

The Relationship Between Indigenous Health and Relevant Sector Standards in Aotearoa New Zealand, Australia and Canada: A Scoping Review

Authors and Affiliations

Dean Cowles ORCID 0009-0003-9280-7687
Research Officer – *Ngāti Awa, Hapū Te Patuwai*, MHSsc(Hons I), PGCertHSc(AdvNsg),
BHSc(Nurs)
School of Clinical Sciences, Faculty of Health and Environmental Sciences
Auckland University of Technology
Dean.Cowles@schl.co.nz
Mobile +64 220400926
Physical address:
Auckland University of Technology North Campus
90 Akoranga Drive
Northcote,
Auckland 0627
New Zealand

Jan Dewar ORCID 0000-0002-6081-292X
Associate Professor – *Kāi Tahu*, DHSc, RN
School of Health, Faculty of Health and Psychological Sciences
Victoria University of Wellington
jan.dewar@vuw.ac.nz
Phone +64 4 463 6596
Mobile +64 272011877
Physical address:
Victoria University of Wellington Kelburn Campus
Kelburn Parade
Wellington 6012
New Zealand

Catherine Cook ORCID 0000-0003-3976-6858
Associate Professor – PhD, RN, RM, M.Couns
School of Clinical Sciences, Faculty of Health and Environmental Sciences
Auckland University of Technology
catherine.cook@aut.ac.nz
Physical address:
Auckland University of Technology North Campus
90 Akoranga Drive
Northcote,
Auckland 0627
New Zealand

© The Author(s) 2026. Published by Oxford University Press on behalf of International Society for Quality in Health Care. This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs licence (<https://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial reproduction and distribution of the work, in any medium, provided the original work is not altered or transformed in any way, and that the work is properly cited. For commercial re-use, please contact journals.permissions@oup.com

Corresponding Author

Dean Cowles
School of Clinical Sciences, Faculty of Health and Environmental Sciences
Auckland University of Technology

Dean.Cowles@schl.co.nz

Mobile +64 220400926

Physical address:

Auckland University of Technology North Campus
90 Akoranga Drive
Northcote,
Auckland 0627
New Zealand

The Relationship Between Indigenous Health and Relevant Sector Standards in Aotearoa New Zealand, Australia and Canada: A Scoping Review

Abstract

Background

Health sector Standards in Aotearoa New Zealand, Australia and Canada increasingly acknowledge the importance of culturally appropriate care for Indigenous populations. Despite this, inequities persist. This review explores how national health Standards intersect with Indigenous health, focusing on Cultural Safety, Indigenous-led governance, Indigenous knowledge, and anti-racism.

Methods

A scoping review methodology was employed to map the breadth of literature across Aotearoa New Zealand, Australia and Canada. Guided by a six-stage framework and the PRISMA-ScR protocol, the review used the qualitative variant – Population/Problem, Interest, Context (PICO) approach – to structure inclusion criteria and search strategies. Literature was sourced from five major databases and supplemented by grey literature. Data from 36 records were charted, synthesised, and analysed through narrative synthesis and stakeholder engagement.

Results

Cultural Safety was consistently identified as more impactful than cultural competency alone, yet most Standards fall short of indicating how Cultural Safety will be measured. Across

1
2
3 records, 75% highlighted the need to address social determinants of health, and 67%
4
5 advocated anti-racism and structural reform. Indigenous-led governance and self-
6
7 determination were linked to improved health outcomes in 50% of the records, though
8
9 practical implementation was uneven. Integration of Indigenous knowledge and holistic
10
11 approaches was supported in 47% of records, but limited by weak policy infrastructure.
12
13 Racism, both systemic and interpersonal, was identified in all studies as a persistent barrier to
14
15 equity. National Standards often lack the enforcement mechanisms to address these issues
16
17 meaningfully.
18
19
20

21 22 Conclusion

23
24
25 This review identified significant gaps between the intent and implementation of health sector
26
27 Standards across Aotearoa New Zealand, Australia, and Canada in relation to Indigenous
28
29 health. Despite formal commitments to culturally appropriate care, systemic barriers, rooted
30
31 in colonisation and policy-practice disconnects, continue to undermine equitable outcomes.
32
33 The findings highlight the need for Indigenous-led evaluation, stronger accountability, and
34
35 the embedding of Cultural Safety, Indigenous leadership, and holistic health approaches to
36
37 drive meaningful and lasting change.
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Introduction

National healthcare Standards provide consistency for implementing and auditing a consistently safe and high quality care context across broad domains such as clinical outcomes and governance. This scoping review critically examines the intersection between Indigenous health and national health sector Standards across Aotearoa New Zealand (henceforth Aotearoa), Australia and Canada. Key focus areas include Cultural Safety, Indigenous-led governance and self-determination, Indigenous knowledge, and anti-racism which are central to understanding how these Standards aim to enhance outcomes for Indigenous peoples. Cultural Safety differs significantly from cultural competence. The latter encompasses the acquisition of knowledge about cultural norms in order to be able to function in an appropriate, non-offensive manner with people from different cultural contexts. By contrast, Cultural Safety, a concept developed by a nursing scholar Irihapeti Ramsden, is a politicised concept that recognises the impact of colonisation and challenges structural inequities and power imbalances, demanding systemic change [1]. Significantly, Cultural Safety is determined by the recipient of care [1]. The concept of Cultural Safety is deeply linked with the social determinants of health (SDH) because culturally unsafe healthcare means inequitable access and engagement. Intergenerational poverty since colonisation also impacts the SDH [2].

The scoping review begins with an overview of health sector Standards. The synthesis of findings offers recommendations to inform future research, strengthen policy frameworks, and support the transformation of health systems to better serve Indigenous communities.

Background

1
2
3 Unifying these national health sector Standards in all three countries is the formal recognition
4
5 of Indigenous rights to safe, equitable, and inclusive health care. This approach aligns with
6
7 the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) [3]. All
8
9 Standards demonstrate some efforts towards recognising the significance of Indigenous
10
11 health, with variable attention to Cultural Safety, the SDH, racism, Indigenous-led
12
13 governance and self determination. The following outlines how each country's Standards
14
15 incorporate these principles.
16
17
18
19

20 The Australian National Safety and Quality Health Service Standards (NSQHS) aim
21
22 to improve safety and quality through continuous improvement and harm prevention [4].
23
24 Their focus on consumer engagement aligns with the UNDRIP, particularly Article 18,
25
26 affirming Indigenous peoples' rights to participate in decision-making [3].
27
28
29

30 Accreditation Canada and the Health Standards Organization (HSO) have developed
31
32 Indigenous Health Standards, including the British Columbia Cultural Safety and Humility
33
34 Standard [5]. They prioritise Cultural Safety, Indigenous engagement, equitable service, and
35
36 quality improvement [5], aligning with UNDRIP's Article 24, which recognises traditional
37
38 healing and the right to the highest attainable standard of health [3].
39
40
41

42 In Aotearoa, the Ngā Paerewa Health and Disability Services Standard (HDSS)
43
44 ensures services are safe, appropriate, and culturally responsive, particularly for Māori and
45
46 diverse communities [6]. It includes consumer rights, cultural competence, and holistic
47
48 wellbeing, reflecting UNDRIP Articles 11 and 23, which support Indigenous practices and
49
50 participatory service development [3].
51
52
53

54 Collectively, these Standards utilise well-established monitoring processes such as
55
56 accreditation, self-assessments, audits, data collection, site visits, stakeholder engagement,
57
58 and health outcome measures.
59
60

1
2
3 While they share commitments to cultural diversity (see Table 1), differences remain.
4
5 Accreditation Canada/HSO offers Indigenous-specific Standards, whereas NSQHS and Ngā
6
7 Paerewa HDSS incorporate Indigenous needs into broader health quality frameworks.
8
9
10 Measurement of commitments to cultural diversity also varies: Accreditation Canada
11
12 prioritises community feedback, NSQHS focuses on clinical outcomes, and Ngā Paerewa
13
14 highlights holistic Māori health models across physical, mental, spiritual, and social domains.
15
16
17
18
19

20 21 Research Aim

22
23 This scoping review aims to explore how national health Standards intersect with Indigenous
24
25 health, focusing on Cultural Safety, Indigenous-led governance, Indigenous knowledge, and
26
27 anti-racism across Aotearoa, Australia and Canada.
28
29
30
31
32
33

34 Research Question

35
36
37 How do national health Standards intersect with Indigenous health in the contexts of Cultural
38
39 Safety, Indigenous-led governance, Indigenous knowledge, and anti-racism?
40
41
42
43
44

45 Methods

46
47
48 A scoping review methodology was utilised as it is well-suited for mapping the breadth of
49
50 existing literature, identifying knowledge gaps, and exploring key concepts [7]. The
51
52 structured review protocol was informed by Carr et al. [7], building on Arksey and
53
54 O'Malley's work [8] and incorporates Levac et al.'s refinements [9]. The review had six
55
56 stages: (1) formulating the research question or objective; (2) identifying relevant literature;
57
58 (3) selecting studies; (4) organising data; (5) synthesising and summarising findings, and (6)
59
60

1
2
3 engaging with relevant stakeholders. This scoping review was Indigenous-led by the first and
4
5 second authors.
6
7
8
9

10 11 Eligibility Criteria

12
13 We applied the qualitative variant – Population/Problem, Interest, Context (PICO) framework
14 – to refine the scope of our research objective. The study population included Māori in
15 Aotearoa, Aboriginal and Torres Strait Islander peoples in Australia, and Canadian First
16 Nations, Inuit, and Métis communities. The area of interest were health Standards
17 encompassing policies, programmes, and frameworks designed to enhance Indigenous
18 healthcare, particularly Cultural Safety and health equity. For the context component, we
19 explored how their implications across the three countries, focusing on Indigenous health
20 outcomes. The years searched, inclusion and exclusion criteria are outlined in Table 2.
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35

36 Information Sources

37
38 As the primary sources for the search, PubMed, Scopus, CINAHL, JSTOR, and SAGE were
39 selected. These databases offer a broad interdisciplinary range of perspectives and are well-
40 suited for exploring the multifaceted nature of Indigenous health and policy.
41
42
43
44
45
46
47
48
49

50 Search Strategy

51
52 As shown in Table 3, the research objective was broken down into key concepts. We
53 generated an expanded list of synonyms, related terms, acronyms, and alternative spellings
54 for each concept to ensure comprehensive coverage. These terms were then strategically
55 combined into search strings using Boolean operators. Grey literature was included from
56
57
58
59
60

1
2
3 credible sources, and a detailed search process log was maintained. Rigorous documentation
4
5 ensured transparency, consistency and reproducibility.
6
7
8
9

10 11 Selection of Sources of Evidence 12

13
14 The screening process began with the extraction of all potentially relevant titles and abstracts
15 using the predefined search terms, subject headings, and search limits. The number of records
16 retrieved from each database was recorded individually to maintain transparency across
17 sources. Duplicate entries were identified and removed, with the number of duplicates
18 documented. The remaining titles and abstracts were screened for relevance against the
19 research aim. Records not meeting the inclusion criteria from this initial review were
20 excluded. The remaining studies were flagged for full-text retrieval.
21
22
23
24
25
26
27
28
29

30
31 Full texts that were inaccessible were documented as unavailable. Full-text records
32 that were obtained were evaluated in detail. Those that failed to meet the criteria were
33 excluded, with reasons noted. The final studies that satisfied all inclusion parameters
34 comprised the literature for the review.
35
36
37
38
39
40
41
42
43

44 Study Selection 45

46
47 As highlighted in Figure 1, the Preferred Reporting Items for Systematic reviews and Meta-
48 Analyses (PRISMA) process was followed to screen relevant literature [10]. After removing
49 duplicate records from the initial search results, titles and abstracts of 1312 records were
50 screened for focus on the relevant study population or accreditation Standards, and 1280
51 records were excluded. Thirty-two records from the identified search databases were
52 retrieved and assessed for eligibility. An additional 26 records from organisations or citation
53
54
55
56
57
58
59
60

1
2
3 searching were also assessed for eligibility. Of the 58 records, 10 were from the identified
4
5 databases and 26 were identified via other methods.
6
7
8
9

10 11 Data Charting Process

12
13
14 Within the data charting process, selected study information included country, aim,
15
16 methodology, methods, study interpretation and contributions to the wider research context.
17
18
19

20 21 22 Results Synthesis

23
24
25 Synthesis commenced with organising data extracted from the 36 included studies. Using a
26
27 data extraction template, key findings were collated to establish an overview of the evidence
28
29 base and identify early patterns and divergences [11]. Relationships within and across studies
30
31 were examined to uncover recurring ideas, discrepancies, and contextual factors.
32
33
34

35
36 A Miro board was employed to visualise the conceptual groupings derived from the
37
38 results and discussion sections. This enabled a clearer exploration of emerging trends and
39
40 potential anomalies within the data, contributing to rigour in the findings.
41
42

43
44 For synthesis rigour, each record's quality and methodological soundness were
45
46 considered. This identified bias or evidence limitations, which were reported in the final
47
48 analysis [12]. A methodical approach was maintained, guided by the PRISMA-ScR
49
50 framework, to ensure reproducibility, clarity, and coherence in how findings were interpreted
51
52 and presented [13].
53
54
55
56
57

58 Stakeholder Engagement

59
60

1
2
3 Guidance was informally provided in-person by experienced auditors in Aotearoa who have
4 audited organisations against the Ngā Paerewa HDSS. These stakeholders were consulted
5
6 early on in the development of the larger research project. They shared insights into the audit
7
8 process, helping to contextualise the research within practical audit environments. The
9
10 primary researcher also brought direct experience, having supported hospitals in Aotearoa in
11
12 meeting the Standards. This collaborative engagement helped identify and understand the
13
14 practical challenges involved in implementing the Standards, supporting findings that are
15
16 relevant to the sector and responsive to its needs.
17
18
19
20
21
22
23
24

25 **Results of data synthesis**

26 **Characteristics of Evidence Sources**

27
28
29 The summary of included sources is as follows: 33 qualitative studies and three healthcare
30
31 Standards. Geographically, 10 studies focused on Aotearoa, 12 on Australia, 13 on Canada,
32
33 and one had a global scope. Studies involving participants included patients (n = 16),
34
35 whānau/families (n = 8), community members (n = 13), health professionals (n = 18), and
36
37 government or health organisations (n = 12). Most studies incorporated multiple perspectives.
38
39 However, few explicitly engaged with national health sector Standards (n = 3), suggesting
40
41 research gaps investigating the relationship between policy intent and practice.
42
43
44
45
46
47

48 Four themes were identified across the dataset (Table 4): Cultural Safety versus
49
50 cultural competence; Indigenous-led governance and self-determination; integration of
51
52 Indigenous knowledge and holistic approaches; and anti-racism and structural change.
53
54 Twenty studies prioritised Cultural Safety over cultural competency. While one record upheld
55
56 cultural competency as sufficient [14], most distinguished between the two – that cultural
57
58 competency involves awareness and skills, whereas Cultural Safety requires environments
59
60

1
2
3 shaped by Indigenous identity and experience [14]. With this theme, 20 studies stressed the
4 importance of addressing SDH and health inequities to achieve Cultural Safety. Eighteen
5 studies supported Indigenous-led governance and self-determination, though some proposed
6 partnership models as a transitional or complementary approach. Seventeen studies endorsed
7 integrating Indigenous knowledge and holistic healthcare models. Finally, 24 studies
8 advocated for anti-racism strategies to drive systemic change.
9
10
11
12
13
14
15
16
17
18
19
20

21 Key Findings

22 23 24 25 26 27 Cultural Safety versus cultural competence

28
29 While many studies discuss cultural competency and Cultural Safety, few explore in-depth
30 the distinctions between the concepts. Cultural competency involves acquiring knowledge
31 and skills to work across cultures [15]. One study argued this framework should underpin
32 culturally safe, Indigenous-led evaluations [16]. The Australian NSQHS Standards support
33 cultural competence with Aboriginal and Torres Strait Islander people [4], but do not address
34 systemic power dynamics and therefore Cultural Safety is unexamined. Only one study
35 viewed cultural competency as sufficient [14], while 10 others in Australia advocated
36 embedding Cultural Safety into all levels of care. Three studies positioned competency as a
37 starting point, with safety achieved through reflection, anti-racism strategies, and Indigenous
38 perspectives [17-19]. Others [3, 14, 20] critique Standards that stop at competency without
39 progressing toward Cultural Safety.
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54

55 Cultural Safety challenges structural inequities and power imbalances, demanding
56 systemic change [1]. This aligns with Accreditation Canada's Indigenous Health Standards,
57 which promote anti-racism, community engagement, and decolonising practice. These values
58
59
60

1
2
3 are also reflected in British Columbia's Cultural Safety and Humility Standard [5] and Ngā
4 Paerewa HDSS [6]. A meta-synthesis of 14 studies by Graham and Masters-Awatere [17]
5
6 called for reconceptualising Māori health care delivery, linking cultural competency with
7
8 deeper sociopolitical awareness. Without strong enforcement mechanisms, two studies
9
10 argued Cultural Safety risks remaining aspirational [16, 17].
11
12
13
14

15
16 Across 27 studies, the enduring impacts of colonisation were central to understanding
17
18 inequities in health access and outcomes. Structural racism, intersectionality, and SDH must
19
20 be addressed to institutionalise Cultural Safety [1, 19-23]. Scholars call for embedding
21
22 Indigenous voices and accountability into national Standards and health pathways [24-28].
23
24 Although current research offers important perspectives on holistic health, equity and the
25
26 significance of Cultural Safety, few studies examine the long-term effects of national
27
28 Standards on Indigenous health outcomes, in some instances perhaps due to the short time
29
30 periods the Standards have been in place.
31
32
33
34
35
36
37

38 Indigenous-led governance and self-determination

39
40 The centrality of Indigenous-led governance and self-determination is a recurring insight
41
42 across the literature. Eighteen studies recognised that when Indigenous communities lead and
43
44 control health services, outcomes significantly improve. Community-led approaches are
45
46 consistently reported as more effective than top-down, government-imposed models.
47
48 Governance models prioritising self-determination, Cultural Safety, and local autonomy tend
49
50 to result in more coordinated, culturally appropriate, and comprehensive service delivery [21-
51
52 33].
53
54
55
56

57
58 Many studies advocate for community-led approaches and Indigenous decision-
59
60 making across all levels of healthcare to support ground-level initiatives. In Canada,

1
2
3 organisations must demonstrate an overarching commitment to Indigenous health equity in
4
5 governance, strategy, and resource allocation [5]. In Aotearoa, Māori should be represented
6
7 in governance and leadership roles to influence decision-making [6]. Despite these mandates
8
9 being progressive, limited information is available from which to determine the success of
10
11 these indicators. This highlights a need for closer monitoring to gather implementation data.
12
13 In Australia, the Standards encourage Indigenous leadership as a strategic priority, rather than
14
15 promote Indigenous governance (D) [4].
16
17
18
19
20
21
22

23 Integration of Indigenous knowledge and holistic approaches

24
25
26 Seventeen studies emphasise grounding health interventions in Indigenous knowledge
27
28 systems and holistic wellbeing. Health is conceptualised as a dynamic interplay of physical,
29
30 spiritual, cultural, and social dimensions. Three studies across Australia and Canada [34-36]
31
32 advocate for co-designed healthcare approaches between Western healthcare and Indigenous
33
34 stakeholders. Although these align with their respective health Standards, four studies [35-38]
35
36 suggest a lack of integration, accountability mechanisms and formal policy infrastructures.
37
38
39

40
41 In Aotearoa, two studies [30, 39] argue for full restoration of Indigenous sovereignty
42
43 and Māori-led frameworks as the foundation for achieving equity. These studies demonstrate
44
45 how Indigenous philosophies can authentically guide practice aligned with the Ngā Paerewa
46
47 HDSS [6].
48
49

50
51 Studies examined how Indigenous knowledge and holistic frameworks are integrated
52
53 into healthcare. For example, two studies [35, 36] used systematic reviews informed by
54
55 community-based participatory research to investigate the role of Indigenous knowledge in
56
57 areas such as suicide prevention and traditional healing.
58
59
60

Anti-racism and structural change

All 36 studies implicitly indicate racism in healthcare. Twenty-four explicitly identify systemic and interpersonal racism, and power imbalances stemming from colonisation. Four studies [21, 22, 30, 40] critique institutional structures and policies that disempower Indigenous communities by limiting autonomy and marginalising knowledge systems. These dynamics reinforced top-down, paternalistic approaches that exclude Indigenous decision-making. Across contexts, systemic racism and historical oppression remain embedded in health governance, hindering culturally safe care [21-22, 40-42].

Two studies across Australia and Aotearoa [20, 28] advocate for integrating Indigenous methodologies into health Standards, mandating anti-racism education and reflective practice, and revising policies to embed anti-racism across clinical and non-clinical settings. These actions are not yet reflected in the Australian NSQHS Standards or Aotearoa's Ngā Paerewa HDSS.

In Canada, there is growing movement among health organisations to embed anti-racism principles. Institutions are urged to adopt zero-tolerance approaches to Indigenous-specific racism, and leadership bodies increasingly issue formal statements confronting colonial harm and committing to systemic change [5].

Discussion

Statement of principal findings

National Standards that recognise unique needs and rights of Indigenous people are a beginning point for remedying the parlous state of Indigenous health. The benefit of national Standards is that there is a uniform of set outcomes against which services have to measure

1
2
3 outcomes. Therefore, Standards provide mandatory expectations without dictating the
4
5 process. Standards alone however will not transform health and social services [43].
6
7 Standards must be backed by rigorous audits to ensure there is continuous quality
8
9 improvement in upholding Indigenous people's rights. We concur with Ng et al [44] that
10
11 system learning is fundamental. A quantitative data-driven reporting process is required to
12
13 operationalise improvement actions and progress towards expected outcomes. The current
14
15 study also highlights the importance of the second strand of health system learning, which is
16
17 a structured approach to education and problem-solving. In this context, health system
18
19 learning entails Indigenous knowledges being integral to theory building and health systems'
20
21 evolution. Fundamental to this process is examining the systems that perpetuate health
22
23 disparities [45]. The findings highlight that there are key areas pertaining to the
24
25 transformation of health systems to better serve Indigenous communities where further
26
27 institutional development is necessary.
28
29
30
31
32
33
34
35
36

37 Interpretation within the context of wider literature

38
39 In this study, key areas include Indigenous-led governance integrating Indigenous knowledge
40
41 and community-led approaches are essential for better outcomes. Racism is a central issue
42
43 relating to colonisation and systemic exclusion. This review supports the argument that
44
45 Indigenous people experience complex biopsychosocial harms from racism, and legal and
46
47 health systems have a pivotal role in protecting rights [46]. Cultural competency is often
48
49 treated as a technical requirement rather than a step toward deeper Cultural Safety. Cultural
50
51 Safety requires systemic transformation, power-sharing, and anti-racism praxis [47]. The
52
53 findings show persistent barriers remain, including limited insight into Indigenous definitions
54
55 of Cultural Safety. Despite policy advancements, Cultural Safety is not consistently
56
57
58
59
60

operationalised. Health systems still prioritise Eurocentric models, marginalising Indigenous approaches [18, 19]. Policies and Standards must centre Indigenous leadership, embed Cultural Safety, and expand Indigenous workforce roles and governance grounded in tino rangatiratanga (autonomy) and co-design [6, 40].

Implications for policy, practice and research

These findings highlight a critical global shift in health systems. Integration of Indigenous knowledge systems into healthcare supports holistic, relational, and preventative models of care that benefit both Indigenous and non-Indigenous populations [17]. Ultimately, Indigenous health equity is a benchmark for the wider healthcare system's responsiveness, integrity, and justice.

All three countries share similarities in their colonial histories and current politicisation of health. The latter can readily eclipse attention focused on fundamental issues such as equity, institutional racism and Cultural Safety. There are several exemplars in the Aotearoa context of steps towards ensuring that policies and direct care are compliant with Māori rights and aspirations. Critical Tiriti Analysis [48, 49] uses the Articles of the 1840 Te Tiriti o Waitangi to retrospectively analyse policy and prospectively to design policies that address Māori leadership. It focuses on Māori leadership, participation and self-determination. In the nursing context, Ke Kaunihera Tapuhi o Aotearoa, the Nursing Council of New Zealand [50] has recently renewed the scope and Standards of registered nurse practice ensuring authentic Māori representation in their development and reflecting alignment with Te Tiriti o Waitangi with an equitable and holistic approach to health. There are numerous examples of high-level collaboration between Indigenous nations to improve health, including a broad focus on planetary health [51].

Strengths and limitations

This study followed a rigorous methodology, using a six-stage scoping review process guided by the PICo and PRISMA-ScR frameworks. The search strategy was documented to ensure transparency and reproducibility. The data charting process was thorough, capturing standard bibliographic information and contextual factors. The use of a Miro board enabled thematic clarity.

Limitations include scant data for Canadian representation, particularly for Inuit and Métis. There is also a lack of explicit research about engagement with Standards. The predominance of qualitative, cross-sectional designs restricts longitudinal insights. Few studies were Indigenous-led, affecting cultural relevance.

Conclusion

This scoping review aimed to explore how national health Standards intersect with Indigenous health across Aotearoa, Australia and Canada, and the implications for health outcomes on Indigenous communities. Although many Standards formally recognise the importance of culturally appropriate care, the review found that there are implications for their rigorous implementation. Persistent systemic barriers, including the enduring effects of colonisation and inconsistent incorporation of Indigenous worldviews, continue to limit equitable healthcare access and outcomes for Indigenous peoples. These structural issues are attributed to the disconnect between policy intentions and practice.

The review highlighted the need for Indigenous-led research and evaluation. The findings call for monitoring and transformative change within healthcare systems.

1
2
3 Embedding Cultural Safety into governance structures, strengthening Indigenous leadership,
4
5 and addressing broader SDH are essential to achieving equitable outcomes. The review
6
7 recommends stronger accountability measures, sustained anti-racism initiatives, and the
8
9 integration of Indigenous healing and holistic health models. By doing so, health Standards
10
11 can move beyond symbolic inclusion and towards tangible improvements.
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

References

1. Ramsden, I. *Kawa Whakaruruhau: Cultural Safety in nursing education in Aotearoa*. Wellington: Ministry of Education, 1990.
2. McGough, S, Wynaden, D, Gower, S *et al*. There is no health without cultural safety: Why cultural safety matters. *Contemporary Nurse* 2022;**58**:33-42.
<https://doi.org/10.1080/10376178.2022.2027254>
3. United Nations. 2007. *United Nations Declaration on the Rights of Indigenous Peoples*. United Nations. <https://social.desa.un.org/issues/indigenous-peoples/united-nations-declaration-on-the-rights-of-indigenous-peoples> (20 April 2025, date last accessed).
4. Australian Commission on Safety and Quality in Health Care. 2021. *National Safety and Quality Health Service Standards (2nd ed.)*. ACSQHC.
<https://www.safetyandquality.gov.au> (20 April 2025, date last accessed).
5. Health Standards Organization. 2022. *British Columbia Cultural Safety and Humility Standard (HSO 75000:2022)*.
6. Standards New Zealand. 2021. *Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)*. <https://www.standards.govt.nz/shop/nzs-81342021/> (20 April 2025, date last accessed).
7. Carr, T, Turner, M, Ramaswamy, R. Scoping review study to identify how communities in the USA, Australia, New Zealand and Canada use quality improvement (QI) approaches to address community health and well-being. *BMJ Open* 2019;**9**:1-5. <https://doi.org/10.1136/bmjopen-2019-034302>

- 1
2
3 8. Arksey, H, O'Malley, L. Scoping studies: towards a methodological
4
5 framework. *International Journal of Social Research Methodology* 2005;**8**:19-32.
6
7 <https://doi.org/10.1080/1364557032000119616>
8
9
- 10
11 9. Levac, D, Colquhoun, H, O'Brien, K. Scoping studies: Advancing the
12
13 methodology. *Implementation Science* 2010;**5**:1-9. [https://doi.org/10.1186/1748-5908-](https://doi.org/10.1186/1748-5908-5-69)
14
15 [5-69](https://doi.org/10.1186/1748-5908-5-69)
16
17
- 18
19 10. Page, MJ, Moher, D, Bossuyt, PM *et al.* PRISMA 2020 explanation and elaboration:
20
21 Updated guidance and exemplars for reporting systematic reviews. *BMJ*
22
23 2021;**372**:n160. <https://doi.org/10.1136/bmj.n160>
24
25
- 26
27 11. Harden, A, Garcia, J, Oliver, S *et al.* Applying Systematic Review Methods to Studies
28
29 of People's Views: An Example from Public Health Research. *Journal of*
30
31 *Epidemiology and Community Health* 2004;**58**:794-800.
32
33 <https://doi.org/10.1136/jech.2003.014829>
34
35
- 36
37 12. Munn, Z, Pollock, D, Khalil, H *et al.* What are scoping reviews? Providing a formal
38
39 definition of scoping reviews as a type of evidence synthesis. *JBIE Evidence Synthesis*
40
41 2022;**20**:950-951. <https://doi.org/10.11124/JBIES-21-00483>
42
43
- 44
45 13. Tricco, AC, Lillie, E, Zarin, W *et al.* PRISMA Extension for Scoping Reviews
46
47 (PRISMA-ScR): Checklist and explanation. *Annals of Internal Medicine*
48
49 2018;**169**:467-485. <https://doi.org/10.7326/M18-0850>
50
- 51
52 14. Cullen, T, Griffith, M, Damodaran, A *et al.* The First Nations experience of accessing
53
54 rheumatology services in a metropolitan hospital: A qualitative study. *Health*
55
56 *Expectations* 2024;**27**:1-9. <https://doi.org/10.1111/hex.14049>
57
58
59
60

15. Ide, Y, Beddoe, L. Attitude or skills? Cultural competence development within an Aotearoa New Zealand bicultural framework. *Aotearoa New Zealand Social Work Review* 2022;**34**:47-60. <https://doi.org/10.11157/anzswj-vol34iss4id954>
16. Maddox, R, Blais, G, Mashford-Pringle, A *et al.* Reviewing health service and program evaluations in Indigenous contexts: A systematic review. *American Journal of Evaluation* 2021;**42**:332-353. <https://doi-org.ezproxy.aut.ac.nz/10.1177/1098214020940409>
17. Graham, R, Masters-Awatere, B. Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. *Australian & New Zealand Journal of Public Health* 2020;**44**:193-200. <https://doi.org/10.1111/1753-6405.12971>
18. Wylie, L, McConkey, S, Corrado, AM. Colonial legacies and collaborative action: Improving Indigenous Peoples' health care in Canada. *International Indigenous Policy Journal* 2019;**10**:1-27. <https://www.jstor.org/stable/48767609>
19. Coombes, J, Hunter, K, Mackean, T *et al.* Factors that impact access to ongoing health care for First Nation children with a chronic condition. *BMC Health Services Research* 2018;**18**:1-9. <https://doi.org/10.1186/s12913-018-3263-y>
20. Laverty, M, McDermott, DR, Calma, T. Embedding Cultural Safety in Australia's main health care standards. *Medical Journal of Australia* 2017;**207**:15-16. <https://doi.org/10.5694/mja17.00328>
21. Fisher, M, Mackean, T, George, E *et al.* Stakeholder perceptions of policy implementation for Indigenous health and Cultural Safety: A study of Australia's 'Closing the Gap' policies. *Australian Journal of Public Administration* 2021;**80**:239-260. <https://doi.org/10.1111/1467-8500.12482>

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
22. Zambas, SI, Wright, J. Impact of colonialism on Māori and Aboriginal healthcare access: A discussion paper. *Contemporary Nurse: A Journal for the Australian Nursing Profession* 2016;**52**:398-409.
<https://doi.org/10.1080/10376178.2016.1195238>
23. Ingham, TR, Jones, B, Perry, M *et al.* The multidimensional impacts of Inequities for Tangata Whaikaha Māori (Indigenous Māori with lived experience of disability) in Aotearoa, New Zealand. *International Journal of Environmental Research and Public Health* 2022;**19**:13558-13573. <https://doi.org/10.3390/ijerph192013558>
24. Rahaman, Z, Holmes, D, Chartrand, L. An opportunity for healing and holistic care: Exploring the roles of health care providers working within Northern Canadian Aboriginal communities. *Journal of Holistic Nursing* 2017;**35**:185-197.
<https://doi.org/10.1177/0898010116650773>
25. Sehgal, A, Henderson, R, Murry, A *et al.* Advancing health equity for Indigenous peoples in Canada: Development of a patient complexity assessment framework. *BMC Primary Care* 2024;**25**:1-15. <https://doi.org/10.1186/s12875-024-02362-z>
26. Taylor, EV, Lyford, M, Holloway, M *et al.* "The support has been brilliant": Experiences of Aboriginal and Torres Strait Islander patients attending two high performing cancer services. *BMC Health Services Research* 2021;**21**:1-15.
<https://doi.org/10.1186/s12913-021-06535-9>
27. Ivers, R, Dickson, M, Taylor, K *et al.* Barriers and facilitators to adherence to Optimal Care Pathways for diagnosis and treatment of cancer for Aboriginal and Torres Strait Islander people. *Australian Journal of Primary Health* 2024;**30**:1-9.
<https://doi.org/10.1071/PY22181>

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
28. Masters-Awatere, B, Cormack, D, Graham, R *et al.* Whānau experiences of supporting a hospitalised family member away from their home base. *Kotuitui: New Zealand Journal of Social Sciences* 2024;**19**:86-104.
<https://doi.org/10.1080/1177083X.2023.2227234>
29. Webb, D, Mashford-Pringle, A, Allin, S *et al.* Comparing federal Indigenous health policy reform in Canada and the United States: The shift to Indigenous self-determination in health care. *Health Reform Observer - Observatoire des Réformes de Santé* 2022;**10**:1-26. <https://doi.org/10.13162/hro-ors.v10i3.5094>
30. Came, H, Baker, M, McCreanor, T. Addressing structural racism through constitutional transformation and decolonisation: Insights for the New Zealand health sector. *Journal of Bioethical Inquiry* 2021;**18**:59-70. <https://doi.org/10.1007/s11673-020-10077-w>
31. Marchildon, GP, Lavoie, JG, Harrold, HJ. Typology of Indigenous health system governance in Canada. *Canadian Public Administration* 2021;**64**:561-586.
<https://doi.org/10.1111/capa.12441>
32. Lavoie, JG, Kornelsen, D, Wylie, L *et al.* Responding to health inequities: Indigenous health system innovations. *Global health, Epidemiology and Genomics* 2016;**1**:1-10.
<https://doi.org/10.1017/gheg.2016.12>
33. O'Neil, J, Gallagher, J, Wylie, L, *et al.* Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance* 2016;**21**:229-244. <https://doi.org/10.1108/IJHG-08-2016-0042>
34. Lethborg, C, Halatanu, F, Mason, T *et al.* Culturally informed, codesigned, supportive care for Aboriginal and Torres Strait Islander people with cancer and their

families. *Australian Social Work* 2022;**75**:165-179.

<https://doi.org/10.1080/0312407X.2021.1916050>

35. Asamoah, GD, Khakpour, M, Carr, T *et al.* Exploring Indigenous traditional healing programs in Canada, Australia, and New Zealand: A scoping review. *Explore: The Journal of Science and Healing* 2023;**19**:14–25.

<https://doi.org/10.1016/j.explore.2022.06.004>

36. Sjoblom, E, Ghidei, W, Leslie, M, *et al.* Centering Indigenous knowledge in suicide prevention: A critical scoping review. *BMC Public Health* 2022;**22**:1-17.

<https://doi.org/10.1186/s12889-022-14580-0>

37. Mack, M. Integrating traditional practitioners within primary healthcare teams:

Development of an accreditation framework. *Healthcare Management Forum*

2024;**37**:S7-S13. <https://doi.org/10.1177/08404704241271108>

38. Larson, S, Bear, CS, Olson, D *et al.* Truth and Reconciliation Commissions and health care system responses for Indigenous Peoples: A scoping review. *Health and Human Rights* 2024;**26**:57–70. <https://www.jstor.org/stable/48778799>

39. Reweti, A, Ware, F, Moriarty, H. A tangata whenua (people of the land) approach to conceptualising Māori health and wellbeing. *Global Health Promotion* 2023;**30**:11-18. <https://doi:10.1177/17579759221130948>

40. Matthews, R. Health ethics and Indigenous ethnocide. *Bioethics* 2019;**33**:827-834.

<https://doi.org/10.1111/bioe.12610>

41. Finlay, SM, Canuto, K, Canuto, K *et al.* Aboriginal and Torres Strait Islander connection to culture: building stronger individual and collective wellbeing. *Medical Journal of Australia* 2021;**214**:S12–S16. <https://doi.org/10.5694/mja2.51020>

- 1
2
3 42. O'Brien, P, Bunzli, S, Lin, I, *et al.* Addressing surgical inequity for Aboriginal and
4
5 Torres Strait Islander people in Australia's universal health care system: A call to
6
7 action. *ANZ Journal of Surgery* 2021;**91**:238-244. <https://doi.org/10.1111/ans.16557>
8
9
- 10
11 43. Hudson, B, Hunter, D, Peckham, S. Policy failure and the policy-implementation gap:
12
13 can policy support programs help? *Policy Design and Practice* 2019;**2**:1-14.
14
15 <https://doi.org/10.1080/25741292.2018.1540378>
16
17
- 18 44. Ng, J, Chan, J, Valencia, J *et al.* Optimising the use of certification findings to
19
20 support healthcare quality measurement and improvement. *New Zealand Medical*
21
22 *Journal* 2025;**138(1616)**:99-106. [https://nzmj.org.nz/media/pages/journal/vol-138-no-](https://nzmj.org.nz/media/pages/journal/vol-138-no-1616/optimising-the-use-of-certification-findings-to-support-healthcare-quality-measurement-and-improvement/afbf237223-1750970330/6939.pdf)
23
24 [1616/optimising-the-use-of-certification-findings-to-support-healthcare-quality-](https://nzmj.org.nz/media/pages/journal/vol-138-no-1616/optimising-the-use-of-certification-findings-to-support-healthcare-quality-measurement-and-improvement/afbf237223-1750970330/6939.pdf)
25
26 [measurement-and-improvement/afbf237223-1750970330/6939.pdf](https://nzmj.org.nz/media/pages/journal/vol-138-no-1616/optimising-the-use-of-certification-findings-to-support-healthcare-quality-measurement-and-improvement/afbf237223-1750970330/6939.pdf)
27
28
- 29 45. Milligan, C, Mantla, R, Blake, G *et al.* Health system learning with Indigenous
30
31 communities: a study protocol for a two-eyed seeing review and multiple case
32
33 study. *Health Res Policy Sys* 2022;**20**:1-10. [https://doi.org/10.1186/s12961-022-](https://doi.org/10.1186/s12961-022-00873-8)
34
35 [00873-8](https://doi.org/10.1186/s12961-022-00873-8)
36
37
- 38 46. Dudgeon, P, Bray, A, & Walker, R. Mitigating the impacts of racism on Indigenous
39
40 wellbeing through human rights, legislative and health policy reform. *The Medical*
41
42 *journal of Australia* 2023;**218**:203–205. <https://doi.org/10.5694/mja2.51862>
43
44
45
- 46 47. Mohamed Shaburidin, Z, Bourke, L, Mitchell, O *et al.* 'It's a cultural thing': Excuses
47
48 used by health professionals on providing inclusive care. *Health Sociology Review*
49
50 2022;**31**:1-15. <https://doi.org/10.1080/14461242.2020.1846581>
51
52
53
- 54 48. Came, H, O'Sullivan, D, & McCreanor, T. Introducing critical Tiriti policy analysis
55
56 through a retrospective review of the New Zealand Primary Health Care
57
58 Strategy. *Ethnicities* 2020;**20**:434-456. <https://doi.org/10.1177/1468796819896466>
59
60

- 1
2
3 49. Came, H, O'Sullivan, D, Kidd, J, & McCreanor, T. (2024). Critical Tiriti analysis: a
4 prospective policy making tool from Aotearoa New Zealand. *Ethnicities* 2024;**24**:985-
5 1004. <https://doi.org/10.1177/14687968231171651>
6
7
8
9
10 50. Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand. 2025. *Standards*
11 *of competence for registered nurses. Nursing Council of New Zealand.*
12 <https://nursingcouncil.org.nz> (20 December 2025, date last accessed).
13
14
15
16
17 51. Redvers, N, Celidwen, Y, Schultz, C *et al.* The determinants of planetary health: an
18 Indigenous consensus perspective. *The Lancet Planetary Health* 2022;**6**:e156-163.
19 [https://doi.org/10.1016/S2542-5196\(21\)00354-5](https://doi.org/10.1016/S2542-5196(21)00354-5)
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Figure Legend

Figure 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources.

End-matter

Contributorship

Dean Cowles (Ngāti Awa, Hapū Te Patuwai), Research Officer, School of Clinical Sciences, Faculty of Health and Environmental Sciences, Auckland University of Technology, was the primary researcher. Dean led the conceptualisation and design of the study, managed data collection and analysis, and was responsible for drafting and revising the manuscript, as well as overseeing all aspects of project administration.

Dr Jan Dewar (Kāi Tahu), Associate Professor, contributed to the study's conceptual framework and methodology, provided academic supervision and strategic guidance, supported manuscript refinement, and contributed to securing research funding.

Dr Catherine Cook, Associate Professor, offered supervisory oversight, contributed to early-stage conceptual development, and supported critical review and refinement of the final manuscript.

Ethics

Ethics approval was granted by Auckland University of Technology Ethics Committee (AUTEK) on the 29th November, 2022.

Ethics Application: 22/346 Developing a Kaupapa Māori methodology to evaluate the impact of the Ngā Paerewa Health and Disability Services Standard for Māori.

Conflict of Interest

No known conflict of interests.

Data Availability Statement

There are no original data used in the manuscript. All referenced research is available on academic databases.

Acknowledgements

The author acknowledges the kaumātua (respected elders) whose cultural guidance and steady support provided clarity and grounding throughout the research. Sincere thanks are also extended to Māori health leaders for their āwhinatanga (mentorship) and for helping to shape leadership grounded in whakapapa (genealogy and identity). Appreciation is given to the audit agencies who offered valuable insights into audit processes and systems. The support of Auckland University of Technology and the Health Research Council is also gratefully acknowledged for enabling this research and contributing to the broader goal of strengthening Indigenous health Standards.

Funding

This work was supported by the Health Research Council of New Zealand [Health Delivery Research Activation Grant 22/773/A to J.D.].

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 1. Key Indigenous Standards relevant to Australia, Canada and Aotearoa New Zealand.

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori- specific Standards)
Strengthening Relationships and Partnerships	Health service organisations are encouraged to build strong partnerships with local Aboriginal and Torres Strait Islander communities, including Aboriginal community-controlled health services (Actions 1.2 and 2.13).	Collaboration with Indigenous leadership in decision-making and community engagement to ensure services align with community values and needs.	Organisations must actively engage with Māori communities, ensuring Māori governance and leadership input (Te Tiriti o Waitangi principles).
Addressing Equity and Safety Needs	Ensure that Aboriginal and Torres Strait	Focus on identifying and reducing health disparities	Equity of access to services for Māori, with targeted

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori- specific Standards)
	Islander safety and quality care needs are embedded in organisational priorities (Action 1.2). Address specific health needs of Aboriginal and Torres Strait Islander populations (Action 1.4).	experienced by Indigenous peoples, ensuring equitable access to care, and addressing systemic barriers to healthcare.	approaches to reduce health disparities for Māori, as per the obligations of Te Tiriti o Waitangi (Standard 1.2).
Cultural Safety and Respect	Organisations must demonstrate respect for the cultural identity of Aboriginal and Torres Strait Islander clients. (Action 5.8).	Cultural safety and humility training for staff, recognition of the impact of colonisation, and respect for Indigenous cultural	Services must demonstrate culturally safe practice, reflecting Māori values, tikanga, and spiritual beliefs. Whānau must be involved in

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori- specific Standards)
		protocols and practices.	decision-making (Standard 1.4).
Workforce Development	Strengthening the Aboriginal and Torres Strait Islander workforce by increasing employment and supporting professional development (Action 1.33).	Recruitment and retention of Indigenous staff, as well as ongoing training on cultural safety, racism, and Indigenous health needs.	Development of a culturally competent workforce that integrates Te Ao Māori (worldview) principles into health care, with specific strategies for recruitment and retention of Māori staff (Standard 2.3).
Holistic Health Care	Aboriginal and Torres Strait Islander health encompasses physical, social, emotional, cultural,	Emphasis on holistic care models that incorporate traditional healing, medicines, and Indigenous holistic	Health services must incorporate Te Whare Tapa Whā (holistic model of health) and other Māori health

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori- specific Standards)
	and spiritual aspects, reflecting a whole- of-life view of health and wellbeing.	worldviews (e.g., spiritual, emotional, mental, and physical aspects of health).	models, recognising the spiritual, physical, mental, and whānau aspects of wellbeing (Standard 1.1).
Governance and Leadership	Leadership must advocate for Aboriginal and Torres Strait Islander health as a strategic priority, including inclusive governance and policies that reflect the needs of Indigenous communities (Actions 1.2 and 1.21).	Organisations must demonstrate an overarching commitment to Indigenous health equity in governance, strategy, and resource allocation.	Māori should be represented in governance and leadership roles within health organisations to influence decision- making processes (Standard 3.4).

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori- specific Standards)
Data Collection and Reporting	Aboriginal and Torres Strait Islander health data must be collected, analysed, and used to drive improvements in care (Action 1.3).	Indigenous data sovereignty is a key principle, requiring organisations to engage Indigenous communities in data governance, with a focus on culturally appropriate data use.	Continuous monitoring and auditing of service quality for Māori populations is required, integrating community feedback and ensuring accountability (Standard 2.2).
Risk Management and Safety	Ensure care for Aboriginal and Torres Strait Islander patients is well-coordinated, addressing social determinants of health, and involving	Safety and risk management strategies must be adapted to meet the needs of Indigenous patients, particularly in remote areas, with	Services must include Māori cultural values and safety within their risk management practices, ensuring culturally safe

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori- specific Standards)
	family support where appropriate (Action 5.13).	focus on culturally safe care.	environments (Standard 3.1).
Family and Whānau-Centred Care	Family support and inclusion in care coordination for Aboriginal and Torres Strait Islander patients is required (Action 5.13).	Patient and family- centred care must involve Indigenous patients and their families in care planning, decision- making, and risk management.	The Whānau Ora approach emphasises family wellbeing, ensuring that health services integrate family-centred care and decision-making (Standard 1.6).
Traditional Healing and Medicines	Encouraging the recognition of Aboriginal and Torres Strait Islander traditional practices within the	Organisations must facilitate access to traditional Indigenous healing practices and medicines alongside	Services must respect and incorporate Māori traditional healing practices and integrate spiritual

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori- specific Standards)
	healthcare setting where appropriate.	Western medical care.	health care (Standard 1.3).

Table 2. Inclusion and Exclusion Criteria for determining literature relevance and eligibility for this review.

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Topics relating to health sector Standards (policies, regulations, frameworks, guidelines), health outcomes (access, equity, quality), cultural safety. • Peer-reviewed journal articles • Grey literature published by reputable organisations and government publications • Published between 2013-2024 • Written in English • Qualitative research • Studies conducted in Aotearoa New Zealand, Australia and Canada • Inclusive of all genders, all ages, and all levels of health (who have had healthcare experiences) • Indigenous population groups (Māori, Aboriginal, Torres Strait 	<ul style="list-style-type: none"> • Studies not directly related to the topic of this literature review • Unpublished studies or grey literature • Works that are not considered to be scholarly or rigorous (blogs, news articles, webpages) for literature reviews • Studies published prior to 2013 • Quantitative research

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Inclusion Criteria

Exclusion Criteria

Islander Peoples, First Nations, Inuit,
Metis)

Table 3. Search strategy.

Search Terms									
Concept:		Concept:		Concept:		Concept:		Concept:	
Health Sector Standards		Health experiences		Indigenous population		Colonisation		Geography	
Health standards	AN	Impact Effects	AN	Indigenous s	AN	Colonialis m	AN	Aotearoa	
Health policies	D	Outcomes	D	Aboriginal	D	Colonial Settlers	D	New Zealand	
Health regulatio ns	OR	Influence Effecte d	OR	Māori First Nations	OR	Colonise	OR	Australia Canada	
Healthcar e standards		Experience Consequenc e		Inuit Metis					
Healthcar e policies		Shape Ramificatio ns		Torres Strait Islanders					
Healthcar e		Implicate Impinge		Native-born Ethnic					

1
2
3 regulatio

4
5 ns

6
7
8 Standard

9
10 s of

11
12 health

13
14
15 Health

16
17 needs

18
19
20 Healthcare

21
22 e needs

23
24
25
26
27 PubMed

28
29
30 ("Health standards" OR "Health policies" OR "Health regulations" OR "Healthcare
31 standards" OR "Healthcare policies" OR "Healthcare regulations") AND ("Impact" OR
32 "Effects" OR "Outcomes" OR "Influence" OR "Experience") AND ("Indigenous" OR
33 "Aboriginal" OR "Māori" OR "First Nations") AND ("Colonialism" OR "Colonial") AND
34 ("Aotearoa" OR "Aotearoa New Zealand" OR "Australia" OR "Canada"))

35
36
37
38
39 Date Done: 10/09/2024

40
41
42 Results: 450

43
44
45 Reviewed: 15

46
47
48 Used: 4

49
50
51
52
53 Scopus

54
55
56 ("Health standards" OR "Health policies" OR "Health regulations" OR "Healthcare
57 standards") AND ("Impact" OR "Effects" OR "Outcomes" OR "Influence") AND

("Indigenous" OR "Māori" OR "Aboriginal" OR "First Nations") AND ("Colonialism" OR "Settlers") AND ("Aotearoa" OR "Aotearoa New Zealand" OR "Australia" OR "Canada"))

Date Done: 10/09/2024

Results: 18

Review: 4

Used: 1

CINAHL

((MH "Health Policy" OR "Health standards" OR "Health regulations") AND ("Impact" OR "Effects" OR "Outcomes" OR "Experience") AND ("Indigenous" OR "Aboriginal" OR "Māori" OR "First Nations") AND ("Colonialism" OR "Settlers") AND ("Aotearoa" OR "Aotearoa New Zealand" OR "Australia" OR "Canada"))

Date Done: 10/09/2024

Results: 6

Reviewed: 1

Used: 0

JSTOR

(("Health standards" OR "Health policies" OR "Healthcare standards" OR "Healthcare policies" OR "Health regulations" OR "Healthcare regulations" OR "Standards of health" OR "Health needs" OR "Healthcare needs") AND ("Impact" OR "Effects" OR "Outcomes" OR "Influence" OR "Experience" OR "Consequence" OR "Shape" OR "Ramifications" OR "Implicate" OR "Impinge") AND ("Indigenous" OR "Aboriginal" OR "Māori" OR "First

Nations" OR "Inuit" OR "Métis" OR "Torres Strait Islanders" OR "Native-born" OR
"Ethnic") AND ("Colonialism" OR "Colonial" OR "Settlers" OR "Colonise") AND
("Aotearoa" OR "Aotearoa New Zealand" OR "Australia" OR "Canada"))

Date Done: 10/09/2024

Results: 366

Reviewed: 1

Used: 0

SAGE

("Health standards" OR "Health policies" OR "Healthcare standards" OR "Healthcare
policies" OR "Health regulations" OR "Healthcare regulations" OR "Standards of health"
OR "Health needs" OR "Healthcare needs") AND ("Impact" OR "Effects" OR "Outcomes"
OR "Influence" OR "Experience" OR "Consequence" OR "Shape" OR "Ramifications" OR
"Implicate" OR "Impinge") AND ("Indigenous" OR "Aboriginal" OR "Māori" OR "First
Nations" OR "Inuit" OR "Métis" OR "Torres Strait Islanders" OR "Native-born" OR
"Ethnic") AND ("Colonialism" OR "Colonial" OR "Settlers" OR "Colonise") AND
("Aotearoa" OR "Aotearoa New Zealand" OR "Australia" OR "Canada"))

Date Done: 10/09/2024

Results: 480

Reviewed: 10

Used: 5

Citation Searching

Via Auckland University of Technology Library database and online searching

Reviewed: 28

Used: 26

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 4. Key themes.

Key Theme	Number of Studies	Percentage
Cultural Safety rather than cultural competence	20	56
Social determinants of health and inequities (sub-theme)	27	75
Indigenous-led governance and self-determination	18	50
Integration of Indigenous knowledge and holistic approaches	17	47
Anti-racism and structural change	24	67

Figures

Figure 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources.

