POPULATIONS AT RISK ACROSS THE LIFESPAN–POPULATION STUDIES

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Facilitators and barriers to leadership and career opportunities in minority nurses in public health departments

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Abstract

Objectives: Elicit information from minority public health nurses regarding experiences and opportunities for leadership development and career advancement in public health departments (PHDs).

Design: Qualitative research design to determine minority nurses' experiences of opportunities and barriers influencing leadership development and career advancement in PHDs.

Sample: Thirty-nine minority nurses from all regions of the United States participated in a telephone interview. Demographics reveal that 46% were African American or Mixed Race, 31% were Hispanic/Latina, 18% were Asian, and 5% were Indian heritage.

Measurements: Participants completed the researcher-designed, open-ended interview which was audio-recorded. The researcher conducted all interviews. Transcriptions were coded for major concepts and then codes were collapsed into major themes by the researcher and consultant in qualitative research.

Results: Six themes were identified from the data: commitment to public health, motivation for leadership development, barriers for leadership development, racism: influence on nurses from minority backgrounds, supports for leadership development, and survival skills.

Conclusions: Participants desired an opportunity for career advancement and leadership development, but encountered entrenched systemic/organizational barriers and obstacles in fulfilling this important role impacting healthcare delivery of minority and underrepresented groups. Public health officials and administrators are challenged to strengthen opportunities for career advancement and leadership development for minority nurses in PHDs.

KEYWORDS
career advancement, leadership development, minority nurses, public health departments

1 | BACKGROUND

Rapid and unprecedented changes worldwide have increased the need for leadership opportunities for racial/ethnic minority nurses in all settings, particularly in public health departments (PHDs) providing access to care for minority and underrepresented groups. Although there has been an increase in RNs providing care in various settings, minority nurses continue to be underrepresented in the workforce (26.7%; Health Resources and Services Administration: National Health Workforce Survey of Registered Nurses in the United States, 2018).

In an earlier national report, *The Future of Nursing; Leading Change, Advancing Health*, the Institute of Medicine (IOM) (2011)

envisioned that a diversified workforce with leadership development is critical in forging new ways of promoting the culture of health for all Americans, particularly for minorities and underrepresented groups. Phillips and Malone (2014) and the Robert Wood Johnson Foundation [RWJF] (2016) confirmed that a diversified nursing workforce with strong leadership skills is needed because they are more likely to serve diverse populations, thereby improving access to and trust in the healthcare system and they also play a key role in policy changes affecting health disparities and inequities facing minority and underrepresented groups. In an urgent plea, the National League for Nursing (NLN) (April 7, 2020) called for "massive investment in nursing education and leadership development in nursing, in light of the growing pandemic crisis of *COVID-19* affecting individuals, communities and healthcare systems worldwide" (p. 1).

The importance of diversifying the workforce is urgent in light of the University of Michigan's *Public Health Nurse Workforce and Enumeration Survey* of local and state PHDs (2013) from 328 local and state PHDs in all 50 states and the District of Columbia. Of 2,700 PHNs, 14% were minority (8% African American, 4% Asian, 1% American Indian/Native Alaskan, and 1% Native Hawaiian), and 4% were listed under Ethnic—Hispanic/Latina. The demographic profile indicates that the majority of nurses (>90%) are female and minority nurses were underrepresented in PHDs as compared to all settings (18% vs. 26.7%). Even fewer were in leadership positions (Public Health Administrator/Director, Nursing Director, and Manager/Supervisor [5%]). Data were not available on leadership positions in nursing; however, Henkel (2016) called for urgent action in response to the *Benchmark Survey*, sponsored by the American Hospital Association that "minorities (gender not reported) were underrepresented in leadership positions, e.g., board members (14%), executive leadership positions (12%), and first and mid-level management positions (17%)" (p. 1).

From a global perspective, countries like the United Kingdom (UK) are experiencing a severe shortage of minority nurses (21.8%) and even fewer in key leadership positions. In 2018, the National Health Service (NHS), the largest healthcare employer in England and one of the largest in the world, completed a study, "Workforce Race and Equity Standards" on key indicators of leadership development and workforce satisfaction in employees. Black Minority Employees (BMEs), listed as nurses, health visitors and midwives were underrepresented in several leadership positions defined as Chief Executive, Executive Directors, and other Senior Managers (6.5%). The study reported that BME staff in nursing roles (29.8%) were more likely to encounter harassment (ridicule and personal insults), bullying and abuse from patients, relatives or the public and other staff as well as personal discipline at work from manager, team leader or colleague in the last 12 months (15.3% vs. 6.4%; NHS Workforce Race and Equity Standards, 2019).

2 | RESEARCH QUESTION

Based on the demographic data on the minority nursing workforce in PHDs and review of published experiences of racial inequalities for minorities in healthcare, a qualitative descriptive study was designed to answer: How do minority nurses in PHDs experience barriers and supports to their leadership development? It further describes their experience of racism, if present, in their work setting. Hearing the voices of the nurses themselves provides a richer perspective on the nurses' experiences and can identify both incentives and barriers to moving into leadership positions in PHDs.

3 | LITERATURE SEARCH

With assistance from a university nursing librarian, an extensive search of the literature from 1990 to 2020 was undertaken using the following electronic databases: CINAHL, PubMed, and Web of Science Core databases. All retrievals were peer-reviewed and in English. Abstracts, reference lists, and table of contents were reviewed for a more detailed evaluation. All studies in nursing and public health publication meeting the inclusion criteria of (a) racial/ethnic characteristics of minority nurses in PHDs; (b) leadership development and career advancement for minority nurses in PHDs and other settings; and (c) racism or discrimination in the work setting were assessed for methodological rigor. The search resulted in 144 articles or studies. Several articles (*n* = 131) were excluded because they focused on minority nursing students in practice settings. Thirteen articles/studies out of 144 met the inclusion criteria and were retained for this review. Seven articles/studies addressed racial/discrimination and one PHN report focused on budget cuts affecting leadership development in PHDs. Five articles/studies focused on mentoring and leadership development of minority nurses in various settings.

4 | LITERATURE REVIEW

There were no published studies on leadership development in minority nurses in PHDs with exception of the *Public Health Nurse Workforce and Enumeration Survey* of local and state PHDs in the United States (University of Michigan – Center of Excellence in Public Health Workforce Studies, 2013). Results showed that 56% of minority nurses believed that promotion opportunities are lacking and 64% desired more opportunities for training and advancement. However, there is some evidence that racism/discrimination has negatively affected minority nurses in the work setting in both the United States and United Kingdom. Schmieding (2000) was one of the first authors to address the underrepresentation of minority nurses in leadership positions across settings. The lack of minority nurses in leadership positions was deeply rooted in the historical legacy of racism, discriminatory beliefs and policies, and racial inequities and promotion and hiring practices. Schmeiding called for changes that limit barriers for minority nurses in leadership positions. Dreachslin and Hobby (2008) linked laws and policies in the United States, governed by economic gains and social and political worldviews of the dominant members of society that have separated

individuals into class status. Consequently, minorities often face uphill battles in pursuing career advancement and leadership development due to systemic or institutional barriers, ranging from alienation, discrimination and implicit bias.

In Truitt and Snyder's (2019) study, minority providers (nurses and certified nursing assistants) in long-term care settings reported racial and discriminatory practices, such as heavier work assignments when compared to their White counterparts, even if they had higher educational status or were employed at a higher rank or a for longer time in the healthcare system. Some patients requested a more knowledgeable or skilled White healthcare provider for care. Minority providers reported that their ambitions and desire for mentoring and educational experiences were challenged; however, they relied on familiar coping strategies, such as consultation with personal support systems, including friends outside of work or family members to potentially avert or buffer the harmful negative effects of racism/discriminatory practices in the work setting. These findings were not unique to the United States, but were reported in research by Coghill (2019) and Likupe and Archibong (2013), and the National Health Services: WorkForce Race and Equity Standards Report (2018) in the United Kingdom investigating indicators of leadership development and workforce satisfaction among BME employees.

In 2005, Hill et al. conducted a survey that examined mentoring for leadership development in 72 minority administrators (Deans, Assistant Deans, and Chair or Department Heads) in BSN or graduate nursing programs in the United States. Findings showed that mentoring relationships increased personal growth, self-confidence, self-awareness, and success in pursuing their current positions. Bessent and Fleming (2003) discussed a four-part leadership enhancement and development project (LEAD) for aspiring minority nurse leaders to counter the negative consequences of racism/discrimination across settings. The LEAD project focused on self-reflection through knowledge of self, integrity, vision, and collaboration supporting career advancement. Bayard, Hassanshahi, Domínguez, and Rivera-Goba (2008) and Dias, Joseph, and Michael (2019) reported that lack of power, networking, and mentorship in the work setting, as well as negative self-perceptions have impacted the low number of minority nurses in higher level leadership positions in all settings. Villaruel, Canales, and Torres (2001) asserted that higher level leadership positions for minority nurses should be regarded as a priority in addressing the healthcare needs of minorities and underrepresented groups.

Several studies in this review confirm that systemic and organizational barriers were powerful influences in leadership development for minority nurses in the United States and United Kingdom. Severe budget cuts have all but eliminated the state and regional public health leadership institutes that previously offered leadership development and career advancement opportunities for staff (Quad Council of Public Health Nursing [PHN] Organizations, 2013). The urgent need to understand how minority nurses view leadership progression in PHDs cannot be overstated because these settings provide much of the timely follow-up

care to minority and underrepresented groups. Based on these findings and gaps in the literature, a qualitative study was needed to understand the experience.

5 | DESIGN

Descriptive qualitative research was chosen to gain new insight into the unknown experiences of minority PHD nurses who are considering leadership development. This approach to qualitative research uses maximum variability approaches to search broadly for persons who have experience in the chosen phenomenon (Sandelowski, 2000). The purpose is not to build a theory or model, but to generate a broad summary of experiences that can later be used for more specific questioning. This design taps into the: who, what, when, and where of events or experiences (Neergaard, Olesen, Andersen, & Sondergaard, 2009).

5.1 | Recruitment

Following approval to conduct the research study from the IRB, The National Association of County and City Health Officials (NACCHO) and the American Public Health Nursing (APHN) Organization granted the researcher permission to access their databases of 34,758 PHNs from state and local PHDs from all 50 states in the United States, including the District of Columbia. Members were encouraged to share the invitation to participate in the study. Participation and responses were confidential. Gift cards were sent to persons who completed the interview. Participants had an opportunity to ask questions prior to the interview and to share additional information at the end. Purposive sampling of 30 was deemed sufficient with one data collection period to share their personal experiences (Morse, 2000). **Inclusion criteria were**: (a) minority status; (b) able to understand written and spoken English; and (c) willing to participate in an audio-taped telephone interview. Excluded was anyone holding a leadership position title (e.g., Public Health Administrator, Nursing Director, and Manager/Supervisor).

5.2 | Data collection

An Interview Guide (IG) was developed that included demographic data, educational background experience in public health, and goals for a leadership position. The IG was reviewed by an expert in the field and pilot-tested on a similar group of minority nurses. Following the collection of demographic data, the IG included open-ended questions to encourage open discussion of considerations related "to assist the participants to talk freely about all the topics on the IG" (Polit & Beck, 2017, p. 279–280). Sample interview questions were:

1. What is your interest and commitment to taking on a higher-level position in public health?
2. Do you want to be a leader in public health?
3. What would be good or bad about that?
4. What do you see as supports or barriers to taking on a leadership position in PHDs?
5. Where is your deepest satisfaction in work?
6. What do you think hinders minority nurses from obtaining leadership positions in PHDs?
7. What do you think would help minority nurses in securing leadership positions in PHDs?
8. What resources are needed for minority nurses to secure leadership position in PHDs?
9. What would you like to see happen to get minority nurses into leadership positions in PHDs?
10. How do you see yourself in making preparation for advancement in PHDs?

The interviews were adapted as they proceeded to allow for further development of interview questions, as concepts arose in the analysis (Houser, 2018).

5.3 | Sample

Thirty-nine minority nurses comprised the sample from all regions of the United States. Participants were employed in their respective PHD for an average of 8 years (range 1–20). Data were collected over a 1-year period from June 5, 2017 to June 30, 2018. Ten (26%) participants were referred by their immediate supervisor or co-worker in the study.

Demographics of participants are presented in Table 1. The entire sample was female aged 24–64 (mean age 42) representative of most nurses in PHDs. Nearly half were African American or Mixed Race (46%) followed by Hispanic/Latina (31%), Asian (18%), and Indian heritage (5%). Most earned a BSN or higher-level degree in nursing (MSN) or MPH (82%); one earned an ADN degree in nursing (3%), and six were enrolled in a higher-level degree or nurse practitioner program (15%). The Hispanic/Latina group was the youngest, with an average age of 40.9, Asians were an average of 42.4 and African Americans or Mixed Race averaged age of 46.7. African Americans or Mixed Race also had a higher percentage of advanced degrees at 64.7%. Over half worked in local/county PHDs versus state PHDs (54% vs. 13%); others were unfamiliar with the type of PHD (33%).

5.4 | Data analysis

Recorded telephone interviews were de-identified, and fictitious names were substituted to protect confidentiality. Data were transcribed by an external company. Both measures safeguard potential bias into the study prior to analysis. Data analysis was concurrent with continuing interviews. Once the preliminary analysis of the data

TABLE 1 Demographics of participants

Total sample size = 39	
Gender	
Female	39 (100%)
Race/ethnicity	
African American/Black or Mixed Race	18 (46%)
Hispanic or Latina	12 (31%)
Asian	7 (18%)
Indian heritage	2 (5%)
Age in years	
24–33	7 (18%)
34–43	11 (28%)
44–53	14 (36%)
54–64	7 (18%)
Educational level	
Earned baccalaureate or higher degree in nursing	32 (82%)
MS/N or Master's in Public Health (MPH)	
Earned associate degree	1 (3%)
Currently enrolled in BSN, MS/N	6 (15%)
MPH or Nurse practitioner program (NP)	
Type of public health department	
Local or county	21 (54%)
State	5 (13%)
Not reported	13 (33%)

produced no new information, data reached a point of **analytical saturation** and interviews were complete (Creswell & Clark, 2011).

5.5 | Analysis strategy

Descriptive analyses were used to describe the study sample from demographic interview questions. The interviews were read and assigned codes to allow the clustering of ideas, using an inductive approach geared to identifying patterns or repeating themes and categories in the data. These themes allowed for a broader understanding of the low numbers of minority nurses in leadership positions in PHDs. Field notes were used to supplement the recording of non-verbal data. The researcher conducted all interviews, and a consultant in qualitative research reviewed codes and themes based on the data.

For initial **analysis**, responses to the IG questions were summarized by capturing "the story" of the nurse's career path in PHN. Patterns that occurred across the sample were sought. In qualitative research, issues of reliability and validity are addressed using standards, such as credibility, trustworthiness, confirmation, consistency, and transferability. *Credibility and trustworthiness* were established by showing all phases of data collection and data analysis. *Trustworthiness* was enhanced by the use of the participants' own language in explicating all findings during interviews. *Confirmation* was established by maintaining an audit trail (interviews and field notes) to trace steps during the analytic process by the researcher.

Confirmation enables the researcher to verify conclusions from the data and minimizes researcher-bias or preconceived impressions. *Consistency* was supported when the researcher and consultant achieved a 90% agreement when data were analyzed. *Transferability* was established through thick, rich descriptions of the data (Lincoln & Guba, 1985). Another critical component of qualitative research is "*reflexivity*, which provides information about the researcher's background or angle of investigation that frames the interpretation of data" (Malterud, 2001, p. 483–484). The researcher's *reflexivity* was shaped by a progressive 10-year history in an inner-city PHD (e.g., staff nurse and clinic team leader) where nurses were valued and respected by PH administrators and staff at all levels.

6 | FINDINGS

6.1 | Themes

Several themes were identified from the data. The first two related to participants' commitment to public health and their motivation for entering leadership in PHDs.

6.1.1 | Commitment to public health

The nurses who volunteered to participate in this study consistently shared the meaning and satisfaction they derived from doing public health work in the community. They acknowledged the rewards of making a difference in a family's health.

Elise reported especially positive relations with patients described as "Seeing their light bulbs go on when they learn something new about their health and feeling like you finally made a difference. It's so important to impact the health and well-being of those served for years and generations to come." Similarly, **Asia** boasted her deepest satisfaction in the work setting by networking and building bridges with community partners, "I enjoy building strong relations with the community because they have included me in important meetings. Establishing buy-in from community partners that I work with (physicians and other providers) is important in improving patient care and patient outcomes."

6.1.2 | Motivation for leadership development

Participants described their expectation of leadership as expanding the scope of their influence in the public health setting. After describing her community development work in the public health setting, **Angela s**tated, "I need to be at the leadership level to accomplish that work [sic]. This is the heart and soul of what PHN leadership is all about. A leadership position will give me a wider impact on meeting those needs [sic]."

Camilla stated "I'm so committed to improving myself in public health; since most of my families are Spanish speaking, I can be more helpful in explaining health conditions and risks and can see that they support healthy behavior change."

6.1.3 | Barriers for leadership development

System barriers were major obstacles in pursuing a leadership position. Overwhelmingly, participants reported that promotions were hand-picked or based primarily on seniority and that interviews are just a formality.

Jonesa presented a common concern from several participants that "Opportunities for leadership positions and promotions are based on who you know, and you must be liked by the person who hires you. It's really like a no-win situation." Another barrier was a lack of mentorship for higher leadership positions and experiences of isolation. **Bethena** expressed feelings of disappointment, while focusing on negative constraints imposed by nurses that did not reach out to other nurses, "We work in our own *silos* and we're not necessarily exposed to people who do different jobs on different levels." **Sofia** shared that systemic barriers in PHDs had a significant effect on personal desires to pursue a leadership position. "Most times I feel like it's no use in trying for fear of being shot down like before or reprisal if I speak up too much. I hear that this happens so much, but we must be strong to navigate the challenges and make it work for us."

The vast majority of the sample confirmed that earning a degree did not guarantee a promotion. **Bianca** reported, "Even if you have a public health degree, there's no opportunity for leadership roles because the playing field is not level and there's not a lot of positions available or open for leadership in PHDs."

Agnes noted that having Spanish as her first language could be a barrier "Sometimes our English language skills is [sic] a battle, especially during job interviews, but I won't give up. I listened to myself on the tape recorder and I'm getting better."

6.1.4 | Racism: Influences on nurses from a minority background

Participants acknowledged their contributions in improving the health and well-being of others; however, they shared personal experiences related to overt and implicit racism and discrimination, as well as a lack of equity and bias affecting opportunities for promotions in the work setting. **Ophelia** reported that even with higher education, there was a need for increasing diversity and equity in the workforce,

> Minority nurses with higher education are in a better position to create a healthier society by helping individuals with health disparities. People doing the hiring are not very good at looking at diversity among various nurses. But it's important to have diverse people in powerful positions because we know that the community we serve and the nation as a whole have

become quite diverse so leadership needs to respond to that.

Paula expressed concerns that racism and discrimination occur too often:

> Your ideas are not acknowledged or confirmed, as well as when job positions are posted and folks are interviewed. It seems like the women who don't have as much experience are getting the jobs when there's some other "women of color" who have more experience. During meetings, I just wonder with all the snide and racist remarks, "what am I, back in the 1950s? I thought we had turned the page regarding this stuff."

Andrea pointed out that they are often characterized as the "Negative Angry Black" Woman. "This negative image is often characterized as confrontational, hostile and arrogant or even that you lack team spirit in which you're overlooked for advancement in a leadership position."

Similarly, **Aletta** reported a demeaning environment,

> You need to fall in line, stay in your place, don't bring any new ideas, and don't ask questions. The last time I did that I received harsh criticism about how things are done as well as negative feedback or judgmental statements from my supervisor that made me cry.

6.1.5 | Supports for leadership development

Participants reported some examples of support from administrators and opportunities for leadership. Positive responses ranged from "I'm here for you," to "You're a good team player." On a personal level, **Tammy** stated that her immediate nurse manager was a constant supporter, "My nurse manager is extremely supportive and asks about projects I'm involved in. She is excited to have her staff trained to basically be her successor and that makes me feel good." **Noelle** was excited about the opportunities for leadership in her PHD,

> We actually have a leadership academy through the county and they encourage people from all levels and different departments to attend to develop you professionally in order to go into a leadership/management position; my managers encouraged me to join and get involved.

There were still some difficulties even with support. **Lisa** shared, "When applying for a leadership position, I was put in the spotlight and it became very overwhelming to somebody who hasn't been developed as one. Feeling exposed without much preparation is not the same as truly supporting leadership development." Similarly, **Jackie**

recalled being treated badly when seeking a leadership position, yet this negative experience was countered by feelings of hope and aspiration.

6.1.6 | Survival skills

Several participants shared what one called "survival skills" for minority nurses in public health who are considering a leadership position.

Susan reported:

> We must find ways to break the "glass ceiling." In order to advance to a leadership position, you must dismantle implicit *bias* because you need more energy to stay in a "toxic environment" than leave it. If we cannot leave, we must make the work environment inclusive; it is important to figure out ways to care for self, especially in a "toxic environment."

Yvette acknowledged the importance of learning "how to navigate political systems to influence change and decision-making of persons in leadership positions." When reflecting on survival skills, **Francesca** held that "minority nurses should be proactive and get involved in professional organizations that commit to leadership training for minority nurses."

In summary, in order to increase the number of minority nurses in leadership positions, **Denise** encouraged "strategic planning and social media exposure (informative educational blogs and newsletters) of PHN as an exciting career pathway for high school students as well as first-year college students who have not yet made a career choice."

Laura stated that "funding is needed to help pursue MS or MPH degrees. Once we obtain higher degrees, we can get our foot in the door or seat at the table. This is needed to encourage conversations with upper management and directors. It's also important to mentor new nurses that's [sic] just starting with us so they will learn the ropes and hopefully stay for a long time. This is how they will navigate those challenges."

7 | DISCUSSION

Minority nurses in this study reported a deep commitment and investment in serving their communities resulting in positive behavioral change (e.g., smoke cessation, adherence to exercise). Many have considered taking on a leadership role in PHDs at the state and national level supporting policy decisions that improve resource allocation supporting access to healthcare. Importantly, minority nurses voiced concern for diversity, equity and inclusion in leadership development and career opportunities for minority nurses in PHDs, but there were many issues that stand in the way including, lack of mobility in the system and patterns of

overt racism and hidden discriminatory practices, which seemedentrenched in policies or decisions about promotions in PHDs. Previous authors cited in this study confirmed these findings. Some participants reported feelings of not being qualified to pursue leadership and others reported that the lack of support for graduate degrees is a hindrance. Supports for leadership included receiving positive evaluation about their work performance and frequent communication with supervisors had a profound effect on their decision to wait for a leadership position; others were discouraged due to lack of support from administrators as well as minority nurse role models in leadership positions. A common response among some participants was the need to "wait it out," while considering the logistics for a future leadership position in PHDs. Diversity, equity, and inclusion of PHD staffing were seriously lacking and critically important in promoting leadership development for minority nurses. An attitude of self-worth was important in leadership development (Bessent & Fleming, 2003); however, this was often threatened in an environment that does not openly value individuals' contributions.

This study fulfilled an important gap in describing the lives of minority nurses as most participants stated, "I'm glad you're doing this study, because we really need changes in PHDs." Experiences of isolation influenced opportunities for peer collaboration and leadership support. Participants confirmed that salaries in PHDs have not kept pace with hospitals offering opportunities for tuition reimbursement and job advancement. Factors working against pursuing leadership were competing demands, e.g., child care and family responsibilities, and high levels of satisfaction in their current position because of patient interaction. The opportunity to shadow leaders and participate in mentoring programs/institutes might reveal new sources of satisfaction. Importantly, public health administrators are encouraged to provide fiscal resources supporting leadership development for minority nurses in PHDs.

8 | LIMITATIONS AND RECOMMENDATIONS

Minority nurses from this sample may have been uniquely committed to leadership development by virtue of their membership in NACCHO and affiliation with the APHN Organization encouragement via monthly newsletter. These findings might differ from the whole group of PHNs, although the interest was in minority nurses who expressed interest in pursuing a leadership position. Since this study has already been completed, the theoretical framework can be utilized to guide subsequent studies. In light of the limited studies in practice settings, future studies on leadership development of minority nurses in practice settings are warranted.

9 | IMPLICATIONS FOR RESEARCH

Survey tools could be developed using these findings to quantitatively measure strengths, barriers, and the experience of racism or discrimination in a larger, more representative sample of minority nurses globally and in all settings. Even more important is a mixed-methods research approach combining qualitative and quantitative research methods examining claims of overt racism or discrimination and perceptions that others who are less qualified were selected for leadership positions in PHDs.

10 | IMPLICATIONS FOR PUBLIC HEALTH NURSING

Individual minority PHNs may find support from these findings, particularly from the survival skills section. However, further work is needed in removing experiences of "racism" and "discrimination" to diversity and inclusion in recruiting and retaining the next generation of minority nurses into leadership positions in PHDs. Findings will be beneficial for nurse leaders and administrators in coaching leadership candidates and in developing opportunities to showcase minority nurses in leadership positions in PHDs. Workshops supporting personal growth and opportunities to gain skills in program and team leadership would benefit both individual minority public health nurses and PHDs. Tailored and culturally-sensitive interventions are needed in narrowing the gap among minority nurses in leadership positions in PHDs. These activities would require economic support; however, the investment would be of particular importance for all stakeholders, such as policymakers, legislators, administrators, and funding agencies in terms of its impact on healthcare delivery in PHDs serving vulnerable and minority populations.

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