchers and academics are attempting to remedy this problem (Bell, 2020; Blanchet et al., 2018; Lane & Waldron, 2021). For example, Blanchet et al. (2018) proposed a critical anti-discriminatory pedagogy (CADP) for nursing practice and education. Another salient example of critical shifts in nursing curricula includes the development of a syllabi evaluation tool (Lane & Waldron, 2021). Emerging from the need to evaluate and modify the content used in nursing education, Lane and Waldron (2021) created a rubric that evaluates syllabi in nursing education. This rubric, which aims to improve nursing curricula through increased representativeness and the elimination of oppressive stereotypes, guides faculty in the development of inclusive and representative syllabi (Lane & Waldron, 2021).

In terms of program admissions, most institutions do not collect disaggregated data that would offer insight into the representativeness of the student body. However, the underrepresentation of Black students in nursing programs had been acknowledged and described, in text and opinion sources, as an issue that is exacerbated by institutional policies and implicit bias. Further, the underrepresentation of Black nurses in the profession is suspected as deriving from the underrepresentation of Black students in nursing programs.

4.3.2.4 Nursing as a Clinical Practice. Social justice and a critical social approach to health are core values in nursing (Blanchet et al., 2018). However, a shift away from these values has created tension in the profession as nurses struggle to reintroduce these values into nursing practice and education (Blanchet et al., 2018). For example, the issue of diversity in the nursing profession in Canada can be attributed to factors such as stereotypes and discrimination, institutional and systemic barriers (i.e.: financial), as well as a lack of representative mentors and role models (CNA, 2009). Etowa et al. (2011) suggest that in order to increase diversity within the nursing profession in Canada, healthcare organizations must educate, recruit, and retain health care professionals of diverse backgrounds and these professionals be representative of the diverse Canadian population. Further, Phillips and Malone (2014) argue that minority nurses have an important role in the healthcare system since they drive the recruitment and retention of a diverse workforce. Finally, to truly diversify the nursing workforce, address intra-professional tensions and improve health outcomes for populations, it is necessary to both eliminate barriers to accessibility that reinforce exclusion and marginalization and to enhance the sense of belonging for groups who have historically been marginalized and excluded from nursing (Boyd, 2019; CNA, 2009; Jefferies, 2021).

Growing attention to anti-Black racism, particularly as it relates to nursing, reinforces both the timeliness and necessity of this review. There is a need to understand the available literature by charting the existing evidence related to Black nurses in Canada. A scan of the literature determined that no other scoping or systematic review on this topic exists. Thus, the objective of this scoping review was to chart the existing evidence regarding Black nurses in the nursing profession in Canada. This review, which is a component of a larger doctoral research project, offers recommendations for future research regarding Black nurses in Canada. Finally, this review contributes to the international call-to-action by the United Nations, to improve the human rights, social wellbeing, and overall health of people of African descent in Canada and globally.

4.3.3 Review Question

What evidence exists regarding Black nurses in the nursing profession in Canada? Specifically, to:

1. Describe how Black nurses have been represented in the literature.
2. Map existing evidence to inform knowledge gaps and priorities for future research.

4.3.4 Inclusion criteria

4.3.4.1 Participants. This review sought studies involving Black nurses. Black nurses are defined as nurses who reside in Canada and identify as being Black or of African descent. Specifically, Black nurses may include immigrants from continental Africa, the Caribbean or United States; people of African descent who reside in Canada; as well as Black folks with ancestral connections to Canada such as African Nova Scotians. No restrictions were placed on other key demographic details such as gender, sexual orientation, class or disability. Studies that did not include participants who were identified as Black nurses were excluded. Furthermore, studies that did not include race-disaggregated findings or results were excluded. For example, studies that focused on internationally educated nurses, which aggregated internationally educated nurses from multiple countries without a clear indication as to which data applied to Black nurses, were excluded.

4.3.4.2 Concept. The concept of interest was the nursing profession, specifically Black nurses in nursing. Thus, sources were considered for inclusion if they referenced an aspect of the nursing profession, including clinical care, education, administration, policy or research. Studies were excluded if they focused on non-nursing care providers [ie: physicians, psychiatrists, physiotherapists], nursing students [ie: diploma or baccalaureate], non-licensed clinical care providers [ie: personal support workers or continuing care assistants], or if the sources aggregated data on various health care providers without clear indication as to which data were nursing specific.

4.3.4.3 Context. The context for the scoping review is Canada. Studies were considered for inclusion if they related to any of the 13 provincial or territorial regions or if the studies were national in scope. Studies that

involved multiple countries were considered for inclusion if they included disaggregated data regarding Canada and Black nurses.

4.3.4.4 Types of Sources. This scoping review considered all qualitative, quantitative, and mixed methods study designs as well as systematic reviews for inclusion. Gray literature such as dissertations, text and opinion papers, as well as organizational reports or policy documents were considered for inclusion in this scoping review. Finally, no restrictions were placed on date of publication, however, language restrictions were limited to English and French.

4.3.5 Methods

The Joanna Briggs Institute (JBI) is an international evidence-based healthcare research organization that is a global leader in the production and dissemination of evidence syntheses. JBI has over 70 collaborating entities globally to promote, support and implement evidence into healthcare practice (Peters et al., 2017). Currently, JBI offers formal methodological training and guidance on 10 types of reviews, with scoping reviews being a common approach. Scoping reviews are an effective approach to map or chart a particular area of research, particularly if that area is unclear or poorly defined. These reviews use the mnemonic, *PCC*, which represents *participants, concept,* and *context*. Scoping reviews are an excellent starting point in research as they help to identify the types of available evidence in a given field, they facilitate the identification and summation of knowledge gaps, they allow for the clarification of key concepts and definitions in literature, they provide an understanding of how research is conducted in relation to a specific topic or field, and they enable the identification of key characteristics or factors related to a concept. Finally, by clarifying working definitions or conceptual boundaries related to topics or fields, scoping reviews serve as excellent precursors to qualitative, quantitative or mixed methods systematic reviews. To this end, this scoping review was conducted in accordance with the JBI scoping review methodology (Peters et al., 2017). The objectives, inclusion criteria and methods guiding this review were published in an *a priori* protocol (Jefferies et al., 2020).

4.3.5.1 Search Strategy. The search strategy was developed in collaboration with a librarian and peer reviewed by a second librarian using the Peer Review of Electronic Search Strategies (PRESS). The search, which was conducted on August 31st, 2020, aimed to locate published studies and gray literature. An initial limited search of CINAHL was undertaken to identify articles on the topic. Keywords in the titles and abstracts of relevant articles, and the index terms used to describe the articles were used to develop the final search strategy used to search databases from inception to present. The search strategy, including all identified keywords and index terms, was adapted for each included information source. Search terms related to the population of interest included African Canadian, Black, African Nova Scotia, immigrant, and minority, as

these terms are used in Canada. Other keywords included nurse and Canada. The search strategy is located in Appendix D. Ancestry searching and forward citation tracing was performed to identify relevant sources. Lastly, searches were restricted to literature published in Canada's two official languages, English and French.

4.3.5.2 Information Sources. Information database sources include CINAHL (EBSCO), MEDLINE (Ovid), Embase (Elsevier), Sociological Abstracts (ProQuest), Gender Studies Database (EBSCO), America: History and Life (EBSCO), PsycINFO (EBSCO), Academic Search Premier (EBSCO), and Scopus (Elsevier). Sources of unpublished studies and gray literature searched included websites of the Canadian Nurses Association, Registered Nurses Association of Ontario, College and Association of Registered Nurses of Alberta, Nova Scotia College of Nursing, and ProQuest Dissertations and Theses Global (ProQuest). Scopus (Elsevier) was also used for the forward citation tracing.

4.3.5.3 Study Selection. Following the search, all identified citations were collated and uploaded into Covidence (Veritas Health Innovation, Melbourne, Australia) and duplicates removed. From the title/abstract stage through to data extraction phase, each study was reviewed by two independent reviewers. At the title/abstract, full-text, and data extraction phases, several articles were screened by two independent reviewers against the inclusion criteria in a pilot test to calibrate the screeners/extractors (Jefferies et al., 2020).

At the title/abstract stage and full-text screening stage items that did not meet the inclusion criteria were excluded. Specifically, sources were screened first according to the context, the next level of screening was based on participants and the final level of screening was the concept. Reasons for exclusion of full text studies not meeting the inclusion criteria were recorded and are reported in Appendix E. Lastly, in accordance with the a priori protocol, any disagreements that arose between the reviewers at each stage of the study selection process were resolved through a third reviewer or through discussion with the review team. The results of the search are reported in the Preferred Reporting Items for Scoping Reviews (PRISMA-ScR) flow diagram (Page et al., 2021).

4.3.6 Data Extraction

The data extraction tool, appended in the a priori protocol, was developed based on a JBI standard extraction form. This extraction form was inserted into the Covidence software and extraction was completed by the first author and checked by a second extractor who was a member of the review team. Conflicts or disputes that arose between the reviewers, regarding inclusion/ exclusion of sources or data extraction, were resolved by a third reviewer or through discussion with the review team.

4.3.6.1 Data Items. Specific data items for which data were sought are found in the extraction tool appended in the a priori protocol (Jefferies et al., 2020). Examples of data items included: source title, year of

publication, source type and authors. Additional source information related to methodological aspects included the: aim/purpose, questions/objectives, study design, framework and sample size; and additional data items including results/key findings with accompanying quotations and statistics relevant to the review objective. Finally, the set of associated assumptions regarding the participants, concept and context were as follows:

4.3.6.1.1 Participants. It is assumed that all Black nurses in Canada have completed nursing training at either the diploma or baccalaureate level. It was also assumed that the use of the term *Black* referred to people of African descent, who identified as such. Conversely, this review did not assume that studies that described participants as visible minority, immigrant, racialized, etc. were exclusively Black nurses. Yet, this review did assume that nurses identifying as immigrating from the Caribbean and continental Africa were Black. This assumption was not made without careful consideration of the population, sample and demographics provided by authors.

4.3.6.1.2 Concept. Assumptions about nursing included the restrictions around licensing and registration in nursing as well as the criteria regarding the use of the title *nurse*. For example, sources that referred to nursing, unless otherwise stated, were assumed to involve practical nurses, registered nurses and/ or advanced practice nurses. In Canada, the term *nurse* is a protected term that cannot be used by non-nursing care providers. The concept of nursing included any practice setting. While any sources that involved pre-licensure nursing students were excluded.

4.3.6.1.3 Context. In terms of context, an assumption around language was made. The search was restricted to French and English, which are the two official languages in Canada.

4.3.6.2 Analysis and Presentation of Results. Data from included sources were extracted and stored in Covidence. After extracting data in Covidence, data were then exported and managed in Microsoft Word. Data were reviewed and organized, by team members, using Microsoft Office Word in addition to hand-written notes. Microsoft Word and hand-written notes were used to generate the categories into which sources were sorted. The approach for summarizing and presenting findings, through the creation of categories is described in the a priori protocol.[7] The presentation of results is done in an appropriate manner to facilitate mapping the existing evidence regarding Black nurses in Canada. Thus, the data are presented narratively in categories as well as in diagrammatic or tabular form, where appropriate. The presentation of the review results aligns with the scoping review objective and review questions of charting the existing evidence regarding Black nurses in the nursing profession in Canada. Finally, the review categories that depict the findings were not developed through a thematic or qualitative process. Rather, the categories are derived directly from the included sources and serve only as a means to classify each source. Additionally, a critical appraisal of sources was not

conducted. Consequently, this review is scoping in nature and should not be conflated with or regarded as a qualitative systematic review.

4.3.7 Results

4.3.7.1 Study Inclusion. The search of databases yielded 688 records with 338 identified through citation tracing. After removing duplicates, 600 titles and abstracts were screened for eligibility and 127 advanced to full-text screening. From this process, 82 full-text articles were excluded based on inclusion criteria. Appendix 2 includes a list of excluded sources and accompanying rationale for exclusion. A total of thirty-seven (n=37) sources were retrieved through the database search and seven (n=7) sources were identified through the gray literature search. Subsequently, 44 sources met the inclusion criteria and 31of these sources underwent data extraction. The PRISMA-ScR flowchart in Figure 1 shows the study selection process.

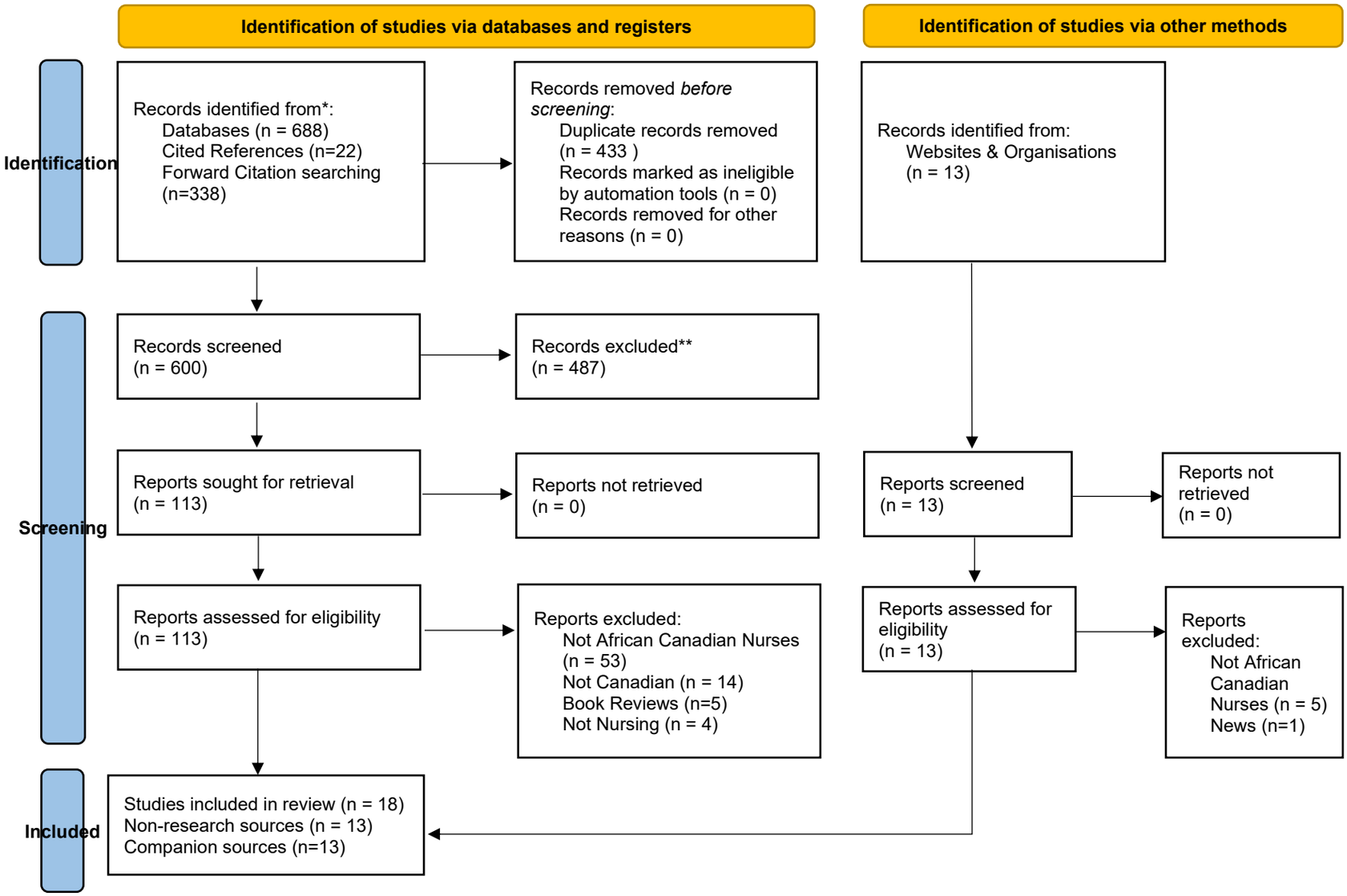
The 44 sources that met the inclusion criteria are classified into two distinct groups: primary sources (n=31) and companion sources (n=13). Primary sources are defined as original and distinct sources, which do not share data with other sources. Companion sources include sources (commentaries and research reports) that were retrieved through the systematic search and met the inclusion criteria, however, they use data from one of the included primary sources. It was necessary to group the included sources in this manner to avoid the duplication of data in the scoping review results and findings. Figure 2 depicts the type of primary sources included in the review.

In this review, only the primary sources (n=31) underwent data extraction. This decision was made to avoid confusion by the inclusion of duplicate data from companion sources (n=13) using data from a primary source. A description of the 31 included sources that underwent data extraction is located in Appendix 3. The companion sources, which are detailed in Appendix 4, did not undergo data extraction and thus are not included in the results sections. The process for selecting primary sources was based on two criteria: 1) comprehensiveness of study design and 2) consistency amongst sources. For example, if there were multiple sources that were generated from an included dissertation, the dissertation was selected as the primary source. There is one exception, where the dissertation is classified as a companion source and the book generated from this research was selected as the primary source. The four primary sources from which all of the companion sources arise are outlined in Table 3

*Primary Sources and Companion Sources*Table 3.

Figure 1

PRIMSA-ScR Flowchart of Study Selection Process



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi:10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

Figure 2

Types of Primary Sources

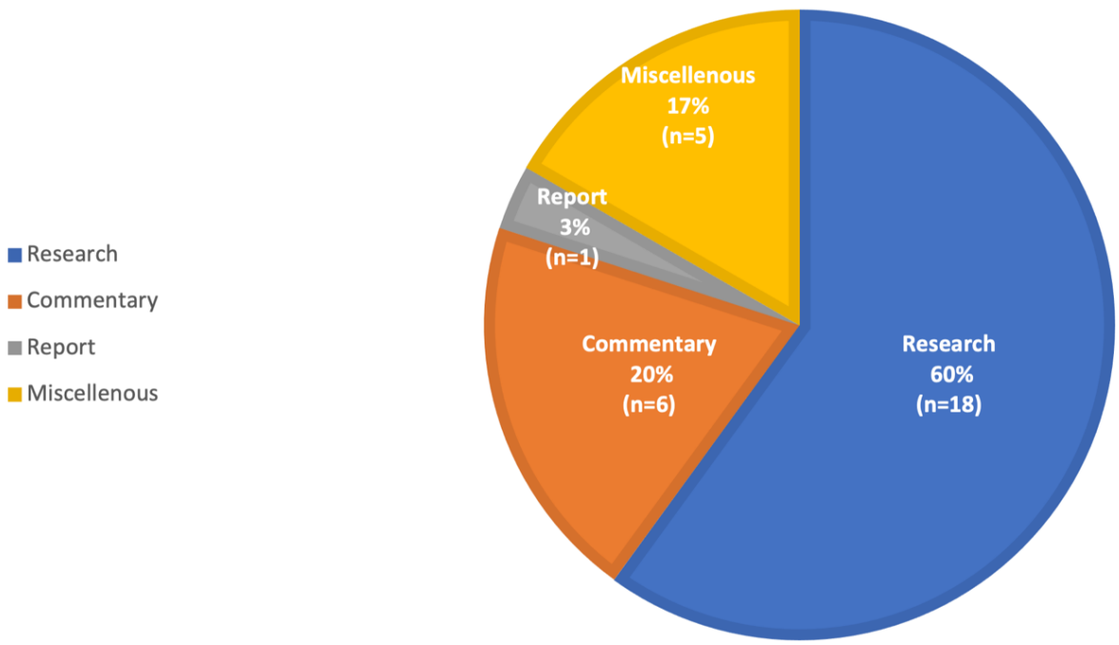


Table 3

Primary Sources and Companion Sources

Primary sources with companion sources - Research Studies (n=4)	Companion sources - Commentaries and Research (n=13)
Boateng (2015)	Boateng (2016) Boateng (2019)
Etowa (2005)	Etowa (2006) Etowa (2007) Etowa (2009)
Flynn (2011)	Flynn (2003) Flynn (2004) Flynn (2008) Flynn (2009) Flynn (2012) Flynn (2015) Shkimba and Flynn (2004)
Hagey (2001)	Turrittin (2002)

4.3.7.2 Characteristics of Included Sources. Of the 31 primary sources included in this review, the year of publication ranged from 1993 to 2020. All included sources were published in English except one (n=1), which was published in French. Another source focused on Francophone-African nurses. All participants are assumed to be adults, over the age of 18. In terms of gender, fourteen sources focused on participants identified as women (n=14), while five (n=5) included both women and men and twelve (n=12) did not specify gender.

Eighteen of the 31 primary sources are classified as research studies (n=18), of which five (n=5) are doctoral dissertations and two (n=2) are books. Table 4 and Table 5 display the list of research studies (n=18) and non-research sources (n=13), respectively. Fourteen of the eighteen research studies were qualitative designs (n=14), in which data collection methods included interviews (n=10) and a combination of methods such as document/ literature review, interviews, group discussions and observation (n=4). One (n=1) of the eighteen studies employed a quantitative study design, as a secondary data analysis and two (n=2) studies used a mixed methods design, which used a combination of interviews and secondary analysis. Finally, one (n=1) study was a systematic scoping review. The theoretical frameworks or methodologies for the research studies included critical social approaches, such as integrative anti-racist frameworks, Black feminist theories, postcolonial feminist perspectives, and intersectionality. Others employed more traditional methodologies including phenomenology, critical ethnography, grounded theory or descriptive.

Table 4

Research Studies (n=18)

Author (Year of Publication)	Research Aim/ Purpose	Methodology/ Design	Methods	Study Location	Nursing Concept
Boateng (2015)	To explore the career pathways and experiences of immigrant and Canadian-born nurses in two Ontario cities.	Qualitative Research *DISSERTATION	Interviews	Ontario [Toronto and London]	Leadership and Career Advancement
Bouabdillah et al. (2016)	To explore the perspectives of visible minority nurses in relation to their career paths.	Qualitative Research Critical Ethnography	Interviews, observations, field notes.	Ontario/ Ottawa	Leadership and Career advancement
Calliste (1996)	To examine experiences of women of colour, specifically African Canadian nurses, organizing and resisting racism in nursing in Ontario and Quebec from the late 1970s to	Qualitative Research Integrative Anti-Racism	Interviews	Ontario and Quebec	Racism

Author (Year of Publication)	Research Aim/ Purpose	Methodology/ Design	Methods	Study Location	Nursing Concept
	the 1990s, from an integrative anti-racism perspective.				
Calliste (1993)	To examine Canada's immigration policy on Caribbean nurses and nursing assistants during the post-war industrial and baby boom period, 1950 to1962.	Qualitative Research	Document review, Literature Search & Interviews	National	Immigration/ Migration
Collins (2004)	To investigate the experiences of immigrant women from the Caribbean who are registered nurses (RNs) in Canada.	Qualitative Research Descriptive *DISSERTATION	Interviews	Ontario	Leadership and Career Advancement
Das Gupta (2009)	To develop a theoretical framework for understanding systemic racism.	Mixed Methods Research *BOOK	Literature review, surveys	Ontario	Racism
Das Gupta (1996)	To describe the experience of racism in nursing in Ontario drawing on the case histories of two Black nurses who have brought complaints against their hospital to the OHRC. [Included this experience of racism in light of experiences documented in other sources.]	Qualitative Research	Interviews & case review	Ontario	Racism
Etowa (2005)	To discover the nature of work life experiences of Black nurses in the health care system in Nova Scotia.	Qualitative Research Grounded Theory *DISSERTATION	Interviews, literature review, field notes, observation, group discussion	Nova Scotia	Worklife/ Diversity in Nursing
Flynn (2011)	To describe the lives of Caribbean and Canadian born Black professional women.	Qualitative Research *BOOK	Interviews	Ontario	History
Hagey et al. (2001)	To document and describe the experiences of immigrant nurses of colour who have filed grievances concerning their employers' discriminatory practices; and to solicit their views of existing policies and recommendations for equity in professional life.	Qualitative Research Analytical Framework: Everyday Racism and Discourse Analysis	Interviews	Ontario	Racism
Keddy (1997)	To recover identities of Black nurses to help shed [light on] social issues that shape the profession today.	Qualitative Research	Interviews (Oral Histories)	Nova Scotia	History

Author (Year of Publication)	Research Aim/ Purpose	Methodology/ Design	Methods	Study Location	Nursing Concept
Labonté et al. (2006)	To ascertain recent trends on health human resource (HHR) flows, perceived reasons for such flows, and key Canadian stakeholder awareness of, and support for, options by which Canada might help mitigate the negative effects of HHR migration from this region.	Mixed Method	Interviews and Secondary Analysis	National	Immigration/ Migration
Modibo (2004)	To present the everyday workplace experiences of racism that African Canadian nurses confronted in some of Toronto's hospitals in the decade that followed the letter's receipt.	Qualitative Research	Interviews	Ontario [Toronto]	Racism
Premji et al. (2014)	To develop a diversity profile of the nursing workforce in Canada and its major cities.	Quantitative Research	Secondary Analysis	National/ Multi-city [Toronto, Vancouver, Montreal, Halifax]	Diversity in Nursing
Prendergast (2014)	To examine the roles of the ideal type and multiculturalism policies within nursing and questions whether it works in favour of internationally educated nurses of colour or more as a hindrance to their educational and promotional development	Qualitative Research Post-colonial, anti-racist feminist and Black Canadian feminist theory *DISSERTATION	Interviews	Ontario	Leadership and Career Advancement
Racine (2009)	To present experiences of everyday racism observed and collected in a critical ethnography among a group of Haitian Canadians in Quebec.	Qualitative Research Post-colonial Feminist perspective/ Critical Ethnography	Interviews	Quebec	Racism
Sands et al. (2020)	To examine the amount, type, sources, distribution, and focus of the conceptual and empirical literature on migration of Caribbean nurses and to identify gaps in the literature.	Scoping Review 5 stage framework	Review of Literature	National	Immigration/ Migration
Stewart (2009)	To examines the impact of race on the workplace experiences of Black women in nursing leadership positions.	Qualitative Research Integrative anti-racism and Black feminism *DISSERTATION	Interviews	Ontario [Toronto]	Leadership and Career Advancement

Table 5

Non-Research Sources (n=13)

Author (Year)	Source Title	Source Type	Concept in Nursing
Congress of Black Women Canada - Toronto Chapter (1995)	End the silence on racism in health care: Build a movement against discrimination, harassment and reprisals	Commentary	Racism
Canadian Nurses Association (2020)	CNA's Key Messages on Anti-Black Racism in Nursing and Health	Key Messages	Racism
Flynn (2019)	Writing Black Canadian Women's History: Where We Have Been and Where We are Going	Commentary	Racism
Flynn (2018)	"Hotel Refuses Negro Nurse ": Gloria Clarke Baylis and the Queen Elizabeth Hotel	Commentary	Racism
Jefferies (2020)	Recognizing history of Black nurses: a first step to addressing racism and discrimination in nursing	Commentary	Racism
Jefferies et al. (2018)	Black Nurse Leaders in the Canadian Healthcare System	Commentary	Leadership
Missen (2010)	De l'Afrique a Winnipeg: Three Nursing Journeys	Commentary	Immigration
Registered Nurses Association of Ontario (RNAO) (2020a)	RNAO stands together with our black sisters and brothers	Announcement	Racism
Registered Nurses Association of Ontario (RNAO) (2020b)	RNAO stands together with our black sisters and brothers	Media statement	Racism
Registered Nurses Association of Ontario (RNAO) (2015)	A History of Diversity & Inclusivity: In celebration of RNAO's 90th anniversary – and to mark February as Black History Month – we take a look back at the association's work on diversity, a matter that has shaped the profession from the mid-20th century to today.	Report	Diversity
Registered Nurses Association of Ontario (RNAO) (2011)	RNs Mark the passing of a true leader	Memorandum	Leadership
Registered Nurses Association of Ontario (RNAO) (2002)	Policy Statement: Racism	Policy statement	Racism
Villeneuve (2003)	Healthcare, Race and Diversity: Time to Act	Commentary	Diversity

4.3.7.3 Sources by Geographical Area. The context for this review was Canada thus, all 31 included sources were from within Canada. Sources display regional trends, with the majority of sources being concentrated in the province of Ontario (n=14). Additional locations included Nova Scotia (n=2), Manitoba (n=1) and Quebec (n=2). While 10 (n=10) sources included participants from multiple provinces or were described as national in scope.

4.3.8 Review Findings

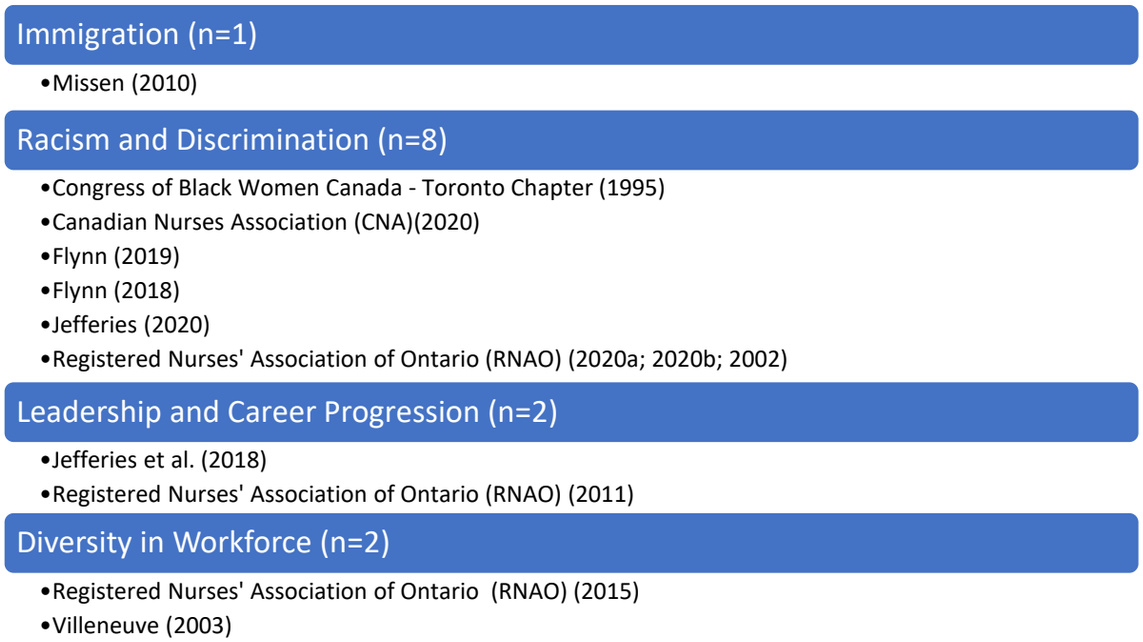
As noted in the a priori protocol, the objective of this scoping review was to chart existing literature regarding Black nurses in the nursing profession in Canada. The results of this review are presented according to five conceptual categories generated from the 31 primary sources. These categories were generated by identifying the aim or purpose of the source, which generally included a central concept such as *racism in nursing*, *leadership* or *immigration*. It is important to note that the nature of this review inevitably resulted in an overlap of key findings across categories. Ergo, sources were classified under the category based on terminology used in the title of the source as well as the in the aim or purpose. It is acknowledged that an argument could be made for a limited number of sources to be classified differently. With this in mind, the presentation of the results of the scoping review should be viewed as intended – a mapping or charting of existing evidence. **Error! Reference source not found.** illustrates the five categories for the research studies, w hile Figure 4 illustrates the four categories for non-research sources and the number of studies classified under each respective category. As shown, the categories include: 1) Historical Situatedness, 2) Immigration, 3) Racism and Discrimination, 4) Leadership and Career Progression, and finally, 5) Diversity in the Workforce. To reiterate, this scoping review maps the existing evidence regarding Black nurses in the nursing profession in Canada. It is not a qualitative review thus, there is no interpretive component nor critical appraisal of methodological quality for the included sources.

Figure 3

Concepts in Nursing: Research Studies (n=18)

Figure 4

Concepts in Nursing: Non-research Sources (n=13)



4.3.8.1 Historical Situatedness. This category focused on situating the historical experiences of Black nurses in Canada. While multiple sources described salient points about the historical context, two research studies explicitly focused on describing the historical experience of Black nurses in Canada (Flynn, 2011; Keddy, 1997). These two sources used a combination of oral histories and archival sources to document the experiences of Black nurses in Canada. Reviewing and documenting the historical accounts of Black nurses in Canada revealed repeated attempts to erase the contributions and presence of Black nurses (Flynn, 2011). However, despite the historical exclusion and attempted erasure of Black nurses from various records, scholars persisted in uncovering these records, documenting stories, identifying issues and addressing conspicuous gaps in nursing history. For example, Flynn's (2011) review of archival documents and records revealed that prospective Black students were not permitted to enter Canadian nursing training institutions until the 1940s. It was determined that the refusal to admit Black students into nursing was done on the basis of racial discrimination and prejudice, which cited race-related factors as the reason for denial of admissions.

The use of oral histories from Black nurses illustrated a portrait of leadership that shed light on social issues that shaped contemporary nursing. Keddy (1997) found that Black nurses in the province of Nova Scotia had professional experiences that differed significantly from those of white nurses. The historical account explains the similarities and difference amongst Canadian-born Black nurses and Black IENs (Flynn, 2011; Keddy, 1997). Both Keddy (1997) and Flynn (2011) found that Canadian-born Black nurses described the impact of being socialized in a predominantly white environment, where experiences of racism and segregation began in childhood. Conversely, Black nurses who immigrated to Canada from Africa or the Caribbean, IENs, reported challenges with national immigration policies and restrictions as well as cumbrous nursing registration and licensing requirements that delayed integrating and gaining acceptance into the profession and the country.

4.3.8.2 Immigration. In the context of this review, immigration refers to the formal processes of people of African descent migrating to Canada. Three research studies (Calliste, 1996; Labonté et al., 2006; Sands et al., 2020) and one commentary (Missen, 2010) described the immigration or migration patterns of Black nurses to Canada. The Caribbean and continental Africa were noted as being amongst the most prevalent countries of origin for immigrant nurses (Calliste, 1996; Labonté et al., 2006; Sands et al., 2020). Complex systemic processes and policies were shown to have a significant impact on the migration patterns of IENs. Restrictive immigration policies paired with poorly defined or unclear processes were found to be recurring obstacles for IENs. Immigrating to Canada, for Black nurses, was aggravated by significant challenges with integration into the nursing profession, consequential to navigating the licensing and registration process. For example,

Francophone-African nurses immigrating to Canada spoke about navigating a complex and unclear immigration process, adapting to more "individualistic cultural" norms as well as enhanced feelings of safety and security in Canada (Missen, 2010). For the IENs who managed to integrate into Canada and the nursing profession, there are accounts of continued issues and challenges. Boateng describes the systemic issues that were encountered by IENs and visible minority nurses in their career pathways and immigration into Canada. IENs encountered more systemic issues within the workplace, more verbal abuse, were excluded from upward career mobility and were denied the opportunity to be a part of decision-making processes (Collins, 2004). Additionally, IENs were found to have a more indirect, convoluted, and lengthy pathway into the nursing profession (Boateng, 2015).

A review of literature, interviews and the analysis of official documents and policies showed that Canadian immigration policies effectively restricted and limited the entry of professional and skilled workers from the Caribbean. One such policy, entitled *Women of Exceptional Merit*, required that Caribbean nurses demonstrate a level of merit that far exceeded the professional qualifications of non-Black nurses to gain entry to Canada. This policy dictated that Black nurses from the Caribbean could be granted temporary entry to Canada if they were deemed to be of "exceptional merit" and with a promise to return to their home countries after their transitory stay (Calliste, 1996; Sands, 2020). *The Women of Exceptional Merit* policy created systemic barriers in regulatory practices and work environments, which Caribbean nurses were forced to navigate (Calliste, 1996; Sands, 2020). Each of the studies that examined immigration and migration argued that there is an urgent need to evaluate and revise immigration policies, and utilize intersectional analysis in research, especially as the migration of Black nurses into Canada accelerates.

4.3.8.3 Racism and Discrimination. Racism and discrimination are terms used to describe the intentional or unintentional stereotypical assumptions and negative treatment based on various factors including race, gender and class. Racism and discrimination were frequently occurring central issues identified in six research studies and eight non-research sources related to Black nurses in Canada. Four of the six sources included discriminatory lawsuits or grievances filed by Black nurses in the provinces of Ontario and Quebec. Racism and discrimination were described as multifaceted issues that occurred interpersonally as well as systemically. These deeply embedded issues were found to permeate multiple levels, from everyday interpersonal interactions to institutional processes and policies as well as the attitudes and ideologies. In terms of interpersonal experiences of racism, Black nurses encountered racism perpetrated by patients, colleagues and supervisors. Nurses reported being subjected to racial slurs in addition to microaggressions relating to their appearance, background or ability to perform their work. For example, Black nurses described everyday workplace experiences that included issues of differential treatment noting that they did not receive standard

professional courtesies (Modibo, 2004). Nurses also reported mistreatment and verbalized racial abuse from patients, such as some patients refusing to be cared for by "Black hands" Modibo (2004, p.111).

Systemic racism included discriminatory institutional and organizational policies, procedures, and processes. Hiring processes, unjustified termination, enhanced surveillance, and lack of organizational support were reported as elements of systemic racism in nursing and healthcare. Calliste (1993) explained how systemic issues including economic restructuring (in the form of lay-offs) disproportionately impacted Black nurses (1993). Additionally, Black nurses highlighted systemic racism in the form of discriminatory hiring practices. Sources that examined the legality of formalized grievances and lawsuits determined that racism was a precipitating factor in all of these proceedings. In one instance, complaints filed with the Ontario Human Rights Commission (OHRC) found that two Black nurses had experienced racism that was gendered and classed Das Gupta (1996). This finding introduces the notion of intersectionality (or triple jeopardy), which occurs when discrimination is attached to three social constructions such as being a woman, racialized and an immigrant. Multiple sources in this review described the racially specific gendered and classist ideologies that were used to justify the racial division of labor, exploitation, and the devaluation of Black nurses.

Nurses who filed grievances regarding discrimination by their employers reported feelings of marginalization, experiencing physical stress and emotional pain, the need to develop strategies to cope and survive.[55] There was also a large amount of fear, lack of support, harassment and ineffective institutional responses that made it difficult for Black nurses to report and take action against racism. A landmark case involving Gloria Baylis is another example of a racial discrimination case in nursing in Canada related to discriminatory hiring practices. The Baylis case (2018), like others, attracted media attention and began to shift attention towards addressing issues of racial discrimination in nursing and society.

The ongoing issue of racism and discrimination in the nursing profession led two prominent nursing organizations in Canada to draft and share statements denouncing anti-Black racism in nursing in Canada. The Canadian Nurses Association (CNA) (2021) identified anti-Black racism as a public health crisis, acknowledged the legacy of anti-Black racism in Canadian nursing history, and described ways that CNA will combat anti-Black racism. While the RNAO, which has challenged discrimination for decades, released a policy statement detailing their stance against racism in nursing (2020). The policy outlined their commitment to creating an environment where all nurses and patients are valued and treated with respect and dignity. These public organizational statements are important considering that multiple sources in this review identified and described racism as a significant determinant in career progression, advancement, promotion and entering formal leadership roles.

4.3.8.4 Leadership and Career Advancement. Leadership and career progression in nursing refers to the vertical and lateral movement within a career. Career pathways, promotions, development, upward movement, opportunities for advancement and obtaining formal leadership roles, were examples of vertical and lateral mobility used to describe career progression and leadership. Five research studies and two non-research sources were classified in this category. The definition of leadership varied across included sources, with some sources referring to leadership exclusively as formal roles or titles such as managers. Sources highlighted systemic barriers to career advancement and mobility, underrepresentation in leadership and managerial roles, job dissatisfaction and a lack of opportunities to support and facilitate advancement. Again, as mentioned above, racism was identified as a significant determinant in career progression, advancement, promotion and entering formal leadership roles for Black nurses.

The notion of career progression, promotion and mobility was interwoven with many sources that discussed leadership. Despite studies examining leadership, Black nurses were found to be underrepresented in management roles. The impact of the exclusion of Black nurses from leadership positions was intensified by nurses having heavier workloads. Collins'(2004) describes how IENs were excluded from lateral and vertical career mobility opportunities, excluded from decision-making, and had repeated negative workplace interactions. IENs experienced more systemic issues within the workplace, more verbal abuse, excluded from upward career mobility and were denied the opportunity to be a part of the decision-making processes (Collins, 2004). Effectively, the career trajectory of Black nurses was fraught with discrimination. For example, nurses spoke about the underrepresentation of Black nurses in leadership positions while describing the ways in which they felt excluded from attaining management positions. The nurses expanded upon their interpretation of systemic barriers to explain how collegial relationships and workload also impacted their career advancement. A lack of managerial support and guidance in addition to heavier workloads were perceived as barriers to promotion. Notably, white nurse managers acknowledged the underrepresentation of Black nurses in leadership roles but felt that the process of career advancement in nursing was both fair and transparent.

When present, Black nurse managers reported feeling undervalued, marginalized, isolated, received differential treatment, experienced criticism and needed to work twice as hard as white colleagues. Specifically, Stewart's (2009) investigation of the impact of race on the work experiences of Black women nurses in formal leadership positions found that these nurses experienced unfair treatment based on race; a lack of guidance and support from peers; feeling invisibility, unimportance; the need to prove oneself as a leader by being "twice as good"; and the need to negotiate racial identity as a benefit or liability (Stewart, 2009). Finally, nurse managers expressed decreased job satisfaction due to these experiences of everyday racism, microaggressions and

negative criticism. An examination of multiculturalism policies in nursing revealed that Black IENs tend to occupied a hybrid space, involving minimal leadership responsibility with no movement into higher levels of leadership. IENs entered the hybrid space due to their multicultural and multilingual abilities being viewed as assets. Yet, despite this, IENs expressed that their work went unrecognized and that they were excluded from policy-making leadership positions. This realization was compounded by the absence of Black nurse leaders in formal leadership positions (Prendergast, 2015). Remarkably, identified an "ideal type" in nursing leadership related to those who occupy policy-making positions, which were found to be white, middle-class nurses (Prendergast, 2015).

4.3.8.5 Diversity in the Workforce. As described in the a priori protocol, diversity in the workforce refers to the active effort to have a profession that includes individuals from a multitude of groups who bring experiential knowledge, insight, and variable difference across aspects such as gender, race, age, sexual orientation, language and ability. The importance of promoting and cultivating diversity in the nursing workforce was a resounding theme present in multiple sources throughout this review. In terms of diversity in the workforce, there are two research studies (Etowa, 2005; Premji & Etowa, 2014) and two non-research sources (RNAO, 2021; Villeneuve, 2003) that were classified under this category.

Etowa's (2005) grounded theory describes how Black nurses navigated and succeeded in nursing while feeling as though they were practicing on the margins of the profession. Nurses felt that despite being an insider by virtue of their education, training, and values, there was an ever-present struggle to navigate a profession in which they considered themselves as practicing outside the center. Key internal and external drivers were identified as necessary to facilitate integration into the profession (Etowa, 2005). Combined with the diminished sense of belonging in the profession, a diversity profile of Canada's nursing workforce, using census data, found that visible minorities were concentrated or over-representation in entry-level nursing positions (Premji & Etowa, 2014). Additionally, linguistic minorities were found to be underrepresented in all areas of the nursing profession. The linguistic component of the nursing workforce is of particular interest in this review, and the nursing workforce more broadly. There is a sizable number of Black nurses who speak French (or another language) as a first language, including those from Francophone-African countries who have reported additional discrimination based on language.

In recognizing the underrepresentation of people of colour in nursing leadership, Villeneuve highlighted the importance of diversifying Canada's nursing workforce through race, gender, and age (Villeneuve, 2003). Achieving a truly diverse nursing workforce was described as requiring multilevel action from local, provincial and federal government and healthcare organizations including an acknowledgment of issues; a commitment to

diversity; conducting race-based research; modifications to nursing curricula and admission policies; the removal of arbitrary barriers hindering IENs from practicing in Canada; and nurturing leadership and career progression (Villeneuve, 2003). Premji and Etowa (2014) reverberate this sentiment in that there is a need for increased diversification in nursing, which can be facilitated by the inclusion of linguistic and visible minority nurses in higher level leadership positions. However, culturally- and linguistically focused initiatives alone are cautioned against, as these initiatives without proper scaffolding, are insufficient in reducing health disparities. Rather, health system reform, including social and economic policies to complement directives, is required to promote diversity in nursing and benefit multiple sectors (Premji & Etowa, 2014).

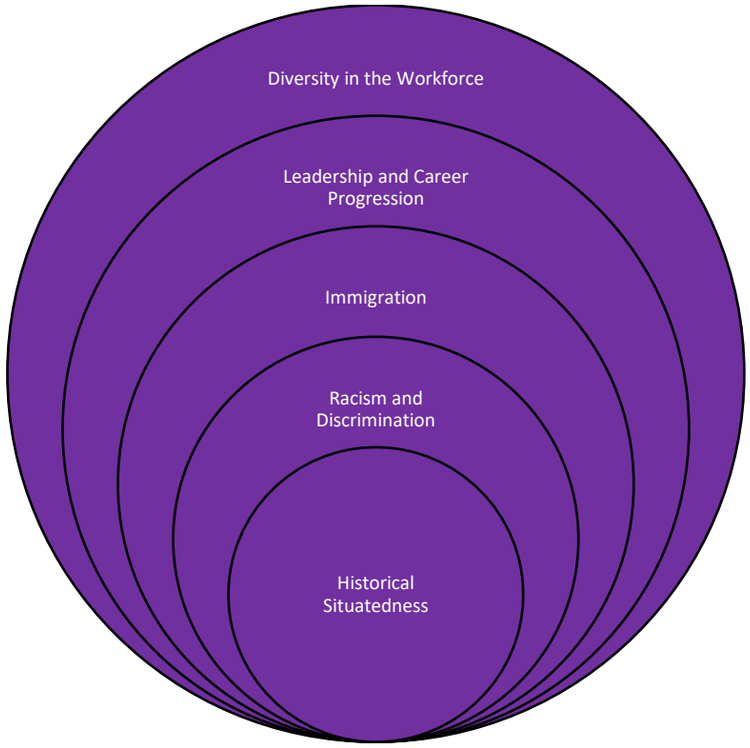
The results of this review reveal an interconnected relationship between the five main categories identified in the literature. This review shows how critical concepts, such as immigration and/or diversity in the workforce, can be traced to the historical situatedness of Black nurses in Canada. Specifically, racism and discrimination, that are manifested through institutional policies, systems, procedures, and interpersonal interactions, reinforced and perpetuated the underrepresentation of Black nurses in the workforce and in leadership positions. Further, despite the results being presented in five overarching categories, many of the included sources overlapped significantly with regards to the five identified categories. For example, the most prevalent category (racism) was woven throughout the majority of the sources in this review. The dominance of racism as a central theme across the majority of sources raises important questions regarding the nature of the literature, and the experiences of Black nurses, in Canada. Figure 5 offers a visual to demonstrate how each of the five categories are interconnected and influence one another.

4.3.9 Discussion

The findings from this review provide a comprehensive overview of the current available evidence that exists pertaining to Black nurses in Canada. The results are presented in relation to the review questions and objectives described above and in the a priori protocol.[7] The categories generated from this review include the historical situatedness; the immigration; racism and discrimination; leadership and career progression and finally, diversity in the workforce. The following discussion provides a succinct recap of the review findings by situating the review findings amongst a larger body of literature and offering interpretation of the findings. Finally, it presents implications for future research and practice by considering critical aspects including how knowledge of history provides insight regarding the current circumstance in addition to direction for the future such as ideas related to immigration, and the mobilization of Black nurses in Canada.

Figure 5

Relationship Between the Five Main Categories



4.3.9.1 Using the Past to Understand the Present and to Inform the Future. This review charts the evidence by situating the historical context for Black nurses in Canada. Uncovering the historical integration of Black nurses into the nursing profession in Canada, from a critical and intersectional perspective, reveals the ways in which anti-Black racism in nursing excluded Black people from the profession (Flynn, 2021; 2011; Jefferies, 2021). Flynn (2021; 2011) describes how Victorian ideals of "true womanhood", including ideals of femininity, purity and respectability were operationalized to not only discriminate against individuals and groups based on gender, race, sexual orientation, ability and class but also dictated *who* could become a nurse. These restrictive ideological standards restricted entry into nursing, and were juxtaposed in direct opposition to stereotypes attached to Black women (Flynn, 2021; 2011; Jefferies, 2021). The repeal of these restrictive discriminatory admissions standards in nursing is largely credited to community activists and organizations that were vocal and active in challenging these practices in Canadian nursing training programs. For example, Oliver and the NCAAP are credited as being a catalyst and playing a pivotal role in challenging discriminatory

admission practices in nursing and facilitating the entry of Black women into nursing programs in Canada (Chaplan, 2020).

4.3.9.2 Situating Within the Literature. Most of the existing literature included in this review classifies Black nurses in Canada into two groups: Canadian-born Black nurses and Black IENs. While there is a larger breadth of literature associated with Black IENs in Canada compared to Canadian-born Black nurses, the phenomena of Black nurses in Canada remains understudied. Moreover, Sands et al. (2020), as well as other scholars, caution against the temptation to aggregate the experience of "all Black nurses" as this blunder tends to mask the nuances that exist within the Black population and warrant additional consideration. To this end, much of this discussion situates the review findings of Black IENs in the wider knowledge-base simply because more research has been done in this area. This does however, highlight another major gap in the existing literature, which will be further described in the implications section.

This review highlighted the various policy-related challenges that Black IENs encountered both with immigration to Canada as well as with integration into the nursing profession (Covell & Sands, 2020; Covell, Neiterman & Bourgeault, 2016). Professional licensing and registration have reportedly taken years for IENs to have their credentials recognized. During this time, many IENs practice in non-licensed clinical roles, such as continuing care assistants or personal support workers. While others, who are educated and trained as specialists, registered, or advanced practice nurses, occupy entry-level or practical nurse roles (Kaphle, 2017). Additionally, this review describes the interprofessional challenges that Black IENs in Canada encountered when attempting to integrate into the nursing profession. Collegial issues, tension with management, being treated as an outsider and negative encounters with patients, including physical and verbal violence, were common issues (Walani, 2015). Whereas, good collegial relationships as well as opportunities to enhance nursing knowledge and skills were shown to have a statistically significant positive association with workplace integration (Covell & Sands, 2020). Everyday work experiences and integration into nursing, corroborate the work of O'Brien Pallas et al (2006). who found that the IEN workforce tended to work longer hours (including overtime) and were more likely to experience physical and mental abuse. O' Brien Pallas et al. (2006) explain that self-rated physical and mental health was lower for IENs, especially as they experienced inequity in learning opportunities as well as job instability or vulnerability. However, despite these challenges, IENs perceived themselves as an asset to the nursing profession, especially in terms of linguistic diversity and cultural practices (Njie-Mokonya, 2016). Which is another sentiment that emerged in this review. As was found in this review, restrictive immigration policies posed significant barriers for Black IENs who sought to migrate to Canada.

Literature shows that IENs entering nursing in Canada are faced with a distinct set of obstacles compared to Canadian-born Black nurses (Blythe & Baumann, 2009; Flynn, 2011; RNAO, 2002). Uniquely challenging to IENs is the task of bridging international certification to practice nursing in Canada. According to Blythe and Baumann (2009), IENs have a later start to their nursing careers in Canada due to issues navigating educational upgrading and language requirements. Similar findings were uncovered in this review (Boateng, 2015). Yet, similar to Canadian-born Black nurses, IENs experienced racism and discrimination, which reduced their opportunity to enter and maintain leadership positions (Blythe & Baumann, 2009). This captures the manner in which multiple factors influence and impact experience. Intersectionality is the term applied to active work, in academia and beyond, which interrogates and challenges systems of oppression that have historically led to the exclusion of factions of society based on nationality, disability, race, class, gender, sexual orientation, age and other social constructs (Crenshaw, 1991; Collins & Bilge, 2016). This review captures how the process of immigration and integration is structured and controlled by social constructs including race, class and gender (Calliste, 1996). Again, intersectional experience of discrimination related to race, class or gender, created significant variations that exist amongst IENs across age, gender, work status, type of work and area of practice (Blythe & Baumann, 2009; Covell & Sands, 2020). Statistical data shows that IENs in Ontario were largely found to settle in more urban centres, which is corroborated by findings in this review since Ontario, which has the largest population of Black people in Canada, contained the majority of the sources regarding Black nurses in Canada.

The immigration of Black IENs has implications for the worsening nurse-shortage in the Canadian healthcare workforce. While attending to anti-Black racism as it presents in interpersonal, institutional, and systemic dynamics is another important consideration to address workforce shortage. This includes nursing since, systemic and institutional processes were identified as major contributors to the underrepresentation of Black students in nursing programs (Flynn, 2011; Keddy, 1997). As explained by Tomblin Murphy et al.(2012), addressing the workforce shortage through recruitment, retention, and deployment of nurses, is a useful approach. Moreover, attending to these matters will likely address the lack of diversity in the nursing workforce and in leadership via critical pathways. Finally, there is a need to examine current processes and establish new ways for filing grievances and complaints.

The results of this review show the ways in which the historical foundation of racism and discrimination in nursing has embedded deep-seated ideologies that continue to govern processes and policies. Several studies discussed intersectionality and the experience of race, class, and gender, for Black nurses (Calliste, 1996; Flynn, 2018; Das Gupta, 1996). Multiple studies integrated intersectionality as a critical component in understanding

the experiences of Black nurses in Canada. Experiences of racism are compounded and further complicated by gendered and class oppression (Calliste, 1996; Flynn, 2018; Das Gupta, 1996). As Calliste (1996) explains, Black women were devalued and exploited due to gender ideologies of womanhood. These social ideologies that established a foundation of exclusion of Black women in nursing continue to be perpetuated in nuanced discriminatory ways (Flynn, 2011; Jefferies, 2021; 2020).

Another interesting finding in this review pertains to leadership. As was described in the literature, there was a glaring underrepresentation of Black nurses in formalized leadership roles in Canadian nursing. However, the results of this review depict varying levels of informal leadership that Black nurses displayed through their activism and nursing practice. Duncan and Whyte (2010) suggest that it is imperative that nursing leadership in Canada begin from a place where social justice is used as a framework to guide decision-making, policies, and political advocacy, to ensure health equity on a global scale. Increased diversity in the area of clinical nursing can mitigate health disparities, such as health care access for minority populations, by increasing community-oriented delivery models of health care and nurse-managed primary care (Carter, 2020). Importantly, transitioning into leadership roles requires a level of readiness from both a personal and organizational perspective. Similar to sentiments expressed by Black nurses in many of the studies, there must be an investment in development opportunities to support nurses as they transition into leadership positions.

4.3.9.3 Black Nurses Social Movement and Mobilization. In response to continued anti-Black racism in nursing as well as the heinous killings of Black persons in North America, especially during 2020, Black nurses in Canada have become more vocal about the collective experience of Black nurses and the health of Black people in Canada. Dominant social issues afflicting the Black population served to ignite several collectives and budding networks that were in their early stages of development. The mobilization of Black nurses in Canada has led to collectives forming across the country to create change at the provincial and national level. At the provincial level, current established collectives include the Association of Black Nurses (Nova Scotia), the Ontario Black Nurses' Network (Ontario), and the Coalition of African, Caribbean and Black Nurses in British Columbia (British Columbia). While the Canadian Black Nurses Alliance (CBNA) and the Pan-African Association of Nurses of African Descent are national organizations that strive to unite Black nurses across Canada. These collectives mobilize at a local level and engage in intra-provincial collaborations to advance nursing.

4.3.9.4 Recommendations for Research. Through the mapping of existing evidence regarding Black nurses in the nursing profession in Canada, our review reveals several implications for research. In terms of research design, the majority of research studies included in this review were qualitative. This indicates

opportunity for future research that uses a variety of designs and methods outside of the qualitative realm to understand this phenomenon through other paradigms, including the use of measures or tools that incorporate an intersectional analysis. Therefore, future research using quantitative or mixed methods would serve to further inform this phenomenon. An intersectional framework was used in several of the included sources, as authors described the ways in which racism was exacerbated by gendered and class oppression. In addition to applying an intersectional framework to understand the dynamics of race, class, nationality, and gender, it would be useful to examine the ways in which disability, sexual orientation and other critical factors impact Black nurses in Canada.

In addition, a number of the sources included were located in Ontario, which is the most populous and diverse province in Canada. As a result, we suggest expanding the geographical reach to include Western Canada, the Atlantic region, the prairies and Northern Canada. A large, national or multi-provincial study that includes a mixed method design is highly recommended, especially since these demographic data pertaining to the Canadian nursing workforce do not include other key indicators. Additionally, there is a substantial body of qualitative literature (n=18) that would benefit from a systematic review of this evidence. There is an opportunity to review the included primary sources and consolidate the myriad policy recommendations that were produced in many of the research studies. Likewise, a systematic review that examines the companion sources identified in this scoping review would provide greater insight. Additional research of interest may include text and opinion reviews as well as reviews that focus on nursing education. Finally, scoping reviews are not intended to make direct recommendations for practice, since the main purpose of this specific type of synthesis is to chart the existing available evidence. Therefore, we simply propose areas that the findings may serve as a foundation to inform future work to inform practice change, which include nursing education, clinical care, research, policy, and administration.

4.3.10 Conclusion

This is the first review that charts evidence regarding Black nurses in Canada. As outlined in the a priori protocol, the review findings are presented by category, to address the review objective and question. These categories include understanding of the historical situatedness, the immigration and migration patterns, racism and discrimination in nursing, career advancement and finally diversity within the nursing workforce. Whether in immigration or leadership and career advancement, the emphasis on policy and the importance of engaging in policy evaluation was resounding. The relevance of this review is extremely important for the Black folks in Canada as well as the nursing profession. For Black folks, it adds a vital piece to the historical record that has glaring gaps and omissions. Collectively, this review facilitates understanding history in a way that enables

forward direction. It is impossible to strive towards equity, diversity, and inclusion in nursing without an honest conversation about the past, as problematic as it may be. Uncovering the past is not meant to place blame but rather generate an understanding as to what the issues were, challenges that persist and ways to more forward together. The legacy of anti-Black racism in the nursing profession was shown to permeate all sectors of nursing – from clinical care, administration, research, policy, and education. To move beyond the historical legacy of anti-Black racism and discrimination in nursing, it is vital to understand the historical context in relation to Black nurses in addition to strategic planning for an inclusive profession.

4.3.11 Limitations

Potential limitations for this review include the search strategy, which may have missed sources. It is possible that human error in screening may have unintentionally excluded sources. Moreover, studies that focused on visible minorities, IENs or nursing cohorts that did not include data that were disaggregated by race and/or ethnicity were excluded. It is possible that these sources included data regarding Black nurses in Canada, however, without adequate disaggregation, the data could not be used.

Chapter 5: Philosophical Underpinnings

This chapter describes the philosophical underpinnings that guide this qualitative study to examine the leadership experiences of ANS nurses. The chapter presents the theoretical and conceptual frameworks that serve as the scaffolding for this qualitative study. The sections in this chapter include three published manuscripts that expand upon the initial presentation of the philosophical underpinning and theoretical perspective that were used to guide this study. Finally, the chapter concludes with the presentation of the conceptual framework that informed the methods, which is a manuscript that is in preparation for submission.

5.1 Overview of Philosophical Considerations and Assumptions

Philosophy includes the guiding assumptions and underpinnings, which inform and arguably determine how individuals understand the world. Understanding the world is inherently connected to an understanding of reality and knowledge (Lincoln & Guba, 1994). To truly understand and describe how reality and knowledge are created or known, it is essential to examine the foundational philosophical components of epistemology, ontology and methodology (Lincoln & Guba, 1994). While, theories provide a common worldview and lens that support and guide thinking related to problems and data analysis (Grant & Osanloo, 2014). Grant and Osanloo (2014) explain that theories are created from a multitude of sources within or across disciplines and that theories are constantly being created, adapted and applied, to better understand phenomena. Wilson-Thomas (1994) explains that theories need not account for all phenomena nor identify absolute truths in order to be deemed useful. Rather, it is argued that theories be relevant to phenomena affecting individuals in their unique contexts.

Through the process of self-reflection and learning have landed me in the naturalistic paradigm. Lincoln and Guba (1994) describe a paradigm as a basic belief system that is established upon ontological, epistemological, methodological and axiological assumptions. Paradigms represent a worldview which does not have a way to establish their ultimate truthfulness and thus must be accepted on faith (Lincoln & Guba, 1994). In research, there are two broad paradigms in which to conduct research. These paradigms are generally known as the positivist and naturalistic paradigm (Lincoln & Guba, 1994). Each of these paradigms can be further divided into approaches which contain additional assumptions that facilitate the understanding of knowledge, reality and ways of knowing. General assumptions within the positivist paradigm include the notion of one objective truth, that the would-be-knower is central to understanding, and the notion of neutrality or remaining neutral (Lincoln & Guba, 1994). Whereas the naturalistic paradigm assumes that there are multiple, subjective realities, that truth is value-laden and relationships are significant and essential to understanding and determining phenomena.

The remainder of this chapter is comprised of three published manuscripts and one manuscript in preparation for publication. The first published manuscript, titled *Understanding the Invisibility of Black Nurse Leaders Using a Black Feminist Poststructuralist Framework* (5.2) is a theoretical paper that presents an argument that details how social and institutional discourse have created and reinforced the underrepresentation and invisibility of Black nurse leaders. The second publication, titled *A Personal Leadership Development Plan for Black Undergraduate and Graduate Nursing Students* (5.3), situates the theoretical foundation of Black feminist leadership alongside transformational leadership, to offer an introductory guide to enhancing leadership capabilities for Black students in nursing. The third published manuscript, titled *Intersectionality: A Book Review* (5.4), is a book review of the seminal text, *Intersectionality* by Collins and Bilge (2020). This book review is included in this dissertation and this philosophical chapter as it 1) is grounded in and analyzes the text from a Black feminist perspective, 2) it includes a terse genealogy of BFT and 3) it shows one of the avenues into which BFT has evolved. Together, these three manuscripts constitute the philosophical and theoretical underpinnings for the qualitative study in question. The chapter concludes with the presentation of a manuscript (5.5) that is currently under development. This manuscript expands upon the theoretical grounding of BFT to present the conceptual framework used to inform and guide this study.

5.2 Understanding the Invisibility of Black Nurse Leaders Using a Black Feminist Poststructuralist Framework

This work in section 5.2 also appears in: Jefferies, K., Goldberg, L., Aston, M., Tomblin Murphy, G. (2018). Understanding the invisibility of Black nurse leaders using a Black Feminist Poststructuralist Framework. *Journal of Clinical Nursing, 27* (15-16), 3225-3234.

5.2.1 Statement of Manuscript Contribution

KJ conceived and develop this manuscript, as part of course work for the doctoral program, with philosophical and theoretical guidance and mentorship from LG and MA. KJ drafted the manuscript while LG and MA offered constructive feedback on this work. LG and MA approved the final version of the manuscript and KJ submitted the manuscript for review. Copyright details are located in Appendix A.

5.2.2 Aims

There are four aims of this paper, which include:

1. To generate discussion related to the invisibility of Black nurses as leaders in health care.
2. To provide an understanding of the historical and contemporary experiences of Black nurses and their entry into the nursing profession.
3. To describe how social and institutional discourses continue to marginalize and oppress Black nurses as

leaders and render them invisible.

4. To show how a Black feminist poststructural framework can be used to explore the invisibility of Black nurses as leaders, among other social and clinical issues.

5.2.3 Design

This is a discussion paper that includes a review of the literature on Black nurses as leaders in health care with a critical analysis using a Black feminist poststructural framework. The emergence of the invisibility and underrepresentation of Black nursing leadership is a predominate emerging theme throughout the literature.

5.2.4 Methods

The methods used in this discussion include a review of the literature on Black nurses as leaders in health care. The review of literature involved a search of electronic databases including CINAHL, NovaNet, PubMed and Google Scholar. Keywords used in the search include: Black; African; Nurses; Leaders; Feminism; Poststructural. Literature was restricted to the English language. Articles were screened by titles and abstracts and full-text was accessed for relevant articles.

> "It is not our differences that divide us. It is our inability to recognise, accept and celebrate those differences."
>
> Audre Lorde

Nursing leadership embodies a variety of skills, knowledge and roles (Canadian Nurses Association [CNA], 2009). The Canadian Nurses Association [CNA] (2009) describes nurse leaders asresearchers, scientists, academics and clinicians, who are involved with policy, research, mentoring and advocacy (CNA, 2009). Nurses serve as leaders in health care organisations, the community and government. Having nurses as leaders and decision makers enables the voice of the nurse and more importantly, the patient and family to be heard. The challenge, however, is that there is a lack of diversity among nurse leaders. Moreover, there is a critical lack of representation of nurses from minority groups in higher level nursing positions and former leadership roles such as managers, charge nurses and registered nurses (Hagey et al., 2001; Premji & Etowa, 2014). The value attached to the visibility and representation of Black nurse leaders within health care cannot be overemphasised, as it has significant implications for Black nurses in practice as well as the Black community as a whole. The presence and visibility of Black nurse leaders has the potential to inform policy, lead to culturally sensitive care and improve the well-being of Black nurses (Premji & Etowa, 2014). Etowa, Wiens, Bernard, and Clow (2007) conducted a mixed methods investigation guided by a Participatory Action Research approach to explore the intersections affecting the health of African Nova Scotian women, their families and

communities. Interviews with 237 Black women revealed that participants often felt discriminated against based on their race and that they had not or would not receive culturally sensitive care, which led to a reluctance in health care seeking behaviour (Etowa et al., 2007).

Black nurses face a myriad of challenges in the nursing profession and more broadly in the health care system, including but not limited to discrimination, underrepresentation and invisibility (Calliste, 1996; Etowa, Sethi, & Thompson-Isherwood, 2009; Flynn, 2009; Premji & Etowa, 2014). These challenges stem from the intersections of race, gender and class (Collins, 2000; Crenshaw, 1991), which then interact to oppress Black nurses in society and specifically within the nursing profession. The challenges experienced by Black nurses manifest themselves in various ways through policies, practices and everyday assumptions that have become normalised beyond detection (Calliste, 1996; Etowa et al., 2009; Flynn, 2009; Hagey et al., 2001; Premji & Etowa, 2014). The discussion of Black nurses as leaders is significant and timely, due in large part to the increased recognition of the historical and structural harms and continued oppression experienced by marginalised communities. Understanding these harms requires critical analysis to further examine their profound impact on the health and well-being of individuals and communities as well as the larger health care system.

The purpose of this paper was to explore the invisibility and underrepresentation of Black nurses in formal and informal leadership roles using a Black feminist poststructuralist framework. The paper will begin with a discussion on Black people in nursing followed by an overview of the selected theory as to how and why power, language, subjectivity and agency are constructed and influenced by the historically ingrained social and institutional discourses of everyday life. The paper will conclude with a discussion on the relevance and significance of this phenomenon in nursing practice.

5.2.5 Background

5.2.5.1 Black Nurses. Diversity in nursing leadership adds value to the nursing profession (Phillips & Malone, 2014; Premji & Etowa, 2014). Phillips and Malone (2014) stated that having individuals from various cultural and ethnic backgrounds enhance the quality of care provided to patients. Thus, having Black nurses as leaders allows for the sensitive development, implementation and evaluation of health care policy and programmes, especially those pertaining to the health care of Black individuals, families and communities (Etowa et al., 2009). However, interpersonal, institutional and systemic barriers in nursing education and in the nursing workforce act as concrete ceilings for Black nurses, preventing vertical movement or career advancement (Connolly, Renault, & Bernard, 2017).

5.2.5.2 Formal Nursing Education. Canadian nursing schools have a history of excluding Black people from admission and obtaining training (Flynn, 2009). Flynn (2009) described how this oppression is evident by the fact that only 13 Black nurses graduated from a nursing programme in Ontario, Canada between 1948–1961. Hine (1982) also described the context in the USA, in that as nursing schools emerged, Black women were denied admission. Despite extensive experience working as untrained nurses in providing care to family members or as domestic workers, Black women faced tremendous challenges when they attempted to enrol in professional nursing schools (Hine, 1982). For example, Hine explains how entrance guidelines stipulated the entry of only one Black student per year.

In addition to the historical challenges with admissions into nursing programmes, the nursing curriculum also tends to be oppressive and restrictive. As stated earlier, the invisibility of Black nurse leaders is evident in the current absence of teachings regarding the impact of influential Black nurse leaders throughout history, namely, Harriet Tubman, Mary Seacole and Sojourner Truth (Donnelly, 2016; Staring-Derks, Staring, & Anionwu, 2015). The invisibility of Black nurses in leadership is also grounded in the foundation that there remains a significant underrepresentation of Black students in nursing programmes (Etowa, Foster, Vukic, Wittstock, & Youden, 2005). The past and current underrepresentation of Black students in nursing is the result of societal challenges related specifically to Black people as well as insufficient recruitment and retention of Black students (Vukic, Steenbeek, & Muxlow, 2016). Vukic et al. (2016) described how the exclusionary historical nursing admission policies have lingering effects, which prevent Black people from considering nursing as a viable career option today. It was suggested that a lack of supports in the form of academic, financial and/or other barriers, combined with the lack or even absence of Black faculty to serve as mentors and role models exacerbate this phenomenon (Etowa et al., 2005). However, Vukic et al. (2016) write that despite efforts such as targeted funding through entrance scholarships, early exposure initiatives and reimaging of application and recruitment materials, there remains significant under-enrolment and high attrition rates among Black people in the nursing programme. In 1996, Calliste suggested that nursing schools must adopt and implement antiracist policies and programmes as well as education and employment equity to counter the underrepresentation of Black people in nursing.

5.2.5.3 Nursing Workforce. The underrepresentation of Black nurses in the workforce is in direct relation to the underrepresentation of Black students in nursing programmes (Phillips & Malone, 2014). Research involving Black nurses reveals a myriad of experiences, challenges and insight into the realities of being Black and being a nurse (Calliste, 1996; Etowa et al., 2009; Flynn, 2009; Hagey et al., 2001; Phillips & Malone, 2014). Flynn (2009) points out how Black nurses recount experiences of racism and discrimination on

their journey to becoming a nurse between 1940–1970 as well as in the profession itself. This is significant because these challenges have been present since Black people first gained entry to nursing schools in the late 1940s and it continues to persist today (Flynn, 2009; Hine, 1982).

Literature shows that Black nurses have endured a tremendous amount of discrimination, racism and oppression, over the years, in the nursing profession (Calliste, 1996; Etowa et al., 2009; Hagey et al., 2001). Calliste (1996) used an integrative antiracist framework to examine data gathered from 30 semistructured interviews with registered nurses, nurse's union officers and community organisers involved in antiracism initiatives for Black nurses to understand the experiences of African Canadian nurses in Ontario and Quebec, Canada in relation to the organisation and resistance of racism in nursing between the 1970s to the 1990s. The interview data were supplemented by an analysis of labour arbitration cases, antiracism conference proceedings as well as organisational data. Calliste (1996) found that Black nurses were disproportionately concentrated at lower levels in the profession as well as being subjected to the racialisation of surveillance in practice, which involved being oversupervised, disciplined and terminated more often than non-Black nurses. Hagey et al. (2001) conducted a descriptive, exploratory study in the late 1990s with nine Black nurses in Ontario, Canada. It was found that Black nurses perceived discriminatory and racist practices as central factors preventing career advancement within the nursing profession (Hagey et al., 2001). Additionally, Etowa et al. (2009) conducted a qualitative investigation using a grounded theory approach to uncover experiences of racism encountered by Black nurses in Nova Scotia, Canada; the study revealed that Black nurses experienced feelings of marginalisation in the nursing profession. Black nurses employ several "survival techniques" as a means to minimise the feelings associated with the experiences of racism and discrimination such as avoidance, identity manipulation and rationalising behaviour (Etowa et al., 2009).

The first Black nurses to practice in Canada in the late 1940s trained and worked in the dominant patriarchal environment of White nurses, White doctors, White students, White administrators and White faculty (Flynn, 2009). This patriarchal environment was built on normalised standards and assumptions created, perpetuated and upheld by the dominant group in society. This inevitably led to oppression and discrimination of those who do not identify as the dominant group (Collins, 2000). Collins (2000) expanded upon this explanation of the oppressive environment encountered on a daily basis by Black individuals in her monumental book regarded as a cornerstone in Black feminist theory. The perspective and analysis provided by Collins (2000) on the oppressive dominant patriarchy, which is explored in greater detail later in the paper, is relevant in situating Black nurse leader invisibility. For example, as previously mentioned, Black nurses describe a sense of feeling pushed to the margins of the nursing profession as a result of colleague and workplace discrimination

and racism, in addition to being made to feel as though they were not competent to practice nor deserving of promotions (Etowa et al., 2009).

In addition to the outward acts of racism and discrimination, microaggressions have a lasting and at times, more severe impact on the self-perception and confidence (Lewis & Neville, 2015) of Black nurses. Microaggressions involve the everyday nuances, taken-forgranted behaviours and communication, which may seem innocent but actually are inappropriate and distressing (Beagan & Etowa, 2009; Lewis & Neville, 2015). As a result of these microaggressions, Black nurses reported feeling physical stress and emotional pain related to not feeling trusted, constantly being scrutinised and other forms of racism at work (Hagey et al., 2001). Das Gupta (2009) also observed that Black nurses and their experience of racism led to mental and physical health problems, reduced access to training and a loss of jobs or promotions. Not only have Black nurses experienced challenges in gaining entry to the nursing profession but Black nurses also face difficulty in moving to upper level positions and leadership roles (Calliste, 1996; Hagey et al., 2001; Premji & Etowa, 2014). Racism and discriminatory practices continue to exist in nursing and prevent Black nurses from moving forward and upward (Calliste, 1996; Hagey et al., 2001). In 1996, Calliste wrote that Black nurses are not only absent at the top of the nursing hierarchy including administrative roles but also in highly technical and specialised roles (i.e. ORs and ICUs). Eighteen years later, visible minorities continue to be significantly underrepresented in upper level positions such as managers and head nurses and are often overrepresented in lower level positions such as nurse aides (Premji & Etowa, 2014).

5.2.5.4 Invisibility in Nursing. Invisibility is directly connected to the social and institutional discourse that has been normalised by the dominant, White patriarchy (Collins, 2000). Another concept linked closely to invisibility is that of colour blindness. Colour blindness refers to behaviours and actions, in which an individual's race and ethnicity are ignored (Lewis & Neville, 2015). Initially, colour blindness may appear to be an equitable approach for interacting with diverse groups of people; however, evidence shows that this colour blindness is as detrimental to mental and physical health as blatant racism. Lewis and Neville (2015) explain that colour blindness is harmful in a way that ignores unique or distinct differences, which may or may not put an individual at a disadvantage; ignoring these differences usually leads to increased feelings of marginalisation and oppression.

To fully understand the phenomenon of the invisibility of Black nurse leaders, the authors employ a critical framework of Black feminist poststructuralism. In what follows, we describe the tenets of a Black feminist poststructuralism framework before using it to analyse the invisibility of Black nurses in leadership.

5.2.5.5 Nursing Leadership. Nursing leadership is an integral component of the nursing workforce; it is multifaceted and embodies differently depending on a nurses' circumstance (Canadian Nurses Association [CNA], 2009; Cope & Murray, 2017; Cummings et al., 2010). Nurse leaders practice in a variety of settings such as managers, charge nurses, researchers, educators and in advanced practice roles including nurse practitioners and clinical nurse specialists (Canadian Nurses Association [CNA], 2009). Cope and Murray (2017) as well as Ferguson (2015) wrote that nurse leaders are the key to influencing the development and advancement of the nursing profession as well as movement towards a healthier future for communities through health and social policies. Characteristics that nurse leaders exhibit, include but are not limited to, time management and organisational skills, the ability to empower/encourage others, innovative thinking as well as intelligence, and critical use of evidence, have all been described in the literature as being essential to being a nurse leader (Canadian Nurses Association [CNA], 2009; Ferguson, 2015). Additionally, nurse leader competencies such as maintaining a global health care perspective, being a visionary, exercising expert decision-making skills and being tech savvy have been described as being essential for future nurse leaders (Huston, 2008). Much of the literature related to nursing leadership is focused on formal nursing leadership roles such as managers, charge nurses and executives (Ferguson, 2015; Huston, 2008; Weberg, 2010).

However, nursing leadership is not reflected solely in formal roles with designated titles. Informal nurse leaders are seen in the coaching, mentoring and supporting of nursing colleagues as well as in advocacy for patients and their care (Canadian Nurses Association [CNA], 2009). Frontline nurses also embody leadership and serve as nurse leaders. Downey, Parslow, and Smart (2011) described how there is very little literature or research focusing on informal nursing leadership and its potential impact. Despite this dearth of evidence, Downey et al. (2011) explained that informal nursing leadership has the potential to lead to workplace and health system improvements. Moreover, the concept of nursing leadership is one that is instilled during nursing education and developed throughout nursing practice, as a result, all nurses have the potential to be leaders (Canadian Nurses Association [CNA], 2009; Cope & Murray, 2017). Therefore, this discussion will focus on the embodiment of nursing leadership in both formal and informal leadership roles for Black nurses.

Historically, nurses have always maintained an active role in leadership, as evident by notable nurse leaders such as Florence Nightingale. While the contributions of Nightingale to the nursing profession have been astounding, the contributions of other notable nurse leaders are often forgotten, overlooked or invisible (Donnelly, 2016; Staring-Derks et al., 2015). In particular, the contributions of historical Black nurse leaders are rarely discussed and their names are not often associated with the nursing profession. The work and content of iconic Black nurse leaders, such as Harriet Tubman, Mary Seacole and Sojourner Truth are not shared,

discussed or celebrated in many nursing programmes (Donnelly, 2016; Staring-Derks et al., 2015). The Black nurse and in particular, the Black nurse leader is often absent in discussion. Not only are Black nurse leaders absent but their experiences, interpretations and ideas are also often rendered invisible (Hine, 1982; Mirza, 2015). Diversity in nursing leadership has the potential to result in significant benefits for patients as it is more inclusive of diverse cultural needs while also addressing harmful unconscious biases and assumptions (Munn, 2017).

Marginalised groups, particularly Black people, have struggled to gain representation and visibility within the nursing profession for decades (Calliste, 1996; Etowa et al., 2009; Flynn, 2009; Hagey et al., 2001; Hine, 1982; Premji & Etowa, 2014). For example, transformational leadership is considered to be central to nursing practice and is often regarded as the gold standard of leadership (Cope & Murray, 2017). However, Hutchinson and Jackson (2013) describe the limitations of nursing leadership theories and frameworks such as those of transformational leadership as they were developed from an exclusive male perspective, often omitting gender and cultural considerations. Additionally, Fischer (2017) discussed the applicability of transformational nursing leadership in nursing education as it has the potential to improve the work environment and faculty retention. However, in discussing the recent bolstering diversity seen in the nursing profession, the conversation only highlights the increased numbers of millennials and men joining the profession, with no mention of visible minorities. The exploration of the literature reveals how and why the challenges of underrepresentation and invisibility are experienced by Black nurses in both nursing practice and leadership.

5.2.6 Black Feminist Poststructuralism

The theoretical underpinnings that inform this analysis combine the tenets of Black feminist theory (Collins, 2000; Crenshaw, 1991; Davis, 1981; Lorde, 1984) with the framework offered from poststructuralism (Aston, 2016; Foucault, 1982; Gavey, 1989; Weedon, 1987). Black feminist poststructuralism allows for an in-depth examination of the multiple ways in which power impacts various intersections of Black nurses, specifically, race and gender. The combination of Black feminism with poststructuralism amplifies the examination of relations of power as well as the discourses that are relevant to understanding Black nurses as leaders. This section serves to highlight the key tenets of Black feminist theory and poststructuralism before explaining how these two theories are aligned to form a framework to understand the invisibility of Black nurses as leaders.

5.2.6.1 Black Feminist Theory

5.2.6.1.1 From Feminism to Black Feminism. Black feminism is a branch of feminism, which specifically focuses on the experience of multiple intersections, namely race, class and gender (Love, 2016).

Black feminism as a critical theory moves the ideas, experiences and interpretations of Black women to the centre of the analysis (Collins, 2000). While the traditional feminist theory has been effective in generating conversation and action related to women's issues, the interests of all women have not been historically represented or addressed. Barbee (1994) explained that traditional feminist research approaches are simply not adequate for understanding and addressing the health and related experiences of Black women. The traditional feminist theory fought for the rights of White, middle class women, while the needs of Black women were unaddressed (Love, 2016). At the time of the feminist movement in 1960, the needs of Black and White women were very different (Barbee, 1994; Hooks, 1984; Love, 2016). The concerns of Black women revolved around race, which needed to be at the forefront of the feminist movement. However, race was absent from the discussions at that time and without addressing the glaring issues intertwined with race, class and gender, there was potential to further marginalise Black women (Barbee, 1994; Collins, 2000; Hooks, 1984; Love, 2016). Love (2016) acknowledged that modern or third wave feminism has addressed these concerns to be more inclusive of minority and marginalised groups. Nevertheless, even today, it remains largely a White perspective. As a result, Black feminism was developed out of the need to not only focus directly on the intersections of race and gender but also on how these intersections influenced the circumstance of Black women (Collins, 2000).

5.2.6.1.2 Using Black Feminist Theory in Practice. Applying a methodology to research that is sensitive to social constructs is necessary for investigations involving Black people, especially Black women, as traditional approaches often overlook the importance of these constructs. Black feminism serves to address the specific needs and challenges experienced by Black women by taking the social constructions of race and gender and applying them as the basis for understanding and investigating phenomenon related to Black women (Crenshaw, 1991; Davis, 1981; Lorde, 1984). Black feminist theory acknowledges the significance of both the historical and social contexts and how these influence behaviour, circumstance and the self (Collins, 2000). For example, stereotypical images are detrimental to the individuals who experience them, which is why Black feminism is useful as it avoids focusing on stereotypical images of Black women by directing us to consider how the intersections of race, class and gender lead to oppression (Love, 2016). While the language used in Black feminist theory has traditionally referred to women, this theory is applicable to the ideas, experiences and interpretations of Black people who identify as male, female, trans or other.

In an integrative review of the literature, Love (2016) attempts to show how Black feminism can be used as a rigorous methodology in nursing research. While Black feminism does not have a specific method, it has been used as a philosophical framework and as a means to guide data collection, analysis and dissemination (Love, 2016). Black feminism has been used in various studies as a philosophical framework to guide research

towards new discoveries by framing questions as population based (Love, 2016). Love (2016) explains that the Black feminist framework has value in numerous fields of research including nursing, psychology, religious studies, women's studies, gender studies, education, political studies and public health.

Another key tenet of Black feminism is the relations of power and knowledge. Love (2016) explains that Black feminism enables the co-creation of knowledge, which allows both the study participants and researchers to share power by questioning, interpreting data and designing interventions. Collins (2000) shows how power is a critical factor in Black feminist work. The matrix of domination (or relations of power) refers to the social organisation where oppressing intersections are created and contained (Collins, 2000). Collins (2000) argued that domination occurs through schools, housing, employment, government and other social institutions. The matrix of domination is useful as it exposes the social, institutional and historical discourses and their role in the perpetuation of oppression (Collins, 2000).

Using Black feminism to guide research and commentary related to Black women leads to the accurate representation of the experiences of Black women (Love, 2016). Furthermore, Love (2016) suggested that nurse researches using Black feminism must see caring as a political act, fight for change and engage in the hope for social justice. Therefore, identifying and considering the interrelatedness of gender, race and the roots of oppression and connecting these to discourses is critical (Barbee, 1994).

5.2.6.1.3 Poststructuralism. Poststructuralism is an approach to social theory, which explores the relations of power involved in particular issues (Foucault, 1982). Foucault (1982) spoke to both relations of power and the influence on individuals or groups as well as knowledge and language. The ways in which we understand and express experience are connected directly to knowledge, language and power (Gavey, 1989). Scholars describe how knowledge is considered socially constructed, nonneutral and inherently linked to power (Aston, 2016; Foucault, 1982). In terms of power, Foucault (1982) described how power is exercised and what it means when power is exerted over another. Additionally, Aston (2016) wrote that relations of power require us to examine how specific interpersonal interactions are influenced by social and institutional discourses or contexts with these particular discourses influencing and determining interactions between individuals in the form of power relations. This view presented by Aston (2016) builds upon that of Foucault's (1982) in that the notion of power does not act directly on individuals or groups but rather upon their actions. While poststructuralism examines the relations of power and use of language, scholars have combined it with feminist theory to explore a variety of health and social issues (Aston, 2016; Baxter, 2008; Gavey, 2011; Weedon, 1987).

Gavey (2011) stated that poststructuralist ideas invite questions that take us beyond the surface of our culturally shared commonsense understandings of the world and acknowledge that distress and dysfunction can

be caused or exacerbated by oppressive life conditions. Thus, the poststructural lens offers a way to understand complexities and contradictions that inhabit and shape our experience in the world (Gavey, 2011). Gavey (2011) further highlighted that feminism alone offers a framework for cultural critique; however, when applied with poststructuralism, it offers a sympathetic theoretical approach for making sense of our lives and the predicaments in which we sometimes find ourselves. Additionally, Aston (2016) described that combining methodologies, as seen with feminist poststructuralism, is inclusive and responsive to relations of power. Feminist poststructuralism is not inconsistent with other forms of feminism as it often shares similar or common concerns as some other social feminist theories (Gavey, 1989). Feminist scholar Weedon (1987) demonstrated how feminist poststructuralism can be used to inform actions that lead to social change. Therefore, feminist poststructuralism is beneficial in providing a theoretical basis for analysing subjectivities of women and men in relation to language, cultural practices and material conditions of life (Aston, 2016).

The following section applies Black feminist poststructuralism to situate Black nurses as leaders in health care. The discussion will incorporate key components of poststructuralism by examining *Power, Social and Institutional Discourses, Language and Meaning, Beliefs, Values and Practices*; and *Subjectivity and Agency*.

5.2.7 Understanding Leadership Through Black Feminist Poststructuralism

5.2.7.1 Power. As previously described, Black feminist poststructuralism allows for an in-depth examination of the relations of power as they relate to phenomenon (Aston, 2016; Collins, 2000; Foucault, 1982; Gavey, 1989), particularly to the invisibility of Black nurses as leaders. Black feminist poststructuralism interprets power as relational through the interaction of multiple intersections, in that power is generated as the result of how race, gender and class differences are viewed and experienced in society and institutions. Relations of power have a significant impact on Black nurses in the nursing profession. Within the nursing profession, race has a major impact on relations of power. Race and power impact interpersonal relationships, the environment, institutions and policies through various discourses (Collins, 2000). The connection between power and discourses is evident in the social and institutional context (Aston, 2016). There are relations of power at work between nurses of different races and ethnicities, as well as between nurses and institutions. This notion of power, in relation to Black nurses, has a historical origin dating back to when Black people were enslaved (Pachai, 1997). The effects of slavery have instilled intergenerational trauma in Black people, which continues to be experienced by individuals today (Pachai, 1997). Pachai (1997) wrote that while the mistreatment and enslavement of Black people is no longer acceptable or legal, there continues to be discourses that perpetuate this marginalisation. The matrix of domination described by Collins (2000) shows how social

institutions such as nursing schools and hospitals perpetuate oppression by operating according to oppressive and hegemonic ideals.

5.2.7.2 Social and Institutional Discourses. Discourses are defined as dominant authoritative systems of knowledge (Gavey, 1989). Social and institutional discourses include the ingrained, everyday circumstances that connect directly to relations of power (Aston, 2016; Collins, 2000). Das Gupta (2009) wrote that racism is often disguised or hidden, which leads to challenges in identifying, understanding and combating it. The hidden racism often arises from normalised or subconscious policies, procedures and practices and as Collins (2000) explained, the matrix of domination and power is intrinsically linked to social and institutional discourses. Evidence shows how these discourses within schools of nursing marginalise Black nurses (Etowa et al., 2005; Vukic et al., 2016). Furthermore, social and institutional barriers are implicated in the underrepresentation of Black students in nursing (Calliste, 1996; Etowa et al., 2005; Hine, 1982). The discourses, which were established through years of oppression and discriminatory values, make it extremely challenging for Black individuals to escape the cycle of oppression.

The Black nurse leader is veiled by the discourses of institutional and systemic racism. This invisibility is the result of generations of oppression and discrimination, which have been embedded as normative (Collins, 2000). The impact of discourses is also found in the nursing curriculum, which use hegemonic and normative approaches to teach nursing practice. For example, the APGAR score is the primary assessment tool used at the time of birth to determine the health status of a newborn by examining physical appearance and physiology (Blake, 2010). In reference to appearance, the APGAR scoring system indicates that a newborn is considered "healthy" if the skin appears pink as opposed to blue (Blake, 2010). However, Blake, 2010 suggested that this scoring is not appropriate for newborns from ethnic origins, especially those of African ancestry, and therefore should be revised to be more inclusive of ethnic diversity. Similarly, nursing texts present a myriad of stereotypes and cultural assumptions to be used during interactions with particular groups. In 2017, a well-known textbook publisher "Pearson" issued an apology and removed pages from a nursing textbook after online criticism describes the sections as being stereotypical, insensitive and racist to specific groups, including Black people (Sini, 2017). These stereotypes, such as those contained in the nursing textbook, are often harmful to the group in question. However, because these assumptions are designed and reinforced by the dominant discourse, they are accepted, normalised and often not addressed. Examples of this can be found in several nursing assessment textbooks, which include writing that Black people tend to perceive pain and suffering as inevitable and that aboriginal people with substance dependence are constantly drug seeking.

Social and institutional discourses shape the content and material that nurses learn related to their assessment skills, knowledge and interpersonal interactions in the nursing programme(s) they attend. Yet, the provision of culturally sensitive care is tied to knowledge about individuals and groups, which often does not correspond to the teachings in textbooks.

5.2.7.3 Language and Meaning. Aston (2016) described language as a critical starting point for feminist poststructuralism, as it exists in historically specific discourses where it has the potential to change depending on the context. This notion is also true of meaning, which is closely linked to language, in that it is not static or fixed but rather it changes based on the context (Aston, 2016). Aston (2016) further articulated that language can serve two purposes; either act as an obstacle to understanding or be used to facilitate liberation. As a result, language gives rise to specific meaning, which is fully dependent on context (Aston, 2016; Weedon, 1987).

The language associated with Black nurse leaders is highly contextual and influential. The term leader can be viewed very differently among Black nurses, depending largely on their subjectivity and agency, or how they have located themselves. Within the Black community, leaders are viewed as individuals who have a strong impact on the community as a whole, such as church leaders and community elders (Etowa, Beagan, Eghan, & Bernard, 2017). However, removing the term "leader" and looking only at what the embodiment of leadership entails reveals that leaders in the Black community are found in many roles including parents, teachers and friends (Etowa et al., 2017).

Another interesting component of language is what is meant by nurse or "to nurse". In the traditional context, nursing within the Black community was not always practiced exclusively by individuals who received specialised training in a formal programme; but rather, it involved the act of providing care to those in need (Hine, 1982). Hine (1982) described how Black women worked for numerous years as untrained nurses before overcoming oppressive obstacles and gaining entry into nursing schools. This traditional view of nursing in Black communities has the potential to impact the practice of Black nurses and their embodiment of formal and informal leadership.

5.2.7.4 Beliefs, Values and Practices. The beliefs, values and practices of an individual or group are important concepts requiring examination and understanding when using feminist poststructuralism (Aston, 2016). The literature points to specific personal and professional beliefs, values and practices that are held by Black nurses (Calliste, 1996; Etowa et al., 2009; Hagey et al., 2001). Examination of these beliefs and values reveal that Black nurses often feel physical stress and emotional pain connected to work related racism (Hagey

et al., 2001). Hagey et al. (2001) described beliefs held by Black nurses that reflect feelings of not being trusted and constantly being scrutinised.

In terms of practice, Black nurses suggest that discriminatory practices prevented upward movement within the profession (Hagey et al., 2001). There is a feeling that their practice as nurses has been unfairly delayed or stopped due to unfair treatment. As described, Etowa et al. (2009) found that Black nurses considered themselves to be surviving on the margins of the nursing profession, employing numerous strategies to help with the challenge of being on the periphery. These include suppressing pieces of themselves, avoiding certain situations or not addressing issues as they arose. Black nurses often use survival strategies to cope with experiences of racism and discrimination in their places of work, which may exacerbate their invisibility (Etowa et al., 2009).

5.2.7.5 Subjectivity and Agency. Subjectivity refers to how individuals position themselves and their ability to be conscious and self-reflexive (Aston, 2016). Aston (2016) asserts that subjectivity is the ability to work through, with or against the various social and institutional discourses that impacts the self. On the surface, Black nurse leaders may identify as being Black. As nurses, however, literature suggests that Black nurses have challenges embodying, acknowledging or realising their role as leaders (Etowa et al., 2009). Black nurses' agency is evident by how nurses choose to respond or act in a particular situation and through the concept of agency discourses have the ability to influence how individuals act, feel and think (Aston, 2016). Agency related to Black nurse leaders can be manifested in a variety of ways. However, Etowa et al. (2017) write that the descriptive and prescriptive construct of the "strong Black woman" (SBW) is pervasive throughout the Black community. The SBW construct suggests that Black women are strong, independent, nurturing and caring, often to the detriment of themselves (West, Donovan, & Daniel, 2016). The strength and caring aspect of the SBW concept situates Black nurse leaders in a position that requires them to act in a particular manner. Black women must be ready and willing to give of themselves and not voice challenges, hardship or stress related to their roles (Etowa et al., 2017; West et al., 2016).

5.2.8 Relevance and Significance for Nursing Practice

Literature shows that Black nurses have specific and unique experiences, which have led to their invisibility and in some cases absence as leaders. The subjectivity and agency among Black nurse leaders is the result of the influence of specific social and institutional discourses described above. Black feminist poststructuralism has the potential to uncover the ways in which generational trauma stemming from slavery and exacerbated by unrelenting racism, discrimination and oppression, has led to the normalisation of these practices in systems, society and institutions (Aston, 2016; Collins, 2000; Love, 2016). Using Black feminist

poststructuralism to explore this phenomenon generates discussion and provides direction to rectify the racism that has led to the invisibility of Black nurse leaders. Furthermore, this discussion may also provide opportunity to strengthen the recruitment and retention of Black nurses in the profession and as leaders as well as addressing the underrepresentation of Black students in nursing programmes. The goal of this discussion was to generate new understanding, awareness and recognition regarding the experiences of Black nurses to improve nursing practice, research, education and policy. The significance of this inquiry has implications that extend beyond Black nurses and nursing practice to patient care, families and communities.

The shifting of population demographics requires that the underrepresentation and invisibility of health care providers be addressed (Phillips & Malone, 2014). Traditional approaches to culturally sensitive care, such as colour blindness, are not effective and must be avoided. Das Gupta (1996) states that blindness of race, gender and class results in serious flaws in understanding related to what is happening in nursing and health care. Health care quality and access significantly lag behind for marginalised groups, especially Black people (Phillips & Malone, 2014). Moreover, literature shows that Black individuals are eager to be treated by Black health care providers, especially nurses, who can sympathise with their historical and social location (Etowa et al., 2007). In all, this points to the dire need for Black nurses to be unveiled, recognised and valued as leaders in the health care system locally, nationally and internationally.

5.2.9 Conclusion

The discussion of race is not a comfortable topic. It challenges conventional thinking and what is perceived as normal or true. The invisibility of Black nurse leaders is the result of generational oppression and discrimination that has manifested in the form of social and institutional discourses. Systemic, institutional and historical discourses perpetuate challenges for Black nurse leaders, which then renders them either invisible or absent in practice. Therefore, examining this phenomenon requires a critical approach that is inclusive of power relations and the impact of various discourses on individuals and groups. This discursive paper was written to highlight the challenges experienced by Black nurses; however, a similar approach would be useful and necessary to address how these constructs impact other visible and nonvisible minorities. Black feminism and feminist poststructuralism have been used in a variety of fields to address issues related to social justice, among others. Black feminist poststructuralism offers an in-depth framework to examine how discourses and relations of power interact to impact Black nurses as leaders. To unveil the Black nurse leader, the dominant patriarch must be named, challenged and dismantled. Without addressing the dominant, oppressive patriarchy, the social and institutional discourses will remain intact and Black nurse leaders will continue to remain invisible.

5.3 A Personal Leadership Development Plan for Black Undergraduate and Graduate Nursing Students

This work in section 5.3 also appears in: Jefferies, K. (2018). A Personal Leadership Development Plan for Black Undergraduate and Graduate Nursing Students. *Canadian Journal of Nursing Leadership*, *31*(4), 57-62.

5.3.1 Statement of Manuscript Contribution

KJ conceived and developed this manuscript, as part of course work for the doctoral program, with feedback provided on the assignment by the course professor. KJ drafted and submitted the manuscript for review. Copyright details are located in Appendix A.

5.3.2 Background

A Leadership Development Plan (LDP) is a document that guides prospective leaders by identifying a personalized leadership goal, objectives and a method for evaluating success (Nelson & Ortmeier 2011). LDPs are essential in nursing, as they guide practice by instilling and refining leadership competencies. As an emerging Black feminist scholar, my leadership philosophy draws heavily on tenets of Black feminism (Collins 2000; Hooks 1984), as this is the lens I have adopted for navigating contemporary society as a Black woman as well as transformational leadership (Cope & Murray 2017). As a Black woman, registered nurse, mother and doctoral nursing student, I recognize and acknowledge my unique subjectivity. Each of my roles has been significant in shaping my current practice; thus, my leadership philosophy is grounded in personal and professional experience.

In reflecting on my leadership journey, it became clear that there is a tremendous need for a leadership framework to guide Black nurses and nursing students as they navigate education and practice. Therefore, this paper presents my leadership philosophy, essential leadership competencies and an LDP that incorporates aspects of Black feminism and transformational leadership. In addition, the focus of my LDP is on graduate education; however, undergraduate students and clinicians, from various racial backgrounds, may also find the content beneficial.

5.3.3 Personal Leadership Philosophy Grounded in Leadership Theory

My personal leadership philosophy is established on the frameworks of Black feminist leadership and the five practices of exemplary leadership for transformational leaders (Harrington 2015; McLane-Davison 2015; Kouzes & Posner 2012). McLane-Davison (2015) explains that Black feminist leadership highlights significant components missing from leadership models that fail to account for the experience and activities of Black feminists and their unrelenting effort towards community betterment and social justice. Moreover, Black feminist leadership is an embedded element within Black feminism, as the inseparable theoretical and practical

components mandate Black feminist leadership throughout. Black feminist leadership emphasizes a collective, bottom-up approach that is grounded in Africana traditions and is in direct response to political and social injustice Adbullah (2007) as cited in McLane-Davison (2015). Thus, knowledge is generated by Black (women) for Black (women) by centering their ideas, experiences and interpretations (Collins 2000). Abdullah (2007) offers the following four components of Black feminist leadership:

1. interlinking of theory and praxis,
2. proactive approach,
3. group-centred approach (focus on the collective) with shared responsibility and investment in the cause and,
4. dynamic activism and advocacy (McLane-Davison 2015).

Transformational leadership, which is considered the gold standard in leadership, has enabled the existence of several models and frameworks (Cope & Murray 2017). Kouzes and Posner (2012) developed the leadership challenge framework containing five evidence-based components of exemplary leadership, including model the way, inspire a shared vision, challenge the process, enable others to act and encourage the heart. This framework aligns with Black feminist leadership and demonstrates how leaders are able to use specific practices to empower and mobilize others to achieve results.

5.3.4 Identifying Valuable Leadership Competencies

Nursing leadership is a dynamic journey requiring guidance from mentors, reflexivity and opportunities to refine leadership competencies (Cope & Murray 2017; Spano-Szekely et al. 2016). Huston (2008) outlines eight essential nursing leadership competencies for nurses in 2020, including global perspective, technological competence, expert decision-making, creating organizational culture, politicizing practice, collaborative skills, balancing authenticity and performance and being adaptable. The competencies offer an opportunity for leaders to expand their practice and address key concerns in healthcare regarding evidence-based practice and diversity and inclusivity (Huston 2008).

Emotional intelligence (EI) describes the ability of an individual to manage their own as well as the emotions of others (Cope & Murray 2017; Spano-Szekely et al. 2016). It is considered a leadership style as well as an attribute of transformational leadership; thus, EI is an essential competency for nurse leaders who focus on people and relationships (Cope & Murray 2017). Moreover, EI is regarded as a desirable leadership competency, as it is commonly observed in graduate-prepared nurse managers (Spano-Szekely et al. 2016).

5.3.5 A Leadership Development Plan for Black Graduate Nursing Students

This LDP is the result of my six years' experience of nursing education and two years of practice, where I recognized significant gaps in supports for success in the nursing program and in practice for Black students and nurses. My experience is corroborated by current literature, which shows that Black nursing students and nurses experience tremendous feelings of isolation, marginalization and a lack of support (Etowa et al. 2009; Loftin et al. 2012; White & Fulton 2015). Although this LDP is not a solution to the challenges encountered by Black nurses, it offers a tangible framework and considerations to guide nursing education and practice.

depicts an easy-to-follow plan, grounded in Black feminism, adapted from Nelson and Ortmeier (2011) and the LEADS framework (Canadian College of Health Leaders [CCHL] 2018). The LEADS framework, which stands for: Lead self; Engage others; Achieve results; Develop coalitions; and Systems transformation, offers a comprehensive approach to leadership development at the individual, organization and system level (CCHL). The initial steps of the LDP involve the identification of a leadership goal, self-reflection and identifying a mentor.

Rombeau et al. (2010) define a mentor as an experienced and trusted individual, who is committed to the personal and professional success of another (mentee). The definition offered by Rombeau et al. (2010) highlights three core concepts of mentoring, namely, *trust*, *experience* and *commitment*. Mentoring improves leadership skills and knowledge, as evidence shows that mentors facilitate success for mentees (Hafsteinsdóttir et al. 2017). Hafsteinsdóttir et al. (2017) explain that mentoring has a positive influence on postdoctoral nurses by increasing research productivity through enhancing research skills, increased peer-reviewed publications, increased grant submissions, funding and extensive collaborative networks.

The leadership goal provides structure and direction for leadership development. The leadership capabilities and objectives are taken from the LEADS framework, which describes capabilities for leaders practicing in caring environments within the Canadian healthcare system (CCHL 2018). The LEADS framework contains five capabilities; however, I selected three that most align with my leadership philosophy and practice. Finally, the strategies and self- and external evaluation methods were derived from my experience as a nurse and student and are included as a means to reduce personal bias and ensure program/practice success.

Table 6

Leadership Development Plan for Black Undergraduate and Graduate Nursing Students

Leadership goals: To identify and enhance the leadership competencies that are instrumental in succeeding as a graduate student, researcher and activist. To practice nursing leadership in such a way that it aligns with the key principles of Black feminist leadership and transformational leadership.			
Self-reflection: Being honest and kind with oneself about current areas of strength and areas for improvements. Acknowledging the difficulty of self-reflection yet embracing all feelings. *Strengths:* Skills and knowledge that are accessible and comfortable. *Areas for improvement:* Skills and knowledge that have not been mastered or exposed to.			
Identify a mentor: Consider admirable attributes and openness to learning from diverse individuals *Essential components:* Experience: expertise (skills and knowledge) in a given area Trustworthiness: promotes atmosphere of ease Commitment: invested in mentee development (Rombeau et al. 2010)			
LEADS framework			
Capability	**Objectives**	**Strategies**	**Evaluation**
Lead self	To increase self-awareness and self-management through personal and professional development initiatives on a monthly basis	• Engage in annual mindfulness workshops to enhance emotional intelligence and other traits • Engage in scholarly discussion by attending conferences, publishing and sharing work	Self: Professional portfolio to track activities; reflective journaling External: Progress reports for PhD (Graduate) program; supervisor feedback
Engage others	To empower others by establishing interdisciplinary teams, engaging in effective communication to foster healthy families, communities and organizations	• Develop ongoing partnerships with key stakeholders and nurture the relationships • Reflect on interpersonal interactions to determine what works well for communication style • Be intentional in understanding the context, needs and capabilities of others, after interactions	Self: Reflective journaling to capture feelings and emotions External: Debriefing with community and key stakeholders
Systems transformation	To demonstrate and engage in systems thinking and transformation by encouraging and supporting innovation, championing change and being future oriented	• Initiating at least one novel small-scale community-based project each year, in partnership with stakeholders • Making a consistent effort to be knowledgeable about the latest trends, innovations and initiatives in the field and related fields on a weekly basis	Self: Monthly checks to determine familiarity with current events and trends External: Advisory groups and stakeholder feedback

5.3.6 Conclusion

A clear, concise and well-articulated plan and vision are necessary in successful nursing leadership development. My leadership philosophy is grounded in the theoretical underpinnings of Black feminism and transformational leadership, which offers a useful approach to leadership for Black nurses. Centring the experiences, ideas and interpretations of Black people as well as emphasizing the significance of people and relationship ensures that practice is relevant to the Black community. This LDP was developed to guide the next few years of my doctoral studies; however, I believe it is a useful tool for all nursing students, clinicians, activists and researchers from various races/ethnicities, especially Black graduate students. The LEADS framework presents attainable leadership capabilities and strategies that align with Black feminist leadership and transformational leadership. As a Black nurse currently enrolled in a doctorate nursing program, I continue to strive towards personal and professional success; yet, I have encountered many obstacles along the way such as identifying and securing a mentor in my field as I navigate graduate school and begin to emerge as a nurse researcher.

5.4 Intersectionality 2nd Edition: Book Review

This work in section 5.4 also appears in: Jefferies, K. (2020). Intersectionality Book Review. *Atlantis, 41*(2), 99-101. Available at: https://journals.msvu.ca/index.php/atlantis/article/view/5544

5.4.1 Statement of Manuscript Contribution

KJ conceived, develop and submitted this book review for review and publication. Book under review: Collins, Patricia Hill and Sirma Bilge, eds. 2020. *Intersectionality*. 2nd Edition. Medford: Polity. Copyright details are located in Appendix A.

5.4.2 Background

The second edition of *Intersectionality* by Collins and Bilge (2020) is a timely release and much-needed follow-up to the first edition published in 2016. The authors tackle important questions and issues related to intersectionality and challenge both the current understanding and applications of the concept. Collins and Bilge effectively expand upon content from the first edition while also addressing the growth and expansion of intersectionality.

The text begins with a comprehensive definition of intersectionality: “[H]ow intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life” (2). The introduction is followed by case studies that examine three different contexts to demonstrate application of intersectionality: the FIFA World Cup, global economic inequality, and the Black women’s movement in Brazil. “These cases both introduce important core ideas of intersectional frameworks and

demonstrate different uses of intersectionality as an analytical tool" (5). This case-study approach facilitates understanding of the six core ideas or key concepts of intersectionality: social inequality, intersecting power relations, social context, relationality, social justice, and complexity. These six key concepts, according to Collins and Bilge, constitute the foundation of intersectionality and provide guidance for its use as an analytical tool. The remainder of the text is dedicated to exploring key criticisms and considerations of intersectionality in relevant areas such as neoliberalism, social media/digital activism, extremism, identity politics, reproductive justice, social protest, workers' rights, critical education, and academia.

By investigating three distinct cases, Collins and Bilge demonstrate how intersectionality is relevant in a multitude of contexts with varying degrees of complexity through the application of intersectionality as an analytical tool. These examples, paired with salient discussion about the mis/use of intersectionality in academia, displays the robust potential of this analytical approach across disciplines. For example, the authors describe how the interconnectedness of theory and praxis has caused confusion in academia, particularly as institutions scale up diversity, inclusion, and equity initiatives. In academic spaces, this confusion is dangerous as intersectionality may be wielded in ways that ultimately reinforce the very inequity and oppression that it is intended to eliminate. Collins and Bilge suggest that efforts to sustain critical praxis may place well-intended people and programs "on a slippery slope leading to watered-down understandings of diversity" (212). Further, "diversity initiatives have increasingly jettisoned structural analyses of social inequality in favor of individual and cultural interpretations of social problems" (211). Paradoxically, the mis/ use of intersectionality has led to more nuanced anti-Black racism, colonialism, heteronormativity, class oppression, and ableism. This confusion and misuse underscore the persistent struggle between academia, activism, and intersectionality.

Fittingly, the authors address pertinent questions regarding the use of intersectionality, such as: Does intersectionality always include an analysis of race or gender or sexuality? Without providing an explicit answer to such questions, the authors' emphasis on the six key concepts within intersectionality and the ways in which these concepts are interconnected and interdependent elucidate possible answers.

While this edition addresses new issues and questions, there are two additional and more immediate areas that are left underexamined. First, the authors employ intersectionality as an analytical tool to interrogate how systems of oppression influence individuals, groups, and societies through the use of six key concepts. Yet, beyond these well-articulated concepts, the authors offer no clear instruction for how to practically "apply" or *do* intersectional analysis. In other words, application of the six key concepts provides some guidance as to how one may approach this work yet a pragmatic, detailed explanation of *doing* intersectionality remains elusive. For some readers, this pliability is welcomed as it permits the often-desired flexibility needed to address social

issues. Further, it is difficult and problematic to prescribe a set formula to highly contextual complex issues. However, for those unfamiliar with or new to critical social theory or for those who require a more pragmatic method of analysis, a "how to" may be appreciated.

The second drawback relates to how intersectionality is juxtaposed with Indigenous ways of knowing. Given the extensive colonial elements embedded within Western theory, a more extensive discussion of decolonization and Indigenous ways of knowing is vital. Toward the end of the text, the authors briefly discuss ways in which intersectionality and Indigenous ways of knowing are situated in academia. Collins and Bilge also repeat throughout the book that many pertinent conversations had to forgo richer discussion. Moreover, the authors acknowledge that many of the issues that were left unpacked would require in-depth exploration in a separate chapter or a text. However, a deeper discussion of how Indigenous ways of knowing have influenced the concept of intersectionality and, conversely, how intersectionality may compliment or hinder Indigenous knowledge systems is necessary. For example, how does intersectionality align, compliment, and/or inhibit the use of other approaches, specifically decolonial and antiracist frameworks?

The above critiques notwithstanding, the second edition of *Intersectionality* aligns well with the field of critical theory and contains many notable strengths. The writing style is accessible to an audience beyond academia. The authors provide a clear and comprehensive definition of intersectionality to serve as an anchor for those interested or invested in intersectionality, particularly as an analytical tool. Yet the text is also in-depth enough to be intellectually rewarding for critical readers. An added strength of this text is the inclusion of an informative and fulsome discussion of the genealogy of intersectionality, which highlights the contribution of writers who preceded Crenshaw, including Toni Cade Bambara (1970), Frances Beal (1969), and the Combahee River Collective (1977). By introducing these early writers, Collins and Bilge provide vivid examples of how the fundamental ideas inherent to intersectionality were applied long before there was a mainstream term. □is allows the authors to challenge misconceptions surrounding the evolution of intersectionality. Moreover, incorporating critical excerpts from these essential, formative works supports the argument for maintaining the connection between theory and praxis.

In summary, Collins and Bilge provide a useful guide to understanding and analyzing the complexities of the world through their interpretation of intersectionality and the six core ideas contained within. This text is a must-read for anyone looking to label their work as intersectional. The authors speak directly to readers open to receiving critical content that challenges traditional knowledge systems by using examples that resonate with a large, diverse audience. The text includes a solid genealogy of intersectionality and applies the theory to various complex and contemporary issues. It also strongly encourages readers to engage with many of the

works that have informed intersectionality, primarily to avoid fragmentation, i.e. the separating of theory from praxis. Understanding the evolution of intersectionality not only strengthens the connection between theory and praxis, it also facilitates use of the concept in ways that align with the intended purpose of identifying and challenging oppression. As an essential text, this edition situates itself well within the larger critical social arena by aligning with the current pulse in academia, activism, and our dynamic social environment.

5.5 A Conceptual Framework to Guide Black Feminist Research

The work in this section, 5.5, is a manuscript currently under development and has been prepared for submission.

> "That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman? Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and no man could head me! And ain't I a woman? I could work as much and eat as much as a man–when I could get it–and bear the lash as well! And ain't I a woman? I have borne thirteen children, and seen most all sold off to slavery, and when I cried out with my mother's grief, none but Jesus heard me! And ain't I a woman?"
>
> Sojourner Truth (1851)

The opening quotation by Sojourner Truth (1851) is acknowledged as an early expression of Intersectionality, a term coined in 1989 by Kimberlé Crenshaw to capture the inter-locking discrimination experienced by Black women in the African diaspora. The African diaspora refers to the global dispersion and migration of Black people around the world. Truth's quotation skillfully illustrates the complex interactions of racial, gendered and class oppression by Black women. Specifically, she demonstrates how the social constructs of femininity and *womanhood* – along with social etiquette and gender norms – were not ascribed to Black women. Rather, Black women, regardless of class, were not viewed as women – being systematically dehumanized – and were not granted the social courtesies or [subpar]standards for all women. Through a lens that concedes that sexism, gendered and class oppression do not affect all women in the same manner, this paper examines this very issue. The imagery in this quotation serves to situate the following discussion in this theoretical paper, which examines how socially constructed intersectional aspects of identity are interdependent and inextricably linked, to reinforce circumstances of [dis]advantage] and marginalization. This theoretical

paper intertwines core elements of nursing and argues that the nursing profession, itself marked by systemic sexism, racism, ableism and heteronormativity, has a role to play in resisting and challenging oppression.

Centuries of intersectional oppression has created a legacy of ancestral trauma and imposed resiliency among Black people that continues to be intensified by contemporary anti-Black racism. The systemic and institutional nature of anti-Black racism – the insidious or nuanced oppression – reinforces the social, political and economic marginalization of Black people, families and communities (DeGruy, 2005; Geronimus, 1992; 1996; 2001; 2006; Higginbotham, 1993). For nursing to address health equity through health promotion in order to optimize health outcomes, an understanding of the manner in which intersectional oppression operates and imposes upon Black women [and people in general] is necessary. The purpose of this paper is twofold. First, the paper presents a theoretically grounded framework, which builds on the assumptions and guiding tenets of Black Feminist Theory (BFT). The framework incorporates three critical concepts; weathering, respectability politics and post traumatic slave syndrome (PTSS), which together form a contemporary understanding of Blackness. Second, this theoretical paper demonstrates how this framework may be applied or used to guide nursing research and policy in a manner that is inclusive, germane, and unapologetically anti-racist. This framework constitutes a theoretically sound approach through which research, from question development to analysis and translation, and policy may be developed, implemented and evaluated.

5.5.1 Black Feminist Theory: Past and Present

Black Feminist Theory (BFT) is a critical social theory that was established in the late 1970s by a collective of Black women who set out to address the unique issues affecting Black lesbian women (Combahee River Collective, 1977; Smith, 2016). BFT serves as the theoretical and philosophical foundation of the contemporary Black feminist intellectual tradition, while simultaneously underpinning Black feminist praxis, a sociopolitical movement that strives to challenge and dismantle the intersecting oppressions (Collins, 2000; Davis, 2018). The intellectual traditions and the sociopolitical praxis – referred to as theory and praxis – are interdependent elements that must be present in unison (Collins, 2000; Davis, 1984; Lorde, 1989).

Over the past decades, BFT has been used to center the experiences, ideas and interpretations of Black women by incorporating the intersections of the socially constructed concepts of race, class, gender and sexuality into analysis (Collins, 2000; Crenshaw, 1991; Davis, 1981; hooks, 1984; Lorde, 1984). Black feminism is a movement that began in response intersectional oppression and to address issues pertinent to Black lesbian working-class women (Collins, 2000; Smith, 2016). The tradition of BFT has since evolved to address widespread Black Feminist issues including gender queer, disability and issues citizenship, nationalism and “no one is illegal” [especially on stolen land] (Bailey & Trudy, 2018; Cooper, 2018; Maynard, 2018).

Situating the philosophical components of BFT is required to begin understanding Blackness and how it is influenced by multiple intersecting aspects of identity. Despite being underused in research, BFT as a theory and methodology has been demonstrated as an approach that provides a philosophically rigorous and relevant process to conduct research involving Black people, groups and communities (Love, 2016; Smith, 2016). This section introduces the philosophical underpinnings and assumptions of BFT; the genealogy of Black Feminism in the diaspora; its critiques; and finally the theoretical foundation upon which the proposed framework is build.

5.5.1.1 Philosophical Underpinnings and Assumptions. Philosophical underpinnings and assumptions serve as the foundation upon which all theories are established. Elements of ontology, epistemology and methodology facilitate theoretical understanding, appropriateness and utilization in research and policy. Ontology, described as historical realism where reality is modified over time by social, political, cultural and economic factors that create institutions, structures and systems presumed to be real, natural or true, asks the question: *What is reality?* and *What is the nature of reality?* (Guba & Lincoln, 1994). As a theory situated in the critical paradigm, where multiple realities are socially constructed and exist under constant influence from internal forces (Guba & Lincoln, 1994), reality in BFT exists in a state of dynamism. There is the reality of Black people as free. Yet, this is juxtaposed against the reality of subjugation, where Black people are born, raised, live, work, play and exist in a world that was designed with their exclusion. The historical realism in BFT suggests that there is a constant and persistent struggle for liberation [from mental and physical bondage], which is rooted in oppressive social, interpersonal, institutional and systemic processes that are a result of colonization.

Epistemology is concerned with the nature of knowledge and truth (Guba & Lincoln, 1994). Guba and Lincoln (1994) explain that, in the critical paradigm, knowledge is socially constructed and influenced by societal power. Epistemology asks: *What is the nature of knowledge?* and *What is basis of true knowledge?* Epistemology determines which questions merit investigation, what frameworks are used to analyze findings, the validity [or truthfulness] of knowledge and how knowledge is used (Collins, 2000). Collins (2000) explains that epistemology consists of an overarching theory of knowledge used to assess knowledge and to determine why we believe what we believe to be true. Collins (2000) posits that an experiential base underlies BFT epistemology. BFT posits that the way to produce and validate knowledge for and about Black people is through learning of the lived experience. Collins (2000) argues that the lived experience of Black people is inherently more valuable, credible and believable than the interpretations and opinions of those who simply read and analyze such experiences, without having also lived as a Black person. BFT posits that knowledge resides

deep within Black womanhood, is not connected to a higher authority and is shared through generations - ultimately forming collective wisdom (Collins, 2000).

Guba and Lincoln (1994) state that methodology asks the questions *How is reality uncovered?* and *How do you go about finding out reality?* This focuses on the process or procedure for conducting investigations to uncover reality or generate knowledge. Discourse is a central component in uncovering reality in the critical paradigm (Guba & Lincoln, 1994). Collins (2000) explains that Black people must also *generate* knowledge. Cooper (2017) argues that Black women create knowledge for the betterment of the Black community; motivated by a sense of care. Despite barriers to knowledge generation, Black women have used alternative methods to produce and validate knowledge (Collins, 2000). For Black women, knowledge is rarely generated in isolation and without dialogue with community members and institutions such as family or church (Collins, 2000). A final note regarding philosophical underpinnings is the notion of values and the importance in nursing and research. Axiology, which what values exist, asks the question of *What do we value?* and more importantly in this context, the role that values play in guiding research and practice. The philosophical underpinnings of BFT posit intersections of oppression as inseparable, intricately connected, and operating in a dynamic manner. The following section describes the genealogy of BFT, offers a glimpse into Black feminism in the diaspora and ends with a brief mention of critiques.

5.5.1.2 Genealogy of Black Feminist Theory. While BFT is understood as beginning in the 1970s with the Combahee River Collective (CRC), it is important to recognize that there is a long tradition of Black feminist work that predates the documented formal statements and literature commonly designated as the origin texts. Truth (1851), Frances Beal (1969), and Toni Cade Bambara (1970) made contributions to the present-day intellectual tradition (Collins & Bilge, 2020). However, the formalization of what is known as BFT was conceptualized by a collective of Black lesbian women who refused to remain silent about the interconnected discrimination of racism, sexism and heteronormativity they experienced in society (Smith, 2016). The CRC, a group of Black feminist scholars, resisted sociopolitical issues that excluded the lived realities of Black lesbians (Smith, 2016). In their canonical public statement, the CRC (1977) described the injustices experienced by Black women and the lack of attention to these issues. These issues, including fundamental dignity and rights to life, were not recognized, acknowledged or included by the three prominent liberation movements, at the time, which challenged the traditional white patriarchal, heteronormative structure of society (CRC, 1977; Smith, 2016). These liberation movements included the feminist, Black and gay liberation movements.

5.5.1.2.1 Feminist Movement. *Feminism* is a fairly modern term that gained popularity long after women began to question and challenge their position in society (Freedman, 2001). The feminist movement,

consisting of a series of waves, addressed issues and concerns related to gender roles and sociopolitical equality for women (Butler, 1990; de Beauvoir, 1949; Freedman; 2001; Friedan, 1963). The first-wave, during the late-19th and early 20th century, focused on the right for *white* women to vote (Freedman, 2001). While the second wave, emerging during the 1960s and 1970s, centered on gender equality in relation to family planning, workforce participation and sexuality/ sexual liberation (Freedman, 2001). The third wave of feminism, during the 1990s, began to acknowledge the intersectional nature of oppression as influenced by sexuality, age, race, class, ethnicity and gender (Curtis & Cardo, 2017). Finally, the fourth wave of feminism, beginning after 2010, addresses sexual violence, rape culture, body positivity and trans women rights (Brunell & Burkett, 2019). Each wave of the feminist movement has been criticized for complacency with white supremacy and failure to adequately interrogate racism and other forms of gendered oppression. Black feminists argued that the central agenda in the feminist movement differed drastically for women of other races, ethnicities, classes and sexual orientations, and that the mainstream feminist movement was not inclusive of the issues pertinent to women who were not white, heterosexual and from the middle class (Barbee, 1994; Collins, 2000; Davis, 1981; Love, 2017; Lorde, 1984; Smith 2016). For example, Collins (2000) and hooks (1984) write that, during the second wave, many Black women were not interested in the same political and social outcomes as the mainstream feminist movement as Black women occupied very different positions socially. It is known that one of the main goals of the second wave feminist movement was to normalize women working outside of the home and to shift domestic duties such as childcare and housework. (Collins, 2000; Davis, 1981; hooks, 1984). Yet, as Collins (2000) and hooks (1984) write, Black women had been working outside of the home for *decades* as domestic workers, usually for white families. To this end, Black women were not interested in advocating for the right to work outside the home or to take on fewer domestic duties within their own home. Instead, Black women sought basic rights already afforded to women.

5.5.1.2.2 Black Liberation Movement. The Black liberation movement, from the 1950s to 1980s, sought to achieve self-determination and liberation for Black people (Collins, 2000; CRC, 1977; Joseph, 2001; Kirkby, 2011). The Black liberation movement mobilized on issues of race and racism to the exclusion of other important intersections such as gender and sexuality. The Black liberation movement aligned with the oppressive ideology of patriarchy as it prioritized issues pertinent to Black men, did not address the oppression experienced by Black women and failed to interrogate the internalized processes that perpetuated further marginalization and oppression (Cooper, 2017; CRC, 1977; Smith, 2016). The nature of intersectional oppression results in Black women experiencing a degree of oppression and discrimination that is not experienced by Black men (Lorde, 1984). Black women struggle against racism and racial oppression with

Black men while simultaneously struggling against sexism and gendered oppression (CRC, 1977). In addition to heteronormative restrictions placed upon Black women, a critical movement involves challenging gendered oppression to situate experiences of transgender, gender queer and non-binary Black people to minimize hyper-marginalization of Black queer folks.

5.5.1.2.3 Gay Liberation Movement. Lastly, the Gay Liberation Movement of the 1960 to mid 1980s is criticized for failing to interrogate white patriarchal ideology as it is accused of not taking into account the realities, experiences and needs of [racialized] lesbian women or gay men who were also racialized (Smith, 2016). The Stonewall Riot, an uprising in the summer of 1969 in New York, is understood as a catalytic event for the gay liberation movement. Yet, as is seen with repeated attempts to erase the contributions of Black social leaders in African diasporic history, the leadership of Black queer folks including Marsha P. Johnson, Sylvia Rivera, Miss Major Griffin-Gracy, Stormé DeLarverie are generally omitted from the Stonewall historical account. Present day Black queer scholars criticize this repeated omission and accuse Pride, the annual celebrations and festivals of self-affirmative, dignity, equality and visibility for Gay, lesbian, bisexual, transgender, and queer folks, as adopting a de-politicized position that aligns with white supremacy and patriarchy, effectively muting the voices of queer and trans people of color.

5.5.1.3 Black Feminist Theory in the Diaspora. While the United States (US) has birthed a strong Black feminist tradition, Black Feminism, as a social movement, has an extensive international history across many countries. With the African diaspora being dispersed across most regions of the world salient issues of nationality, geographical location and historical context significantly influence the experience of Blackness and thus, BFT. Globally, BFT is heavily influenced by contextual elements of the US. However, the conceptualization, understanding and expression of BFT across the diaspora offers alternative perspectives, varied contexts and insights, especially in considering intersections of nationality and geographical location as a significant component in the experience of Blackness. As a result, the interpretation and understanding of BFT continues to evolve and expand as more is uncovered and written about BFT and the various adaptations throughout the diaspora. Ergo, it is necessary to discuss BFT beyond the dominant US context to postulate the intricacies within the Black experience across international borders. This section presents a succinct overview of the conceptualizations and writings of BFT that exist globally, including Black British Feminism, Afro-Brazilian Feminism and Black Canadian Feminism. Importantly, this overview does not encompass an exhaustive account of BFT nor does it include BFT on the continent of Africa. This omission is not to deny nor dismiss the relevance of BFT across the continent but rather, there are weighty considerations related to

Afrocentricity, BFT and various African traditions, which require discussion that extends beyond the scope of this paper.

5.5.1.3.1 Black American Feminism. Black Feminism in the U.S is often thought of as ground zero for action against the oppression of Black women. The reason for this is multifaced including the positionality of the US in the global sphere. The US has grappled with overt historical and contemporary racial issues, as well as social mechanisms that foster Black scholarship (Bristow et al., 1994). Contributors to the expansion of Black feminist intellectual tradition in the U.S include bell hooks, Barbara Smith, Audre Lorde, Angela Davis, Beverly Guy-Sheftall, Alice Walker and Octavia Butler. However, Collins (2000) posits that Black feminists and those who contributed to the emergence and growth of Black feminism were not necessarily academics or scholars. Many Black feminists shared knowledge and insight through creative art forms such as stories, music, dance and poetry or through their activism and community engagement, which are not traditionally captured, reproduced, shared or valued in academic spaces (Collins, 2000; hooks, 1984; Lorde, 1984). For example, Sojourner Truth, born into slavery, is regarded as a Black feminist leader, due to her social activism for Black women's rights (Collins, 2000).

5.5.1.3.2 Black British Feminism. Black British Feminism is also the title of a collection of Black Feminist texts and scholarship that explores postmodern themes in gendered and racialized oppression (Mirza, 1997). The text provides an overview of BFT in Britain over a span of 20 years. Notable Black British feminists featured in the collection include Hazel Carby, Amina Mama, Pratibha Parmar and Amrit Wilson. Mirza (1997) explains that the Black British movement began when Black women began to document the work experiences and political challenges of Black migrant women. By the 1980s, Black British feminists initiated a critical dialogue with white British feminists. Similar to Black feminists in the U.S, Black British feminists were driven by the need to expose the sociopolitical conditions experienced by Black British women (Mirza, 1997; 2014; 2015). There is a substantial amount of work underway by Black British feminists and scholars of color, which is focused on dismantling institutional racism and decolonizing the academy (Ahmed, 2017).

5.5.1.3.3 Afro-Brazilian Feminism. The Transatlantic Slave Trade saw approximately 12 million Africans captured and transported around the world (Adams, 1925). South America, specifically Brazil, was one of the primary destinations for enslaved people who were captured and taken from West Africa. Consequently, Brazil, and Latin America in general, are home to a significant number of Black people. Nearly 45% of Brazilians are of African descent, and Brazil has the largest Black population in the world, second only to Nigeria (Lebon, 2007). Despite internal conflict and ongoing evolution of identity, the large population of Afro-Brazilians has led to the development of anti-racist movements and activism. Pons Cardoso (2016) writes that

Afro-Brazilian feminism emerged across various regions of the country in the 1980s during the time known as the “political opening”, which involved a shift from the militant authoritarian regime towards top-down liberation. At this time, women began to develop and put forth projects and ideas for racial and gender equality, sexual diversity and sociopolitical liberation. The Afro-Brazilian Feminist movement emerged as a response to historical and persistent inequalities of race, class, gender, sexual orientation and the necessity to create a space to engage in the struggle for social justice on their terms (Pos Cardoso, 2016).

5.5.1.3.4 Black Canadian Feminism. significant differences between Black feminist scholarship in Canada and the US. In the U.S, Black history and the impact of racism, slavery and segregation has been acknowledged as a legitimate field of inquiry (Bristow et al., 1994). Whereas, in Canada, such recognitions and acknowledgments of racism, slavery and segregation remain a significant point of contention and denial. The historical presence and existence of Black people in Canada has yet to be properly acknowledged and reconciled. The erasure of Black people, particularly Black women, from mainstream history in Canada, is evident from the glaring exclusion of Black people in historical Canadian records (Bristow et al., 1994; Wane, 2007). This omission is a recognized as a clear and deliberate attempt to further oppress and disenfranchise Black people in Canada. The portrayal of Canada as a uniformly colonial Anglo/ Franco culture reinforces the marginalization of Black people. Eurocentrism, which serves as a cornerstone of white supremacy and the foundation of Canada, denies and excludes the experiences of those who do not align with these perceived ideals. The historical omission is continued in the inherent racism of Canadian scholarship and intellectual tradition. Resisting erasure, Black feminists in Canada contribute to the evolution and intellectual expansion of BFT through scholarship, art, literature, film and activism. Like the greater Black diaspora, Black feminists in Canada have contributed immensely to the collective knowledge that is BFT. The writings of Black Feminists in Canada are paired with community-based activism and organizational praxis (Bernard, 2015; Brand, 2001; 1994; Bristow et al., 1994; Massoquoi & Wane, 2007; Maynard, 2017; Reece, 2007; Wane, 2007).

In addition to generations of community-based movements and activism by Black women in Canada, there is a growing number of Black feminist writers and critical texts. Seminal texts such as Bristow et al.’s (1994) collection of essays, from six Black-identifying women in Canada, describes the ways in which intersectional oppression exists in Canada. The authors interrogate how anti-Black racism is experienced by both Black men and Black women in Canada, yet Black women encounter an additional degree of hardship and marginalization. The authors further situate Black women in Canada by writing a feminist history that addresses the resounding issue of historical accounts that 1) perpetuate the erasure of Black people in Canada, 2) are told largely by me and 3) often exclude women. Bristow et al. (1994) explain that the historical experiences of

African Canadian women involving the survival of both racialized and gendered oppression warrant careful examination and recognition.

An additional germinal text regarding BFT in Canada is that of Massoquoi and Wane (2007). Massoquoi and Wane's (2007) *Canadian Perspectives on Black Feminist Thought* presents a collection of essay that captures the Black Feminist Massoquoi (2007) argues that Black women do not need to be overly concerned with abstractly theorizing. Rather, since these acts serve to inform theory. time is better spent in reconceptualizing paradigms, ways of individual and collective empowerment and the development of space for scholarship. Repressive patterns within Euro-centric frameworks do not encourage nor facilitate the development of relevant or inclusive frameworks for Blackness. Thus, it is necessary to generate, conceptualize and evolve knowledge systems that do not brew dependency on theories, frameworks and approaches to knowledge generation that do not adequately situate Black people in Canada.

5.5.2 Black Feminist Theory and Power

One of the critical components to consider and discuss in relation to BFT is power. Power in critical theory is defined as relational, produced and reproduced through the interaction of intersections and how these intersections are viewed and experienced in society and institutions (Jefferies, 2018; van Dijk, 1993). In BFT, power exists in a series of interconnected domains (Collins, 2000). These domains, which constitute the matrix of domination (MoD) include: Structural, Disciplinary, Hegemonic and Interpersonal. The MoD describes privilege and its operation upon individuals, groups and society (Ritzer, 2005). Ritzer describes the MoD interactions of race, class, gender, ability, and sexual orientation as interlinked with one another, creating variation in the manifestation of oppression. The intersecting nature of these oppressions make it extremely difficult to make sense of Black lived experience without accounting for and considering each component (Collins; 2000; Ritzer, 2005). BFT and the Matrix of Domination, as described by Collins (2000) goes beyond simply identifying which intersecting oppressions exist in a particular situation to go further and explain how these intersections interact with one another and how they are organized to create positions of advantage or disadvantage for individuals and groups (Collins, 2000).Table 7 displays the four domains of power and associated descriptions, identified and defined by Collins (2000).

Table 7

Matrix of Domination (MoD) (Collins, 2000)

Domain	Description

Structural Domain of Power	Large-scale interlocking institutions are organized and created to reproduce subordination ie: education; health; justice; labor
Disciplinary Domain of Power	Manage power relations through bureaucratic hierarchies and surveillance rather than with explicitly racist and/or sexist policies. Notion that people are controlled by the politics and bureaucracy of institutional and organization operations.
Hegemonic Domain of Power	Shapes the ideology, culture and consciousness of individuals. Connects or links the structural, disciplinary and interpersonal domains.
Interpersonal Domain of Power	Includes the routine, day-to-day practices and how people interact and treat each other.

5.5.3 Criticisms of Black Feminist Theory

There are several criticisms of BFT and of its use in research. BFT has been accused of lacking legitimacy, and objectivity, being divisive, having a Euro-centric foundation and being narrow in its focus (Cooper, 2018; Hudson-Weems, 1995; 1997; Lorde, 1984). In terms of legitimacy and objectivity, critics argue that BFT begins from a highly subjective and biased position. Some scholars view BFT as divisive, unnecessary and harmful (Hudson-Weems, 1995; 1997; Staples, 1979). Hudson-Weems (1995; 1997) and Staples (1979) explicitly oppose BFT and suggest that it diverts attention away from the anti-racist movement and that it casts Black men in a negative light. By incorporating gender [and class] into the conversation on Black liberation, it divides an already vulnerable community and diverts energy that would benefit the collective struggle of Black people (Hudson-Weems, 1995). However, as Cooper (2017) and Lorde (1984) note, Black women and trans folk experience hyper-marginalization within the Black community and muting these necessary discussions will not address the issue. Another criticism of BTF is that it is simply white feminism in Black face and that BFT is built on a foundation of oppression (Hudson-Weems, 1997; 1995). Lorde (1984) counters that Black women have legitimate and specific issues that affect their multifaceted lives and addressing these issues does not eclipse discussion regarding racism (Lorde, 1984). The last criticism concerns the legitimacy or validity of Black knowledge and Black ways of knowing. Despite the history of Black intellectual traditions in the U.S, BFT continues to experience push-back and marginalization as a legitimate approach to conducting research (Cooper, 2017; Love, 2016). This is in large part due to the fact that knowledge is measured and validated by the very systems and ideologies that oppress subjective and multiple realities (Cooper, 2017; Lorde, 1984).

Table 8 is the culmination of existing and ongoing work from Black feminist theorist as well as an evolving understanding and utilization of BFT in my own research, advocacy, practice and activism.

Table 8

Assumptions and Guiding Principles of BFT

Pillar	Description
A Historical Situatedness and Grounding	Requires a rich and thorough investigation into history and traditions. Contemporary BFT maintains the significance of historical and social contexts while simultaneously avoiding reinforcing stereotypical or racial images of Black women.
Use of Critical and Unapologetic Language	BFT is explicit in its name; eliminating ambiguity and is unapologetic about the nature of the inquiry. BFT requires the use of unapologetic language in theory and praxis.
Towards Individual and Collective Liberation	Dedication and commitment to individual and collective liberation. While BFT centers the experiences of Black women as a collective, BFT continually adapts and creates space for the diversity that exists among Black people.
Centering Black Women	The compounding effects of sexism and racism are such that Black women experience a particular form of oppression that is not captured by investigating race or gender in isolation. Sexism does not affect all women in the same manner, nor does racism affect all Black people in the same way. Despite having evolved to include varied intersecting oppressions that influence the lives of Black people, BFT continues to prioritize and center the experiences, ideas and interpretations of Black women. Black feminists posit that Black women are a hyper-marginalized group, and that issues that affect Black men, transgender and gender diverse people, children, families and communities all have a resounding impact on Black women.
Intersecting Oppressions	Ensuring that race is always an included factor. Recognizing and encouraging the incorporation of how intersections work and are worked upon. Examines the interaction of race, class, gender, sexual orientation, disability and class.
Inextricable Link Between Theory and Praxis	The ongoing and deliberate use and integration of knowledge to address inequity and power imbalances.

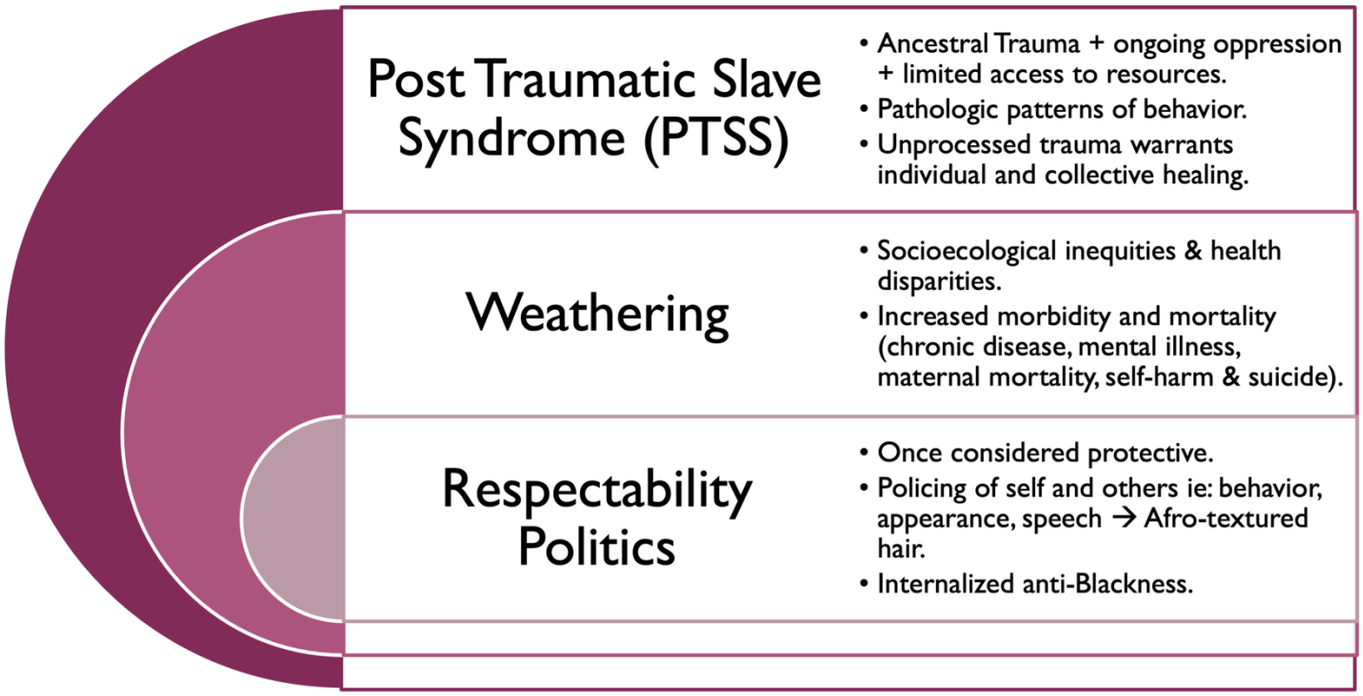
5.5.4 Conceptual Framework to Situate Blackness

A conceptual framework offers structure in the presentation of information to explain the natural progression of phenomena by taking what is known about a phenomenon and using it to inform understanding (Grant & Osanloo, 2014). Conceptual frameworks promote the understanding and applicability of abstract concepts into policy and practice (Wilson-Thomas, 1994). The use of conceptual frameworks, as a tool, in nursing is helpful in guiding practice, including policy and research. Grant and Osanloo (2014) explain that conceptual frameworks generally consist of a set of assumptions, concepts and beliefs that guide research by describing important factors, variables and constructs to suggest a relationship or connection amongst them.

This grounding facilitates the focus on relationships between various factors and provides direction for how problems can be explored (Grant & Osanloo, 2014). Finally, when theoretically informed, conceptual frameworks offer a logical, structured, visual representation of how ideas and concepts relate to one another within the theoretical framework (Grant & Osanloo, 2014). To facilitate the uses of BFT in nursing, particularly as a way to interrogate anti-Black racism, this theoretical paper expands upon the theoretical foundation of BFT to incorporate three interrelated concepts regarding Blackness. The three concepts include *respectability politics, weathering* and *Post Traumatic Slave Syndrome* (see Figure 6).

Figure 6

Conceptual Framework Integrating Respectability, Weathering and PTSS



5.5.4.1 Respectability Politics. Respectability politics is described by Higginbotham (1993) as the manner in which Black people monitor or surveil themselves and others within the Black community in relation to their appearance, behavior or speech. Higginbotham (1993) argues that, in an attempt to achieve and maintain respect and acceptance in a society that problematizes Blackness, Black people may condemn common practices, attitudes, behaviors and actions among other Black people. Rather than embracing inherent differences, those who subscribe to respectability politics insist on conformity to Eurocentric norms,

mannerisms, and morals (Higginbotham, 1993). Lee and Hicken (2016) explain that these visual and behavioural modifications are coupled with an invisible psychological arming behavior used to prepare for prejudice and discrimination. Examples throughout popular culture and scientific literature demonstrate the ways in which Black people adjust their appearance and behaviour to avoid stereotypes, prejudice and discrimination (Lee & Hicken, 2016). A prominent example of respectability politics concerns hair. Afro-textured hair, in its natural state, is often viewed as unkempt and unprofessional. With regards to the concept of professionalism, Black people are often encouraged to modify their natural hair by cutting dreadlocks, removing braids or chemically processing hair to straighten it. Lee and Hicken (2016) found that regardless of socioeconomic status, Black people frequently modified their actions or behaviors to receive quality service or avoid discrimination.

Proponents of respectability politics argue that Black people should be attentive to how they are perceived, and that respectability politics should be preceded by a sound assessment of the goals, manner of practice and context in which it is used (Kennedy, 2015). Kennedy (2015) suggests that while respectability politics has not eliminated anti-black racism, it has been instrumental in reducing racial discrimination, harm and death. Whereas critics argue that respectability politics positions Blackness as the problem, rather than the hegemonic ideologies that created and reinforce anti-Black racism. Critics contend that respectability politics unfairly places blame and responsibility on individuals for issues and prejudice that are systemic and cannot be remedied by individual actions alone. Cooper (2017) expounds that respectability politics once served as a protective strategy for Black women to navigate a hostile and threatening society to avoid acts of sexual assault and other forms of bodily harm.

5.5.4.2 Weathering. In geology, the term weathering is used to describe the process of breakdown, wearing or change in appearance (and arguable in strength and durability) by a substance after prolonged exposure to mechanical, biological or chemical elements such as rainwater, extreme temperatures and biological activity (Geological Society, 2018). Geronimus (1992) proposed the weathering hypothesis in relation to the health of African American women, stating that the health of Black women deteriorates at an earlier and accelerated rate as a consequence of an accumulation of systemic and pervasive socioeconomic inequities. Incessant experiences of social, political and economic exclusion and marginalization lead to cumulative deleterious health effects for Black people, especially Black women (Geronimus, 2001; 2006b). While research shows that Black men and Black children also exhibit significant signs of weathering (Das, 2013; Schmeer & Tarrence, 2018), Geronimus (2001) suggests that Black women are particularly vulnerable to the effects of weathering.

Geronimus (1996; 2001; 2006) and Das (2013) describe the physiologic consequences of repeated exposure to stress and stress hormones. Geronimus, Hicken, Keene and Bound (2006a) suggest a direct relationship between weathering and life expectancy, stating that morbidity and mortality disproportionately affects Black people. This issue presents itself in serious health issues such as maternal mortality and chronic disease, which have been found to disproportionately affect Black people. Black people experience poorer health at earlier ages than the general population, accumulating suboptimal health outcomes, and producing stark disparities in health (Geronimus et al., 2006b). In addition, the compounded effects result in disproportionate physiological deterioration, causing younger Black people to show characteristics of morbidity and mortality typically seen in older white individuals.

The weathering hypothesis simultaneously highlights the imposed resiliency and the vulnerability that Black people experience. In one instance, the weathering hypothesis reveals how Black people have endured and survived harmful and persistent mental, physical and emotional trauma in multiple forms. Yet, Black people are faced with a "racism storm" they must weather, whether in the form of microaggressions or more overt racism. Everyday experiences of racism, while traumatic, has moulded a people of tremendous strength through imposed resiliency. However, persistent and relentless trauma is damaging to even the strongest of substances. Thus, as rocks erode due to exposure over time, so too does the mental and physical health of Black people (Jefferies (SBW), 2020).

5.5.4.3 Post Traumatic Slave Syndrome (PTSS). DeGruy (2005) explains that Post Traumatic Slave Syndrome (PTSS) is the persistent and ongoing emotional and behavioral response, carried through multiple generations, which descendants of enslaved Black people display in reaction to trauma. Scholars argue that the trauma inflicted during the enslavement era did not end with the abolition of slavery (DeGruy, 2005; Sule et al., 2017). DeGruy (2005) and Sule et al. (2017) expound that the emotional and behavioral responses to slavery, racial segregation (e.g. through the Jim Crow laws) and lynching continue. The trauma of these historic horrors has resulted in a conditioned response.

The Diagnostic Statistical Manual of Mental Disorders V (DSM-5) presents a description of disorders, associated symptoms and the potential causes, and is used by clinicians for diagnoses (DeGruy, 2005). DeGruy (2005) builds her case for PTSS on the foundation of Post Traumatic Stress Disorder (PTSD). PSTD, described in the DSM, is now widely accepted and well-known as a debilitating condition, causing individuals to experience physical, mental and emotional distress after a traumatic event[s]. PTSD is diagnosed under the following circumstances: Serious threat of harm to one's life or physical wellbeing; Threat or harm to one's children, spouse or relative; Sudden destruction of one's home or community; Witnessing the injury or killing

of another person as the result of accidental or physical violence; Hearing about the kidnapping, torture or killing of a loved one.

DeGruy (2005) contends individuals who were enslaved experienced at least one [if not all] of these traumatic episodes simultaneously and repeatedly. Slavery, a state-designed system, destroyed individuals and families through mental, physical, emotional sexual and spiritual assault. The assault on the bodies and minds of Black people, was deliberate, intentional, and had the effect of dehumanizing. Antebellum calls for a more "humane" type of slavery were not sufficient for the liberation of Black people. The eventual abolition of slavery was not followed by processes and programs for individual or collective healing. Thus, the effects of the trauma were never treated or addressed (DeGruy, 2005; Sule et al., 2017). Furthermore, after the abolition of slavery, the liberation of Black people remained evasive, as generations of Black people were forced to navigate through Jim Crow, lynching and segregation (DeGruy, 2005; Sule et al., 2017).

These experiences resulted in a very defeated mindset. Belief is a powerful concept (DeGruy, 2005; Lipton, 2005) that is woven throughout PTSS (DeGruy, 2005). For example, vacant esteem, which is the term applied to the emotional state of feeling or believing that one has little or no worth, is one of the core behaviors of PTSS. Vacant esteem is often accompanied by depressive feelings, negative self-perception and hopelessness (Sule et al., 2017). Other core behaviors of PTSS include an ever-present anger and racist socialization. Ever-present anger is described as the constant state of frustration while racist socialization involves looking at Black people through *racist white eyes,* policing and criticizing of the Black self and Black others (DeGruy, 2005).

The lasting effects of more than 400 years of indoctrination and physical and mental colonialization cannot be dismissed or erased solely by the implementation of laws and policies. The structures and systems that once promoted and now continue to reinforce the dehumanization of Black people are persistent and continue today (Sule et al., 2017). Sule et al. (2017) argue that the past is relevant, the trauma and pain suffered must be acknowledged as having intergenerational effects and being ingrained into one's identity (Sule et al., 2017). Nursing must participate in an open and honest dialogue about the contemporary impact of slavery and systemic structures that perpetuate race-related trauma throughout society, especially healthcare (Sule et al., 2017).

Chapter 6: Methods

The following chapter outlines the methods used to conduct the examination of the leadership experiences of ANS nurses in healthcare. A description of the study design, study population and sample as well as eligibility criteria and recruitment strategies are presented. Additionally, an explanation of the specific data collection and analytical techniques in addition to the ethical consideration are presented. The chapter ends with a discussion detailing the trustworthiness of the study and the strategies employed to address aspects of credibility, dependability, confirmability and transferability. To note, a similar description of the methods outlined below are also found in section 7.2, which is a manuscript currently under review.

6.1 Study Design

This study employed a qualitative study design to understand and describe phenomena through the examination and exploration of experience. This qualitative study was guided, from the initial study conception through to the analysis, by the theoretical underpinnings of BFT, which was described in Chapter 5. The use of BFT, which is a critical social approach to research that centers the experience, ideas and interpretations of Black women, was used to facilitate knowledge discovery, generation and utilization in relation to the leadership experiences of ANS nurses. Specifically, BFT enabled the examination and understanding of how social constructs such as race, class, and gender, influenced leadership for ANS nurses.

6.2 Population

The true size of the population [ANS nurses] is not presently known. As one of the largest health professional groups in Canada, there are approximately 448,044 regulated nurses with an active license (Canadian Institute for Health Information [CIHI], 2019). There are three distinct categories of nurses in Canada, including licensed practical nurses; registered nurses and; advanced practice nurses (APNs). Advanced practice nurses include clinical nurse specialists and nurse practitioners. Of the 448,044 regulated nurses in Canada, approximately 130,710 are licensed practical nurses (LPNs) [or registered practical nurses (RPNs) in Ontario], 6,115 are registered psychiatric nurses, 304,558 are registered nurses (RNs) and 6,661 are nurse practitioners. In Nova Scotia, there are approximately 15,000 nurses (Nova Scotia College of Nursing [NSCN], 2022). In terms of nursing workforce demographics, current data is disaggregated according to age and gender only. In Canada, there are currently no disaggregated data including key indicators such as race or ethnicity. To this end, it is impossible to determine the true size of the population of ANS nurses since there is no national or provincial race-disaggregated database for nurses.

6.3 Sample, Sampling Technique and Saturation

Accordingly, in adherence with qualitative methodology, purposive sampling was used to recruit participants who were able to meaningfully inform the phenomenon of interest. Snowball sampling, which is a particular purposive sampling technique, was employed. Snowball sampling involved the recruitment of study participants who then recommended other potential study participants. In terms of sample size, this study aimed to recruit between six to 10 participants. Six to 10 participants was identified as both an adequate and ideal sample size for qualitative research (Boddy, 2016). Qualitative methodological literature indicates that sample sizes should remain on the lower end when the purpose of the inquiry is focused on the depth of analysis rather than the decontextualization and generalizability of phenomenon (Boddy, 2016; Creswell, 2013; Sandelowski, 1995). However, Sandelowski (1995) explains that sample size, for qualitative inquiry, is determined based on the purpose, methods, and intent of the research. For example, there is tremendous insight and understanding available from even a single participant account, when depth of analysis is the focus (Stake, 1995).

Another important concept that is useful in guiding and informing sampling – and data collection – in qualitative research is saturation. Saturation refers to the conscious process, decision-making and point in sampling and data collection where the researcher begins to identify a recurrence of themes and ideas (Creswell, 2013; Saunders et al., 2018). Put another way, saturation is the point in data collection when there is no new information being discussed by participants (Streubert, 2007). There are multiple layers of saturation including conceptual or theoretical saturation, which is achieved when there are no new concepts being generated during individual interviews as well as across the study overall (Saunders et al., 2018). Research guided by this concept requires continued sampling (i.e. interviewing) until there are no new themes or information being generated within participant accounts or across the sample overall (Creswell, 2013; Saunders et al., 2018; Streubert, 2007). Saturation is used to justify sample sizes as well as to protect participants from unnecessary over-sampling.

Sampling considerations from qualitative methodological literature were then examined alongside BFT to inform an appropriate approach to sampling for this study. After considering the arguments within BFT regarding knowledge generation, it was determined that this study would not restrict or limit the number of participants sampled. Black feminist scholars posit that both the individual and collective Black experience is highly subjective and unique and that while similarities and common themes will emerge within, throughout and across participants' accounts, there is a richness that exists within each of these accounts (Collins, 2000; hooks, 1984). Further, Cooper (2017) argues the necessity for incorporating alternative approaches to knowledge generation and discovery that extend beyond the traditional, restrictive and less inclusive ways of

knowing. Challenging tradition to include experiences and accounts of individuals and groups that have been historically absent in research is done through incorporating trustworthy non-traditional knowledge systems and approaches to knowledge generation. Moreover, this study, which includes participants from a historically marginalized group, where their participation and sharing of experience has been silenced, offers an opportunity for participants to have their stories and experiences both heard and integrated into the larger body of knowledge. From a Black feminist perspective, continued sampling and data collection is appropriate, within reason to generate in-depth knowledge regarding phenomena.

6.4 Eligibility and Recruitment

Participants were eligible to participate in this study if they identified as both a nurse and were of ANS heritage. Nurses were required to either possess an active license and registration with a regulated nursing organization or to have possessed a license in the recent past. Nurses at all practice levels ranging from LPNs, RNs and APNs, including nurse practitioners and clinical nurse specialists, were eligible to participate. There were no restrictions on areas of practice thus, nurses practicing in the areas of clinical [i.e.: acute, community, long-term] care, policy, education, research, and administration were eligible to participate. With respect to ANS ancestry, participants were eligible to participate if they had at least one Black parent who was born and raised in Nova Scotia. Finally, this study was gender non-specific; therefore cis- and trans- men and women as well as gender diverse and non-binary ANS nurses were eligible to participate.

Participants were considered ineligible to participate and excluded from the study if they were not a nurse. For example, baccalaureate nursing students, non-licensed clinical care providers such as continuing care assistants or personal support workers, and other health providers were not eligible to participate. Additionally, participants were excluded if they did not have at least one Black parent who was born in Nova Scotia.

Recruitment for this study occurred from January, 2020 until June, 2020. Participants were recruited using word of mouth, email correspondence through personal and professional networks as well as social media. A poster advertisement, located in Appendix H, was shared on the personal Twitter and Facebook pages of the researcher.

6.5 Ethical Considerations

Ethical approval for this study was obtained from the Nova Scotia Health and IWK Health Centre Research Ethics Boards (REBs) prior to recruitment and data collection. Ethical approval from NSH was obtained in December, 2019. While ethical approval from the IWK was obtained in January, 2020. Lastly, each participant was offered a $30 token of appreciation for their participation in the study.

Free, informed consent from participants was sought for this study. The consent process was completed once eligibility with each participant was confirmed. A consent form was forwarded to participants via email prior to each interview. The consent form was signed and returned by participants. The consent form contained information regarding the purpose of the research, the potential risks and benefits involved with participation as well as contact information for the researcher, the study supervisors, and a list of additional resources for participants to access if they encountered uncomfortable emotions or feelings arising during or after the interview. The consent form was written in English, at a college/ university reading level, in plain language. The consent form, located in Appendix I, was approved by each of the REBs. Finally, participants were informed of the option to end the interview or withdraw from the study up until a two-week period after the interview.

6.6 Data Collection

Data were collected through one-on-one semi-structured interviews using an interview guide, appended in Appendix J, reviewed and approved by the REBs and a committee of experts, who possess expertise in health research, nursing, leadership, health systems, and qualitative data collection. Additionally, the committee of experts includes researchers who possess expertise in the areas of critical theory, social justice and the ANS experience. Data collection occurred over a three-month period, from March to June, 2020, during the initial/ first wave of the COVID-19 pandemic. The semi-structured interview guide contained a series of questions with associated probes, which was designed to explore the participants' nursing practice, roles on the care team and experience with formal and informal leadership. Additionally, the interview guide intended to elicit what leadership meant to the participants, who they considered to be a leader, and what capabilities or capacities leaders were perceived to possess. Finally, the interviews were conducted via telephone, ranged from 30-90 minutes in duration, were audio recorded and then transcribed verbatim by a professional transcriptionist.

The last question of the interview was directed towards the praxis component of the guiding methodology, which involved asking the participants what they felt would help facilitate and support ANS nurses in formal and informal leadership roles. It was felt that this question would offer valuable insight that would inform knowledge translation activities. The aim of the interviews was to learn about the lived experience of ANS nurses as related to nursing leadership within their own practice (Rubin & Rubin, 2005). More directly, inquiring about the perception of leadership for ANS nurses was intended to generate knowledge related to the processes within nursing practice that produce and reproduce power; the meaning ascribed to leadership by ANS nurses; the systemic and institutional processes that act as facilitators or barriers to leadership; how the intersections of race, class and gender influence nursing leadership; and how nursing

leadership has the potential to influence the health of the ANS community. Finally, the interview guide did not undergo an initial pilot test.

6.7 Data Analysis

Data analysis was an iterative process, where data were organized and then classified into generative themes and subthemes through a process of reading and rereading the interview transcripts. Figure 7 details the six common actions of qualitative analysis employed in this study (Creswell, 2013).

6.7.1 Data Storage and Management

The audio files were deidentified and stored on the password protected laptop of the researcher. While hard copies of files were stored in a locked cabinet in the researcher's home.

Figure 7

Actions to Guide Qualitative Data Analysis[24]

Actions
1. Organize and prepare data.
2. Conduct a preliminary read of all transcripts.
3. Read and reread transcripts to generate categories according to analytical framework.
4. Organize themes and subthemes.
5. Represent data according to research purpose and questions.
6. Formulate interpretation of data.

6.7.2 Analytical Framework

Specifically, the CDS analytical framework involved the interrogation of three distinct yet interconnected structural levels. Table 9 outlines a succinct visual of the three structural levels. The analytical framework employed in this study was the three-dimensional framework, of CDS, constructed by van Dijk. In the general sense, discourse analysis is an analytical technique that involves a multitude of approaches used to analyze language and language components (Hodges et al, 2008). CDS, more specifically, is a particular branch of discourse analysis that interrogates the manner in which language – in the form of talk and text – is used in the production and reproduction of power (van Dijk, 1993; 1995; 2013). van Dijk posits that CDS is best viewed as a social movement or attitude, rather than a methodology or method, as it attracts critical scholars who are politically and socially engaged and invested in the practical uses of research to create and sustain

change. CDS has the potential to move beyond the simple examination of language to investigate the existence, organization and operation of institutions to understand how individuals and groups are influenced by patterns of thought and speech (Hodges et al., 2008). CDS interrogates structures at the discourse, social, and cognitive level, with the depth of analysis dependent upon the nature of the inquiry.

6.7.2.1 Discourse structures. At the discourse level, the focus of analysis was on the specific language and words used by participants. This analysis did not interrogate discourse on the microlevel of syntax or semantic. Rather, the data, in the form of participant transcripts, were read to identify words and phrases used by participants, which described their perception or experiences of leadership.

6.7.2.2 Social structures. The analysis of the social structures involved an interrogation of the social structures in which the participants practiced. Social structures are understood to encompass elements such as institutions, policies and social standards or norms. The two overarching institutions that were identified and examined for the purpose of this study were: 1) Nursing and 2) Healthcare.

6.7.2.3 Cognitive Structures. Van Dijk (1993) explains that [social] cognition is responsible for monitoring communicative forms of interaction. Cognition allows us to make sense of and give meaning to social events, institutions and power dynamics (van Dijk, 1993). Cognition mediates understanding between the micro and macro levels of society, between discourse and action as well as between individuals and groups or the larger collectives (van Dijk, 1993). The cognitive analysis involved an examination of the participants' words and experiences to construction and understanding of leadership, their perception of leadership and the meaning ascribed to leadership.

Table 9

Critical Discourse Studies (CDS) Three-Dimensional Framework

Level	Description
Discourse Structures	Identifies and examines talk and text: language and words used by participants.
Social Structures	Identifies and examines social, institutional, and systemic processes, policies, and/or practices.
Cognitive Structures	Considered the interface between Discourse and Social Structures. Identifies and examines the perception and meaning ascribed to the experience or phenomena.

6.8 Trustworthiness

Trustworthiness is an essential component of qualitative research, in that it assures readers that the information being presented is valuable and useful (Creswell, 2013; Lincoln & Guba, 1985). There are various strategies that can be employed for attaining trustworthiness such as reflexive journaling, peer-debriefing, audit trails and detailed description of methods. This study addressed trustworthiness by attending to the concepts of credibility, confirmability, dependability and transferability as outlined by Lincoln and Guba (1985). Table 10 displays each of these components and the associated strategies that were used to enhance trustworthiness.

6.8.1 Credibility

Peer-debriefing was one strategy used to attend to credibility of the findings. Credibility is defined as the degree of confidence in the truthfulness of findings. Throughout the duration of the data collection and analysis, I met regularly with my committee to discuss emerging ideas and to receive guidance. In addition to meetings with my doctoral advisory committee, I had weekly meetings with my supervisor, who provided guidance and insight regarding the analysis. A final element of the peer-debriefing strategy included meeting with a convened ANS advisory committee of health experts. The debriefing process was beneficial as it provided a safeguard to address any feelings or emotions that arose which may impact my judgment. I also verified my data analysis with my committee members and supervisor. Peer-debriefing was used as a means to ensure that the themes that emerge from the data reflected the participants' experiences and to ensured a clear understanding and representation of the data findings. The peer-debriefing process involved meeting with supervisors and committee members to discuss the emerging themes. Additionally, reflective journaling was used to assist in understanding the role that my values and beliefs had on the study and to reflect on the research process and recognize any bias that may arise.

6.8.2 Confirmability

Lincoln and Guba (1985) describe confirmability as the degree of neutrality of the study's findings, where the findings are based on participant data and not the bias or motives of the researcher. In this study, confirmability was addressed through reflective journaling and a thorough audit or examination of the data, findings, interpretations and recommendations (Lincoln & Guba 1985). Confirmability was also attended to by writing notes following each interview, as a way to account for personal reflections, thoughts and emerging ideas. Reflective journaling involves writing personal notes and reflections. It occurred throughout the duration of my dissertation (Creswell, 2013). As an individual with an insider perspective, journaling enabled me to identify my personal biases and describe how these will inform my analysis (Guba & Lincoln, 1994). Moreover, engaging in regular personal reflections ensured alignment with BFT as self-inclusion and reflective writing are

significant components of BFT (Collins, 2000; hooks, 1984; Lorde, 1984; Smith, 2016). My reflections and perspectives about the data were also captured through reflexive journaling.

6.8.3 Dependability

The extent to which the study can be repeated by other researchers to achieve similar findings. Lincoln and Guba (1985) explain that credibility and dependability are inextricably linked, meaning that attending to credibility simultaneously attends to dependability as well. Essentially, dependability and confirmability are established through an in-depth audit of the research process (Creswell, 2013). Thus, an inquiry audit trail that includes the methods used to collect and analyze the data as well as the data itself, is made available (Lincoln & Guba, 1985).

6.8.4 Transferability

Transferability refers to the ability of the study findings to be applied to similar groups or populations in other contexts (Lincoln & Guba, 1985). To address transferability, I have included a detailed description of my research which will allow the reader to determine whether or not these findings are transferrable to their problem (Lincoln & Guba, 1985). As discussed by Lincoln and Guba (1985), it is not the responsibility of the researcher to provide an index as to whether or not the information is transferrable, but rather to provide a thick, rich, descriptive database that facilitates the decision process for the reader. As mentioned earlier, the purpose of this research is not to be transferable or generalizable to a larger or different group but rather to present a holistic understanding of the leadership experiences of ANS nurses.

Table 10

Trustworthiness of Findings

Component	Description of component	Strategy performed by researcher
Credibility	The degree of confidence in the truthfulness of findings.	Peer-debriefing: Weekly supervisory meetings; monthly expert committee meetings; consultation with ANS advisory group. Reflective journaling.
Confirmability	The degree of neutrality of the study's findings. Findings are based on participant data and not bias or motivation of researcher.	Provision of an audit trail detailing the process of analysis. Reflective journaling.
Dependability	The extent to which the study can be repeated by other researchers to achieve similar findings.	Inquiry audit: Involves an external review and examination the research process, specifically the analysis.

Transferability	The ability of the research findings to be applied to similar groups or populations in other contexts?	Thick, detailed and rich description of methods, which permits readers to determine whether findings are transferrable to their problem.

In addition to the above-mentioned criteria for achieving trustworthiness in qualitative study, Lincoln and Guba (1994) present additional components to address the overall quality and goodness of research, which may be helpful when working within a critical paradigm. These include the historical situatedness of the inquiry, the extent to which the inquiry is able to erode existing ignorance and the degree to which the inquiry acts as a stimulus for action (Lincoln and Guba, 1994).

Chapter 7: Findings

The purpose of this research was to examine the leadership experiences of African Nova Scotian nurses in healthcare practice. The guiding questions for this research were: 1) What are the leadership experiences of ANS nurses and 2) How do ANS nurses perceive leadership? This studied employed a theoretically informed conceptual framework established on the key tenets of Black Feminist Theory. The conceptual components of the framework consist of the core notions of weathering, respectability politics and post traumatic slave syndrome. Data were collected using one-on-one participant interviews and data analysis used the analytical framework, which was guided by BFT, followed the three-dimensional framework of Critical Discourse Studies.

This chapter of the dissertation will begin with a general presentation of select demographic elements regarding the study participants. The findings of this study were conceptualized into three overarching sections. Thus, the chapter will then present the findings of this study in the following sequence: First, a descriptive presentation of findings pertaining to ANSs as a distinct people including identity, education and approaches to care. Next, Section 2 presents an interpretive description of two overarching themes that center around the notion of Institutions of Care, namely: 1) 'Black Tax' in Nursing and 2) Nova Scotia Healthcare as an Archaic Institution. Finally, Section 3 presents an interpretive analysis of the philosophy and practice of leadership by ANS nurses. Section 7.2 of this dissertation includes a manuscript that provides a succinct overview of the findings from this qualitative study. The manuscript, which is under review, includes a brief background of ANSs and nursing [leadership] as well as an overview of the methods employed to conduct this study. Additional details regarding the methods for this study are contained in Chapter 6.

7.1 Participant Demographics

A total of 18 ANS nurses participated in this study. Participants were born and raised in various ANS communities across the province of Nova Scotia. Participants had varying years of nursing experiences spanning from recent graduate up to retiree. Practice areas span from community to acute care, with all age ranges (ie: maternal, newborn, child; adults; seniors) mental health. Due to the size of the population of interest, several key demographic information, including but not limited to gender, age, income and other important indicators, will not be included nor described in this dissertation. This is done in order to protect the privacy, confidentiality and identity of the study participants. Additionally, quotations will not be linked to participants in any manner, and names of select organizations and towns/ cities will be omitted in order to ensure anonymity.

7.2 African Nova Scotian Nurses and Leadership in Healthcare: A Qualitative Study

This work in section 7.2 also appears in: Jefferies, K., Martin-Misener, R., Tomblin Murphy, G., Gahagan, J. & Thomas Bernard, W. African Nova Scotian Nurses in Healthcare: A qualitative study. (Under review).

7.2.1 Statement of Manuscript Contribution

KJ conceived and developed this manuscript, which constitutes a succinct overview of the doctoral research study. Each author (RMM, GTM, JG and WTB) provided guidance and mentorship throughout the research process and in the development of the ideas contained within this manuscript. KJ drafted the manuscript while RMM provided comprehensive feedback.

7.2.2 Background

African Nova Scotians (ANSs) are a culturally distinct group within the larger Black population in Nova Scotia. ANS heritage and the context of their arrival in Nova Scotia, dating back to the 1600s, as enslaved or "free" people, resulted in a particular socialization, culture, and way of being (ANSA, 2019; Pachai, 1997; Whitfield, 2018; UN, 2017). There are approximately 22,000 ANSs; comprising approximately 2.4% of the Nova Scotian population (ANSA, 2019). ANSs represent one of the largest racially visible groups in Nova Scotia at 37%; with 72% of ANSs identifying as third generation or greater (ANSA, 2019). There are approximately 50 ANS communities located across Nova Scotia, which were early settlements, some of which are designated as historic sites and many others that remain populated and active (ANSA, 2019; Pachai, 1997; UN, 2017). Higher rates of chronic disease such as high blood pressure, diabetes and mental illness has contributed to a significantly worse health status for ANSs compared to that of the general population of Nova Scotia (Kisley et al., 2008; UN, 2017). According to Kisely et al. (2008), ANSs experience chronic illnesses at a rate of 13-43% higher than the general Nova Scotia population. In 2017, the United Nations (2017) released a report concluding that racism remains rampant in Canada, particularly in Nova Scotia, and that significant disparities persist in terms of education, health, employment, and housing. Anti-Black racism, which permeates policy, practice, decision making and systemic processes, results in discriminatory treatment that compromises health (BHA, 2018). Addressing anti-Black racism in healthcare requires practitioners who are competent, invested in change and are in positions to instigate reform (Phillips & Malone, 2014). Nurse leaders challenge health inequities and disparities through their knowledge and skills, by influencing health policy, shifting practices, and contributing to the transformation of the larger healthcare system (Downey et al., 2011; Ferguson, 2015; Huston, 2020). Unfortunately, there is an underrepresentation of ANSs in the nursing profession, specifically in leadership roles (Etowa et al., 2009; Premji & Etowa, 2014).

Current literature does not capture ANS nurses and their leadership experiences. Rather, existing Canadian literature focuses largely on the experiences of Black immigrant nurses, in larger more diverse metropolitan regions such as Ontario, Canada. To this end, the purpose of this study was to critically examine the leadership experiences of ANS nurses in healthcare practice. Guiding questions for this study were: 1) What are the leadership experiences of ANS nurses and 2) How do ANS nurses perceive leadership? This research offers insight into how ANS nurses are instrumental in addressing health inequities and disparities to improve health outcomes for individuals, families and communities. Lastly, this study is relevant to medicine and other health professions, which similar to nursing are augmenting recruitment and retention strategies to facilitate the entry of ANSs into healthcare.

7.2.3 Methods

7.2.3.1 Study Design. This qualitative study was guided by the theoretical underpinnings of Black Feminist Theory (BFT). BFT is a critical social approach to research that centers the experience, ideas and interpretations of Black women, to facilitates knowledge generation and utilization regarding the impacts of social constructs (Bristow et al, 1994; Collins, 1990; Davis, 1981; hooks, 1984; Lorde, 1984; Massaquoi & Wane, 2007). BFT facilitates the examination of social constructs such as race, class, and gender, on leadership for ANS nurses.

7.2.3.2 Participants. The true size of the population [ANS nurses] is not presently known. In Canada, there are approximately 448,044 regulated nurses with an active license (Canadian Institute for Health Information [CIHI], 2019). Of this, approximately 130,710 are licensed practical nurses (LPNs) [or registered practical nurses (RPNs)], 6,115 are registered psychiatric nurses, 304,558 are registered nurses (RNs) and 6,661 are nurse practitioners (CIHI, 2019). Specifically, in Nova Scotia, there are approximately 14,000 nurses (CIHI, 2019; NSNS, 2015). In terms of demographics, nursing workforce demographic data is disaggregated according to age and gender however, key indicators including race/ethnicity are not yet available (CIHI, 2020; 2019). As a result, there is currently no national or provincial race-disaggregated data for nurses. Accordingly, in adherence with qualitative methodology, purposive sampling was used to recruit participants who were able to meaningfully inform the phenomenon of interest (Sandelowski, 1995).

7.2.3.3 Eligibility Criteria. Participants were eligible to participate in this study if they identified as both a nurse and were of ANS heritage. Nursing encompasses clinical care, policy, education, research, and administration.[23] Thus, nurses practicing in any of these areas were eligible to participate in this study. Additionally, nurses at all practices levels ranging from LPNs, RNs and advanced practice nurses (APNs), including nurse practitioners and clinical nurse specialists, were eligible to participate. With respect to ANS

heritage, participants were eligible if they had at least one Black parent who was born and raised in Nova Scotia. Finally, this study was gender non-specific; therefore cis- and trans- men and women as well as gender diverse and non-binary ANS nurses were eligible to participate.

7.2.3.4 Recruitment. Participants were recruited using word of mouth, email correspondence through personal and professional networks as well as social media [Twitter and Facebook].

7.2.3.5 Data Collection. Ethical approval for this study was obtained from the Nova Scotia Health and IWK Health Centre Research Ethics Boards (REBs) prior to recruitment and data collection. Data were collected through one-on-one semi-structured interviews using an interview guide reviewed and approved by the REBs and a committee of experts. Data collection occurred over a six-month period. The interviews were conducted via telephone, ranged from 30-90 minutes in duration, were audio recorded and then transcribed verbatim by a professional transcriptionist. Participants provided informed consent prior to data collection. Lastly, each participant was offered a $30 token of appreciation for their participation in the study.

7.2.3.6 Data Analysis. Data analysis was an iterative process, where data were organized and then classified into generative themes and subthemes through a process of reading and rereading the interview transcripts. Figure 7 details the six common actions of qualitative analysis employed in this study (Creswell, 2013). Specifically, the Critical Discourse Studies (van Dijk, 2015; 1995; 1993) analytical technique involved the interrogation of three distinct yet interconnected structural levels. Table 11 outlines a succinct visual of the three structural levels. Finally, trustworthiness of the findings was established by attending to credibility, confirmability, dependability and transferability (Creswell, 2013; Lincoln & Guba, 1985; van Dijk, 2015; 1995; 1993). Particular strategies used to address the components of trustworthiness are outlined in Table 10.

Table 11

Critical Discourse Studies (CDS) Three-Dimensional Framework (van Dijk, 2015; 1995; 1993)

Level	Description
Discourse Structures	Identifies and examines talk and text: language and words used by participants.
Social Structures	Identifies and examines social, institutional, and systemic processes, policies, and/or practices.
Cognitive Structures	Considered the interface between Discourse and Social Structures. Identifies and examines the perception and meaning ascribed to the experience or phenomena.

7.2.4 Results

Eighteen ANS nurses participated in this study. Participants were raised in various communities across the province of Nova Scotia. Participants had varying years of nursing experience spanning from recent

graduate to retiree. Practice areas ranged from community to acute care with patients across the lifespan. Due to the size of the population of interest, key demographic data, including but not limited to gender, age, income, and marital status, were not included nor described in this study. The intentional omission of such data is not to dismiss the importance of these factors but rather to protect the privacy and confidentiality of the study participants. Additionally, quotations are not linked to participants in any manner, and names of individuals, organizations and towns/cities are omitted to ensure anonymity.

The findings of this study, depicted in Table 12, were conceptualized into three overarching sections, each containing themes and subthemes. The first section includes descriptive findings pertaining to the understanding of ANSs as a distinct group or population; encompassing aspects of identity, education, tradition and resiliency. The second section includes an interpretive description of interactions with and perspective of healthcare in Nova Scotia; including concepts related to diversity, medical- vs. community-based care and competency in practice. The third section provides an interpretive formulation of leadership as perceived and practiced by ANS nurses. Critical elements of this section include leadership as a core component of nursing as well as the connection between community and leadership. Table 12 displays an overview of the study findings.

Table 12

Overview of Study Findings: Sections, Themes and Subthemes

Section	Theme and Subthemes
Section 1: African Nova Scotians as a Distinct People	Situating ANS Identity
	1. *The Power of Socialization: Setting the Foundation*
	2. *"We Are Not Homogenous": A Place that Feels Like Home*
	3. *Navigating Social Constructs*
	The Leaky Pipeline in Education
	1. *Early Education: From Colorblind to Invisibility*
	2. *Transitioning to Postsecondary: Patching the Leaky Pipe*
	3. *Fitting a Mould: A Non-traditional Student in a Traditional Institution*
	An Ethic of Care
	1. *"Caring is in My Blood": A[n] [Inter]Generational Tradition of Care*
	2. *"My Duty to Educate": Leaning In and Taking the Lead*
	3. *Caring for the Self: On Mental, Emotional and Spiritual Wellbeing*
Section 2: Institutions of Care	'Black Tax' in Nursing
	1. *Nursing as a Service: The Blending of Art and Science*
	2. *Nursing Politics: Navigating Intra-Professional Tensions*
	3. *Nursing Education: Primed for Praxis*
	4. *Invite Only!: Gatekeepers, Policies and Structural Design*

Section	Theme and Subthemes
	Nova Scotia Healthcare as an Archaic Institution 1. *Who is at the Table?: Inclusion Beyond Tokenism* 2. *Competency Gaps: Mistrust, Discrimination, and Patient Harm* 3. *Community-oriented Care within a Medical-based Model: Providing the Best Care*
Section 3: Leadership Philosophy and Practice	Leadership Reimagined: Lifting as We Climb 1. *"It's Part of Your Job": Leadership as Integral to Nursing* 2. *Along the Pathway to Success: Climbing the Professional Ladder* 3. *Black Feminist Leadership: A Practice and Philosophy Rooted in Community-oriented Care*

7.2.4.1 Section 1: African Nova Scotians: A Distinct People. *African Nova Scotians: A Distinct People* explores how being born and raised in Nova Scotia constituted a particular experience of Blackness. Nova Scotia was viewed as a province that has deeply ingrained racism, which forced an exodus of ANSs over a series of decades. Participants shared how not seeing themselves positively represented in affluent sectors of society had an impact on self-determination, confidence and career planning. Feelings of invisibility and a lack of career guidance was particularly pronounced in the early years of education. Yet, participants described vivid memories of early exposure to informal caregiving, provided by women in their family, which had profound influence on their entry into nursing. The following quotes illustrates critical aspects of socialization and early exposure to caring.

> You know, I grew up in Nova Scotia. And we know the battles that we faced. I grew up in a rural town. And nobody understands the struggle like we understand the struggle. Actually when you try to express your struggle to someone Caucasian or someone that's not lived the black experience, they're totally oblivious, and actually is quite invalidating. They actually discount how you feel and tell you how you shouldn't feel that way because, "Oh, we just don't see colour and we accept everybody for who they are." It's like, oh, I'm glad that's your experience but that has not been my lived experience. (Participant Quote 1)

> So I've always, ever since I was young, I always liked to do like sciences or I was really into like math. And then when I was young, my grandmother had Alzheimer's disease. So me and my cousins would take care of her a lot and stuff like that. And they just kind of like always knew that I wanted to do something in healthcare. So whether it be like nursing or medicine or something along those lines, I always knew I want to do something that way. (Participant Quote 2)

7.2.4.2 Section 2: Institution of Care. The *Institution of Care* reveals participants' views of the Nova Scotia healthcare system as an archaic institution. Participants expressed internal struggle with care delivery in the medical-based health system. A lack of diverse practitioners and ideas was viewed as a contributor to a "broken" paternalistic system that did not empower patients nor promote health. Further, absent or inaccurate content in nursing education raised questions regarding practice competency. Shortcomings in nursing education were identified as reinforcing negative stereotypes that fuelled mistrust and increase the likelihood of patient harm. To compensate for the drawbacks and gaps in care delivery, participants believed that a shift away from the medical-based approach towards a more community-oriented practice was necessary to both promote and sustain optimal health. The following two quotes illustrate this:

> I then learned to see what healthcare has looked like. You know, so-and-so comes in. Oh, they just have pain. Give them this. And boom, there's no further investigation of this because they're not here for that, and everything else seems fine. So it just seems like you're a pill pusher. (Participant Quote 3)

> And that was a little bit unfortunate because, you know, I think it's so important to really get a good fix on what's happening in the communities. It's fine to work at shared care centres, big hospitals and everything. But when you find out what's happening in the community, where does a person live, what kind of food are they eating, you know, that kind of thing. Do they have housing? You know, the reasons why people go into hospitals are because of all those reasons. And if we can help on the outside, you know. (Participant Quote 4)

7.2.4.3 Section 3: Leadership Philosophy: Embodying the Practice. The final section describes the guiding philosophy and practice of leadership by ANS nurses. Participants were explicit in their belief that leadership is not separate from nursing but rather, it is an integral component of nursing practice. Moreover, participants identified themselves as leaders, whether or not they held a formal leadership title. Expanding on this notion, the philosophy and practice of leadership centered around a strong connection to community – including the seamless and intentional integration of advocacy into care. Lastly, the attainment of leadership, as defined by participants, was made possible by internal drivers as well as external facilitators including instrumental mentors and allies who shared opportunities, provided encouragement, and supported the personal, educational and professional endeavors of participants. The following quotations demonstrate these findings.

> But the people in the community, when someone was sick, the women of the community got together, whether it was cleaning the house, whether it was cooking food, whether it was making pads. I remember my grandmother making quilting pads for incontinence pads. So that tradition was there too

> for community. And when I got into nursing, for leadership, I never thought of leadership. What I thought of, oh my God, people in the community don't know about this. What can I do? I'm here. (Participant Quote 5)
>
> If you don't see yourself reflected, right, at least from my perspective, the way I look at it. In my nursing days when I saw a black nurse who was in a senior position, that was sort of a motivator for me. First of all, for me to do well, but also to see, well, there's something I can aspire to be, you know. So I think that seeing that is important. (Participant Quote 6)

7.2.5 Interpretation

7.2.5.1 Summary of Main Results. This qualitative study provides an initial understanding and conceptualization leadership as perceived and practiced by ANS nurses. Specifically, the findings reveal how ANS nurses possess a leadership philosophy that is centered around community. As explained, the study findings were divided into three overarching sections, each of which addressed an aspect of the research purpose and guiding questions. Together, the three sections construct a basis for understanding how aspects of personhood, including identity and socialization, are important elements in shaping values, beliefs and practices. Leadership was understood to be an integral component of nursing practice that encompasses a deep-seated commitment to community-oriented care. Leadership was considered to extend beyond a formal title, with nurses identifying as leaders based on their knowledge, abilities, perspective, and practice.

7.2.5.2 Situated With Literature. The findings of this study align with the existing body of knowledge related to Black nurses in Canada. A scoping review (Jefferies et al., 2020; Jefferies et al., 2021) charting the available literature on Black nurses in the Canadian nursing profession found five primary areas of focus within the literature: historical situatedness; immigration; racism and discrimination; leadership and; diversity. The findings in this study align with the results of the scoping review including issues regarding leadership, diversity and racism in nursing. Additionally, findings from this study align with landmark studies Flynn (2011) and Etowa et al. (2009) that examined historical and contemporary experiences of Black nurses in Nova Scotia. Etowa et al. (2009) generated a substantive theory suggesting that nurses perceived themselves as practicing on the margins of the nursing profession. Whereas Flynn (2011) identified historical evidence revealing how Black women were actively denied admission to nursing training facilities in Nova Scotia and across Canada. The findings also corroborate the larger body of knowledge pertaining to the experiences of Black nurses (including Black immigrant nurses) and leadership, in Canada. However, the heterogeneity of Blackness indicates that there are both nuanced and stark difference in experience amongst Black people in Canada. To this end, this

current study is novel, and addresses a gap in the literature, as the first to focus explicitly on the significance of ANS heritage in relation to nursing, leadership and healthcare.

7.2.5.3 Future Direction. Translating the findings into policy and practice is an essential next step. Future direction of this research spans four critical areas. The first is education, which underscores the need to examine institutional processes regarding recruitment and retention of ANS students in nursing, including at the graduate level, with an emphasis on mature students. Utilization of similar evidence to shift institutional policy has already begun at Dalhousie University (Dal News, 2021). The second and third areas are policy and practice, which involves informing care directives, health policies and guidelines, while attending to stereotypes and implicit bias that diminish patient care. These findings suggest that competent and relevant care provision has the potential to enhance trust as well as improve the overall health of communities. Again, Nova Scotia Health has launched a series of initiatives to address disparities at the community level (NSH, 2020). The fourth area is research, which warrants mixed methods investigations to address gaps in national nursing workforce data across practice areas. Research that examines the role of nurses in community practice, particularly their work with marginalized populations, would offer direction for improving care access by addressing social and structural determinants of health. Finally, the implications of these findings extend to ANS physicians and allied care professionals. With intentional structural efforts by institutions such as Dalhousie University, which has established pathways to facilitate the entry of ANSs into medicine, it would be beneficial to understand the experiences of ANS physicians, the implications for interprofessional education and insight related to practice.

7.2.6 Limitations

Limitations in this study include the operational definition of ANS heritage, which did not adhere to the recently developed description, which defines ANS as: *African Nova Scotians (who also self-identify as Indigenous Black, Africadian, Afri-Scotian or Scotian) are descendants of free and enslaved Black Loyalists, Black Refugees, Maroons and other Black people who were settled across 52 indigenous (original) land-based Black communities*. Moreover, eligibility relied on self-reporting of nurse status and ANS heritage. Limitations with data collection include: telephone interviewing (as opposed to in-person) during the initial wave of the COVID-19 pandemic. While additional techniques that would enhance trustworthiness of findings, including member-checking or triangulation, were not performed. Finally, this study did not collect nor report any disaggregated data beyond ANS ethnicity.

7.2.7 Conclusion

This qualitative study begins to address a critical gap in the Canadian nursing workforce literature. By acknowledging the unique experience of Blackness and the contemporary health issues that exist for ANSs, this

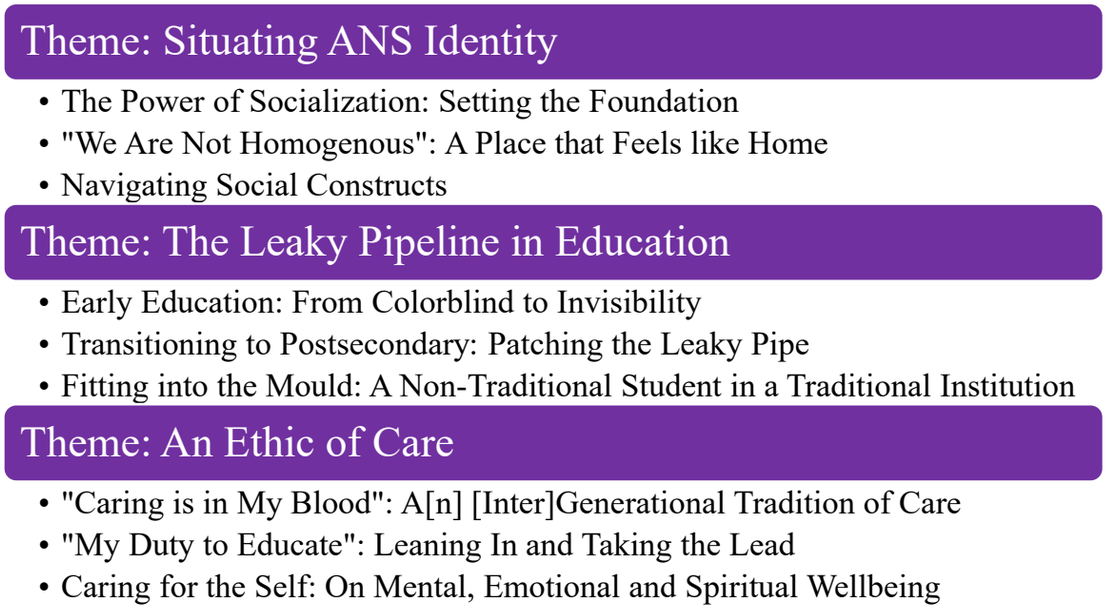
study sought to understand leadership as perceived and practiced by ANS nurses. Key findings elucidate the importance of community-oriented practice as well as the deep-seated belief that leadership as a fundamental component of and integral to nursing practice. Specifically, the findings suggests that ANS nurses are well positioned to provide leadership in their collaborative work to address health disparities and improve health outcomes. Likewise, this study has implications for education, practice, research and policy through nursing workforce demographic surveys, interprofessional education and community-based practice.

7.3 Section 1: African Nova Scotians as a Distinct People

This section of the findings presents the interplay of socialization, tradition and the development of an ethic of care for ANS nurses. It contains three themes, each with associated subthemes, which illustrate critical aspects that informed the embodiment and practice of leadership for ANS nurses. The subthemes, as illustrated in Figure 8 include *Situating ANS Identity*; *The Leaky Pipeline in Education* and, *An Ethic of Care*.

Figure 8

Section 1: African Nova Scotians as a Distinct People



7.3.1 Theme: Situating ANS Identity

The context around identity and the meaning attached to ANS identity was a salient theme throughout this research. Identity is understood as being influenced by the biological, genetic and socially constructed elements of personhood. Participants described the significance of their ancestry and identity in various

instances, shedding insight on the meaning ascribed to being ANS. For example, something as seemingly simple as the terminology used to describe themselves, as a people, varied between participants. Various terms used by participants to self-identify include: ANS, Black Nova Scotian, Indigenous Black and Scotian.

One participant described their experience in using the term *African Canadian* in relation to a job application. The application encouraged applicants to "self-identify", if they were a member of a selected group. The participant negotiated the use of this term and the decision to self-identify as *African Canadian* as they were uncertain of the potential ramifications of doing so. The following quote illustrates two critical aspects: how one self-identifies and what are the implications of doing so. Similarly, this quote also captures the disdain that the participant had for the term "minority", which is often still used in certain contexts.

> R#10: I remember when I was applying for jobs, I was hesitant. And I know this sounds crazy, I was hesitant, I was like questioning whether I should identify as African-Canadian in my application. And my partner is like, "You should. It's not that I was ashamed but I was like, hmm, like would that maybe deter some employers, right? Like they would never say it but just like inside their head, right. So I'll be honest, sometimes I was like I'm just going to leave it out, I'm just going to not put anything. And then in some applications I've tried putting that I'm a visible minority – I hate that word. I put that I was a visible minority.

In addition to the terminology used to refer to ANSs, another salient aspect of identity centered around physical appearance. Several participants described the challenges attached to their perceived racial ambiguity. The persistence of perceived racial ambiguity by others was described as a microaggression. Further, the recurring question of "where are you from?" was received differently depending on the ethnicity/ race of the asker. For example, the question posed by a Black person, especially an ANS, was received as an inquiry about family, ancestry and the ANS community of origin. Whereas, when posed by a non-Black person, specifically a white person, the question was perceived as a microaggression. When the question is posed from a non-Black person, the question was generally followed by additional questions and inquiries about where the person was "really from" implying that the participant, whose lineage is rooted in Nova Scotia was likely newly arrived.

> R#1: But it gets annoying when people are asking where I'm from, and then the follow-up, "Are you really from, are your parents from, like were you born there?" I have that conversation regularly. It's implied, yeah. So in [another province], I'd say, oh, I'm from Nova Scotia. And then now that I'm in Nova Scotia, I still the conversation like, oh, I'm from here, yeah. "Oh, whereabouts?" I say [a rural town]. "Oh…" It's still… It's non-verbal and it is my interpretation of it but I've had this conversation

enough that I feel like… And when it's coming from a black patient, they're legitimately curious to know if we know any of the same people. And they're not like questioning the validity of what I'm saying. Where it's like a white patient is actually trying to figure out why I look the way I do.

R#15: You know, and them simply using the terminology of, you know, coloured or this and that. And always asking, you know, where are you from? They don't think I'm from here, kind of thing. You know, they think I'm Caribbean. And it's like do you not know… First off, do you not know history in NS? Like we have Black communities.

The concept of identity presented itself with other Black – non-ANSs – as well. The transatlantic slave trade involved the transportation of enslaved Africans to various parts of the world throughout the 16th-18th centuries. Nova Scotia, and other parts of Canada, became home to the descendants of enslaved Africans from the Transatlantic Slave Trade. Despite the challenge of retracing ancestry through the migration of their ancestors, many ANSs can trace their ancestry to West Africa. This information is not only useful in relation to a greater understanding of self, the topic of ancestry and lineage also serves as a useful connection point in conversation. For one participant, completing an ancestry DNA test and tracing their ancestry to present-day Ghana provided a revealing exchange with a patient.

R#13: I had this patient who was from Ghana for an outpatient procedure. And we were having a conversation, and she asked if I was Black. And I said, yes, I am. But… She asked like where I was from. And I'm like I'm from Nova Scotia. And it was just this really funny conversation where she didn't think about what happened to the slaves after they left her country.

Building on the importance of appearance and ancestry in relation to ANS identity, the social construct of Blackness became apparent. Several participants identified themselves as "Black" despite having a parent who is not Black or ANS. This exemplifies the notion that "being Black" extends beyond the biological consideration associated with ethnicity. Blackness encompassed both the biological or genetic components in addition to more psychological [mental/ cognitive views] and social aspects. With participants who were often described as racially ambiguous or in circumstances where one parent was not Black, identity was shown to transcend appearance. One participant expand on the racial composition of their family, noting that they have both a white side and Black side of the family. Yet, despite this, the participants still viewed and considered themselves to be Black.

R#15: I mean I grew up around Blacks, whites. I have a whole white side of the family. I've got a whole black side of the family.

Building on this overarching theme are three generative subthemes: *The Power of Socialization: Setting the Foundation*; "*We Are Not Homogenous": A Place that Feels Like Home* and; *Navigating Social Constructs*.

7.3.1.1 The Power of Socialization: Setting the Foundation. Many participants recounted various experiences throughout their childhood and upbringing that influenced their outlook on the world and more importantly their perception of themselves. Early experience in childhood reinforced the socialization of being Black. As one participant shared, growing up and attending an all-white school had " …a lot of challenges". The challenges ranged from name calling to learning "…how to put up with some of the stuff…" that was distressful and unpleasant but was a way of life. The second quote captures the sentiment that ANSs, by definition of the raised environment, were conditioned to "put up" with things that people should not have to endure. The following two quotes capture this.

> R#12: Well, to be honest with you, I grew up in a rural community. But growing up in a town as the only bi-racial family at the time. There's a lot of challenges, let me tell you. I went to an all-white school. You know, you get the name calling. You know, I was the kid that wore the braids. You know, that stuff.

> R#18: Because I'm born and raised here, I sort of have learned how to put up with some of the stuff that maybe I shouldn't put up with. But like I said, I'm just grateful for a livelihood to provide for my children.

Another issue that arose within the conversation of socialization is around the notion of colorblindness. The majority of participants spoke about the ways in which there was a disconnect in the messages that they received from people compared to how they were treated. Participants described how they were socialized from a very young age to see race – or to view themselves as Black – despite living in a society that purports colorblindness and to 'not see race'. Participants also shared their frustrations and how they were fed up with hearing the tone-deaf phrase of 'I don't see color'. This way of viewing the world – through a colorblind lens – was considered to be a root of many problems in society and healthcare as well as simply disrespectful. As one participant explains:

> R#3: So I'm like, you know, I know I'm Black. You know I'm Black. Can't you see I'm Black? You know what? Can't you see I'm Black. And don't tell me that you don't see colour because that is so disrespectful. And also in my job, I don't have any problem with confronting my colleague if I hear them talking about a client who is expressing concerns around racism or race and how they're impacted.

This same participant continued to expound on the particular experience of Blackness that resulted from being raised in a predominantly white environment. Participants described a unique type of struggle that was only understood by those who have actually "lived the Black experience".

> R#3: You know, I grew up in Nova Scotia. And we know the battles that we faced. Like, you know, I grew up in a rural town. And nobody understands the struggle like we understand the struggle. Actually, when you try to express your struggle to someone Caucasian or someone that's not lived the Black experience, they're totally oblivious, and actually is quite invalidating. They actually discount how you feel and tell you how you shouldn't feel that way because, "Oh, we just don't see colour and we accept everybody for who they are." It's like, oh, I'm glad that's your experience but that has not been my lived experience.

Expanding on aspects of socialization, participants shared how socialization – as an ANS – in a predominantly white society had a profound impact on them. In addition to this personal impact, participants also highlighted how the socialization between ANSs and the larger Black population of Nova Scotia – consisting of immigrants from the Caribbean and continental Africa – were different. The following quote shows how one participant describes being socialized to think of themselves as a "Black woman", while also introducing the difference in socialization for Black people in Nova Scotia.

> R#2: But she's a Black Nova Scotian. And most of the people that she deals with are West Indian or African. And it's sometimes difficult because… And I can speak candidly, we're different. We had a different upbringing. We're socialized in some way. I'm socialized to think of myself as a Black woman. And if that person didn't wait on me, why are they not? It's because I'm Black. But that may not be the case at all. Do you know what I mean? It might have nothing to do with my colour. Maybe that person's busy or… I don't know what's going on in their lives or whatever. But that's the way I was socialized. Do you know what I mean? If you come from a Caribbean country, they have a different socialization than we do. I think what we have in common is the colour of our skin, and how we are accepted in Canadian society. Because when you get here, it's a whole different ball game.

This participant quote reinforces the perception that socialization for ANSs is an extremely different experience of Blackness and how there is a "distinct difference" between people of African descent who immigrated to Nova Scotia and ANSs.

R#5: So, there is a distinct difference between the people of African descent and us as African-Nova Scotians. I think there is a difference. Now, certainly you see more around now than you did in the past. But I think there is a distinct difference.

The experience of being born and raised in Nova Scotia was contrasted to that of migrant Black people who arrived [more recently] from continental Africa and the Caribbean. Participants spoke about how they perceived the difference of socialization in a pre-dominantly white environment (Nova Scotia) compared to socialization in a predominantly Black environment (Africa or the Caribbean). Several participants acknowledged how ANSs have also occupied a position of "minority" status in Nova Scotia. Representation. Being well aware that they are "the only one".

R#13: Like I don't know, just like amusing highlight of how different we are, you know. We've always been the minority. And that's not the experience of the African community that's come here from other parts of the diaspora on the whole. When you're from a country where everybody is Black, you're not going to think about the impact of not seeing it. You know, until you're thrown into it and it's this massive cultural shock.

Each of the previous two quotes also include an acknowledgement of the "massive culture shock" or the personal realization of Blackness that accompanies the arrival of Black immigrants to Nova Scotia. Many participants spoke to how they assisted colleagues with the transition and navigation of racial tensions in nursing and healthcare. The following quote offers a vivid illustration of how integration for Black immigrants can be challenging when having to navigate systems.

R#18: Some people will be like, "I can't take it. I'm leaving." There was a young lady who came in from another province. She was another black nurse. But she didn't stay. She felt very much bullied. And her and I never worked together. And I couldn't for the life of me understand why… I think she was there three years maybe. Why they never ever put us together. And she ended up leaving. I don't think that, you know, sometimes when people aren't from Nova Scotia, they don't understand the ways of sometimes that people are here.

In contrast to the perception of the "massive culture shock" that Black immigrants were thought to experience, participants described their own experiences of "culture shock" when they were immersed into extremely large Black communities, where Blackness is pervasive and affluent. For example, travelling outside of Canada, to certain parts of the U.S or the Caribbean, exposed participants to Black communities that were more integrated to the larger society and were represented in professional careers.

R#18: I've had some experiences in the Caribbean and just seeing how things are different even in the United States with the population versus here. It's just different. Because you know that Black communities here are quite isolated somewhat, right. It's a different experience. It's almost being a Black Canadian going to the Caribbean is almost like almost a culture shock in some ways… No, it's just you've never seen that. Like to go through like somewhere in the States like Atlanta or Florida, you know, and seeing veterinarians that are Black, doctors that are Black, you know. Bank tellers and hotel managers and… It's just a totally different experience.

7.3.1.2 "We Are Not Homogenous": A Place Called Home." This subtheme underscores the complexities in the sentiment of a home that feels like home. Participants shared their raised experiences, as well as contemporary experiences, that contributed to a sense of belonging as Nova Scotia residents. The extensive ancestral connections to Nova Scotia and the deeply embedded sense of community were counteracted by larger societal issues such as discrimination, which reinforced a feeling of otherness. Nova Scotia was regarded as a province with pervasive racism that posed ongoing challenges for ANS and Black people, more broadly. Many of the larger societal or more systemic issues were reinforced by beliefs held by other people, particularly in relation to ANS communities. Participants shared some of the stereotypes and prejudices that they encountered with colleagues. For example, the beliefs and stigma attached to certain ANS communities was an issue that participants regularly challenged. One participant referred to this phenomenon as *geographical racism:*

R#6: And I surmised that it was because it was a Black community that there were stories going around, you know. So that was one thing that I recall, you know, just geographical racism, I call it.

R#3: But we live in Nova Scotia, right, and we have issues around racism. And we're denied jobs because of our race, because of our postal code.

Participants shared how these challenges forced a wave of ANS migration out of the province. The out-migration of ANSs was captured by one nurse who described the phenomenon of a mass exodus of ANSs from Nova Scotia to Ontario. This wave, occurring during the 1980's and 90's saw a sizeable number of ANSs leave Nova Scotia and relocate to Ontario.

R#13: We're not at all homogenous. And, you know, Nova Scotia's Black community is changing very quickly because we have, you know, like in the '80s and the early '90s, we had such a huge migration of our Black community to Ontario. And all of my ancestors, like from like 300 years back, have all been from here. And so, you know, it's interesting because you definitely see that difference of experience

when you have blending of the other parts of our diaspora that are coming into Nova Scotia. And you have this wonderful diversity that's growing. But you also have a lot of people who don't understand the Black experience of Nova Scotians.

In addition to this historical migration, or mass exodus, of ANSs to Ontario, participants identified numerous challenges with securing employment and generalized underrepresentation and racism that resulted in a need to seek employment in another city, province or country. Ontario, specifically Toronto, was acknowledged as a common destination for many ANSs. Moreover, it was thought that in order to be successful [especially in nursing], it was necessary to leave the community and at times, the province. Some participants remarked on the feeling of being 'forced out' of the province in order to secure a job as a nurse.

R#18: So my second cousin, she moved to Toronto. They both moved to Toronto to train. No, not to train but to get jobs. So they were a few years ahead of me. Like mom was like, "Well, you have to move, and they're not really hiring here. I don't know that you'd want to get it to." So it's something that I sort of didn't go into right away…But at the time when I graduated, there were no jobs here.

For participants who practiced in other jurisdictions, outside of Nova Scotia, the push to leave the province was often countered with an equally strong push to 'return home'. Despite practicing in seemingly more inclusive and progressive jurisdiction, participants described a strong desire to return to Nova Scotia to practice nursing and be with family.

R#4: I remember saying to my mom when I had finished nursing, I remember saying to her, "You know, I wonder if I should come home. I wouldn't mind trying to live in Halifax and nurse there." And she said, "Don't come home, child, because they don't make the same money there as they make everywhere else. So just stay behind where you are." I still remember that.

Building on the larger theme on ANS identity, is the challenge to the assumption that all Black people – specifically all ANSs – share the same experiences. Participants articulated how, even within the ANS community, there were differences in experience that could be connected to geographical location [living in the city vs. a rural community] as well as other aspects of personhood. For example, some participants described a strong connection to their ANS identity, while simultaneously acknowledging that the ANS community itself is not homogenous. As one nurse described below:

R#13: Because, of course, there is, you know, sort of assumptions made about where I'm from, what kind of culture I have. You know, what my knowledge is around the Black community. You know, I'm

not from HRM, for example. But when I'm working, if there's a Black patient from one of the historic Black communities within HRM, I'm asking them. Like their experience isn't mine. Like I live in the country. My Black community is one of the larger ones outside of HRM. I'm from a Black community in which agriculture is very important. You know, like our values are different than the values of other African-Nova Scotian communities, of other African-Nova Scotian people, you know. And so there's always this sort of struggle of we need to speak about it, you know, and talk about the issues of race and of gender and of class. And I need to do that. But I also need people understand that we are not homogenous.

To build on this notion, another participant described their experience of socialization, being connected to the ANS community yet being raised outside of the ANS community. There was a desire to live in close proximity of the community. The importance of having a tight-knit community is evident in the following account. This observation was made in the context that there were ANSs who earned enough money to improve their living circumstances but instead choose to live in the community. One participant expressed their view of how "we do it to ourselves" in this defeated cycle of being a participant in reinforcing the oppression. This highlights a critical aspect of socialization, where the conditioning to see oneself as "not worthy" becomes ingrained and difficult to move beyond.

R#2: And for the number of years I lived there, we were the only Black family in the community. And I wonder why that was? Because there were certainly Black people who made enough money to live there. It's an upper middle-class neighbourhood. But there were Black people who earned enough money to live there. But what was it about that neighbourhood that people never wanted to live there? And it's like I think we do it to ourselves sometimes. We have this we're not worthy. And I think that starts at childhood, that you have to tell people that you are worthy, that you're special, that you need…you're just as good as anybody else, and you don't have to hold your head down.

7.3.1.3 Navigating Social Constructs. Participants described various instances that impacted them profoundly on a psychological level. This subtheme, *Navigating Social Constructs,* captures the ways in which the participants understood, made sense of and dealt with complex and even traumatic phenomena. The constant, internal processing of traumatic experiences had an unfortunate effect of callous formation, creating a metaphoric hardness or hardening. The adoption of a collective identity, whether ANS or Black, meant that nurses not only empathized with global Black trauma and victimization but that this collective pain and trauma strongly impacted the mental wellbeing of participants. For example, on a more universal scale, during the time

of the interview, there was a flood of grotesque harm [even death] perpetrated against Black people globally, but specifically in the local and national context. As one participant explains:

> R#16: Like lately I've seen these little comments on Instagram, on Haligonia.ca, "Oh, all that stuff that's happening in the States, it doesn't affect us here." Like if you're Black, it's going to affect you… So Saturday was a sad day for me. And things normally don't really get to me like that. But like every time I was on Facebook or Instagram, just seeing all this stuff, and I'm like I need to take a break because I can't…like I can't take this. And I'm like I don't even think I'd go to a march because I'd start crying because it's like this is what I have to do? Like because I'm Black, just to be Black?

On a more local, everyday scale, most participants recounted numerous experiences of microaggressions and forms or 'everyday racism' throughout their nursing career. Again, these experiences seriously impact mental health and wellbeing of the participants, with one providing vivid imagery through the analogy of a rock that erodes over time. The psychological erosion pushed this participant to seek counselling services.

> R#8: I do everything I can. But the little snarky remarks and all, it weighs on a person. It doesn't matter how smart you are, how strong-willed you are, if you've get the trickle of water that's trickling over a rock, soon enough it's going to erode. I was moments away from a nervous breakdown. I had to go to a psychologist for about a year. And I mean I just don't think it's fair and it's not right.

Microaggressions were not regarded as innocent occurrences that did not impact the overall mental health of those who experienced them. Rather, they were experienced as extremely distressing and having a significant impact on someone. Another participant quote expands on the impact of microaggressions and how they heighten feelings of anxiety and insecurity.

> R#3: Like you know, micro or racial aggressions that we experience definitely heightens that anxiety and triggers those feelings of, you know, being insignificant or not enough or not smart enough or whatever. Like those sorts of things definitely do have an impact. And I still experience that. Not as much, but I have experienced that even in my current job where I've been profiled.

The internalization of everyday experiences of racism, including in the form of microaggressions and unprocessed ancestral trauma, is a precursor for understanding two of the common archetypes or controlling racial images discussed by participants. The archetypes include the *angry Black woman* and the *strong Black woman (SBW)*. Each of these social constructs, which are rooted in historical oppressive societal ideologies, showed up in direct and indirect reference by participants.

The *angry Black woman* archetype or social construct perpetuates an image of an aggressive, intimidating, unreasonable and disagreeable Black woman who is often angry and, loud, speaks with a condescending tone and is never happy. Participants reported hyper-awareness of being perceived or label as an angry Black woman and as a result were always monitoring of their speech and behavior – worrying about how this may be received – including tone-policing themselves and constantly balancing assertiveness with the fear of being perceived as too aggressive. Participants shared how the alternative to the angry Black woman construct was to be constantly happy and smiling; there was no middle ground. The first illustrative quote depicts one participant's interaction with colleagues who were describing other Black nurses as aggressive. This participant, who knew the Black nurses, understood that this was the manner in which they spoke, which the participant did not perceive to be aggressive.

> R#14: Yes. I just happen to know who these nurses are, and they don't know that. But they just like are always like talking about how like aggressive they are and stuff like that. And I know that it's just they're not like aggressive at all, it's just the way that they talk to each other.

The following two illustrative quotes were shared by participants and capture direct reference to the angry Black woman archetype. Each of these quotes illustrate the process by which participants engage in constant reflection about how they speak and what they say – in a manner that goes beyond the more general mindfulness around speech. The quotes also show the fear or avoidance of being associated with this label as well as the fears of how being perceived as an angry Black woman threatens their job or career. This demonstrates how the construct is able to be weaponized and used as a controlling mechanism.

> R#13: Yeah, okay, so I think in some ways it is a hindrance because when I speak up, there's the stereotype of a Black woman who's angry, you know. And so I have to kind of tone police myself sometimes because I know how I will sound. And you have to think about your career. And so you don't want to sound like the angry Black woman. You know, not that you should have to police that, you know, because anybody else could say the same thing you did in the exact same tone, and it will be interpreted as, wow, what an assertive person.

> R#3: And I still experience that. Not as much, but I have experienced that even in my current job where I've been profiled. Like you know, don't ever show anger as a Black woman, right. Like you should always be smiling. You know, let's see your teeth, and everything is good. You could be going through so much pain and so much turmoil and anything else but, you know, just be happy. Because if you're not

happy then you're an angry black woman. And that's something that intimidates some folks. And then they're going to start treating you differently. I've had that happen here.

The second archetype or social construct that participants referenced directly or indirectly is the *Strong Black Woman (SBW)* archetype. Multiple participants shared their perspective regarding the archetype and how it showed up in their lives. A few of the participants made direct reference to the SBW construct with most explaining the drawback of this label. However, other participants spoke directly to the construct and how they aspired to this title.

Given the complexity of the SBW construct including the five main pillars that constitute the construct, several participants described salient aspects of the SBW construct in relation to their nursing practice. Examples of the ways in which aspects of the construct were described indirectly include: through the socialization to just deal with things, and not talk openly about issues or problems; presenting an unwavering image of strength; selflessness and prioritizing the comfort of others always before themselves; and forgoing personal needs for the collective good. As one participant explains:

R#2: I remember sitting down talking to a group of older Black women about menopause. And they were saying, "We never thought we'd sit down and talk about this openly. Like yeah, you get depressed, yes, there's nothing wrong with being depressed." … So, you know, I think we need to do more of that. Like what's your strength and what can you bring to the table? And I think we don't really give ourselves enough… We don't acknowledge ourselves. Like we don't give ourselves enough praise for who we are and where we…and be proud of who we are and what we stand for. I don't know but I meet a lot of Black women who really don't acknowledge their strengths.

Several other participants explained how their socialization of being raised in a pre-dominantly white society that problematizes Blackness, resulted in the need to "put up with" issues or problems that should not have to. The idea of 'not rocking the boat" became a survival tactic to prevent the loss of "livelihood" that might compromise their family's situation. Essentially, participants endured suffering in various forms in order to not disturb the comfort of others.

R#13: Because I'm born and raised here, I sort of have learned how to put up with some of the stuff that maybe I shouldn't put up with.

Becoming "harder", intentionally ignoring racism and microaggressions, making jokes and training oneself to not take things personally, were strategies that were evoked as a protective mechanism by

participants. One participant explains the elements of the origin of this construct in that Black [and other minority groups] were not considered as being capable of becoming a healthcare practitioner.

> R#7: I think I've just become, I don't want to say like harder or like I don't know what the word really is, but I have just learned to kind of not take it personal. Because I know that there are a lot of people out there who are ignorant to different types of cultures, and they just see their majority culture. They don't see the minority as being people who can do this kind of stuff. Do you know what I mean? Like be like nurses and doctors and all that kind of stuff. Because they come from a different time. So now it's just I kind of will make a joke out of it sometimes. Other times I won't even really acknowledge it. I guess it just really depends on my mood for the day.

Another participant, when asked whether their race had an impact on their nursing practice, responded by emphasizing that they became accustomed to ignore things like that. Again, these sentiments feed into the pillars of the SBW construct.

> R#17: Not so much. If I have, I've completely ignored it, to be honest. Because like I've just become accustomed to ignoring things like that. Nothing that really like sticks out. But obviously I ignore things.

Finally, the totality of socialization, the importance of ancestry and the daily experiences navigating social constructs including microaggressions, was acknowledged as a process that was exhausting and debilitating while simultaneously a major contributor to participants' resiliency. A few participants expressed how their experiences, including the negative, were extremely formative in shaping who they became, how they practiced nursing and budding sources for their approach to leadership. The challenging aspects contained within the construction of ANS identity made participants stronger but at a cost. The following quote captures the various aspects within the theme *Situating ANS Identity.*

> R#4: I think it's done a lot of... I think it's totally shaped me 100 percent. Because it's… I hate to really sound completely negative because I'm certainly proud of where I've come from and who I am, and I'm very proud of my family and who they are and what they've come through. But I think because of their experiences, because of my experiences, and I think that has sort of made me stronger. I think it's made me want to advocate more. I think it's made me want to mentor more. It's made me want to not be like that. If anything, it's what made me want to be 360 degrees beyond that or past that. So I think what it's done is it shaped my life positively as far as my career.

7.3.2 Theme: The Leaky Pipeline in Education

The Leaky Pipeline in Education is a them that attempts to capture and illustrate larger systemic and institutional gaps that pose significant challenges for success and result in some students being dismissed or overlooked. This theme sets a foundation for understanding the leadership of ANS nurses as the early educational experience has profound implications experiences in higher education, professional careers and overall self-worth. Despite being dismissed or overlooked in school, these participants became successful nurse leaders in various facets of their nursing career. The notion of a leaky pipeline in education for ANS learners [students] is interconnected with the previous subtheme of socialization. Salient aspects of mental and social interactions produce a unique circumstance and relationship for ANSs and their early education. Of importance, most participants remarked on the shortcomings of the Nova Scotia education system in relation to ANS communities. The subthemes, as shown in Figure 8, which comprise this overarching theme include 1) *Early Education: From Colorblind to Invisibility; 2) Transitioning to Post-secondary: Patching the Leaky Pipe; 3) Fitting a Mould: Non-traditional Students in a Traditional Institution*

7.3.2.1 Early Education: From Colorblind to Invisibility. Early education encompasses elementary and secondary school and the experiences of participants during this time. Participants remarked on the education system in Nova Scotia and the significant gaps that exist. The early experiences left an impression on the participants. Junior high and high school (grades 7 through 12) were noted as a critical point in a student's trajectory and as a point in time where things were liable to "go left" without adequate intervention. The findings contained within this subtheme formulate around the notion that the success and future trajectory of ANS students was unimportant and not a priority in the education system. Despite not receiving adequate educational guidance from teachers or counsellors in elementary and secondary school, there were community programs that off-set these gaps. Participants described the ways in which the education system failed to support and facilitate the success of Black students. The education system in Nova Scotia, particularly in certain areas, was considered to be "substandard". For example, neither teachers nor guidance counsellors took an interest in the future pursuits of ANS students.

> R#6: Because in Nova Scotia, our school system, the education system, and particularly in Black communities, was substandard… And so things kind of started from there. And so I dropped math. So I have to take science again. I needed biology. So I took biology. And I did have 11 math and I didn't have 12 math. So I had to do that prior to going to nursing. And you know, it was difficult because I was older, I had a child at home. Studying was an issue. You know, finding the time. But I got through it.

> R#15: I went to a local high school. And over there they weren't really focused on certain people's career paths. I don't want to say they weren't looking at the Black folks but they weren't.

Some participants explicitly stated that they were told or led to believe that they were not smart enough to succeed academically. This translated into some participants feeling as though a career in nursing was beyond their reach. For example, one participant recounted the trends that they observed in their local community, which involved ANS students being transferred from academic courses to foundational courses. As described by the participant, this practice was both discriminatory and problematic as it restricts future educational and career possibilities and "screws their future". Even participants who displayed a keen interest in math and science or those who were involved in extracurricular activities, including student council, were not encouraged by teachers or staff to pursue post-secondary education. Participants described an interest in math and science however, this was typically ignored by educators. As a result, some participants imposed limits upon themselves as they perceived college as a more viable option than university, in spite of their academic and extracurricular accomplishments. The following quote shows a commonly described circumstance of how many participants expressed a keen interest in math, science, and continuing education yet received little guidance, from teachers and staff, when it came to postsecondary education.

> R#9: And really, no one in my family had ever gone to university. I've never had like a university experience to kind of draw upon as well anyway. And that's something that I think is huge. Because I didn't have that kind of background to know what university would be like to even know that it might be a possibility. So that really kind of targeted me towards going to NSCC as well, because that was just…that seemed like an easier flow or way to kind of get into a program as opposed to I had no idea about university at all. And I didn't have the support there. And even like through school, I didn't have the guidance counselors or anybody saying, you know, "Why aren't you going to university?" Which in hindsight is crazy because like I was student council president, I had good grades, I was involved in a ton of different activities and extracurricular. There was no way that I wouldn't be able to manage university. But it was just never a conversation that was ever had.

Addressing the gaps in education required a shift in the operation of the education system as well as investment from parents. Participants described the incredible challenges that both students and parents encountered since the education system was not designed to facilitate the success of Black students. Through personal experience and second-hand accounts, it was considered unwise for parents to rely on the education system, including teachers and staff, to support and encourage Black students in their academic pursuits.

However, participants acknowledged and sympathized with parents who themselves likely navigated the tempestuous education system without success. One participant recalls how her mother supported her drive and success in school, which inspired her to be a “strong Black woman”. This participant’s experience illustrates how receiving encouragement from their mother was instrumental in instilling powerful beliefs of self-confidence and belief in the self that they could attain anything they desired.

> R#7: I think it comes a lot from like the parents, like the family. Like for me, my mom encouraged me to be anything that I wanted to be ever since I was young. And she always knew that she wanted me to be something more. Do you know what I mean? And like that really helped me a lot because I knew I was like, okay, like I have to be… like I have to have a good career, and like be able to provide for myself, and love what I do. So I find a lot of it should come from the family. Which is sad because I feel like a lot of times now it doesn't. Like the parents are just sending their kids to school and they're hoping that the school is just going to figure everything out for them. But in reality it's not like that at all. Like you have to be… Like I remember when I was a kid, like my mom would like make me do… Like she had like a video recording of like times tables, and like making me read different types of like science books, and like do like so much extra other than just going to school. Do you know what I mean? So then that gave me a thirst for more knowledge and wanting to enter into a course like a healthcare career., to be like a strong black woman, really, an individual. So yeah.

In describing representation in society, one participant described the lack of educational curricula, presenting content related to the history of ANSs and Black people in Canada. In addition to gaps in supportive and adequate programming, gaps in the curriculum were highlighted by participants as well. One participant described the parallels in their nursing education to that of high school, where the history of Black people in Canada was sparse, if present at all. Omitting content on Black people in Canada was regarded as a blatant dismissal of the presence of ANSs in Nova Scotia and Black people in Canada. The following quote illustrates this notion:

> R#8: There was nothing… Like it’s almost like going back to high school. When you're sitting in history class, and you have like African history, and then the opposite page, like there’s three paragraphs and then it's moved on. There was nothing in my books that reflected us. There was nothing in the books that reflected us. No, nothing. Except when we did the Alzheimer's unit, we touched on the Aboriginals because we talked about smudging and things like that there when they’re coming to the end of life. But I can't remember anything on our people. I can't remember anything on our people.

Lastly, the importance of representation in the education system was further explained by participants expressing the importance of having Black teachers. In addition to course content that reflected and included ANSs and Black people in Canada, participants expressed appreciation for those educators – both Black and non-Black – who were extremely supportive. The following quote illustrates that a supportive network, especially in education, extends beyond representation of Black educators and teachers in the system. Supportive networks were considered impactful and necessary for participants to feel as though they could aspire to be and do more.

> R#18: Because this little community raised me, right, between church and school, the few Black teachers that I did have. Or even, you know, the ones that are local who are very supportive that may not have been Black but will stick with me forever.

7.3.2.2 Transitioning to Post-secondary: Patching the Leaky Pipe. This subtheme captures the critical programs and supports that facilitated the transition to post-secondary education, for many participants. The transition to postsecondary education describes critical community-focused initiatives that facilitated the movement of participants into college and university. This includes former as well as long-standing programs that include partnerships with institutions. Specifically, the transition to postsecondary education and nursing specifically was eased by targeted programs such as the Black Educators Association (BEA) math camp, and the Dalhousie University-based programs including PLANS, the Transition Year Program (TYP) and the former Black nursing student's program at the School of Nursing (SON). Each of these programs were described as instrumental in the successful completion of the nursing program. As the following quote shows, participation in the BEA math camp was one opportunity for students to explore and cultivate their interest in math and science. Importantly, participants' accounts show how their interest in math and science became more apparent and clear in high school.

> R#17: Junior high, I was more so into math and science. Like I went to the Dal BEA math camp. So I was always like into like math and science. In junior high, I wasn't really thinking a lot about like what I was going to do. It wasn't until like I really hit high school. But anything like math and science really, I was like all over basically.

While the BEA math camp encouraged many aspects of personal and academic development, it was a useful post-secondary preparatory program for students. In terms of university-based programs, many participants referred to two specific programs in sharing contributors to their academic and professional success. The first program of interest is the former Black nursing students' program at the SON. This program,

which included multiple components that intersected secondary school and university, was regarded as an integral component of the participants' journey to becoming a nurse. The uniqueness of this program, which was situated within the Dalhousie SON, is such that participants described their participation as program attendees (in secondary school), as nursing student leaders (undergraduate students) and as mentors (practicing nurses). The first quote is a description of one participant's experience attending the SON Black nursing students' program during junior high school. The participant shares how meaningful it was to go to the SON and learn about nursing as well as have the opportunity to practice various clinical skills. They also described the impact of this program on Black students, the significance of early academic exposure to nursing, and the benefits to their own educational trajectory and future success.

> R#7: And I love to make people feel like that. Like from my community or all the surrounding Black communities really. When I was younger, I went to a nursing camp at Dalhousie for Black students. So that also helped me to say, okay, this is what I really want to do as well. Because we went there, we did like a whole bunch of like cool little things that nurses do. Like doing needles and like putting on little finger casts and different stuff like that. So now, they have like a camp in the summer which was similar to the camp that I attended when I was younger. Strictly for Black students in junior high school, just trying to get them introduced to healthcare. So whether it be nursing or medicine or physio or anything within like the nursing profession. So how it works is they start them off a bit earlier. So junior high. So that when they get to high school, they can pick the right courses. So like they know they have to take their sciences and their math and all that kind of stuff.

This next quote shares how some participants assumed the role of student-mentor within the SON Black nursing students' program. This was perceived as an important leadership opportunity that allowed students to mentor Black students in secondary school as well as develop and grow their own personal leadership capacities. Again, the benefits of early exposure to nursing and the academic environment, before high school, were described as a necessary key to facilitate recruitment, retention and success of ANSs in nursing. Participants explained how participation in this program was a critical element in setting students up for success.

> R#11: So what I loved is that camp that I was able to take a part of when I was a nursing student. And it got students… They were either grade 8 or grade 9. Because the goal was before they went into high school, and having sort of an idea of what sort of courses they would need to take to be able to set themselves up to be successful in getting into a nursing program. Now, the thing is, that was just at a

> local level of Halifax. Which I guess is where the biggest population of African-Nova Scotian students would be. But it would have been great... I know I would have really valued an experience like that when I was in junior high, high school. I did have the opportunity to go to science camp at St. F.X. for, you know, kind of the Colchester region that they picked individuals to go. And again, I was the only African-Nova Scotian student. And so I just think having specific opportunities for African-Nova Scotian students to take part in different…of an exposure, whether it's to nursing or health professions or whatever, I think experiences for learning in youth is huge.

In addition to highlighting the benefits of the SON program, the above quote also captures the challenge of accessibility of programs and supports for more rural communities compares to those situated in the urban centre. The limitations of regional-based initiatives was seen as a drawback since a significant portion of the available programming was more widely available in the more urban center of HRM as opposed to rural communities. This was not to dismiss issues of accessibility that were experienced by urban ANS communities nor to discount the importance of programs such as the BEA. However, the above quote captures more nuanced gaps that persist, amongst rural and urban communities, despite targeted initiatives.

Other participants shared their experiences of being a nurse-mentor in the SON program. They described the long-lasting relationships that they established with the students in the program as well as the value and importance of a program that was designed to address the institutional and systemic barriers that impacted the recruitment, retention and representation of Black students in the nursing program and in the nursing profession. Specifically, participants explained the importance of being able to confide in someone from the same community who looked like then, shared similar experiences, were able to validate their experience as well as draw on similar experiences to enhance understanding.

> R#5: Yeah, well, at one point in time I sat on a committee at Dal whereby we mentored young nurses who were in the program at Dal. And just mentoring them, just somebody available for, you know, to hear and to listen to what you're experiencing or to share experiences with, and not to be second guessing what you're feeling. I think they were grateful. And at one point in time early in that program at Dal, we were paired up with a student. But she and I would meet and have lunch and, you know, talk about different issues. So that was really good. And there's a couple of other students that I have met with and, you know, just chatted. And just chatting and talking about, you know, challenges they would experience.

The second program that was discussed with reverence and appreciation by participants was the Transition Year Program (TYP) at Dalhousie. The TYP was described as a life-changing program that provided essential financial support and offered a safe, family-like space where participants could go, feel comfortable and be themselves. The following quote illustrates the degree of importance that this program held for one participant.

> R#16: So that's when I heard about TYP. And then filled out the application forms, applied. And I'll never forget the day I saw the letter. And the letter was like "you're accepted". And that day I was like my life is just going to be changed. Like that was a changing day in my life.

Building on this sentiment, this same participant shares the level of comfort and openness that they experienced at the TYP house. The level of comfort at the TYP house was contrasted with participants' experience in nursing. This contrast included the notion of being the "only one" or one of two or three students in a class of nearly 200 students. This realization made TYP feel like a safe haven for participants during their nursing program. Even when the nursing program became extremely busy and trips to the TYP house became less frequent, knowing that the TYP house was there provided a sense of safety and reassurance.

> R#16: Like I could go there any time. That's the thing. To this day I could probably just go down there. Like I could go to class and I could just be like go hang out at the TYP house and do my work, or just go sit down and talk to Wanda…So it was always like you had that spot where you could go hang out and just be around people like you. It's like all day you're sitting in a huge auditorium, and there's what, four of us? Like at the beginning, I went there often. But towards the end, I didn't because I was just like trying to get my work done and do these 20 page papers because the work got more intense. But then I always knew that it was there. Like I'd know that I could always go there if I needed to.

In addition to the comfort of an inclusive space that was dedicated to ANS and Mi'Kmaq students, the financial resources provided by TYP were acknowledged as the solely avenue for financing the university education. Participants explained the ways in which class or socioeconomic status had impacted their lives and the possibility for continued education. Socioeconomic status was apparent from the description of experiences and accounts provided by participants. In many circumstances, participants reported financial constraints as very real limitations to pursuing post-secondary education. One participant reported that "putting money away" was not a priority in the family. The sentiment of financial constraint was shared by other participants as well. The financial support offered through TYP was vital. Participants who attended TYP described how the program, including the scholarship, made attending university both a possibility and a reality. Without TYP,

participants did not know how they would have been able to afford tuition, especially coming from low-income families. The following quote exemplifies one instance of how the dynamics of first generation student status, gender and class all intersect in a manner that impacts opportunities for continued education.

> R#10: So I pursued kind of investigating around to TYP and what the program was. It was an awesome program. I got accepted into it. You know, did the first year of TYP, passed, graduated, you know, from that program. And I think that was really a key factor in giving me that financial support because of course my mom came from a low income family, low income…. You know, her mother never pursued school, never worked. So my mother didn't have the means to kind of help me get through university. And even if she had, she just…I don't think she had… She didn't really anticipate like putting money away so that I could… so that it would take off some financial burden from me in the future. So the TYP scholarship was really integral in kind of giving me the opportunity to pursue post-secondary education.

While another participant explains how TYP was viewed as the sole option to pay for postsecondary education.

> R#16: Well, basically, I went to Dal, the TYP, luckily. Otherwise I don't know how I would have paid for schooling.

However, a couple participants shared their views outlining what they perceived as a shadow side of the TYP program. This was discussed by participants who they themselves (or members of their family) were not eligible for admissions to TYP or participants who knew of others who did not qualify for the program. One participant explain how TYP is an extremely beneficial program for the ANS community but at the same time, it widens the gap of inaccessibility – effectively creating more roadblocks – due to the restrictive admissions criteria. Again, the obstacles of program funding and tuition cost is apparent.

> R#18: My own personal experience or the people in my family that may have been denied opportunities that they've tried for. Well, I think maybe funding would be a huge, humongous…. Like it would somewhat help if there were funding available for people where it was designed somewhat like the TYP program. Because everybody doesn't fall into the outlines of the TYP program. I think it's the funding. Like having to have that type of even the expectations of the entrance marks, as what I'm understanding right now, for the program in this city at Dal… I feel that some of the stuff that's being implemented are more roadblocks.

Another participant, expanding upon the financial barriers pursing nursing as a career, briefly highlighted what is considered to be extremely restrictive admissions criteria for a program that focuses on the transition of ANSs into university. The quote also captures the participant's views regarding ways to enhance the recruitment of ANSs into nursing.

> R#14: I feel like a very vague way would be like to see more Black nurses. The financial component of it is huge. I have lots of friends that just won't go to post-secondary because of the financial component. Like I know that TYP exists. But there are a lot of things you have to like qualify for to get that. Like I feel like that was a thing, more people would go into nursing. And if they just even knew what nurses did. Because they just assume there's only bedside nursing and that. And they don't even really know what you do.

7.3.2.3 Fitting a Mould: A Non-traditional Student in a Traditional Institution. The final subtheme in this section is *Fitting a Mould: A Non-traditional student in a Traditional Institution.* The foundation of this subtheme is juxtaposed against the traditional image or view of the typical [or ideal] student. Based on the experiences described by the participants, majority of them are considered as non-traditional or atypical students who had a different path into nursing. This subtheme encompasses the circumstance of the first generation university student; the mature student; the parent; the spouse/ partner; the breadwinner; and the caregiver. Some participants held several of these positions simultaneously.

Whether it involved obtaining a high school diploma from an alternative program or entering postsecondary education through a program such a TYP, many of the participants expressed the ways in which they did not fit the traditional mold of a typical student. Beyond this, participants expressed the distress they experience regarding the lack of consideration for students who had additional obligations outside of their school including work, parenting, caring for family, financial responsibilities and not financially dependant on family, as well as being a first-generation university student. The experience of being a non-traditional student was acknowledged as being "harder" when additional responsibilities, beyond academics, were present. The quote below captures the gendered dynamics of being a wife, mother, and having additional responsibilities all while being a student.

> R#2: And you know, we talked to the young people, young women who were pregnant. You know, like your life is not over. It's harder. Because I went back to school. I did all my education except my high school education as a married woman. And it's like with children. And if you really want to do it, it takes a lot out of you but you can do it. I don't know what your circumstances are. But, you know, if you're a

mother and you're a wife, and you've got responsibilities, it's harder to do it. But it's still attainable. But you can do it if you want to do it.

Another challenge in terms of education is the notion of being a first-generation university student. The experience of being a first generation university student was captured throughout participant accounts', with some participants explicitly stating these challenges. Being the first in their family to pursue post-secondary education was identified as a major learning curve. There were few home-based resources that participants could seek out for support and guidance in the decision-making process or the application process. The obligations of life for a non-traditional student were compound by the challenges associated with being a first-generation university student. Being a first-generation student meant that participants had few people in their immediate family to whom they could turn to for guidance or support. The challenges of being a first-generation student presented itself in navigating the application process, course selection, and more general or basic knowledge around postsecondary education. For example, a few participants remarked on the limited "dinner" or household conversations involving continuing education. Participants described navigating the application, admissions and transition process to university on their own and without guidance from members of their immediate family since they were often the first in their family to pursue post-secondary education. The following quotes illustrate some of these challenges:

R#14: I wanted to be a nurse and I've wanted to be a nurse since I was 19. But no one in my family had gone to university. Like I was the first person in my family to go to university. So I didn't think that I was capable of it. So that was kind of a deterrent. So I decided to do my CCA first to see if I would even enjoy it before I put myself through like the possibility of going to university. And so like I've worked in various nursing homes like before going to university and during.

Another participant quote illustrates another aspect of the experience of being a first-generation student and how there were not many people to seek out and go to for advice with something as specific as admissions applications or as broad as entering medicine or nursing.

R#15: Me and my brother were the first in the family to go to university, and that was it. So it kind of not took everyone by shock but it was, you know, I didn't really have anyone to look to in terms of who was in the healthcare profession. I didn't really know many people that were nurses or were doctors because there ain't none that way down here.

The influence of ancestry was another critical factor that impacted participants' experience as a first-generation university student. As one participant described, many of the earlier generations of ANSs were

denied opportunities to be educated. The sacrifice of ancestors was recognized as a part of family history that paved the way for future generations to access and attain more. Finally, this participant shared how there were more opportunities available for ANSs to pursue various types of careers, despite many of the persisting social issues.

> R#11: You know, I was self-motivated because of, you know, I thought about, you know, what an opportunity for me to… And my dad always was like education is so important, right. Because my dad's parents, who are both African-Nova Scotian, they didn't have… They were denied those opportunities, right. So for me, it was always about valuing like this is an opportunity that I've been given and not to waste it. And certainly not everyone is going to think like that or... That's just my experience of what kept me moving forward. Like I remember at even just my high school graduation, I was the only one that cried. But I was thinking about the significance of it, right. Like my grandfather couldn't read. He was illiterate. I've been very, very blessed to have a plethora of education opportunities that have set me up so that I can have the job that I want and live a comfortable life. And that's not lost on me, that that's from the sacrifice of others in my family history, right.

The following quote, which reinforces earlier sentiments regarding the first-generation student experience, also incorporates how one participant negotiated remaining in their home community compared to leaving to pursue their career interests. There was a sense of needing to leave their home community to be better positioned to achieve career goal however, it conflicted with being young and dependant on family.

> R#4: Like my mom, my aunts, some people like that, they didn't come very far as far as education. And because of that, it was never a conversation about you're going to go to college, you're going to go to university. You never heard those kinds of things. And so I knew that if I wanted anything to do with medicine, I'd have to leave. And of course leaving, and especially leaving young, means that there's consequences, right, because who's going to support you, where are you going to live? So you sort of live the best way you can day-to-day, people-to-people until that moment comes where you find the window of opportunity to be able to go to school. And so for me, it came in my mid twenties. And then I went to school.

Lastly, several participants describe the experience of working, usually in healthcare as continuing care assistant (CCA) or personal support workers (PSW), before and/or during studying nursing. A few participants described the experience of studying nursing during the day and working as a CCA or PSW on the weekends and in the evening. The need to work while studying connects to another salient element of the interaction of

gender, class and race, of many participants' journey to nursing. Most of the participants acknowledged their level of expertise and knowledge in relation to nursing care. Working in these roles while studying nursing was a common thread for many participants as a point at which they begun this journey in caring. The notion of early exposure to care, is explored further in the following theme.

7.3.3 Theme: An Ethic of Care

The theme *An Ethic of Care* is a powerful theme that sets the foundation upon which understanding nursing, nursing leadership and a tradition of care is established. For many participants, the provision of care was a commonplace act that they witnessed in their homes and in their communities. As will be outlined in the subthemes, many of the participants had a connection to the healthcare system or the fundamentals of caregiving, through the women in their family. This connection however, was rarely in the formal sense of licensed caregivers. Rather, the connection to the healthcare system, and caregiving more generally, was through work and roles including cleaning/ housekeeping, informal caregiving and unlicensed clinical care roles. Participants witnessed care provided by women in their family including their mothers, grandmothers, aunts and cousins. Early exposure to caregiving practices and the focus on attending to needs beyond the physical, served as the prime backdrop upon which numerous participants established their approach to care.

In terms of positive professional representation of Black workers, participants remarked on this underrepresentation by suggesting that there were no Black nurse role models. While this observation of the lack of professional role models is understood to be true, many participants described powerful imagery and memories of critical role models in their lives: Black women. As will be further described and expanded upon in the subtheme of "*Caring is in My Blood": A[n] [Inter]Generational Tradition of Care*, the domestic work and homecare provided by Black women in the community left a lasting impression on many participants. Black women in the community who modelled caring behaviour included mothers, grandmothers and aunts. Further, Black women demonstrated various behaviours and practices that were observed and then imprinted upon participants. Through much of their domestic work in the community, Black women modelled basic yet critical elements of caring, competence, and selflessness that is foundational to nursing. The subthemes for this theme include: 1) *"Caring is in My Blood": A[n] [Inter]Generational Tradition of Care 2) "My Duty to Educate": Leaning in and Taking the Lead 3) Caring for the Self: On Mental, Emotional and Spiritual Wellbeing*

7.3.3.1 Subtheme 1: "Caring is in My Blood": A[n] [Inter]Generational Tradition of Care. A number of participants described an early and influential connection to the concept of care and caregiving from an early age. For many participants, their early exposure to care occurred in the home and community.

Participants shared accounts of participating in the care of family members who were being cared for in the home. It was not uncommon for infirm family or community members to be cared for in the home as opposed to a hospital or care facility. This exposed participants to equipment and practices that were used to support patients. For example, bed pans, incontinence pads, hospital beds, wheelchairs/ walkers and medications were everyday household items. For example, one participant shared that a member of their household had a hospital bed in the living room.

The following two quotes show how play [in childhood] was a meaningful experience and largely influence participants by exposing them to nursing and caring. Specifically, toy doctor kits or family first-aid kits were provided to participants as children, which they played with and used to "take care of" family and friends. Playing with these items was thought to be a nice way to introduce possibilities to children, especially in lieu of having formal healthcare providers in the family.

> R#10: It was a big challenge, I would call it, for me because I came from a family where a lot of people, really when I think about it, my entire family, there's not many people in even my extended…like my larger family that ever pursued post-secondary education. But when I was younger I wanted to be a doctor when I was young. Like I always wanted to be a doctor. I remember when I was a kid, my mom would have a little first-aid kit. I would always like fix my friends up. Kids around the neighborhood when they would come, I would always… If they were cut or if they had like a wound or something, they'd be like, "Participant, like come do my legs." So I feel like I always in my heart wanted to do something healthcare-related.

> R#12: My dad used to buy me the doctor kit when I was a kid. And he would be the patient, and I would be the nurse. And when he would come off night shift, he'd lay on the couch and he's like, "Okay, you take care of me. I'm sick." And I'd go around with my little doctor kit, wrapping his foot up and taking his temperature and stuff like that.

Other participants received early exposure to care and the healthcare system through volunteering. Volunteering at the local hospital or care facility was both a memorable and influential experience. For example, participating in activities such as "tea and sales" was memorable. Another participant described the importance of volunteering at a local hospital, where their mother worked in a non-clinical role. The participant shared their routine of volunteering in a program at the hospital. Again, this experience served to introduce participants to caring and healthcare at an early age.

R#9: I was always involved in a lot of extracurricular stuff. So every Sunday I would go and volunteer at the hospital. It was a volunteer program that was run out of the hospital. So I would go every Sunday and volunteer and spend time there.

Another participant described the significance of visiting their grandmother and seeing her white uniform, pins and scissors. The memory stands out as inspirational since it instilled an interest and an affinity towards nursing. Seeing the way that care was provided, either at home or work, is where some participants explain as the beginning of their interest in nursing.

R#12: So I didn't have a big encouragement, other than from my grandmother. Because of going to my grandmother's house, I'd always seen her in white uniform coming home at 3:00. And I can remember her like saying, "You come over tomorrow and visit at lunchtime. Come over and visit me." And I always remembered like hanging out the line of clothes, the uniforms, and looking at them. And seeing her taking safety pins out of her pockets, and nail clippers and stuff. And I was like… But… And then my mom always had me ironing her white uniforms growing up. So, I mean my… I have fantastic parents. Very supportive on anything that I wanted to do, and were the kind of people that showed you…taught me to be independent and not have to rely on anybody…I guess it was I just had really two role models, right. But it was… It started off with the going as a child in and out of nursing homes. That's where it started. I'd visit my grandmother and go to my mother's work.

Despite participants witnessing varying aspects and degrees of homecare by their family members [often for family/ community members] many of these carers were not formally trained in healthcare provision. Some participants explained that they came from "a family of carers" or that "caring is in their blood" despite the lineage not having any formally trained caregivers or practitioners. Various descriptions or examples of being surrounded by caregivers was another common thread. The maternal line was a salient thread woven throughout the participants experiences, both professionally and personally. Additionally, ANS women had a powerful and lasting impact on participants. Participants spoke of growing up and observing their mothers and grandmothers and the ways in which they cared for family members as well as members of the community. As one participant shared about her grandmother:

R#16: Yeah, my grandmother raised me. She took care of so many kids in the community. And not only kids like, you know, older people. They'd come and she would make sure that she'd give them a meal.

Another participant describes going to work and watching both their mother and grandmother provide care as CCAs. The following quote illustrates the notion of *the tradition of care* as non-licensed care providers in the maternal line.

> R#12: Well, as a child I was always taken to the local long-term care centre to visit my grandmother, who was a continuing care worker there. And then my mother was a continuing care worker. And my mom always had me doing things, you know, like tea and sales. Every year she had me doing that as a child. Like selling tickets or working the whatever, or talking to some of the elderly patients. And I think that's where it all started.

One participant described the impact of being surrounded by nurses in their family and the importance that had on their own career aspirations. However, the majority of participants described the absence of relatives who were trained nurses. The participants shared how the women in their family worked alongside nurses – rather than as trained nurses. The following quote captures a common thread related to the distant familial connection to nursing and the commonness of carers in the family.

> R#7: So I'm actually the first person in my family to… Well, I guess on my father's side, my great aunt, she was a nurse, a registered nurse. She actually lived down like in the rural area. And then yeah, like my other aunt was like a CCA. But like nothing close. Like my mom wasn't a nurse or anything like that.

An additional illustrative quote shows a similar sentiment regarding the lack of trained nurses in the family but the understanding that they were surrounded by caregivers and that everybody around them was a caregiver. Again, this belief captures a powerful element that participants weaved into their nursing and leadership.

> R#16: I believe there were but they weren't like in my immediate family. But everybody around me were caregivers.

As illustrated in the following quote, participants who lived in multigenerational homes, received additional exposure to the ways in which care was provided by the women in their family. Women in the community would get together to care for the sick and infirm. Specifically, activities would involve care for the person and family including aspects such as cleaning the home, preparing meals, child care, and the previously described activities to assist daily living including medication administration as well as the making and use of incontinence pads. Participants both saw firsthand and participated in the use of hospital beds, incontinence

pads, medications. Participant involvement with the care of elder family members and other community members exposed participants to caring and notions of community-focused/ person-centered care from an early age. This served as an important foundation upon which participants built their nursing values, beliefs and practices.

> R#7: So I've always, ever since I was young, I always liked to do like sciences or I was really into like math. And then when I was young, my grandmother had Alzheimer's disease. So me and my cousins would take care of her a lot and stuff like that. And they just kind of like always knew that I wanted to do something in healthcare. So whether it be like nursing or medicine or something along those lines, I always knew I want to do something that way.

A quote from another participant illustrates how participants viewed themselves as being from a family of caregivers or amplifying the notion of 'caring being in their blood'.

> R#17: Healthcare runs in my family. I had two grandparents that lived with me. And I was always interested in their medication, the side effects and why they were taking it. And my mom's a homecare worker. So taking care of people has always…is basically in my blood. So my mom's a CCA. She works for homecare. So she goes into people's homes. And then my grandmother was a nurse's aide. So it's kind of like generationally it runs in my family.

Finally, multiple participants describe how they have always been caring people, which is what led them to their career in nursing. Initially, participants were interested in different careers such as medicine, teaching or pharmacy but after numerous personal experiences, there was a heightened drive to pursue nursing. Surprisingly, this drive was able to be sustained despite not seeing Black nurses in their communities.

> R#14: I mean it's a pretty generic answer but I find that I really do enjoy like helping people. And that was a way that I could do it. I don't even know how it came to be actually because when I was a kid I wanted to be a teacher. And then as an adult, I was just like I want to be a nurse. But like I said, I just didn't think I could do it. Like I didn't have any role models that were nurses. There's no Black nurses in my town. So there might be one now. But there wasn't growing up. No, they were all white nurses there.

7.3.3.2 Subtheme 2: "It's My Duty to Educate": Leaning in and Taking the Lead. The subtheme "*It's My Duty to Educate"* incorporates the overwhelming feeling, expressed by participants, to be involved or engaged in educating other. This also involved participants feeling as though they were the spokesperson for the Black population or on Black issues. Internal and external drivers were thought to contribute to the pressure or

responsibility that they felt as a nurse. Being the 'only one' often meant that participants constantly had to make decisions regarding when to engage in discussions to educate others about "Black issues". This presented as feeling pressured due to an unspoken obligation to constantly being the person to educate others on the "Black experience". Participants described the mental fatigue and exhaustion that accompanied having to educate others. The following quote captures how some participants believed that it was their duty to educate patients who held prejudice or racist views.

> R#8: You have your patients that are prejudiced or racist. But I always go back to and thinking, okay, well, that's the area where they're coming from, right. However, it's my duty to educate them.

Another quote highlights the internal conflict that other participants expressed. It was described as "exhausting" to have to constantly explain basic concept, which should have been taught or learned, to people. While the previous quote showed one aspect of this *duty to educate,* the following quote takes a different approach. The participant expressed how it really should not be their duty or job to educate other. However, they felt compelled to do this work because they knew that if they did not do this then no one else would.

> R#13: And also personally, it gets exhausting because it shouldn't be my job to have to explain these things to people. But if I don't then nobody else is. And I see other colleagues, you know, other Black colleagues who struggle with it because they're either black and new to Nova Scotia and dealing with sort of that silent racism that we see far too often, you know, or they're from the Black community here but haven't taken on that responsibility within a leadership role and feel like they don't have a place to say it.

This same participant, when probed, provided a general account as to how and why they eventually step into the role to educate others. As displayed in the quote, they weigh factors such as whether they have the time to invest mentally and emotionally in a conversation or who is the best person to approach in the situation. The participant's description also captures the nuance and the difference in the impact of microaggressions on ANSs who were raised in Nova Scotia. This exemplifies one of the ways in which socialization to ones' subjectivity and the experience of Blackness is different for those who were born and raised in Nova Scotia compared to those who were not. Finally, this quote introduces the challenges encountered with the underrepresentation of ANS and Black leaders. When all of the leadership or management team does not look like you, it was considered to be more challenging to pursue issues and file grievances, especially when the process was not entirely clear or transparent.

R#13: Sometimes it depends on the day. You know, you sort of look at like do you have the time to invest in a conversation that's going to be difficult, you know, when something comes up that shouldn't. You know. And how do you address it? Do you address it with an employer or do you address it with that individual, you know? And you have to kind of think through all of the ramifications of how that's going to play out, you know. And so I've had colleagues where they haven't wanted to say anything because they've had, you know, daily micro aggressions for a long period of time. And, it's unwitnessed often because, you know, people won't say anything until they're the only other person in the room and ask an awkward question. And so it's sort of been like a learning curve for me because I often used to not say something. And then I saw how it was affecting some of my colleagues, you know. And less so for Black colleagues who aren't from Nova Scotia because they didn't really deal with micro aggressions, and so they don't always pick up on it, you know. Whereas when you're from here and you've heard it every damn day, you pick up on what people are saying. And so I started speaking out a little bit more. And I try to kind of make myself available as like a, I don't know, as a support person if they want to go and tell their employer about what's happening. Because, you know, that's a big difficulty, right, when you need to go to somebody who is a leader to say I have a problem with this fellow colleague who, you know, your skin is like, and there's nobody in leadership who looks like me. You know, it's difficult to actually pursue that.

Building on the previous idea of having a duty to educate other, some participants described their frustration around the expectation of being the spokesperson for the ANS or Black community. As one participant explains, they thought it was inappropriate for them to be asked to always share insight and strategize on how best to engage with the Black population. This participant acknowledged that these sorts of questions required more direct consultation with the patient population. The following quote also captures an awkward conversation with their manager, where their manager suggested that the participant could “teach” one of the patients how to be Black.

R#9: Yeah. And then always being called upon to kind of speak for everyone. To say, well, what can we do? I’m like well, you know, you just can’t ask me. Or my favourite thing… Like there were very few times that we actually had Black clients come through. But I can remember having a Black client come through, and having a supervisor tell me, “Okay, well, you should be partnered with them,” because they were struggling with identity. And they're like, “You can teach them how to be Black.” Yes, this is the manager that said this to me. So just kind of not even…like that concept of not getting it at all, and

thinking that that was an okay moment. Like, “Well, it's great because you're here so we can get you to teach them how to be Black.” And I'm like, “no”.

A second quote shows the push back and conflict with being the spokesperson on Black issues. Yet, this participant did recognize and appreciate the extent to which they were able to be involved in creating meaningful change in certain areas.

R#13: Professionally, it's come up as well where I've had that same kind of, you know, being asked to be the spokesperson, kind of thing. So there's that part of it. And in terms of like there's that micro aggression and that kind of struggle piece. But I feel I've also been able to kind of make some changes.

The duty to educate expanded beyond feeling these internal and external draws. Participants explained how they felt a sense of duty to be involved in supporting their community as well. Being an advocate and being visible as a leader and mentor in the community was a welcomed activity by some participants. This highlighted a very clear distinction between the service work to the community and to the general population. Service to the community – through mentorship, engagement, care and general support – was viewed as welcome worked, while, the burden of having to work and educate people within a system that is often resistant, assumptive and dismissive of ideas, was regarded as an exhaustive task. Building on the notion of this internal sense to be an involved, active and engaged community leader, the following quote illustrates how one participant expressed the necessity for ANSs who are in nursing and other positions, to be visible as a leader. Many participants expressed a very clear and palpable desire to do more in the community and to “give back.”

R#18: I would like to give back. You know, I have my own children and I can be a mentor to them and, you know, a rock for them. But there's also other people out there that I would like to help too, right. Because I see how we struggle here as Indigenous Blacks, and it’s tough.

7.3.3.3 Subtheme 3: Caring for the Self: Mental, Emotional and Spiritual Wellbeing. The final subtheme that informs understanding the broad theme of *An Ethic of Care,* is *Caring for the Self*: *Mental, Emotional and Spiritual Wellbeing.* This subtheme presents practices and concepts shared by participants that were found to be essential in their professional roles. Attending to their overall mental state was necessary to safeguard against falling into a cycle of negative thoughts or emotions. Acknowledging the numerous challenging experiences that may arise on a daily basis did not present itself as a major issue. However, experiences of racism on a daily basis, whether in the form of microaggressions or not, were considered to be mentally and emotionally taxing. On a day-to-day basis, microaggressions add up and lead to challenging experiences. One participant described the extreme challenges that they encountered in their work, which

caused them to seek out professional counselling support. The participant explained how daily microaggressions, conflict with colleagues and generalized disrespect created an environment in which they felt was mentally exhausting and unsafe.

In addition to seeking professional counselling services, participants shared how they developed a variety of coping mechanisms and strategies over time. one participant described how they developed effective coping mechanisms over time. They acknowledged how in the pat, prior to developing effective coping strategies, that microaggressions would weigh on them for days and alter their mental state. Being able to effectively process emotions and not "get stuck" was necessary to protect themselves against feeling drained on entering a negative cycle of thoughts.

> R#3: I have better coping than I did back then. And the type of work that I do around processing emotions is extremely helpful for that. So I don't get stuck. I don't get stuck with it as long as I used to get stuck in that. Yeah, it still happens. And then when you confront people, they're less likely to come back at you. That's the one thing that I learned. And that's why I find my courage, it's like if I deal with this now then they're not going to come at me that way as much anymore. And I'm in the driver's seat. If I show them my comfort with my blackness then they can't use my blackness as a weapon against me.

This same participant continued to describe how they operationalize their coping mechanisms to address issues and challenges directly. The follow quote shows the critical steps required to settle any mental distress. Recognizing and acknowledging the feelings is an important place to begin.

Beyond the coping mechanisms described, the participant incorporates their spiritual wellbeing into caring for self. The description of spirit and the importance of maintaining equilibrium or balance is evident. Additionally, transcending fear is another critical action to protecting ones mental and emotional wellbeing.

> R#3: I'm like, okay, I'm feeling this way. If I go home at the end of the night, and if this is not something that's resolving quickly in my spirit then I need to bring it back and I need to find the courage to bring it back. I can't be fearful. I can't do this in the face of fear. I have to come back and I have to say, hey, you know what, I'm sorry if this hurts you but I need to express this. What happened yesterday had this impact on me. When I go home, I can't sleep. You know, this bothers me. So we need to talk about this. This is the stuff that we teach in mental health. And if we can't practice what we teach. What are we doing here? It's like I'm going to tell you how I'm feeling, and I'm going to be authentic about that. I don't like what's going on here, I don't like how I'm feeling. And I could be misinterpreting it. But that's me and this is my feelings.

Building on this connection to spirituality and the important role that it plays in mental and emotional wellbeing, several participants shared how they use prayer on a regular basis to guide their practice and to overcome daily adversity. Prayer and connecting with God displayed a level of faith that transcended the participants' nursing practice and was present in their lives. As one participant describes below, prayer was a helpful tool used on a daily basis, even during "hostile" times, as a way to ensure that they maintained a standard of care that was guided by selflessness and love, and free from any residual tension.

> R#18: And even hostile at times. I say my little prayer on my way to work every day. Lord, let my hand do your work and your work only.

Another participant expands on the importance of prayer and their connection to God. The blessing of being in a position to support and comfort patients was a truly humbling experience. Seeing the beauty of life and death amplified the perspective on life and seemingly simple gestures or activities such as getting out of bed. This act of humbling and entering a state of gratitude, enhanced mental and spiritual wellbeing by offering alternative ways to view and exist in the world.

> R#10: You know, death is one of those things, we can never escape it. I just feel like God really just blessed me to put me in this position because after I started working, it gave me a very different outlook on life as a person. I'm so humbled now. I wake up every day and I'm like thank you, God, like amen, for getting me out of bed. Like just stuff that you don't think of because you just take it for granted, right.

Inspiring the future generation of nurses was an important aspect of caring for the self as well. These inspirational words and reflections were spoken by participants who overcame challenges to arrive at a place in their nursing career where they feel fulfilled. Specifically, the participants share insight for developing and maintaining a healthy self-image and belief in oneself that they can achieve all to which they aspire. Another shared the importance of surrounding yourself with a supportive group of people, who add value to your life rather than detract. Another nurse shared extremely practical tips for success including focus, determination and prioritizing goals. The quotes below illustrate these sentiments.

> R#3: Because I'm just an average everyday little girl from a rural town in Nova Scotia, right, who really wasn't sure if she could do this. But I did it. And you know, if I can do it, anybody can do it. If you put your mind to it? And that's one thing I've always told those that I mentor, you have to make school your priority. Anything that doesn't support that got to go. It's got to go or you're not going to make it. You're not going to be able to do it. So you know, if people in your life don't support you, get rid of them. If

your job doesn't support you, get rid of it. You have to be able to do things that supports being a student and, you know, studying and doing well and, you know, writing your papers and all that stuff. So to make sure that you succeed. So it's all about focus.

R#4: Don't do what I did and play yourself down. Like make yourself be proud of who you are, and say that, and let that emanate from who you are.

Again, another participant builds upon the notion of determination and self-confidence to share the importance of being open and willing to step outside of your comfort zone. Acknowledging that racism is an issue that continues to persist does not mean that moving forward is not an option.

R#2: So I think in any walk of life or any chosen profession, you have to just come with that I'm good, and I love people, and I want to give, and I have to give this, and you have to walk proudly. You know, sometimes people don't go into places because they think, oh, they not comfortable. And you have to go where you're not comfortable. And I think that in nursing, we have to go where we're not comfortable. We have to tell kids that, you know, it's not all easy. It's not going to be comfortable. There's going to people who are nasty to you. How do you overcome that? You know, you don't just go and say, I don't want to do this anymore, or, you know, it's racism. I think we just have to accept that there's going to be racism. I went to school in a small town. I got the best education. Now, I had a teacher in grade three, who was the most racist woman. My grandmother used to say, "They have to teach everybody the same. They can't single you out and teach you different. Take it in. You're not there for a social. You're there to learn." And I think that's what you have to do with anything.

In exploring how best to encourage ANSs to consider nursing as a career option, participants shared deeply insightful thoughts around this. As the following quote highlights, the words of encouragement from participants were generated from their own experiences, including the challenges and successes.

R#8: Yeah, like you know, to let them know, how great nursing is because it is a great profession. It really is a great profession. And just to direct them and let them know, it's a hard course, but it's attainable.

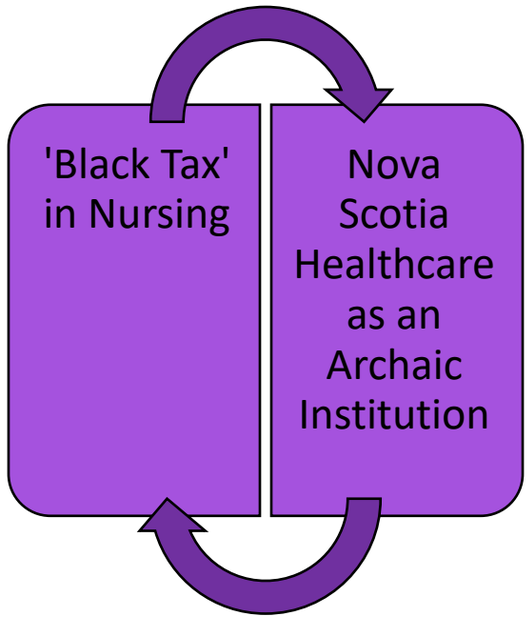
7.4 Section 2: Institutions of Care

Section 2 includes the analysis of two separate yet interconnected institutions. The nursing profession and the healthcare system are classified as the two main themes in this section which constitute the *Institutions of Care* for this study. Not only were these two institutions identified as central concepts at the outset of the

study, in the purpose and question formulation process, they also were common threads that were described and interrogated by participants themselves. The two themes, illustrated in Figure 9 are titled '*Black Tax' in Nursing* and *Nova Scotia Healthcare as an Archaic Institution.* The figure below depicts the interconnectedness of nursing and the healthcare system. Together, these two institutions of care [re]produce power dynamics that create marginalization and privilege. The first of the two overarching themes, '*Black Tax' in Nursing,* is presented below.

Figure 9

Section 2: Institutions of Care



7.4.1 Theme: 'Black Tax' in Nursing

Becoming a nurse is an experience that is highly variable depending on a multitude of personal and environmental factors. However, even within this degree of variability, there are common experiences, challenges and processes that all hopeful nurses need to endure. Further, once nursing education is complete, there is an equally varied experience that accompanies the integration into the nursing profession. Again, this transition contains universal experiences including the completion of an accredited nursing education/ training program, a competency examination, and the hiring process. This journey is acknowledged as challenging yet rewarding. The integration into the nursing profession however, is further complicated by social constructs, which produce power dynamics that either create circumstances of advantage and disadvantage or privilege and

marginalization. Social constructs that are contradictory to the ideological foundation, established policies and beliefs of individuals in positions of power, produce circumstances that add an additional degree of hardship and burden to an already strenuous process. The additional hardship or burden that is layered upon the journey to nursing is non-negotiable, and a reality that must be attended to in order to protect oneself.

Black tax is a term that attempts to capture the added mental, physical, emotional and spiritual burden that Black people are forced to negotiate as they navigate institutions and spaces (as well as interact with individuals), where power dynamics exist. Black tax is an omnipresent, insidious notion that exists as a undertone or low frequency buzz, in contexts where racial hierarchies exist. Black tax is impacted by other social constructs including gender, class, sexual orientation and disability. While Black tax is regarded as a universal concept that does impact all Black-identifying individuals, the amount of attention or focus that one gives to this concept and the degree to which people must 'pay this tax' varies. The following quote captures the general sense of this concept by acknowledging the challenges that may arise in the nursing profession while also being attentive to and mindful of ones' subjectivity.

> R#5: Because it is, for lack of a better word, it is a grueling world that you're in. You know, there's all the stuff… You've got to remember about the procedures and what you have to do. But also at the same time, you also have to protect yourself.

Examining the leadership experiences of ANS nurses in healthcare revealed how Black tax exists throughout the nursing profession. By interrogating the nursing profession through the identified frameworks, five subthemes within the larger theme of *'Black Tax' in Nursing* emerged. These five subthemes, each of which interrogates salient components of participants' experiences in relation to nursing practice, include*: 1) Nursing as a Service: The Blending of Art and Science 2) Nursing Politics: Navigating Intra-Professional Tensions 3) Nursing Education: Primer for Praxis 4) Invite Only!: Gatekeepers, Standards and Structural Design.*

7.4.1.1 Subtheme 1: Nursing as a Service: The Blending of Art and Science. Nursing was thought of and described as a service that included a specific perception and approach to nursing and caregiving. Nursing as a service-based profession was understood to require the setting aside of personal biases and ego in order to provide the best care for patients. The nature of the care provided to patients was described as encompassing a vast range of mental, emotional, spiritual and physical needs. Participants acknowledged that it was easy to fall into a pattern that focused more on tasks, administrative work and less attention to patients needs. To counteract this, one participant expressed that it is necessary to remember that despite everything that may be happening in a busy unit, the main goal is to care for the patient. The following participant quote reflects this sentiment.

R#18: I just think sometimes people just have to remember that we're there to care for the patient. So any of our own personal feelings need to be left at home.

Depending on the area of practice, participants remarked on the challenges they encountered when their beliefs related to nursing as a service-based professional conflicted with colleagues. Nursing was recognized as a dynamic profession, with a lot of opportunity and possibilities for career fulfillment, and a fairly good wage. However, various aspects of nursing and the challenges that can arise, were described as possible issues that made providing care difficult for some. For example, in specific care areas, it is necessary to support patients at end-of-life, deal with bodily fluids and faecal matter, and see patients through extremely difficult times. Participants acknowledged that this is not the only way that nurses care for patients yet, it communicated that the essence of nursing practice begins with patients. With that frame of mind, participants felt that it was absolutely necessary for someone to enter the profession because they truly enjoyed nursing and all that it encompasses. The following two quotes highlight the recurring thread of nursing as a service as well as the need to truly be passionate about nursing and ultimately, caring for people.

R#12: I mean it's a good profession. It pays well, you know. But you've got to be in it because you love it. And sometimes you can even say to staff members – Well, why are you even in nursing if you hate it so much?

The second quote continues to further illustrate this notion of nursing as a service by describing particular aspects of holistic care.

R#2: Well, I think it's because it's a service industry where it's not nice. Well, you know, nursing is… you know, like it's cleaning up blood, it's cleaning up body fluids, it's cleaning up, you know, feces, people are urinating. People are at their worst when they're sick. Because, you know, maybe they're a very nice person when they're well, but they're not nice when they're sick. You know, I've gone in the rooms and had people throw the tray at me because they're not happy. I don't think it had anything to do with my colour. I think it had to do with the situation they were in at the time…So why would you spend four years to train for something that is a service that's really sometimes appreciated and sometimes not? Because you kind of have to love nursing to really appreciate it. Because I mean we all can't be sitting at the desk as administrators. You know, even in my role, you know, I had to sit there and listen to people tell me stuff that I had to say I hope this doesn't show on my face that I'm shocked. And at the same time I'm thinking what can I do to help this person? You know, like how can I gain their trust, what am I going to do, what can I offer this person? …It's not an easy job to do. And I think that maybe people see

that as that, or maybe people don't want that responsibility like to go into specialized units. Because of what you do, you're dealing with death. Like people don't want to deal with death. You know, it's like cleaning up bodies and tying them up and getting them ready for the mark. It's not pleasant, you know. Maybe it's just the nature of the job. What in involves, yeah. If it's for you, if you're suited for this. Nursing is very intimate.

Expanding on the perception of nursing as a service, participant made a comparison or distinction between more traditional views and practices within nursing compared to the evolution and outlook for nursing. The idea that nursing was first and foremost a service to be provided to patients, is expanded by the discussion of how attending to the social, wellness and promotional aspects of health did not "have that kind of traditional nursing feel".

R#9: Well, I knew I wanted to stay within mental health. And a lot of the nursing roles that I had had didn't have that kind of traditional nursing feel to them. It was a lot of looking at other ways to kind of increase well-being. And so definitely a lot of my role focused around that social piece, the wellness piece, the engagement piece. And that was something that I really enjoyed.

Another important element underlining the subtheme of nursing as a service is the distinction between the emphasis on theory-based knowledge and practical-based knowledge. Several participants noted that it was essential for nurses to possess both the theoretical as well as practical knowledge in nursing. However, one participant expressed concern with the overemphasis on the theoretical-based knowledge and how some baccalaureate programs did not include enough "practical hands-on learning for nurses". The perceived shift in focus – from practical to theoretical – was a suspected contributor to diminished care in the acute care or hospital setting. For example, not receiving assistance or support for basic everyday activities, including toileting, was mentioned as one example for the shift in approaches to care. The following quote exemplifies how one participant perceived this shift education as a disservice to patients. The participant recounted a conversation with a patient who expressed great concern regarding the outlook of health care since they were not able to receive assistance to use the washroom.

R#6: One of the things that I found to be quite problematic is that there is… And I know you need to have the theoretical background, you need to have all of the information that that kind of fuels what we do. But I think that there needs to be more practical hands-on learning for nurses. I just spoke with somebody today who had been recently in the hospital. She fell down and broke her hip – a senior. And, you know, I just called to see how she was. And she said, "Oh, the hospital was terrible. The healthcare

system has gone down. We're in trouble. You know, things have changed so much." And, you know, she said, "I couldn't get help when I wanted to go to the bathroom." Just the basic things, right. And so I know that the healthcare system is struggling because there aren't enough staff and things like that. But, you know, I remember back in my day… even though it was heavy and we dealt with very, very heavy patients, we had large workloads, but we still tried to maintain, you know, a degree of I'm here to help you. You know, what you can't do for yourself, I'm here to help you with that. You know, we still encouraged people to do what they could for themselves. But if they couldn't, you know, we tried to try to accommodate or tried to be there. And anyway, so I think it's just so important to make sure that students have hands-on clinical experience, community, wherever it is, and community hospital. But that sometimes maybe there aren't good mentors within the hospital system. You know, maybe that may be the issue, I'm not sure. But this person that I was speaking with today, and I've spoken to so many people over the years, and they're so disappointed with hospital. And, you know, it shouldn't be that way. Even though I know people are stressed and it's hard and it's difficult, but there has to be a level of professionalism that helps us stay committed to a patient, to the patient care.

Nursing as a service was reinforced by senior nurses who recalled heavy workloads and complex patients and how they worked to maintain a sense of service and person-centeredness in their practice. Viewing nursing as a service was thought to require a sense of willingness to help and be present for the patients beyond their clinical needs. As the nursing profession continues to evolve, the nature of care and knowledge evolves as well. The shifts towards more theory-based knowledge appeared to coincide with a shift away from more practical-based knowledge and hands-on nursing. Nursing is not evolving within a vacuum but rather within a larger system or institution that is healthcare. It seems that an evolution of the healthcare system and the complexity of patients needs has created a shift in the ways in which nursing is practice. As one participant shared their views on the discrepancy between theoretical and practical knowledge, there was an emphasis on the importance of more hands-on training or experience:

> R#18: Textbook can be one thing but going out there and practicing it and actually doing it hands-on is another thing.

The tension between theoretical and practical knowledge extended beyond the level of preparedness upon graduation for new nurses. There was also the unspoken assumption that the theoretical or 'book-smarts' outweighed the practical or hands-on experience. This caused participants to ponder where the value [of knowledge] is placed nursing. Some of the participants raised an important question about the value placed on

practical and hand-on knowledge, experience, and expertise. As the following quote illustrates, participant expressed concern with the overemphasis and reliance of theoretical knowledge or 'book-smarts'. This participant shared how their employer suggested that a new graduate nurse would have the same knowledge and experience as the participant, who had been practicing for more than 20 years.

> R#5: My boss at the time was really interested in having my position re-evaluated. And so I had to meet with the various higher ups. And one of them told me… Now at that point time, I would have been practicing in an advanced practice role for about 20, 25 years. And that person told me that a new graduate from Dal would have as much knowledge and experience as I would have. And I must say, I kind of smiled but I thought big R was in the room there.

In addition to the perception of nursing as a service, participants described nursing as a profession that was concerned with and invested in the care of persons as a whole. This idea manifested in the form of participants explaining how caring for a patient required caring for the range of physical, mental, emotional and spiritual needs of the person. This belief was paired with the belief that patient care transcended the professionally or institutional imposed limits to scopes of practice. A simple yet powerful example of this is that, if a patient required toileting, it was understood that this support could be provided by any care provider present rather than deferring this 'task' to another team member. Caring for the whole person was viewed as contrary to the operation of some institutions, units and policy directives, which were thought to invoke scope of practice as a governing idea that restricted opportunities to provide person-centered care. The following quote includes a participants interaction with a patients' family after they attended to the varied needs of the patient:

> R#8: And then it would come to, "Is [participant] on today? I don't want you. I want [participant] to come in." It is because I would take the time, right. Then you would have family members say, "Oh, my gosh, [participant], you stand out above everybody else. It doesn't matter if they need to use the bathroom. Like you know, you're only supposed to be doing medication. But you have no issue taking them to the bathroom or change them." And I would tell them, like you know, well, I'm here to care for them so it really doesn't matter what they need, that's what I'm here for, right. "Well, I got to go…. I'm going to go tell your manager." And I would tell them, "Please don't do that." Because if you do, it puts a target on my back. Which it did. Because, well, how can we have this black girl on the floor that's better than all the rest of these here white people, right? It's not supposed to be. And that's their mindset,

right. But stop and see what I'm doing, and you can see why I'm standing out above the rest. Because I'm treating them like humans, right.

Nursing as a service extended beyond the patient to include families as well as the larger community. The care for patients was understood to extend beyond the individual and to encompass a multitude of aspects such as family, social and structural determinants. This view was described as being influenced by early childhood experiences with the healthcare system, connection to community and the belief that there was "a better way to nurse". Participants described how they welcomed and encouraged families to be involved in caring for patients. Including the family in patient care was perceived to be an important aspect of nursing, which increased patient satisfaction and trust from both the patient and their family. However, some participants expressed how this conflicted with the views and perceptions of their colleagues and how they felt about or interacted with families. The following quote illustrates how a family-centric approach to nursing was thought to enhance understanding the immediate circumstance and improve care.

> R#14: I have more like sensitivity, I feel, towards like people of colour, but towards people in general. I feel that it's like, I don't know, it's impacting me in the sense where I don't just jump to conclusions. Like I always consider that there's like a background reason as to why something's happening before I assume the worst of a person. Like yeah, I find that's like a big thing. And I'm big on family-centred care. Like the family being involved. Because I find a lot of the other nurses will complain about the family members. But I'm like, why wouldn't you just talk to them and just like figure out what's going on?

7.4.1.2 Subtheme 2: Nursing Politics: Navigating Intra-Professional Tensions. The legacy of dynamics or tensions that exist in nursing were salient in participant descriptions. Three of the common dynamics or tensions that were a reoccurring theme with several participants include: nurses eating their young, RN/LPN interactions, and feeling a sense of belonging. The integration into nursing, and career satisfaction, was impacted by the need to navigate some of these legacy intra-professional nursing tensions.

In reference to nurses eating their young, participants described instances of tension between themselves as new graduate nurses or nurses new to a particular unit or practice area. Age, rather than years of practice – which do not always align – was cited as a major determinant related to this phenomenon. As described by the following quotes, there were clear instances where participants felt as though older nurses would intentionally give younger nurses a hard time. The term "old" and "jaded" was used by one participant to describe nurses who were perceived as not being interested in helping or supporting new/ junior nurses acclimate. It was felt that nurses who were "on their way out the door" or nearing retirement were biding time and were less

interested in facilitating the successful transition of new nurses. Navigating this dynamic was a skill that participants developed over time, which allowed them to identify senior nurses who were supportive of their integration and success. The participant described their attempt to uncover common ground with colleagues as a way to integrate and achieve a sense of belonging. Again, the relevance of navigating social constructs presents as participants questioning how they are perceived, whether that be too aggressive or harsh.

> R#4: Well, I think, and not for myself, you know, it's a shame to hear that saying and to just still know that it's out there many years later – about nurses eating their young. And certainly I felt that when I first started nursing. I truly, truly felt that. And I felt like I was never going to fit in. I felt like I would get a common ground in a conversation where like I had children, and a lot of these nurses had children. So you know, I would say, "Oh, how are your kids? Where do your kids go to school?" Like different, you know, commonalities like that. But I very much felt left out in those conversations. And I think I was left to my own devices. I thought maybe it was me, maybe I was aggressive, maybe I came off too harshly. But I don't think so because I always knew what I wanted to be taught. So I can't really say that there's a nurse that sticks out in my mind as someone who took me under their wing and mentored me. And I think again that's what led me to always strive me to make sure that that never happened again to somebody else. And that's why I think I have such a strong, strong sense of mentorship even today with the nurses.

Another participant expands on the professional tension of nurses eating their young. This was described as the absence of the willingness to help or support junior nurses.

> R#16: Like they should be helping me out. Like you know what I mean? But these were older people that have been doing this for five million years. They're jaded. They're on their way out the door. They're ready to retire. They're sick of the place. They're sick of the politics. They're like in their 70s. You know. Which not all of them are like that. It just so happens that people that unfortunately I was around, you know, that's how they were acting.

Another element that builds on the tension within the profession tension or dynamic was the feeling of needing to prove oneself in order to gain acceptance or respect by colleagues before integrating into the unit or group. A number of participants shared this sentiment of feeling the need to prove themselves to senior nurses. Some participants felt that their appearance and "looking young" contributed to assumptions regarding their level of knowledge or skill.

R#14: I find my personal experience for the most part, initially people tried to like… because they think I look a lot younger than what I am, they try to treat me like I don't really know what's going on. So initially they try to act as though I know nothing. And I always get angry about that. So then I kind of present myself in a different way. So I do find that that happens a lot where I feel like I have to prove that I'm like just as good as everyone else.

This same participant continues by describing one of the strategies that they used in certain situations, depending on who they were working with. This strategy, term code-switching, is an action that lends itself to respectability politics, where one modifies their appearance, behavior or speech (including language and tone), to align with what are considered as more Eurocentric ideals. This was considered as the pillars upon which the concept of 'professionalism' was established. In this instance, the participant explained how they felt pressured to "code-switch" by talking "white" in order to receive respect from colleagues.

R#14: It really depends on who I'm working with. But a lot of the time I feel like I have to talk a certain way to get respect. Like I do notice that if I don't code switch, people automatically dismiss me. Like if I don't talk white. Like what people say is white, even though it's not.

Importantly, the challenging experiences of this legacy tension or dynamic in nursing were contrasted by interactions with senior nurses who were extremely helpful and supportive of the transitional process. Some of the same participants who described the tension with senior nurses also provided counter experiences and fond memories of particular nurses who fostered a supportive learning environment for them as a junior nurse to grow and flourish.

The other legacy dynamic in nursing is the relationship between RNs and LPNs. In nursing, there is an existing hierarchy that is based on a multitude of factors including level/ type of education, scope of practice and policy. This hierarchy, as is the case with most hierarchal structures, causes a particular type of power dynamics. Nursing is no exception. Based on level and type of education, LPNs are generally assumed to practice from a more narrowly focused scope of practice and work with patients who are less complex medically. This is in contrast to the wider scope of practice at the RN level, which sees RNs assume the care of medically complex patients. Beyond this, NPs, which are APNs or nurses with graduate level education and training, have an even wider scope of practice to the extent where care encompasses prescribing and medical decision-making. The differences in education between the nursing designations is significant however, issues arise when nursing designations or titles are conflated with competence and effectively become the default. Recognizing these assumptions and the legacy tension, both RNs and LPNs, in this study, were quick to push

back against the conflation of title with competence by addressing assumptions around knowledge, critical thinking, and the ability to work not only autonomously but to lead care teams all while caring for patients.

In terms of clinical practice, the value placed upon hands-on practical experience was highlighted by several participants who acknowledged the shifts in nursing education for RNs and LPNs. Again, this connected to the earlier explored concept of theoretical vs. practical experience. As the following quote illustrates, LPNs were thought to enter the clinical practice setting with more hands-on experience compared to RNs.

> R#12: I find LPNs are more prepared. That's my take. They have more hands-on experience than the nurses coming from St. F.X. Yeah, I find the LPNs have the more hands-on. And the RNs coming in have more the book smarts of it all. But with procedures and stuff like that, it's different. Like LPNs are bang on their stuff.

Questioning this dynamic permitted participants to raise important questions around profession-specific beliefs or assumption and policies that were thought to reinforce many of these assumptions. For example, one participant shared how they were often assumed to be an RN because of their demeanor and approach to nursing. This participant explained how people were often surprised to learn that this participant was an LPN. Additionally, LPNs were aware of the hierarchy in nursing and some participants were inspired to advance in their career. This sentiment was highlighted from the LPN perspective in terms of career advancement and progression. However, the concept of nursing hierarchy conflicted in participant accounts. In one instant, participants acknowledged the importance of competency and not conflating that sentiment with a title. Yet, participants also described the desire to advance in their careers. For most of these accounts, it is unclear whether the desire to advance and progress in their career was from a more internal desire or whether the push was linked to power dynamic within nursing and the institutional forces more broadly.

Recognizing the inherent power dynamics, participants pushed back against the beliefs and directives that created and reinforced an unhelpful power dynamic between LPNs and RNs. Participants who identified as RNs felt as though LPNs were more than competent to care for complex patients and they did not agree with the restrictions proposed by policy that used language and sentiments to suggest otherwise. The display of competence and leadership from LPN was evident in participants' description of their role in caring for patients as well as being an active leader in the healthcare system more generally. Many participants felt that more emphasis should be placed on competence rather than defaulting to title and scope. Again, from a community-focused lens, it is more about competency and capability rather than a default to title.

R#16: So on that floor, it's RNs only. It was because it's so acute that like LPNs didn't, I guess… Quote, unquote, they tried to say the LPNs don't have the qualifications. However, LPNs are doing more. And I would stick up for them on my other floor because it's like you guys are giving the heavy loads to the LPNs when you're all RNs.

In addition to navigating the legacy nursing tensions, integrating into the nursing professional was described as a challenging feat by several participants. Specifically, participants described the challenge of finding common ground to connect with colleagues. It was often felt that efforts to integrate did not result in feelings of acceptance into the 'profession' or group. Some participants attributed this to race and felt as though being Black added an additional barrier or consideration to the integration. While others described how several social constructs, including gender and class created an additional barrier for the integration into nursing. One participant's account shows how a diminished sense of belonging combined with daily microaggression were enough to consume someone's mind and spirit, is depicted below.

R#3: There's so much that needs to be repaired in terms of like, you know, I see, when I was in clinicals, how they treated Black people, how they treated cleaners, how they treated, you know, the unit aides, the amount of disrespect. Because I know if they're treating them like that, how are they going to treat my Black face if they're treating the white person that's the unit aide and the cleaners like garbage? And they're all separate. They don't even acknowledge or say hi to them. You're not acknowledging me. I can't go to work every day feeling those micro racial aggressions and thrive. I can't because it consumes my mind and my spirit.

In addition to the above sentiments, several participants recounted instances of surveillance and feeling excessively scrutinized. The feeling of being watched or being under surveillance offers an example of the ways in which 'Black tax' exists for some participants.

R#7: Well, I feel like it would…it will always have an effect. But I mean it's hard to…it's sad to say that because there aren't enough of us. Like you're always… Like I feel like I always have a different experience than somebody else. Like I always feel like I have to do things like 100 percent right because if I don't then the next nurse will come on, and the patient will be like, "Well, it was the Black one," and everybody knows who it is. You know what I mean? So I found that it kind of made me work harder and want to be better for myself and for my patients. And just always keeping my head high and owning up to everything that I do as a nurse, making sure that my assessments and all that stuff are good, and just being a great leader for the patient and for like the interdisciplinary team.

Another participant quote reiterates this notion of being watched. However, as the quote reveals, this participant was being monitored by their manager – via surveillance camera – after receiving reports that the participant was not responding to call bells on the unit. After reviewing surveillance footage, the manager explained the situation to the participant. The participant shared their frustration with the clear failure of transparency and accountability, which participants suggested is used liberally against Black nurses but never in their favor.

> R#8: So the next time I went back on my day shift, I got called into the manager's office. And she said, "[Participant], I need to speak to you." And I said, yeah. And I said, what's going on? She said, "First off, I was told that you don't answer the call bells when the call bells are ringing. But you can just disregard that because I watched you all morning, and you don't stop." So I'm thinking, well, if you watched me all morning, why are you bringing this to my attention? Go back to whoever told you this blatant lie about me and correct them.

7.4.1.3 Subtheme 3: Nursing Education: Primed for Praxis. The third subtheme within the larger theme of *Black Tax in Nursing,* examines nursing education. Participants discussed the challenge of being "the only one" in their program and the gaps in nursing curricula that created disagreeable circumstances in class. These experiences occasionally forced participants into early nursing advocacy, where they were called on to be the spokesperson or to teach others, including professors. For example, participants explained how they were often either the only one or one of two/ three other Black students in their class of almost 200 students. Not only did participants find this to be challenging, many shared how aspects of being a non-traditional student greatly influenced their experience in nursing. For example, standing out as the only Black student was tough however, adding the additional layers of being a mature student, a working parent and a first-generation university student, compounded the effects.

> R#7: Like in my nursing class, I only had… like it was me and another Black girl in our whole like class of like 180 or 160 students. So as a student, like when I would go like in our clinical group and all that kind of stuff, I always felt like I stood out. You know what I mean? But I always felt like I stood out in those different situations.

The next participant quote expands on this idea by illustrating how each of these unique circumstances created a dynamic that several participants described needing to navigate.

> R#3: There were just a few of us. I thought in a room of 130 people, I'm like holy crap. You know. And coming from TYP to being in a room full. And TYP was the most exhilarating in terms of I felt

comfortable. I felt very uncomfortable going to Dal and being in... But, you know, I had the Black Student Advisory Centre, I had the TYP house where I could go, and I had these meetings that we would have monthly - meet and greets – and stuff with, you know, other people from other… you know, Black nurses and the mentors, and that kind of thing. But it was very intimidating. Very intimidating. And most intimidating because of the environment and feeling like I never really… I don't have any nurses in my family. I don't have any doctors, anybody that's done a science degree. Like who am I going to talk to about this? When I look around, like a lot of these people, I think probably come from families of nurses and families of doctors, or at least know somebody, and talk in this lingo, and…you know. But it was not only being in an environment that I didn't really feel comfortable in or accepted in, like there was nobody really gravitating towards me and saying, "Oh, would you like to hang out?" Plus, I'm a mature student. I'm not doing what they're doing. I'm leaving from school and I'm going to work. I have children already. So that element as well, I felt outside. And then, like you know, I'm there and I'm feeling like, okay, I don't really fit in here for a number of reasons. And I was struggling to find that kind of place. And, you know, your assignments sometimes you had to do with partners, and all that kind of thing. So it wasn't easy. It wasn't easy. So, you know, those things were definitely impactful. And at times, it was just kind of like how am I going to do this, how am I going to get through it? But it was my friends that I came through TYP with that kept me grounded in that. You know, because we would still meet up at different times and still go places and do things.

In terms of the content being taught in their nursing programs, participants consistently described significant gaps in course material. Participants shared that they did not receive education related to patients who were not white. However, in the rare instances when other ethnic or racial groups were incorporated into teaching, the content was described as being extremely stereotypical and prejudice.

R#14: We're like taught from like a white perspective, like a European perspective. I found that in classes like they would teach things that weren't true. Like we did the Tina up thing where you talked to Tina on the computer. You had to like interact with her and try to give her… You had to like be good at asking the questions so you could get the actual answer. So they were saying that there were all these things wrong with Tina. And some of them like were true. But there was one thing that they commented on, which was like the darkness around her neck and how that was a health issue. And I'm like it can be, but lots of people who are darker complexion just naturally have that discolouration around their neck. But they were putting it like all my classmates' head that that's just automatically wrong. So I'm like, you know what, you're going to go into the workplace and you're going to offend someone who's Black.

> And guess what, you've just ruined that like relationship from being anything, because that's not true. So I felt like they were just giving false information. And then also when they would cover a topic of anyone who wasn't white, they would just be like, "Oh, you'll see something different." But they never told you what you would see that was different. Like they'd be like, "Oh, you're looking at oral mucosa. And for someone who is white, it will be pink. And for someone who is like black, it'll be a different colour." But then the next topic just starts. And you're like, well, what colour is it going to be? Like how am I going to save these lives of these people if I don't even know what's going on?

Other participants recall the only course in their nursing program that attempted to introduce students to aspects of diversity and other factors that impact health. Participants remarked how this course, despite effort to address concepts of diversity, usually created more issues. The following two quote highlights two separate experiences in this one course. Each shares the drawbacks and how the course missed the mark. The second quote provides additional depth related to their experience of being assigned to present on a Black population without receiving any form of education on various racial or ethnic groups in Canada or Nova Scotia.

> R#11: Just one course. Yeah, one out of the whole four years, right. And it was trying to cover like a lot of stuff in terms of social determinants of health, right. So yeah, that was very miniscule. I don't know what the curriculum is like now, but certainly I think there does need to be a greater inclusion of diversity, of race, of religion, of, you know, gender identity -- all these sorts of things. Like kind of more relational things of…

> R#16: Well, for that class, it was actually like the teacher assigned like each group. I don't know, a group of people to discuss. And I think my group was Jamaica or Jamaicans… I don't know, I just think that the course, it was just us doing a presentation on a group of people. Like that's what the whole course was. Instead of them, they should be teaching about Black people. They should be teaching about native people. Yes, of course they teach about white people. But you need to teach about who else is here. Like now even there's more Asian people, there's Syrian people. So it's like they need to cut the crap with the presentations that we need to go find the information. I think they need to get the information and present it and quiz people on…you know. Like you know about Black people. But even in regards to medication, because medication affects Black people differently.

Lastly, nursing school was a primer for praxis in that participants often developed a sharp and eloquent way to critically assess situations and determine when it was best to voice their concerns. A few participants described instances where they were placed in situates whereby the onus of educating classmates and professors

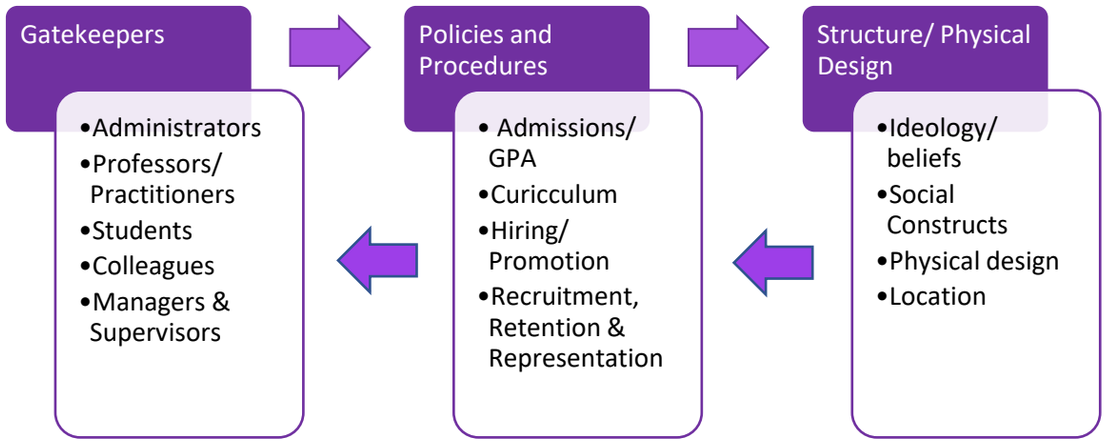
fell upon them. This often required the participant, who was one of two or three Black students, to provide a history lesson on the experiences of Black people in Canada, explain the social determinants of health and justify strategies and initiatives such as Affirmative Action.

> R#10: There were some heated topics. And, you know, I remember I think was just me and one other ANS student at the time in this class because we always kind of followed each other and tried to stay in the same classes together just for support… And I remember there were some heated topics about like employment equity and affirmative action. And, you know, of course being a predominantly white class, there were some people who would say like, "I don't believe in affirmative action." And I was like, wait a minute, like, no, no, no. Like… And then I hate to bring up like history, and like social determinants of health, and like how we have systemically been oppressed. And I hate to bring up like the Black card, as people say. But I was just like we are just…we are in the condition we are based on like systemic issues, like historical issues. Like there's nothing we can do change that. But I feel like white people just don't understand that. And I felt like at that point, from a leadership perspective, I was advocating for my population and my community. That was big in a nursing school from a nursing student perspective, right, about leadership?

7.4.1.4 Subtheme 4: Invite Only!: Gatekeepers, Policies and Structural Design. This subtheme builds on the previous subthemes in this section to show how a bidirectional current heightens the Black Tax in nursing and perpetuates the insulation of the nursing profession. Specifically, the process is implicated during integration at the educational or training level as well as the professional practice level. The bidirectional current includes three layers that serve to uphold and reinforce each other. These three layers include gatekeepers, policies, and structural design. Figure 10 depicts this process. centers around the notion of having to prove oneself in order to gain entry and acceptance into the "in group" of nursing. This process of integration was described by participants at multiple levels including gatekeepers; policy; structural. It is important to note that participants placed more emphasis on the gatekeepers and policy layers however, few participants spoke about the structural layer.

Figure 10

Process of Integration into Institutions



As a bidirectional process, it is possible to view and examine this from either direction. Going from left to right, beginning with gatekeepers, this level depicts personnel or individuals who utilize institutional policies and procedures to uphold and reinforce institutional ideology, which acted as a concrete ceiling. The gatekeepers were described as operationalizing policies and procedures in a discretionary manner, which was often discriminatory. This was done in order to safeguard the profession by filtering out less desirable or seemingly "unsuitable" candidates, in an attempt to maintain the purity of nursing.

Some participants described how administrators, or other individuals who served as the initial point of contact, for accessing information in entering nursing were not only dismissive of the participant's inquiries but mislead or misdirected participants. For example, the following quote includes a recount of an exchange between one participant and their interaction with an administrator involved with admissions.

> R#16: I remember the day I went to… What's that lady's name? She's probably still there. The one that does the initial, that you apply to get into. Oh, what is her name? It's at the School of Nursing. You know when you go there and you fill out your application forms and all that stuff. So she was like showing me the papers. And I'm saying, okay… I'm looking the courses. I was like oh, I can't wait to take this course, I can't wait to take this class. And she's like, "Well, you've got to make sure you get in first." And I was like, oh, I'm pretty sure I'm going to get it. Like that type of attitude. I'm like no, like I know I'm going to get in because I just know. And she's like, "Well, don't start picking things now. You better get in first."

Another participant describes a similar exchange with an administrator where they were misdirected and almost missed the opportunity to enroll. Gatekeepers were described as intentionally withholding crucial information, such as the status of an application, or discussing program information in a manner that made assumptions about the ability of the participant to enrol in the program. As shown in the quote below, gatekeepers often serve as the initial touch point and these interactions often have a significant impact on the outcome of the experience.

> R#3: If I had walked away upset and not spoke with anybody, I mean that would have changed my whole life, I think. It was potentially life changing. Like you know, because I wasn't accepted into any other program. I didn't apply for any other programs. So anyway. So that was my first experience with the School of Nursing.

Beyond the academic setting, gatekeepers were implicated in career progression and advancement as well as perks within the profession or healthcare system. One participant described the challenge of being overlooked throughout their career despite extensive experience and qualifications. The notion of nursing being an "old girl's club" was used to reinforce the idea that the nursing profession is an exclusive club into which members are analyzed and critiqued for suitability according to factors beyond their nursing abilities.

> R#4: I feel honestly, and it's a shame to say in this day and age with everything that's evolved, I feel very much that if I was somebody that was Caucasian, that I would have been further ahead than what I am now…And even now where I'm at, I know that it just feels like the old boys club or the old girls club. And, you know, it sparked me into almost writing a book called If Only They Could See Me or if they could see me. And so I'd write the story about my life and what it's like. But I really do think that my race has a lot to play with the fact that I haven't been in leadership positions. But even still, I know that I would never go higher than that. And, you know, I guess one has to sort of resign themselves to the fact that it is what it is. But I really do feel that if I was born a different color, I would be a lot further ahead with the experience that I have.

The second level includes the policies and processes that are constructed from the ideological design, which were crafted to the intentional and unintentional exclusion of specific groups, including Black people. Concepts of meritocracy fall into this category, which includes the policies and procedures such as hiring, admissions, curriculum, representation in addition to recruitment and retention. Again, with this layer, participants recalled how these policies and procedures were often weaponized against them. A few participants

highlighted a discrepancy between the university admissions requirements for the nursing program and core elements that actually contribute to someone being a successful nurse. The participant explained:

> R#18: Like I don't know how it's helping the Indigenous or the Black students grow in number. But that's just me. I'm older than a lot of the children coming out of the school now, so maybe I'm out of touch. But to have an expectation of I think it's like 90-something, that to me it's very… I know that you want the marks to be even, you want everybody to be on the same processing of the information, and should be able to understand science, biology, chemistry that's going to be needed, statistics. I get that. But I do think that the limits have been set so high that you may see a dwindling in the people that actually go towards those roles.

In addition to policies and procedures being used as a means to keep participant out, there were limited processes available to file complaints or grievances. Participants shared how a lack of transparency or sufficient channels made this particularly challenging. The following quotes capture how participants described the inherent challenges of being unsure as to where to go with concerns or issues.

> R#6: The other thing is that there needs to be a place where people feel comfortable - nursing students or black feel comfortable talking about their concerns without being penalized. And I don't know if that happens. You know, I'm not sure whether they have that or not, you know. Because I know people who have dropped out of the program and, you know, they didn't feel that they had anywhere to go with their concerns.

> R#18: I've actually had to go to the union. I put a claim in with Human Rights. And the union, you know, I got pushed around and pulled around. It wasn't the supportive backbone that I was expecting. You're only given a year, right. Which I don't think is fair. But hey, I'm biased because I've been in the situation. You have a year to…basically from the date of to bring it forward to them. So if the union bypasses that year because you're doing meetings between them and the institution, how can you bring a claim to Human Rights? And you're not even made aware of it.

7.4.2 Theme: Nova Scotia Healthcare as an Archaic Institution

There were a number of participants who had clinical practice experience in other contexts including different provinces and countries. For these nurses, the Nova Scotia healthcare system was compared to the healthcare system of other provinces and countries, which were considered to be more progressive and advanced in terms of patient care and concepts or ideas regarding health and personhood. The gaps and drawbacks within the Nova Scotia healthcare system were more strongly identified by nurses with experience

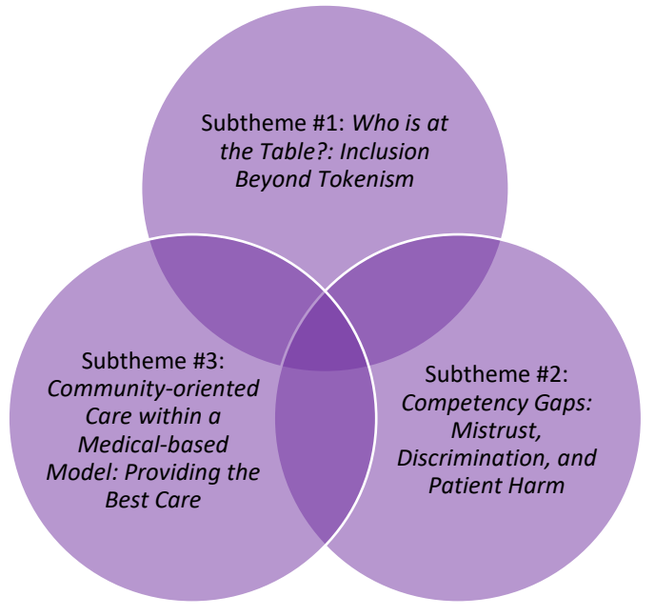
practicing in another jurisdiction or context however, nurses with a dominant Nova Scotia-based practice also identified major drawbacks and challenges with the system. This is amplified by the perceived lack of empowerment for patients. Participants who had practice experience in other jurisdictions outside of Nova Scotia remarked on this. The follow three quotes contain explicit views about the Nova Scotia healthcare system.

> R#4: Honestly, I see it more in Nova Scotia again than I do anywhere else. So I don't know, I still think Nova Scotia is backwards and they still need to come to grips with the fact that the world is changing around them.
>
> R#1: I find Nova Scotia doesn't really hold or promote like educational and leadership opportunities. Whereas in another province, I found there was always like conferences and workshops, and there was funding with the hospital and the union to go to take advantage. Whereas I don't find either of those in Nova Scotia.
>
> R#2: Because I mean if the same stuff is going on in Nova Scotia that's gone on for the last… Some things have gotten better but there's still not as much as there should be. The gains are not as it should be. And Nova Scotia is a small place. So you have more opportunity. Like Toronto is a big place. You have to find your way around to find what's what. Nova Scotia, you could call somebody and somebody will know something that can lead to something else, that can lead to something. Do you know what I mean?

As described, the overarching theme of *Nova Scotia Healthcare as an Archaic Institution* is further divided into three subthemes that both build upon and expand the understanding of the healthcare system in Nova Scotia and the ways in which it is perceived as an institution. Figure 11 illustrates the subthemes for this overarching theme, which include *1) Who is at the Table?: Inclusion Beyond Tokenism; 2) Competency Gaps: Mistrust, Discrimination, and Patient Harm; 3) Community-oriented Care within a Medical-based Model: Providing the Best Care.*

Figure 11

Section 2 – Theme: Nova Scotia Healthcare as an Archaic Institution



7.4.3 Subtheme 1: Who Is at the Table? Inclusion Beyond Tokenism

Who is at the Table? Inclusion Beyond Tokenism encompasses several different components including diversity of ideas, processes as well as the people or healthcare providers within the system. Inclusion beyond tokenism was conceptualized as a way to describe the participants' accounts of navigating an institution and spaces that were complex and layered. For example, the push towards meeting a quota often left participants feeling as though they were being used by organizations, institutions or people, to show that they have a Black person as part of the team. The other challenge that participants encountered was the power dynamics that existed when participants were the 'only ones' at the table. Some participants recount how their contributions to discussions were dismissed and how non-verbal ques were used to convey disinterest and even disrespect. This also caused internal conflict where including diversity for the sake of diversity was viewed as conflicting. In one instance, it was great to see this move towards more inclusion of diverse individuals. Yet, participants also questioned and wondered about the motives of stakeholders.

Diversity as described by participants in this study, was considered a simple yet necessary way to inform care delivery and foster trust, on multiple levels. Whereas a lack of diversity was regarded as harmful to both patients and collegial dynamics. One participant explained the importance of diverse representation and visibility in healthcare by describing the how it relates to the ANS community by helping patients feel more at ease in an unfamiliar environment.

R#7: So I'm a really big advocate for Black people in the healthcare field because I feel like it's really needed and it's important, especially in Nova Scotia, because we have such big Black communities. And like I said, for them to feel represented in the healthcare field. Like when they see you, it's just like it's amazing. It's a good feeling…Well, for me, I am, like I said, like I'm a real big advocate for nursing and trying to get more Black nurses in the hospitals because I know the way that the black community feels like when they see a Black person. Like it's like I'm the best thing in the whole wide world. It doesn't matter who I am, any of that stuff.

Another illustrative quote expands on the common thread of the importance of visibility and representation in healthcare from the patient perspective as well as operationally. ANS representation in nursing and in healthcare was regarded as improving health outcomes for the community by incorporating alternative experiences and information into care directive and institutional policies.

R#6: And patients have stated how good it is when they come into this place and they see that there are Black nurses here that understand what they're going through, who may have been in the same shoes that they've been, who have dealt with racism at the workplace, who have dealt with racism and classism, you know, throughout… in Nova Scotia and in the HRM. And so, you know, they feel great about having someone that understands and that knows. They don't have to explain everything to the last detail because we understand. So that's one of the reasons why I think that we need Black nurses - because we need to mirror our community. You know, this is our world that we live in. Yes, why shouldn't we have Black nurses? Why shouldn't we have Asian nurses? Why shouldn't we have, you know, people that represent this community? Yeah. But Black nurses are crucial, right. In this space where I'm working., we need to have Black nurses.

This same participant continued:

R#6: The other reason is that when we come to a hospital, health centre, physician offices, we bring another perspective. There are things that I recall when I first started working here. You know, there wasn't any kind of testing for sickle cell anemia then, you know. We meet regularly here to talk about things that need to be implemented. And one of the things many years ago that we talked about was having screening for sickle cell. And so, you know, now we screen all prenatal patients. So we bring a different perspective. So people can see that, you know, it's not only, you know, PKU that needs to be screened at the IWK, it's not only thyroid for infants, we need to be screening Black babies for sickle cell anemia. And so we can see things through a different lens when we have Black people, Black

healthcare professionals working in an area, you know, and we can bring a perspective that wasn't there before.

Inclusion beyond tokenism was thought to extend into how information and content regarding the ANS community was incorporated [or not] into policies and teaching within healthcare. Several participants highlighted the blatant omission of information that reflects and incorporates the experiences of ANSs. Ranging from the failure to acknowledge ANSs as a distinct people with a specific yet varied experience of Blackness to the exclusion of fulsome and reflective content to the basic understanding of the historical circumstance of ANSs. Participants felt that including content that situates ANS communities, their history, and includes a growing understanding of their health needs would enhance the overall function of the system. This information was considered to be exceptionally vital for healthcare providers and patients, especially those who may be unfamiliar with the historical context of Nova Scotia and the Black community. As one participant explained:

> R#11: Certainly I see that there's a bigger push. I know like the one thing I find that's tricky that I've had a conversation with one of my co-workers is when people kind of include diversity for the sake of diversity and not…so that they can say, "Oh, this, we're diverse. We're including these individuals," in a certain experience versus… I guess the motivation of why people want to include those sorts of experiences. Now, do I care their motivation or should I just be happy that we're having opportunities to hear from more diverse individuals? So I feel like we are… Because people are expressing that, we're trying to have more experiences that have more awareness.

Again, the motive behind decision-making and planning was called into question as some participants explained that it usually felt as though incorporating ANSs into the equation was always an add-on or after thought. Often times, the inclusion of ANS community members or voices in healthcare was seen as performative and strategic as opposed to an honest investment and interest in improving community circumstance. This was contrasted with other historically marginalized groups in Nova Scotia as well. Participants expressed frustration with the fact that ANSs have been in Nova Scotia for over 400 years yet there is so little known or incorporated into care directives. While information that is known or shared, was regarded by some participants as inaccurate, false, over-generalized and included harmful stereotypes. The need to include ANSs in decision-making and planning

Further, being the only one at the table was lonely, with one participant describing how some nurses did not want to be 'sitting at the table' in recognizing that they would be sitting there by themselves. Being in a space where you are the only one and feeling as though you are not listened to or valued was a challenge. This

same participant recounts how, despite their position as a charge nurse, that their voice was still discounted and they were made to feel as though their input did not matter. The following three quotes weave together the notion of invisibility in leadership spaces as well as the desire to connect with colleagues in order to be seen.

> R#3: Like you know, when we say nursing leadership, I use us sort of like in roles in collaboration with other professions. I see that as us being at the table, at the leadership tables. I see us being at the leadership tables within organizations, and designating from our body who would be the best person in terms of the skillset to be at that table, you know, and to voice the concerns, to articulate the concerns. But has the confidence to voice concern. Because so many times when we're on our units and they're asking us questions or concerns, we're not heard. We're not even seen. So we don't have a voice. So, you know, that's my dream. And I hope I get to see it before I die…And I think I've got a lot of years left. Well, I hope I've got a lot of years left.

> R#13: Oh, goodness, it's challenging. So I specifically have Black nurse colleagues at work who I will connect with. And we try to, you know, either get together for lunchtime or, you know, like if we can time it so that we can all kind of go for like a walk together or something on a break, we try to do those things. Because you need a space where you're not the only one who looks like you.

> R#3: We're struggling at the bottom, trying to get up. And some of us don't even want to be there because we're sitting at the table all by ourselves. And you're not listened to, you know. I mean I've sat at Capital Health tables in leadership meetings, being the charge nurse, being around the leadership table in Addiction Services, and I may as well have stayed on the unit and worked with the clients because my voice meant nothing. I could talk and they'd be just like I'm not talking. I may as well not talk because they don't hear me. They don't value my opinion. They don't value what I have to say. And that's evident. It's blatant. I've sat in leadership meetings where the director literally turned her back to me as I'm speaking and rolled her eyes at me.

This led to the discussion around the need to actively recruit nurses and other healthcare providers from the Black community. And it was felt that ANSs should have a voice at the table and that the community voice should be included in any programs or initiatives that are being established. The following two quotes illustrate participant views on the integration of diverse voices and ideas into decision-making.

> R#5: Well, that's the operative word. We should have a voice at the table. And any programs that they're setting up should involve us. We should be involved. Like, for example, if you think here when, you know, I'm feeling really proud that yes, we have a person who is the African-Nova Scotian health

consultant. However, for at least 10 or 15 years, we've had the Francophones, we've had the gay, lesbians, we've had the Acadians. So why are we always just an add-on? Because we are a group, you know. And to have to fight for that, you know. So I think that it should be automatic when you're setting up a program of any sort like that, it should be…there should be somebody Indigenous… You know, you should cover everybody, not just be an add-on, and not be told that your numbers are small.

R#11: You know, I think I've always been super aware that there's no one else that looks like me. I think that's like an apparent thing unfortunately in my unit. Have I had negative experiences related to that? No. But certainly I think that, you know, it is… Like it's sad to me that there isn't more. Because again, like I said, growing up, what was important to me is seeing myself reflected in society, right. And so if you're coming in and you don't see yourself represented or reflected… And for me, I had never seen that in nursing. So, you know, I am grateful that I get to be a representative. And I take that very seriously, and it means a lot to me that I've been able to be in a position in my life that I've been able to gain the education that I have, and have opportunities for leadership because it is important. I think anytime someone is in a leadership position that is of a minority, it's an important and incredible, and something that should be celebrated. And you know, our physician team is quite diverse, I find that. But our nursing team is still lacking.

Racist views perpetrated by patients followed a common pattern in that most occurrences involved older patients or those with debilitating mental health disturbances such as dementia or Alzheimer's disease and in practice settings such as long-term care facilities. In terms of age, participants noted generational differences and how some ideas and beliefs were much more common and acceptable years ago. Patients who were from a certain "era" were considered to be stuck in a time when using derogatory language to refer to Black people was acceptable. One participant described how, early in their nursing career, they felt as though they startled a patient because the patient was not use to seeing a Black person in such a position but rather in lower societal positions ie: as servants. This was also evident by the language or terminology that patients would use in reference to participants. For example, participant described several antiquated and derogatory terms – some of which are no longer used or have a connection to a specific era or time period. In addition to age or being from a specific era, participants also described how patients who experienced age-related debilitating mental illnesses such as dementia or psychosis, were more likely to express racist views. The nurses again expressed that the racist views did not bother them as much. Similar antiquated or derogatory terms were used by patients with dementia or experiencing psychosis. The following series of quotes are shared by various participants and

capture the challenges that arise in specific healthcare settings with older patients and those who experience mental health disturbances such as dementia and psychosis.

> R#2: You know, I'll forgive you if you're psychotic. I've been called everything. I thought my name was bitch once. You know, I've been called out of my name a few times, and stuff like that.
>
> R#4: But I still have to say that, you know, like when I think of my nursing career and I think of colour, I would just remember that period like working the night shifts. I hated night shifts because of it. Where every time I turned, somebody or whatever, I would startle them. And that was because I knew they were used to Black people as slaves or Black people not in that kind of position. And I just put up with it. I just did it because they were elderly and they didn't know better, right. And I certainly don't get that anymore. That's one thing I will say, I don't get that anymore. But, you know, it was really quite poignant then.
>
> R#15: Oh, patients, all kinds of shit. I get so much stuff with, you know, dealing with the elderly. And it's always the elderly of course.
>
> R#16: But when you have a few white patients that are in psychosis, it's like, "Oh, Black this and Black that." And I'd be like really? Like I'd just, you know, laugh at them because they don't know what they're saying. I'm like that don't hurt. Like you know that doesn't hurt me, right? Like that doesn't bother me. Like they would think that that's affecting me. But nah.

Often, when participants encountered racism from patients or colleagues, there was no follow up to deal with the matter. A few participants shared how colleagues would reassure them that comments were not that offensive, were a joke, or should not be over blown. These types of responses, or the failure of supervisors to adequately attend to matters, left participants feeling at a loss for how to deal with these recurring situations.

> R#18: Yes, I would say that. Yeah, I can't say that it hasn't. And I've been asked to not come into patients' rooms that I've been given because I don't look like anyone who they've seen in their experience. I've been told I don't speak properly, and they would not like to see me for the rest of the shift. And then when I ask to be switched, it's humming and hawing. Meanwhile I'm fighting back tears because I've never been told that I don't articulate right, I don't look like anybody else that's taking care of me at this point, and what could I ever be able to help them with.

Racist views and sentiments were encountered by participants during their clinical practice [while in nursing school] by patients as well. Participants described feeling singled out from other students, based solely

on appearance. While it may appear as those age and mental health status offered a ‘temporary pass’ for the expression of racist views, one participant described a scenario where she decided to engage in the process of teaching to assist the patient in understanding the inappropriateness of their racist comments during their student nursing clinical placement. This participant took on the burden of educating a patient about racism. Black tax during nursing education. In the first quote, the participant shares how they were usually singled out by their appearance.

> R#7: So like I remember like one of my first clinicals, it was at like a nursing home. And of course, like a lot of the residents had like dementia and all that kind of stuff. So I just remember like… And it happens still to this day, that like some of the patients would like call me, “Oh, like the coloured girl,” and da-da-da. So it just made me feel like I was more like sticking out. Like I'm a student like all the rest of these guys are student. So why is it that I have to be identified by my appearance? Do you know what I mean? Like I'm doing everything that I should be doing. But I guess it's just with the times. Now it doesn't bother me as much as it did back then.

Another participant recounts their encounter with a patient who used a derogatory term in their presence. This participant explained how they dealt with the situation and how it forced them into a. unique situation that their classmates did not encounter or have to endure.

> R#10: Oh, my gosh, yes. And then you feel like you're all alone. You feel like in a sense you're all alone. It’s like my God, I have no one that looks like me, no one that can relate to me. Of course as a nurse, you encounter things just being visibly Black. It's just a given, especially in older populations, I find. Oh, my gosh, I’ll never forget the first time I had an older man where I used to work, like he said ‘the n-word’. And I was like whoa! It was like oh, my gosh, as a student, I was like okay… He used the word. He didn’t say it to me directly but he said it in conversation to refer to Black people. And I was really assertive, and I was like okay, you can't use that word. It's a derogatory term towards people that look like me. It’s very offensive. It's going to affect our patient-nurse relationship, I said. So that's not acceptable. You cannot use that word. Like you cannot. And he was an older man. And he was like, “I didn't mean to like say it like that.” I was like I get that, and I get that you come from a time where it was more acceptable to say that. But now in this day and age, it is unacceptable and it's highly offensive.

The participant continued:

> R#10: It was so hard. And I remember when I told my instructor… Just because I was so like mentally strong, right. She was like, “Do you want to keep this patient?” I was like, oh, 100 percent, I’ll keep this

patient. I just wanted to let you know that I was very assertive and told him. I said, if it continues… And I was, obviously if you want to change the assignment. But it's funny because he actually liked me and he would look for me and he's like, "Where's [participant]? Where's [participant]?" But I just had to explain to him. Because a lot of people from that population, they just, I hate to say it, but they're ignorant. They just… They don't know. Some of them, they're just so used to saying that. And I'm like, no, it's not acceptable. Not at all.

7.4.4 Subtheme 2: Competency Gaps: Mistrust, Discrimination, and Patient Harm

Competence in healthcare is an important subtheme as it has significant implications for the care provided to ANS and Black patients, which relates to the level and degree of trust. Trust in the healthcare system, including the providers, was believed to be enhanced by competent care provision. Nurses felt that this had significant implications for the health and wellbeing of ANSs as well as the greater Black diaspora. Throughout this study, nurses remarked on the quality of care provided to ANSs as well as the information that informed the care directives and decisions made by HCPs. Nurses emphasized the necessity for policies and care decisions to be evidence-informed, which includes evidence generated from avenues beyond the traditionally accepted approaches. Participants described the ways in which trust was established and nurtured between themselves [as nurses] and with the community.

Needs of the ANS community are often missed and fall through the cracks in terms of service delivery. The fact that ANSs and competent approaches to care with this population caused confusion amongst participants who believed that the historical legacy of ANSs in the province [Nova Scotia] warranted more comprehensive education and training that included working with this community.

R#4: We've been a marginalized population in Canada, let alone Nova Scotia. You have some patient advocates, like Aboriginal patient navigators. Do you have any Black patient navigators? You know, there's nothing like that. So one of the things I see is we've certainly not done ourselves any favours with bringing up anything in the curriculum to do with Black people.

R#10: When I first started, my heart was in community nursing just because I wanted to work in a place where I could support a population that looked like me and that had various social determinants of health that I could relate to, right. I feel like populations like people where I come from, from a low income neighbourhood, they're the type of people that fall through the cracks. They refer to some people as frequent fliers. We don't get the same level of healthcare as more affluent populations. So I wanted to work in that setting. I did a clinical at North End Community Health Centre. I loved it there. It's like I

would love to work here. Like this is where I feel like I just would love… I loved the environment. It's a collaborative practice. But everyone's telling me, [Participant], get your two years at least of med surg experience and then, you know, you could transition. So I was applying for med surg jobs. Because a lot of the qualifications I felt I didn't meet, and it was frustrating because, you know, even if I saw a community position, I just didn't have the experience, right. And even some surgery, med surg jobs, they're like you need this many years experience. I'm like how can I get my foot in the door? Like everything you need like some type of experience, right.

The gaps in healthcare were particularly pronounced and affected patient populations who were historically marginalized. Examples of gaps in care for ANSs as patients, as observed and shared by participants, related to basic hair and skin care as well as a general understanding of life circumstance. Participants remarked on how receiving poor treatment from practitioners in the care setting led to the perpetuation of distrust.

R#8: I had one of the patients from our community. And they were brushing her hair, and this and that. And I said, whoa, you guys, she needs oils in her hair, she needs grease. And they're looking at me like I'm crazy. And I'm saying she needs lotion on her skin. Like put some cream on her. Like you know what I mean? But our skin needs that daily.

While in relation to skin care, one participant connected the value of having diversity and representation in nursing practice and the healthcare setting. Incorporating the variations and complexity of lived experience meant that people from historically marginalized and excluded groups could inform care delivery and policy development. The following quote displays how one participant experienced this.

R#6: You know, it's awful, I recall back in back in the '80s when we would do backrubs. The nurses would do backrubs. We used to use Alco gel. It was called Alco gel. And that was pure alcohol. It's bad for anybody's skin. But for Black skin, it was horrendous. And so one of the things that I spoke with our manager about was can we have a different kind of cream? Can we have some Vaseline Intensive Care at least? You know, because this is very harsh for the skin.

Participants went further to describe the dangers of assumption-based care. The following two quotes display an extremely harmful power dynamic that reveals how assumption-based care paired with a lack of understanding community practices has the potential to lead to unfortunate circumstances such as the removal of children from a family. Not only do the following two quotes show how prejudice and stereotypes exist in healthcare, they also show how competency gaps in nursing practice create more harm than good.

R#6: Even as far as when newborns are born, black newborn babies are born, they have Mongolian spots. Well, I think everybody knows what they are now, hopefully. But back in the day, you know, I recall a woman who came to the black women's health program, she said that they called community services on her when she brought her baby in for a check-up to the IWK. Community services was called. She was put in one room, her baby was put in another room because her baby had bruises on their back, on his back and on his backside. And it was Mongolian spots. This was a newborn, you know. And anyway, so I guess the other reason is so we can add to the knowledge about our race, about Black people, you know. Because it just needs to be… There just needs to be more information. People need to understand. Not only just understand our physical, things that are physical, like sickle cell anemia, like Mongolian spots, but also understand… you know, to understand a bit of the history. What has that person encountered in their life? What… You know, what kinds of things have they dealt with before they come into this centre or before they can go into a hospital, and they're upset and they're angry because you said something? Can we just bring another perspective? Can you have somebody who understands, you know, who maybe can shed a little light on that situation? So that's another reason.

Another participant expounded on the potential ramifications related to assumption-based care or stereotypes that were poorly informed.

R#18: Like in particular, like speaking up for me, maybe a resident, and just letting them know, well, the things that you may feel are making you think that a patient isn't qualified to take care of their child because they don't make eye contact with you. It may be something that's cultural. And speaking up and just letting them know. Well, you know, there's a history here that you may not be aware of because you're not maybe from this province and the interactions with this particular community and coming into the hospital setting.

In addition to the distrust that was reinforced by poor care, participants were vocal about how off-the-cuff comments by colleagues and their prejudice against the ANS community – and racially visible groups in general were often tone deaf and increased the likelihood of diminished care. The following quote captures this sentiment.

R#6: And I was tired from going into a room with other staff, and the room going silent as soon as I dropped in because they had been talking about, oh, Mr. so-and-so from this community, or Mr. so-and-so from that community, and oh…you know. And all the people that come in to visit, "Oh, here they come again with their entourages," and that kind of thing, you know. And I was really tired of it. I was

happy in one sense that when I was assigned to patients that I would get Black patients because I could help care for their skin properly and their hair, you know. But it was also a statement about the staff and the nurse managers that I worked with that…and I had to address that, you know. And I appreciate you assigning me with patients of African descent because I can care for their hair and so on. But I think other people should be assigned as well, you know.

Gaps in ongoing education in the clinical and practice setting was cited by participants as a significant cause of competency gaps in nursing practice and healthcare delivery. The following two quotes include participants' views of drawbacks with current approaches to continuing education.

R#15: They're always doing, you know, these lunch and learns. But a lot of things, like they're not community-based, you know, education opportunities. They're always based off of healthcare. You know, management of diabetes or management of certain patients in an acute care setting. So it's not like, you know, a lot of diversity education. Hell, no. It's rare that you see that. But it I guess depends on the individual who's willing to teach the education. Maybe they're not, I don't know, knowledgeable enough to teach these types of things. You know, cultural diversity or… So that's what I've been noticing it to be, is a lot of times it's, you know, they've got the specialists teaching, you know, specialized courses. Which that is the issue. You shouldn't have that. Because you know, the area of focus is just based off of that specialized subject only, you know.

R#11: And like I said, you know, the more education that one can receive, I think there's benefit in that in just, you know, having a more well-rounded base. I mean there's always learning that can be done. And so, yeah, any… Like anything that I can do, I love to. Especially in terms of cultural competencies too, of increasing that. That is what I would say would be the one thing that I feel that I need more education on, is cultural competency and the opportunities for that that. I find what I crave most is more on cultural competency in that regards on mental health and helping to support those people. But I find that there's been a bigger push, as our staff has expressed that too. And then our educators looking for opportunities, and putting on, you know, learning opportunities that fit.

In addition to gaps in continued education in the practice setting, participants felt that there was a major issue with content that was taught in nursing school. Several participants pointed to nursing education as not only reinforcing harmful stereotypes in relation to diverse patient populations but also as being implicated in the inadequate preparation of nurses to care for diverse groups.

R#17: They did try to incorporate different ethnicities into our education. But I found it was more stereotypical things. Then I remember we had this, what was it called, simulation thing online or whatever, and it was a Black lady. And just different characteristics that she had that white people don't have. Kind of like hair on her upper lip or her elbows are darker. Like certain things like that that just people don't understand. And I feel like that weren't really talked about as much - that it's very common. Or like when you wash a Black person's skin, that the facecloth often gets dark because their skin is dark and it's dead skin coming off of them. Like just certain things that you're going to see out in practice, and you're just going to be like what? And you're not going to understand, when you should have been like educated on it.

R#15: I don't really know what community nurses are doing. But when I was taking community through Dal, I can tell you, there sure as hell wasn't none of that shit. You know, it's like hey, let's do a care plan or, you know, like just dumb shit that is still, you know, based off of your pharmaceutical, you know, your medication heavy based type of nursing. Like it's very misleading. Yeah, it's like okay, so it's like it's a broken system that's not meant to be fixed essentially. Because they're taught first… You know, you're taught medicine, you're taught drugs, you're taught all these treatments. And it's like, well, all right, so I guess you know how to solve the problem then. No, we know how to manage it, not solve it.

Other participants explained the problems that they encountered with the simulation, especially considering skin discoloration and variations. Participants felt that these simulation often taught and reinforced false and inaccurate information related to Black people. Inaccurate and stereotypical information, combined with the sparseness of content in general, was described as a severe disservice to the patients, the students as well as the therapeutic relationship.

R#14: You had to like interact with her and try to give her… You had to like be good at asking the questions so you could get the actual answer. So they were saying that there were all these things wrong with Tina. And some of them like were true. But there was one thing that they commented on, which was like the darkness around her neck and how that was a health issue. And I'm like it can be, but lots of people who are darker complexion just naturally have that discolouration around their neck. But they were putting it like all my classmates' head that that's just automatically wrong. So I'm like, you know what, you're going to go into the workplace and you're going to offend someone who's Black. And guess what, you've just ruined that like relationship from being anything, because that's not true. So I felt like

they were just giving false information. And then also when they would cover a topic of anyone who wasn't white, they would just be like, “Oh, you'll see something different.” But they never told you what you would see that was different. Like they’d be like, “Oh, you’re looking at oral mucosa. And for someone who is white, it will be pink. And for someone who is like Black, it'll be a different colour.” But then the next topic just starts. And you’re like, well, what colour is it going to be? Like how am I going to save these lives of these people if I don't even know what's going on?

The lack of community-oriented care was connected to gaps in the nursing education curriculum. Participants expressed concern with their own education and the gaps in information related to community nursing, the social determinants of health and general exposure to diverse patient populations and experiences. Stereotype and stigma attached to certain communities, as described in the previous section [geographical racism], some participants recalled encounters with colleagues and specific organizations that struggled to provide care to members of particular ANS communities. There is a need for non-Black nurses to feel comfortable visiting ANS communities, as public health nurses, or simply in providing care to ANSs who present in the acute care setting. This would enhance familiarity with people from various communities. One participant recounted how Public Health struggled to locate nurses who were comfortable going to certain ANS community to perform well-baby checks on moms and babies.

R#3: Because there wasn't a lot of Black nurses at Public Health. There was no Black nurses at Public Health at the time. And they were having issues with nurses feel comfortable going into areas like Mulberry Park, Uniacke Square, right, to help with moms and the babies.

R#4: But I don't see any Black content. I've never seen a move towards Black content. I've never seen a move towards anything as far as health assessment with a Black person. Anything like that within the curriculum. And the sad part is in Nova Scotia, I see that a lot of people have not moved forward. They're still in that same mindset. And I'm talking like potential patients like the society when it comes to healthcare are still in that mindset of you're taking care of me, they know best. They're not empowered. They don't seem to be empowered. And I'm not sure why but they're just not empowered within and amongst themselves. But there's no Black education in nursing. There never has been. And I don't know if there ever will be.

All of the participants in this study either mentioned or spoke in great detail about the importance of community, the necessity of incorporating a community-focused lens in practice and the ways in which their nursing practice was grounded in community-oriented ideologies. The resounding importance of community-

oriented care is the central pillar that sets the foundation for the following chapter on *leadership.* Participants described the ways in which they addressed the shortcomings of the healthcare system by engaging in community-level care. This took the form of community-based health programs and initiatives, teaching, mentorship and homecare. Participants felt it was necessary to have more emphasis on community-focused care and a more thorough understanding of how community is tied to health. The following two quote are presented as a precursor to the following subtheme, which includes an examination related to how participants negotiated their community-oriented approach to care within a medical-based health system.

> R#6: And that was a little bit unfortunate because, you know, I think it's so important to really get a good fix on what's happening in the communities. It's fine to work at shared care centres, big hospitals and everything. But when you find out what's happening in the community, where does a person live, what kind of food are they eating, you know, that kind of thing. Do they have housing? It really is very… You know, the reasons why people go into hospitals are because of all those reasons. And if we can help on the outside, you know.

> R#9: I definitely think there needs to be more of an emphasis around community and like community involvement. And so whether that's exposure, more exposure activities where people get out and get into the different communities to kind of see what different environments look like. Because I feel like a lot of the people… I don't know, I feel like it's a very different reality for some people to kind of see what other communities look like and how to then support people.

7.4.5 Subtheme 3: Community-oriented Care Within a Medical-based Model: Providing the Best Care

One of the most dominant and common threads woven throughout this research is the concept and idea of community-oriented care. This is one of the most prominent and salient threads that emerged throughout this research. The participants in this study described the benefits of community-oriented care, the necessity for fostering health in individuals, families and communities as well as the challenges of not doing so. The insight regarding community-oriented care was often juxtaposed against the more traditional medical-based model. The medical-based model is viewed as a faulty component of the health care system. This subtheme expands the understanding of *Nova Scotia Healthcare as an Archaic Institution*, which has been situated as antiquated, a dinosaur, and not attentive to the true needs of individuals, families or communities.

In listening to the participants' their experience in navigating the healthcare system to support and care for patients, a vivid image of the current approach to care was generated. Generally speaking, the medical-based approach to care involved a disconnect from patients and their family, an environment that was driven by the

disjointed management and treatment of aliments [rather than disease prevention or supportive management], the overuse of medications and medical interventions, and ultimately a system that did not empower patients. The following quotes show how healthcare was highly medicalized and considered to be more reactive and management of disease focused rather than on prevention.

Issues with the medical-based approach to care were identified as problematic with participants feeling as though they were “pill pushers”, in a “heavily medication-based” system. This also resulted in participants feeling personally conflicted with medical-based approaches to care. Entering the healthcare system for care, through an acute care channel was viewed as a risky situation. It was acknowledged that the initial and main concern upon entry is whether or not someone is medically stable. However, it was believed that once someone enters the system, there is not real concern or worry about community needs. Additionally, participants in certain acute care settings felt as though the healthcare system did not adequately empower or educate patients to care for themselves holistically. Instead, they received medications and were sent on their way. Identifying that the hospital is not concerned with anything beyond the acute, immediate issues and anything beyond the acute is pushed to the family doctor or community setting, participants expressed drawbacks of this approach to care. Especially in instances where patients were given medication without adequate investigation, care planning or proper health education.

> R#15: But you know, I then learned to see what healthcare has looked like. You know, so-and-so comes in. Oh, they just have pain. Give them this. And boom, there’s no further investigation of this because they’re not here for that, and everything else seems fine. So it just seems like you’re a pill pusher. Well, I’m not someone who takes a lot of medication myself. So you know, every time what we’re giving this medication for, I think this could be the issue for the person. Well, let’s investigate it. No, they have a family doctor for it. Okay, so then I may know what’s wrong with them but I can’t order tests, you know, and further investigating. Instead it's someone else’s problem. But just give them Tylenol for now. So that’s my mindset on all of it. So I don’t want to sit there and tell people hey, go into nursing because it’s this, this and this, when I’m already able to identify so many flaws in the system.

Another participant expressed their views on the medication-based approach and the challenges of balancing the best interests of the patient with collegial power dynamics. Again, the personal conflict in the approach to care is evident. This created tensions between participants and their colleagues when there was a desire to go beyond simply providing medications.

R#8: Because I just find they're all one team there. And as long as you don't go against the grain, so to speak, you're golden. But I have issues as well with say it's nighttime and it's time to give the patients their medication, and if there's a patient that takes a sleep aid, right. And you know, okay, you're going to give them the sleep aid. And well, you might end up having to get them something again, I don't know, maybe around 1:00 in the morning, depending upon... Or you might have to call the doctor. "Oh no, we're just going to give them a the cocktail, give them everything that we can give them." Like you know what I mean, that we're not going to get in trouble for it. To me I think that's abuse. I don't… Like you know, I'm not doing that. I refuse to do that, right. And when you refuse to do that there then it… The next day when they come in, "Oh, my gosh, they slept all day," or they did this here, or they're so rallied, blah, blah, blah. "You should have did…" No, I'm going by exactly what my MAR tells me. And I am not giving that patient three and four different sleep aids at one time because to me it's abuse. So when you don't that, like you know what I mean, it's like the target's put on your back because then you're labeled as a troublemaker. And then you become ostracized, right. But like I say to my girlfriend all the time, you know what, they can ostracize me all they want because I have a duty to keep these patients safe. And when I am doing that, I'm not keeping them safe. I'm putting them in harm's way. So like you know, it's just… There's good days there, and then there's bad days.

It was acknowledged that continued training and education in health care was largely based on healthcare and disease management rather than preventative strategies and cultural considerations in care. One participant pointed to a lack of awareness and education on the educator's part as they wondered whether it was related to who was willing to teach/ provide these workshops and whether or not they were knowledgeable. While there was an acknowledgement of the importance and vitality to remaining current and up-to-date on the best practices as well as knowing how to care for simple and complex medical conditions, this all needed to occur along the foundation and backdrop of cultural competence. The healthcare system was described as being broken.

As mentioned, the value placed on community-oriented care was a resounding thread shared by the majority of participants. Some of the common elements that constituted participants' view of community-oriented care included: caring for all needs/ holistic; an understanding the social and structural determinants of health; and approaches to move services into the community for better access – meeting people where they are. Many of the participants that practice in the acute care setting questioned their role as an actor in the healthcare system. Some nurses expressed deep concern/ were conflicted about the care they provided and the feeling that it simply was not addressing the foundational issues or underlying causes. One participant eloquently illustrated

their internal conflict and the sense of not feeling fulfilled in their acute care role. While another expresses concern related to the accessibility of healthcare services:

> R9: I think you're just within, I think, mental health, working within mental health, and seeing the lack of representation from the African-Nova Scotian community accessing services. And so not having that representation, and not having that reflected within the workforce as well, right. Because like I was the only Black nurse. There were some other youth care workers and things. But just not having that representation, even if we were to have clients to come in to access these services. And I think how important that is, that you have professionals that are representative of the client that you want to see in these programs. And it just wasn't something that happened. So that was kind of a negative kind of experience because I know that there are youth out there that could benefit from some of these programs and services that aren't accessing the services. And just kind of the structure of how some of the services are set up that create barriers that make it so that people aren't able to access those services. But it's how the programs are structured and what the programs look like in terms of the staff and some of the expectations around the programs that don't take into consideration other aspects of how to best engage with people.

The need for community-based supports was amplified by several critical factors described by the participants. One of these factors is the fact that many aging ANSs have and continue to remain at home with their families as opposed to going to an institution. This was considered to be a culturally specific phenomenon, as one participant described the underrepresentation of Black patients in transitional care units or in long-term care facilities. This participant referenced "caregiver burnout" as a likely driver of institutional or long-term care for loved ones and how this notion is not common in Black or Indigenous families. Patients from the Black community were coming into the hospital because of pneumonia, for meds or because they were sick – not for respite care or due to burn-out because people continue to be looked after at home by large families. However, the nature of generational differences was acknowledged as a mechanism that made staying at home possible. With larger families, aging loved ones had a greater support network to remain at home. Yet, in thinking about the "next generation" and what that means for homecare, this participant expressed concern.

> R#12: Yeah, because a lot of times they don't end up on transitional care. More Black people are staying home and being looked after at home. I don't see many coming into our floor and then heading to a nursing home. Yeah, it's not often, I can say that … You know, it's kind of like here with the native population too. I find it's rare on my floor to have a native or a black person on our floor. They're

staying home longer, and being looked after at home. And it's not usually the diagnosis of caregiver burnout either, where you see that. A lot of times when it's caregiver burnout, it's like they're just dropped off. "I had enough. It's like I've had enough. I can't do it anymore." But you don't see that so much with the Black population or the native population.

Building on this notion of homecare and the need to receive care at home, another critical factor identified relates to social circumstances that influenced the care-seeking patterns of ANSs. For example, the following quote clearly outlines the dilemma that some aging ANSs faced in relation to their homes and the implications for seeking care. The following quote illustrates this sentiment:

R#2: I said, Listen, Black people work too hard. They have these little houses. We didn't have mortgages. We had to scrape. You know, it's like it may not mean anything to you and it might look humble to you, but people really worked hard to have a roof over their head. They're not leaving home." "So why don't you put those resources in place that is going to keep them in their house, and hire some people from the community? Because people used to say to me, "[Participant], if you weren't Black, we wouldn't let you in here." And they would say that to me, you know. And it's like put those people… And they started doing… Now, I don't know what they do now, but they started doing that. And I didn't even think of that as leadership. What I thought about that as, just what's good for the community, what's good for my people, you know.

One alternative that was described as an approach to bridging the gaps of accessibility to healthcare services and addressing some of the harmful practices therein was the notion of empowering patients through health literacy. Health literacy was described as a critical component of community-oriented care delivery. Increasing health literacy, which involved health and wellbeing education, illness management and fostering an openness and willingness to discuss health issues, was posited as essential within the ANS community. The following quote shows how fostering trust in a community setting enables sensitive conversations to be had and information to be shared. For example in reference to diabetes, referring to it as "sugar" and associating it solely with obesity. Then exploring other health issues such as breast cancer, alcohol or drug dependency and how the perception of these chronic illnesses differ for the Black community.

R#4: So that's kind of where it started for me. I just remember wanting it for a long, long time. Then the other thing was the fact that I think a lot of it… And now it's coined health literacy and information literacy. But I think a lot of it as well is because I would hear my family talk about this person or that person who went to the hospital. And when somebody would say, "Well, what did are they in for," or,

> “How are they dealing,” or, “What tests,” or whatever they did, they'd say, “I don't know. I don't know. I don't know.” It's kind of like the head buried in the sand, kind of effect.

Participants felt it was important for the community to learn and know how to care for themselves and each other. The lack of empowering patients in the acute care setting was one factor. The other issue was linked to this in that teaching in the acute care setting in not directed at health promotion but rather management of aliments and dependence on a system, medications and health providers.

> R#15: I wouldn't look to the acute care setting for them to make the change. It would be community nursing. Community nursing. Simply because we have to educate our people. Because that’s what a lot of it is. You know, you see them come in…There’s no teaching. There’s no understanding as to what it is – you know, diabetes and management and what this looks like, and why your sugars are so high, this, this and this. And that’s an issue that all…like every race, you know, faces lack of understanding. So it’s like okay, we have this issue with our black people not knowing how to manage themselves but also we have an issue with everyone else not knowing how to manage themselves. So let’s look at the healthcare professionals as you all suck at teaching.

This same participant continued to explain the importance for patients to be active in their health since the system was not designed to support ANSs or other historically marginalized groups.

> R#15: Yeah. Which is why I’m like no, we’ve got to take care of ourselves, you know, mentally and physically before you can try to, you know, go through a system that isn’t designed for you to be taken care of. You know, you can’t rely on that. So you have to be the one that you rely on. And then when the time comes to, I don't know, reach out, it’s let’s hope at this point, you know, we have some sort of diversity within the field. You know, that’s like the last boat you want to have. Because you want to just take care of yourself essentially, is what I was trying to say.

Finally, the importance of incorporating prayer and spirituality was woven into a few of the participant’s reflections regarding their care and how they attempt to attend to their patients holistically. The importance of incorporating spirituality in nursing practice became profoundly clear in participants’ discussions about caring for patients at end-of-life. One participant regarded nurses to be “like God’s angels on earth” and how this perspective facilitated the ability to ensure that patients were comfortable and had a “dignified, peaceful death.” Another participant, understanding the important role of God and spirit in their patient’s life, sat in the evenings to pray and listen to gospel music with a patient who was near end-of-life. The act of attending to the spiritual needs of patients was considered a necessary component of care.

R#10: But being spiritual, and I tell people like…I say we're like God's angels, you know, on earth here. Like just making people comfortable and giving them that quality of life and, allowing them to have a dignified, peaceful death, right. It's just so rewarding. More than any money I could receive out of a career.

7.5 Section 3: Leadership Philosophy and Practice

The third and final section that completes the findings of this study analyzes the perception of leadership for ANS nurses. Participants shared how their philosophy and approach to leadership was grounded in a sense of community-oriented care. An approach to leadership that is grounded in community gave way to the development of a perception of leadership that transcended formal titles or roles. Moreover, the community-oriented approach enabled participants to assume dynamic types of leadership roles in both the community and acute care setting. The following three subthemes highlight the salient threads that interweave to present a conceptualization of the overarching theme: *Leadership Reimagined: Lifting as We Climb.* Figure 12 illustrates the three subthemes that comprise this theme. The following section will further explore how each of these subthemes adds a critical component to the reimagination of leadership.

Figure 12

Section 3: Leadership Reimagined: Lifting as We Climb

7.5.1 Subtheme 1: "It's Part of Your Job": Leadership as Integral to Nursing

This subtheme captures salient aspects of leadership, as defined by participants. In sharing their leadership philosophy and practice, participants described their views and definition of leadership, who they considered to be a leader and what leadership entailed. For majority of the participants, leadership was viewed as an integral and inextricable component of nursing practice. It was felt that leadership was just a "part of your job". Participants explained that all nurses have the capacity to be a leader, by virtue of the profession. However, participants also acknowledged that leadership is a practice that requires intention, cultivation, evaluation and reflection. Participants provided numerous examples of how leadership was embedded in the very fabric of what it means to be a nurse. This perception of leadership, being a core component of nursing, extended to the idea that one is "always a nurse" and that one does not stop being a nurse when they leave work. Being a nurse is a component of one's identity that several participants considered significant. Within this subtheme, participants explored concepts of professional responsibility, the common conflation of management with leadership as well as personal leadership style and the required competencies for nurse leaders.

As described, leadership was regarded as a critical and fundamental element of nursing practice. Participants felt strongly about nurses having a professional responsibility to be leaders in healthcare. Opportunities to enter leadership and cultivate this professional responsibility was described as including committee work, involvement with policies, participating in research, attending professional development and education sessions as well as patient advocacy. One participant explained how nurses are bound by a code of ethics to ensure that they are practicing optimally.

> R#13: And so for me, I guess it's just that, I don't know, when we were sort of talking in nursing school about ethics, around how we care for our populations, how we, you know, improve our practice, the only way to do that is with what's out there in terms of the most recent evidence. And so I put a high value on that. And so it's a challenging discussion to have with others who don't put that same value on it. They want to do their work and go home. And, you know, part of me is like but that's not what nursing is. It's not a job where you can just go to work and then take off your hat and leave. You have this professional responsibility and, you know, you're not a nurse when you're at work and then never a nurse at home. Like you're always a nurse.

When asked about the importance of seeking out professional development activities to grow and develop individual leadership capacity, participants responded by indicating that it is a "part of your job". Seeking out professional development opportunities and continuing to expand ones' knowledge and skills was understood as a requirement for renewing the nursing license. This sentiment was paired with the belief that leadership was essential to being well positioned to better serve the population. Some participants explained that their participation in professional development – and other activities outside of their job description – was indeed a part of their job, as they identified needs and took action to address those needs. The following two quotes illustrate this shared sentiment.

> R#2: Well, that's part of your job, you know. No, but it's part of your job. When you apply for your nursing license, part of it is how much did you do professional development? I thought that was open to every nurse…And I didn't even think of that as leadership. What I thought about that as, just what's good for the community, what's good for my people, you know.

> R#6: You know, I was just doing my job. Personally, I felt like I was just doing just what I do. I just encourage people. I just want to see people excel and do well in their lives, and to feel that they have some control, and not feel that they don't have skills.

Expanding on the belief that leadership is a part of the professional responsibility within nursing, some participants questioned what they perceived as resistance from colleagues to explore professional development opportunities. A small number of participants described the unique position of nursing, where there are financial incentives to encourage professional development. Yet, participants were perplexed that more nurses did not pursue this. In addition to the incentives that nurses receive to complete professional development opportunities, it was recognized that any nurse can be a leader and that all nurses have an ethical or professional responsibility to assume leadership roles in various capacities. Again, this perception underlines the notion that leadership transcends designated roles or titles. The following quote highlights the standards that are expected within a regulated profession such as nursing.

> R#13: I like to think of nursing leadership as roles in which nurses are able to advance their profession. And I'm being a bit vague about what type of person that could be because I think any nurse can be a part of nurse leadership. And I think every nurse has a bit of a responsibility to be a part of nurse leadership. And I try to harp on that with nurses that I work with. Some certainly don't have the same value as I do on, you know, the input into leadership. But, you know, I think that all nurses have that responsibility in some way. You know, we're a regulated profession with a certain amount of ethics and accountability to the public in terms of advocacy. And I think that part of that is taking on leadership in whatever way you can

In addition to the belief that nurses have a professional responsibility to be leaders, there was a clear distinct made between leadership and management. Often, these terms are conflated and individuals who hold management positions are classified as leaders. Participants did not reinforce the notion that managers are by default leaders. Rather, participants explained the inherent differences between leading/ leadership and managing/ management. There was an acknowledgement of this common error however, participants, especially those who practiced in acute care settings, shared their views regarding this matter. Participants highlighted how being an effective leader and an effective manager were not interchangeable. For example, one participant remarked on what they considered to be a disconnect between management and the operation of the unit. This disconnect was viewed as an issue as it impacts everyday nursing practice especially with regard to understanding workload, overtime, implications for patient safety, and a basic sense of openness with employees. Examining the differences between leading and managing segued into participants providing concrete examples of characteristics and capabilities required for those who are considered leaders. Several non-negotiable traits included the ability to communicate effectively, an interest in inquiry and discovery, possessing knowledge and expertise in clinical and non-clinical areas in addition to cultural competence.

R#15: No, there's a lot of charge nurses, there's a lot of managers, there's a lot of people that are in management positions that essentially aren't the best roles for them. And I have a problem with all that…But you know, working alongside a few of the different charge nurses, you can really kind of see which ones are the best at their job based off of, you know, how approachable they are, how good of a communicator they are, their work ethic. I find that's what makes their title so important as they have these good qualities. And, you know, that's good leadership.

Beyond describing the differences between leadership and management, participants shared their perspective on what they understood to be essential leadership competencies. There were several common traits identified by participants. For example, the importance of education and learning was highlighted as an important trait for leaders. Along this line was another key trait, which was a passion for teaching. As the following quote shows, working closely with students and being knowledgeable to teach and support students or junior nurses was highly valued.

R#7: Well, of course, like in order to be like a good nurse leader, you need to be well educated. So you have to stay like up to date with everything. Make sure that you're up to date with your policies and all that kind of stuff. Especially when it comes to the students, I find, because they're like so eager to learn and all that kind of stuff. And just even if you don't know the policy 100 percent, just knowing like where to find it, where to show them how to find it. And then just kind of going through things with them, and then just being by their side like when they're doing like new tasks. So like putting in catheters or IVs or whatever it is. And just kind of like being a leader and guiding them while they're doing the tasks.

The importance of remaining curious and intentional about learning was identified and shared by participants as critical traits for leaders. For example, professional development and continued learning, including culturally competent care and mental health, were viewed as essential practices for leaders.

R#11: And like I said, you know, the more education that one can receive, I think there's benefit in that in just, you know, having a more well-rounded base. I mean there's always learning that can be done. And so, yeah, any… Like anything that I can do, I love to. Especially in terms of cultural competencies too, of increasing that. That is what I would say would be the one thing that I feel that I need more education on, is cultural competency and the opportunities for that that. I find what I crave most is more on cultural competency in that regards on mental health and helping to support those people. But I find

that there's been a bigger push, as our staff has expressed that too. And then our educators looking for opportunities, and putting on, you know, learning opportunities that fit.

Emphasis on cultural competency was repeatedly expressed by participants and was another commonly viewed trait that participants felt was overlooked as an important leadership trait. One participant explained major disconnects and the issue that arise when individuals in a leadership position lacks the fundamental competencies to execute the role effectively. This observance was captured by one participant who described these challenges surrounding the lack of awareness of the life and experiences of ANSs and other groups who immigrated to Canada, including Filipino people.

R#15: Yeah. But I always find that like it's the individuals that are in, you know, these roles that kind of lack so much understanding and awareness to how to deal with, you know, people from other cultures. And that's something I see with, you know, the Filipino population. You know, anyone migrating outside of Canada.

The understanding that leadership is an element that is embedded within nursing practice was a common and highly resounding sentiment shared amongst the majority of the participants in this study. Participants explained various examples and instances in which they displayed leadership qualities and characteristics. Their leadership was evident in their advocacy, approach to patient care, systems-wide thinking and strategic planning. Depending on the area of practice, some participants felt more strongly that leadership was a core component and requirement to practice in a specific area. For example, practicing in a highly specialized areas, or when managing a unit with 20+ patients and limited staff, necessitated that participants be effective leaders.

An additional element that was recognized by participants, as necessary for leaders, was the practice of interdisciplinary collaboration. Interdisciplinary collaboration was understood as a critical component of leadership since health and wellbeing intersected multiple sectors and disciplines. For example, some participants described their collaboration with social workers and educators to address community-specific health needs. The following quote depicts how one participant perceived collaboration as an essential component of leadership.

R#3: Well, when I think of nursing leadership for me, I think about mentoring, I think of passing knowledge along, sharing knowledge and information. I think of us having times where we can come together collectively and engaging in conversations, meaningful conversations about black health in the black community. When I think about leadership and nursing leadership, I don't see us in silo. I don't see nurses as silo. Because whether we're in nursing or social work or in other areas of health and all this,

our business can cross over. Like you know, when we say nursing leadership, I use us sort of like in roles in collaboration with other professions. I see that as us being at the table, at the leadership tables. I see us being at the leadership tables within organizations and designating from our body who would be the best person in terms of the skillset to be at that table, you know, and to voice the concerns, to articulate the concerns. But has the confidence to voice concern. Because so many times when we're on our units and they're asking us questions or concerns, we're not heard. We're not even seen. So we don't have a voice. When we really have more of a voice. So, you know, that's my dream. And I hope I get to see it before I die. And I think I've got a lot of years left. Well, I hope I've got a lot of years left. Because I mean like I work with someone and, you know, and I do a lot of stuff with her. And she's a social worker. You know, it's just different perspectives on stuff. And it's good to have that, you know, working in a collaborative model.

Finally, participants commented on their own personality traits and how that influenced or contributed to leadership potential and style. For example, being more of an introvert and being soft-spoken were traits that participants recognized impacted how they were perceived as leaders.

R#11: I know I'm a more introverted person. And so for me, my leadership style I feel like has been more quiet and by example. And I think, yeah, being a leader is being able to, you know, just reflect positive behaviours and be able to influence others through that example that you provide. And then certainly enabling yourself through education, I think that's an important part of nursing leadership.

R#1: Like for my personality, I'm pretty quiet as far as like I don't talk a whole lot, especially in a group. And when I do talk, it's quiet. And I feel like people that don't get the chance to know me might interpret it as being like lack of, I don't know, confidence, maybe experience or competence. Whereas once you get to know me, it's me either. It's just I'm just quiet.

7.5.2 Subtheme 2: Along the Pathway to Success: Climbing the Professional Ladder

Along the Pathway to Success is a subtheme that captures the varied experiences and journey throughout the participants nursing career. It includes the discussion of facilitators and barriers encountered in practice. Some of the more salient components of this subtheme include the exploration of the importance of mentors, role models and allies along participants' journey; challenges advancing in their career; and the experience of discrimination in career advancement. Most of the participant in this study expressed an interest in career progression and advancement. There was a desire to climb the professional ladder, move into advance practice

roles or to simply cultivate a nursing practice that was fulfilling and meaningful. The following quote illustrates one of the common sentiments shared by many participants in terms of maintaining a desire to advance and avoid becoming complacent in their career.

> R#10: And I can even say honestly speaking, like I've become a little bit comfortable in my career where I am right now because I've been there for a few years and I love it there. But I feel like a lot of nurses, I don't know if I can speak for everyone, but if it wasn't for like having that drive, it's very easy to just fall into your career and just kind of like stay there. You really have to have that internal drive or have someone supporting you or pushing you in the background, right.

Climbing the professional ladder was a salient theme threaded throughout several participant accounts. Career advancement encompassed progression from the LPN to RN designation as well as from the RN to APN designation in addition to promotion within the current designation. Participants described a series of circumstances that greatly influenced or circumvented career advancement such as: financial barriers, parenting or being a caregiver, time commitment, perception of degree difficulty, and policy or structural issues such as bridging programs and GPA requirements. The following series of three quotes all capture critical aspects related to the pursuit of graduate education and entering the Masters program to become a nurse practitioner or a graduate prepared nurse. Participants negotiated the desire to continue their education and broaden their scope of practice. However, this desire was challenged by various circumstances. The first participant acknowledged how a Masters degree was required in order for them to advance in their particular clinical setting.

> R#1: I was just thinking it would also be good because it would give some education without having to go through the huge like undertaking of furthering formal education. I do think like what can I do to broaden my scope and like further my skills and the depth of my knowledge? And I feel like I keep coming back to a master's. I don't know if I want to put my life like on hold for two years. But if I could have like, you know, a few hours or days to dedicate to a learning opportunity, that would be way easier for me to fit in my schedule right now.

Another participant shared their interest in pursuing their Masters to become a nurse practitioner. Yet, similar to the above quote, continuing education was a pursuit that generally was held in the back of participants' minds.

> R#10: So it's nice. But I always in the back of my mind, I'm like I always wanted to pursue my master's and be a nurse practitioner. So I'm trying to keep my goals in mind. Like I don't want to… I just don't

want to get too comfortable, right. But then I always had that goal in mind. I'm like master's, master's, master's.

The final illustration of the negotiation between the desire to pursue a Masters and the perceived barriers is a quote that depicts how institutional processes and policies reinforce limits for career advancement and progression. Several participants discussed the inherent issues with restrictive GPA guidelines. Participants interested in advancing in each level of nursing noted the drawbacks of the reliance solely on GPA. Instead of reviewing the extensive experience, career accomplishments, commitment to nursing and health as well as potential to advance nursing, participants remarked that determining admissions only on GPA was a serious drawback and reinforced inequities in the ANS community.

R#13: So you know, you've got the TYP program. But you can only do that for undergrad. So, you know, I'm in the scenario where because I was young and stupid, I can't go get a master's because my GPA wasn't good enough and I've been out of nursing school for so many years. You know, and it's one of these things where it's like so ridiculous. It's like I've done so much ongoing education and leadership that if you could just take like one of those courses, like LSAT or PSAT and those types of things, if you could do something like that, and say you've got the requirements, or have a transition year program. Because we know that people who, you know, are from black communities probably have to work to go through school. You know, there aren't as many scholarship opportunities. Or even if you do get scholarships, you still have to work because maybe you're going to school and have kids, or maybe you're going to school and you're providing for your family, and all of those things. Or you're older and you've also got your bills to pay. And so the experience of a Black Nova Scotian person going to university aren't at all considered. Yeah, like if I wanted to advance further in terms of nursing professional practice, education, that kind of thing, I need a master's, right. And so you end up limiting yourself, you know, because of what you did years before.

Other participants expressed interested in bridging into the baccalaureate program to become an RN. Similarities were observed between participants interested in bridging into the RN program and those participants who were interested in pursuing their Masters. For example, financial constraints, time commitment and perceptions about the difficulty of the program – and their ability to be successful – as well as institutional restrictions related to GPA, were described as a deterrent. These concerns about affordability of education, work-life responsibilities and family obligations transcended educational programs. Both undergraduate and

graduate nursing programs were viewed as inaccessible in addition to the opportunity to bridge from the LPN to RN level.

Continuing education to advance their career, some participants acknowledged challenges with advancing in the nursing profession. Participants explored the impact of social constructs on their ability to advance in nursing. Social constructs such as race, class and gender, were interrogated by participants as they shared insight into the role that these factors played. Participants recognized that social constructs such as class, had an impact on their experience and particularly their advancement in nursing. However, participants highlighted how their race was an extremely influential determinant in their nursing career. In addition to the challenges encountered by participants who desired to advance their career through continue education -either graduate education or bridging into the baccalaureate program – participants also shared their experience with career advancement that involved moving into leadership roles. Participants reflected on how they perceived their race to be a significant determining factor in the progression of their careers. Race was acknowledged as a significant determinant in career progression, advancement and moving into various leadership roles. Some participants shared that despite their extensive clinical experience, continued education, mentorship, character traits, that race always seemed to be a significant factor.

> R#4: I think as far as class, I've seen leaders that were chosen that are upper, middle and lower class. So I don't really think that's it. I still think that we have this barrier that we can't see beyond, and it happens to be colour. And I think I'll die thinking that. Which is a shame because I just feel like we've come far but we've really not come that far… But I think because I was born in a Black family, I feel like I was marginalized somewhat. And I feel like some people maybe didn't want to do it or didn't mean to do it, but they did do it. And so I don't think that people see us as equals necessarily. And I don't think they realize how powerful we really could be if they let us aspire to leadership ability and roles. I think it's really a loss for them because I am good, I am a Black nurse, I did grow up in Nova Scotia, and I am a leader. So, yeah, I think that's really kind of what I want to leave it with.

Another illustrative participant quote reveals the internal dialogue or thought process that several participants described in relation to being perceived or selected as a leader.

> R#6: I'm wondering, when I was at the local hospital, whether or not I could have been charge nurse, you know. Or I wonder about that, if I hadn't been Black, you know. Similarity, when I worked at another organization, I often wondered, hmm, why couldn't I have not been in charge? And sometimes

it was because of seniority because people were there longer. But that's always been a question in my mind, you know.

In discussing the influence of social constructs on leadership in nursing and healthcare, one participant questioned the gendered nature of leadership in nursing. The overrepresentation of men observed in upper level, formal leadership roles, was perceived a peculiar. As illustrated in the quote below, one participant wondered about the ease at which men move through nursing education and the profession. This participant's musing extended deeper to question the desirability of traits for leadership roles, such as ambition.

R#1: I have noticed like there's a disproportionate amount of males in leadership roles versus the amount of males in nursing overall. If you understand at all then yeah. Which makes me wonder the reasons behind that. Like are women not ambitious for those roles or are men more ambitious. I think there's probably something to be said about they're more favored, like they're chosen more often. And from what I've seen in nursing school, like professors like them. Like it's more effortless. Like their journey throughout nursing school and through their practice. Like patients, co-workers, doctors give them a benefit without having to prove themselves. And this is like just my own experience. It's not any research that I've read. Yeah, that's what I've been seeing.

Again, participants expressed suspicion around the motives and intentions of diversity initiatives. The next quote displays questioning of the motivations behind diversity initiatives and the strategies that organization employ. Similar to the concerns raised by participants about tokenism in healthcare, there were equal concerns surrounding the motivations for the creation of various positions.

R#15: I feel like it kind of goes back to, you know, kind of what I was saying earlier about the roles of, you know, these educators and people kind of taking them up, sitting in the position for a while. But I mean when it comes to men, it's like they'll create a role for a man because they're trying to continue to diversify the field. So if they have one man, it's like, well, it would be good to have, you know, a male manager – as if that would really make much of a difference or not…Yeah. But I wouldn't say that they actually value it. I think they're just trying to make it seem like they're diversified. Like that's the issue. You know, it's like systemic racism still.

Moving beyond the challenges and barriers identified as impacting career advancement, participants highlighted critical factors that facilitates their advancement in nursing. This description included a number of key actors that were instrumental to their career progression, professional development and personal growth. Unsurprisingly, several participants mentioned the same role models – inspirational nurses who had a

longstanding reputation for their support of ANS nursing students. Some of these mentors were affiliated with the Dalhousie SON, while others were affiliated with community organizations and health centers. One such nurse was a well-known mentor and colleague for some of the participants in this study. Specifically, this nurse mentor helped to instill a deep sense of confident and self-advocacy that enabled participants to be successful in their education.

> R#3: Oh, yeah, it was really the best thing. I still keep in contact with my nurse mentor today. One of them. I had two, you know. And I keep in touch with one of them to this day. Yeah, she was my nurse mentor. And we still reach out and touch base and have lunch every once in a while. I value her knowledge, her experience, the confidence. And you know, what she's gone through over the years. She's had experiences that I haven't had, you know. Yeah. So no, that sort of thing I think is really…it's important. It's so important to have.

Several participants described other participants in this study as having an impact on their experience in nursing. The participants who received guidance from more senior participants regarded these nurses as mentors and role models. Participants shared the various types of support that was received including mental and emotional support while navigating nursing school. Receiving mentorship throughout nursing education was critical for success in the program while simultaneously providing the building blocks for the development of leadership capacity. Participants emphasized the importance of having someone available to provide reassurance, boost confidence, validate experience and offer unconditional mental, spiritual and emotional support. The following quote includes a description of this support.

> R#10: Like there's times in my career, even when I was still at Dal, you know, it was emotionally taxing. Always had her to, you know, be there to support me spiritually, mentally, emotionally. She always gave me that like reassurance and confidence. Like "You are amazing and you can do anything you set your mind to."

The importance of non-Black allies and mentors was described by participants as well. This highlights important notions including struggles to feel included and supported. The first is the underrepresentation of Black mentors. The second is the role that non-Black leaders play in the lives of ANS nurses. Multiple participants spoke of one professor within the SON who they regarded as an extremely supportive person who assisted participants in various ways from personal advocacy, navigating the program, incorporating diverse content in classes and active mentorship. Additionally, other participants spoke of non-Black allies and mentors,

including nurses and physicians, who played a critical role in creating and providing opportunities for career advancement. The following quote shows one participant's expression of this.

> R#2: And I think the thing is, in Nova Scotia, and at the time that I was working in our own community, people didn't appreciate you and your education. And so they didn't have a tendency to, I don't know, hold you up or help you out. The people who helped me were white. The people who encouraged me were white. When I needed backup, except for close friends, that came from the people that I worked with or the people who told me about opportunities or people I either met through university and met through volunteering. And they were white women.

Participants shared how the visibility – seeing Black nurse leaders – was extremely important to both encourage and inspire advancement in nursing. The underrepresentation of Black nurses, especially in leadership positions, was not a deterrent for some participant. Yet, there was acknowledgement that seeing more Black nurses in leadership positions, especially for students and junior nurses, has the ability to eased some of the conflicting feelings and experiences. The following quotes include participants' expression of the importance of visibility as viewed from various entry points in nursing and healthcare.

> R#11: But to me, looking at it, all the leadership positions that I saw coming into the organization, whether it was the educators, all those people like first when we were just hired as new grads, all those individuals that spoke to us, the majority, we saw a lack of diversity.

Building on the importance of visibility and representation as an initial point within healthcare, the following two quotes reveal how early exposure to is essential for both children as well as junior nurses.

> R#5: If you don't see yourself reflected, right, at least from my perspective, the way I look at it. In my nursing days when I saw a Black nurse who was in a senior position, that was sort of a motivator for me. First of all, for me to do well, but also to see, well, there's something I can aspire to be, you know. So I think that seeing that is important.

> R#13: Yeah. I would love to see more involvement like tying education and health care professions together. So, you know, like my local tutoring group has asked me to come in and talk to kids. Because unless they see other nurses who… Like if they're not seeing healthcare professionals who look like them, it's not going to be something they think they can do. You know, if all they're seeing when they go into the hospital that is from the black community are, you know, aides and housekeepers… And not

that those jobs aren't valuable and meaningful. But if that's what they're seeing, that's all they will pursue.

Finally, the importance of visibility and the apparent underrepresentation of Black nurses in nursing leadership was connected directly to issues of representation within the nursing profession, as a whole. Participants acknowledged the underrepresentation of Black nurses in leadership, which pushed some participants to pursue more formal and informal leadership roles and to be more visible as a leader. Participants felt that it was imperative that aspiring nurses as well as children and youth in the community saw themselves reflected in affluent sectors of society and in higher positions. The two illustrative quotes below share participants' collective perception of the necessity to enhance visibility and representation, which often required the participant to step into this role.

R#9: Well, I think having more of a support within the nursing kind of field. So having other nurses there that are representative of you, and having people that you can talk to, and kind of really build that network. And then having a pool of really strong nurses that they can then move into leadership roles. Because I feel like a lot of the time you're so isolated that you don't have that support that's required to build the knowledge and to build what's needed to move into some of those leadership roles.

R#11: And so, again, that they can see themselves reflected. I think that would have been helpful for me. It certainly didn't deter me that I didn't see anyone like me but it certainly was just something that I noticed. And for nursing leadership in general, I think sometimes like… well, as I'm having this conversation, I'm like I need to be a bigger leader because, you know, like if I want to see diversity, you know, if there's things you want to see, you kind of have to be that person because there is the lack of that. And I think it is significant. Any time that, you know, I have the opportunity to be in charge and other people see that, whether it's nursing students and parents, I think even that is important.

7.5.3 Subtheme 3: Black Feminist Leadership: A Practice and Philosophy Rooted in Community-oriented Care

The subtheme *Black Feminist Leadership: A Practice and Philosophy Rooted in Community-oriented Care* captures two critical elements in the perception of leadership as described by participants align with the key pillars with BFT. Participants described how they did not regard their work as leadership or choosing to step into a leadership role. Rather, participants described how they adopted various leadership roles simply by identifying needs and taking action to address those needs. In addition to addressing individual needs, there was always the understanding that when the community is taken care of, the members will also be taken care of.

This approach to leadership was generated by understanding the social circumstance and context that exists within communities in addition to establishing and maintaining a nursing practice that strengthens the wellbeing of community. The following two quotes capture this leadership philosophy and practice that extends beyond titles or designations and is grounded in an unwavering commitment to community-oriented care and advancement.

> R#6: Not just nursing and being a manager or being in an administrative position in your workplace but being a leader in the community and being a champion to the community for people to be whole and to be healthy, you know.

> R#2: But the people in the community, when someone was sick, the women of the community got together, whether it was cleaning the house, whether it was cooking food, whether it was making pads. I remember my grandmother making quilting pads for, you know, like incontinence pads. So that tradition was there too for community. And when I got into nursing, for leadership, I never thought of leadership. What I thought of, oh my God, people in the community don't know about this. What can I do? I'm here.

Again, for many participants, their early childhood experience had a profound impact on their desire to enter nursing as well as to practice nursing in a way that was attentive to the unique needs and experiences of people. The following quote shows a depiction of the belief.

> R#4: But I have to thank them because …it's enabled me to see that I don't want others to be treated the way I was as a patient, as a young child. I want them to be empowered and take care of themselves. And I don't want to be the one that's making the decision. I want to make decisions with them. So I think that maybe if I grew up in another province, maybe I wouldn't be like that. I don't know. But for me, when I think of my memories growing up, that's what it's done for me. It's made me want to be the opposite of what I saw and what I grew up with.

Participants' accounts further illustrate how the perception of leadership transcended official titles or roles. Leadership was considered to be a practice that required a central and robust focus on community health and the needs therein. Participants described how being in the community, educating people, and empowering people were important actions that constituted true leadership. Leading "outside of the box" was the phrase that came to mind for one participant as they reflected on what leadership means, particularly for Black nurses. This participant describes the challenges that Black nurses encounter when they attempt to lead within the box. Leading people and units became difficult for participants who felt constrained by traditional view or

approaches to leadership. Interestingly, the SBW archetype emerges in several participant accounts of leadership. The two following quote captures how participants perceived leadership.

> R#5: When I think about nursing and leadership, I think about being in the community, assisting people, whether it be in school, whether it be in, you know, people in their own residence, assisting people to give them an education, but also assisting them to be… you know, to take care of and be advocates for themselves. You know, when I think of leadership, I think of advocacy. And I think of being…. How can I say this? Sharing what your community is saying, sharing what the residents in your community consider important health concerns for them, and working diligently to try to meet those needs. You know, I'm very community-minded. So, you know, that's my thought process, I think. Not just nursing and being a manager or being in an administrative position in your workplace, but being a leader in the community and being a champion to the community for people to be whole and to be healthy, you know.

The second quote illustrates how this archetype is reinforced in nursing leadership through the normalization and endurance of high stress levels.

> R#3: Yeah, when I think of leadership, when I've done leadership stuff… And like I mean I've been a charge nurse role. I don't really see that… Like I see leadership in a very different light. I see it in more of a cultural leadership role. Because when I think about nursing, Black nursing leadership, I think outside of the box. Because in those boxes, how much really can we lead? Who's following? The white folks aren't following us. They're drumming to their own beat, right? You know, yes, we can lead, you know, units. We're more than capable of doing that. A lot of times we do it a heck of a lot better because we can endure higher levels of stress than what some of our Caucasian counterparts can. You know what I mean? So we can handle those situations. No problem, hands down, right. We can function, operate extremely well under stress. That's our life. We've been doing that all our lives, right.

The practice of formal leadership in nursing was not always a possibility for some participants. A few participants described a multitude of challenges – systemic and other – which made it difficult to attain formal leadership roles such as charge nurse, manager or other advanced practice roles. As a result, participants decided to focus their energy and attention on more informal leadership practices, including mentorship and community-based advocacy. This created a heightened recognition, value, appreciation and emphasis on informal leadership practices. Informal leadership was a common thread throughout the perception and practice of leadership by participants, particularly as some expressed feelings of not having an opportunity to be in

formal leadership roles. Ultimately, this led participants to practice leadership in an informal capacity, which ultimately amplified the value and importance of mentorship and advocacy in the community.

> R#4: I didn't feel like I had an opportunity to be a formal leader. So I lead informally because I can't lead formally. I was never given that opportunity. It's not that I couldn't like rise up to that. I certainly had it within me. But I felt that because I couldn't do it that way, that I did…I led informally a lot. I'm very much a mentor. And I would take on nurses who were internationally educated and needed to be precepted. I'd always take a preceptor. Even the new physicians, you know, I would sort of take them under my wing. So I think in my mind, I was a leader. But the only way that I could really demonstrate that was informally. As far as head nurse position, charge nurse positions, things like that, again, I hate to use that word white people, but that's what I grew up with. But I felt like that's who got that. I felt that that was never going to be an opportunity for me. And even if you applied, and as good as you were and as good as your evaluations were, there was always somebody else that was going to get it. So I just sort of forgot about it for a while and sort of turned my energies towards more informal leadership. So I would say that honestly a lot of us lead informally, but are not recognized as leaders in a formal sense. Which is really quite a shame.

Several participants shared extensive insight regarding their involvement in community-oriented programs and initiatives. Collaboration with community and provincial organizations was described as a central element of leadership. Examples of these community initiatives include women's groups, children's programming in schools, daycares, career days in local high schools and tutoring in the local community. Many programs were embedded within ANS communities i.e.: Mulgrave Park, Uniacke Square, North Branch Library, and the Preston township. Additionally, participants were actively engaged in advocacy and initiatives with organizations focused on Black health in Nova Scotia, including the Health Association of African Canadians and the Association of Black Social Workers as well as larger provincial organizations including Public Health, the Department of Health and NSHA.

> R#5: And it comes out of an African-Nova Scotia's health strategy. So I guess when I think about the impact in terms of leadership, certainly through the Health Association, a number of years ago we started meeting with the various organizations like mental health, public health, who were dealing with folks in the black community just to get a sense and to help them understand what was going on in our community, and to understand that as black people, we're not homogeneous, nor do we present in the same way white folks do. So it's been that…Constant advocacy, yes.

Participants shared extensive examples of advocacy and mentorship, which were woven into the perception of leadership held by many participants. Advocacy encompassed being present for and empowering patients and colleagues as well as identifying and supporting more community-based needs. The following quote captures how advocacy, mentorship and interdisciplinary collaboration are each related to the overall conceptualization of leadership.

> R#7: Well, for me, nursing leadership would probably be doing like teaching and stuff like that. So precepting students and just kind of like showing them the ropes and all that kind of stuff. Of course, like when you're nursing, like you're the front line, you're there one hundred percent with your patient. So nurses have a great like leadership role in that way as well because we know our patient sometimes better than a doctor does. But being that person for the patient. So like a patient advocate and just making sure that we're doing everything that we can for the patient. So being kind of like the leader of the interdisciplinary team for the patient.

Finally, the importance of interdisciplinary practice in leadership was extended by participants' vision of establishing a network or system of support, where Black practitioners, scholars and community can converge, learn together and improve overall community health. Participants remarked on the existence of such groups and initiatives in the US by describing how an initiative, which resembles a framework similar to the US would be useful in Nova Scotia and Canada. One participant explained how there was an early attempt to develop a network for Black nurses in Nova Scotia years ago but due to various reasons, it did not take hold. As shown below, having a network of Black nurses was considered to have the potential to address gaps in mentorship, share ideas, develop community-oriented strategies to improve health and foster leadership among ANS nurses.

> R#13: Yeah, I think that the concepts of nursing leadership, you know, it's a part of our scope and a part of our ethics. And I think that those types of things, scope and ethics, need to be incorporated into every single class. You know, because if you're going to say that we want to foster a culture of diversity then you need to include diversity everywhere. You need to do the same thing with encouraging nursing leadership. And so you have to kind of foster that along every step of the way, through every sort of course. And then amongst the Black community, you know, like with Black nurses, I think when you have an opportunity to have groups together, you know, like whether it's associations or what have you, when you can have groups get together, then within that you can say we want to foster leadership amongst ourselves. How are we going to do that? And have something that is grown from within the community rather than pushed upon the community. You know, I sort of look at like there's a lot of good

models for things like within the US because they have such a large Black population, you know, compared to us.

Chapter 8: Discussion

The purpose of this chapter is to offer an interpretation of the study findings and situate this study within the larger body of literature. This chapter begins by restating the research purpose and guiding questions. After the study findings are summarized and interpreted, this section situates the study findings within the literature and the larger body of knowledge. This chapter then describes the significance of this study and the implications. The chapter closes with a series of recommendations, including a published call-to-action commentary, as well as the limitations of the study.

8.1 Restating the Research Purpose and Questions

The purpose of this qualitative study was to critically examine the leadership experiences of ANS nurses in healthcare practice. The questions that guided this study included: 1) What are the leadership experiences of ANS nurses and 2) How do ANS nurses perceive leadership?

8.2 Summary of Findings in Relation to Research Purpose

This qualitative study provides an initial understanding and conceptualization of leadership as perceived and practiced by ANS nurses. Specifically, the findings reveal how ANS nurses possess a leadership philosophy that is grounded in community-oriented care. The study findings are presented in three overarching sections, each of which maps onto a specific aspect of the research purpose. Moreover, the guiding questions helped to further frame the both the analysis and interpretation of findings from this study. Together, the three overarching sections construct a basis for understanding important elements in shaping perceptions of leadership. The three sections map directly onto the research purpose and the three main concepts that constitute the purpose, which are *leadership, ANSs [nurses] and healthcare.*

- Section 1: ANSs as a Distinct People
- Section 2: Institutions of Care
- Section 3: Leadership Philosophy and Practice

Section 1, which locates *ANSs as a Distinct People,* offers insight into aspects of personhood, including ancestry, identity, and socialization, which inform how leadership is perceived and practiced by ANS nurses. Section One builds on existing information to provide additional evidence for understanding ANSs as a distinct group and community of people. For example, the theme *Situating ANS Identity* reveals the complexity of socialization in a predominantly white society and how this experience has a direct impact of self-determination, confidence and self-belief. The impact of socialization becomes apparent in the examination of educational experiences as well as the influence of socially constructed concepts such as race and gender. The theme *The Leaky Pipeline in Education* showed how self-determination was shaped and formed by early

childhood educational experiences and the obstacles that were overcome in order to continue education at the post-secondary level. Navigating systems, including education, which were described as consistently underserving Black students, created turbulent trajectories that impose additional hardship. Effectively, the leaky pipeline forced circumstances [and imposed resiliency] that led to highly adaptable, flexible, resourceful and ultimately successful individuals – but at what cost? With this in mind, it is important to note that this study does not capture nor reflect the instances where individuals were unable to persist and overcome the numerous systemic and institutional obstacles and barriers. Finally, the theme *An Ethic of Care* provides critical insight into the development and nature of care and a caring philosophy. Early exposure to caregiving by women in the household and community had a profound influence on the perception and ultimate practice of leadership. Again, the development of an ethic of care, which provided a foundation upon which approaches to nursing and leadership were formed, were grounded in community. Finally, the practices of leaning into experience and caring for the self, offered insight into how this ethic of care was practiced with oneself and with others.

Section 2, titled *Institutions of Care*, builds upon the groundwork established in Section One. The findings in Section Two situate institutions as power structures to interrogate how these social structures [re]produce power dynamics. Section Two includes two separate yet interrelated institutions, each of which constitutes a one of the two themes. The first institution and corresponding theme involves nursing [or the nursing profession]. The theme '*Black Tax' in Nursing* describes the process of negotiating professional tensions and fundamental profession beliefs within nursing while simultaneously navigating the profession as a Black person. Paying Black Tax involves the extra physical and mental strain that accompanies personhood, which spans from daily microaggressions to more widespread, insidious and nuanced processes. These challenges are exemplified in accounts of navigating intra-professional relationships and in attempting to ascend the professional ladder. Lastly, this theme includes an interrogation of the *Invite Only!* reputation, which denies access to entering the nursing for those deemed as "less suitable". This theme expands the understanding of the notion of a 'concrete ceiling', which suggests that there is a predetermined restriction in terms of career trajectory. Yet, despite the concept, which suggests an impenetrable passage, there is evidence that suggests that this concrete ceiling has begun to crack.

The second institution and theme that constitutes Section 2 is focused specifically on the healthcare system in Nova Scotia and is titled *Nova Scotia Healthcare as an Archaic Institution*. Again, this theme maps directly onto the research question by providing additional insight into the context in which perceptions of leadership were formed and where leadership was practiced. This theme used participant accounts to examine what inclusion truly means and what is required in order to achieve a sense of inclusion and belonging that is

not performative or resembling tokenism. One of the largest challenges that becomes apparent in this theme circles back to the importance of community and the need for healthcare to be community-oriented. The emphasis on community-oriented care was discussed alongside inclusion as well as pervasive competency gaps that results in substandard care delivery and harm to patients. Together, these *Institutions of Care* preview the formulation of the interpretive overarching section that consolidates the practice and perception of leadership for ANS nurses.

The third and final section that completes the findings from this study is *Leadership Philosophy and Practice.* Section Three is situated upon the previous two Sections in that many of the subthemes and threads throughout the study convene at the interpretive level of leadership amongst ANS nurses. Leadership was found to be an integral component of nursing practice that encompasses a deep-seated commitment to community-oriented care. Leadership, as a practice and philosophy, was considered to extend beyond a formal position or title, with nurses identifying as leaders based on their knowledge, abilities, perspective, and practice.

8.3 Situating Findings Within the Literature

The findings of this study align with the existing body of knowledge related to Black nurses in Canada. A scoping review charting the available peer-reviewed and grey literature regarding Black nurses in the Canadian nursing profession shows that the literature is able to be classified into five primary areas of focus: historical situatedness; immigration; racism and discrimination; leadership and; diversity. The findings from this qualitative study align with the key results of the scoping review including issues regarding leadership, diversity and racism, in nursing. The scoping review also captured research that included participants who would be classified as ANS. While the results of the scoping review did not include sources that focused exclusively on ANS nurses, three of the included sources did acknowledge and discuss the similarities and differences that exist amongst ANS nurses and Black immigrant nurses in Canada (or Nova Scotia). To this end, this study begins to address this gap in knowledge by examining leadership as it pertains to ANS nurses.

The findings from this study align with three landmark studies that examined the historical and contemporary experiences of Black nurses in Nova Scotia. The first is a qualitative study that used oral histories to recover the identities of Black nurses in Nova Scotia (Keddy, 1997). The findings from Keddy's (1997) historically situated study are corroborated by the current study, both of which found that Black nurses who were born in Nova Scotia described experiences of overt and systemic racism beginning in early childhood. Similar to Keddy (1997)'s work, this study found that nurses experienced racism and discrimination throughout childhood as well as during attempts to gain admissions to nursing school.

The second landmark study is that of Flynn (2011), which includes a consolidation of qualitative interviews and document review, to understand the lives of Caribbean- and Canadian-born Black nurses in Canada. Flynn identified historical evidence revealing how Black women were actively denied admission to nursing training facilities in Nova Scotia and across Canada, until the 1940s. The current study includes findings that depict the ways in which ANSs, who were interested in pursuing [or advancing in nursing] continue to encounter restrictions around admissions into nursing education. Flynn (2019) also described attempts to erase, dismiss and ignore the presence of Black women in Canada. The findings from this study found similar attempts to minimize or erase the presence of ANSs by the blatant omission of content and information in educational curriculum [from elementary to postsecondary] and healthcare literature, despite ANSs having a significant and longstanding presence in Nova Scotia. Finally, like Flynn's (2009) work, the current study exemplifies how nurses felt as though they were under surveillance and that their suitability for their position was scrutinized by colleagues, patients and administrators.

The final study, which constitutes the foundation for understanding the experiences of Black nurses in Nova Scotia, is the work of Etowa (2005; 2009). Etowa's grounded theory research generated a substantive theory suggesting that Black nurses in Nova Scotia perceived themselves as practicing on the margins of the nursing profession. Participants in this study discussed similar feelings, which are captured largely in the '*Black Tax' in Nursing* theme. The findings from this current study reflect those of Etowa's (2005; 2017), which showed how issues of diversity and representation were pervasive in the workplace, in education and curricula, within professional literature as well as in leadership. Lastly, Etowa's work determined that race was considered to be one of the most significant factors (2006).

Expanding upon the findings from Etowa (2005; 2006), which identified race as the most significant factor, both Calliste (1996) and Das Gupta (1996) described the compounding effects of gender and class on race. Within the nursing profession, racism was gendered and classist (Calliste, 1996; Das Gupta, 1996). The gendered and classist nature of racism emerged in the study findings throughout each of the three overarching sections. For example, the subtheme of non-traditional student captures this sentiment.

The findings also corroborate the larger body of knowledge pertaining to the experiences of Black nurses (including Black immigrant nurses) and leadership, in Canada. In terms of leadership, this study aligns with the findings generated by other qualitative research that examined the experiences of Black immigrant nurses [or IENs] in relation to leadership (Boateng, 2015; Bouabdillah, 2016; Collins, 2004; Prendergast, 2014; Stewart, 2009). For example, Bouabdillah (2016) and Collins (2004) both found that Black nurses encountered myriad challenges in career advancement and progression. The career pathway or trajectory was considered to

be discriminatory as both lateral and vertical career mobility were limited (Bouabdillah, 2016; Collins, 2004). Again, this study reflects similar descriptions of challenges progressing and advancing in the nursing profession. Prendergast described a unique finding of the "ideal type" when considering who is promoted in nursing. The concept of the "ideal type" lends itself to insights from Stewart, who found that Black nurse managers attributed significant workplace challenges – including differential negative treatment, feeling unimportant, needing to work twice as hard or prove oneself, and navigating everyday racism or microaggressions. The current study findings are in accordance with this work.

The findings of this study deep our understanding and knowledge related to ANS nurses, healthcare and leadership. This evidence helps to advance our efforts towards a comprehensive understanding of the larger context of nursing practice in Canada. This study offers a deeply layered analysis of how aspects of personhood, which have historically been absent in considerations of nursing, impact nursing practice and specifically leadership. This work contributes to existing knowledge while at the same time, challenging our collective understanding of how subjectivity is important. However, the heterogeneity of Blackness indicates that there are both nuanced and stark difference in experience amongst Black people in Canada. To this end, this current study is novel, and addresses a gap in the literature, as the first to focus explicitly on the significance of ANS ancestry in relation to nursing, leadership and healthcare.

8.4 Significance of Study Findings

8.4.1 Significance for Nursing and Healthcare

The significance of the findings from this study are presented with two foci in mind: nursing and healthcare; the ANS community. These findings are significant for nursing and more broadly healthcare. There is a great deal of insight relating to ANS nurses as care providers, within the larger healthcare system, as well as important considerations regarding care delivery to ANSs as patients. This study challenges longstanding assumptions and approaches to nursing and healthcare. Critically examining the leadership experiences of ANS nurses reveals opportunities to improve upon organizational and institutional commitments to improve the health outcomes of Black populations in Nova Scotia. In addition to addressing barriers for ANS nurses in education and healthcare, this study provides extremely useful insight into how healthcare delivery can better serve ANS patients and communities as well as other communities that have been historically marginalized. This study adds evidence to enhance healthcare delivery and address existing gaps in care provision and education. For example, the emphasis on community-oriented care, the connections to the social and structural determinants of health as well as the important considerations for nursing education is informative.

8.4.2 Significance for Community

As indicated in the introductory chapter of this dissertation, the significance of this study extends beyond the institutions of nursing and healthcare. This study holds tremendous value for the ANS community. In addition to incorporating the experiences of individuals who have been historically excluded from research and literature, this study consolidates experience and narrates an inspirational journey to fill in elements of the historical record. As a distinct people, ANSs have made progress in distinguishing and reclaiming aspects of identity that have been lost. The effort to reclaim identity is one that began long ago and has a deep foundation in oral history. I believe that this study presents an authentic and truth chapter in the larger story of ANS history.

8.5 Implications of Study Findings

8.5.1 Implications for Nursing Practice

The implications for nursing practice can be explored in two facets. The first is related to nurses, which involves understanding and addressing practice and learning environments that contribute to an overall sense of belonging. This ranges from intra- and interprofessional/ disciplinary dynamics as well as wider departmental and organizational dynamics, all of which influence the environments and sense of belonging. The second consideration relates to patients. Nursing practice is known to have a direct influence on patient outcomes. Findings in this study showed instances of poorly informed approaches to care. To this end, it is possible that these findings generated a larger dialogue about competency and the provision of competent care that extends beyond the physiological elements to include greater aspects on personhood as well as the social and structural determinants of health.

8.5.2 Implications for Nursing Education

The implications for nursing education span three key areas. Specifically, this study holds implications for nursing education curriculum, program admission (including recruitment and retention at the undergraduate and graduate level), and representation among students, faculty and staff. The implications for nursing education are relevant to each of the nursing education programs in Nova Scotia. Cape Breton University, Dalhousie University, St. Francis Xavier and the Nova Scotia Community College each have a responsibility to evaluate their program given their geographical location amongst the widespread ANS communities, and the populations represented within their institutions.

With regards to curriculum, this study shows some of the more salient gaps in content, particularly as it relates to the ANS population, community-oriented care, and the social and structural determinants of health. An example of work that has already begun to shift in this direction includes the evaluation of curriculum to

incorporate representative and non-stereotypical content and information about various groups. Lane and Waldron (2021) developed a comprehensive rubric that serves as an accessible template to evaluate course syllabi. The rubric, which was designed to enhance the inclusion of diverse and non-stereotypical content in nursing curricula, is being used to address some of the issues that exist.

The second area of focus concerns program admissions and the related processes and initiatives that enhance the recruitment and retention of ANS students. Specifically, this study draws attention to the unique consideration regarding the shift in the demographics of students in the program. Students are entering the program with specific life circumstances, which counter the traditional image of a student. The shift in life demands of students suggests that it would be useful for programs to consider how to best accommodate non-traditional students – those who take a less traditional route to nursing education. This is an important consideration, since more students are entering the nursing program after having completed a previous degree, had a career in another sector, are parents, are first-generation university students, are caregivers for aging family members, are mature students or have other responsibilities that are counter to how nursing program typically operate. Ergo, examining institutional processes regarding recruitment and retention of ANS students in nursing, including at the graduate level with an emphasis on mature students, is necessary.

The final implication for nursing education is related to representation across the student, faculty and staff. Due to the unavailability of important data, it remains unclear how many ANS nurses currently hold staff or faculty positions in post-secondary institutions. Additionally, it is unclear as to how many ANS students populate the nursing programs. This study should inspire institutions to examine this issue [or representation] and implement strategies to address the gaps in ANS representation in nursing. Especially since many of the issues with representation in the nursing profession and in leadership are directly connected to issues of recruitment, retention and representation in nursing programs.

8.5.3 Implications for Nursing Research

Similar to the suggestion put forth in the scoping review, an important next step for research would be to conduct a national nursing workforce demographic survey that collects and disaggregates data in relation to multiple aspects of personhood as well as nursing practice. This demographic mapping of the Canadian nursing workforce would include demographic indicators such as race, ethnicity, sex, gender (identity and expression), age, sexual orientation, disability, creed and religion. Beyond these data of personhood, data pertaining to practice area, years of experience and career trajectory would be beneficial to inform our understanding of the Canadian nursing workforce.

In addition to a national demographic nursing workforce survey, more in-depth qualitative or mixed methods studies, to understand the experiences of specific populations within the nursing workforce would be valuable. For example, the experience of IENs has been documented however, there is a gap in literature that examines the experiences of IENs who work as non-licensed clinical care providers such as continuing care assistants or personal care/ support workers. In addition to using qualitative or mixed methods to uncover evidence regarding the vast nursing workforce, there is a need to employ non-traditional methodologies and tools in research. Incorporating knowledge systems and ways of knowing that extend beyond traditional theoretical and methodological approaches to knowledge generation and discovery is highly appropriate, relevant and necessary especially in working with groups that have been historically excluded from research. Finally, moving away from the focus on individuals and groups, it would be useful for organizations and institutions to perform an internal quality appraisal of important practices such as hiring and admissions processes; the filing of grievances or complaints as well as the procedures for promotion and advancement. Each of these aspects came through in the findings as areas of concern therefore, the onus is on the institutions to review and amend as necessary. This action may offer additional insight into the nature of the practice/ learning environments as well as the sense of belonging.

8.5.4 Implications for Nursing Policy

Translating the findings into useful and actionable policy is an essential next step. These findings have the potential to inform care directives, health policies and guidelines, while attending to stereotypes and implicit bias that both perpetuate intra-professional discrimination and diminish patient care. Examining the language used in policy is an initial step. However, critically evaluating the content and operationalization of specific policies, in collaboration with appropriate stakeholders, is required. Policies related to hiring and admissions, which are often defended as being “merit-based” is one example of an opportunity to critically examine and evaluate policy. Further, evaluating specific care directives in collaboration with ANS health professionals, to enhance competency and relevance, has the potential to improve trust and accessibility, which in turn leads to improved overall health of communities. Lastly, increased awareness regarding the interconnectedness of education, healthcare and nursing enables identifying and leveraging policy windows to facilitate reform and foster change.

8.6 Recommendations

The recommendations that emerge from this study are classified into two categories. The first set of recommendations include general recommendations, which are less directive and are intended to be open to uptake as fitting for the context. As shown in the integration process diagram, addressing barriers from two

layers alone (ie: gatekeepers and policy, which are transient) is useful only to a limited extent. For sustained shifts, it is imperative to address all three levels simultaneously, especially since the ideological foundation is prescriptive and structures will always revert. Efforts to augment the systems are ineffective without larger internal deep ideological shifts.

8.6.1 Organizational Recommendations

In recognizing the progression that Nova Scotia Health has made over the recent years, in partnering with the ANS community, the recommendation is for this work to continue. Examples of advances within Nova Scotia Health include the launch of the ANS Health Strategy and the appointment of a project coordinator. Another important strategy was evident in the partnership with community organizations and practitioners to address health service accessibility issues and mobilize care, which was observed with the COVID-19 community-based clinics. Expanding these current partnerships and exploring novel opportunities to engage with other important sectors such as education and labour, is another important step NSH could take.

In tandem with NSH recommendations, it would be important for other governance bodies, such as the IWK Health Centre, and health facilities across Nova Scotia, to create opportunities to integrate and incorporate pertinent information and content about the ANS community into the institutions. As described in a news release, in February, 2020, the IWK Health Centre acknowledged the Black population in Nova Scotia by raising the Pan-African flag for the first time. This gesture was described as meaningful to ANSs and the broader Black population in Nova Scotia. Ergo, both NSH and the IWK would benefit from strengthening community partnerships and incorporating content regarding ANS communities (including historical and contemporary content) into care directives, facility orientation, strategic direction and institutional priorities.

The final general recommendation is strengthening pathways that facilitate the integration of ANS practitioners and staff into the systems. This complements the previous recommendation concerning the incorporation of information and content pertaining to ANSs. Again, the intentional and strategic integration of ANSs – and their expertise – requires deliberate processes and mechanisms to ensure that this process is truly inclusive as opposed to tokenistic.

8.6.2 Institutional Recommendation: An ANS Nursing Education Program Strategy

The ANS Nursing Education Program Strategy is a recommendation for a program that, includes a partnership between NSH and SONs, and presents considerations for facilitating the recruitment and retention of ANSs into nursing programs. In addition to facilitating the entry of ANS students into nursing programs, this strategy attempts to address the retention and representation of ANS students in nursing programs through a series of embedded processes and initiatives. Moreover, the program attempts to address issues of

representation at the staff and faculty levels. It is important to note that this program does not introduce novel concepts of ideas related to this specific context or the ANS community. Rather, this program is meant to build upon longstanding successful initiatives that support ANS students, including the Transition Year Program (TYP) and the Indigenous Black and Mi'kmaq (IB&M) Initiative through the Schulich School of Law as well as other comprehensive programs such as PLANS. Additionally, this program incorporates elements from the exceptional successful former SON program that was established by Etowa et al. (2005), which saw over a 100% increase in the enrollment and completion of the program for Black students, while it was active.

Since one of the major findings of this study captures the educational trajectory through undergraduate nursing education as well as barriers to graduate education, this program presents three pillars for nursing programs to consider. These include program-wide consideration; undergraduate- specific considerations, and graduate- specific considerations. The recommendation is for a comprehensive and embedded ANS Nursing Education Program Strategy that necessitates an active partnership between nursing programs, the Nova Scotia provincial government and NSH.

Key Components for SON programs:

1. Cohort programing for incoming undergraduate and graduate students that is modelled after the IB&M Law program. Examples of key activities required for the cohort program include:
    a. An orientation week prior to the commencement of the program
    b. Bi-monthly meet-ups (twice per semester)
2. Hiring of an ANS nursing coordinator – at part-time or full-time status, depending on the need.
3. Hiring and support of ANS nursing faculty – in both the teaching and research/ tenure track.
    a. Both the ANS nursing coordinator and the ANS nursing faculty would be directly involved in the operation of the ANS Nursing Strategy Program, including but not limited to the admissions process (including interviews and application review), recruitment and retention initiatives, and mentorship.
4. Foster partnerships with community and institutional stakeholders (ie: the Health Association of African Canadians; PLANS) to actively and deliberately recruit ANS students into the nursing program.
5. A final requirement includes ensuring enhancing the representation of the ANS community by introducing ANS history and health into existing curricula or a new Faculty-wide ANS and Health course. This will address gaps in content that participants identified as either absent or stereotypical when present.

Key Components for Undergraduate Programs

The three key elements for the undergraduate program include:

1. The embedding of protected seats for ANS students
2. The formalized development of a pathway from the TYP program into the Dalhousie SON.
3. The establishment of a bridging program* from:
    a. NSCC to SONs in Nova Scotia (Dalhousie)**
    b. Clinical LPN practice to SONs in Nova Scotia (Dalhousie)**

    *Requires partnership and investment from provincial government, NSH and SON programs

    **A bridging program currently exists at Cape Breton University and St. Francis Xavier

Key Components for the Graduate Program

1. Protected seats, and funding, per year for six ANS nurses to enter the Masters program
    a. Two students per stream (ie: professional, NP, thesis) however, this is flexible depending on interests of applicants
    b. Requires announcement of a call-of-interest using appropriate community, organizational, academic and professional channels to generate awareness and begin the active recruitment process to identify and select up to six ANS nurses to join the program.
    c. This would resemble a similar successful initiative that existed within the Dalhousie SON Masters program that facilitated the entry and completion of neonatal nurses into the NP program.
2. Protected seat and funding for one ANS to enter the PhD program
3. The creation of at least one postdoctoral fellowship position that is jointly situated within the SON and the Black Studies Research Institute at Dalhousie
4. Use the Prior Learning Assessment (PLA) tool that is common practice through the Faculty of Graduate Studies, in consultation with the ANS nursing coordinator and faculty, to assess each of the applicants. The lack of a holistic assessment, beyond GPA, was identified by participants as a barrier to continued education. Operationalizing the PLA, in collaboration with ANS consultation, would help to address this.

Finally, because the findings depict an erasure of the ANS community and because racism was determined to exacerbate and amplify other forms of discrimination, it is imperative that the findings and subsequent recommendations from this study do not become intertwined and masked by other important strategies such as equity, diversity and inclusivity (EDI) initiatives. While extremely relevant and necessary,

relying solely on EDI is not sufficient to address the inherent institutional and systemic issues of anti-Black racism that arise, as it is not effective in interrogating the root of this type of oppression. Thus, the final recommendation comes in the form of a published commentary that I was invited to develop and submit in a special issue with the Canadian Journal of Nursing Leadership. The special issue, titled: *The Future of Nursing* was designed to share strategic insight and direction from critical nurse leaders on important issues in nursing to enhance the outlook for the profession. My commentary, which presents an unapologetic approach for nursing to move beyond our historical legacy of anti-Black racism and into a domain of anti-racist practice. The following section contains this published call-to-action commentary.

8.7 Advancing Nursing in Canada: Toward the Elimination of Anti-Black Racism

This work in section 8.7 also appears in: Jefferies, K. (2021). Advancing Nursing in Canada: Towards Eliminating Anti-Black Racism. *Canadian Journal of Nursing Leadership, 34*(4); 139-143.

8.7.1 Statement of Manuscript Contribution

KJ conceived, develop and submitted this manuscript for review. Copyright details are located in Appendix A.

8.7.2 Background

The COVID-19 pandemic exposed the most vulnerable sectors of society. The human rights and well-being of Black people have been brought to the forefront in the wake of this pandemic. Compounding this, the televised mistreatment of Black people has led to mounting calls-to-action on a global level. As one of the most trusted professions, nurses are in an optimal position – and have an ethical duty – to address historic oppression and ongoing discrimination to achieve inclusivity within the profession and as part of care provision in Canada. In Canada, we are beginning to acknowledge that racism, specifically anti-Black racism, exists in our country. Yet, despite ongoing revelations about our egregious historical and contemporary mistreatment of Black and Indigenous Peoples, our immediate reaction when confronted with these truths is to rationalize, justify or distance ourselves from the acts and consequences of colonialism. We attempt to settle our dissonance by convincing ourselves [and others] that *we are not as bad as the US*, that Canada is a world leader in multiculturalism and inclusivity and that racism simply does not exist in Canada. As Canadians, we want this to be true; we *need* this to be true. However, it is not. It is duplicitous to claim to value diversity and the attainment of a truly inclusive multicultural society without accountability for the past, acknowledgement of the present and collaborative efforts to redefine the future.

In nursing, there is a degree of complacency and fear as well as an unwillingness to examine the fundamental professional values and beliefs related to racism. The past two years challenged our country and

our profession in the most extreme ways. The COVID-19 pandemic exposed deeply entrenched issues in society and healthcare while imposing much needed discomfort, which forced us to examine what it means to be a nurse. These collective challenges revealed the strength of nurses as well as problematic elements in the foundation of the profession. Building on these revelations, the elimination of anti-Black racism in nursing requires a critical review of nursing history in Canada and how that history influences and reinforces current practice. The current socio-economic climate requires nurses to embrace their role as transformational leaders by instigating practice shifts and health system reform. This commentary, situated within a special issue that envisions the future of nursing in Canada, aims to advance the effort to eliminate anti-Black racism in nursing by challenging historic and contemporary issues within nursing and providing direction toward a more inclusive future for nursing.

8.7.3 Beyond Equity, Diversity and Inclusion

The issue of representation of Black nurses is not a matter of qualification or suitability. The under-representation of Black nurses throughout the nursing workforce, particularly in formal leadership positions, is the result of antiquated ideologies and discriminatory traditions within nursing. These discriminatory practices date back to the overt racial segregation that formed the foundation of Canadian society, including the deliberate exclusion of Black women from nursing schools. Arguably, we have made remarkable gains compared to when nursing began in Canada; however, the legacy of anti-Black racism continues to be a driver in nursing even today.

Anti-Black racism is the specific form of discrimination that manifests as the policies, practices and decisions within institutions that knowingly or unknowingly reinforce discriminatory beliefs, attitudes and prejudice toward Black people (BHA 2018). For example, growing recognition of the gender pay gap shows that women generally receive lower wages than men (Statistics Canada 2019). Similar research shows a racial pay gap in that Black employees receive lower wages than white employees (ANSA 2014). Inequities in social advancement and access to resources become more pronounced when race, gender and other factors are analyzed together. *Intersectionality* is a critical social concept that facilitates an understanding of the dynamic interaction of unique aspects of personhood, such as race, gender (expression and identity), sexual orientation, disability and class. Intersectional analysis exposes how power dynamics influence everyday interactions across individual experiences and societies in ways that produce power imbalances, privilege, disadvantage and marginalization (Collins and Bilge 2020; Crenshaw 1989).

Boyd (2019) argued that analyzing racial segregation is critical to understanding the relationship between racial inequities in the workforce and population health in general. Boyd (2019) described racial

segregation as the composition of four distinct yet interconnected processes of racial exclusion and discrimination, which reinforce and perpetuate a cycle of exclusion (or under-representation). The four processes of racial segregation are as follows:

1. *White hegemony*: This establishes and enforces racial hierarchies that situate decision-making power with white people.
2. *White normativity*: This naturalizes power imbalances and asymmetry between white and non-white people as primarily meritocratic.
3. *White privilege*: This directly and indirectly preferences white people by enabling disproportionate access to socio-economic resources (e.g., home ownership, generational wealth and education).
4. *White supremacy*: This denotes the construction and maintenance of a racial ordering of humans and resources that justify and reinforce racial dominance for white people.

Situating anti-Black racism and intersectionality alongside Boyd's (2019) framework of racial segregation offers a concrete approach to address discrimination and move toward the elimination of anti-Black racism in nursing and healthcare. To fully and sustainably eradicate anti-Black racism in nursing, all four processes of racial segregation must be investigated and addressed simultaneously (Boyd 2019). Without this basic yet fundamental approach, any attempt to augment representation and access will serve only to reinforce inequity rather than reduce it. Trying to advance equity, diversity and inclusion (EDI) without attending to all four processes of racial segregation explicitly and simultaneously is mediocre at best. Therefore, while it is important for nursing to enhance EDI efforts, it is equally important to intentionally and unapologetically interrogate racial segregation and decolonize nursing. This approach will also serve to safeguard against the bleaching of EDI in ways similar to that of intersectionality.

8.7.4 Pushing the Limit: Abolition as Healthcare

As our profession moves toward eliminating anti-Black racism and enhancing inclusivity for nurses who have been historically marginalized and excluded due largely to their race, our profession is called to step up for another issue: abolition. Abolition involves the fundamental reimagining of creative and compassionate responses to social harms that avoid perpetuating violence and trauma (Paynter et al. 2021). This highly political stance both recognizes and condemns the disproportional rates at which Indigenous People, Black People and People of Colour are incarcerated in Canada (Owusu-Bempah et al. 2021; Paynter et al. 2021). A significant percentage of the prison population comprises people who have committed non-violent crimes, have experienced the worst forms of violence and sexual assault themselves, are poor, were precariously housed and/or suffer mental health distress (Paynter et al. 2021). Essentially, prisons confine many people who require

the basic human necessities, sympathy and care, but instead end up receiving the worst form of treatment and punishment. A nursing position statement (Paynter et al. 2020) calls upon nurses and nurse allies to join the movement to abolish prisons. The statement argues that, beyond disproportional incarceration rates, prisons exist within a system of punishment that inflicts long-lasting irreparable mental and physical trauma upon individuals, families and communities. The adverse impact of incarceration on mental, physical and spiritual health is a healthcare crisis that is in direct opposition to the core tenets of nursing, including equitable treatment, care and health promotion (Paynter et al. 2020).

8.7.5 Conclusion

The aim of this commentary is to contribute to the elimination of anti-Black racism in nursing by engaging in honest and meaningful strategic planning as a profession. The centring of Blackness and anti-Black racism in nursing is not an attempted erasure of non-Black lived experiences. This commentary is meant to challenge our current approach to anti-Black racism, understand why it has stalled and consider alternatives to inform our approach and advance our profession. Eliminating anti-Black racism in nursing is necessary to advance nursing and improve the health outcomes for all Canadians. To achieve this, all anti-racist work must incorporate a complete and thorough interrogation of racial segregation and integrate unique intersectional experiences that extend beyond race, as Black people include folks who exist at various intersections. As mentioned, this commentary is situated with the other papers in this issue – each meant to provide critical insights and directions for the future advancement of nursing in Canada. Amplifying our individual and collective nursing voice to denounce human rights violations, social injustice and racism is not bold or radical nursing, it *is* nursing. In conclusion, I offer this commentary as encouragement to nursing students, nurses and nurse allies alike to go beyond our comfort zone and change the way we do things. The future of nursing is inclusive.

8.8 Study Limitations

To reiterate the study limitations as presented in 7.1 (CMAJ) article, the findings from qualitative research are not intended to be generalized to larger groups. Rather, readers, including stakeholders such as policy-markers and decision-markers, are encouraged to carefully review the study and determine whether aspects of the findings herein are transferrable and useful in other contexts. In terms of the study, there are several limitations to acknowledge. The first is regarding the operational definition of ANS heritage, which was used to determine eligibility criteria. The definition operationalized in this study did not adhere to the newly available definition that was developed by the ANS Strategic Council. The definitions reads: *African Nova Scotians (who also self-identify as Indigenous Black, Africadian, Afri-Scotian or Scotian) are descendants of*

free and enslaved Black Loyalists, Black Refugees, Maroons and other Black people who were settled across 52 indigenous (original) land-based Black communities. This definition was not used in this study simple because it was not available during the initial stage of the research process. Another limitation with sampling is that eligibility relied on self-reporting of nurse status and ANS heritage.

In terms of methods, limitations with data collection include the use of telephone interviewing as opposed to in-person interviews. Additionally, the interviews occurred during the initial wave of the COVID-19 pandemic, between March and June, 2020. The telephone interviews were conducted within a two-hour timeframe, during an afternoon, on a day selected by each participant. Additionally, the semi-structured interview guide did not undergo a pilot test prior to use and only one interview was conducted with each participant. While additional techniques that would enhance trustworthiness of findings, including member-checking or triangulation, were not performed. Another limitation is that this study did not collect nor report any disaggregated data beyond ANS ethnicity. Finally, as a doctoral candidate and trainee, there were limitations inherent in my research knowledge and skills as I navigated the learning process.

Chapter 9: Conclusion

This dissertation constitutes a body of work that adds significant value to understanding a segment of the Canadian nursing profession, by centering Black nurses. The historical and ongoing issue of anti-Black racism continues to impact Black nurses across Canada. Within the larger cohort of Black nurses in Canada, there is another group of nurses, whose ancestry has greatly influenced their trajectory in nursing. Specifically, ANS nurses constitute a group of particular interest, as their experience of Blackness has been extensively shaped by socioeconomic factors. Ergo, this qualitative study used a conceptual framework, built upon the theoretical underpinnings of BFT, to elucidate the leadership experiences of ANS nurses. By examining the leadership experiences of 18 ANS nurses, an account of the perception and practice of leadership was generated. The findings from this study, which are presented in three overarching conceptual sections, portrays a journey of perseverance, determination, and inspiration. ANS nurses shared extensive insight beginning with the significance of their ancestry, through to their socialization, education, nursing practice and leadership. The culmination of their life experience depicts how these nurses assumed leadership roles by virtue of their presence in the nursing profession.

This study illuminated persistent and equally concerning processes, attitudes and practices within nursing, healthcare and education. The interrogation of nursing and healthcare as institutional structures, which are implicated in the [re]production of power dynamics, revealed that the issues that impact ANS nurses extend to ANS patients, communities and other historically marginalized groups. For nursing to continue advancing towards a profession that is both inclusive and competent in care provision towards the various health needs of diverse patient populations, it is essential for ANS nurses to be effectively integrated into formal and informal leadership roles. True integration of ANS nurses extends beyond diversity quotas, tokenism or simple representation to include the integration of ideas, contributions and experiences. Finally, in addition to active recruitment and retention, ensuring that ANS nurses are able to practice leadership as it aligns with their community-oriented leadership philosophy, positions ANS nurses to effectively participate in decision-making, policy, practice and research, to enhance nursing, healthcare and the health of the ANS community.

References

Abdullah, M. 2007. “The Emergence of a Black Feminist Leadership Model.” In K. B. Waters & C. B. Conaway (Eds), *Black Women’s Intellectual Traditions* (pp. 328-345). Burlington, Vermont: University of Vermont Press.

Abrams, J. A., Maxwell, M., Pope, M., & Belgrave, F. Z. (2014). Carrying the world with the grace of a lady and the grit of a warrior. *Psychology of Women Quarterly*, *38*(4), 503-518. https://doi.org/10.1177/0361684314541418

African Nova Scotian Affairs (ANSAa). (2022). African Nova Scotian Community: a look back. Available at: https://ansa.novascotia.ca/community

African Nova Scotian Affairs (ANSAb). 2014. African Nova Scotians Today. Available at: <https://ansa.novascotia.ca/sites/default/files/inline/documents/ansa-stats-research-2014-11.pdf>.

Amuchie, N. (2016). “The forgotten victims”: How racialized gender stereotypes lead to police violence against Black women and girls: Incorporating an analysis of police violence into feminist jurisprudence and community activism. *Seattle Journal for Social Justice*, *14*(3), 617-668.

Andrews, N., Greenfield, S., Drever, W., & Redwood, S. (2017). Strong, female and Black: Stereotypes of African Caribbean women’s body shape and their effects on clinical encounters. *Health*, *21*(2), 189-204. https://doi.org/10.1177/1363459315595847

Ashley, W. (2014). The angry lack woman: The impact of pejorative stereotypes on psychotherapy with Black women. *Social Work in Public Health*, *29*(1), 27-34. https://doi.org/10.1080/19371918.2011.619449

Aston, M. (2016). Teaching feminist poststructuralism: Founding scholars still relevant today. *Creative Education*, *7*, 2251–2267. https://doi.org/10.4236/ce.2016.715220

Barbee, E. L. (1994). A black feminist approach to nursing research. *Western Journal of Nursing Research*, *16*(5), 495–506. https://doi.org/10.1177/019394599401600504

Baxter, J. A. (2008). Feminist Post-structuralist discourse analysis: A new theoretical and methodological approach? In K. Harrington, L. Litosseliti, H. Sauntson, & J. Sunderland (Eds.), *Gender and language research methodologies* (pp. 243–255). Basingstoke, UK: Palgrave Macmillan.

Beagan, B. L., & Etowa, J. (2009). The impact of everyday racism on the occupations of African Canadian women. *Canadian Journal of Occupational Therapy*, *76*(4), 285–293. https://doi.org/10.1177/000841740907600407

Bell, B. (2021). White dominance in nursing education: A target for anti-racist efforts. *Nursing Inquiry 28*(1), Article e12379. https://doi.org/10.1111/nin.12379

Blake, D. (2010). Do we assess 'colour' appropriately using the APGAR score? *Journal of Neonatal Nursing*, *16*(4), 184–187. https://doi.org/10.1016/j.jnn.2010.03.002

Bernard, W. T., & Smith, H. (2018). Injustice, justice, and Africentric practice in Canada. *Canadian Social Work Review*, *35* (1), 149–157. https://doi.org/10.7202/1051108ar

Black Health Alliance (BHA). 2018. Anti-Black Racism. Available at: <https://blackhealthalliance.ca/home/antiblack-racism/>.

Blanchet Garneau A, Browne AJ, Varcoe C. (2018). Drawing on antiracist approaches toward a critical antidiscriminatory pedagogy for nursing. *Nursing Inquiry, 25*(1).

Blythe J, Baumann A. (2009). Internationally educated nurses: Profiling workforce diversity. *International Nursing Review, 56*(2):191–7.

Boateng, G. (2015). Exploring the Career Pathways, Professional Integration and Lived Experiences of Regulated Nurses in Ontario, Canada. [University of Western Ontario]. https://ir.lib.uwo.ca/etd/3236

Boateng G, Adams TL. (2016). "Drop dead … I need Your job": An exploratory study of intra-professional conflict amongst nurses in Two, Ontario Cities. *Social Science & Medicine, 155*:35–42. https://doi.org/10.1016/j.socscimed.2016.02.045

Boateng G, Schuster R, Odei Boateng M. (2019). Uncovering a health and wellbeing gap among professional nurses: situated experiences of direct care nurses in two Canadian cities. *Social Science & Medicine*, ;242

Bonilla-Silva, E. 2014. Racism Without Racists: Color-Blind Racism and the Persistence of Racial *Inequality in America* (4th ed.). Lanham, Toronto: Rowman & Littlefield Publishers, Inc.

Bouabdillah, N., Holmes, D. & Tourigny, J. [Visible minority nurses and vertical mobility in hospitals]. *Recherche En Soins Infirmiers*, *127*, 71–81. https://doi.org/10.3917/rsi.127.0071

Bowleg L. (2020). We're Not All in This Together: On COVID-19, Intersectionality, and Structural Inequality. *American Journal of Public Health*, *110*(7):917. doi:10.2105/AJPH.2020.305766

Boyd, R.W. 2019. The Case for Desegregation. *The Lancet, 393*(10190): 2484–85. doi:10.1016/S0140-6736(19)31353-4.

Boyer Y. (2017). Healing racism in Canadian health care. *Canadian Medical Association Journal, 189*(46):E1408–9.

Bristow P, Bristow D, Carty L, Cooper A, Hamilton S, Shadd A. We're rooted here and they can't pull us up essays in African Canadian women's history. Toronto, Ontario: University of Toronto Press; 1994.

CADTH Peer Review of Electronic Search Strategies (PRESS) (CADTH, 2021). Available at: https://www.cadth.ca/press-peer-review-electronic-search-strategies-0

Calliste, A. (1993). Women of 'Exceptional Merit': Immigration of Caribbean Nurses to Canada. *Canadian Journal of Women & the Law*, *6*(1), 85–102.

Calliste, A. (1996). Antiracism organizing and resistance in nursing: African Canadian women. *La Revue Canadienne de Sociologie et d'Anthropologie/ Canadian Review of Sociology and Anthropology*, *33*(3), 361–390. https://doi.org/10.1111/j.1755-618X.1996.tb02457.x

Canadian College of Health Leaders [CCHL]. 2018. "LEADS in a Caring Environment Framework." Retrieved May, 2018 from: <https://www.leadscanada.net/site/framework>.

The Canadian Encyclopedia. (2018). Black Cross Nurses in Canada. Available at: https://www.thecanadianencyclopedia.ca/en/article/black-cross-nurses-in-canada

Canadian Institute for Health Information (CIHI). (2020a). Proposed standards for race-based and Indigenous identity data. 24 July 2020. Available at: https://www.cihi.ca/en/proposed-standards-for-race-based-and-indigenous-identity-data

Canadian Institute for Health Information (CIHI). (2020b). A profile of nursing in Canada, 2019 [infographic]. Ottawa, ON: CIHI; 2020. Available at: https://www.cihi.ca/en/a-profile-of-nursing-in-canada-2019-infographic

Canadian Nurses Association. Position statement: Nursing leadership. 2002. Available at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiaxv_U55j1AhWbQc0KHSiZAw8QFnoECAMQAQ&url=https%3A%2F%2Fwww.cdha.nshealth.ca%2Fsystem%2Ffiles%2Fsites%2F125%2Fdocuments%2Fcna-position-statement-nursing-leadership.pdf&usg=AOvVaw13Ru-3aQIJJIHxEtpGkb-M

Canadian Nurses Association [CNA]. (2009). *Sustaining the workforce by embracing diversity*. Canadian Nurses Association. [cited 20 Aug 2021] https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/hhr_policy_brief5_2009_e.pdf

Canadian Nurses Association [CNA] (2009). *Nursing leadership position statement*. Retrieved from https://www.cna-aiic.ca/en/downloadbuy/leadership

Canadian Institute for Health Information (CIHI). (2020c) Nursing in Canada 2020: Data Tables. Available at: https://www.cihi.ca/en/registered-nurses

Canadian Nurses Association. Framework for the practice of registered nurses in Canada: 2015 [internet]. [cited on 2020 Apr 24]. Available from: https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/framework-for-the-pracice-ofregistered-nurses-in-canada.pdf?la=en&hash=55716DC66A8C15D13972F9E45BE4AC7AE0461620.

Canadian Nurses Association. Position statement: Nursing leadership. https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/nursing-leadership_position-statement.pdf

Canadian Nurses Association. (2020). CNA's Key Messages on Anti-Black Racism in Nursing and Health. Available at: https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/anti-racism-key-messages_e.pdf?la=en&hash=413A57BA251745BD496E88FF8AAE81DEC761A7AF

Carruthers, C. A. (2018). *Unapologetic: A Black, queer, and feminist mandate for radical movements.* Beacon.

Carter, B. (2020). Achieving diversity, inclusion and equity in the nursing workforce. Revista Latino-Americana De Enfermagem, 28. https://doi.org/10.1590/1518-8345.0000-3254

Chaplan R. (2020). Pearleen Olive Canada's Black Crusader for Civil Rights. Canada: Breton Books.

Cheek, J., & Gibson, T. (1997). Policy matters: Critical policy analysis and nursing. *Journal of Advanced Nursing*, *25*(4), 668-672. https://doi.org/10.1046/j.1365-2648.1997.1997025668.x

Clandinin, D. J. (Ed.). (2007). *Handbook of narrative inquiry: Mapping a methodology.* Sage Publications.

Collins,E. (2004). Career mobility among immigrant registered nurses in Canada: Experiences of Caribbean women. [University of Toronto (Canada)], 6(1):85-102. http://ezproxy.library.dal.ca/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=109843971&site=ehost-live

Collins P. Black feminist thought. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. Boston: Unwin Hyman, 1990.*

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). Routledge.

Collins P, Bilge S. Intersectionality. Cambridge, UK; Malden, MA: Polity, 2016. Print. Key Concepts (Polity Press).

Collins, P. H., & Bilge, S. (2020). *Intersectionality* (2nd ed.). Polity Press.

College of Licensed Practical Nurses of Nova Scotia [CLPNNS]. 2013. "Guidelines for Licensed Practical Nurses in Nova Scotia: The Professional Practice Series – Leadership." Retrieved May, 2018 <http://clpnns.ca/wp-content/uploads/2013/09/Leadership-Guidelines2.pdf>.

Congress of Black Women Canada - Toronto Chapter. (1995). End the silence on racism in health care: Build a movement against discrimination, harassment and reprisals. Available at: http://riseupfeministarchive.ca/wp-content/uploads/cbwc-1996-endsilenceracismhealthcarrdeputationcitycouncil.pdf

Connolly, D., & Renault, L. (Interviewers) & Bernard, W. T. (Interviewee). (2017). *African Nova Scotian women face concrete ceiling* [Interview audio file]. Retrieved from CBC Listen http://www.cbc.ca/listen/shows/information-morning-ns/segment/14916504

Cope, V., & Murray, M. (2017). Leadership styles in nursing. *Nursing Standard*, *31*(43), 61–70. https://doi.org/10.7748/ns.2017.e10836

Corbin, N., Smith, W., & Garcia, J. (2018). Trapped between justified anger and being the strong Black woman: Black college women coping with racial battle fatigue at historically and predominantly White institutions. *International Journal of Qualitative Studies in Education*, *31*(7), 626-643. https://doi.org/10.1080/09518398.2018.1468045

Covell CL, Rolle Sands S. (2021). Does Being a Visible Minority Matter? Predictors of Internationally Educated Nurses' Workplace Integration. *Canadian Journal of Nursing Research, 53*(4), 366-375.

Covell CL, Neiterman E, Bourgeault IL. (2016). Scoping review about the professional integration of internationally educated health professionals. *Human Resources for Health, 14*(38).

Crenshaw, K. 1989. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *The University of Chicago Legal Forum* 1989: 8. <http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241-1299. https://doi.org/10.2307/1229039

Creswell JW. Qualitative inquiry and research design. Choosing among five approaches (3rd ed). Thousand Oaks, CA: Sage; 2013.

Cummings, G., Macgregor, T., Davey, M., Lee, H., Wong, C., Lo, E., & Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies*, *47*(3), 363. https://doi.org/10.1016/j.ijnurstu.2009.08.006

Dalhousie University. Dal Health expands the number of prioritized seats for Mi'kmaq and African Nova Scotian students in the Bachelor of Science Nursing program. Dal News. 2021 Nov 19. [cited 2022 Jan 4]. Available at: https://www.dal.ca/faculty/health/news-events/news/2021/11/19/dal_health_expands_the_number_of_prioritized_seats_for_mi_kmaq_and_african_nova_scotian_students_in_the_bachelor_of_science_nursing_program.html

Dalhousie University. 'A Distinct People': Updated African Nova Scotia Strategy gets close-up at in-person event. Dal News. 2021 Oct 26. [cited 2022 Jan 4]. Available at: https://www.dal.ca/news/2021/10/26/-a-distinct-people---updated-african-nova-scotia-strategy-gets-c.html

Dalhousie University Faculty of Medicine. Education Equity: Commitment to Diversity, Equity and Inclusion. [cited 2022 Jan 4]. Available at: https://medicine.dal.ca/departments/core-units/admissions/about/affirmative-action-policy.html

Das Gupta, T. (1996). Anti-black racism in nursing in Ontario. *Studies in Political Economy*, *51*, 97–116. https://doi.org/10.1080/19187033.1996.11675330

Das Gupta, T. (2009). *Real nurses and others: Racism in nursing*. Halifax, NS: Fernwood Pub.

Davis, A. Y. (1981). *Women, race & class*. Random House.

DeGruy, J. (2005). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*. Uptone Press.

Donnelly, G. F. (2016). In praise of Harriet Tubman; nurse, spy, abolitionist. *Holistic Nursing Practice*, *30*, 191.

Donovan, R., & West, L. (2015). Stress and mental health: Moderating role of the strong Black woman stereotype. *Journal of Black Psychology*, *41*(4), 384-396. https://doi.org/10.1177/0095798414543014

Dow, D. M. (2015). Negotiating "the welfare queen" and "the strong Black woman": African American middle-class mothers' work and family perspectives. *Sociological Perspectives*, *58*(1), 36-55. https://doi.org/10.1177%2F0731121414556546

Downey, M., Parslow, S., & Smart, M. (2011). The hidden treasure in nursing leadership: Informal leaders. *Journal of Nursing Management*, *19*(4), 517. https://doi.org/10.1111/j.1365-2834.2011.01253.x

Duncan, S. & Whyte N. (2010). Global leadership priorities for Canadian nursing: a perspective on the ICN 24th Quadrennial Congress, Durban, South Africa. *Nursing Leadership, 23*(1):16–21.

Edge, D. (2010). Falling through the net—Black and minority ethnic women and perinatal mental healthcare: Health professionals' views. *General Hospital Psychiatry*, *32*(1), 17-25. https://doi.org/10.1016/j.genhosppsych.2009.07.007

Encyclopaedia Britannica. (2019). Florence Nightingale: British nurse, statistician and social reformer. Available from: https://www.britannica.com/biography/Florence-Nightingale.

Essed, P. (1991). *Understanding everyday racism an interdisciplinary theory*. Sage. https://doi.org/10.4135/9781483345239

Etowa, J.B (2005). Surviving on the margin of a profession: experiences of Black nurses. (Thesis). 2005. [University of Calgary (Canada)]. Available at: http://ezproxy.library.dal.ca/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=109846275&site=ehost-live

Etowa, J. (2006). Fostering healthy work environments for minority nurses in Nova Scotia. *Nursing in Focus, 7* (2),15–8.

Etowa, J. (2007). Negotiating the boundaries of difference in the professional lives of black nurses. *The International Journal of Diversity in Organizations, Communities, and Nations: Annual Review*, *7*(3), 217–26. Available at: https://doi.org/10.18848/1447-9532/CGP/v07i03/39378

Etowa, J. B., Beagan, B. L., Eghan, F., & Bernard, W. T. (2017). "You feel you have to be made of steel": The strong Black woman, health, and well-being in Nova Scotia. *Health Care for Women International*, *38*(4), 379-393. https://doi.org/10.1080/07399332.2017.1290099

Etowa, J. B., Foster, S., Vukic, A. R., Wittstock, L., & Youden, S. (2005). Recruitment and retention of minority students: Diversity in nursing education. *International Journal of Nursing Education Scholarship*. https://doi.org/10.2202/1548-923x.1111

Etowa, J., S. Price and S. Debs-Ivall. (2011). "Strengthening the Ethno-Cultural Diversity of the Nursing Workforce in Canada." *International Journal of Arts & Sciences* 4(26): 75–87.

Etowa, J. B., Sethi, S., & Thompson-Isherwood, R. (2009). The substantive theory of surviving on the margin of a profession. *Nursing Science Quarterly 22*(2), 174–181. https://doi.org/10.1177/0894318409332781

Etowa, J., Wiens, J., Bernard, W. T., & Clow, B. (2007). Determinants of black women's health in rural and remote communities. *The Canadian Journal of Nursing Research*, *39*(3), 56.

Feder, S. (Director). (2020). *Disclosure* [Film]. Field of vision; Bow and Arrow Entertainment; Level Forward.

Ferguson, S. L. (2015). Transformational nurse leaders key to strengthening health systems worldwide. *The Journal of Nursing Administration*, *45*(7–8), 351. https://doi.org/10.1097/NNA.0000000000000212

Fischer, S. A. (2017). Transformational leadership in nursing education. *Nursing Science Quarterly*, *30*(2), 124–128. https://doi.org/10.1177/0894318417693309

Flynn K. (2004). Race, class, and gender: Black nurses in Ontario, 1950-1980 [dissertation]. [Ottawa]: National Library of Canada/ Bibliothèque nationale du Canada; 2003. *Dissertation Abstracts International. Section A: Humanities & Social Sciences*, *64*(08), 3105–3105.

Flynn, K. (2004). Experiences and identity: Black immigrant nurses to Canada, 1950-1980. In *Sisters or Strangers?: Immigrant., Ethnic, and Racialized Women in Canadian History.* (pp. 381-398).

Flynn, K. (2008). "I'm glad that someone is telling the nursing story." *Journal of Black Studies*, *38*(3):443–60.

Flynn, K. (2009). Beyond the glass wall: Black Canadian nurses, 1940-1970. *Nursing History Review*, *17*(1), 129-152. https://doi.org/10.1891/1062-8061.17.129

Flynn, K. (2011). *Moving beyond borders: A history of Black Canadian and Caribbean women in the diaspora.* University of Toronto Press.

Flynn, K. (2012). Flynn K. 'I'm not your typical nurse': Caribbean nurses in Britain and Canada. *Women's History Magazine (1476-6760), 69:*26–35.

Flynn K. (2015). "She cannot be confined to her own region": Nursing and nurses in the Caribbean, Canada, and the United Kingdom. In *Within and Without the Nation: Canadian History as Transnational. History* (pp. 228–248). https://www.scopus.com/inward/record.uri?eid=2-s2.0-84966738857&partnerID=40&md5=275cfd24294183c029bf413fd0cc94c8.

Flynn,K. (2018). "Hotel Refuses Negro Nurse ": Gloria Clarke Baylis and the Queen Elizabeth Hotel. *Canadian Bulletin of Medical History/ Bulletin Canadien d'histoire de La Medecine*, *35*(2), 278–308. https://doi.org/10.3138/cbmh.256-042018

Flynn, K. (2021). They are more than research subjects: Recognizing the accomplishments of Black Canadian nurses. *Nursing Clio: Beyond Florence.* Available at: https://nursingclio.org/2021/01/31/they-are-more-than-research-subjects-recognizing-the-accomplishments-of-black-canadian-nurses/

Flynn, K., Aladejebi F. (2019). Writing Black Canadian women's history: Where we have been and where we are going. In *Reading Canadian Women's and Gender History*.63–89. Available at: https://www.scopus.com/inward/record.uri?eid=2-s2.0-85068374258&partnerID=40&md5=8e6806468f3b3a959b961300445cc6b9

Foucault, M. (1982). *The Subject and Power. Critical Inquiry, 8, 777-95*. Retrieved from http://www.unisa.edu.au/Global/EASS/HRI/foucault_-_the_subject_and_power.pdf

Gavey, N. (1989). Feminist poststructuralism and discourse analysis. *Psychology of Women Quarterly*, *13*(4), 459–475. https://doi.org/10.1111/j.1471-6402.1989.tb01014.x

Gavey, N. (2011). Feminist poststructuralism and discourse analysis revisited. *Psychology of Women Quarterly*, *35*(1), 183–188. https://doi.org/10.1177/0361684310395916

Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity & Disease*, *2*(3), 207-221.

Geronimus, A. T. (2001). Understanding and eliminating racial inequalities in women's health in the United States: The role of the weathering conceptual framework. *Journal of the American Medical Women's Association*, *56*(4), 133-136.

Geronimus, A. T., Hicken, M., Keene, D., & Bound, J. (2006). "Weathering" and age patterns of allostatic load scores among Blacks and Whites in the United States. *American Journal of Public Health*, *96*(5), 826-833. https://doi.org/10.2105/AJPH.2004.060749

Green, B. (2019). Strong like my mama: The legacy of "strength," depression, and suicidality in African American women. *Women & Therapy*, *42*(3-4), 265-288.https://doi.org/10.1080/02703149.2019.1622909

Hafsteinsdóttir, T., D. van der Zwaag and M. Schuurmans. (2017). "Leadership Mentoring in Nursing Research, Career Development and Scholarly Productivity: A Systematic Review." *International Journal of Nursing Studies* 75: 21–34. doi:10.1016/j.ijnurstu.2017.07.004.

Hagey, R., Choudhry, U., Guruge, S., Turrittin, J., Collins, E., & Lee, R. (2001). Immigrant nurses' experience of racism. *Journal of Nursing Scholarship*, *33*(4), 389–394. https://doi.org/10.1111/j.1547-5069.2001.00389.x

Harden-Bradford, J. (Host). (2018, April 25). Shedding your superwoman status. In *Therapy for Black girls*. https://therapyforblackgirls.com/podcast/

Harrington, J. (2015). "A Place of their Own: Black Feminist Leadership and Economic and Educational Justice in São Paulo and Rio de Janeiro, Brazil." *Latin American and Caribbean Ethnic Studies* 10(3): 271–87. doi:10.1080/17442222.2015.1087840.

Henry D. (2018). Rediscovering the art of nursing to enhance nursing practice. *Nursing Science Quarterly, 31*(1):47–54.

Henry, F., Enakshi, D., James, C. E., Kobayashi, A., Li, P., Ramos, H., & Smith, M. S. (2017). *The equity myth: Racialization and Indigeneity at Canadian universities.* UBC Press.

Higginbotham, E. B. (1993). *Righteous discontent: The women's movement in the Black Baptist church, 1880-1920*. Harvard University Press.

Hill, S. A. (2009). Cultural images and the health of African American women. *Gender & Society*, *23*(6), 733-746. https://doi.org/10.1177/0891243209346308

Hine, D. (1982). From hospital to college: Black nurse leaders and the rise of collegiate nursing schools. *Journal of Negro Education*, *51*(3), 222-237. https://doi.org/10.2307/2294691

Hine, D. (1989). *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950*. Bloomington, Indiana UP. Print. Blacks in the Diaspora.

Hoffman, K., Trawalter, S., Axt, J. R., & Norman Oliver, M. (2016). Racial bias in pain assessment and treatment recommendations and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America*, *113*(16), 4296-4301. https://doi.org/10.1073/pnas.1516047113

hooks, B. (1984). *Feminist theory: From margin to center* (2nd ed.). South End Press.

hooks, b. (1993). *Sisters of the yam: Black women and self-recovery.* Between the Lines.

Huston, C. (2008). Preparing nurse leaders for 2020. *Journal of Nursing Management*, *16*(8), 905–911. https://doi.org/10.1111/j.1365-2834.2008.00942.x

Hutchinson, M., & Jackson, D. (2013). Transformational leadership in nursing: Towards a more critical interpretation. *Nursing Inquiry*, *20*(1), 11–22. https://doi.org/10.1111/nin.12006

James C, Este D, Thomas Bernard W, Benjamin A, Lloyd B, Turner T. Race & well-being: the lives, hopes, and activism of African Canadians Black Point, Nova Scotia: Fernwood Publishing; 2010.

James, C., & Turner, T. (2017). *Towards race equity in education: The schooling of Black students in the Greater Toronto Area*. York University. https://edu.yorku.ca/files/2017/04/Towards-Race-Equity-in-Education-April-2017.pdf

Jefferies, K. (2020). Recognizing history of Black nurses: A first step to addressing racism and discrimination in nursing. *The Conversation*. https://theconversation.com/recognizing-history-of-black-nurses-a-first-step-to-addressing-racism-and-discrimination-in-nursing-125538

Jefferies K. (2020). The Strong Black Woman: Insights and Implications for Nursing. *Journal of the American Psychiatric Nurses Association*. doi:107839032098390.

Jefferies, K., Aston, M., Murphy, G. T. Black Nurse Leaders in the Canadian Healthcare System. *Nursing Leadership (1910-622X)*, *31*(4), 52–56. https://doi.org/10.12927/cjnl.2019.25756

Jefferies, K., L. Goldberg, M. Aston and G. Tomblin Murphy. (2018). "Understanding the Invisibility of Black Nurse Leaders Using a Black Feminist Poststructuralist Framework." *Journal of Clinical Nursing* 27(15–16): 3225–34.

Jefferies K, Martin-Misener R, Murphy G, Helwig M, Bernard W, Gahagan J. (2020). African Canadian nurses in the nursing profession in Canada: a scoping review protocol. *JBI Evidence Synthesis, 19*(4):883-890.

Jefferies K, Price S. African Nova Scotian Grit: A Scholarly Personal Narrative About Nursing Leadership. Health Populations Journal. 2021.

Jefferies, K., Richards, T., Blinn, N., Sim, M., Kirk, S., Dhami, G., Helwig, M., Iduye, D., Moody, E., Macdonald, M., Tomblin Murphy, G. & Martin-Misener, R. (2021). Food security in African Canadian communities: a scoping review. *JBI Evidence Synthesis, 20*(1), 37-59.

Jefferies K, States C, MacLennan V, Martin-Misener R, Murphy G, Helwig M, Bernard W, Gahagan J. Black nurses in the nursing profession in Canada: a scoping review. [under review 2021];19(4):883-890.

Jefferies, K., D. Tamlyn, M. Aston and G. Tomblin Murphy. (2018). "Promoting Visible Minority Diversity in Canadian Nursing." *Canadian Journal of Nursing Research*. doi: 10.1177/0844562118795812.

Jefferies K, Tomblin Murphy G, Helwig M. (2020). Food security in African Canadian communities: a scoping review protocol. *JBI Evidence Synthesis, 18*(5):1108–15.

Jerald, M. C., Cole, E. R., Ward, L. M., & Avery, L. R. (2017). Controlling images: How awareness of group stereotypes affects Black women's well-being. *Journal of Counseling Psychology*, *64*(5), 487-499. https://doi.org/10.1037/cou0000233

Jerald, M. C., Ward, L. M., Moss, L., Thomas, K., & Fletcher, K. D. (2017). Subordinates, sex objects, or sapphires? Investigating contributions of media use to Black students' femininity ideologies and stereotypes about black women. *Journal of Black Psychology*, *43*(6), 608-635. https://doi.org/10.1177/0095798416665967

Kaphle L. (2017). *My experienced and recommendations for supporting IENs.* Available at: https://www.nnpbc.com/my-experiences-and-recommendations-for-supporting-iens-by-laxmi-regmi-kaphle-rn/

Kasprzak, E. (2019). Why are black mothers at more risk of dying? *BBC News*. https://www.bbc.com/news/ukengland-47115305

Keddy,B. (1997). Portrait of Leadership: Stories Shed New Light on Nursing History. *Registered Nurse Journal*, *9*(3), 9–11.

Kisely, S., Terashima, M., & Langille, D. (2008). A population-based analysis of the experience of African Nova Scotians. *Canadian Medical Association Journal*, *179*(7), 653-658. https://doi.org/10.1503/cmaj.071279

Kouzes, J. & Posner, B. (2012). *The Leadership Challenge*. CA: Jossey Bass. Loftin, C., S. Newman, B. Dumas, G. Gilden and M. Bond. 2012. "Perceived Barriers to Success for Minority Nursing Students: An Integrative Review." *ISRN Nursing* 2012: 806543. doi:10.5402/2012/806543.

Labonté, R., Packer, C. & Klassen, N. (2006). Managing health professional migration from sub-Saharan Africa to Canada: a stakeholder inquiry into policy options. *Human Resources for Health*, *4*, 22.

Lane, J. (2020). Intersectionality and Investigating Systems of Privilege and Oppression in Nursing and Health Research. Canadian Journal of Nursing Research, 52(4), 243–245. https://doi.org/10.1177/0844562119900741

Lane J, Carrier L, Jefferies K, Yu Z. (2019). Diverse Representation in Nursing Leadership: Developing a Shared Position Statement on Allyship. *Creative Nursing, 25*(4):316-321.

Lane J, Waldron I. Fostering equity, diversity and cultures of inclusiveness through curricular development. *Journal of Nursing Education, 60*(11).

Liao, K., Wei, M., & Yin, M. (2020). The misunderstood schema of the strong Black woman: Exploring its mental health consequences and coping responses among African American women. *Psychology of Women Quarterly*, *44*(1), 84-104. https://doi.org/10.1177/0361684319883198

Lincoln, YS. & Guba, EG. (1985). Naturalistic Inquiry. Newbury Park, CA: Sage Publications.

Lewis, J. A., & Neville, H. A. (2015). Construction and initial validation of the gendered racial microaggressions scale for black women. *Journal of Counseling Psychology*, *62*(2), 289–302. https://doi.org/10.1037/cou0000062

Lorde, A. (1984). *Sister outsider: Essays and speeches.* Crossing Press.

Love, K. (2016). Black feminism: An integrated review of literature. *ABNF Journal*, *27*(1), 11–15.

MacDonnell, JA. (2005). Situating the political in nurses' lives: The intersection of policy, practice and career for lesbian health advocates. University of Toronto (Canada).

Maddalena, V., W. T. Bernard, S. Davis-Murdoch and D. Smith. (2013). "Awareness of Palliative Care and End-of-Life Options Among African Canadians in Nova Scotia." *Journal of Transcultural Nursing* 24(2): 144–52. doi:10.1177/1043659612472190.

Massaquoi N, Wane N. Theorizing empowerment Canadian perspectives on Black feminist thought. Toronto Ontario: Inanna Publications and Education. 2007.

Mclane-Davison, D. (2015). "Lifting: Black Feminist Leadership in the Fight against HIV/AIDS." *Affilia* 31(1): 55.

McPherson K. (1998). Bedside Matters: The Transformation of Canadian Nursing, 1900-1990. Labour / Le Travail, 41:253.

McPherson K. (2005). The Nightingale influence and the rise of the modern hospital. In: Bates C, Dodd D, Rousseau N, editors. On all frontiers: four centuries of Canadian nursing. 73-88. Ottawa, Ontario: University of Ottawa Press.

Mirza, H. S. (1995). Black women in higher education: Defining a space/finding a place. In L. Morley & V. Walsh (Eds.), *Feminist academics: Creative agents for change* (pp. 145-155). Taylor & Francis.

Mirza, H. S. (2006). Transcendence over diversity: Black women in the academy. *Policy Futures in Education*, *4*(2), 101-113. https://doi.org/10.2304/pfie.2006.4.2.101

Mirza, H. (2015). Decolonizing higher education: Black feminism and the intersectionality of race and gender. *Journal of Feminist Scholarship*, *7*, 1–12.

Missen, B. De l'Afrique a Winnipeg: Three Nursing Journeys. *Canadian Nurse, 106*(6):19-22.

Mobley, S., & Johnson, J. (2019). "No pumps allowed": The "problem" with gender expression and the Morehouse College "Appropriate Attire Policy." *Journal of Homosexuality*, *66*(7), 867-895. https://doi.org/10.1080/00918369.2018.1486063

Modibo, N. (2004). The shattered dreams of African Canadian nurses. *Canadian Woman Studies*, *23*(2), 1101-117.

Morgan, P. D. (2019). "Black Don't Crack" masks a painful reality for many Black Canadians. *The Huffington Post*. https://www.huffingtonpost.ca/entry/racism-health-careblack-dont-crack_ca_5d3b0e86e4b0a6d6373ea19d

Munn, F. (2017). Everyone stands to gain from diversity in leadership. *Nursing Standard*, *32*(6), 12. https://doi.org/10.7748/ns.32.6.12.s13

Nash, R. J. (2004). *Liberating scholarly writing: The power of personal narrative.* Teachers College Press.

Nelson, T., Cardemil, E. V., & Adeoye, C. T. (2016). Rethinking strength. *Psychology of Women Quarterly*, *40*(4), 551-563. https://doi.org/10.1177/0361684316646716

Nelson, S.E. and J.G. Ortmeier. (2011). *Awaken, Align, Accelerate: A Guide to Great Leadership*. Edina, MN: Beavers Pond Press.

Njie-Mokonya N. (2016). Internationally educated nurses' and their contributions to the patient experience. *Online Journal of Issues in Nursing, 21*(1).

Nova Scotia Health (NSH). (2020). Research meets community: Equitable, culturally specific heart health for African Nova Scotians. 2020-21 Annual Report. Available at: https://www.nshealth.ca/AnnualReport2020-21/research-meets.html

Nova Scotia's Nursing Strategy (NSNS). (2015). *Nursing Strategy.* Available at: https://novascotia.ca/dhw/nurses/documents/Nursing-Strategy-2015.pdf

O'Brien-Pallas, L., & Wang, S. (2006). Innovations in health care delivery: responses to global nurse migration--a research example. *Policy Politics and Nursing Practice,7*(3S):49S-57S.

Owusu-Bempah, A., M. Jung, F. Sbai, A. Wilton and F. Kouyoumdjian. (2021). Race and Incarceration: The Representation and Characteristics of Black People in Provincial Correctional Facilities in Ontario, Canada [Epub ahead of print]. *Race and Justice*. doi:10.1177/21533687211006461.

Pachai, B. 1997. *People of the Maritimes*. Halifax, NS: Nimbus.

Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ, 372*: 71. doi: 10.1136/bmj.n71. Available at: http://www.prisma-statement.org/PRISMAStatement/FlowDiagram

Patterson A, Veenstra C. (2016). Black-White health inequalities in Canada at the intersection of gender and immigration. *Canadian Journal of Public Health, 107*(3):E278–84.

Paynter, M., K. Jefferies, L. Carrier and L. Goshin. (2021). Feminist Abolitionist Nursing. *Advances in Nursing Science, 45*(1), 53-68. doi:10.1097/ANS.0000000000000385.

Paynter, M., K. Jefferies and L. Carrier. (2020). Nurses for Police and Prison Abolition/Infirmieres pour l'abolition de la police et des prisons/Enfermeras para la abolicion de la policia y las prisiones. *Public Health Nursing* 37(4): 471–74. doi:10.1111/phn.12766.

Peters MDJ, Godfrey C, McInerney P, Baldini Soares C, Khalil H, Parker D, et al. (2017). Chapter 11: scoping reviews. In: Aromataris E, Munn Z, editors. JBI Reviewer's Manual [internet]. Available from: https://reviewersmanual.joannabriggs.org/.

Phillips, J. M., & Malone, B. (2014). Increasing Racial/Ethnic diversity in nursing to reduce health disparities and achieve health equity. *Public Health Reports*, *129*(2), 45–50. https://doi.org/10.1177/00333549141291S209

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences.* State University of New York Press.

Porter, C. J. (2017). Articulation of identity in Black undergraduate women: Influences, interactions, and intersections. In L. D. Patton & N. N. Croom (Eds.), *Critical perspectives on Black women and college success* (pp. 88–100). Routledge. https://doi.org/10.4324/9781315744421

Premji, S., & Etowa, J. B. (2014). Workforce utilization of visible and linguistic minorities in Canadian nursing. *Journal of Nursing Management*, *22*(1), 80–88. https://doi.org/10.1111/j.1365-2834.2012.01442.x

Prendergast, N. (2015). Multiculturalism Policies: Identifying the dialectic of the "ideal type" within the practices of Canadian nursing. *Dissertation Abstracts International*.

Price, S. & McGillis Hall, L. (2014). "The History of Nurse Imagery and the Implications for Recruitment: A Discussion Paper." *Journal of Advanced Nursing, 70*(7): 1502–9. doi:10.1111/jan.12289.

Prostate Cancer Canada. (2018). *Black Men and Prostate Cancer*. Retrieved September, 2018. <http://www.prostatecancer.ca/Prostate-Cancer/Care-and-Support-Post-Treatment/Black-Men-Prostate-Cancer>.

Racine,L. (2009). Haitian Canadians' Experiences of Racism in Quebec: A Postcolonial Feminist Perspective. In *Racialized Migrant Women in Canada: Essays on Health, Violence and Equity* (pp. 265–294). https://www.scopus.com/inward/record.uri?eid=2-s2.0-84967341226&partnerID=40&md5=5b5fe1abe411db2678a7c4ead56152b0

Reece, R. Canadian Black Feminist Thought and Scholar-Activist Praxis. In *Theorizing empowerment Canadian perspectives on Black feminist thought*. Toronto Ontario: Inanna Publications and Education. 2007, pp 266-284.

Rizvic, S. (2020). Why race-based data matters in health care. *Institute for Canadian Citizenship.* Available at: https://www.inclusion.ca/article/why-race-based-data-matters-in-health-care/

RNAO. (2020a). RNAO stands together with our black sisters and brothers. Available at: https://rnao.ca/news/rnao-stands-together-our-black-sisters-and-brothers

RNAO. (2020b). RNAO stands together with our black sisters and brothers. Media Release. Available at: https://rnao.ca/news/media-releases/rnao-stands-together-our-black-sisters-and-brothers

RNAO. (2021). A History of Diversity & Inclusivity: In celebration of RNAO's 90th anniversary – and to mark February as Black History Month – we take a look back at the association's work on diversity, a matter that has shaped the profession from the mid-20th century to today. Available at: https://rnao.ca/sites/rnao-ca/files/RNJ-JanFeb2015-90Diversity.pdf April 22, 2021

RNAO. (2011). RNs Mark the passing of a true leader. Available at: https://rnao.ca/sites/rnao-ca/files/11.Joan_Lesmond_Sept-Oct_2011-10.pdf

RNAO. (2002). Policy Statement: Racism. Available at: https://rnao.ca/policy/position-statements/racism#:~:text=The%20Registered%20Nurses%20Association%20of,provision%20of%20quality%20health%20care.&text=Racism%20is%20systemic%20in%20our%20society%20and%20endemic%20in%20our%20institutions

Rombeau, J., A. Goldberg and C. Loveland-Jones. *Surgical Mentoring Building Tomorrow's Leaders*. New York: Springer. 2010.

Sands, S. R., Ingraham, K., Salami, B. O. Caribbean nurse migration—a scoping review. *Human Resources for Health, 18*(1):1-10

Sandelowski M. (1995). Sample size in qualitative research. *Research in Nursing and Health, 18*(2), 179-183.

Seacole. (2021). *Read Mary's Story*. Available at: https://www.maryseacoletrust.org.uk/learn-about-mary/

Shkimba, M., & Flynn, K. (2004). 'In England we did nursing': Caribbean and British nurses in Great Britain and Canada, 1950–70. *New Directions in Nursing History*, pp: 157–73.

Shockley, K. G. (2008). "Africentric Education Leadership: Theory and Practice." *International Journal of Education Policy and Leadership, 3*(3): 1–12.

Sini, R. (2017). *Publisher apologizes for "racist" text in medical book. BBC Trending*. Retrieved from http://www.bbc.com/news/blogs-trending-41692593

Spano-Szekely, L., M. Quinn Griffin, J. Clavelle and J.J. Fitzpatrick. (2016). "Emotional Intelligence and Transformational Leadership in Nurse Managers." *The Journal of Nursing Administration* 46(2): 101–8. doi:10.1097/NNA.0000000000000303

Staring-Derks, C., Staring, J., & Anionwu, E. (2015). Mary Seacole: Global nurse extraordinaire. *Journal of Advanced Nursing*, *71*(3), 514–525. https://doi.org/10.1111/jan.12559

Statistics Canada. (2016). Data tables: 2016 census [internet]. Available from: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rpeng.cfm?LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=0&GK=0&GRP=1&PID=110531&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=120&VID=0&VNAMEE=&VNAMEF=.

Statistics Canada. (2018). *Census Profile.* 2016 Census. Statistics Canada Catalogue no. 98–316–X2016001. Ottawa. Released November 29, 2017.

Stewart, P. (2009). Themes of racial discrimination in the experience of Black female nurse managers. [University of Toronto (Canada)]. Available at: http://ezproxy.library.dal.ca/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=109853066&site=ehost-live

Tomblin Murphy G, Birch S, MacKenzie A, Alder R, Lethbridge L, Little L. (2012). Eliminating the shortage of registered nurses in Canada: An exercise in applied needs-based planning. *Health Policy, 105*(2-3):192-202.

Tomblin Murphy G, MacKenzie A, Alder R, Birch S, Kephart G, O'Brien-Pallas L. (2009). An Applied simulation model for estimating the supply of and requirements for registered nurses based on population health needs. *Policy Politics and Nursing Practice, 10*(4), 240-251.

Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Annals of Internal Medicine, 169*(7):467–73.

Turrittin J, Hagey R, Guruge S, Collins E, Mitchell M. (2002). The experiences of professional nurses who have migrated to Canada: Cosmopolitan citizenship or democratic racism? *International Journal of Nursing Studies*, *39*(6), 655–667.

Tuyisenge G. & Goldenberg S. (2021). COVID-19, structural racism, and migrant health in Canada. *The Lancet*, *397*(10275); 650-652. Available at: https://www.thelancet.com/article/S0140-6736(21)00215-4/fulltext

Twomey JC, Meadus R. (2016). Men nurses in Atlantic Canada: Career choice, barriers, and satisfaction. *The Journal of Men's Studies, 24*(1):78–88.

United Nations. (2021). International decade for people of African descent 2015-2024 [internet]. Available from: https://www.un.org/en/observances/decade-people-african-descent/background.

United Nations Report. (2017). "Report of the Working Group of Experts on People of African Descent on its Mission to Canada." Human Rights Council. Available at: <https://ansa.novascotia.ca/sites/default/files/files/report-of-the-working-group-of-experts-on-people-of-africandescent-on-its-mission-to-canada.pdf>.

van Dijk T. Critical Discourse Analysis. The Handbook of Discourse Analysis. Wiley. Blackwell. 2015 Retrieved from: http://www.discourses.org/OldArticles/Critical%20Discourse%20Analysis.pdf

van Dijk T. (1995). Aims of Critical Discourse Analysis. *Japanese Discourse, 1*(1), 17-27.

van Dijk T. (1993). Principles of critical discourse analysis. *Discourse & Society, 4*(2), 249-283. doi:10.1177/0957926593004002006

Villeneuve, M. (2003). Healthcare, race and diversity: time to act. *Hospital Quarterly, 6*(2):67-73.

Vukic, A., C. Jesty, S. V. Mathews and J. Etowa. (2012). "Understanding Race and Racism in Nursing: Insights from Aboriginal Nurses." *ISRN Nursing,* 196437.

Vukic, A., Steenbeek, A., & Muxlow, J. (2016). Increasing the representation of the black population in the health professions in Canada. *Journal of Cultural Diversity*, *23*(2), 50–52.

Walani, SR. (2015). Global migration of internationally educated nurses: Experiences of employment discrimination. *International Journal of Africa Nursing Science, 3*:65–70.

Wane, N. (2007). African women and Canadian history: Demanding our place in the curriculum. In *Theorizing empowerment Canadian perspectives on Black feminist thought*. Toronto Ontario: Inanna Publications and Education. 2007, pp 129-152.

Wane, N. (2007). Canadian Black Feminist Thought: Re-imagining new possibilities for empowerment. In *Theorizing empowerment Canadian perspectives on Black feminist thought*. Toronto Ontario: Inanna Publications and Education. 2007, 296-309.

Watson, Natalie N., and Carla D. Hunter. (2015). "Anxiety and Depression Among African American Women: The Costs of Strength and Negative Attitudes Toward Psychological Help-Seeking." *Cultural Diversity and Ethnic Minority Psychology 21*(4), 604-12.

Watson, N. N., & Hunter, C. D. (2016). "I had to be strong": Tensions in the strong Black woman schema. *Journal of Black Psychology*, *42*(5), 424-452. https://doi.org/10.1177/0095798415597093

Watson-Singleton, N. (2017). Strong Black woman schema and psychological distress: The mediating role of perceived emotional support. *Journal of Black Psychology*, *43*(8), 778-788. https://doi.org/10.1177/0095798417732414

Weberg, D. (2010). Transformational leadership and staff retention: An evidence review with implications for healthcare systems. *Nursing Administration Quarterly*, *34*(3), 246–258. https://doi.org/10.1097/NAQ.0b013e3181e70298

Weedon, C. (1987). *Feminist practice and poststructuralist theory*. Oxford, UK: B. Blackwell.

Wentzell B. (2021). One of Nova Scotia's first Black nurses remembered for ground-breaking career. *Canadian Broadcasting Corporation.* Available at: https://www.cbc.ca/news/canada/nova-scotia/clotilda-yakimchuk-obituary-1.5989490

West, C. M. (2008). Mammy, Jezebel, Sapphire, and their homegirls: Developing an "oppositional gaze" toward the images of Black women. In J. Chrisler, C. Golden & P. Rozee (Eds.), *Lectures on the Psychology of Women* (4th ed., pp. 286-299). McGraw-Hill.

West, L. M., Donovan, R. A., & Daniel, A. R. (2016). The price of strength: Black college women's perspectives on the strong Black woman stereotype. *Women & Therapy*, *39*(3-4), 390-412. https://doi.org/10.1080/02703149.2016.1116871

White, B. and J. Fulton. (2015). "Common Experience of African American Nursing Students: An Integrative Review." *Nursing Education Perspectives* 36(3): 167–75.

Whitfield HA. Black slavery in the Maritimes: A history in documents. Broadview Press; 2018.

Woods-Giscombe, C., Robinson, M., Carthon, D., Devane-Johnson, S., & Corbie-Smith, G. (2016). Superwoman schema, stigma, spirituality, and culturally sensitive providers: Factors influencing African American Women's use of mental health services. *Journal of Best Practices in Health Professions Diversity*, *9*(1), 1124-1144.

Wong S, Wong J. (1980). Representation of racial minority students in selected Canadian university schools of nursing. *Journal of Advanced Nursing, 5*(1):83–90

World Health Organization. (2020). *Health policy*. http://www.who.int/topics/health_policy/en

Appendix A: Copyright Release Forms for Journals

Manuscript 5.4

Monday, December 6th, 2021

Atlantis
Mount Saint Vincent University
Halifax, Nova Scotia

I am preparing my PhD thesis for submission to the Faculty of Graduate Studies at Dalhousie University, Halifax, Nova Scotia, Canada. I am seeking your permission to include a manuscript version of the following paper(s) as a chapter in the thesis:

Jefferies, K. Intersectionality Book Review. *Atlantis, 41*(2), 99-101. Available at: https://journals.msvu.ca/index.php/atlantis/article/view/5544

Canadian graduate theses are collected and stored online by the Library and Archives of Canada. I am also seeking your permission for the material described above to be stored online with the LAC. Further details about the LAC thesis program are available on the LAC website (www.bac-lac.gc.ca).

Full publication details and a copy of this permission letter will be included in the thesis.

Yours sincerely,

Keisha Jefferies

Permission is granted for:

a) the inclusion of the material described above in your thesis.

b) for the material described above to be included in the copy of your thesis that is sent to the Library and Archives of Canada (formerly National Library of Canada) for online storage.

Name: Katherine Barrett Title: Managing Editor

Signature: [redacted] Date: Dec 12, 2021

Manuscripts 3.5 and 5.3

Monday, December 6th, 2021

Canadian Journal of Nursing Leadership
Toronto, Ontario

I am preparing my PhD thesis for submission to the Faculty of Graduate Studies at Dalhousie University, Halifax, Nova Scotia, Canada. I am seeking your permission to include a manuscript version of the following paper(s) as a chapter in the thesis:

Jefferies, K. (2018). A Personal Leadership Development Plan for Black Undergraduate and Graduate Nursing Students. *Canadian Journal of Nursing Leadership*, *31*(4), 57-62.

Jefferies, K., Aston, M. & Tomblin Murphy, G. (2018). Black Nurses Leaders in the Canadian Healthcare System. *Canadian Journal of Nursing Leadership*, *31*(4), 50-56.

Canadian graduate theses are collected and stored online by the Library and Archives of Canada. I am also seeking your permission for the material described above to be stored online with the LAC. Further details about the LAC thesis program are available on the LAC website (www.bac-lac.gc.ca).

Full publication details and a copy of this permission letter will be included in the thesis.

Yours sincerely,

Keisha Jefferies

Permission is granted for:

a) the inclusion of the material described above in your thesis.

b) for the material described above to be included in the copy of your thesis that is sent to the Library and Archives of Canada (formerly National Library of Canada) for online storage.

Name: Susmita Dey Title: Production Manager, Longwoods Publishing

Signature: [redacted] Date: December 9, 2021

Manuscript 8.7

Monday, December 6th, 2021

Canadian Journal of Nursing Leadership
Toronto, Ontario

I am preparing my PhD thesis for submission to the Faculty of Graduate Studies at Dalhousie University, Halifax, Nova Scotia, Canada. I am seeking your permission to include a manuscript version of the following paper(s) as a chapter in the thesis:

Jefferies, K. (2021). Advancing Nursing in Canada: Toward Eliminating Anti-Black Racism. *Canadian Journal of Nursing Leadership*. (In Press)

Canadian graduate theses are collected and stored online by the Library and Archives of Canada. I am also seeking your permission for the material described above to be stored online with the LAC. Further details about the LAC thesis program are available on the LAC website (www.bac-lac.gc.ca).

Full publication details and a copy of this permission letter will be included in the thesis.

Yours sincerely,

Keisha Jefferies

Permission is granted for:

c) the inclusion of the material described above in your thesis.

d) for the material described above to be included in the copy of your thesis that is sent to the Library and Archives of Canada (formerly National Library of Canada) for online storage.

Name: Susmita Dey Title: Production Manager, Longwoods Publishing

Signature: [redacted] Date: December 9, 2021

Manuscript 2.2

Monday, December 6th, 2021

Health Populations Journal
Dalhousie University
alifax, Nova Scotia

I am preparing my PhD thesis for submission to the Faculty of Graduate Studies at Dalhousie University, Halifax, Nova Scotia, Canada. I am seeking your permission to include a manuscript version of the **following paper(s) as a chapter in the thesis**:

Jefferies, K. (2021). African Nova Scotian Grit: A Scholarly Personal Narrative About Nursing Leadership. *Health Populations Journal, 1*(1), 34-42.

Canadian graduate theses are collected and stored online by the Library and Archives of Canada. I am also seeking your permission for the material described above to be stored online with the LAC. Further details about the LAC thesis program are available on the LAC website (www.bac-lac.gc.ca).

Full publication details and a copy of this permission letter will be included in the thesis.

Yours sincerely,

Keisha Jefferies

Permission is granted for:

a) the inclusion of the material described above in your thesis.

b) for the material described above to be included in the copy of your thesis that is sent to the Library and Archives of Canada (formerly National Library of Canada) for online storage.

Name: Christie Stilwell Title: Co-Editor in Chief, Healthy Populations Journal

Signature: [redacted] Date: Dec. 7, 2021


CCC RightsLink®
Home
Help
Live Chat
Sign in
Create Account
African Canadian nurses in the nursing profession in Canada: a scoping review protocol
Author: Keisha Jefferies, Ruth Martin-Misener, Gail Tomblin Murphy, et al
Publication: JBI Evidence Synthesis
Publisher: Wolters Kluwer Health, Inc.
Date: Oct 16, 2020
Copyright © 2020, © 2021 JBI
Wolters Kluwer
License Not Required
Wolters Kluwer policy permits only the final peer-reviewed manuscript of the article to be reused in a thesis. You are free to use the final peer-reviewed manuscript in your print thesis at this time, and in your electronic thesis 12 months after the article's publication date. The manuscript may only appear in your electronic thesis if it will be password protected. Please see our Author Guidelines here: https://cdn-tp2.mozu.com/16833-m1/cms/files/Author-Document.pdf?_mzts=636410951730000000.
BACK
CLOSE WINDOW

JOHN WILEY AND SONS LICENSE
TERMS AND CONDITIONS

Dec 20, 2021

This Agreement between Dalhousie University -- Keisha Jefferies ("You") and John Wiley and Sons ("John Wiley and Sons") consists of your license details and the terms and conditions provided by John Wiley and Sons and Copyright Clearance Center.

License Number	5203821151438
License date	Dec 07, 2021
Licensed Content Publisher	John Wiley and Sons
Licensed Content Publication	Journal of Clinical Nursing
Licensed Content Title	Understanding the invisibility of black nurse leaders using a black feminist poststructuralist framework
Licensed Content Author	Gail Tomblin Murphy, Megan Aston, Lisa Goldberg, et al
Licensed Content Date	Jul 23, 2018
Licensed Content Volume	27
Licensed Content Issue	15-16
Licensed Content Pages	10
Type of use	Dissertation/Thesis
Requestor type	Author of this Wiley article

Format	Electronic
Portion	Full article
Will you be translating?	No
Title	PhD candidate
Institution name	Dalhousie University
Expected presentation date	Mar 2022
Order reference number	1987
Requestor Location	Dalhousie University 5869 University Avenue Halifax, NS B3H 4R2 Canada Attn: Dalhousie University
Publisher Tax ID	EU826007151
Total	0.00 CAD

Terms and Conditions

TERMS AND CONDITIONS

This copyrighted material is owned by or exclusively licensed to John Wiley & Sons, Inc. or one of its group companies (each a"Wiley Company") or handled on behalf of a society with which a Wiley Company has exclusive publishing rights in relation to a particular work (collectively "WILEY"). By clicking "accept" in connection with completing this licensing transaction, you agree that the following terms and conditions apply to this transaction (along with the billing and payment terms and conditions established by the Copyright Clearance Center Inc., ("CCC's Billing and Payment terms and conditions"), at the time that you opened your RightsLink account (these are available at any time at http://myaccount.copyright.com).

Terms and Conditions

- The materials you have requested permission to reproduce or reuse (the "Wiley Materials") are protected by copyright.
- You are hereby granted a personal, non-exclusive, non-sub licensable (on a standalone basis), non-transferable, worldwide, limited license to reproduce the Wiley Materials for the purpose specified in the licensing process. This license, **and any CONTENT (PDF or image file) purchased as part of your order,** is for a one-time use only and limited to any maximum distribution number specified in the license. The first instance of republication or reuse granted by this license must be completed within two years of the date of the grant of this license (although copies prepared before the end date may be distributed thereafter). The Wiley Materials shall not be used in any other manner or for any other purpose, beyond what is granted in the license. Permission is granted subject to an appropriate acknowledgement given to the author, title of the material/book/journal and the publisher. You shall also duplicate the copyright notice that appears in the Wiley publication in your use of the Wiley Material. Permission is also granted on the understanding that nowhere in the text is a previously published source acknowledged for all or part of this Wiley Material. Any third party content is expressly excluded from this permission.
- With respect to the Wiley Materials, all rights are reserved. Except as expressly granted by the terms of the license, no part of the Wiley Materials may be copied, modified, adapted (except for minor reformatting required by the new Publication), translated, reproduced, transferred or distributed, in any form or by any means, and no derivative works may be made based on the Wiley Materials without the prior permission of the respective copyright owner. **For STM Signatory Publishers clearing permission under the terms of the STM Permissions Guidelines only, the terms of the license are extended to include subsequent editions and for editions in other languages, provided such editions are for the work as a whole in situ and does not involve the separate exploitation of the permitted figures or extracts,** You may not alter, remove or suppress in any manner any copyright, trademark or other notices displayed by the Wiley Materials. You may not license, rent, sell, loan, lease, pledge, offer as security, transfer or assign the Wiley Materials on a stand-alone basis, or any of the rights granted to you hereunder to any other person.
- The Wiley Materials and all of the intellectual property rights therein shall at all times remain the exclusive property of John Wiley & Sons Inc, the Wiley Companies, or their respective licensors, and your interest therein is only that of having possession of and the right to reproduce the Wiley Materials pursuant to Section 2 herein during the continuance of this Agreement. You agree that you own no right, title or interest in or to the Wiley Materials or any of the intellectual property rights therein. You shall have no rights hereunder other than the license as provided for above in Section 2. No right, license or interest to any trademark, trade name, service mark or other branding ("Marks") of WILEY or its licensors is granted hereunder, and you agree that you shall not assert any such right, license or interest with respect thereto NEITHER WILEY NOR ITS LICENSORS MAKES ANY WARRANTY OR REPRESENTATION OF ANY KIND TO YOU OR ANY THIRD PARTY, EXPRESS, IMPLIED OR STATUTORY, WITH RESPECT TO THE MATERIALS OR THE ACCURACY OF ANY INFORMATION

CONTAINED IN THE MATERIALS, INCLUDING, WITHOUT LIMITATION, ANY IMPLIED WARRANTY OF MERCHANTABILITY, ACCURACY, SATISFACTORY QUALITY, FITNESS FOR A PARTICULAR PURPOSE, USABILITY, INTEGRATION OR NON-INFRINGEMENT AND ALL SUCH WARRANTIES ARE HEREBY EXCLUDED BY WILEY AND ITS LICENSORS AND WAIVED BY YOU.

- WILEY shall have the right to terminate this Agreement immediately upon breach of this Agreement by you.
- You shall indemnify, defend and hold harmless WILEY, its Licensors and their respective directors, officers, agents and employees, from and against any actual or threatened claims, demands, causes of action or proceedings arising from any breach of this Agreement by you.
- IN NO EVENT SHALL WILEY OR ITS LICENSORS BE LIABLE TO YOU OR ANY OTHER PARTY OR ANY OTHER PERSON OR ENTITY FOR ANY SPECIAL, CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY OR PUNITIVE DAMAGES, HOWEVER CAUSED, ARISING OUT OF OR IN CONNECTION WITH THE DOWNLOADING, PROVISIONING, VIEWING OR USE OF THE MATERIALS REGARDLESS OF THE FORM OF ACTION, WHETHER FOR BREACH OF CONTRACT, BREACH OF WARRANTY, TORT, NEGLIGENCE, INFRINGEMENT OR OTHERWISE (INCLUDING, WITHOUT LIMITATION, DAMAGES BASED ON LOSS OF PROFITS, DATA, FILES, USE, BUSINESS OPPORTUNITY OR CLAIMS OF THIRD PARTIES), AND WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THIS LIMITATION SHALL APPLY NOTWITHSTANDING ANY FAILURE OF ESSENTIAL PURPOSE OF ANY LIMITED REMEDY PROVIDED HEREIN.
- Should any provision of this Agreement be held by a court of competent jurisdiction to be illegal, invalid, or unenforceable, that provision shall be deemed amended to achieve as nearly as possible the same economic effect as the original provision, and the legality, validity and enforceability of the remaining provisions of this Agreement shall not be affected or impaired thereby.
- The failure of either party to enforce any term or condition of this Agreement shall not constitute a waiver of either party's right to enforce each and every term and condition of this Agreement. No breach under this agreement shall be deemed waived or excused by either party unless such waiver or consent is in writing signed by the party granting such waiver or consent. The waiver by or consent of a party to a breach of any provision of this Agreement shall not operate or be construed as a waiver of or consent to any other or subsequent breach by such other party.
- This Agreement may not be assigned (including by operation of law or otherwise) by you without WILEY's prior written consent.
- Any fee required for this permission shall be non-refundable after thirty (30) days from receipt by the CCC. These terms and conditions together with CCC's Billing and Payment terms and conditions (which are incorporated herein) form the entire agreement between you and WILEY concerning this licensing transaction and (in the absence of fraud) supersedes all prior agreements and representations of the parties, oral or written. This Agreement may not be amended except in writing signed by both parties. This Agreement shall be binding upon and inure to the benefit of the parties' successors, legal representatives, and authorized assigns.

- In the event of any conflict between your obligations established by these terms and conditions and those established by CCC's Billing and Payment terms and conditions, these terms and conditions shall prevail.
- WILEY expressly reserves all rights not specifically granted in the combination of (i) the license details provided by you and accepted in the course of this licensing transaction, (ii) these terms and conditions and (iii) CCC's Billing and Payment terms and conditions.
- This Agreement will be void if the Type of Use, Format, Circulation, or Requestor Type was misrepresented during the licensing process.
- This Agreement shall be governed by and construed in accordance with the laws of the State of New York, USA, without regards to such state's conflict of law rules. Any legal action, suit or proceeding arising out of or relating to these Terms and Conditions or the breach thereof shall be instituted in a court of competent jurisdiction in New York County in the State of New York in the United States of America and each party hereby consents and submits to the personal jurisdiction of such court, waives any objection to venue in such court and consents to service of process by registered or certified mail, return receipt requested, at the last known address of such party.

WILEY OPEN ACCESS TERMS AND CONDITIONS

Wiley Publishes Open Access Articles in fully Open Access Journals and in Subscription journals offering Online Open. Although most of the fully Open Access journals publish open access articles under the terms of the Creative Commons Attribution (CC BY) License only, the subscription journals and a few of the Open Access Journals offer a choice of Creative Commons Licenses. The license type is clearly identified on the article.

The Creative Commons Attribution License

The Creative Commons Attribution License (CC-BY) allows users to copy, distribute and transmit an article, adapt the article and make commercial use of the article. The CC-BY license permits commercial and non-

Creative Commons Attribution Non-Commercial License

The Creative Commons Attribution Non-Commercial (CC-BY-NC)License permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.(see below)

Creative Commons Attribution-Non-Commercial-NoDerivs License

The Creative Commons Attribution Non-Commercial-NoDerivs License (CC-BY-NC-ND) permits use, distribution and reproduction in any medium, provided the original work is properly cited, is not used for commercial purposes and no modifications or adaptations are made. (see below)

SAGE's Author Archiving and Re-Use Guidelines

These guidelines should be followed by authors of Contributions published in a SAGE subscription journal, including authors whose Contributions were published under a previous version of the author guidelines. For a list of exceptions to these guidelines, please see below.

Three versions of the Contribution are referenced in these guidelines:

- **Original Submission:** the version submitted by the author before peer review
- **Accepted Manuscript:** version updated to include the author's revisions after peer review, prior to any typesetting for the journal. is often the version accepted by the editor
- **Final Published PDF:** copy-edited and typeset Publisher's PDF, the same version published on the journal's website

Green Open Access: SAGE's Archiving and Sharing Policy

You may share the **Original Submission** or **Accepted Manuscript** at any time after your paper is accepted and in any format. Your sharing the **Original Submission** or **Accepted Manuscript** may include posting a downloadable copy on any website, saving a copy in any repository or network, sharing a copy through any social media channel, and distributing print or electronic copies. Please note some journals will consider papers that have been posted as preprints prior to submission and you may check a journal's policy regarding considering previously-posted papers by referring to the journal's submission guidelines.

For information on use of Institutional Repository (IR) copies by authors and IR users, see Posting to an Institutional Repository - Green Access.

You may use the **Final Published PDF** (or **Original Submission** or **Accepted Manuscript**, if preferred) in the following ways:

- in relation to your own teaching, provided that any electronic distribution maintains restricted access
- to share on an individual basis with research colleagues, provided that such sharing is not for commercial purposes
- in your dissertation or thesis, including where the dissertation or thesis will be posted in any electronic Institutional Repository database
- in a book authored or edited by you, at any time after the Contribution's publication in the journal.

Provided that:

- Access to the Original Submission and Accepted Manuscript is provided at no charge.
- Any re-use terms for users of websites and repositories (where your **Original Submission** or **Accepted Manuscript** are posted) restricted to non-commercial and no derivative uses.
- You may not post the **Final Published PDF** on any unrestricted website or repository without permission from SAGE.
- You may not republish or translate any version of your Contribution in another journal without prior permission from SAGE.

- The journal as the original publication of your Contribution is appropriately credited by including the full citation information each your Contribution, or excerpts, are further distributed or re-used:
    - After your Contribution has been accepted for publication and until it is assigned a DOI, please include a statement that Contribution has been accepted for publication in the journal.
    - Once full citation information for your Contribution is available, please include this with your posted Contribution, in a format similar to the following:
      Author(s), Contribution Title, Journal Title (Journal Volume Number and Issue Number) pp. xx-xx. Copyright © [year] (Copyright Holder). DOI: [DOI number].

Journal Exceptions

Exceptions to this Author Re-Use policy: The following journals have a different author re-use policy in place. The re-use terms for these journals are stated in the Contributor Agreement used by the Journal.

If you have questions regarding the following titles, contact the permissions team through our SAGE Permissions Portal.

- California Management Review
- Journal of Dental Research
- JDR Clinical & Translational Research
- Acta Radiologica (from January 2018)
- Index on Censorship
- Pain News
- Political Insight
- Recherche et Applications en Marketing

Related Information

Authors of Contributions published as SAGE Choice or in a Gold Open Access journal should reference Reusing Open Access and SAGE Content. For a list of SAGE's Gold Open Access journals, please see Gold Open Access journals.

Authors of Contributions published under a Creative Commons license may re-use their work under the terms of the Creative Commons license attached to their Contributions and additionally have all rights to re-use their work stated above.

For information about requesting permission for content published in SAGE journals, see Process for Requesting Permission.

For information about author copies, see Author e-prints policy.

If you are submitting a manuscript to a SAGE journal and wish to include previously published materials within the manuscript, visit our Author Gateway Copyright and Permissions FAQs.

Last updated: 31 July 2020

Appendix B: Search Strategy

Search	Query	Records retrieved
1	(MH “Blacks”)	49,546
2	(MH “Nurses+”)	202,379
3	1 AND 2	1226
4	TI ((Black OR African OR Coloured) N4 (nurse OR nurses OR nursing)) OR AB ((Black OR African OR Coloured) N4 (nurse OR nurses OR nursing))	1391
5	3 OR 4	2323
6	(MH “Canada+”)	91,956
7	TI (Canad* OR “British Columbia” OR Alberta OR Saskatchewan OR Manitoba OR Ontario OR Quebec OR “New Brunswick” OR “Nova Scotia” or “Prince Edward Island” OR Newfoundland OR Labrador OR “Northwest Territories” OR Yukon OR Nunavut) OR AB (Canad* OR “British Columbia” OR Alberta OR Saskatchewan OR Manitoba OR Ontario OR Quebec OR “New Brunswick” OR “Nova Scotia” or “Prince Edward Island” OR Newfoundland OR Labrador OR “Northwest Territories” OR Yukon OR Nunavut)	70,730
8	6 OR 7	120,516
9	5 AND 8	26

Note. Search conducted October 10, 2019, on CINAHL (EBSCO).

Appendix C: Data Extraction Tool

Information to be Extracted	Response
Date:	
Review:	
Extraction components:	
Article title:	
Year of publication:	
Authors:	
Article citation:	
Article type (research, policy, commentary):	
Article aim/purpose:	
Article questions/objectives:	
Theoretical framework (if presented/applicable):	
Study design (if presented/applicable):	
Methods (data collection and analysis, if applicable):	
Study population (including participant description eg, African Canadian, Black, African Nova Scotian, immigrant) and sample size (if presented/applicable):	
Context (including setting and location eg, province, city):	
Concept (including type of nursing practice eg, clinical care, education, research, administration and/or policy):	
Results/key findings (if presented/applicable): Sample demographics – Themes/sub-themes – Level of significant/confidence intervals –	
Article recommendations/implications for nursing practice (policy, education, administration, clinical care, and research):	
Gaps identified by article:	
Additional notes:	

Appendix D: Full Search Strategies

CINAHL

	Search Date: August 31st, 2020	
#	**Query**	**Results**
S9	S5 AND S8	154
S8	S6 OR S7	137,843
S7	TI (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut) OR AB (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut)	84,317
S6	(MH "Canada+")	102,452
S5	S3 OR S4	8,815
S4	TI ((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies OR "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses)) OR AB ((Black OR African OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses))	7,756
S3	S1 AND S2	1,820
S2	(MH "Nurses+")	224,727
S1	(MH "Blacks") OR (MH "Minority Groups")	63,761
	Uploaded to Covidence 147 (7 duplicates removed)	

#	**Searches**	**Results**
1	exp african continental ancestry group/ or african americans/	86940
2	Minority Groups/	13959
3	1 or 2	98483
4	exp Nurses/	88336
5	3 and 4	474
6	((Black or African or Afro* or Coloured or Colored or Caribbean or West Indian or West Indies or "of colour" or "of color" or minority) and (nurse or nursing or nurses)).ti,ab,kw,kf.	7438
7	5 or 6	7732
8	exp Canada/	159063

#	Searches	Results
9	(Canad* or "British Columbia" or "British Colombian" or Alberta or Albertan or Saskatchewan or Saskatchewanian or Manitoba or Manitoban or Ontario or Ontarian or Quebec or Quebecer or Quebecois or "New Brunswick" or "New Brunswicker" or "Nova Scotia" or "Nova Scotian" or "Prince Edward Island" or "Prince Edward Islander" or Newfoundland or Newfoundlander or Labrador or "Northwest Territories" or "Northwest Territorian" or Yukon or Yukoner or Nunavut or Nunavummiut).ti,ab,kw,kf.	169248
10	8 or 9	238193
11	7 and 10	154
	Uploaded to Covidence 80 (74 duplicates removed)	

Embase

No.	Query	Results
#9	#5 AND #8	188
#8	#6 OR #7	287456
#7	canad*:ti,ab,kw OR 'british columbia':ti,ab,kw OR 'british colombian':ti,ab,kw OR alberta:ti,ab,kw OR albertan:ti,ab,kw OR saskatchewan:ti,ab,kw OR saskatchewanian:ti,ab,kw OR manitoba:ti,ab,kw OR manitoban:ti,ab,kw OR ontario:ti,ab,kw OR ontarian:ti,ab,kw OR quebec:ti,ab,kw OR quebecer:ti,ab,kw OR quebecois:ti,ab,kw OR 'new brunswick':ti,ab,kw OR 'new brunswicker':ti,ab,kw OR 'nova scotia':ti,ab,kw OR 'nova scotian':ti,ab,kw OR 'prince edward island':ti,ab,kw OR 'prince edward islander':ti,ab,kw OR newfoundland:ti,ab,kw OR newfoundlander:ti,ab,kw OR labrador:ti,ab,kw OR 'northwest territories':ti,ab,kw OR 'northwest territorian':ti,ab,kw OR yukon:ti,ab,kw OR yukoner:ti,ab,kw OR nunavut:ti,ab,kw OR nunavummiut:ti,ab,kw	227083
#6	'canada'/exp	189364
#5	#3 OR #4	9967
#4	(black:ti,ab,kw OR african:ti,ab,kw OR afro* OR coloured:ti,ab,kw OR colored:ti,ab,kw OR caribbean:ti,ab,kw OR 'west indian':ti,ab,kw OR 'west indies':ti,ab,kw OR 'of colour':ti,ab,kw OR 'of color':ti,ab,kw OR minority:ti,ab,kw) AND (nurse:ti,ab,kw OR nursing:ti,ab,kw OR nurses:ti,ab,kw)	9509
#3	#1 OR #2	1250
#2	'nurse'/exp	182676
#1	'black person'/exp OR 'minority group'/exp	145793
	Uploaded to Covidence 69 (119 duplicates removed)	

Sociological Abstracts

Search	Databases	Actions
S3	1 AND 2	**27**
S2	ti(Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward	**50775**

Search	Databases	Actions
	Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut) OR ab(Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut)	
S1	ti((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies OR "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses)) OR ab((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies OR "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses))	**567**
	Uploaded to Covidence 18 (9 duplicates removed)	

Gender Studies Database

#	Query	Results
S3	S1 AND S2	31
S2	TI (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut) OR AB (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut)	21,030
S1	TI ((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies OR "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses)) OR AB ((Black OR African OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses))	701
	Uploaded to Covidence 18 (13 duplicates removed)	

America: History & Life

#	Query	Results
S3	S1 AND S2	10
S2	TI (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut) OR AB (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut)	66810
S1	TI ((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies OR "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses)) OR AB ((Black OR African OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses))	124
	Uploaded to Covidence 5 (5 duplicates removed)	

PsycINFO

#	Query	Results
S8	S2 AND S7	45
S7	S1 OR S6	2,848
S6	S4 AND S5	173
S5	DE "Nurses" OR DE "Psychiatric Nurses" OR DE "Public Health Service Nurses" OR DE "School Nurses"	32,449
S4	(DE "Blacks") OR (DE "Minority Groups")	67,326
S3	S1 AND S2	45
S2	TI (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut) OR AB (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut)	54,759

#	Query	Results
S1	TI ((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies OR "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses)) OR AB ((Black OR African OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies "of colour" OR "of color" OR minority) AND (nurse OR nursing OR nurses))	2,821
	Uploaded to Covidence 17 (28 duplicates removed)	

Academic Search Premier

#	Query	Results
S3	S1 AND S2	38
S2	TI (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut) OR AB (Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia" OR "Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut)	480,039
S1	TI ((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies OR "of colour" OR "of color" OR minority) N4 (nurse OR nursing OR nurses)) OR AB ((Black OR African OR Coloured OR Colored OR Caribbean OR West Indian OR West Indies "of colour" OR "of color" OR minority) N4 (nurse OR nursing OR nurses))	1,527
	Uploaded to Covidence 13 (25 duplicates removed)	

Scopus

(TITLE-ABS-KEY((Black OR African OR Afro* OR Coloured OR Colored OR Caribbean OR "West Indian" OR "West Indies" OR "of colour" OR "of color" OR minority) W/4 (nurse OR nursing OR nurses))) AND ((TITLE-ABS-KEY(Canad* OR "British Columbia" OR "British Colombian" OR Alberta OR Albertan OR Saskatchewan OR Saskatchewanian OR Manitoba OR Manitoban OR Ontario OR Ontarian OR Quebec OR Quebecer OR Quebecois OR "New Brunswick" OR "New Brunswicker" OR "Nova Scotia")) OR (TITLE-ABS-KEY("Nova Scotian" OR "Prince Edward Island" OR "Prince Edward Islander" OR Newfoundland OR Newfoundlander OR Labrador OR "Northwest Territories" OR "Northwest Territorian" OR Yukon OR Yukoner OR Nunavut OR Nunavummiut)))
48 results

Appendix E: Articles Excluded at Full-Text – With Rationale

Context Issue (Not specific to Canada)

1. Cassiani SHDB, Lecorps K, Rojas Canaveral LK, da Silva FAM, Fitzgerald J. Regulation of nursing practice in the Region of the Americas. Revista panamericana de salud publica = Pan American journal of public health. 2020;44(csl, 9705400):e93.
2. D'Antonio P. Thinking about place: Researching and reading the global history of nursing. Texto Contexto Enferm. 2009;18(4):766–72.
3. Grypma SJ. Leadership in history. Profile of a leader: unearthing Ethel Johns's "buried" commitment to racial equality, 1925. Nurs Leadersh 2003,16(4):39–47.
4. Jefferies K. A Personal Leadership Development Plan for Black Undergraduate and Graduate Nursing Students. Nurs leadersh (Tor ONT).2018, 31(4):57–62.
5. Jefferies K. The Strong Black Woman: Insights and Implications for Nursing. J Am Psychiatr Nurs Assoc. 2020.
6. Jefferies K, Goldberg L, Aston M, Tomblin Murphy G. Understanding the invisibility of black nurse leaders using a black feminist poststructuralist framework. J Clin Nurs (John Wiley & Sons, Inc). 2018;27(15–16):3225–34
7. Johnson SA. Healing in silence: black nurses in Charleston, South Carolina, 1896-1948. Medical University of South Carolina 2008.
8. Kawi J, Xu Y. Facilitators and barriers to adjustment of international nurses: An integrative review. Int Nurs Rev. 2009,56(2):174–83.
9. Lewenson SB, Graham-Perel A. You don't have any business being this good: An oral history interview with Bernardine Lacey. Am J Nurs. 2020;120(8):40–7
10. Likupe G. The skills and brain drain what nurses say. J Clin Nurs (John Wiley & Sons, Inc). 2013;22(9–10):1372–81
11. Ocho ON, Wheeler E, Sheppard C, Caesar-Greasley L-A, Rigby J, Tomblin Murphy G. Nurses' preparation for transitioning into positions of leadership—A Caribbean perspective. J Nurs Manage. 2020,28(6):1356–63.
12. Ohr SO, Jeong S, Parker V, McMillan M. Organizational support in the recruitment and transition of overseas-qualified nurses: Lessons learnt from a study tour. Nurs Health Sci. 2014;16(2):255–61
13. Xu Y. Racism and discrimination in nursing: Reflections on multicultural nursing conference. Home Health Care Manag Pract. 2008;20(3):284–6.

14. Young J. Revisiting the 1925 Johns Report on African-American nurses. Nurs Hist Rev. 2005;13(bqa, 9303945):77–99

Population Issue (Not specific to Black nurses in Canada)

1. Agnew V, Hagey R, Turrittin J, Das Gupta T. Racial discrimination in nursing. In: Interrogating Race and Racism. Toronto, Ontario: University of Toronto Press; 2007. 206–36 p.
2. Bell B. White dominance in nursing education: A target for anti-racist efforts. Nurs Inq [Internet]. 2021;28(1). Available from: https://www.scopus.com/inward/record.uri?eid=2-s2.0-85090159403&doi=10.1111%2fnin.12379&partnerID=40&md5=9e5527db95846cbec584b607282c5c26
3. Blanchet Garneau A, Browne AJ, Varcoe C. Drawing on antiracist approaches toward a critical antidiscriminatory pedagogy for nursing. Nurs Inq.2018,25(1).
4. Blythe J, Baumann A. Internationally educated nurses: Profiling workforce diversity. Int Nurs Rev. 2009,56(2):191–7.
5. Choiniere JA, MacDonnell J, Shamonda H. Walking the talk: Insights into dynamics of race and gender for nurses. Policy Polit Nurs Pract. 2010;11(4):317–25
6. Covell CL, Neiterman E, Bourgeault IL. Scoping review about the professional integration of internationally educated health professionals. Hum Resour Health. 2016;14(1).
7. Covell CL, Rolle Sands S. Does Being a Visible Minority Matter? Predictors of Internationally Educated Nurses' Workplace Integration. Can J Nurs Res. 2020.
8. Creese G, Stasiulis D. Introduction: Intersections of Gender, Race, Class, and Sexuality. Stud Polit Econ.1996, (51):5–14.
9. Duncan S, Whyte N. Global leadership priorities for Canadian nursing: a perspective on the ICN 24th Quadrennial Congress, Durban, South Africa. Nurs leadersh (Tor ONT). 2010,23(1):16–21.
10. Dyck I. Negotiating citizenship: migrant women in Canada and the global system. Fem Rev.2004, (77):201–3.
11. English HA. The journals of Helen Anne English, field Matron on the Little Pine Reserve, 1913-1917. Saskatchewan History Magazine. 1993;45(2):37–42
12. Etowa JB, Foster S, Vukic AR, Wittstock L, Youden S. Recruitment and retention of minority students: Diversity in nursing education. Int J Nurs Educ Scholarsh. 2005;2(1):12p–12p
13. Glasgow VM. Race and employment equity in nursing leadership: Perceptions of racialized and non-racialized registered nurses [Internet]. ProQuest Information & Learning; 2019.

14. Goodwin JO. Improving the recruitment and retention of registered nurses through the identification of critical success factors: A comparative study of the United States and Canada. Central Michigan University.2010.
15. Guruge S, Donner G. Transcultural nursing in Canada. Can Nurse. 1996 Sep;92(8):36–40
16. Hussain H, McGeer A, McNeil S, Katz K, Loeb M, Simor A, et al. Factors associated with influenza vaccination among healthcare workers in acute care hospitals in Canada. Influenza other Respir viruses. 2018,12(3):319–25.
17. Jefferies K, Tamlyn D, Aston M, Tomblin Murphy G. Promoting Visible Minority Diversity in Canadian nursing. Can J Nurs Res. 2019;51(1):3–5
18. Knight M. Friends of African nursing (Canada). Can Oper Room Nurs J. 2011, 29(1):16–20.
19. Labun E. The Red River College model: Enhancing success for Native Canadian and other nursing students from disenfranchised groups. J Transcult Nurs. 2002;13(4):311–7.
20. Lane J, Carrier L, Jefferies K, Yu Z. Diverse Representation in Nursing Leadership: Developing a Shared Position Statement on Allyship. Creat Nurs. 2019,25(4):316–21.
21. MacDonnell JA. Situating the political in nurses' lives: The intersection of policy, practice and career for lesbian health advocates. University of Toronto (Canada); 2005.
22. Mansell D, Hibberd J. Forcible sterilization in Canada, 1920-1940. "We picked the wrong one to sterilise": the role of nursing in the eugenics movement in Alberta, 1920-1940. Inter Hist Nurs J. 1998, 3(4):4–11.
23. Mansell D, Hibberd J. "We picked the wrong one to sterilise": The role of nursing in the eugenics movement in Alberta, 1920-1940. Int Hist Nurs J. 1998;3(4):4–11
24. Maree J, Fitch MI. Holding conversations with cancer patients about sexuality: Perspectives from Canadian and African healthcare professionals. Can Oncol Nurs J. 2019,29(1):64–76.
25. McPherson K. Bedside matters: The transformation of Canadian nursing, 1900-1990. The Transformation of Canadian Nurs. 1900-1990. 2003.
26. Meyer M, Estable AR, MacLean L, Peterson WE. Family Home Visitors: Increasing Minority Women's Access to Health Services. J Health Dispar Res Prac. 2010,3(3):1–20.
27. Mill J, Davison C, Richter S, Etowa J, Edwards N, Kahwa E, et al. Qualitative research in an international research program: Maintaining momentum while building capacity in nurses. Int J Qual Methods. 2014;13(1):151–69

28. Moyce S, Lash R, de Leon Siantz ML. Migration Experiences of Foreign Educated Nurses: A Systematic Review of the Literature. J Transcult Nurs. 2016,27(2):181–8.
29. Moynagh M. Writing Black Canadas. Can Lit. 2008;(198):158–9
30. Neiterman E, Bourgeault IL. The shield of professional status: Comparing internationally educated nurses' and international medical graduates' experiences of discrimination. Health. 2015;19(6):615–34
31. Neiterman E, Bourgeault IL. Professional integration as a process of professional resocialization: Internationally educated health professionals in Canada. Soc Sci Med. 2015;131:74–81.
32. Nevitt J, Tunis B. White caps and black bands: Nursing in Newfoundland to 1934 (1978). Atlantis. 1980;5(2):235–9
33. Njie-Mokonya N. Internationally educated nurses' and their contributions to the patient experience. Online J Issues Nurs. 2016,21(1).
34. Nourpanah S. "Maybe we shouldn't laugh so loud": The hostility and welcome experienced by foreign nurses on temporary work permits in Nova Scotia, Canada. Labour Travail. 2019, (83):105–20.
35. O'Brien-Pallas L, Wang S. Innovations in health care delivery: responses to global nurse migration--a research example. Policy Polit Nurs Pract. 2006,7(3S):49S-57S.
36. Omene M. A Study of the Experiences of Black Caribbean Women in the Saskatchewan Labour Force. Masters Abstr Int .2001,39(03):733–733.
37. Oosterbroek T, Ponomar V. "It All Depends": How Minority Nursing Students Experience Belonging During Clinical Experiences. Nurs Educ Perspect.2014,35(2):89–93.
38. Pittman P, Aiken LH, Buchan J. International migration of nurses: Introduction. Health Services Research. 2007,42(3, part2):1275–80.
39. Prentice D, Moore J, Crawford J, Lankshear S, Limoges J. Collaboration among Registered Nurses and Licensed Practical Nurses: A Scoping Review of Practice Guidelines. Nurs Res Pract .2020.
40. Ramji Z, Etowa J. Towards a conceptual framework for workplace integration of internationally educated nurses. Manage Educ Int J. 2015;15(3):1–11
41. Rasmussen BM, Marie Garran A. In the Line of Duty: Racism in Health Care. Soc Work. 2016,61(2):175–7.
42. Richmond AH. Caribbean immigrants in Britain and Canada: socio-economic adjustment. Int Migr.1988,26(4):365–86.
43. Runnels V, Labonté R, Packer C. Reflections on the ethics of recruiting foreign-trained human resources for health. Hum Resour Health. 2011;9

44. Rutherdale M. Introduction. Caregiving on the Peripher: Hist Perspect on Nurs and Midwifery in Can. 2010;3–32.
45. Spitzer DL. In visible bodies: minority women, nurses, time, and the new economy of care. Med Anthropol Q. 2004,18(4):490–508.
46. Tastsoglou E, Miedema B. "Working Much Harder and Always Having to Prove Yourself": Immigrant Women's Labor Force Experiences in the Canadian Maritimes. Adv Gender Res. 9:201–33.
47. Timer JE, Clauson MI. The use of selective admissions tools to predict students' success in an advanced standing baccalaureate nursing program. Nurse Educ Today. 2011;31(6):601–6
48. Tomblin Murphy G, Birch S, MacKenzie A, Alder R, Lethbridge L, Little L. Eliminating the shortage of registered nurses in Canada: An exercise in applied needs-based planning. Health Policy. 2012,105(2–3):192–202.
49. Tuttas CA. Perceived racial and ethnic prejudice and discrimination experiences of minority migrant nurses: A literature review. J Transcult Nurs. 2015;26(5):514–20.
50. Twomey JC, Meadus R. Men nurses in Atlantic Canada: Career choice, barriers, and satisfaction. J Mens Stud. 2016,24(1):78–88.
51. Varcoe C, McCormick J. Racing around the classroom margins: Race, racism, and teaching nursing. In: Teach Nurs: Dev A Stud-Centered Learn Environ. 2012. 437–66 p.
52. Walani SR. Global migration of internationally educated nurses: Experiences of employment discrimination. Int J Afr Nurs Sci. 2015, 3:65–70.
53. Wong S, Wong J. Representation of racial minority students in selected Canadian university schools of nursing. J Adv Nurs (Wiley-Blackwell). 1980;5(1):83–90

Concept Issue (Not specific to nursing)

1. Maiter S. Using an anti-racist framework for assessment and intervention in clinical practice with families from diverse ethno-racial backgrounds. Clin Soc Work J. 2009;37(4):267–76.
2. Nurse DB, McNeil D. What's a black critic to do? Interviews, profiles and reviews of black writers. Can Ethn Stud. 2004;36(2):162–4.
3. Sztainbok V. Presumed incompetent: The intersections of race and class for women in academia. Resources for Feminist Research. 2016;34(3/4):157-161,164.
4. THOMPSON C. Cultivating Narratives of Race, Faith, and Community: The Dawn of Tomorrow, 1923-1971. Can J Hist 2015,50(1):30–67.

Other Category: (Book Review)

1. Bates C, Dodd D, Rousseau N. On all frontiers: Four centuries of Canadian nursing. University of Ottawa Press. 2005.
2. Butler A. Moving Beyond Borders: A History of Black Canadian and Caribbean Women in the Diaspora. Can Ethn Stud 2013,45(3):159–61.
3. Fingard J, Guildford JV. Mothers of the municipality: Women, work and social policy in post-1945 Halifax. 2005.
4. Foth T. Moving Beyond Borders: A History of Black Canadian and Caribbean Women in the Diaspora. Nurs Hist Rev. 2013,21:151–2.
5. Wyche KF. Review of Moving beyond borders: A history of Black Canadian and Caribbean women in the diaspora. Affilia: Journal of Women & Social Work. 2013;28(4):475–6.

Appendix F: Description of Included Studies (Primary Source Only)

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
Boateng, G. 2015. Exploring the Career Pathways, Professional Integration and Lived Experiences of Regulated Nurses in Ontario, Canada	Qualitative Research Interviews Dissertation	This study explores the career pathways and experiences of immigrant and Canadian-born nurses in two Ontario cities utilizing a qualitative research design consisting of 70 in-depth interviews.	Leadership and career advancement	Ontario/ Toronto and London	Ethnic minority/ Black/	70 RNs and RPNs 42 immigrant nurses 15 IENs	Canadian-born nurses have a shorter, more direct pathway to nursing. IENs and VMs face systemic issues. VMs experience verbal abuse.
Bouabdillah et al. 2016. Infirmières issues de minorités visibles et mobilité vertical en milieu hospitalier [Visible minority nurses and vertical mobility in hospitals]	Qualitative Research Postcolonical approaches/ Critical Ethnography Interviews, observations, field notes.	To explore the perspectives of visible minority nurses in relation to their career paths.	Leadership and career advancement	Ontario/ Ottawa	Immigrant visible minority	8 visible minority nurses 1st or 2nd generation immigrant	Barriers kept nurses at lower levels in institutional/ nursing hierarchy, including discriminatory hiring and promotion process.
Canadian Nurses Association (CNA). 2021. CNA's key messages on anti-Black racism in nursing and health	Key Messages	CNA supports the call for enhanced collection and analysis of race and ethnicity data in partnership with racialized communities. We further call for collaborative structures to ensure	Anti-Black racism in nursing	National	Black	N/A	Anti-Black racism as a part of Canadian nursing [history].

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
		identified health disparities are addressed					
Calliste, A. 1996. Antiracism Organizing and Resistance in Nursing: African Canadian Women*	Qualitative Research Integrative anti-racism Interviews	This study examines women of color, specifically African Canadian nurses, organizing and resisting racism in nursing in Ontario and Quebec from the late 1970s to the 1990s, from an integrative anti-racism perspective.	Racism in Nursing	Ontario and Quebec	African Canadian / Black	Women 22 RNs	Racially specific gender and classist ideologies reinforce the racial division of labour, exploitation and devaluation of black women's labour. Economic restructuring has disproportionate impact on black nurses.
Calliste, A. 1993. Women of 'Exceptional Merit': Immigration of Caribbean Nurses to Canada	Qualitative Research Document review, Literature Search & Interviews	This study examines Canada's immigration policy on Caribbean nurses and nursing assistants during the post-war industrial and baby boom period, 1950 to 1962.	Immigration policies	National	Caribbean / Black	Caribbean women	Canadian immigration policy restricted the entry of professional and skilled Caribbean workers. Demonstrates how immigration was controlled by race, class, and gender.
Collins, E. 2004. Career mobility among immigrant registered nurses in Canada: Experiences of Caribbean women.	Qualitative Research Descriptive Interviews *Dissertation	This qualitative research study investigated the experiences of immigrant women from the Caribbean who are registered nurses (RNs) in Canada.	Leadership and career advancement	Ontario/ Toronto	Caribbean	Women 14 Canadian-Caribbean RNs	Nurses were excluded from opportunities for upward and lateral career mobility, decision making.

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
Congress of Black Women Canada - Toronto Chapter. 1995. End the silence on racism in health care: Build a movement against discrimination, harassment and reprisals	Commentary/ Announcement	Announcement regarding the presentation of their report which included 63 recommendations, themes and initiatives	Anti-Black racism in nursing	Ontario/ Toronto	Black	Black nurses and healthcare workers	Black nurses and other health care workers unfairly dismissed from their jobs, work excessive overtime and have no support in the workplace.
Das, Gupta, T. 1996. Anti-Black Racism in Nursing in Ontario	Qualitative Research/ Interviews & case review	This article describes the experience of racism in nursing in Ontario drawing on the case histories of two Black nurses who have brought complaints against their hospital to the OHRC.	Racism in nursing	Ontario	Black	Women 2 Black nurses	Nurses experienced racism that was gendered and classed. Racism operated at various levels including everyday life, at work and attitudes of management and workers.
Das Gupta, T. 2009. Real nurses and Others: Racism in Nursing	Mixed Methods Research Exploratory	The initial objective was to lay bare the common experiences, patterns, features and surface manifestations of systemic racism in nursing in Ontario.	Racism in Nursing	Ontario	African/ Black Canadian	Female	The development of a theoretical framework for understanding systematic racism in racism.
Etowa, J. 2005. Surviving on the Margin of a Profession:	Qualitative Research Grounded Theory	This study sought to discover the nature of work life experiences of Black nurses in the	Work-life experiences	Nova Scotia Halifax	Black	20 RNs 3 men 17 women *14ANSs	Although Black nurses are very much insiders by virtue of their professional education, nursing values and culture, they often

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
Experiences of Black Nurses	Interviews, literature review, field notes, group discussion, observation *Dissertation	health care system in Nova Scotia					see themselves practicing outside the center.
Flynn, K. 2018/ "Hotel Refuses Negro Nurse ": Gloria Clarke Baylis and the Queen Elizabeth Hotel	Commentary Intersectionality	Drawing on excerpts from the court transcript, this article expands and complicates intersectionality as a theoretical framework to include other markers of difference. This article focuses on Gloria's role in the lawsuit.	Discrimination Lawsuit	Quebec / Montreal	British-trained Caribbean nurse	1 RN Woman	Chronicling the struggle to integrate into Canadian nursing. Without knowledge of nursing's exclusionary history, Gloria's experience could easily be interpreted as an isolated occurrence.
Flynn, K. 2011. Moving Beyond Borders: A History of Black Canadian and Caribbean Women in the Diaspora	Qualitative Research Interviews BOOK	The lives of Caribbean and Canadian born Black professional women are the central focus of this research.	Experiences navigating education, training, paid and unpaid work	Ontario (mainly) Manitoba, Nova Scotia	Black And Caribbean Canadian Nurses	35 Black women (nurses). 13 born in Canada and 22 born in Caribbean	
Hagey, R. et al. 2001. Immigrant Nurses' Experiences of Racism	Qualitative Research/ Analytical framework: Everyday racism and	To document and describe the experiences of immigrant nurses of colour who have filed grievances	Racism	Ontario	Immigrant women of colour	Female 9 immigrant nurses of color	All nurses interviewed experienced reprisals as a result of complaining or filing grievances. Unfairness encountered in the redress process.

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
	Discourse Analysis Interviews	concerning their employers' discriminatory practices; and to solicit views of existing policies and recommendations for equity in professional life.					
Jefferies, K. et al. 2018. Black Nurse Leaders in the Canadian Healthcare System	Commentary	This article highlights a growing gap in the Canadian nursing workforce, specifically in nursing leadership. Black nurses are significantly underrepresented in nursing and even more so as nurse leaders.	Leadership	National	Black	Not applicable	Facilitating viability and representation of Black nurse leaders. Drawing on their experiential knowledge, Black nurse leaders are able to assist in the development of policies, practice standards and health system reform to better serve the Black community.
Jefferies, K. 2020. Recognizing history of Black nurses a first step to addressing racism and discrimination in nursing	Commentary	Canada's history of racism and segregation has contributed to residual anti-Black racism that remains present in Canadian nursing.	Racism in nursing	National	Black	Not applicable	Nursing can learn from bold, innovative ideas and work towards adopting anti-racist frameworks in education and practice. This begins by actively recognizing, appreciating and celebrating Black nurses and their contributions in nursing.
Keddy, B. 1997. Portrait of Leadership: Stories Shed	Qualitative Research Interviews (Oral Histories)	The use of oral histories to recover identities of Black nurses can help shed	Black nurses and nursing history	Nova Scotia	Black	Female 5 Black nurses (3 ANSs, 1	Nurses who spent their childhood in the province (NS) spoke of overt, systemic racism; and, had limited access

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
New Light on Nursing History		[light on] social issues that shape the profession today.				African, 1 Caribbean)	to Schools- not accepted to program (photo sent with application).
Labonté, R. et al. 2006. Managing health professional migration from sub-Saharan Africa to Canada: a stakeholder inquiry into policy options	Mixed methods Interviews and Secondary Analysis	We conducted a study to ascertain recent trends on health human resource (HHR) flows, perceived reasons for such flows, and key Canadian stakeholder awareness of, and support for, options by which Canada might help mitigate the negative effects of HHR migration from this region.	Migration of nurses from sub-Saharan Africa	National	Sub-Saharan African (SSA)	N/A	Sub-Saharan Africa is not presently a significant source of nurses to Canada, but trends demonstrating a slow but steady increase.
Missen, B. 2010. De l'Afrique a Winnipeg: Three Nursing Journeys	Commentary	To tell the stories of three Franco-Africans who chose to pursue a new life and career in a new land.	Immigration	Manitoba, Winnipeg	Franco-Africans	3 nurses (2 women, 1 man)	
Modibo, N. 2004. The shattered dreams of African Canadian nurses	Qualitative Research Interviews	To present the everyday workplace experiences of racism that African Canadian nurses confronted in some of Toronto's hospitals in the decade that followed the letter's receipt.	Racism	Toronto, Ontario	African Canadian	Female 15 African Canadian nurses	The issues of mistreatment compared to that of their White counterparts in the workplace and verbal abuse by patients for Black nurses.

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
Premji, S. & Etowa, E. 2014. Workforce utilization of visible and linguistic minorities in Canadian nursing	Quantitative Research Secondary Analysis	This study seeks to develop a diversity profile of the nursing workforce in Canada and its major cities.	Diversity profile in the nursing workforce in Canada	National/ Multi-city [Toronto Vancouver, Montreal, Halifax]	Visible and linguistic minority	Male and female	Provides a diversity profile of the nursing workforce for Canada and its major cities. VMN over-represented in lower-level frontline positions.
Prendergast, N. 2014. Multiculturalism Policies: Identifying the dialectic of the "ideal type" within the practices of Canadian nursing	Qualitative Research Theoretical framework: Post-colonial; Anti-racist feminist; Black Canadian feminist *Dissertation	This research examines the roles of the ideal type and multiculturalism policies within nursing and questions whether it works in favour of IENs of colour or more as a hindrance to their educational and promotional development	Leadership	Ontario	Internationally educated nurses (IENs) of colour living in Canada	Female 10 RNs (IENs of color)	Findings exposed multiculturalist ideology was not as useful as initially thought. Relationship between the ideal type and multiculturalism policies.
Racine, L. 2009. Haitian Canadians' Experiences of Racism in Quebec: A Postcolonial Feminist Perspective	Qualitative research Post-colonial feminist framework Critical ethnography Interviews	This chapter presents experiences of everyday racism observed and collected in a critical ethnography among a group of Haitian Canadians in Quebec.	Racism	Quebec	Haitian Canadians	4 homecare nurses	Experiences of racism in the workplace from patients and colleagues. Discrimination present in hiring practices.
Registered Nurses Association of Ontario (RNAO)	Announcement	The launch of a Black nurses' task force to tackle anti-Black	Racism	Ontario	Black	Not applicable	RNAO recognizes that racism is systemic in Canadian society and endemic in institutions.

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
(2020a). RNAO stands together with our black sisters and brothers		racism in nursing in response to the marches and rallies organized to honor the life of George Floyd and the many other Black lives that matter.					
Registered Nurses Association of Ontario (RNAO) (2020b). RNAO stands together with our black sisters and brothers	Media Statement	Express solidarity with those who suffer at the hands of law enforcement and those who experience gross inequities because of their skin color.	Racism	Ontario	Black	Not applicable	RNAO has had 3 Black past presidents Follow RNAO online for more information and updates.
Registered Nurses Association of Ontario (RNAO) (2015). A History of Diversity & Inclusivity	Report		Diversity	Ontario	Black	Not applicable	Importance of diversity and inclusivity in all of RNAO's work.
Registered Nurses Association of Ontario (RNAO) (2011). RNs Mark the passing of a true leader	Memorandum	Remembering a nurse leader	Leadership	Ontario	Black	Ms. Lesmond's decorated career	
Registered Nurses Association of Ontario (RNAO) (2002). Policy	Policy Statement	RNAO is committed to an environment where all nurses and clients are treated with dignity and	Racism			Not applicable	RNAO is committed to achieving an environment where all members of the profession have equal opportunities to participate

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
Statement: Racism		respect and where diversity is valued.					fully in the nursing profession to their maximum potential and where clients receive care that is respectful of cultural needs.
Sands, S.et al. 2020. Caribbean nurse migration—a scoping review	Research – Scoping Review (5 stage framework)	The aim of this scoping review was to examine the amount, type, sources, distribution, and focus of the conceptual and empirical literature on migration of Caribbean nurses and to identify gaps in the literature.	Migration of Caribbean nurses	National	Caribbean nurses	4/18 sources were Canadian (22%)	Findings include migration patterns and trends; post-migration experiences; past and present policies, programs, and practices; and consequences of migration to donor countries.
Stewart, P. 2009. Themes of racial discrimination in the experience of black female nurse managers	Qualitative/ Interviews	This study examines the impact of race on the workplace experiences of Black women in nursing leadership positions.	Nursing leadership	Ontario/ Toronto	African Canadian	Female 16 Caribbean nurse leaders	Racial discrimination in healthcare negatively impacted work experience for Black nurse managers.
Villeneuve, M. 2003. Healthcare, Race and Diversity: Time to Act	Commentary	In Canadian nursing, beyond the staff nurse level there appear to be few persons of colour in formal decision-making, leadership or policy positions. When we look around at our nursing leaders, managers,	Diversity within Canadian healthcare	National	Visible minority, Black, African	N/A	In Canadian nursing, beyond the staff nurse level there appear to be few persons of colour in formal decision-making, leadership or policy positions.

Authors, Year, Title	Design/Method	Aim/Purpose	Concept	Province/ City	African Canadian Terminology	Gender & Sample	Key Findings
		directors, boards, faculty and decision-makers, we do not see the Canadian mosaic mirrored back. Rectifying these disparities across the health professions is long overdue, and the time has come to act.					

Appendix G: Included Studies (Companion Source Only)

1. Boateng GO, Adams TL. (2016). “Drop dead … I need Your job”: An exploratory study of intra-professional conflict amongst nurses in Two, Ontario Cities. Soc Sci & Med. 155:35–42.
2. Etowa, J. (2006). Fostering healthy work environments for minority nurses in Nova Scotia. Nursing in Focus Fall. 2:15–8.
3. Etowa, J. (2007). Negotiating the boundaries of difference in the professional lives of black nurses. International Journal Div in Organizations, Communities, and Nations. 7(3):217–26.
4. Etowa J, Sethi S, Thompson-Isherwood R. (2009). The substantive theory of surviving on the margin of a profession. Nursing Science Quarterly. 2009;22(2):174–81.
5. Flynn K. Race, class, and gender: Black nurses in Ontario, 1950-1980 [dissertation]. [Ottawa]: National Library of Canada/ Bibliothèque nationale du Canada; 2003.
6. Flynn K. (2008). “I'm glad that someone is telling the nursing story.” J Black Stud. ;38(3):443–60.
7. Flynn K. (2009). Beyond the Glass Wall: Black Canadian Nurses, 1940–1970. Nurs Hist Rev. 2009;17(1):129–52.
8. Flynn, K. (2011). Moving beyond borders: A history of Black Canadian and Caribbean women in the diaspora. Toronto: University of Toronto Press; 2011.
9. Flynn K. (2012). 'I'm not your typical nurse': Caribbean nurses in Britain and Canada. Women's History Magazine. 2012;69:26–32012.
10. Flynn K. (2015). “She cannot be confined to her own region”: Nursing and nurses in the Caribbean, Canada, and the United Kingdom. Within and Without the Nation: Can Hist as Transnatl Hist. 2015;:228–50.
11. Flynn K, Aladejebi F. (2019). Writing Black Canadian women’s history: Where we have been and where we are going. Read Can Women’s and Gend Hist. 2019;:63–89.

12. Shkimba M, Flynn K. (2004). ‘In England we did nursing’: Caribbean and British nurses in Great Britain and Canada, 1950–70. New Dir in Nurs Hist. 2004:157–73.
13. Turrittin J, Hagey R, Guruge S, Collins E, Mitchell M. (2002). The experiences of professional nurses who have migrated to Canada: Cosmopolitan citizenship or democratic racism?. *International Journal of Nursing Studies, 39*(6):655–67.

Appendix H: Advertisement and Recruitment Letter

My name is Keisha Jefferies and I am a registered nurse and PhD student in nursing at Dalhousie University. I was born and raised in New Glasgow, Nova Scotia and have been living in Halifax,

Nova Scotia since 2005. I graduated from the nursing program at Dalhousie in 2013, after which I practiced in the neonatal intensive care unit at the IWK Health Centre for 2 years. I then returned to Dalhousie for graduate education. Currently, I am working on a research project that is attempting to understand the experiences of African Nova Scotian nurses in healthcare practice.

I am recruiting participants who identify as African Nova Scotian, Black Nova Scotia or Black, with at least one Black parent who was born in Nova Scotia. I am interested in interviewing licensed practical nurses, registered nurses and advanced practice nurses (nurse practitioners and clinical nurse specialists), who identify as African Nova Scotian to learn about leadership experiences in the nursing profession. Nurses must be at least one year post-graduation and have experience practicing nursing in Canada. The interviews will take place at a time and location that is convenient for you. Confidentiality is of the upmost importance thus, every effort will be made to ensure that your privacy is protected. The commitment to privacy and confidentiality is in compliance with the Nova Scotia Health Authority Research Ethics Board requirements on ethical conduct for research.

The goal of my research is to understand how race, class and gender influence nursing practice and nursing leadership. Please note, nurses are not required to hold an official leadership position (charge nurse, manager, etc.) in order to be eligible to participate in this research.

If you are eligible to participate in this research, please contact Keisha Jefferies at keisha.jefferies@dal.ca

Appendix I: Consent Form

Informed Consent Form Non-Interventional Study

STUDY TITLE:	*A critical examination of the Leadership Experiences of African Nova Scotia nurses in Healthcare Practice*
PRINCIPAL INVESTIGATOR:	*Keisha Jefferies, School of Nursing, Faculty of Health, Dalhousie University, 5869 University Avenue, Halifax, Nova Scotia, B3H4R2* *Phone: 9022336432* *Email: keisha.jefferies@dal.ca*
FUNDER:	*The principal investigator is being funded by Vanier Canada Graduate Scholarship, Killam Trust, the Faculty of Graduate Studies and the School of Nursing (Dalhousie University), Research NS (Scotia Scholars), BRIC NS, Johnson Scholarship Foundation and the Nova Scotia Health Authority (Diversity Bursary)*

1. Introduction

You have been invited to take part in a research study. A research study is a way of gathering information on a treatment, procedure or medical device or to answer a question about something that is not well understood. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

You may take as much time as you wish to decide whether or not to participate. Feel free to discuss it with your friends and/ or family.

Please ask the principal investigator to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.

The principal investigator will:

- Discuss the study with you
- Answer your questions

You are being asked to consider participating in this study because you have identified yourself as an African Nova Scotia (or Black Nova Scotian) nurse.

2. Why is there a need for this study?

The purpose of this study is to understand how race, class and gender impact the leadership experiences of African Nova Scotian nurses in healthcare practice. This research is important as it may help to inform strategies and initiatives in nursing practice and education, which may strengthen leadership opportunities for African Nova Scotian nurses. Understanding the experiences of African Nova Scotian nurses may also lead to opportunities for addressing health issues within the African Nova Scotian community.

We know that Black nurses encounter many challenges in nursing practice, as the result of their race. Black nurses report experiences of racism from patients and colleagues in addition to unfair treatment by supervisors. We also know that Black nurses are significantly underrepresented in the nursing profession and in leadership roles throughout healthcare. Much of the research available, about Black nurses, is from Ontario or the United States. Additionally, this research tends to focus on the experiences of African American nurses or immigrant nurse populations. Thus, there is less research available that offers insight to the experiences of African Nova Scotia nurses.

To gain a better understanding of the experiences of African Nova Scotian nurses in leadership and health care practice, we will be conducting informal interviews with 40 African Nova Scotian nurses. Understanding, strengthening and supporting leadership involvement of African Nova Scotian nurses is likely to have a positive impact on the health of the African Nova Scotian community, all Nova Scotians and the Canadian healthcare system. The evidence from this research will be used to inform policies in nursing education and practice.

3. How Long Will I Be In The Study?

This study requests that each participant be involved in one in-person informal interview. The length of the interview is approximately 90 minutes (1.5 hours). The entire study is expected to take about two years to complete and the results should be known at the end of the two year period.

4. How Many People Will Take Part In This Study?

It is anticipated that up to 40 people will participate in informal interviews in this study at various locations throughout Nova Scotia and possibly Canada.

5. How Is The Study Being Done?

This research will use one-on-one in-person interviews to collect information about the leadership experiences of African Nova Scotian nurses. One-on-one interviews involve a private conversation/ meeting between the principal investigator and each participant. The informal interviews will be conducted in a location that is private, comfortable and selected by the participant. Lastly, the informal interview will last about 90 minutes (1.5hours) and involves the principal investigator asking the participant several questions related to their nursing practice.

6. What Will Happen If I Take Part In This Study?

The interview questions are designed to explore nursing practice and leadership as well as how African Nova Scotian nurses perceive leadership. Questions will address experiences related to nursing practice, oppression (racism, sexism, ableism, etc.) and the formal (charge nurse, manager) and informal (mentoring) aspect of leadership.

The principle investigator will contact you to arrange a convenient date, time and location for the interview. A private room will be available, at Dalhousie University, for those who deem that location as convenient. Each interview will be about 90 minutes (1.5 hours) in length and will take place in a private location at Dalhousie University or another convenient location of your choosing (such as participant's home or a local café). You will be asked to participant in one interview to speak about your experiences related to nursing leadership. With your consent, the informal interviews will be audio taped. There is also the option to participate in this study through telephone or video calling. Video calling would include the use of Skype, WhatsApp or FaceTime, for participants who are unable to meet in person.

There is no obligation to participate in this study and if you initially decide to participate but then later change your mind, there will be no consequences for withdrawal. If you agree to take part in this study, you will be asked to identify a day, time and location that would be convenient.

7. Are There Risks To The Study?

There are no physical risks in participating in this study. You may become uncomfortable during the informal interview while discussing your experiences with nursing leadership, as an African Nova Scotian nurse. The principal investigator will attempt to provide appropriate responses and will offer you the option to stop the informal interview at any time. Additionally, you may disclose information that may identify people or facilities. To minimize such risk, the principal investigator will encourage participants to refrain from using names. All names and identifiers will be deleted during the transcription process. Transcription is taking the words and dialogue on the audio tape and writing or typing it word for word. Additionally, during the informal interview, the principal investigator will remind participants that the information shared is private and confidentiality will be maintained. There are no medical risks to you from

participating in this study but taking part in this study may make you feel uncomfortable, anxious or distressed, as you recount your personal experiences. You may refuse to answer questions or stop the interview at any time if you experience any discomfort.

With interviews conducted in cafés, the participant's home or using video calling, it is not possible to guarantee the same level of privacy that a private location would offer.

To protect your information, we will not keep your name or other information that may identify you with the information; only a code number. Files that link your name to the code number will be kept in a locked cabinet. Although no one can absolutely guarantee confidentiality, using a code number makes the chance much smaller that someone other than the research staff or other authorized groups or persons (discussed later in the consent form) will ever be able to link your name to your sample or to any test results.

Additionally, due to unique characteristics and patterns of speech, there is a possibility that you may be identified by someone who knows you, if direct quotations are included in the presentation of findings. Our team will work to minimize this risk as much as possible.

8. Are There Benefits Of Participating In This Study?

We cannot guarantee or promise that you will receive any benefits from this research. However, a possible benefit includes feelings of support and validation by sharing personal experiences in nursing. Additionally, your participation may or may not help other Black nurses by providing information that may be used to address issues or challenges in nursing education and practice.

9. What Happens at the End of the Study?

It is anticipated that the results of this study will be published and/ or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. You will also be provided with a copy of the study findings, if you desire.

10. What Are My Responsibilities?

As a study participant you will be expected to participate in an informal interview.

11. Can My Participation in this Study End Early?

Yes. If you chose to participate and later change your mind, you can say no and stop the interview at any time. If you wish to withdraw your consent please inform the principal

investigator. While you may choose to withdraw from the study at any point in time, information collected through the interview process will not be able to be withdrawn from the study beyond two weeks, after the interview. After two weeks, the principal investigator would have begun to analyze and combine information for each of the interviews and the process of separating this information would potentially breach confidentiality. Therefore, you will be able to withdraw your participation at any point and you may withdraw your information for up to two weeks after the interview with the principal investigator.

A decision to stop being in the study will not affect any work performance evaluations you may have. Lastly, the Nova Scotia Health Authority Research Ethics Board and the principal investigator have the right to stop participant recruitment or cancel the study at any time.

12. What About New Information?

You will be told about any other new information that might affect your health, welfare, or willingness to stay in the study and will be asked whether you wish to continue taking part in the study or not.

13. Will It Cost Me Anything?

There are no medical risks to you from participating in this study however, taking part in this study may make you feel uncomfortable. Therefore, you may refuse to answer questions or stop the interview at any time if you experience any discomfort. The principal investigator will be able to provide a list of supports and services, which you may access, if you become distressed and would like to speak with a counselor. The cost of this service is not covered by the study however, the principal investigator would gladly assist you in navigating the Employee Assistant Program (EAP) offered through your employee, which usually offers cost-free services.

Compensation

Participating in this study may result in added costs to you such as costs for parking, transportation, etc. You may be reimbursed for some study related expenses (parking, transportation). Please bring your receipts with you. The principal investigator will also provide each study participant with a token of appreciation, in the form of a $30 gift certificate for Amazon.ca or Wal-Mart. If you require compensation for parking or transportation, this value, up to $5, will be added to your gift certificate.

Research Related Injury

If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your participation in the study and agree to participate as a subject. In no way does this waive your

legal rights nor release the principal investigator, the research staff, the study sponsor or involved institutions from their legal and professional responsibilities.

14. What About My Privacy and Confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. As described, any findings that are presented will be removed of identifiers in order to protect your identity. However, complete privacy cannot be guaranteed. For example, the principal investigator may be required by law to allow access to research records.

Lastly, if you decide to participate in this study, the principal investigator will collect only the information needed for this study.

Access to Records

This study does not require access to your personal health data or records. However, other people may need to look at the information collected for the study to ensure it is correct and to make sure the study followed the required laws and guidelines. These people might include:

-
    - Committee members, research supervisors.
    - The Nova Scotia Health Authority Research Ethics Board (NSHA REB) and people working for or with the NSHA REB because they oversee the ethical conduct of research studies within the Nova Scotia Health Authority.

Use of Your Study Information

The research team and the other people listed above will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated.

The research team will keep any personal information about you in a secure and confidential location for 7 years and then destroy it according to NSHA policy.

You have the right to be informed of the results of this study once the entire study is complete.

The REB and people working for or with the REB may also contact you personally for quality assurance purposes.

Your access to records

You have the right to access, review, and request changes to your study data. If you would like a copy of your transcript, you can contact the principal investigator using the email or cell phone number provided in section 16.

15. Declaration of Financial Interest

The principal investigator is funded by Vanier Canada Graduate Scholarship (Vanier-CGS); Killam Trust, Dalhousie University Faculty of Graduate Studies and the School of Nursing, BRIC NS, Research Nova Scotia, the Johnson Scholarship Foundation and the Nova Scotia Health Authority. These organizations are providing financial support to the principal investigator to conduct this study. The amount of funding received is sufficient to cover the costs of conducting the study.

16. What About Questions or Problems?

For further information about the study you may call or email the principal investigator, who is the person in charge of this study.

The principal investigator is: Keisha Jefferies.
Telephone: 9022336432
Email: keisha.jefferies@dal.ca

17. What Are My Rights?

You have the right to all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction before you make any decision. You also have the right to ask questions and to receive answers throughout this study. You have the right to withdraw your consent at any time.

If you have questions about your rights as a research participant, and/or concerns or complaints about this research study, you can contact the Nova Scotia Health Authority Research Ethics Board manager at 902-473-8426 or Patient Relations at (902) 473-2133 or 1-855-799-0990 or healthcareexperience@nshealth.ca. You may also contact the Research Office at the IWK Health Centre at (902) 470-7879, Monday to Friday between 8:00 am and 4:00 pm.

In the next section you will be asked if you agree (consent) to join this study. If the answer is “yes”, please sign the form. Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities.

18. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

A Critical Examination of the Leadership Experiences of African Nova Scotia Nurses in Healthcare Practice

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting my nursing practice.

☐ I **agree** to audio recordings as described in this consent form.

_____	_____	____ / _____ / ____
Signature of Participant	Name (Printed)	Year Month Day*
_____	_____	____ / _____ / ____
Signature of Person Conducting Consent Discussion	Name (Printed)	Year Month Day*
_____	_____	____ / _____ / ____
Signature of Principal Investigator	Name (Printed)	Year Month Day*

Note: Please fill in the dates personally

I will be given a signed copy of this consent form.

Appendix J: Semi-Structured Interview Guide

1. How would you describe your experience in nursing practice?
    a. Tell me about your career path?
    b. What about your practice experience?

2. When I say *nursing leadership*, what comes to mind for you?
    a. What does nursing leadership mean to you?

3. Tell me about your experience with nursing leadership.
    a. What are your experiences being mentored as a junior nurse?
    b. What are your experiences mentoring junior nurses?

4. How has race (being Black) influenced your experience in nursing leadership?
    a. What about other concepts, including: class, gender, sexuality, ability, misogyny?
    b. Tell me about other factors that influence your experience with leadership?

5. How does your place of work encourage, support or positively reinforce your leadership?
    a. Tell me about educational opportunities/ continuing competencies (ie: committee participation).
    b. What about professional development (conferences etc.)?

6. Tell me about your positive experiences in nursing leadership.
    a. Please share some of your more challenging experiences.

7. What do you believe would encourage more Black nurses to be involved in leadership?

8. How can the health care system (organizations) better assist Black nurses as leaders?
    a. What about in nursing education?

9. Is there anything else you would like to share?