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INTEGRATIVE REVIEW

An integrative review of racism in nursing to inform anti-racist nursing praxis in Aotearoa New Zealand

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Abstract

Aim: To synthesise international literature to identify mechanisms that maintain racism in nursing and understand the factors that contribute to designing and implementing anti-racist praxis to inform nursing in Aotearoa New Zealand.

Design: An integrative literature review was undertaken, integrating Indigenous Kaupapa Māori methodologies to ensure a cultural and philosophical lens.

Methods: Peer-reviewed literature published, between January 2011 and July 2023 were sourced. Of 1296 articles, 16 met the inclusion criteria and 4 were identified via citation chaining. In total, 20 articles were included. The Johns Hopkins Research Evidence Tool was applied, findings extracted, and thematic analysis completed utilising Indigenous Kaupapa Māori principles.

Data Sources: Databases, including CINAHL, Scopus, PubMed and Aus/NZ Reference Centre, were searched in July 2023.

Results: Two key themes were identified: (1) colonial active resistance to change; and (2) transformational, visionary, and proactive nursing.

Conclusion: Nurses are well-positioned to confront the structures that maintain racism in health and education systems but are often actors in maintaining status quo. Anti-racist praxis can be a mechanism for nurses to reimagine, redefine and transform nursing care, leadership, and nursing education to begin to eradicate racism.

Reporting Method: This integrative review adhered to the 2020 Preferred Reporting for Systematic Reviews and Meta-Analyses (PRISMA) method.

Patient or Public Contribution: No patient or public contribution.

Implications for the Profession: Racism remains prevalent in nursing and the healthcare system. It is necessary to implement anti-racist praxis and policies that resist, deconstruct, and dismantle power and racism while validating Indigenous values, beliefs and practices. This is vital to deliver equitable health care.

Impact: This integrative review presents lived realities and knowledge of Indigenous and racially minoritised nurses and scholars, alongside nursing allies to inform anti-racist praxis. This evidence signifies that it is time to walk the walk to challenge the colonising systems and processes that hold racism in place.

KEYWORDS
anti-racist praxis, equity, Indigenous, institutional, Māori, nursing workforce, racism

1 | INTRODUCTION

Across the globe, Indigenous and racially minoritised workforces are underrepresented, with reports of racism and unequal access to education, career opportunities, and pay (Curtis et al., 2019; Iheduru-Anderson, 2020). Following the *Black Lives Matter* social movements there has been a resurgence of activity to promote anti-racist and decolonising nursing praxis (Waddell-Henowitch et al., 2022). For Indigenous and racially minoritised nurses, the compounding intersectionality of being Indigenous, Black, or a person of colour, a nurse, often female, and the subsequent experience of racism, patriarchy and discrimination, results in high levels of burnout in an already overburdened and underrepresented workforce (Taylor et al., 2020). Achieving a nursing workforce ethnically representative of the community they serve is a key factor to addressing health inequity (Brockie et al., 2023; Chalmers, 2020; Hunter & Cook, 2020a; Iheduru-Anderson, 2020). This review aimed to synthesise international literature to identify mechanisms that maintain racism in nursing and understand the factors that contribute to designing and implementing anti-racist praxis to inform nursing in Aotearoa New Zealand (NZ).

Racism is the unfair and avoidable disparities in power, agency to exercise authority, resources, and opportunities, which are held in place by organised structures (Paradies, 2016, 2018). Racism has been consistently linked with poorer mental and physical health outcomes and reduced healthcare access (Paradies et al., 2015). Indigenous peoples are particularly disaffected, experiencing exclusionary processes and discrimination resulting from colonising practices, which remain embedded in society and institutional systems (Paradies, 2016; Smith, 2021). Racist health systems, driven by westernised political, managerial and biomedical ideologies, are replicated, delivering healthcare that fails to embody Indigenous and minoritised worldviews (Brockie et al., 2023; Came et al., 2020; Reid et al., 2019). As a result, health disparities between Indigenous and racially minoritised populations and their (mostly European) settler populations remain unfair and unacceptable (Moewaka Barnes & McCreanor, 2019; Wispelwey et al., 2023).

In Aotearoa (NZ), Smith et al. (2021) found racism operated at four main levels: First, internalised racism, where racial minoritised groups believe negative colonial stereotypes, for instance, Māori nurses conform to the stereotype of being inferior or second class nurses, resulting in shame and embarrassment. Second, interpersonal racism is the implicit or explicit prejudice-based assumptions that are demonstrated when discrimination is upheld by the inaccurate misconceptions of the dominant group, resulting in disrespect, avoidance, and diminishment of the racially minoritised group. Third, institutional racism are the structures, systems, and processes that perpetuate colonial power imbalance and are evidenced by sustained nursing workforce inequity between Māori and non-Māori. Fourth, societal racism is the maintaining of colonial power to privilege the dominant group, for example, a well embedded colonial western health system that continues to benefit the White Europeans that it has been designed by and for, restricting access to healthcare for Māori.

What does this paper contribute to the wider global community?

- This review provides the nursing profession with an understanding of how racism in nursing is maintained by individuals and systems.
- By identifying and privileging the lived realities of Indigenous and racially minoritised nurses the review gives direction to nursing education and healthcare systems to create sustainable anti-racist policies and praxis.

The ongoing colonising processes, enacted by the British Crown and maintained by Euro-centric systems of governance, have been profoundly racist, privileging white Europeans over Māori (the Indigenous people of Aotearoa (NZ)) (Came et al., 2020; Cram et al., 2019; Reid et al., 2019). Recent inquiries highlight breaches of Te Tiriti o Waitangi (New Zealand's founding treaty document of 1840 between Māori and the Crown) across the health sector. Breaches have included reduced access to healthcare for Māori; underrepresentation of the Māori health workforce; and racism, specifically identified within the nursing profession (Health and Disability System Review, 2020; Waitangi Tribunal, 2019).

2 | BACKGROUND

In Aotearoa (NZ), despite persistent rhetoric to address workforce inequities and increase the capacity and capability of Māori (Health and Disability System Review, 2020; Ministry of Health, 2020, 2023), there has been no change to the Māori nursing workforce disparity gap for the past several decades (Chalmers, 2020).

Although Māori are 17.6% of the national population, Māori nurses consist of just 7.5% of the total nursing workforce (Nursing Council of New Zealand, 2019; StatsNZ, 2022). Additionally, Māori nurses report constantly working to address racism and bias in the nursing workforce and within the structures of the health system (Davis et al., 2021; Hunter & Cook, 2020b; Komene et al., 2023). Significant to this are the experiences of cultural overloading and the additional unpaid and unrecognised work (Komene et al., 2023), together with the need for Māori nurses to negotiate across complex and fragmented services to ensure culturally safe care for whānau Māori (Māori families) (Davis et al., 2021).

Cultural safety was introduced by Irihapeti Ramsden in the early 1990s in Aotearoa (NZ) and has since been adopted internationally by other colonised nations, including Australia, Canada, Central America and the United States (Papps & Ramsden, 1996; Power et al., 2022; Ramsden, 1990). Cultural safety is "defined by the patient and their communities, and … measured through progress towards achieving health equity" (Curtis et al., 2019, p. 14). It is described as a set of behaviours that reflect practice that is rooted in acknowledging and analysing inherent power differentials, engaging in critical self-reflection, and being accountable for culturally safe care (Cox & Best, 2022; Curtis et al., 2019). Kawa Whakaruruhau (Ramsden, 1990) was an Indigenous concept specifically to create culturally safe spaces for Māori nurses to practice, as determined by Māori nurses, for the betterment of Māori (Papps & Ramsden, 1996).

Since the late nineteenth century in Aotearoa (NZ), nursing has privileged Western perspectives through legislation, regulation, and education (Wilson et al., 2022). The ability to deliver and implement meaningful change in nursing has been stymied by health systems that are racist; by political resistance; and by the prevailing dominance of Western preferences and needs as being universal (Came et al., 2020; Hunter & Cook, 2020b; Wiapo & Clark, 2022). This pattern reflects a history of colonisation, dominated by oppression that continues to uphold racism and white privilege at both individual and system levels (Came et al., 2020; Kidd et al., 2020; Paradies, 2016).

In July 2022, Aotearoa (NZ) moved to a new national health system through the Pae Ora (Healthy Futures) Act 2022, intended to transform healthcare. Under this Act and in accordance with Te Tiriti o Waitangi, Te Aka Whai Ora (Māori Health Authority) was created to partner with Te Whatu Ora (Health NZ) to ensure workforce equity and equitable health outcomes for Māori (Ministry of Health, 2023). However, with a change to a conservative right-wing political agenda in November 2023, the coalition government's 100-day plan includes actions which uphold racism and pose a risk to accrued gains for Māori and Māori health (Pitama et al., 2024). Actions include the disestablishment of Te Aka Whai Ora; a review of Te Tiriti o Waitangi principles, including language and cultural practices; the repeal of smokefree legislation; and withdrawal from the United Nations Declaration of Independence on the Rights of Indigenous Peoples (New Zealand Government, 2023).

3 | THE REVIEW

This review has arisen from the urgent need to understand the complexity of racism and the impact for nursing within westernised colonial systems with the intent of informing anti-racist praxis. The term *praxis*, used throughout this review, refers to the critical consciousness and action that nurses require to work holistically and deliberately towards anti-racist solutions (Velasco & Reed, 2023).

4 | AIM

The review aimed to synthesise international literature to identify mechanisms that maintain racism in nursing and understand the factors that contribute to designing and implementing anti-racist praxis to inform nursing in Aotearoa (NZ).

5 | METHODS/METHODOLOGY

5.1 | Design

The integrative review was guided by Whittemore and Knafl's (2005) five strategies to enhance rigour. These strategies guide problem identification, literature search, data evaluation, data analysis and presentation. A comprehensive and systematic literature review complied with the Preferred Reporting for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021) to evaluate, critique and synthesise existing research (Data S1). This methodology supported the inclusion of quantitative, qualitative, mixed and discursive methods literature.

The integrative review method was further framed by Kaupapa Māori methodologies, which sit within an umbrella of decolonising methodologies. Linda Tuhiwai Smith et al. (2021) describes how such decolonising methodologies provide an alternative viewpoint from which solutions and cultural aspirations can emerge. Kaupapa Māori research is conducted by, for, and with Māori and aims to enhance self-determination; validate Indigenous values, systems and knowledge practices; and challenge prevailing Western discourse, hegemonies and racism (Cram et al., 2019; Smith, 2021). The application of Kaupapa Māori principles across international literature was intentional, recognising that while this approach is specific to Māori, it serves as a guide to acknowledge the contribution of Indigenous knowledge, scholars and communities. Throughout the review process, the research team consistently reflected on and ensured the central application of these principles at each stage (Table 1).

5.2 | Search methods

The search strategy was developed by the authors and databases searched included CINAHL, Scopus, PubMed and Aus/NZ Reference Centre for literature from 2011. The initial search was carried out in

TABLE 1 Integration of Kaupapa Māori principles in research stages.

Research stage	Application of Kaupapa Māori research principles
Problem identification	The research question was framed to be responsive to achieving health equity for Indigenous peoples. The approach prioritised evidence that supported an Indigenous perspective (Pihama, 2010; Smith, 2021)
Literature search	The search prioritised Indigenous terminology and used Indigenous concepts as search terms (Pihama, 2010)
Data evaluation	Literature was scored higher if it included at least two of three Kaupapa Māori research principles, being: the research was led by Indigenous people; and/or research participants were Indigenous; and/or the research took a strength-based approach to benefit Indigenous people (Smith, 2021)
Data analysis	Thematic analysis of the data was aligned with the principle of whanaungatanga (relationships) to synthesise the data and identify the connections and insights that the literature presented (Smith, 2021)

TABLE 2 Search terms.

nurse OR nursing OR "health workforce" OR "health practitioner*" AND racis* OR anti-racis* OR racial*
AND
practice OR education OR praxis OR policy OR equit*
AND
"cultural safety" OR competence OR indigenous OR maori

June 2023 by CW and repeated independently by both EK and SA. Keywords and phrases from the research question (nurses; understanding racism in nursing; anti-racist nursing praxis) were identified and then brainstormed. Search terms and synonyms were identified using an iterative process from reading literature (Table 2). The relevancy of the literature was determined by evaluating the abstract against the search terms.

5.3 | Inclusion and exclusion criteria

Inclusion and exclusion criteria were developed at the outset and further refined as literature was identified (Table 3).

TABLE 3 Inclusion and exclusion chart.

Inclusion criteria	Exclusion criteria
Written in English and/or Te Reo (Māori language)	Literature that considered discrimination/racism towards other (non-Indigenous, non-Aboriginal) marginalised groups
Peer-reviewed primary research, discussion articles, and literature reviews	Postgraduate theses, including PhDs
Literature published between 201 and 2023	Literature that more broadly considered cultural safety/competence
Literature from colonised countries with Indigenous, Aboriginal, Black and people of colour, populations including Aotearoa (NZ), Australia, Canada and the United States	Literature that focussed on racism by health professionals, which affected health outcomes
Racism within the nursing workforce across all sectors, including education, leadership, policy and clinical settings	
Considered white privilege, power, colonisation and structures that maintain racism in nursing	
Considered anti-racism strategies in nursing and/or cultural safety	

5.4 | Search outcome

Relevant records from the database searches ($n=1296$) were extracted into Endnote X19 reference manager. Duplicates ($n=303$) were removed leaving 983 articles which were title and abstract screened by three authors (CW, EK and SA) independently against the inclusion and exclusion criteria and discussions occurred to resolve any disputes. A total of 27 were selected for retrieval and full text review against the relevancy criteria (University of Otago, 2017) (Table 4) and 11 were excluded. Ultimately, 16 articles met the inclusion criteria, and all selected articles underwent reference checks and citation mining using Scopus (Wohlin, 2014), with an extra seven articles identified, of which four were included in the literature review. Hence, the final review comprised a total of 20 articles (Figure 1).

5.5 | Quality appraisal

Evidence quality and strength was assessed using The Johns Hopkins Research Evidence Tool (Dang et al., 2022). Each article was given a level of evidence strength from Level I to Level III (for primary research) and Level IV to Level V (for literature and other non-research evidence) and then graded as high, good or low quality. Articles were reviewed against items such as relevancy of research question, design of study, and study findings. Literature was evaluated by authors CW and EK independently with conflicts being

TABLE 4 Relevancy score.[a]

Relevancy score	Score description
1	Important: Direct relevance to three or more search concepts: nursing, structures that maintain racism or anti-racist nursing praxis or equitable health for Indigenous and racially minoritised populations
2	Relevant: Needs to be included as a brief reference, supportive background material, strengthens similar studies, and useful background information
3	Borderline: May be worth consideration depending on research findings
4	Irrelevant: Title or abstract showed potential, but the content does not relate to the topic

[a]Relevancy Score adapted from University of Otago (2017, p. 12).

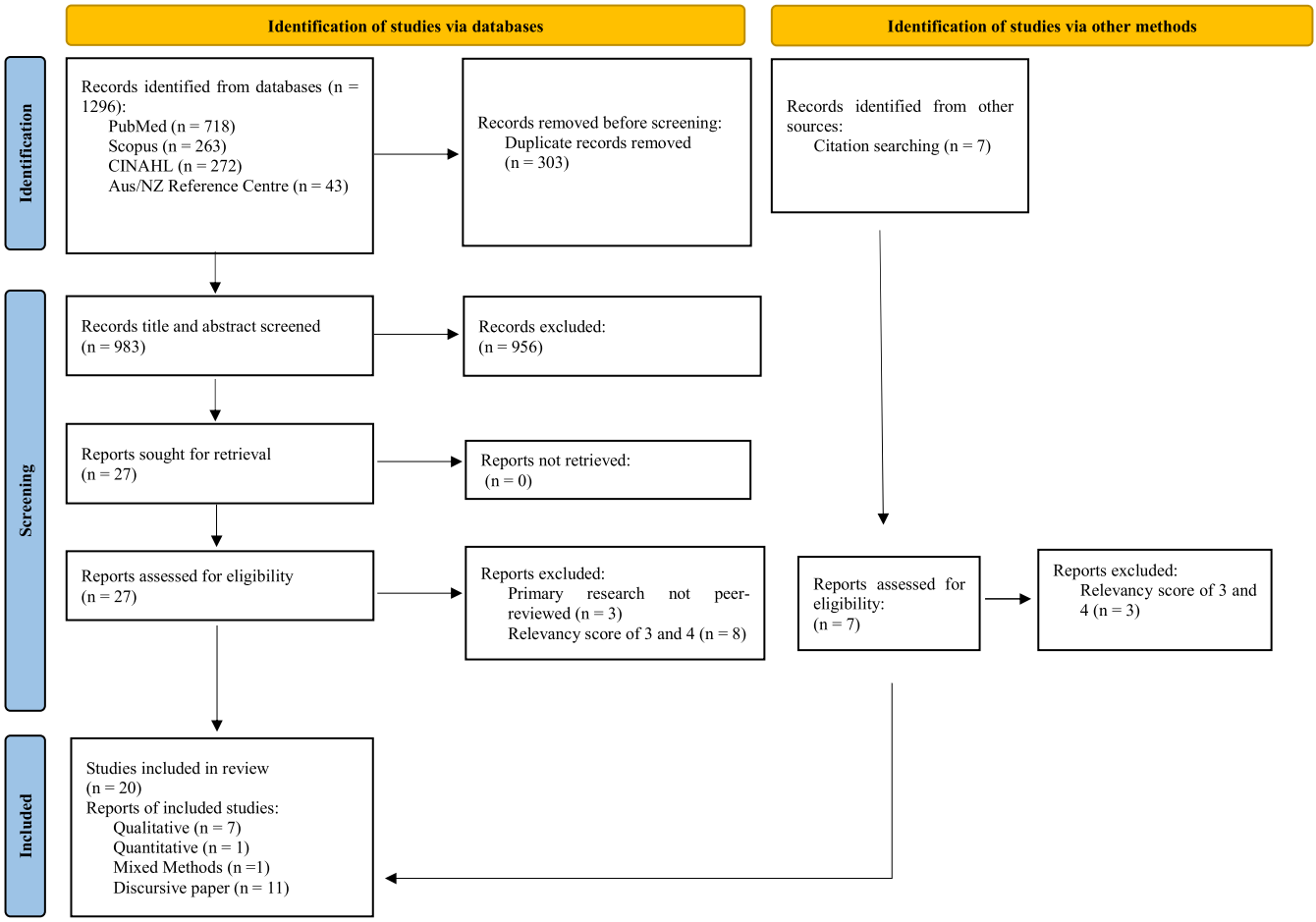

FIGURE 1 PRISMA diagram highlighting the integrative literature review search strategy.

discussed to reach consensus. No articles were excluded based on the quality appraisal (Dang et al., 2022). The ethnic status of authors of the articles was considered and recorded as Māori, Indigenous, Black, non-Indigenous (Data S1).

5.6 | Data abstraction and synthesis

A systematic approach was used to abstract and synthesise the data from the literature (Whittemore & Knafl, 2005). Data was extracted from the findings of the articles into a summary table (CW). The research employed a qualitative approach blended with Kaupapa Māori for the collection and analysis of textual data. Inductive thematic analysis was used to identify, analyse and interpret patterns within the articles using six key phases including familiarisation, code generation, constructing themes, revising and defining themes and finally producing a report (Braun et al., 2019).

Kaupapa Māori principles (Smith, 2021) ensured Indigenous processes remained central throughout the abstraction and analysis. All authors (of whom four were Māori) were involved

in the development of themes. Once consensus was reached, two key themes with subthemes were identified: (1) colonial active resistance to change, with subthemes: racism as a breach of Indigenous rights, challenging racism in practice, and inequity as the status quo; and (2) transformational, visionary and proactive nursing, with subthemes: the contribution of non-Indigenous and white nurses; the contribution of Indigenous and racially minoritised nurses; nurses working in partnership; and solutions for transformation.

6 | FINDINGS

Twenty articles in total met the inclusion and exclusion criteria (Table 4) and were included in this review. Of the articles reviewed seven (35%) were qualitative (Brockie et al., 2023; Came et al., 2022; Hunter & Cook, 2020a, 2020b; Huria et al., 2014; Kidd et al., 2020, 2021; Van Bewer et al., 2021), one (5%) was quantitative (Cooper Brathwaite et al., 2021), one (5%) was mixed methods (Cooper Brathwaite et al., 2023), and the rest were discursive papers (55%) (Bell, 2021; Hickey et al., 2022; Hunter, 2019; Iheduru-Anderson, 2020; Iheduru-Anderson & Wahl, 2022; Kelly & Chakanyuka, 2021; McFadden et al., 2023; Oda & Rameka, 2012; Talamaivao et al., 2021; Weitzel et al., 2020; Wilson et al., 2022). Three (15%) articles were informed by Kaupapa Māori approaches, two (10%) were literature reviews, seven (35%) were case reports and critical commentary, one (5%) was a case study, and one (5%) was a clinical experience. Nine (42%) articles had at least one author who was Māori, six (30%) articles had at least one Indigenous author, four (20%) articles had a sole author who identified as Black, and in one (5%) article the author identified as non-Indigenous. Nine (42%) of the articles originated from Aotearoa (NZ), seven (35%) from Canada, and four (20%) from the United States.

The articles reviewed described racism and the impact of colonial processes as constructs that benefit non-Indigenous and white people as well as significantly contributing to inequity. Fifteen of the twenty articles reiterated that nurses must resist, deconstruct and dismantle power and racism in all forms, while validating Indigenous values, beliefs and practices as vital to equitable health care. All 20 articles analysed discussed anti-racism or racism and 16 articles discussed the specific role of non-Indigenous and white nurses in responding to systemic racism and accountability for racism within their practice. Three articles spoke specifically about allyship, and two described what this looked like in practice. Six articles identified that nursing education is failing to address racism and five articles discussed the role of regulatory bodies, policy, or the Waitangi Tribunal to address racism and inequity in healthcare. Two central themes emerged from the research on understanding racism in nursing to inform anti-racist nursing praxis: colonial active resistance to change; and transformational, visionary and proactive nursing.

6.1 | Colonial active resistance to change

We have termed this theme, colonial active resistance to change, to describe how privileged groups continue to resist change, which perpetuates the existence of racism and ongoing breaches of Indigenous rights. The literature showed that colonial constructs privilege non-Indigenous and white people and obscure their ability to deconstruct and critically analyse the associated benefits of their position (Bell, 2021; Kelly & Chakanyuka, 2021; Kidd et al., 2020; Talamaivao et al., 2021; Weitzel et al., 2020; Wilson et al., 2022). Ad hoc strategies, inaction, and active resistance is exhibited by non-Indigenous and white nurses within healthcare systems (Came et al., 2022; Iheduru-Anderson & Wahl, 2022). The three subthemes identified were: racism as a breach of Indigenous rights; challenging racism in practice; and inequity as the status quo.

6.1.1 | Racism as a breach of Indigenous rights

The links between racism and detrimental health contravene national and international human and Indigenous rights (Came et al., 2022; Kelly & Chakanyuka, 2021). Racism is identified as a social determinant of health, but significantly it is also now recognised as a determinant of life or death (Kelly & Chakanyuka, 2021). In Aotearoa (NZ), it is widely accepted that the unequal and unfair treatment of both Māori nurses and Māori patients is a breach of Te Tiriti o Waitangi (Hunter, 2019; Talamaivao et al., 2021; Wilson et al., 2022). Indigenous and racially minoritised communities and nurses repeatedly express dissatisfaction with a system that struggles to acknowledge, consider, and enact their rights (Hunter & Cook, 2020a, 2020b; Kelly & Chakanyuka, 2021; Kidd et al., 2021). While a diverse nursing workforce is inevitable, prioritising the health and wellbeing of the Indigenous and racially minoritised populations that nurses serve is critical (Kidd et al., 2020; Oda & Rameka, 2012; Weitzel et al., 2020; Wilson et al., 2022). Indigenous knowledge systems, for example, Te Ao Māori (Came et al., 2022; Hunter, 2019; Kidd et al., 2020, 2021; Wilson et al., 2022) and two-eyed Seeing (McFadden et al., 2023), mitigate the impact of deficient health experiences and the historical effects of colonisation, institutional racism, and power differences (Came et al., 2020; Kidd et al., 2020; McFadden et al., 2023; Talamaivao et al., 2021; Weitzel et al., 2020).

6.1.2 | Challenging racism in practice

Indigenous and racially minoritised nurses are critical to the health workforce, although racism continues to marginalise and silence them and their contributions (Bell, 2021; Talamaivao et al., 2021; Wilson et al., 2022). The lack of urgency and commitment from apathetic nursing leadership holds racist structures in place (Brockie et al., 2023; Cooper Brathwaite et al., 2023). By developing critically reflective practices and openly examining beliefs, unconscious

biases, and stereotyping provides the opportunity to attend to the challenges of racism and discrimination (Bell, 2021; Hickey et al., 2022; Kelly & Chakanyuka, 2021; Kidd et al., 2020, 2021; McFadden et al., 2023; Talamaivao et al., 2021; Weitzel et al., 2020; Wilson et al., 2022).

The nursing profession holds considerable power, however, it needs to own and respond to the complexity that racism presents (Bell, 2021; Weitzel et al., 2020). Insights from senior nurses revealed racism thrives when nurses are not equipped to challenge racist behaviours, racist structures in the workplace, and the wider health system (Kelly & Chakanyuka, 2021; Kidd et al., 2020; Wilson et al., 2022). Inaction towards racism results in Indigenous and racially minoritised nurses experiencing significant mental distress, cultural overburdening, loss of confidence, and isolation (Cooper Brathwaite et al., 2023; Hunter & Cook, 2020a, 2020b; Huria et al., 2014; Iheduru-Anderson, 2020; Iheduru-Anderson & Wahl, 2022; Kidd et al., 2021; Wilson et al., 2022).

Anti-racist education is considered mandatory in undergraduate, postgraduate, and continuing professional development and orientation programmes (Bell, 2021; Iheduru-Anderson & Wahl, 2022; Van Bewer et al., 2021). The normalisation of white privilege in nursing education enforces race ignorance, requiring explicit deconstruction of white supremacist ideology and privilege (Bell, 2021; Iheduru-Anderson, 2020). Race ignorance was demonstrated by nurses holding a strong belief in the nursing profession as a caring profession and, therefore, non-racist and non-oppressive (Bell, 2021; Iheduru-Anderson & Wahl, 2022; Kelly & Chakanyuka, 2021). Despite the rhetoric of cultural safety and anti-racist systems, oppression in health flourishes when nurses do nothing to disrupt the status quo resulting in the perpetuation of racism and a disconnect with Indigenous and racially minoritised nurse realities (Bell, 2021; Kelly & Chakanyuka, 2021; Weitzel et al., 2020; Wilson et al., 2022).

6.1.3 | Inequity as the status quo

The responsibility of privileged white nurses is to commit to positioning whiteness as a location for the critical analysis of inequity (Hickey et al., 2022; Hunter, 2019; Kelly & Chakanyuka, 2021; Talamaivao et al., 2021; Van Bewer et al., 2021; Weitzel et al., 2020; Wilson et al., 2022). Evidence concluded that the nursing profession is falling short of advocating for social justice and becoming more knowledgeable about inequity (Bell, 2021; Hickey et al., 2022; Iheduru-Anderson & Wahl, 2022). By continuing to report on health data that focuses on health disparities, this reinforces racist attitudes and victim blaming, rather than exposing structural and systemic privileging (Bell, 2021; Kidd et al., 2020). Indigenous and racially minoritised nurses reported on the paralysis and fragility of white nurses to respond to racism, leading to the silencing of Indigenous voices and a culture of avoidance (Iheduru-Anderson & Wahl, 2022; Kidd et al., 2020; Van Bewer et al., 2021).

Culturally safe practice is fundamental to addressing inequity yet has failed to be effectively implemented (Came et al., 2022; Cooper Brathwaite et al., 2023; Wilson et al., 2022). Robust mechanisms are required by regulatory nursing organisations to create accountability for actioning anti-racism and supporting anti-racist praxis (Brockie et al., 2023; Wilson et al., 2022). The self-assessment (e.g. professional portfolios) of cultural competence, which is frequently used by regulatory authorities, is inadequate and requires new strategies to measure and enforce culturally safe practice (Wilson et al., 2022).

6.2 | Transformational, visionary and proactive nursing

The need to enact real change is urgent and that change requires a radical shift in thinking (Talamaivao et al., 2021). This theme, transformational, visionary and proactive nursing, is intentionally the last as it demonstrates a continuum of moving towards anti-racist praxis. Literature on developing anti-racist praxis in nursing demonstrates that knowledge is inextricably linked with power (Came et al., 2022; Iheduru-Anderson, 2020; Kelly & Chakanyuka, 2021; Weitzel et al., 2020). Anti-racist praxis is achieved through critical self-reflection of nursing practice and health systems and is a way to address achieving equitable, health outcomes for Indigenous and racially minoritised populations (Bell, 2021; Brockie et al., 2023; Hunter, 2019; Kelly & Chakanyuka, 2021; Kidd et al., 2020, 2021; Oda & Rameka, 2012; Talamaivao et al., 2021; Wilson et al., 2022). This theme has four subheadings to address racism in nursing: the contribution of non-Indigenous and white nurses; the contribution of Indigenous and racially minoritised nurses; nurses working in partnership; and solutions for transformation.

6.2.1 | The contribution of non-Indigenous and White nurses

Strengthening the capacity and capability of nurses to realise anti-racist praxis can potentially transform healthcare, nursing relationships, and health outcomes (Brockie et al., 2023; Hickey et al., 2022; Hunter, 2019; Kidd et al., 2021; Van Bewer et al., 2021; Wilson et al., 2022). Anti-racist praxis must begin with self-awareness and the acknowledgment of systemic racism (Came et al., 2022; Cooper Brathwaite et al., 2021) for nurses to then move towards an understanding of their own culture and the theory of power relationships (Bell, 2021; Iheduru-Anderson, 2020; Kidd et al., 2020; Weitzel et al., 2020). Nurses need to develop competencies to critique discourse and practices that underpin and reinforce oppressive, monocultural perspectives (Hunter, 2019; Iheduru-Anderson & Wahl, 2022; Kelly & Chakanyuka, 2021).

Identifying racism is vital to prevent inequitable access to healthcare for Indigenous and racially minoritised populations (Cooper Brathwaite et al., 2023; Kelly & Chakanyuka, 2021; Kidd et al., 2021). The role of non-Indigenous nurse allies is to work alongside other racially privileged nurses (Bell, 2021; Hickey et al., 2022; Hunter, 2019; Kidd et al., 2021; Wilson et al., 2022). Weitzel et al. (2020) offer

examples of resistance movements in the United States that nurses can draw on to strengthen nursing practice to advocate and act as allies. Allyship requires nurses in a position of privilege and power to work genuinely and authentically with Indigenous and racially minoritised nurses (through critical self-awareness), to shift power by leveraging and transferring resources (Hickey et al., 2022). Nurses have an ethical mandate and social responsibility to amplify the voices of those communities that have lived experiences of oppression, including racist oppression (Hickey et al., 2022; Weitzel et al., 2020).

6.2.2 | The contribution of Indigenous and racially minoritised nurses

Indigenous and racially minoritised nurses hold insider knowledge offering an essential perspective for change transformation in the health system (Brockie et al., 2023). However, they have been in most instances unable to overcome racist structures in the historical and contemporary health systems (Bell, 2021; Came et al., 2022). Action first and foremost from non-Indigenous and white nurses is needed so that minoritised nurse voices are amplified to lead the reform required for systemic change (Came et al., 2022; Talamaivao et al., 2021; Van Bewer et al., 2021). Nurse leaders (Indigenous and racially minoritised) are essential across the health and education sector to influence anti-racism to counter current tokenistic, isolating, and detrimental leadership roles (Brockie et al., 2023; Hunter, 2019; Talamaivao et al., 2021; Weitzel et al., 2020; Wilson et al., 2022). Indigenous and racially minoritised nurses require support from representative nursing leadership to dismantle internalised colonial processes and intergenerational racism and promote retention and career development (Brockie et al., 2023; Cooper Brathwaite et al., 2021; Huria et al., 2014; Iheduru-Anderson & Wahl, 2022; Kidd et al., 2021; Weitzel et al., 2020).

6.2.3 | Nurses working in partnership

Commitment and action to authentic partnership with considered power sharing to achieve equity are fundamental to anti-racist praxis (Came et al., 2022; Iheduru-Anderson, 2020; McFadden et al., 2023). Anti-racist praxis is partnership in action, requiring nurses to combine advocacy and allyship to amplify the voices of the communities who experience racism (Hickey et al., 2022; Weitzel et al., 2020). Partnership relies on privileged white nurses to be led by Indigenous and racially minoritised nurses with lived experiences of racism to collectively strengthen anti-racist praxis in the workforce (Came et al., 2022; Kidd et al., 2020, 2021; Van Bewer et al., 2021; Weitzel et al., 2020).

6.2.4 | Solutions for transformation

Solutions were identified across the literature to address racism at all levels of the health and tertiary education systems. Creating and strengthening leadership positions with support from non-Indigenous allies promoted recruitment, retention, and career development opportunities at all levels of the health and tertiary education systems (Brockie et al., 2023; Cooper Brathwaite et al., 2021). As an anti-racism strategy, tertiary education programmes should work in partnership with cultural content experts who have lived experience (Bell, 2021). Further, the necessity to ensure all nurses in practice, education, and leadership have access to Indigenous knowledge systems, including cultural principles and practices, needs to be consistently applied (Kidd et al., 2020; McFadden et al., 2023; Wilson et al., 2022). Van Bewer et al. (2021) specifically reported on an anti-racism framework, utilising theatre-enabled critical dialogue, collective analysis, and reflection that responded to and provided nurses and nurse educators with the tools to reimagine race and confront racism within their practice. However, toolkits to address racism are limited and rely on political and individual will, despite policy recommendations (Talamaivao et al., 2021). Mechanisms embedded in systems are imperative to enforce a response to address racism, such as the Waitangi Tribunal in Aotearoa (NZ), which responds to racist legislation, policy, and practice; anti-racism groups generating and having a national space to publish evidence; and regulatory requirements of the nursing profession (Came et al., 2022; Weitzel et al., 2020).

7 | DISCUSSION

This review has highlighted the persistent failure of nursing to enact anti-racist praxis to achieve equity of the nursing workforce and health equity. Through the review, we synthesised international and Aotearoa (NZ) literature to identify the mechanisms that maintain racism in nursing, and to understand the factors that contribute to designing and implementing anti-racist praxis. While our starting point and ultimate purpose was to address racism and find solutions for racism as experienced by Māori nurses, the findings are likely relevant to Indigenous and racially minoritised nurses working elsewhere in the globe.

Nursing is perceived to be a caring profession with high levels of public trust (Kelly & Chakanyuka, 2021). However, historically embedded colonial processes, racism, discrimination and inequity, continue to privilege non-Indigenous and white nurses (Chalmers, 2020; Cooper Brathwaite et al., 2021; Cram et al., 2019; Iheduru-Anderson, 2020; Wilson et al., 2022). White privilege perpetuates the stronghold of racism and associated power differentials (Came et al., 2020; Paradies, 2016). Consequently, culturally safe nursing practice, which is integral to anti-racist praxis, has been diluted from its original intent (Bell, 2021; Cooper Brathwaite et al., 2021; Curtis et al., 2019; Iheduru-Anderson, 2020; Talamaivao et al., 2021).

Ongoing approaches to measure cultural competency, often through tick-box exercises, have become sufficiently embedded that the transition to culturally safe practice has become obscured

(Came et al., 2022; Hunter & Cook, 2020a, 2020b; Walker, 2020). Educational initiatives to address racism, have had minimal success, often lacking rigour, guidance, and role modelling (Came et al., Cooper Brathwaite et al., 2023; Heke et al., 2019; Hunter & Cook, 2020a; Kidd et al., 2020; Paradies et al., 2015; Rae et al., 2022). In Aotearoa (NZ), the four articles of Te Tiriti o Waitangi—Kawanatanga (governorship), Tino Rangatiratanga (self-determination), Ōritetanga (equity), and Wairuatanga (traditional and spiritual beliefs and practices)—provide a critical framework for anti-racist praxis for nurses to understand their accountabilities and how they can transform nursing care (Came et al., 2022).

Cultural safety, however, cannot be taught in isolation from the structural mechanisms that hold the status quo in place (Cooper Brathwaite et al., 2021; Heke et al., 2019; Oda & Rameka, 2012). The ongoing paralysis and fragility of white nurses within a discourse of avoidance and institutionally racist systems, perpetuate racism and the burnout of non-white nurses (Bell, 2021; Kidd et al., 2020; Komene et al., 2023; Van Bewer et al., 2021). Not only do Indigenous and racially minoritised nurses deal with racism in their everyday work and lives, but they are also confronted with colonial active resistance where defensive actions intentionally maintain the status quo (Hickey et al., 2022; Iheduru-Anderson & Wahl, 2022; Kidd et al., 2020). The explicit development of culturally safe spaces for Indigenous nurses, to implement their knowledge frameworks enacts Indigenous customary practices, such as Kawa Whakaruruhau, and would go some way to mitigating negative experiences (Papps & Ramsden, 1996; Wilson et al., 2022).

Significant education and professional development is necessary to translate anti-racist knowledge into nursing practice (Brockie et al., 2023; Hunter, 2019; Hunter & Cook, 2020b; Iheduru-Anderson, 2020). Education frameworks require safe spaces that facilitate critical dialogue, participative learning, sharing, and self-reflection to confront racism in their practice (Davis & Came, 2022). Further, nurses require a moral desire to address social justice, with education delivered through an ethical and social justice lens (Hunter & Cook, 2020a). Critically, nurses as experts, with lived experience, are necessary to develop culturally safe pedagogy and deliver nursing education (Hickey et al., 2022; Hunter & Cook, 2020b; Iheduru-Anderson, 2020; Van Bewer et al., 2021; Waddell-Henowitch et al., 2022).

Addressing underrepresentation in the nursing and tertiary education workforce is crucial to eliminating racism and the health disparity gap (Brockie et al., 2023; Came et al., 2022; Cooper Brathwaite et al., 2021; Curtis et al., 2019; Wilson et al., 2022). Consequently, by valuing the contribution of Indigenous and racially minoritised nurses, and particularly honouring Indigenous knowledge systems, enables advocacy and the transformation of health and wellbeing of local communities (Hunter, 2019; Kidd et al., 2020; McFadden et al., 2023; Wiapo & Clark, 2022; Wilson et al., 2022).

The findings demonstrated that nursing practice has struggled to mitigate the stronghold of racism, white privilege, and associated power differentials (Iheduru-Anderson, 2020; Kelly & Chakanyuka, 2021; McFadden et al., 2023; Weitzel et al., 2020). The examination of power dynamics, across all sectors and levels of the health workforce, is necessary if anti-racism approaches are to be embedded in nursing (Cooper Brathwaite et al., 2021; Iheduru-Anderson, 2020; Smith et al., 2021; Talamaivao et al., 2021). To progress anti-racist praxis, all nurses will need to acknowledge and understand the wider context of the impact of colonisation on health and the moral imperative to promote social justice (Chalmers, 2020; Hunter & Cook, 2020a; Kidd et al., 2020; Reid et al., 2019).

Further to progressing anti-racist praxis and partnership, white nurses in a position of power and privilege, need to introspectively navigate the realities of racial injustice (Hickey et al., 2022). This then provides the platform for white nurses to move towards allyship. Nursing allyship requires the development of authentic relationships with those who have been silenced and marginalised through racism; advocacy to actively disrupt behaviours and systems that sustain inequity; and commitment to honour promises made of diversity, equity, inclusion, and Indigenous rights (Hickey et al., 2022; Mainwaring & Davis, 2022; Waitangi Tribunal, 2019; Weitzel et al., 2020).

International frameworks, including the United Nations Declaration of Independence on the Rights of Indigenous Peoples (2007), and national frameworks, such as Te Tiriti o Waitangi, guarantee the protection, rights, survival, dignity, and wellbeing of Indigenous peoples (Te Kāhui Tika Tāngata/Human Rights Commission, n.d.). Colonial power does not relinquish easily and as such these frameworks have failed to eliminate racial and health disparities (Brockie et al., 2023; Came et al., 2020; Reid et al., 2019). Across the health and tertiary education sector, reporting and auditing data on racism is essential, together with effective organisational processes to respond to racist incidents (Bell, 2021; Kidd et al., 2020; Paradies, 2018). Reforms are required at multiple levels of the health, education, and professional regulatory systems, if we are to realise constitutional transformation (Brockie et al., 2023; Cooper Brathwaite et al., 2023; Rae et al., 2022).

8 | STRENGTHS AND LIMITATIONS

This integrative review synthesised evidence from 20 articles published in English between 2011 and 2023. The themes identified arose from literature exploring racism in nursing experienced by Indigenous and ethnic minorities to inform anti-racist praxis. The review was conducted by four Māori nurses and scholars and one non-Indigenous nurse scholar, all with experience of working in health, leadership and tertiary education in Aotearoa (NZ). To minimise the impact of colonising processes, we intentionally prioritised a Kaupapa Māori methodology to ensure Indigenous knowledges were privileged. However, we acknowledge that while Kaupapa Māori is a decolonising methodology, it will not be generalisable across other Indigenous and ethnic minority populations. Literature was included from quantitative, qualitative, mixed methods, and discursive papers. However, there was an evident lack of research in this space in nursing, with a greater volume of literature that captured expert viewpoints though did not meet inclusion criteria for rigour.

Understanding different search terms from non-Māori Indigenous populations and broadening the search to discover Indigenous and ethnic minority literature, not readily available through mainstream databases, might yield more evidence for inclusion in the review.

9 | CONCLUSION

This integrative literature identified mechanisms that maintain racism experienced by Indigenous and racially minoritised nurses to understand the factors that contribute to designing and implementing anti-racist praxis. The review was underpinned by Kaupapa Māori as a decolonising methodology. The review found that colonial active resistance was deeply embedded at individual, professional, and institutional levels, which maintained the status quo and persisting inequities experienced by Indigenous and racially minoritised nurses. However, the review identified multiple strategies which, with intentional and concerted effort at all levels of the health and nursing education sector, could promote anti-racist praxis.

The nursing profession can and must play a key role in promoting anti-racist praxis. Anti-racist praxis will uplift, honour and value Indigenous and racially minoritised nurses for their contributions. It is no longer acceptable for non-Indigenous and white nurses to feel paralysed or to actively resist challenging the impact of racism and racist structures. Nurses hold power and are well-positioned to create change, acting as allies. Anti-racist praxis affords all nurses the opportunity to transform the health workforce, healthcare and health outcomes, so that everyone benefits. It is now more timely than ever for nurses to rise to this challenge.

10 | RELEVANCE TO PRACTICE

Anti-racist praxis begins with non-Indigenous and white nurses developing critical consciousness to understand their positionality, power, and privilege in the world, particularly the impact of colonisation in relation to racism, Indigenous rights and equity. Developing genuine and authentic relationships with Indigenous and racially minoritised nurses and communities is necessary for active allyship and the intentional shifting of power and resources. At the same time, Indigenous and racially minoritised nurses require space to dismantle internalised colonial processes, reclaim their Indigeneity and knowledge practices, and identify racism.

The education of nurses requires a fundamental paradigm shift to embed undergraduate, postgraduate, and professional development programmes with culturally safe pedagogy that consistently promotes anti-racist praxis and equity of health and workforce. Indigenous knowledge systems, values and cultural practices require prioritisation throughout nursing programmes to develop cultural and relational competence. Indigenous knowledge experts and racially minoritised nurses with lived experience are essential for developing pedagogy and facilitating learning of anti-racist praxis. Adopting creative and innovative learning strategies and using Indigenous meeting or ceremonial houses (such as marae in Aotearoa (NZ)) emphasises the significance and necessity of addressing racism.

Nursing regulatory bodies need to adopt mechanisms that support the transition to anti-racist praxis in nursing. Cultural safety demands complex reflection, communication and listening skills and improved mechanisms are required to ensure self-evaluation of cultural safety is effective and measures anti-racist praxis. Anti-racist frameworks need to be highly visible and embedded in nursing competencies. In Aotearoa (NZ), the articles of Te Tiriti o Waitangi provide such an anti-racist framework. Further, specific frameworks are required to support the cultural safety of Indigenous nurses, such as Kawa Whakaruruhau for Māori nurses, which must be Indigenous-led.

Anti-racist frameworks must be integral to health service delivery, education, managerial processes and governance. There is a pressing need for constitutional reform to promote Indigenous rights and treaties and counter regressive policies and political interference that risk cultural erasure and perpetuate harm. Indigenous-centric legislation, policies and processes will combat colonial and institutionally racist systems. Focusing on achieving a health workforce that is at least representative of the Indigenous and racially minoritised population requires intentional recruitment and training strategies. Retention requires successful transition into a workplace free from racism and intentionally promoting the career progression of Indigenous and racially minoritised nurses into leadership positions, including in education and research. In Aotearoa (NZ), a national plan to combat racism is critical. Improving the quality and reporting of data on racism in nursing is essential alongside requirements to ensure health organisations have effective policies and processes to manage racist incidents and promote anti-racist praxis. Prioritising Indigenous rights and the rights of racially minoritised groups, enhancing political will, and advocating for constitutional transformation are imperative steps to achieve anti-racist praxis.

AUTHOR CONTRIBUTIONS

CW, SA, TC were involved in the original conceptualization of the paper and all contributed to the design, analysis, and writing. CW, SA, EK, TC contributed to the data collection, data curation, methodology including the ethical procedures and data analysis plan. CW conducted the data analysis with data oversight, discussion, critique and validation by SA, EK, JD and TC. CW drafted the introduction and literature review and methodology and results/themes sections with support and critique by SA, EK, JD and TC. The discussion was led by CW and SA with contributions by EK, JD and TC. There was no funding sourced to undertake these analyses. Supervision was provided by SA and TC. CW ran the project administration. All writing was reviewed by the entire team CW, SA, EK, JD and TC.

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None.

DATA AVAILABILITY STATEMENT

The data that support the findings of this review are openly available. All literature cited is accessible through PubMed, Scopus, AusNZ, Google Scholar, CINAHL.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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