









DISCURSIVE PAPER

Indigenous social exclusion to inclusion: Case studies on Indigenous nursing leadership in four high income countries

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Abstract

Aims and objectives: This discursive paper provides a call to action from an international collective of Indigenous nurse academics from Australia, Canada, Aotearoa New Zealand and the USA, for nurses to be allies in supporting policies and resources necessary to equitably promote Indigenous health outcomes.

Background: Indigenous Peoples with experiences of colonisation have poorer health compared to other groups, as health systems have failed to address their needs and preferences. Achieving health equity will require leadership from Indigenous nurses to develop and implement new systems of care delivery. However, little is known about how Indigenous nurses influence health systems as levers for change.

Design: A Kaupapa Māori case study design.

Methods: Using a Kaupapa Māori case study methodology, coupled with expert Indigenous nursing knowledge, we developed a consensus on key themes. Themes were derived from three questions posed across the four countries. Themes were collated to illustrate how Indigenous nurses have provided nursing leadership to redress colonial injustices, contribute to models of care and enhance the Indigenous workforce.

Results: These case studies highlight Indigenous nurses provide strong leadership to influence outcomes for Indigenous Peoples. Five strategies were noted across the four countries: (1) Indigenous nationhood and reconciliation as levers for change, (2) Indigenous nursing leadership, (3) Indigenous workforce strategies, (4) Development of culturally safe practice and Indigenous models of care and (5) Indigenous nurse activism.

Conclusions: In light of 2020 declared *International Year of the Nurse and Midwife*, we assert Indigenous nurses' work must be visible to support development of strategic approaches for improving health outcomes, including resources for workforce expansion and for implementing new care models.

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Relevance to clinical practice: Curating strategies to promote Indigenous nurse leaders around the world is essential for improving models of healthcare delivery and health outcomes for Indigenous Peoples.

KEYWORDS

education and leadership, Indigenous, inequity, minority, native, nursing, workforce

What does this paper contribute to the wider global clinical community?

- These case studies demonstrate how Indigenous nurse leadership and models of health delivery can meet Indigenous and non-Indigenous community needs, currently not met by mainstream models of health care.
- Our vision is for an Indigenous nursing workforce that matches its population characteristics, has national and regional targets and aligned strategies for Indigenous workforce development and leadership with corresponding resources and political will.

1 | INTRODUCTION AND BACKGROUND

There are an estimated 476 million Indigenous Peoples worldwide in over 90 countries (The World Bank, 2020). Approximately seven million live within the high-income countries of Aotearoa New Zealand (NZ), Australia, Canada and the USA. These nations share similar colonial histories that were initiated 400–500 years ago in Canada and the USA and 200 years ago in Australia and NZ. Although there are significant differences in time and space, the shared stories are similar and the lasting effects on the health status and economies of Indigenous People persist today (Axelsson et al., 2016; Jackson Pulver et al., 2010; Moewaka Barnes & McCreanor, 2019). Indigenous Peoples make up about five per cent of the world's population but account for fifteen per cent of the world's extreme poor (Anderson et al., 2016; The World Bank, 2020) and are more likely to be alienated from their land and food resources (Gracey & King, 2009), be victims of violence and murder (NZ Family Violence Death Review Committee, 2017; Power et al., 2020; United Nations, 2020), have their children removed illegally or without just cause (Amnesty International, 2020; Kapa-Kingi, 2019; Rouland et al., 2019), experience discrimination, stigma and racism (Cormack et al., 2018; Crengle et al., 2012; Harris et al., 2012; King et al., 2009) and be socially excluded (Dhir Kumar et al., 2020). These current and historical social conditions directly undermine Indigenous Peoples' self-determination and ability to care for themselves, their families and communities (Gracey & King, 2009).

Governments are attempting to resolve past injustices to Indigenous Peoples by 'recognizing and acknowledging past grievances, historical wrongs and injustices legitimates those whose political, spiritual and cultural practices have been brutally universalised into the values of their colonisers through processes of assimilation, integration or genocide' (Sullivan, 2016). This reconciliation is also about establishing and sustaining mutually respectful relationships between Indigenous Peoples and non-Indigenous people. Several barriers to reconciliation have been noted (Indigenous Corporate

Training Inc., 2019): (1) Difficulty in accepting historical truths about colonisation (ie why should Indigenous Peoples have any say, colonisation happened a long time ago?); (2) Indifference about Indigenous Peoples, often established by the Doctrine of Discovery, otherwise known as viewing of Indigenous Peoples as being less than human (eg they have lower education levels and health literacy, and therefore, do not deserve the best health care); (3) Misconceptions about Indigenous Peoples primarily related to presumptions of stereotypes of incompetence (ie Indigenous Peoples do not follow instructions or attend appointments); and, (4) The daunting task of reconciliation may be viewed as overwhelming. Reconciliation is not a universal process with colonised countries having very different approaches.

The reconciliation process in Aotearoa (NZ) is state-led, state-controlled and state-determined, with the Government acknowledging Treaty breaches. Recently a Treaty claim on healthcare services and outcomes (Wai2575) found Treaty breaches systematically provided poorer access to health care, poorer quality care and less choices in health care with poor governance and leadership for Māori (Waitangi Tribunal, 2019a). Māori are demanding constitutional reform to the Crown processes that they 'had no part in determining' to address the ongoing impacts of colonisation and ensuring that Treaty breaches are acted on and resources are provided for transformational change (Came & da Silva, 2011; Mutu, 2018).

On 13 February 2008, then Australian Prime Minister Kevin Rudd offered an official *Apology to Australia's Indigenous Peoples* which is now commonly known as 'the apology'. The apology was prompted after inquiry that led to the Human Rights and Equal Opportunity Commission's creation of the *Bringing Them Home* Report (1997). It acknowledged the generations of forced removal of Indigenous Australians commonly referred to as the stolen generations. Aboriginal and Torres Strait Islander Peoples in Australia never ceded territory or sovereignty. No treaty was brokered. Instead, the doctrine of Terra Nullius (land belonging to no one) was invoked (McMillan & Rigney, 2018). The Council for Aboriginal Reconciliation was established in 1991; however, this has not

TABLE 1 Overview of Indigenous Peoples from Aotearoa, Australia, Canada and the USA

	Aotearoa New Zealand	Australia	Canada	USA
Indigenous Peoples	Māori	Aboriginal/Torres Strait Islander Peoples	First Nations, Inuit and Métis Peoples	Native American (American Indian, Alaska Native, and Native Hawaiian) ^{*,**}
Year Colonised	First documented European contact in 1642, with colonization occurring in from 1769 with the arrival of Captain James Cook	1788	1763	First contact 1492
Number of tribes	Approximately 175 Iwi groups	250 Language groups ^e	636 Nations 50 First Nation Inuit Métis 70 languages	574 Federally recognized 66 State recognized ^k
Treaty/treaties signed	1840, Te Tiriti o Waitangi	None	1867	370 ratified ^k
Current Indigenous population	775,836 ^{a,*}	798,400 ^f	1,673,780 ^j	2.9 million single race 5.7 million combined-race ^l
Proportion of the National Population	N = 4.9 million (16.5%) ^a	N = 24.2 million (3.3%) ^f	N = 7.06 million (4.9%) ^j	N = 328 million (1.7%) ^k
Life Expectancy Gap (compared to reference group)	7.3 years ^b	11.5 years ^g	First Nation – 9 years Inuit – 13 years Métis – 4 years 8.6 years (average) ^j	5 years ^k
Living in Poverty	32% ^c	24.4% (urban – 53.4% (remote) ^h	25% ⁱ	38.2% on reservations ^k
Proportion of nursing workforce who are Indigenous	8% ^d	1.1% ⁱ	3%	0.2% ^k

^aStatsNZ, (2020).^bMinistry of Health (2018).^cHealth Quality & Safety Commission (2008).^dNursing Council of New Zealand (2019).^eAIATSIS (n.d.).^fAustralian Bureau of Statistics (2016).^gAustralian Institute of Health and Welfare (2020).^hMarkham and Biddle (2018).ⁱAustralian Institute of Health and Welfare (2016).^jStatistics Canada (2018).^kIndian Health Service (2016).^lUnited States Census Bureau (2020).

*In New Zealand, ethnicity is self-defined based on any Māori ancestry.; **1.2 million classified as Native Hawaiian and other Pacific Islanders.

resulted in self-determination, reparation or equitable health outcomes (Collins & Thompson, 2018). A more recent, Indigenous led initiative called for a 'Makarrata Commission' (Yolngu word for treaty) to oversee 'a process of agreement-making' and 'truth-telling'

during the establishment of a 'First Nations' voice in the constitution (Collins & Thompson, 2018).

In Canada, 2020 marks the five-year anniversary of the release of the Truth and Reconciliation Commission's Final Report.

The Commission was established because of the Indian Residential School Settlement Agreement, the largest class action settlement in Canadian history. The report includes 94 calls to action to further reconciliation between Indigenous and non-Indigenous People (Government of Canada, 2019). The report also highlighted an absence of authentic engagement by nurses willing to examine their roles of complacency in the continued colonisation of First Nations, Inuit and Metis Peoples (Symenuk et al., 2020).

As of 2020, in the USA, there has been no national effort for Truth and Reconciliation; however, in 2012 the State of Maine established the Maine-Wabanaki State Child Welfare Truth and Reconciliation Commission. The commission was established to report on events related to Wabanaki children and their families from the establishment of the Indian Child Welfare Act (ICWA) 1978–2012 (Collins et al., 2014).

In healthcare systems, Indigenous Peoples' needs are often silenced or invisible, with western health care failing to deliver accessible, high-quality, culturally relevant care (Jackson Pulver et al., 2010; Kurtz et al., 2014). Social exclusion consists of multidimensional processes driven by unequal power relationships across four dimensions – economic, political, social and cultural – and can deny individuals of security, dignity and the opportunity to lead a better life (Popay, et al., 2008). Additionally, the social determinants of health, the non-medical factors that influence health, and the systematic failure to meet Treaty obligations and to provide quality, culturally appropriate health care to Indigenous Peoples has resulted in persistently poor health outcomes (Jackson Pulver et al., 2010; Wilson et al., 2018). This is evidenced by Indigenous populations experiencing lower life expectancy, with noted life expectancy gaps at birth: 10 years in Australia; 7 years in New Zealand; 5.5 in Canada; 4.8 years in the USA (Anderson et al., 2016). However, there are significant within-group differences, for instance between states and reservations. Table 1 outlines characteristics of Indigenous Peoples across Australia, Canada, Aotearoa New Zealand and the USA.

Nurses comprise the largest sector of the health workforce in the world, with 27.9 million nurses and midwives accounting for nearly 60% of the world's health workforce (World Health Organization, 2020). Nurses are ideally positioned to meet the needs of Indigenous Peoples. However, given the nursing profession is based on a caring philosophy that aims to support 'human dignity, integrity, autonomy, altruism and social justice' (Fahrenwald et al., 2005), as an international group of Indigenous nurse academics from Australia, Canada, Aotearoa New Zealand and the USA, we argue that nursing has systematically failed Indigenous populations (West et al., 2010). This is confirmed by: (1) The shortage of Indigenous nurses (Smiley et al., 2018; Wilson et al., 2011); (2) Lack of Indigenous nursing content and models taught in education or the inclusion of Indigenous knowledge (Rocheouste et al., 2016; Stansfield & Browne, 2013; Wilson et al., 2011); (3) Absence of culturally appropriate health services tailored to Indigenous Peoples (Li, 2017; Wilson et al., 2018); (4) Limited Indigenous nurse educators (Rocheouste et al., 2016; Smiley et al., 2018); (5) Lack of Indigenous nurse scientists who engage in Indigenous-centric research (Jeffries-Stokes et al., 2015);

and, (6) No academic-practice transition supports and pathways to support and retain new Indigenous nurse graduates (Kurtz et al., 2017) – all of which contribute to persistent structural and health inequities (Jackson Pulver et al., 2010). We assert that Indigenous nurses are strategically positioned to lead the healthcare needs of Indigenous Peoples and establish the vision for equity to meet the 2030 Agenda for Sustainable Development, which promises to leave no one behind and reach those furthest behind first (United Nations, 2015).

Nurses can be powerful agents of social change and justice, but this effort does not rest primarily with nurses, they need the support of governments, healthcare institutions and professional organisations (Institute of Medicine, 2011). Yet, there is a distinct lack of leadership and political will in giving voice and power to Indigenous nurses, and in prioritizing Indigenous health as a core component of nursing education and workforce development (West et al., 2010). Undergraduate and postgraduate education for nurses, and recruitment and retention of Indigenous Peoples into nursing careers, are limited and often have little influence or resources (Wilkie, 2020). There has been minimal oversight and accountability for strategies, policies and frameworks implemented for ensuring nurses can safely engage with Indigenous communities (Wepa & Wilson, 2019). Although the inclusion of cultural safety is mandated in New Zealand and Australian nursing degrees (Australian Nursing & Midwifery Accreditation Council, 2019; Nursing Council of New Zealand, 1996, 2011) and code of conduct (Nursing Midwifery Board of Australia, 2018; Nursing Council of New Zealand, 1992, 2011), there is little evidence that this has translated into practice. Without a commitment to strategies promoting cultural safety in nursing education and practice and growing the Indigenous nursing workforce, health inequity for Indigenous Peoples will persist. Therefore, the purpose of this discursive paper is to highlight that in order to achieve health equity, we must curate and transform systems to support Indigenous Peoples that are shaped by Indigenous nurses and communities.

2 | METHODS: CASE STUDIES

The complexity of Indigenous worldviews requires an exploration beyond simple methodologies; hence a Kaupapa Māori case study design was used to highlight the work of Indigenous nurses in Aotearoa (NZ), Australia, Canada and the USA (Pihama et al., 2002). Originating in Aotearoa, New Zealand, and rooted in Indigenous academics, Kaupapa Māori research is a philosophy, theory, methodology and practice of research for the benefit of Indigenous Peoples (Māori Health Committee, 2010; Smith, 2015). This methodology privileges and normalises Indigenous knowledge and looks for solutions to achieve the cultural aspirations of Indigenous communities, including self-determination (Haitana et al., 2020; Smith, 2013). Within Kaupapa Māori research, researchers affirm Indigenous worldviews and critique colonial constructions (Cram et al., 2006). Various research methods can be employed in Kaupapa Māori research, with the chosen method tailored to address the specific

research question and study design (Haitana et al., 2020). In this paper, a case study method was used to illustrate how each of the four countries have responded to Indigenous Peoples, and how Indigenous nurses can be instrumental in shaping change. A case study can be described as an 'intensive, systematic investigation of a single individual, group, community, or some other unit in which the researcher examines in-depth data relating to several variables' (Pihama et al., 2002).

We used collective expert Indigenous nursing knowledge and a collaborative decision-making methodology to develop a consensus on key themes (Heale & Twycross, 2018; Wilson et al., 2019). Themes were derived from questions posed across the four countries: (1) What is the impact of colonisation on health outcomes for Indigenous populations? (2) What exemplars of nursing leadership are associated with improved Indigenous well-being? and (3) how is Indigenous nursing leadership fostered and supported? A collaborative decision-making method was operationalised via regular digital conferencing meetings and rigorous discussions on each of the questions. A consensus was agreed on the themes with each representative from the country offering examples from their context, local knowledge and science. These were collated and discussed with case studies exemplifying how Indigenous nurses can create system-level change to advance health outcomes of Indigenous Peoples.

2.1 | Aotearoa New Zealand

2.1.1 | Māori nursing leadership and activism

Given the significant health inequities of Indigenous Māori in New Zealand (Health & Disability System Review, 2020; Hobbs et al., 2019; Ministry of Health, 2018; Waitangi Tribunal, 2019a), ensuring there is a well-prepared Māori nursing workforce is vital to improving the well-being of its Peoples (Mbuzi et al., 2017). In New Zealand, Indigenous Peoples are 16.5% of the 4.9 million total population, yet only 8% of the nursing workforce identifies as Māori (Nursing Council of New Zealand, 2019; StatsNZ, 2020). The New Zealand Nursing Workforce Governance Group set a target date for equity in the Māori nursing workforce; by 2028, it is expected that the Māori nursing workforce will match the percentage of Māori in the New Zealand population (Ministry of Health, 2017). This target requires each District Health Board (DHB) to implement strategies, although Māori nursing capacity varies across regions (Nursing Council of New Zealand, 2017). Without corresponding high-level nursing leadership, strategies and resourcing, it is unlikely that this target will be met (Chalmers, 2020).

The causes of Māori nursing workforce inequity are relatively complex and multifactorial (Wilson et al., 2011). Recruiting Māori into nursing careers is problematic with inaccessible pathways (Curtis et al., 2012) and absence of Māori nurse tutors and professors as mentors and role models (McAllister et al., 2019). Retaining Māori nurses in the workforce is also difficult, and the number is

projected to continue declining. Reasons for leaving the workforce vary, but most agree it is often inherently due to issues related to their colonial history (ie experiences of systemic racism and cultural insensitivity) Such experiences often lead to Māori nurses being overworked and undervalued (Huria et al., 2014; Manchester, 2018). There are significant pay inequities for Māori nurses, particularly working for Māori health providers with the government refusing to address pay parity for Māori nurses (Radio New Zealand, 2020). In 1990, New Zealand implemented cultural safety into practice largely influenced by Dr Irihapeti Ramsden, a Māori nurse, after witnessing unsafe cultural practice by nurses (Papps & Ramsden, 1996). While annual endorsements of culturally safe practice are required each year for nursing registration, there remain accounts of racist and unsafe behaviours towards Māori nurses and patients (Graham & Masters-Awatere, 2020; Huria et al., 2014). This year (2020) saw a landmark decision that called on a non-Indigenous nurse to account for making inappropriate and offensive racist comments on social media against Māori nurses. The decision by the New Zealand Health Practitioners Disciplinary Tribunal to censure the nurse and cancel her nursing registration signalled that such racist behaviours will no longer be tolerated (New Zealand Health Practitioners Disciplinary Tribunal, 2020).

In New Zealand, there are also emerging accredited undergraduate nursing programmes that are designed to privilege Māori knowledge; for example, the Te Ōhanga Mataora: Bachelor of Health Sciences Māori Nursing at Te Whare Wānanga O Awanuiārangi (Te Whare Wānanga O Awanuiārangi, n.d.) and the Māori Programme, Te Ara Oranga, at Manukau Institute of Technology (Manukau Institute of Technology, 2019). These programmes are designed to foster Māori knowledge as a foundation for caring and thereby create a workforce designed to meet the specific cultural needs of Māori. There have also been purposeful strategies for fostering leadership among Māori nurses, including Ngā Manukura o Āpōpō (translates to leaders for tomorrow), a national leadership and training programme specifically designed for Māori nurses and midwives. The Māori nursing leadership programme has led to a range of leadership activities to improve Māori health outcomes by graduates (Ngā Manukura o Apopo, n.d.). These strategies have evolved under the leadership of Māori nursing leaders who have advocated at the highest levels of government. A trailblazer in her own right, Margareth Broodkoorn was the first Chief Nursing Officer of New Zealand to be of Māori descent. Her tenure, which recently ended in 2020, heavily focused on enhancing cultural understanding and strengthening the Indigenous nursing workforce (New Zealand Nurses Organisation, 2020).

Lastly, Māori nurses have been at the forefront of constitutional change in New Zealand. Māori nurses provided evidence at the Waitangi Tribunal for Treaty breaches in the Wai2575 health-care services and outcomes (Baker, 2018), and a Māori midwife led a Treaty claim (Wai2823) on the Oranga Tamariki Act 1989 and its application for the uplifting of Māori babies and children without sufficient evidence in child protection services (Dewes, 2020; Waitangi Tribunal, 2019b). Māori nursing activism has and will continue to

be paramount in facilitating mainstream services responsiveness to Māori, while in parallel creating and innovating Māori health services. In summary, together these strategies are contributing to increased recruitment of Māori nurses, facilitating Māori nursing leadership and creating safer and more self-determined Māori health and social services for Māori families and communities.

2.2 | Australia

2.2.1 | Constitutional reform as a strategy to record Indigenous Peoples and nurses

In the 2016 census, Indigenous Peoples were reported to be 3.3% of the 24.2 million total population (Australian Bureau of Statistics, 2016). Indigenous nurses and midwives represent 1.1% ($n = 3187$) of the Australian nursing and midwifery workforce (Australian Institute of Health & Welfare, 2016). Historically, as in many colonised nations, the collection of workforce labour history data for Indigenous nurses and midwives has been highly problematic. Australia's Indigenous Peoples were not included in census data until after the 1967 Referendum: in large part due to the relentless work of Indigenous nurse activists and leaders such as Dulcie Flower and Isabelle Ferguson (Best & Gorman, 2016). The inaugural 1979 Aboriginal Health Report identified there were 'few nurses and nurse trainees, and a limited number of nurse aides' (House Standing Committee on Aboriginal Affairs, 1979, p. 125). This reporting was deeply flawed as Indigenous women's labour force histories in nursing or midwifery were not undertaken (Best, 2015; Best & Bunda, 2020; Best & Gorman, 2016).

The 1967 Referendum resulted in the inclusion of Indigenous Australians in census data, and therefore, workforce data, meaning the federal government could legislate on behalf of Indigenous Australians. This meant that state and territory services could be federally funded, which fuelled the development of community-controlled Indigenous services (Best, 2005). In Australia, the health of Indigenous Australians saw a fundamental change in service delivery and community self-determined processes in 1971 when the doors of the Redfern Aboriginal Medical Service (AMS) in Sydney opened. Sister Dulcie Flower, herself a Torres Strait Islander registered nurse and midwife started this, and the significance cannot be overstated. For the first time in postcolonial Australia, Indigenous nurses and midwives could work for their people outside of the hospital system in community-controlled, Indigenous health services and still work uniquely for Aboriginal and Torres Strait Islander Peoples (Best, 2005). Today, Australia has over 140 Aboriginal Community Controlled Health Organizations (ACCHOs) that operate across Australia, delivering comprehensive primary healthcare services (National Aboriginal Community Controlled Health Organization (NACCHO), 2020). These ACCHOs are initiated and operated by local Indigenous communities and vary from being highly urbanised to very remote services (NACCHO, 2020). Indigenous nurses and midwives participate in this culturally safe space delivering primary healthcare services to Indigenous Australians.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) recently updated the Registered Nurse Accreditation Standards, which govern curriculum within Australian universities (2019). Standard 3.7 dictates that, 'the program's content and subject learning outcomes embed principles of diversity, culture, inclusion and cultural safety for all people' (ANMAC, 2019, p.16). Standard 3.10a mandates that 'the program includes Aboriginal and Torres Strait Islander Peoples' history, culture, and health taught as a discrete subject' and 3.10b, 'content relevant to health outcomes of Aboriginal and Torres Strait Islander is embedded throughout the program' (ANMAC, 2019, p.16). Despite indigeneity, being routinely collected during annual registration, in 2020 the Nursing and Midwifery Board of Australia (2018) still do not publish the numbers of Indigenous nurses and midwives in their registration data. In summary, these case studies highlight Indigenous nurses' activism and advocacy in developing new models of care in the Australian context to improve outcomes for Indigenous communities.

2.3 | Canada

2.3.1 | Contributing to systems transformation: Indigenous health nursing research

Health inequity for Indigenous populations in Canada continues to widen despite advances in health care, technology and Indigenous health research (Greenwood et al., 2018). Canada's universal health-care system is considered one of the best in the world, yet Indigenous Peoples, 4.9% of the 7.06 million population (Statistics Canada, 2018), continue to experience much poorer health outcomes (Allan & Smylie, 2015; Brown et al., 2005). There has been a systematic failure to provide leadership and implement national Indigenous public health policies and develop Indigenous workforce strategies (Richmond & Cook, 2016). This is reflected in the disproportionate numbers of Indigenous nurses and health professionals (Canadian Nurses Association, 2014). Only 3% per cent ($n = 13,200$) of approximately 440,000 regulated nurses, (registered nurses, licensed practical nurses, registered psychiatric nurses and nurse practitioners) in Canada, are Indigenous. However, it must be noted that Indigenous nurses are the largest component (74.5%) of the Indigenous health workforce and therefore can be important in providing missing leadership in Indigenous health (University of Saskatchewan College of Nursing, 2016). Despite the importance of Indigenous nurses to the workforce, the characteristics and contributions of employed Indigenous nurses are not routinely and accurately reported (Canadian Nurses Association, 2014). This is an issue in that it: (1) negates the value and substantial contributions of Indigenous nurses to the Canadian healthcare system (2) inhibits healthcare systems from maintaining a diverse, representative workforce that can meet communities' needs (Bourque Bearskin et al., 2016) and (3) fails to resolve solutions to reduce systemic racial and discriminatory health provision.

Over the last five years since the Truth and Reconciliation Calls to Action (Government of Canada, 2019), minimal progress has been

made to address discriminatory healthcare systems and increase the numbers of Indigenous health workforce. A recent report by Turpel-Lafond (2020) exposed deep, widespread lack of cultural safety and direct and indirect racism, with 84% of Indigenous respondents reporting ethnic discrimination, and 52% of Indigenous healthcare workers experiencing racial prejudice at work. In addition, one third of non-Indigenous healthcare workers witnessed racism or discrimination directed to Indigenous patients. This highlights the inadequate education and training programs within undergraduate and post-graduate curricula, with no accountability for reporting, addressing and eliminating racism. There are longstanding historical practices of suppression of Indigenous nurses and Indigenous knowledge systems, and this lack of political will to address policies is merely maintaining the marginalisation, racism and reduced positive health outcomes for Indigenous Peoples (Starblanket, 2020; Vukic et al., 2012; Turpel-Lafond, 2020).

To address systemic barriers and challenges in nursing education, the Canadian Institute of Health Research (CIHR), in partnership with the Canadian Nurses Foundation and provincial health authorities, recently funded six Indigenous Health Chairs in Nursing. These roles aimed to ensure the inclusion of nursing Indigenous knowledge within colonial systems through respectful engagement of, and guidance by, Indigenous nurses, local knowledge holders and communities in the redesigning of health services (Bourque Bearskin et al., 2020; Government of Canada, 2019). This initiative is timely and aligned with the World Health Organization (WHO) Year of the Nurse and Midwife 2020, recognizing the significance of social justice and power differential related to racism and discrimination (2020). The initiative also supports the position of the ANAC (2009), now known as the Canadian Indigenous Nurses Association of Canada, that Indigenous nurses are pivotal in providing culturally safe and secure healthcare services that bring Indigenous health nursing knowledge to the forefront, grounded in Indigenous ontology, epistemology, axiology and methodology. Through this initiative, specific outcomes are directly related to achieving health equity and addressing historical suppression of Indigenous nursing and knowledge systems that are associated with marginalisation of traditional practices and poor health outcomes for Indigenous Peoples (Goodman et al., 2017). In summary, Indigenous nurses in Canada can provide necessary leadership for creating a larger Indigenous workforce, progressing Indigenous nursing academia and addressing racism in the healthcare system with their non-Indigenous allies.

2.4 | USA

2.4.1 | Addressing the mental health treatment gap: Minority Fellowship Programme

Native Americans bear a greater burden of morbidity and mortality compared to the rest of the US population; however, there are significant differences based upon geography (Roubideaux et al., 2012).

In total, there are 5.7 million (1.7%) combined race and 2.9 million (0.9%) single-race Native Americans among a total population of 332 million (United States Census Bureau, 2020). There are 574 federally recognised tribes in the USA (National Congress of American Indians, 2020) and about 63 state recognised tribes, including Native Hawaiians, indicating they are eligible for state but not federal health-related services that are part of federal recognition. Guaranteed health care by treaty, the U.S. Department of Health and Human Services Indian Health Service (IHS) agency provides health-related services to federally recognised tribes, comprised of a user population of 2.56 million people in 37 states (Indian Health Service, 2020a). The subgroup of Native Americans receiving health care through IHS are described as 'having the worst health outcomes' of any ethnic group in the USA (United States Commission on Civil Rights, 2004); unfortunately, Indian Health Service is funded at 60% of healthcare needs of eligible Native Americans, significantly contributing to early death and a greater burden of disease (Indian Health Service, 2020a).

Native American nurses are integral to the health care delivered to Native American people throughout the USA, with over 60% of nurses working across IHS identifying as Native American. Of the 3.9 million active nurses in the USA 0.3%, identify as Native American: over a 10-year (2010–2020) period, there has been no change in the number of Native American nurses (Health Resources & Services Administration, 2019). Meanwhile, the overall IHS nurse vacancy rate is 23% and as high as 40% in some IHS areas, while the Advance Nurse Practitioner vacancy rate is 36% and as high as 60% in some IHS areas (Indian Health Service, 2016). Within the IHS system, there are several initiatives to increase the number of Native American nurses and enhance leadership (Indian Health Service, 2020b). Aimed at increasing the number of nurses delivering care to Native Americans, the American Indians into Nursing Programme recruits, provides support and scholarships by grant awards to five universities and colleges. As an example, the 30-year Recruitment and Retention of American Indians into Nursing (RAIN) programme has graduated over 200 nurses; almost 80% of Native American nurses working in North Dakota (home to RAIN) are graduates of the RAIN programme (University of North Dakota College of Nursing, 2020). Additionally, the Niganawenimaanaanig nursing programme has significantly increased the recruitment and retention of American Indian nurses at Bemidji State University, Minnesota (Wilkie, 2020). The National Nurse Leadership Council, housed within the IHS, seeks to ensure that the Indian Health System Nursing Programme representatives effectively participate in the establishment and implementation of agency strategies to achieve the IHS mission. IHS also offers scholarships for a minimum two-year commitment and loan repayment for nurses willing to serve in high need areas. However, IHS is unable to offer competitive salaries contributing to the higher vacancy rate especially in rural and remote communities (Indian Health Service, 2016). The nursing workforce shortages found within Native American communities is a contributing factor to the barrier of achieving optimal health outcomes for Native American people and is especially

problematic for efficiently responding to the Covid-19 pandemic. Additionally, founded in 1993, the National Alaska Native American Indian Nurses Association (NANAINA) was established to advocate for improved health care among Native Americans and to promote development of nurses. Across the nation, there is an estimated 35 doctoral prepared (Doctor of Nursing Practice [DNP] and Doctor of Philosophy [PhD]) Native American nurses, with few staying in academia or research (Henly et al., 2006; Moss, 2015).

The Minority Fellowship Programme (MFP) at the American Nurses Association (ANA) is an excellent example of the support needed to enhance the Indigenous nursing workforce. The mission of the MFP/ANA is to educate ethnic minority nurses with expertise in mental health and substance use disorders that are prepared to assume leadership positions in education, research, practice and health policy (American Nurses Association, 2020). Fellows receive mentorship and guidance by the MFP/ANA to lead in creating, transmitting and utilizing knowledge and skills to improve the health of Native American people during vulnerable situations such as the Covid-19 pandemic. In 1974, the National Institute of Minority Health (NIMH) established the Ethnic Minority Fellowship Programme to support the education of ethnic minority individuals in mental health and substance abuse disorders, which is now supported by the Substance Abuse and Mental Health Service Administration (SAMHSA). Over the course of 45 years, the MFP/ANA has supported the education and training of more than 350 ethnic minority nurses at the doctoral level with focused expertise in mental health and substance use, including 18 Native American nurses, who have received educational preparation and degrees at the PhD level. The overall goal of the MFP/ANA is to increase the number of under-represented minority nurses in behavioural and mental health graduate or doctorate degrees (American Nurses Association, 2020). To date, most Native American nurses who have completed the MFP/ANA programme accepted positions in academic institutions. However, very few have been able to establish a programme of research, with the exception of Dr. Lowe, who established the Center for Indigenous Nursing Research for Health Equity (INHRE), which aims to achieve health equity through education, service and research by collaborating with Indigenous groups and organisations across the globe (Moore, 2018), in part by utilizing the Talking Circle Intervention (Lowe et al., 2016, 2019). In summary, these strategies have highlighted the USA's strategies led by Indigenous nurses to increase recruitment and retention of Indigenous nurses and develop programmes of research, which emphasise Indigenous knowledge, despite the absence of a national strategy to address Native American health disparities or the shortage of Native American nurses.

2.5 | Summary of case studies

These case studies have highlighted how Indigenous nurses are strategically positioned to lead efforts to address health inequities among Indigenous Peoples. We have provided examples of how Indigenous health inequities have prompted strategic increases in

Indigenous nursing education leadership and Indigenous workforce strategies, and how Indigenous nurses are creating constitutional and system-level changes to support Indigenous Peoples' well-being. The State of the World's Nursing Report (World Health Organization, 2020) provides compelling evidence of the value of the nursing workforce and reports the nursing workforce is growing; however, this growth is not equitable.

3 | DISCUSSION

The aim of this paper was to highlight case studies to demonstrate how Indigenous nurses can progress and influence Indigenous health aspirations and outcomes across the four high-income countries of Aotearoa New Zealand, Australia, Canada and the USA. These four countries share remarkably similar colonizing histories, with similar systematic erosion of the health and social well-being of Indigenous Peoples. Each of the four countries are at different stages of addressing these aspirations yet highlight similar pathways to addressing the well-being of Indigenous Peoples within a colonised health system. First, all Indigenous Peoples require acknowledgment of Indigenous nationhood and reconciliation as a foundation for addressing health inequity. Health systems will not change unless inequity is exposed and there is political will and action to change it. Second, the creation of Indigenous leadership is essential, and non-Indigenous nurses cannot lead and support the development of Indigenous strategies (although allies are required) in academic institutions, clinical or policy settings. Examples of Indigenous nursing leadership has had immeasurable ripples across the health systems from bedside cultural safety practice to influencing governmental policies. Third, the development of national, regional and service workforce development strategies to actively recruit and maintain Indigenous nurses into the profession is required. Without purposeful strategic direction, leadership and resourcing, the Indigenous nursing profession will not grow. The fourth theme is the development of non-racist and self-determined models of care led by Indigenous community needs. To do this, there must be recognition that mainstream models of care that are consistently under-delivering and underperforming for Indigenous Peoples be replaced by holistic Indigenous models of care that are frequently led by Indigenous nurses, Indigenous community workers and Indigenous doctors. The fifth and final common thread in these case studies is nurse activism. Indigenous nurses who see broken systems are standing up for their communities to make a difference, in often very hostile environments. These strategies will now be discussed.

We have described reconciliation and Treaty processes as a strategy to redress colonial injustices as levers to facilitate system-level changes in health care. Reconciliation is a significant lever to hold governments and policymakers to account for colonial health systems that have generationally harmed and marginalised Indigenous Peoples, although with varying success. Such 'one-size-fits-all' approaches disregard collectivist Indigenous cultural systems, and while convenient, dismisses promoting health equity needs of

Indigenous Peoples (Mitchell & Wilson, 2019; Wilson et al., 2018). Mainstream health systems maintain colonialism through notions of Universalism as a 'fair' strategy to provide health care. However, this fails Indigenous Peoples as it systematically privileges the values and preferences of the dominant (White) culture (Matheson et al., 2020). In nursing, colonisation is manifest in several ways, with case studies highlighting how Indigenous nurses are not routinely counted in health workforce statistics – rendering us invisible. The State of Nursing 2020 Report also excluded Indigenous nurses, reinforcing the precarious position of Indigenous nurses and Indigenous Peoples generally within the broader global and national nursing communities (Chalmers, 2020). Nursing ethnicity data that include Indigenous nurses should be an essential component of monitoring the nursing workforce and keeping the system accountable for monitoring progress and highlighting gaps. Other manifestations of inequity experienced by Indigenous nurses are the undervaluing of Indigenous nurses' knowledge and expertise. This is most obvious when highlighting how Indigenous nurses experience poorer pay conditions when compared to their non-Indigenous nursing colleagues, despite Indigenous patients often having higher and more complex needs. Indigenous nurses across the various nations also highlighted how experiences of racism from other nurses, within nursing education, health systems, and from their patients, influenced retention of Indigenous nurses. We contend that pay parity, alongside culturally safe nursing education and health systems are required as a minimum standard to maintain and recruit Indigenous nurses into the profession.

Indigenous nurses are ideally positioned to lead changes in health system reform for Indigenous communities. Our 'insider' knowledge and understanding positions us well to respond to and meet the health aspirations and needs of Indigenous Peoples (Mitchell & Wilson, 2019; Wilson et al., 2018). In addition, ethnic concordance in patient-healthcare provider relationships has been highlighted as an important lever for improving health outcomes (Mitchell & Wilson, 2019; West et al., 2011). Yet, recruitment and retention of Indigenous Peoples into nursing education and then nursing practice is a perpetual problem despite nursing regulatory and professional bodies seeing this as a priority area (Ministry of Health, 2017). This requires a strong and capable Indigenous nurse workforce and leadership to provide culturally safe care. Given the small numbers of Indigenous nurses, to facilitate this shift, there is an urgent need to enrol, support and graduate much larger numbers of Indigenous students from Indigenous communities into nursing degrees (Health Workforce New Zealand, 2012; West et al., 2011; Wilkie, 2020). In New Zealand, the development of Indigenous nursing programmes, specific Indigenous recruitment programmes in Aotearoa New Zealand, Australia, Canada and the USA and mandatory cultural safety are strategies to address the reluctance of Indigenous Peoples to enter into nursing careers. In parallel, efforts to create a culturally safe non-Indigenous nursing workforce require nurses to be insightful about their own cultural values, beliefs and practices and how these biases influence nursing care. This will require strong Indigenous nursing leadership to shaping strategic

education and health delivery policies. For example, in Australia, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016-2023) guides health workforce policy and planning by setting targets, prioritizing and monitoring progress (Australian Health Ministers' Advisory Council, 2017). In New Zealand, the Nursing Workforce Governance Group set a target date for equity in the Māori nursing workforce (Nursing Council of New Zealand, 2019). In Canada, as part of its commitment to Indigenous Health Research, the Canadian Institute of Health Research (CIHR) has funded six Indigenous Research Chairs in Nursing. The USA has yet to include an Indigenous nurse and leadership strategy in initiatives to address health disparities or inequities. Nevertheless, addressing pervasive health inequities requires identification of key levers that will most effectively support the needed policy and programme changes, and identifying the resources to shift those levers and to implement and sustain the identified changes, such as a funding stream for advancing nursing leadership and in academia and research. While there may be challenges to overcome in realizing these national goals, these are important first steps in improving the Indigenous nurse workforce.

For Indigenous Peoples, achieving health equity must be strategic, purposeful and focused. Reconciliation must do more than acknowledge past wrongs; we must move towards reparation and constitutional change that addresses the self-determination and sovereign nationhood of Indigenous Peoples. Indigenous health services are responding by developing new self-determined models of care; however, most rely heavily on government funding, insurance and contracts that are systematically under-resourced and underfunded when compared to mainstream health services (Health & Disability System Review, 2020; Siddons, 2018). More importantly, they rely on the mainstream/dominant culture's health structures and systems that do not recognise Indigenous Peoples' aspirations and right to self-determination in how they want to receive care. As the largest profession in health care globally, nursing must stand on a long legacy of advocacy and activism to support a transformational healthcare system to support Indigenous Peoples aspirations, without undermining Indigenous nurses' ways of knowing. Indigenous services, Indigenous nursing education and strategies for Indigenous Peoples need the unique leadership of Indigenous nurses. This will demand awareness, political commitment and acknowledgement rather than denial and disregard of these significant and complex problems (Gracey & King, 2009). Global efforts such as the Sustainable Development Goals cannot be fully achieved for Indigenous Peoples without the support of Indigenous nurses, and the support of nurses and midwives collectively (American Association of Colleges of Nursing, 2017; Cohen et al., 2002; Doolen & York, 2007; Mitchell & Wilson, 2019). We assert that there is a need for international, national and regional service targets for the Indigenous nursing workforce and a re-distribution of resources and power to support Indigenous nursing leadership to address Indigenous Peoples' health experiences and outcomes. Then, and only then, can Indigenous Peoples address well-being in ways that privilege our ways of knowing and help us to determine our own solutions to truly heal.

TABLE 2 Case study summary of Indigenous nurses' actions and outcomes

Case study focus	Activities/actions to improve outcomes for Indigenous Peoples	Outcomes
Aotearoa New Zealand		
Māori nursing leadership, education and activism	Ministry of Health target date set for equity in the Māori nursing workforce by 2028	Small increases in Māori nursing workforce
	Cultural safety implemented in 1990	Māori nursing degrees that value Indigenous knowledge
	Bachelor Māori nursing programs are being established	Gradual increases in Māori nurses in leadership positions (ie Chief nurse is Māori)
	Ngā Manukura o Āpōpō Māori leadership program demonstrating impact	Compulsory cultural safety undergraduate curricula since 1990
	Māori health workforce development strategies	New Zealand Nursing Council Disciplinary Tribunal taking racism and unsafe cultural practices seriously
	Māori nurses leading constitutional change through activism	Policy changes to ensure that Māori health is a priority (but resourcing and ability to commission services Māori want, are limited)
	Māori in senior nursing leadership positions (ie New Zealand's Chief Nursing Officer, Margareth Broodkoorn (2019–2020) was Māori	Treaty claims that affect health and social determinants of well-being
Australia		
Indigenous nurse workforce data and the activism of Indigenous nurse professional Eldership	Constitutional reform and recognition needed to underpin the National Aboriginal Community Controlled Health Organization (ACCHO) led by Indigenous nurses	ACCHO are established and providing care for Aboriginal communities
	In 2019, the Australian Nursing and Midwifery Accreditation Council (ANMAC) recently updated the Registered Nurse Accreditation Standards to include 'Aboriginal and Torres Strait Islander Peoples' history, culture, and health taught as a discrete subject' and 'content relevant to health outcomes of Aboriginal and Torres Strait Islander is embedded throughout the program'	Cultural safety and Indigenous Peoples history are core nursing curricula in Australia
	Advocacy regarding transparency in nursing ethnicity data	Indigenous nurses are now being counted, but data not routinely reported or available
Canada		
Indigenous Health Research Chair in Nursing	Indigenous Nursing leadership in academia	Report that identified widespread racism in Canadian health care
	Six funded Nursing Research Chairs in Indigenous health Identify solutions for Indigenous Peoples by Indigenous Peoples	Significantly increased Indigenous knowledge and leadership in academia
USA		
Native American health and health care	Minority Fellowship Programs	18 Native American nurses supported for PhD in mental health and substance abuse disorders
	RAIN and Niganawenimaanaanig program to increase recruitment and retention of Native nurses	200 Native American nurses graduated from RAIN
	NANAINA to create a network of Indigenous nurses and improve professional development	Increase in Native American nurse recruitment and retention for Niganawenimaanaanig; 35 doctorally prepared Native nurses
	Center for Indigenous Nursing Research for Health Equity (INHRE)	Biannual global Indigenous Nursing Summit by INHRE

As with any case study, generalisation of findings may be limited. While these case studies from each country highlight important strategies that are being used by Indigenous nurses, they are by no means comprehensive or an exhaustive overview of Indigenous health strategies. There are Indigenous solutions that are not included in

these case studies, and other Indigenous health professionals, community workers and communities have considerable contributions to this space. We also acknowledge that as Indigenous nurse academics, researcher bias has influenced how we have collectively framed and interpreted these case studies. Despite these limitations, these

findings provide important directions and evidence that Indigenous nurses can and do make important contributions to influence and address equity for Indigenous Peoples.

4 | CONCLUSIONS

Globally, as Indigenous nurses and scholars we are accountable to the people we serve, our families, communities, and to each other. Furthermore, we are mandated as nurses to advocate for human rights, health equity, social justice, which includes sovereignty and security of Indigenous Peoples. Indigenous Peoples have waited long enough, and we now demand urgent action to address longstanding and unfair systematic disparities in health. This is a call to action that will require peeling away the layers of invisibility and bringing Indigenous People and Indigenous nurses to the forefront. Indigenous nurses and midwives are ideally placed to lead, transform and resist ongoing forms of colonial violence and create new health and well-being services that work to embrace Indigenous Peoples' aspirations and preferences. Let us move from blaming Indigenous Peoples for their inequitable health burdens, to supporting their rights to self-determine what is best for themselves. Through amplifying Indigenous nurses' voices and leadership, we can collectively transform our health systems to be fairer, caring and effective.

5 | RELEVANCE TO CLINICAL PRACTICE

Developing a strategy to enhance Indigenous nurse leaders from Aotearoa New Zealand, Australia, Canada and the USA will contribute to innovative Indigenous models of care and increase the Indigenous workforce to improve outcomes for Indigenous Peoples.

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The term 'Indigenous' commonly refers to Aboriginal Peoples globally (National Aboriginal Health Organization, 2003), regardless of borders, constitutional or legal definitions and is in keeping with Indigenous rights movements (Frideres & Ludwin, 2014). Indigenous Peoples is a global term encompassing all Indigenous People. Aotearoa New Zealand: Māori. Australia: Aboriginal. Canada: First Nations, Inuit, and Metis. US: Native American is a national term inclusive of American Indian and Alaska Native.

CONFLICT OF INTEREST

The authors declare no potential conflicts of interest with respect to the research, authorship, or publication of this work.

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