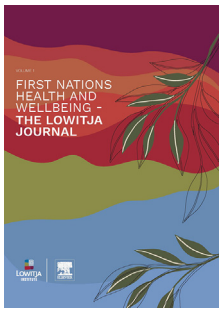

Review

First Peoples' cultural medicines: A review of Australian health policies using an Indigenous critical discourse analysis approach

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Abstract

Purpose First Peoples in Australia tend to have shared holistic understandings of health and wellbeing that emphasise strong interconnections among family, community, culture and Country. Central to this holistic health framework is First Peoples' cultural medicines, which most First Peoples use or want to use, and have been used for millennia to heal the bodies, minds and spirits of First Peoples. This review aimed to explore and document the inclusion and representation of cultural medicines across national level policies and practice guidelines for health professionals. These policies intend to support effective and appropriate healthcare for all Australians, including First Peoples.

Methods Australian national health policies that guide the practice of Australian Health Practitioner Regulation Agency registered health professionals and Aboriginal and Torres Strait Islander health workers/Indigenous

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liaison officers were systematically reviewed to explore their representation of cultural medicines in these policies. The review was informed by Indigenous critical discourse analysis that was modified to suit the review context. National level health policies from March to June 2023 were mapped and 52 policies eligible for inclusion were identified. Policies were downloaded and imported into NVivo for analysis. NVivo text search queries were conducted and nine policies were found to include any content about cultural medicines.

Main findings Three overarching themes were found: 1) Absence of national leadership; 2) Disproportionate onus placed on Aboriginal and/or Torres Strait Islander health practitioners; and 3) Lack of detail and actionable directives. There was a distinct lack of representation of cultural medicines in national health policies, with most of these policies not providing any clear guidance for health professionals. The responsibility was too heavily placed on First Peoples health professionals to lead the healthcare related to cultural medicines.

Principal conclusions The significant lack of national leadership and actionable directives around cultural medicines is concerning. To uphold cultural safety and the rights of Australia's First Peoples, it is critical to have clear policy guidance, resources and training that support all Australian health professionals to engage with cultural medicines and see it as part of their responsibility.

Keywords: Policy; Health system; Traditional medicine; Indigenous Peoples; Indigenous rights; Cultural safety

Highlights

- First Peoples hold holistic understandings of health and wellbeing.
- First Peoples' cultural medicines are the oldest continuing medicines practiced globally.
- National health policies do not include adequate guidance around cultural medicines.
- Disproportionate onus is placed on First Peoples health professionals.
- There is a lack of national leadership around First Peoples' cultural medicines.

Background

Aboriginal and Torres Strait Islander Peoples (respectfully called First Peoples in this review) comprise more than 250 distinct language groups, each with unique cultural practices. Across this rich diversity, First Peoples share a holistic understanding of health that includes interconnections to family, community, culture and Country (Garvey et al. 2021; Fredericks et al. 2011). Underpinning and supporting the holistic health and wellbeing of First Peoples are equally diverse and complex systems of traditional medicines, knowledges and practices that have been passed down orally for millennia and continue to afford physical, spiritual, emotional and cultural benefits for First Peoples (Gall et al. 2018; Gall et al. 2021; Fredericks et al. 2011). While various terms have been used to describe First Peoples' diverse healing practices, this paper uses 'cultural medicines' to reflect the diversity of medicine practiced across different First Peoples' groups and the non-static

nature of those practices, being grounded in First Peoples' traditions that adapt and change across time. Cultural medicines are diverse across Australia and tend to belong to six different areas: 1) physical medicines (inhaled, topical and ingested medicines); 2) native Australian foods (foods as medicine); 3) Ceremony (healing ceremonies, dances and songs); 4) Spiritual medicine (spiritual and energetic medicines); 5) Traditional healers (as determined by each specific language group/clan/nation); and 6) Country as medicine (i.e. both tangible and intangible parts of Country).

Cultural medicines and their underlying philosophies form a medical paradigm that is distinct from the biomedical paradigm that is predominant in healthcare globally. Perhaps because of its ubiquitous application across cultures, biomedicine is often erroneously considered as unbiased and culturally neutral, despite being a cultural artifact of European scientific thinking and reductionist ideology (Harding 1998). Since Australia's colonisation by the British Empire began, paternalistic policies based on the premise of assimilation and grounded in a biomedical approach to healthcare have largely disregarded First Peoples' customs, customary law and culture, including cultural medicines. Despite this, valuable knowledges and practices of cultural medicine have survived and continue to be used to heal First Peoples (Oliver 2013; Gall et al. 2019b; Gall et al. 2021; Gall et al. 2018; Fredericks et al. 2011). However, cultural medicines are not always known or accessible, resulting in many First Peoples seeking out other traditional complementary and integrative medicines (TCIM) to address their holistic health and wellbeing needs (Gall et al. 2018; Gall et al. 2021). Little research attention has specifically been given to First Peoples' use of cultural medicines, with TCIM estimates of usage ranging from 19 to 89 per cent (Gall et al. 2019b; Gall et al. 2018; Gall et al. 2021). While usage of these medicines may be high among First Peoples, some First Peoples report feeling unsafe to disclose their use to health professionals (Gall et al. 2019b; Prior 2009), describing feelings of reluctance and fear if they perceive that the healthcare environment lacks respect or value of First Peoples' culture (Gall et al. 2019b; Prior 2009).

The substantial benefits of cultural medicines are known to First Peoples, as described by First Peoples' Elders nationally. Cultural medicines are the oldest continuing medicine in the world, having been practiced since time immemorial, enabling First Peoples to not only survive, but thrive in this country. Research has recently explored the contemporary use of cultural medicines, both as a standalone modality and in complement with biomedical treatments for all people; First Peoples reported benefits of a spiritual, emotional and cultural nature, whereby cultural medicines brought holistic balance to the whole being (Gall et al. 2019a; Gall et al. 2019b; Gall et al. 2021; Gall et al. 2018). Despite these clear benefits, a range of barriers to safe and sustained access and usage of cultural medicines have been identified. Firstly, colonisation has impacted First Peoples' ability to access and use their cultural medicines, with practicing one's culture previously considered to be illegal, forcing cultural medicines and associated practices to 'go underground' in order to protect them; this has had very real implications for First Peoples' health and wellbeing (Dudgeon et al. 2023). Challenges in cultivating native Australian foods and physical medicines are rapidly mounting due to environmental degradation and ecological changes in Australia's landscape, as well as increasing restrictions and constraints on land access for First Peoples (Standen et al. 2022). Additionally, barriers to cultural medicines usage include: poor awareness of cultural medicines among health professionals and health services (Gall

et al. 2019a); the lack of universal subsidies for treatment; colonial academic institutions that have historically marginalised, misrepresented and ignored First Peoples' knowledges; difficulties with sustained funding for local cultural medicines programs; and a lower authority and status of cultural medicines, which are typically considered as a last resort, discounted or appropriated in the therapeutic environment (Wedel 2009; Fredericks et al. 2011). Further, health professionals report feeling ill equipped and poorly supported to advise or discuss cultural medicines with their patients (Gall et al. 2019a; Mollart et al. 2019; Pirotta et al. 2010). Broad barriers to ensuring access to cultural medicines through the mainstream health system include: limited accreditation mechanisms for cultural medicines and traditional healers, and a lack of regulatory governance structures (Williams et al. 2023) (noting that current accreditation and regulation practices are not appropriate for cultural medicines and its healers, needing fundamental change to ensure that they align with First Peoples' culture). These extensive arrays of structural barriers are substantially hindering widespread access to and usage of cultural medicines, limiting the important benefits that cultural medicines can afford First Peoples and all Australians.

Underpinning Australia's healthcare system is a network of policies and guidelines, termed healthcare policy (World Health Organization 1999; de Leeuw et al. 2014), which provides a critical framework for the regulation of all aspects of health services and professionals. Healthcare policy comprises a variety of documentation, including: government policy directives and guidelines, disease-specific optimal care pathways, and hospital guidelines and standard operating procedures (de Leeuw et al. 2014). Australia's healthcare system is structured within a three-tiered governmental framework: federal, state/territory and local. There are eight state/territory jurisdictions, each responsible for overseeing a range of government departments, along with private and not-for-profit service providers (Australian Institute of Health and Welfare 2018). The federal government focuses on resource allocation and national policy, whilst states and territories mostly deal with healthcare delivery. All levels of government create and regulate healthcare policy (Australian Institute of Health Welfare 2022) and healthcare policy directly guides and impacts all aspects of healthcare (Horrill et al. 2019). Representation of cultural medicines in Australian healthcare policy is currently unknown; however, anecdotal accounts from First Peoples health professionals suggest an absence of guidance around cultural medicines in national health policies, to inform and support them when a patient is using or wanting to use cultural medicines. This apparent lack of policy guidance around cultural medicines is a significant concern, given its importance in First Peoples' culture and value in supporting their unique health and wellbeing needs.

To address this knowledge gap, this study aimed to explore and document the inclusion and representation of cultural medicines across national level policies and practice guides for health professionals. It identified any policy gaps in the guidance for Australian health professionals to support and advise their patients around the use of cultural medicines. Specifically, it aimed to find out two things: 1) Are there any national level health policies in Australia that are likely to have an impact on healthcare provision, that provide guidance for health professionals on First Peoples' cultural medicines? 2) If any do have this guidance, what discourse is used to describe cultural medicines and how might it impact the perceptions of cultural medicines of those who

read it? To achieve this, Australian national health policies that guide the practice of the Australian Health Practitioner Regulation Agency (Ahpra) registered health professionals and Aboriginal and Torres Strait Islander health workers/Indigenous liaison officers were systematically reviewed to explore and synthesise their inclusion and representation of cultural medicines in these policies. Further, the discourse of cultural medicines in these policies was critically examined and the likely impact this has on both practice and society was considered.

Methods

Acknowledgement of Country

All of this work was only made possible by our Mother, by Country. We acknowledge Country by paying tribute to her in the words of Elder Aunty Theresa Sainty. Aunty Theresa is a prominent Elder from Lutruwita (now called Tasmania) who wrote these words to honour Country in our work. She is a co-author of this paper and an Elder Governor providing cultural guidance over all our research. We honour her and pay our respects to her.

> *Country is not necessarily nature. In fact, Country is both the tangible and intangible. She is what we see; but also what we know to be, to feel; Sky Country – the stars, planets etc – are our ancestors. Being able to look and see our star ancestors is part of maintaining our health and wellbeing; Sea Country/Freshwater Country – just by visiting such places lifts our spirit; thereby having a positive effect on our health. Even when we walk in a park in the middle of a concrete jungle, we do so in the knowledge that those Old People who have come before us also walked there, held ceremony there, spoke and sang to Country and danced for her.*

Author positionality

When conducting research, transparency is important to enable critical scrutiny of the findings. This includes a positionality statement to provide insight into the lens and potential paradigms and biases of those people conducting the work. Authorship includes eight First Peoples (AG, DA, NH, MK, TS, AH, ZG, ATG) and five non-First Peoples allies (MS, JW, MC, AF, KA). Specifically, authorship includes two First Peoples Elders (TS, ATG), one First Peoples young person (ZG) and five key sector representatives (MS, MK, AH, MC, AF). Lastly, the authors have experience across multiple sectors, including: extensive expertise in policy (MS, AF, MC, AH, JW), education (DA, TS), public health (AG, MS, NH, MK, AH, KA, MC, JW, ZG), First Peoples health and wellbeing research (AG, NH, MK, KA, ZG, ATG, JW) and cultural medicines (AG, JW). The authors form a co-design research group (CoDeR group) for a larger co-design project (excluding MC and AF).

Policy mapping

Authors AG and MS developed the policy mapping process, which is a new and novel approach, drawing on AG's experience conducting reviews and MS's knowledge of policies and the health system. The policy mapping process was conducted from 2 March to 8 June 2023, and included three steps: 1) collaboratively define inclusion and exclusion criteria and develop initial policy map; 2) internal expert review by both policy experts and the CoDeR group, to refine the inclusion/exclusion criteria and agree on the policy mapping process; and 3) external expert review of mapped policies by First Peoples health professionals to assess whether the identified policies are relevant and exhaustive. The detailed policy mapping process can be seen in Figure 1 and the finalised inclusion and exclusion criteria are shown in Figure 2.

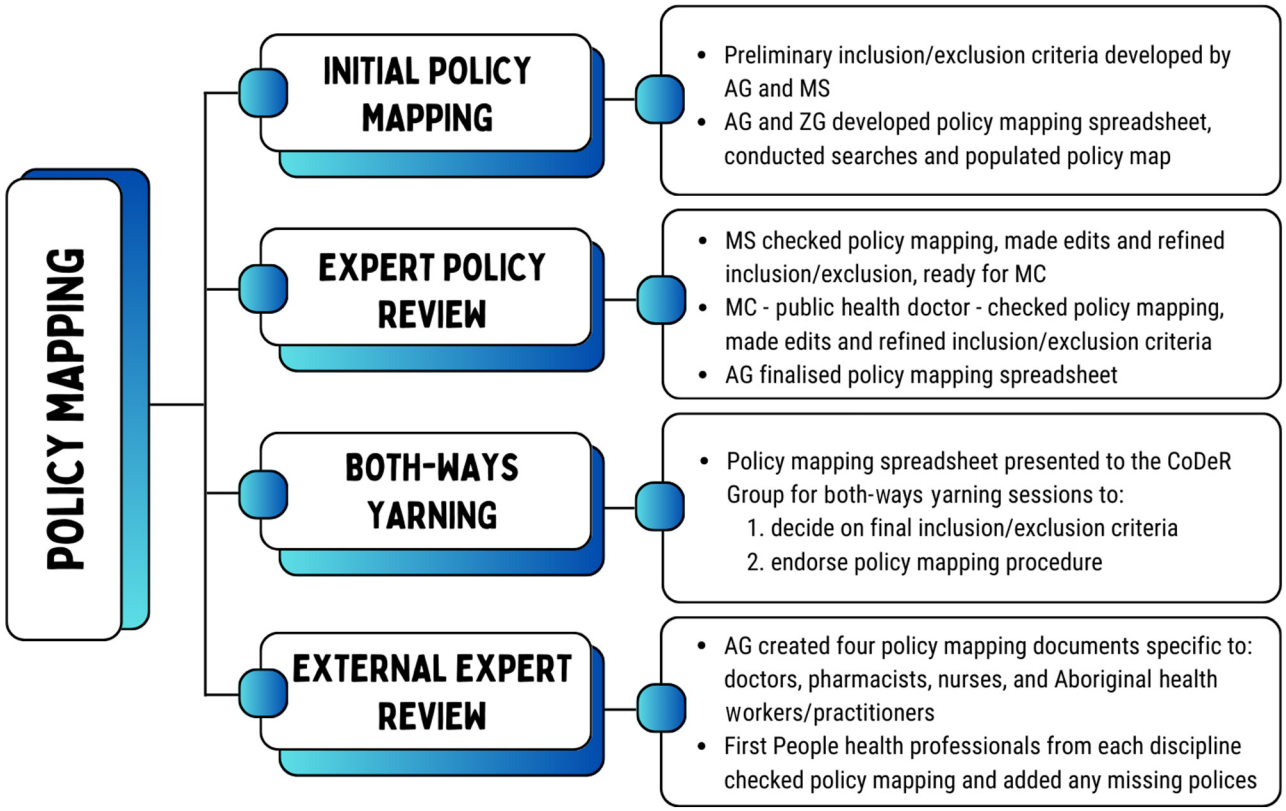

Figure 1: Detailed policy mapping process.

Data extraction

All included polices were uploaded to NVivo 12 (NVivo 12) ready for data extraction. Text search queries in NVivo were used to locate relevant content related to cultural medicines in the policies. Initial search terms were developed using terms that AG had previously used (Gall et al. 2021; Gall et al. 2018), and new terms with greater specificity for cultural medicines. Search terms were tested and reviewed by the CoDeR group to determine the final set of terms. Due to the lack of a universally accepted definition of cultural medicines, discussions centred around what aspects of cultural medicines would need to be represented in policies for cultural medicines to be considered 'included' in the policy. For this reason, while cultural medicines are understood to include traditional healers, physical plant medicines, healing ceremonies, traditional foods, Spirit/Spirituality and Country as our nurturer and healer, only explicit mentions of cultural medicines were deemed appropriate to answer the research question. As such, the CoDeR group agreed on the final search terms (Figure 3) to identify cultural medicines content for extraction. AG conducted the Nvivo text search queries, and extracted other relevant data needed for analysis (see Analysis), including: authoring organisation, policy title, target audience, First Peoples' involvement in the policy development (as determined by inclusion of community-controlled organisations or

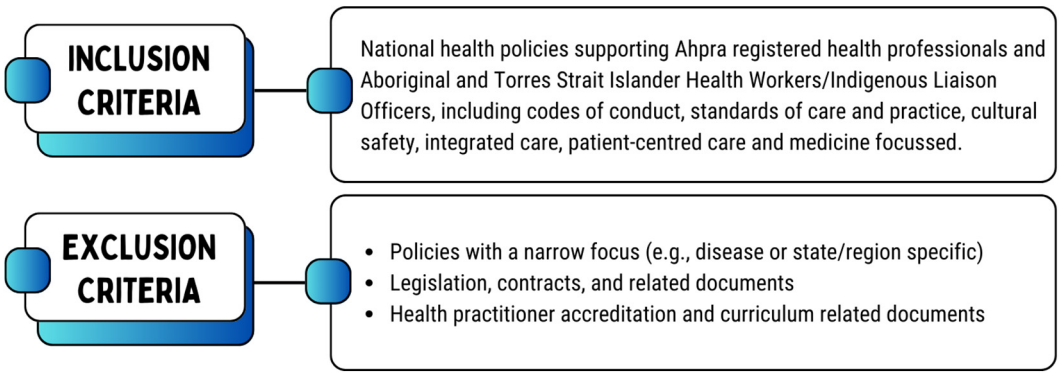

Figure 2: Policy inclusion and exclusion criteria as agreed by the co-design group.

individuals identified as such in the policy), and cultural medicines content (including where the content was located within the policy).

Analysis

Indigenous critical discourse analysis – modified

This review drew on a theoretical and methodological analysis approach developed by Hogarth (2017) called Indigenous critical discourse analysis (ICDA) (Hogarth 2017). Hogarth purposively brings together Rigney's (1999) Indigenist research principles and Nakata's (2007) Indigenous standpoint theory and aligns them with Fairclough's (1989) critical discourse theory (Rigney 1999; Nakata 2007; Fairclough 1989). This serves a dual purpose: 1) providing an Indigenous theoretical base combined with authors' positionality and Indigenist lens; and 2) overlaying an established discourse theory that highlights the power of language to maintain, legitimise or ignore social inequalities and injustice. Indigenous Critical Discourse Analysis provides First Peoples with a strategy of resistance to the highly prevalent deficit discourse evident across multiple sectors in Australia (Hogarth 2017).

Hogarth's ICDA method proposes two main levels of analysis: 1) Descriptive and 2) Interpretation and explanation; where level one looks at the textual features of the policy itself and drills down into any areas of particular interest or concern, and level two is a much broader analysis of how those textual features then interact with, and potentially impact on and in, society. Further critical discourse analysis in general provides a contextual analysis that delves into the

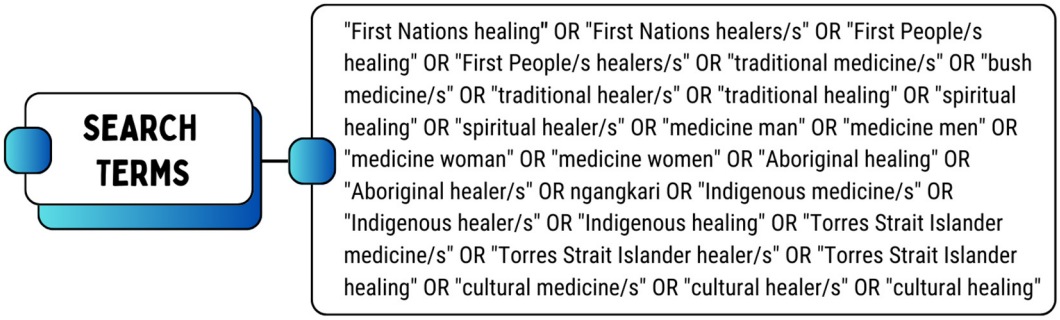

Figure 3: Final search terms for NVivo 12 text search queries.

history of the piece of literature under review. These three levels of analysis are well suited to the scrutiny of a single policy and provide extensive and deep insights into its discourse. However, for the purpose of this multi-policy review, these aspects of ICDA and other critical discourse analysis methods were modified to then analyse and describe the contents of a set of policy documents to suit the review context (Figure 4).

To achieve this, the cultural medicines content in each policy was focused on and the textual features data were aggregated to compare and contrast themes across the policy documents that were identified through the ICDA method. Further, as textual feature analysis of the entirety of the policy text was unsuitable to conduct across disparate policies, but was important to providing the underlying context behind the textual features used within the policies, this study focused on the cultural medicines content of each policy at the descriptive level. The findings were then presented under three main sections:
1. Policy characteristics (whole aggregated dataset);

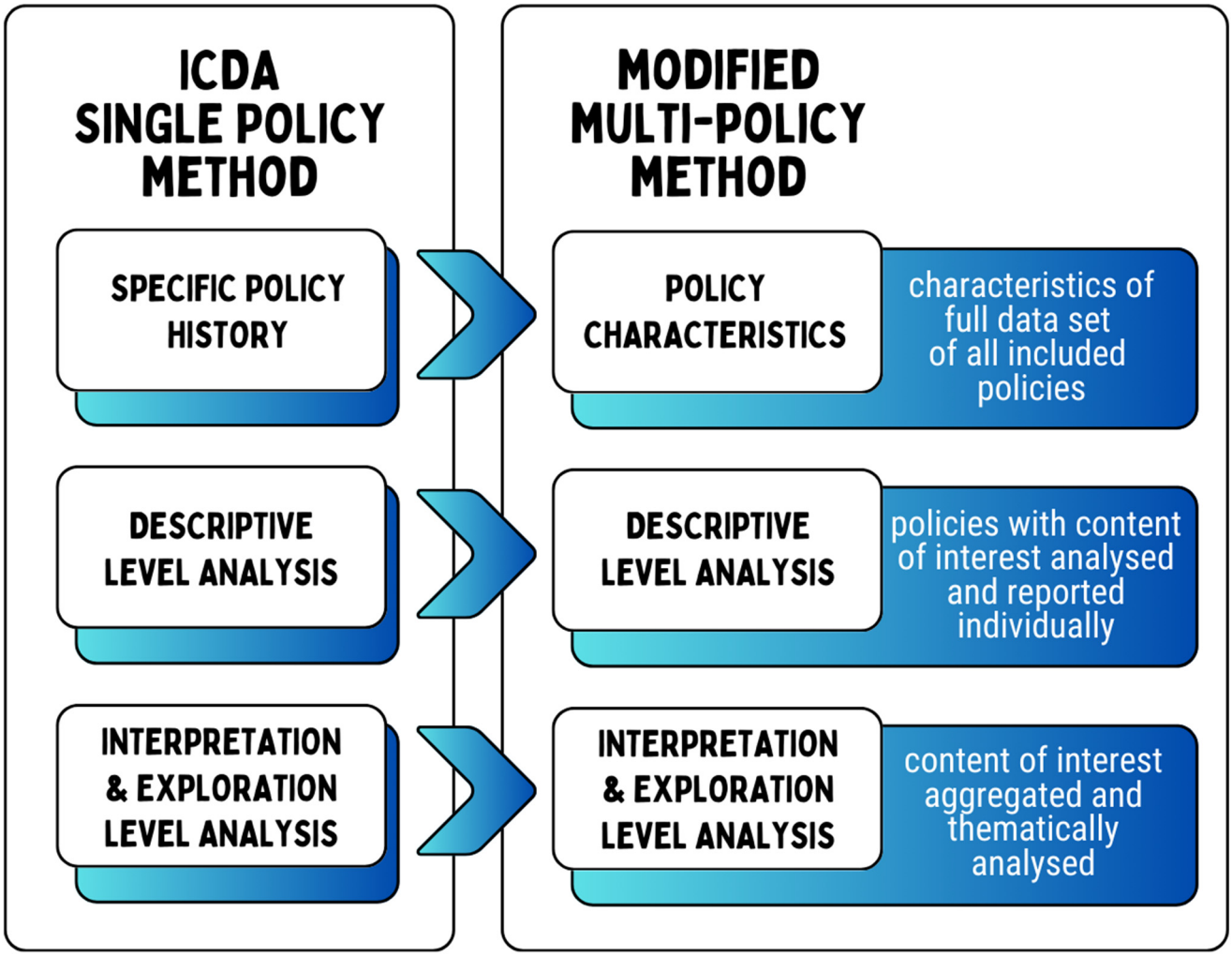

Figure 4: Modification of the Indigenous critical discourse analysis (ICDA) method for use with a multiple policy review.

2. Descriptive level (only the cultural medicines content of each policy); and 3. Interpretation and explanation (aggregated cultural medicines content data). Section 1 provides a high-level overview of the 52 included polices and a basic contextual analysis. Section 2 looks at each of the policies that included any cultural medicines content individually, providing a descriptive analysis of the included cultural medicines data. Section 3 takes a deeper dive into the aggregated descriptive content provided in Section 2, providing findings at the interpretation and explanation level.

Initial analysis

To perform initial analysis of the data and provide context around the included policies, AG developed questions based on the review research question and guided by the ICDA analysis method. It is important to note that these questions were used as a guide when coding and analysing the data; they did not form distinct headings in the results. Specifically, the data were asked seven questions: 1) Where is the cultural medicines content located within the policy documents? 2) How is the cultural medicines content framed? 3) Was the inclusion of cultural medicines content purposeful? 4) Does the policy provide any specific guidance around cultural medicines? 5) What discourse was used to describe cultural medicines (e.g. value laden, deficit or strengths-based)? 6) Do the policy authors make their views regarding cultural medicines clear? and 7) What impact is the policy likely to have on practice? AG conducted initial analysis of the data using these guiding questions and sent the initial findings to the authorship for comment. AG then refined the initial findings to incorporate the feedback, before initiating collaborative yarning.

Collaborative yarning

To facilitate the analysis process, collaborative yarning (Bessarab and Ng'Andu 2010; Shay 2021) was used with the CoDeR group to ensure that a collective of First Peoples guided the analysis process to ground the approach and findings in First Peoples' worldviews (however, as there are no Torres Strait Islander people in the CoDeR group, their distinct views were missing). Collaborative yarning is a culturally appropriate method of analysis that uses a flexible and inclusive approach to allow multiple researchers and stakeholders to be more engaged with the process of the research and co-analysis of the data (Bessarab and Ng'Andu 2010; Shay 2021). AG held two collaborative yarning sessions: the first with majority First Peoples CoDeR group members, and the second with non-Indigenous and First Peoples members combined.

Analysis process

AG conducted the initial analysis by firstly coding each policy with cultural medicines content using standard ICDA methods. Extracted data were analysed to first look at those policies that included cultural medicines content from a descriptive level, then the interpretation and explanation level. Initial findings were presented at the first collaborative yarning session, where as a group the findings were interrogated and ultimately agreed upon. The updated findings were then presented at the second collaborative yarning session, undergoing the same process. AG then updated the findings and aggregated the data together under common themes extracted under ICDA analysis methods, to present the themes in a review format. These updated themes were disseminated to all authors for comment. The results of this iterative and collaborative process are presented here.

Results

Section 1: Policy characteristics

A total of 52 national health policies that guide the practice of Ahpra registered health professionals and

Aboriginal health workers/Indigenous liaison officers were included in this review. These policies were authored by the Australian Commission on Safety and Quality in Health Care (ACSQHC) (n = 5) (Australian Commission on Safety and Quality in Health Care 2024), Ahpra and National Boards (n = 19) (Ahpra & National Boards 2024), Central Australian Rural Practitioners Association Inc. (CARPA – which produce clinical guidelines used throughout remote and Central Australia) (n = 4) (Central Australian Rural Practitioners Association Inc 2024), the Australian Federal Government (n = 11) (Parliament of Australia ND), Pharmaceutical Society of Australia (PSA) (n = 4) (Pharmaceutical Society of Australia 2025), Royal Australian College of General Practitioners (RACGP) (n = 6) (Royal Australian College of General Practitioners 2025), and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) (n = 3) (National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners 2025) (see Appendix A for full data set).

A notable lack of cultural medicines content was evident across and within the 52 policies, with nine of the policies including any explicit mentions of cultural medicines, and some of these only including cursory references to cultural medicines: one by ACSQHC, one by Ahpra, four by CARPA, two by the Australian Federal Government and one by PSA. Of these nine, seven included First Peoples in the development stage of the policy, with varying levels of involvement identified. Relevant target audiences for the policies included health professionals working in rural and remote locations (n = 4), health services in general (n = 3), pharmacists (n = 1) and Aboriginal and Torres Strait Islander health practitioners (n = 1). Of the nine policies that included cultural medicines content, one is authored by ACSQHC and one by Ahpra, which are two organisations that are the key health service accreditation and health professional regulation bodies in Australia. Failure to adhere to the policies of these organisations has direct impact on the health service (Australian Commission on Safety and Quality in Health Care 2023) and health professionals (Ahpra & National Boards 2022) working within it. Most of the other included policies are explicitly positioned as subordinate to ACSQHC and Ahpra policies.

Section 2: Description of cultural medicines within each policy

The findings of this analysis of the representation of cultural medicines within the policies that included some cultural medicines content are individually presented for each of the nine policies, followed by a short synthesis of the overarching representation of cultural medicines across the policy landscape. The extracted policy references to cultural medicines are presented verbatim in Appendix B.

Policy 1: National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health (authored by ACSQHC)

The National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health (User Guide) is a manual to accompany the National Safety and Quality Health Service (NSQHS) Standards intended to support health services to implement First Peoples-specific actions included in the NSQHS Standards. The NSQHS Standards aim to 'protect the public from harm and to improve the quality of health service provision' (Australian Commission on Safety and Quality in Health Care 2021); the standards are mandated in all hospitals, day procedure services and public dental services in Australia. The User Guide includes six actions from the NSQHS Standards specific to First Peoples' health: four actions under the Clinical Governance Standard; one under the Partnering with Consumers Standard; and one under the

Comprehensive Care Standard. The User Guide contents are not mandated. The search identified three cultural medicines references in this policy.

Cultural medicines reference 1.1 – Policy 1 (p. 32). The cultural medicines content found in this section pertains to Action 1.33 in the National Standards: 'Action 1.33: The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.' (NSQHS Standards p.12). The reference is in Action 1.33 within the User Guide, under the heading 'Creating a Welcoming Environment'. In this policy, a 'welcoming environment' is described as one that allows First Peoples to feel safe, comfortable, accepted, respected, listened to and to receive high-quality care. Reference 1.1 is in the final section of Action 1.33, where 'suggested strategies' to achieve this action are provided. This reference suggests that 'traditional practices' may include cleansing ceremonies and 'bush medicines' (a term sometimes used when referring to the 'physical medicines' domain of cultural medicines). The policy states that the development of these policies and protocols should be guided by the local First Peoples' acceptable practices. While they do not give instruction around how to ascertain acceptable practices, they acknowledge the need for a place-based approach. This is important for First Peoples who come from various nations/language groups with distinct cultural practices. The 'Examples of Good Practice' section at the end of the policy includes case studies exemplifying how the actions in the User Guide have been implemented in practice. Three case studies include the development or presence of a 'cultural garden'; however, no detail is given about the nature or reason for the garden and there is no reference to the garden as cultural medicines.

Cultural medicines reference 1.2 – Policy 1 (p. 45). The cultural medicines content in this section pertains to Action 2.13 in the NSQHS Standards: 'Action 2.13: The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs.' (ACSQHC Standards p. 19). It is in the last section, 'Examples of Good Practice', where case studies are provided on how health services have worked in partnership with First Peoples' communities. There is no mention of cultural medicines in the main body of this document under Action 2.13. Further, the main section of the policy is focused on health professionals and health services partnering with the community, so the examples are presented within this context. Cultural medicines reference 1.2 relates to Ngangkari, the 'traditional healers of the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara (NPY) lands in the remote western desert of Central Australia' (Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council 2023). The example describes Ngangkari providing support to the health service in the form of literacy and resources. There is no mention of Ngangkari providing cultural medicines.

Cultural medicines reference 1.3 – Policy 1 (p. 49). The cultural medicines content in this section pertains to Action 1.2 in the User Guide: 'Action 1.2: The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people.' (User Guide p. 48). The cultural medicines content is also listed under 'Examples of Good Practice' and not mentioned in the main sections of the policy. Reference 1.3 describes an example of good practice, where a service developed a policy to enable patient access to Ngangkari services: 'Developed a policy to allow [N]gangkaris to provide care to patients in the hospital, at the patient's own cost' (p. 49). This was not included as an example under Action 1.33. This

reference also includes mentions of Ngangkari doing a 'welcome' to open the emergency department, and that they 'organised [N]gangkaris from different language groups to cleanse the hospital as required, based on patient feedback'. While these references to Ngangkari provide examples of how cultural medicines healers can work alongside a health service, they are not about the cultural medicines, rather how Ngangkari achieve 'cultural safety' for the hospital. There is no mention of how the Ngangkari are included and to what capacity or extent, which does not present any guidance on cultural medicines use in the clinical space for health professionals.

Policy 2: Professional capabilities for registered Aboriginal and Torres Strait Islander health practitioners (authored by Ahpra)

Ahpra works in partnership with 15 different national boards to '…ensure that Australia's registered health practitioners are suitably trained, qualified and safe to practice'. Ahpra develops the policies and sets standards that all registered health practitioners must meet to be able to practice in Australia. This policy provides the scope of practice for Aboriginal and Torres Strait Islander health practitioners (Aboriginal and/or Torres Strait Islander health practitioners), outlining Aboriginal and/or Torres Strait Islander health practitioners' capabilities that facilitate their ability to 'practice safely' and maintain their registration to practice in Australia. This policy is arguably one of the highest in the hierarchy of policies that impacts clinical practice. The search identified one cultural medicines reference in this policy.

Cultural medicines reference 2.2 – Policy 2 (p. 13). The cultural medicines reference in this section is listed under 'Domain 2: Professional and ethical practitioner' and specifically capacity 4: 'Advocate on behalf of the patient/client and their family when appropriate'. This content in Reference 2.2 juxtaposes the terms 'traditional healing/medicine' and 'alternative pathways for healing', which causes ambiguity about the type of traditional medicine being referenced and a lack of clarity of whether this refers to cultural medicines or not. Further, this section is vague in its articulation of how Aboriginal and/or Torres Strait Islander health practitioners might advocate for clients who prefer cultural medicines, stating they should '… make recommendations to other practitioners' when they 'recognise' that it is 'appropriate to intervene'. Placing this responsibility on Aboriginal and/or Torres Strait Islander health practitioners assumes that they have appropriate knowledge to advocate for their clients on issues surrounding cultural medicines, have the respect of other health practitioners, and have the authority to make this decision on a patient's behalf. Whilst the policy supports this 'enabling component' of Aboriginal and/or Torres Strait Islander health practitioners' key role capabilities, the reality of how it is enacted in a healthcare setting is unclear.

Policies 3 to 6: CARPA remote primary healthcare suite of manuals

This suite of four remote primary healthcare manuals was developed via a collaboration between the Central Australian Aboriginal Congress, CARPA, CRANAplus and Flinders University. The manuals included in this suite are the CARPA 'Standard treatment manual for remote and rural practice', 'Women's business manual for remote and rural practice', 'Clinical procedures manual for remote and rural practice' and 'Medicines book for Aboriginal and Torres Strait Islander health practitioners'. A statement prefaces each of these manuals, specifying that these manuals do not permit the health practitioner to work '…outside their scope of practice or health service policies', which positions these manuals as subordinate to other polices, like the two included above (Ahpra and ACSQHC – see Figure 5). This hierarchy is important to consider when

assessing the references to cultural medicines in these manuals.

Cultural medicines reference 3 to 6.1 – Policy 3 (p. x); Policy 4 (p. x); Policy 5 (p. 2); Policy 6 (p. 8). Three of the manuals include a statement under the 'Cultural tips' section of the manual around the importance of acknowledging, respecting and listening to community members about their cultural practices. The cultural medicines reference is itself quite brief; however, it is grouped with the second point, which explains that cultural medicines use is 'common' and that it is 'very important' that health professionals 'acknowledge, respect and listen' to their patients about their cultural medicines use.

In the Clinical procedures manual, the statement is included under the 'Cultural safety' section at the beginning of this document. While this mention of cultural medicines is similar to the other three manuals, there is an additional statement: 'Traditional medicines/therapies can work in conjunction with Western medicine'. While notable, this does not provide advice on what to do if a patient discloses cultural medicines use or seeks guidance around cultural medicines use. Use of the words 'can work' could indicate the authors' non-committal approach to cultural medicines; however, the iteration that cultural medicines is 'very important' to consider when working with a patient prompts the reader to consider their preconceived ideas towards cultural medicines. Use of the word 'in conjunction' suggests an active role of cultural medicines in a patient's health; however, the presence of this phrase also suggests that cultural medicines will not 'work' without conventional biomedicine being present. There is also, potentially, a challenge posed to the reader here, who is likely/potentially biased towards biomedicine and potentially naive or against cultural medicines.

Cultural medicines reference 3.2 – Policy 3, Standard treatment manual for remote and rural practice (p. iv). Cultural medicines are mentioned here under the 'Preface' in reference to the artwork included on the cover of the policy. It is stated that 'The painting tells the story of some women who are ill due to the

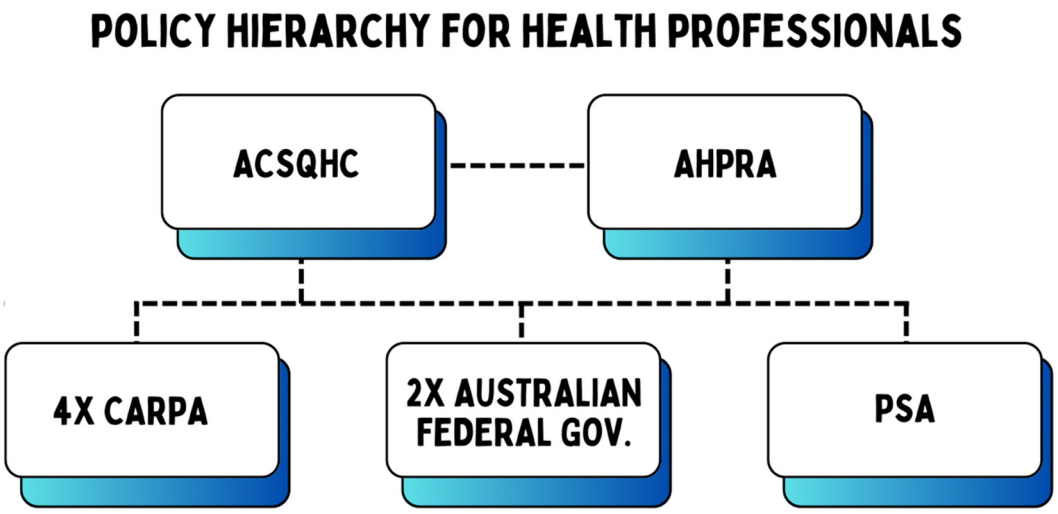

Figure 5: Hierarchy of the nine policies that included cultural medicines content.

loss of their 'souls' (kurrunpa). They are being healed by Ngangkaris (traditional healers) who are restoring their souls.' This description of the painting gives a small insight into what a Ngangkari can do, but is not intended to form part of the clinical practice recommendations within this policy. It represents a respectful inclusion of cultural medicines in this policy; however, the painting itself is not included in the digital downloadable version of this policy.

Cultural medicines reference 3.3 – Policy 3, Standard treatment manual for remote and rural practice (p. 465). Cultural medicines are mentioned once more in the CARPA Standard treatment manual, under 'Rashes' in section 7 of the policy. This inclusion of cultural medicines is simply advising the health practitioner to ask a patient who presents with a rash if they have used any 'bush medicine' or other alternative medicines, suggesting the use of such medicines as being the potential cause of a rash. There is no inclusion of cultural medicines as a possible treatment, despite the use of cultural medicines as a treatment being mentioned in the opening of the policy.

Cultural medicines reference 4.2 – Policy 4, Women's business manual for remote and rural practice (p. 317). The only other explicit* mention of cultural medicines is in the 'Menopause' chapter of the CARPA Women's business manual for remote and rural practice, under the heading 'Treatment of specific menopause problems'. The words 'Traditional methods used by grandmothers or traditional healers' are listed after 'Hypnosis, cognitive behavioural therapies, Vitamin E' under the heading 'Complementary therapies'. Like other mentions of cultural medicines reported in this review, this grouping of cultural medicines with other complementary medicines convolutes the two and implies reduced importance of cultural medicines to First Peoples. This gives the impression that accepting and validating cultural medicines may be a clinical risk, thereby dismissing the importance of cultural choice for First Peoples seeking to access locally derived cultural medicines.

Cultural medicines reference 5.2 – Policy 5, Clinical procedures manual for remote and rural practice (p. 379). Cultural medicines is only mentioned once within the clinical section of this policy; in Chapter 11 under 'Management plan', then 'Do', then 'Psychological health'. There are two dot points in succession, stating: 'Consider involving traditional healers. Family will advise and arrange.', then 'Self-help strategies – use family/friends for support and rest, cultural activities (e.g. hunting, painting, spending time on country, bush medicine)'. Both of these inclusions promote self-determination of the patients in this setting, specifically in relation to mental health. However, they do not give any clear indication for health professionals more broadly, especially in relation to all aspects of the patient's health. However, there are no clear protocols or information for health professionals supporting First Peoples with a variety of needs to work two-ways across modalities enshrined in patient choice.

Cultural medicines reference 6.2 – Policy 6, Medicines book for Aboriginal and Torres Strait Islander health practitioners (p. 24). This policy is specifically directed at Aboriginal and/or Torres Strait Islander health practitioners, stating that it has been provided because Aboriginal and/or Torres Strait Islander health practitioners 'may not be able to access or read other common medicine reference books'. Under the heading '6 steps to follow when supplying a medicine', the cultural medicines content is located under 'Step 2 – Follow the RIGHTS', where

*Note: the chapter on 'Labour and birth' contains references to First Peoples' traditional birthing practices, which include ceremonies and rituals. However, this review only included explicit mentions of cultural medicines to answer the research question.

the policy methodically steps the Aboriginal and/or Torres Strait Islander health practitioners through a checklist of things they need to ensure are 'right' in the content of providing medicines. Under the heading 'RIGHT medicine' it states: 'Is it [the medicine] safe for this person: ALWAYS ask about allergies, pregnancy, breastfeeding, other medical problems (e.g. kidney trouble), other medicines including over the counter and bush medicines'. This statement is immediately followed by 'could it interact with other medicines the person is taking?', which needs to be understood as referring to the new medicine that is potentially being provided by Aboriginal and/or Torres Strait Islander health practitioners. While in theory this should lead to the cultural medicines taking precedent over the new medicine being given, the lack of a clear recommendation or stipulation to that effect renders this unlikely.

Policy 7: National Medicines Policy 2022 (authored by Australian Government)

The Australian Government's National Medicines Policy 2022 (NMP) is a 'refresh' of the previous version released in the 2000s (Department of Health and Aged Care 2022b). The Australian Government formed a committee to undertake stakeholder consultation to update this 'high-level framework focused on the availability and the use of medicines and medicines-related services' (p. 1). While the previous version of the NMP did not include any mention of cultural medicines, the current NMP includes one mention of cultural medicines.

Cultural medicines reference 7.1 – Policy 7 (p. 1). Previously in the NMP, cultural medicines were assumed to be included under the terminology 'traditional medicines'. The 2022 version has explicitly named cultural medicines and describes them as 'therapeutic options, products and interventions used to prevent, treat, monitor, manage or cure a disease or health condition'. This addition is an acknowledgement of the legitimacy of cultural medicines and distinguishes them from other types of 'traditional medicines' in Australia. While an important and pivotal change for this policy, this does not provide any guidance to health professionals.

Policy 8: National Aboriginal and Torres Strait Islander Health Plan 2021–31 (authored by Australian Government)

The National Aboriginal and Torres Strait Islander Health Plan 2021–31 (Health Plan) was developed in '… true partnership between the Health Plan Working Group and Implementation Plan Advisory Group, comprised of Aboriginal and Torres Strait Islander health experts, and governments' (p. 4). The policy contains three mentions of cultural medicines.

Cultural medicines reference 8.1 – Policy 8 (p. 62). In this reference, cultural medicines are framed within the context of culturally safe care that is 'trauma aware', 'healing-informed' and is said to 'prioritise healing'. However, the guidelines around achieving culturally safe care are prefaced with the conditional language 'where possible', demonstrating the passivity of ensuring culturally safe care as merely a plight that may or may not be achievable, rather than the key ingredient to the positive experience, trust and wellbeing of First Peoples. Despite instruction to 'facilitate access to traditional healers', there is no guidance on how to achieve this. The reference to cultural medicines here is within the context of mental health and suicide prevention.

Cultural medicines reference 8.2 – Policy 8 (pp. 72 and 89). The only other sections where cultural medicines are included in this policy appear to have been inadvertently included. On pages 72 and 89, cultural medicines are mentioned as being part of the case

studies included in the policy to highlight other issues. One reference to cultural medicines is the Mayi Kuwayu study (The National Study of Aboriginal and Torres Strait Islander Wellbeing), which lists 'traditional healing' under the 'cultural domain' that they are collecting data on for their research study. The second reference to cultural medicines is part of Case study 7, which talks about a service that listed 'traditional medicine' at the end of a list of services provided. It is unclear whether this is referring to cultural medicines or other traditional medicines (e.g. Traditional Chinese medicine). Regardless, both of these mentions do not provide any guidance to health professionals around cultural medicines.

Policy 9: Guideline for pharmacists supporting Aboriginal and Torres Strait Islander Peoples with medicines management (authored by Pharmaceutical Society of Australia)

Owing to its specificity regarding physical medicines in Australia, this discipline-specific policy was included in the original mapping. While this policy is influential, it has far less impact on the practice of pharmacists than policies of Ahpra, and arguably no direct impact on other health professionals. This is largely owing to it being a non-compulsory tool to guide quality practice. However, it remains an important overarching policy in the medicine space that has potential to impact other policies and practice, and was therefore included in this review.

Cultural medicines reference 9.1 – Policy 9 (pp. 10–11). There are three instances where cultural medicines are mentioned in the 'terminology' section of this policy, under 'bush medicines' on page 10, and 'medicines list' and 'traditional healing' on page 11. The presence of cultural medicines in this section of the policy points towards them being included in a meaningful enough way within the policy itself to warrant explanations in this section.

The definition of the term 'bush medicine' includes two sentences: the first frames this medicine as only being used by First Peoples, and the second states that this 'practice is ongoing and has been in place for thousands of years', speaking to both the non-static nature of cultural medicines and long history of use.

The definition of the term 'medicines list' includes one sentence that explains what is included under this term. The surprising part here is the part '… complementary, bush or alternative medicines, and traditional healing forms.' Here we see 'bush' is its own word, separate to 'complementary' and 'alternative' so it is not conflated with these other medicines. Also, this is further emphasised by the inclusion of 'traditional healing', which is defined further down in the policy on the same page.

The last definition, 'traditional healing', is simply stated as meaning 'The use of traditional healers, healing songs and bush medicine' which indicates that this terminology is explicitly speaking about cultural medicines and is one of the only mentions in this review that speaks to diversity of practices included as part of cultural medicines.

Cultural medicines reference 9.2 – Policy 9 (p. 12). Cultural medicines are mentioned under 'Guideline overview' in a section about cultural safety. This reference flags the relevance of cultural medicines to cultural safety; however, there is no specific instruction for the pharmacists or clear stance taken by the PSA. The inclusion of the phrase 'prior to colonisation' in this reference causes some ambiguity. It might indicate that cultural medicines are an outdated, primitive approach to health; alternatively, it might highlight the marked changes that 'colonisation' wrought on Australia and the lives of First Peoples,

therefore encouraging the pharmacist to consider this in the context of cultural safety. Considering the definition of 'bush medicine' on page 10, the latter is probable.

Cultural medicines reference 9.3 – Policy 9 (p. 24). In this reference, cultural medicines are used as an example in the cultural safety section for 'health beliefs related to wellness and the cause of illness/injury, treatment of the condition(s)' and grouped with 'food beliefs and diet', as well as family/kinship, roles/responsibilities and death/dying. They are listed in a separate point to 'concept of health' and 'cultural and gender-specific protocols and practices'. These are all given as examples of things that the pharmacist is encouraged to 'learn about' to improve their provision of culturally safe care; however, there is no specific advice to guide the pharmacist on how to engage with clients about cultural medicines. Given that this policy is directed to pharmacists, there is a tension between providing culturally safe care (including support of cultural medicines) and safety regulations that the pharmacist must abide by. The context of this policy positions it below the higher-level policies that stipulate how the pharmacist must practice in order to maintain their registration, which may leave pharmacists unable to support the use of cultural medicines.

Cultural medicines reference 9.4 – Policy 9 (pp. 25 and 40). Whilst the following reference is positioned in a policy that is a guide and lower in the hierarchy than others like Ahpra, this is by far the most detailed mention of cultural medicines in the current review. The framing of cultural medicines here is in the context of cultural safety. The section covers detailed information, including: cultural medicines overview and positioning of cultural medicines as the primary form of healthcare pre-colonisation; overview of cultural medicines use; reasons for use; encouraging pharmacists to acknowledge that biomedicine may not meet a patient's needs and thus cultural medicines may be used instead; recording of the use of cultural medicines is encouraged, especially on platforms like My Health Record, which may increase awareness of cultural medicines amongst a treating team; and encouraging respect of a patient's choice to use cultural medicines as an element of culturally safe care.

The detailed inclusion of this section speaks to a commitment to awareness of cultural medicines by the PSA, and it is a very respectful inclusion of cultural medicines in a national health policy document. The document acknowledges that pharmacists may feel conflicted when cultural medicines are being used; however, there is very clear guidance to record their use, which does not conflict with any other policy that is considered higher up in the hierarchy. Whilst this specific guidance is useful, it is the only direct piece of guidance within the guideline and provides little explicit guidance for pharmacists when making decisions.

One element of concern in this section is that Aboriginal and/or Torres Strait Islander health practitioners have been mentioned as a health professional who may provide further information about cultural medicines to 'help ensure their safe use', which may not be accurate, given the large diversity among First Peoples groups and knowledge across Australia, and may place the pharmacist, Aboriginal and/or Torres Strait Islander health practitioner and client in an unsafe position. Whilst reiterating the issues within the Ahpra guideline around Aboriginal and/or Torres Strait Islander health practitioners and their perceived cultural medicines knowledge, this reference within this PSA document may help to mitigate the power imbalance that may

exist between Aboriginal and/or Torres Strait Islander health practitioners and pharmacists; however, this would depend on individual Aboriginal and/or Torres Strait Islander health practitioners' knowledge of cultural medicines.

Cultural medicines reference 9.5 – Policy 9 (p. 37). This reference to cultural medicines has been used to improve the readers understanding of First Peoples' potential understanding of how medicines work, but may inaccurately simplify the use of cultural medicines. While the example given here may be true for how some First Peoples perceive the use of medicines as being for acute care, cultural medicines are also often used for non-acute reasons. This is an important inclusion considering the context of this document and its intended purpose. This mention of cultural medicines connects back to the guidance given in the text selection in this policy about cultural medicines. This serves to further embed the importance of recording the use of cultural medicines in the policy user's mind.

Section 3: Inclusion and representation of cultural medicines across the policy landscape

While ICDA conventionally solely focuses on the discourse of one policy and how that discourse impacts social, cultural and political practices and beliefs, this study presents an overarching analysis and consideration of the discourse of cultural medicines across the broader policy landscape. It particularly focused on the implications for clinical practice and First Peoples (both health professionals and patients). This overarching thematic analysis identified the following themes: Absence of national leadership; Disproportionate onus placed on Aboriginal and/or Torres Strait Islander health practitioners; and Lack of detail and actionable directives.

Absence of national leadership

As cultural medicines are the traditional medicines of the Traditional Owners of Australia, the lack of references to them at the national policy level is emblematic of the institutional racism that exists in the Australian healthcare system and reinforces the perception that First Peoples' culture is not noteworthy in guiding health professionals' practice. Indeed, this suggests and reinforces a lack of respect for cultural medicines, fuelling the racism and disrespect for First Peoples and their culture that is seemingly omnipresent in the Australian health system (Watego et al. 2021). Across the national policy landscape there is also a notable absence of position statements around cultural medicines; this is problematic at the service and practice level of healthcare, where decisions are expected to be made in accordance with policy recommendations. This is of particular concern with policies that include cultural medicines content authored by Ahpra and ACSQHC, as these two governing bodies have significant control over the service and practice level of healthcare in Australia.

Of the nine policies that included any cultural medicines content, clear direction around cultural medicines in the mainstream clinical setting was notably absent from the two policies authored by Ahpra and ACSQHC. These two organisations are the key health service accreditation and health professional regulation bodies in Australia and play a critical role in what transpires in the clinical practice setting. As touched on above, this policy mapping did not identify any position statements from either Ahpra or ACSQHC regarding cultural medicines. While it is noteworthy that these two powerful actors in the Australian health sector have included cultural medicines in one policy each, they do so without clear

directions or a position statement for those who are expected to enact these policies. Using the Ahpra policy as an example, simply telling an Aboriginal and/or Torres Strait Islander health practitioner that they should 'advocate' for First Peoples patients wanting to use cultural medicines is problematic. Without any guidance on what that advocacy could or should look like, or what would be considered 'overstepping the line', ambiguity remains as to whether enacting such advocacy could result in termination of their registration (therefore, no longer allowed to practice).

The lack of inclusion of cultural medicines in ACSQHC and Ahpra policies weakens, if not entirely undermines, the recommendations around cultural medicines made in the subordinate policies (see Figure 5). Like above, without clear guidance from ACSQHC and Ahpra of where their boundaries lie, enacting recommendations from subordinate policies could invoke unforeseen repercussions from ACSQHC and/or Ahpra. This clear absence of national level leadership within the Australian health system is concerning.

Disproportionate onus placed on Aboriginal and/or Torres Strait Islander health practitioners

The nature of the inclusion and representation of cultural medicines in these policies is telling of unspoken but inherent power imbalances and the implied role and responsibilities of Aboriginal and/or Torres Strait Islander health practitioners in anything involving cultural medicines. Within all the included Ahpra policies, only Aboriginal and/or Torres Strait Islander health practitioners are specifically mentioned with respect to cultural medicines. Further, the *Medicines book* authored by CARPA states: 'The *Medicines book* is designed to be used by clinicians, especially Aboriginal and Torres Strait Islander health practitioners…'. Lastly, while arguably the most detailed and respectful inclusion of cultural medicines was found in the sole PSA policy reviewed, it also directs pharmacists to seek out the Aboriginal and/or Torres Strait Islander health practitioners when cultural medicines come up in their practice.

It is understood that the CARPA, Ahpra and PSA documents are well-meaning policies that aim to be respectful of the knowledge that Aboriginal and/or Torres Strait Islander health practitioners rightly hold; however, when considered across the whole national policy landscape, the reviewed policies inherently place disproportionate workloads on already overburdened Aboriginal and/or Torres Strait Islander health practitioners. This links to the concept of 'cultural load' of which some are now referring to as 'colonial load' (Guenzler 2024), where all First Peoples health professionals (regardless of discipline) are burdened with unfair expectations to provide advocacy, education and cultural knowledges to non-First Peoples staff in biomedical care settings (Sivertsen et al. 2023; Topp et al. 2022). This approach implies that cultural medicines are essentially only relevant to Aboriginal and/or Torres Strait Islander health practitioners and absolves all other health professionals from this same responsibility. By singling out Aboriginal and/or Torres Strait Islander health practitioners, these policies are undermining the tenet that culturally safe and appropriate care is everybody's responsibility and relegates cultural medicines to the periphery, once again. In order for something to be deemed 'culturally safe', it must be evaluated by and deemed to be safe by the First Peoples patients themselves (Ramsden 2002). Further, it must use an approach that eradicates the power imbalances inherent in the included policies; this includes power imbalances in healthcare between health providers and also healthcare systems (Ramsden 2002; Fredericks et al. 2011; Sherwood and Edwards 2006).

Moreover, by solely identifying Aboriginal and/or Torres Strait Islander health practitioners in this way, this suggests that this workforce is responsible for advocating to senior health professionals. This so-called 'authority to advocate' places yet another unfair burden on Aboriginal and/or Torres Strait Islander health practitioners to advocate for patients, which in the absence of clear guidance arguably places Aboriginal and/or Torres Strait Islander health practitioners in an unsafe and unsupported position (Topp et al. 2022). Indeed, recognising the diversity across First Peoples' cultural and language groups, each with their own distinct cultural practices, and similarly distinct practices around cultural medicines, it is unreasonable to assume that any given health professional would possess such diverse knowledge to apply to all patients in their care; this is no different for Aboriginal and/or Torres Strait Islander health practitioners (Topp et al. 2022). Additionally, the presence of racism within Australia and its health system is well known and can affect patient-clinician and clinician-clinician interactions (Watego et al. 2021; Gall et al. 2019b). With such perverse racism within the health system itself, how can Ahpra expect Aboriginal and/or Torres Strait Islander health practitioners to advocate for their patients in such a culturally unsafe environment?

This is further convoluted by states and territories having jurisdiction over the specific scope of practice that they allow Aboriginal and/or Torres Strait Islander health practitioners to perform in their health services. For example, in New South Wales, Aboriginal and/or Torres Strait Islander health practitioners are not authorised to possess, supply or administer medicines under the *NSW Poisons and Therapeutic Goods Act 1966* and the *Poisons and Therapeutic Goods Regulation 2008* (NSW Ministry of Health 2018), where in Queensland under the *Medicines and Poisons Regulation 2021* they have varied authority over medicine management (Rural and Remote Clinical Support Unit et al. 2021). These large variances in the roles of Aboriginal and/or Torres Strait Islander health practitioners, especially whether they even have the authority to work with medicines in general, has clear implications for successful advocacy around the use of cultural medicines.

Lack of detail and actionable directives

While there are some references to the need for culturally safe communication between health professionals and patients about cultural medicines in subordinate policies, these policies fail to provide clear advice or guidance around specific actions for health professionals. There is no information to guide actions related to informing patients about treatment options, potential benefits, potential interactions, or sources of information about cultural medicines. One policy recommends that Aboriginal and/or Torres Strait Islander health practitioners ask patients whether they are using cultural medicines and then direct them to look up whether the medicine could interact with other medicines the patient is taking. However, how can anyone action this directive when little to no information currently exists to answer these questions? It is unsurprising then that cultural medicines were only described in further detail in the pharmacy policy, given the predominance of concern about physical cultural medicines interacting with pharmaceutical drugs. This inclusion appears intended only to manage the risk of potential drug interactions, and offers no indication, evidence or advice on the potential benefits of cultural medicines. Again, this inclusion and representation of cultural medicines in the policies reinforces the view that they offer little or no therapeutic value and instead are implicated as an issue of concern that must be managed. Lastly, as outlined above, the cultural medicines content in the

Ahpra policy provides very little guidance to Aboriginal and/or Torres Strait Islander health practitioners about what to do when cultural medicines are being used. This puts an unreasonable onus on the Aboriginal and/or Torres Strait Islander health practitioners to make decisions around cultural medicines without affording them any real guidance or power to do so, which also needs to be considered under this theme.

Discussion

This study sought to examine if and how cultural medicines are represented in national level health policies in Australia. It systematically reviewed Australian national health policies that guide the practice of Ahpra-registered health professionals and Aboriginal and Torres Strait Islander health workers/Indigenous liaison officers (Aboriginal and/or Torres Strait Islander health practitioners). It explored and synthesised the inclusion and representation of cultural medicines across the included policies and critically examined the discourse of cultural medicines in these policies. The findings of this review unequivocally demonstrate a concerning lack of cultural medicines guidance in national policies to support health professionals to deliver culturally safe and holistic care to First Peoples related to cultural medicines, with most of these policies failing to provide guidance on the topic whatsoever. Further, in those policies that included reference to cultural medicines, the wording and/or positioning of the reference used placed undue onus and responsibility on Aboriginal and/or Torres Strait Islander health practitioners to know or find out the most suitable course of action. The absence of national leadership and actionable directives around cultural medicines is unacceptable and of grave concern. In considering the implications of these findings for both health practice and the health and wellbeing of First Peoples, there are several areas of concern which are discussed below.

Health professionals must function in a vacuum of guidance

It was found that few policies adequately describe and explain cultural medicines, to support health professionals to deliver holistic care to First Peoples. Through Indigenous critical discourse analysis, this research highlighted and analysed the policy gaps regarding cultural medicines in health policy documents. First Peoples scholars, Parter et al. (2023), reported the correlation between cultural determinants of health and health outcomes, including beliefs and knowledge around traditional healing (Parter et al. 2023). They also noted the challenges in truly embedding culture into Australian policies, healthcare and clinical practice. Providing clear policy guidance, resources and training that require health professionals to engage with cultural medicines and view them as part of their responsibility to a diverse group of patients is crucial for cultural safety, upholding of First Peoples' rights and valuing powerful healing practices from First Peoples. However, it is known that First Peoples report feeling unsafe to disclose their use of cultural medicines to health professionals, due to the various negative stigmas surrounding this (Gall et al. 2019b; Prior 2009), and that health professionals report feeling ill-equipped and poorly supported to advise or discuss cultural medicines with their patients (Gall et al. 2019a; Mollart et al. 2019; Pirotta et al. 2010), so highlighting the critical need for change.

Further, while health professionals making decisions in this policy-void environment is obviously problematic, the larger implications for this and the direct impact it has on the overarching discourse around First Peoples' health is lesser known. Reilly et al. (2014) provide a clear

assessment of how policy discussions being attempted in a research vacuum can cause further subjugation and harm to First Peoples; specifically, the harm caused by non-First Peoples researchers applying a Eurocentric lens to their research and arriving at dangerous negative conclusions about First Peoples, which in turn informs education, policy and practice. It is probable that the same is true when decisions are made by non-First Peoples in decision-making roles for health provision and practice. There is a dire need for clear position statements from both Ahpra and ACSQHC to support Aboriginal and/or Torres Strait Islander health practitioners and services to enact the very little guidance that this review identified and provide much more clarity to the health sector as a whole around cultural medicines and the vital role they play in health and wellbeing of First Peoples.

Persistent subjugation of First Nations' knowledge

The critical policy discourse analysis revealed a lack of substantial inclusion or discussion on cultural medicines in policies and frameworks that guide practice, regulation and standards for health professionals. Comparing Australia's recognition of cultural medicines in policies with other countries is challenging, due to the unique public health infrastructure and history of First Peoples in Australia. However, this policy discourse provides insight into how cultural medicines are discussed (if at all) from a predominantly Western and biomedical perspective that drives settler-colonial hegemony in health practices (Sherwood and Edwards 2006). Similarly, Jones and Liyange (2018) discuss Ayurveda as a traditional medical system (along with others) in Sri Lanka, noting the 'struggle to survive against the onslaught from biomedicine, they were forced to professionalise and institutionalise' (p. 162). This led to subsidised government funding streams and recognition in law, but Ayurveda practices and clinics did not integrate into the official public health system.

Australia is still in the early stages of reforming policies for First Peoples. Although First Peoples' cultural medicines are insufficiently mentioned in health policies, and early draconian policies and dominance of biomedicine are evident, this does not diminish First Peoples' rich history and extensive knowledge of cultural medicines in Australia. This history and knowledge can be shared by First Peoples; however, a reciprocal approach is required. True reciprocity involves both disciplines learning from one another and involves critical thinking to achieve the best possible outcomes for First Peoples. Turpin et al. (2022) compiled Queensland's First Peoples' medicinal plants in the field of ethnomedicine and ethnobotany and provided examples of interactions between European scientists and First Peoples, demonstrating that traditional knowledge in health and medicine has always been present and reputed by many (Turpin et al. 2022). Australia needs to practice reciprocity and develop a health system that works for First Peoples, driven by principles of self-determination, authenticity, holism, equal decision-making and First Peoples stewardship (Sherwood and Edwards 2006).

Failure to enact the rights of First Peoples

Carrie et al. (2015) assert that while the nascent adoption of the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) sets internationally accepted standards and obligations, such as on the right to access traditional medicines and practice cultural healing, there has been a general lack of informed implementation in its execution of national health policy instruments (Carrie et al. 2015). The inclusion of cultural medicines in policies and procedures is fundamental for cultural inclusivity and awareness of diverse choices to healing. Previous

research suggests a widespread lack of translatable materials of different international agreements and obligations. Rooney et al. (2023) argue that the integration of cultural medicines or traditional therapies into Australia's healthcare system is necessary to continue the commitment to decolonising institutions (Rooney et al. 2023). This research has shown that cultural medicines are largely absent from healthcare practice and policy. All institutions that support the healthcare system must work reciprocally and learn from First Peoples' traditional and cultural practices and skills.

While it is important to strive for improved access and acknowledgement of cultural medicines in health systems, there are equally critical considerations around the protection, ownership and benefits of cultural medicines knowledge and intellectual property to protect First Peoples against exploitation, misappropriation and biopiracy of their knowledges and skills (Robinson and Raven 2017). The processes of European colonisation continue to subjugate, misappropriate and devalue many cultural medicines systems and practices, through the continued ubiquity and domination of biomedicine. In 2012, the World Health Organization (WHO) called for the increased statutory regulation of TCIM (World Health Organization 2013), as well as imploring Member States to foster recognition of cultural medicines or equivalent into national health agendas and systems as per the WHO Traditional Medicine Strategy 2014–23. Moreover, ensuring Country is not harmed in the process is vital; the sustainability of cultural practices and First Peoples maintaining primary access to cultural medicines must stay at the forefront. Indeed, biopiracy has been shown to contribute to the loss of biodiversity and subsequent mainstream interest in certain bioactive plants, which can lead to First Peoples no longer being able to access them (Cottrell 2022).

There is an urgent need for Australia to enact international policies and laws, especially the United Nations General Assembly 2007 (UNDRIP), United Nations Convention on Biological Diversity (CBD) (Secretary-General of the United Nations 1993), Kunming-Montreal Global Biodiversity Framework (GBF) (Convention on Biologocal Diversity and United Nations 2022), Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity (Nagoya Protocol) (Secretariat of the Convention on Biological Diversity 2011) and the WIPO Treaty on Intellectual Property, Genetic Resources and Associated Traditional Knowledge (World Intellectual Property Organization 2024) to ensure the preservation and protection of First Peoples' cultural knowledges and mitigate associated risks.

Conclusion

The research presented here underscores the significant lack of representation of cultural medicines in Australia's national health policies. Among the few policies that do mention cultural medicines, most fail to provide clear guidance and actionable directives, and undue responsibility is placed on Aboriginal and/or Torres Strait Islander health practitioners to lead care related to cultural medicines. This policy gap creates uncertainty and undermines the confidence for health providers and professionals in delivering holistic and culturally centred care to First Peoples.

Cultural medicines have been used by First Peoples since time immemorial and continue to be used today to achieve and maintain balance of the whole being. Accordingly, the recent addition of cultural medicines in the National Medicines Policy 2022 (Department of Health and Aged Care 2022a) definition of 'medicines' offers a crucial opportunity to enact sustainable, strengths-based changes in the current policy

landscape. By embedding actionable and inclusive, strengths-based, culturally safe, patient-centred practices for the use of cultural medicines, meaningful progress can be made for First Peoples' health and wellbeing. This is especially necessary in policies by Ahpra and ACSQHC, who hold significant influence over health practice in Australia. There needs to be a shift towards medical and health pluralism, which is crucial for honouring the knowledge and culture of First Peoples in Australia. WHO's 2008 Beijing Declaration has long advocated for national policies, standards and regulations to guide the safe and place-based use of and collaboration between health systems and traditional medicines and practices (Abbott 2009). It is about time that Australia took heed of international standards, especially UNDRIP, CBD, GBF and the Nagoya Protocol.

We envision a future where First Peoples accessing or seeking cultural medicines are fully supported by communities and the entire healthcare system. Practitioners of cultural medicines should be recognised as equal members of multidisciplinary teams, with their preferences for working across various community settings respected. Currently, the language, context and development of policies mentioning cultural medicines, whether explicitly or ambiguously, suggest that cultural medicines are not well understood within the health field and curricula, not seen as equally relevant, and/or perceived as a clinical risk. This is not a call for Ahpra registration of cultural medicines; quite the opposite. This is a call to re-Indigenise healthcare, where cultural medicines resume their sovereign place in healing for First Peoples alongside biomedicine. As the oldest continuing medicine practice in the world, cultural medicines should be shown the respect they rightfully deserve.

Author contributions

A. Gall: Conceptualisation, data curation, formal analysis, funding acquisition, methodology, project administration, writing – original draft, writing – review and editing. M. Stephens: Conceptualisation, data curation, methodology, formal analysis, writing – review and editing. Z. Gall: Conceptualisation, data curation, formal analysis, methodology, project administration, writing – review and editing. D. Armour: Conceptualisation, formal analysis, writing – review and editing. N. Hewlett: Conceptualisation, formal analysis, writing – review and editing. M. Kennedy: Conceptualisation, formal analysis, writing – review and editing. T. Sainty: Conceptualisation, formal analysis, supervision, writing – review and editing. A. Hulme: Conceptualisation, formal analysis, writing – review and editing. J. Wardle: Conceptualisation, formal analysis, writing – review and editing. M. Campbell: Conceptualisation, methodology, writing – review and editing. A. T. Gall: Conceptualisation, formal analysis, writing – review and editing. A. Furlong: Conceptualisation, writing – original draft, writing – review and editing. K. Anderson: Conceptualisation, formal analysis, supervision, writing – original draft, writing – review and editing.

Declaration of interests

The authors declare that they have no competing interests.

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Supplementary material

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