International Journal For Quality In Health Care, 2026, 38(1), mzag029
https://doi.org/10.1093/intqhc/mzag029
Published: 7 March 2026
Systematic Review

OXFORD

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

The relationship between Indigenous health and relevant sector Standards in Aotearoa New Zealand, Australia, and Canada: a scoping review

Dean Cowles[1,*], Jan Dewar[2], Catherine Cook[1]

[1]School of Clinical Sciences, Faculty of Health and Environmental Sciences, Auckland University of Technology, Auckland, New Zealand
[2]School of Health, Faculty of Health and Psychological Sciences, Victoria University of Wellington, Wellington, New Zealand
*Corresponding author. School of Clinical Sciences, Faculty of Health and Environmental Sciences, Auckland University of Technology, North Campus, 90 Akoranga Drive, Northcote, Auckland 0627, New Zealand. E-mail: dean.cowles@schl.co.nz

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 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, synthesized, 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 records, 75% highlighted the need to address social determinants of health, and 67% advocated anti-racism and structural reform. Indigenous-led governance and self-determination were linked to improved health outcomes in 50% of the records, though practical implementation was uneven. Integration of Indigenous knowledge and holistic approaches was supported in 47% of records, but limited by weak policy infrastructure. Racism, both systemic and interpersonal, was identified in all studies as a persistent barrier to equity. National Standards often lack the enforcement mechanisms to address these issues meaningfully.**

Conclusion: **This review identified significant gaps between the intent and implementation of health sector Standards across Aotearoa New Zealand, Australia, and Canada in relation to Indigenous health. Despite formal commitments to culturally appropriate care, systemic barriers, rooted in colonization and policy-practice disconnects, continue to undermine equitable outcomes. The findings highlight the need for Indigenous-led evaluation, stronger accountability, and the embedding of Cultural Safety, Indigenous leadership, and holistic health approaches to drive meaningful and lasting change.**

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 politicized concept that recognizes the impact of colonization 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

Handling Editor: Reece Hinchcliff
Received: 31 July 2025. **Revised:** 23 December 2025. **Accepted:** 17 January 2026

© 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 reprints@oup.com for reprints and translation rights for reprints. All other permissions can be obtained through our RightsLink service via the Permissions link on the article page on our site—for further information please contact journals.permissions@oup.com.

social determinants of health (SDH) because culturally unsafe healthcare means inequitable access and engagement. Intergenerational poverty since colonization 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

Unifying these national health sector Standards in all three countries is the formal recognition of Indigenous rights to safe, equitable, and inclusive health care. This approach aligns with the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) [3]. All Standards demonstrate some efforts towards recognizing the significance of Indigenous health, with variable attention to Cultural Safety, the SDH, racism, Indigenous-led governance and self-determination. The following outlines how each country's Standards incorporate these principles.

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

Accreditation Canada and the Health Standards Organization (HSO) have developed Indigenous Health Standards, including the British Columbia Cultural Safety and Humility Standard [5]. They prioritize Cultural Safety, Indigenous engagement, equitable service, and quality improvement [5], aligning with UNDRIP's Article 24, which recognizes traditional healing and the right to the highest attainable standard of health [3].

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

Collectively, these Standards utilize well-established monitoring processes such as accreditation, self-assessments, audits, data collection, site visits, stakeholder engagement, and health outcome measures.

While they share commitments to cultural diversity (Table 1), differences remain. Accreditation Canada/HSO offers Indigenous-specific Standards, whereas NSQHS and Ngā Paerewa HDSS incorporate Indigenous needs into broader health quality frameworks. Measurement of commitments to cultural diversity also varies: Accreditation Canada prioritizes community feedback, NSQHS focuses on clinical outcomes, and Ngā Paerewa highlights holistic Māori health models across physical, mental, spiritual, and social domains.

Research aim

This scoping review aims to explore how national health Standards intersect with Indigenous health, focusing on Cultural Safety, Indigenous-led governance, Indigenous knowledge, and anti-racism across Aotearoa, Australia and Canada.

Research question

How do national health Standards intersect with Indigenous health in the contexts of Cultural Safety, Indigenous-led governance, Indigenous knowledge, and anti-racism?

Materials and methods

A scoping review methodology was utilized as it is well-suited for mapping the breadth of existing literature, identifying knowledge gaps, and exploring key concepts [7]. The structured review protocol was informed by Carr *et al.* [7], building on Arksey and O'Malley's work [8] and incorporates Levac *et al.*'s refinements [9]. The review had six stages: (i) formulating the research question or objective, (ii) identifying relevant literature, (iii) selecting studies, (iv) organizing data, (v) synthesizing and summarizing findings, and (vi) engaging with relevant stakeholders. This scoping review was Indigenous-led by the first and second authors.

Eligibility criteria

We applied the qualitative variant—Population/Problem, Interest, Context (PICo) framework—to refine the scope of our research objective. The study population included Māori in Aotearoa, Aboriginal and Torres Strait Islander peoples in Australia, and Canadian First Nations, Inuit, and Métis communities. The area of interest was health Standards encompassing policies, programmes, and frameworks designed to enhance Indigenous healthcare, particularly Cultural Safety and health equity. For the context component, we explored how their implementation and impact varied across the three countries, focusing on Indigenous health outcomes. The years searched, inclusion and exclusion criteria are outlined in Table 2.

Information sources

As the primary sources for the search, PubMed, Scopus, CINAHL, JSTOR, and SAGE were selected. These databases offer a broad interdisciplinary range of perspectives and are well-suited for exploring the multifaceted nature of Indigenous health and policy.

Search strategy

As shown in Table 3, the research objective was broken down into key concepts. We generated an expanded list of synonyms, related terms, acronyms, and alternative spellings for each concept to ensure comprehensive coverage. These terms were then strategically combined into search strings using Boolean operators. Grey literature was included from credible sources, and a detailed search process log was maintained. Rigorous documentation ensured transparency, consistency and reproducibility.

Selection of sources of evidence

The screening process began with the extraction of all potentially relevant titles and abstracts using the predefined search terms,

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

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 organizations 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.	Organizations 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 Islander safety and quality care needs are embedded in organizational priorities (Action 1.2). Address specific health needs of Aboriginal and Torres Strait Islander populations (Action 1.4).	Focus on identifying and reducing health disparities experienced by Indigenous peoples, ensuring equitable access to care, and addressing systemic barriers to healthcare.	Equity of access to services for Māori, with targeted approaches to reduce health disparities for Māori, as per the obligations of Te Tiriti o Waitangi (Standard 1.2).
Cultural Safety and Respect	Organizations 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 colonization, and respect for Indigenous cultural protocols and practices.	Services must demonstrate culturally safe practice, reflecting Māori values, tikanga, and spiritual beliefs. Whānau must be involved in 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, and spiritual aspects, reflecting a whole-of-life view of health and wellbeing.	Emphasis on holistic care models that incorporate traditional healing, medicines, and Indigenous holistic worldviews (e.g. spiritual, emotional, mental, and physical aspects of health).	Health services must incorporate Te Whare Tapa Whā (holistic model of health) and other Māori health models, recognizing 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).	Organizations 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 organizations to influence decision-making processes (Standard 3.4).
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 organizations 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 family support where appropriate (Action 5.13).	Safety and risk management strategies must be adapted to meet the needs of Indigenous patients, particularly in remote areas, with focus on culturally safe care.	Services must include Māori cultural values and safety within their risk management practices, ensuring culturally safe environments (Standard 3.1).

(Continued)

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

Table 1 Continued.

Standard	Australian NSQHS (Aboriginal & Torres Strait Islander)	Accreditation Canada/HSO (Indigenous Health Standards)	Ngā Paerewa HDSS (Māori-specific Standards)
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 emphasizes 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 healthcare setting where appropriate.	Organizations must facilitate access to traditional Indigenous healing practices and medicines alongside Western medical care.	Services must respect and incorporate Māori traditional healing practices and integrate spiritual health care (Standard 1.3).

Table 2 Inclusion and exclusion criteria for determining literature relevance and eligibility for this review.

Inclusion criteria	Exclusion criteria
• 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 organizations and government publications • Published between 2013 and 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 Islander Peoples, First Nations, Inuit, Metis)	• 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

subject headings, and search limits. The number of records retrieved from each database was recorded individually to maintain transparency across sources. Duplicate entries were identified and removed, with the number of duplicates documented. The remaining titles and abstracts were screened for relevance against the research aim. Records not meeting the inclusion criteria from this initial review were excluded. The remaining studies were flagged for full-text retrieval.

Full texts that were inaccessible were documented as unavailable. Full-text records that were obtained were evaluated in detail. Those that failed to meet the criteria were excluded, with reasons noted. The final studies that satisfied all inclusion parameters comprised the literature for the review.

Study selection

As highlighted in Fig. 1, the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) process was followed to screen relevant literature [10]. After removing duplicate records from the initial search results, titles and abstracts of 1312 records were screened for focus on the relevant study population or accreditation Standards, and 1280 records were excluded. Thirty-two records from the identified search databases were retrieved and assessed for eligibility. An additional 26 records from organizations or citation searching were also assessed for eligibility. Of the 58 records, 10 were from the identified databases and 26 were identified via other methods.

Data charting process

Within the data charting process, selected study information included country, aim, methodology, methods, study interpretation, and contributions to the wider research context.

Results synthesis

Synthesis commenced with organizing data extracted from the 36 included studies. Using a data extraction template, key findings were collated to establish an overview of the evidence base and identify early patterns and divergences [11]. Relationships within and across studies were examined to uncover recurring ideas, discrepancies, and contextual factors.

A Miro board was employed to visualize the conceptual groupings derived from the results and discussion sections. This enabled a clearer exploration of emerging trends and potential anomalies within the data, contributing to rigour in the findings.

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

For synthesis rigour, each record's quality and methodological soundness were considered. This identified bias or evidence limitations, which were reported in the final analysis [12]. A methodical approach was maintained, guided by the PRISMA-ScR framework, to ensure reproducibility, clarity, and coherence in how findings were interpreted and presented [13].

Stakeholder engagement

Guidance was informally provided in-person by experienced auditors in Aotearoa who have audited organizations against the Ngā Paerewa HDSS. These stakeholders were consulted early on in the development of the larger research project. They shared insights into the audit process, helping to contextualize the research within practical audit environments. The primary researcher also brought direct experience, having supported hospitals in Aotearoa in meeting the Standards. This collaborative engagement helped identify and understand the practical challenges involved in implementing the Standards, supporting findings that are relevant to the sector and responsive to its needs.

Results of data synthesis

Characteristics of evidence sources

The summary of included sources is as follows: 33 qualitative studies and three healthcare Standards. Geographically, 10 studies focused on Aotearoa, 12 on Australia, 13 on Canada, and one had a global scope. Studies involving participants included patients ($n = 16$), whānau/families ($n = 8$), community members ($n = 13$), health professionals ($n = 18$), and government or health organizations ($n = 12$). Most studies incorporated multiple perspectives. However, few explicitly engaged with national health sector Standards ($n = 3$), suggesting research gaps investigating the relationship between policy intent and practice.

Four themes were identified across the dataset (Table 4): Cultural Safety versus cultural competence; Indigenous-led governance and self-determination; integration of Indigenous knowledge and holistic approaches; and anti-racism and structural change. Twenty studies prioritized Cultural Safety over cultural competency. While one record upheld cultural competency as sufficient [14], most distinguished between the two—that cultural competency involves awareness and skills, whereas Cultural Safety requires environments shaped by Indigenous identity and experience [14]. With this theme, 20 studies stressed the importance of addressing SDH and health inequities to achieve Cultural Safety. Eighteen studies supported Indigenous-led governance and self-determination, though some proposed partnership models as a transitional or complementary approach. Seventeen studies endorsed integrating Indigenous knowledge and holistic healthcare models. Finally, 24 studies advocated for anti-racism strategies to drive systemic change.

Key findings

Cultural safety versus cultural competence

While many studies discuss cultural competency and Cultural Safety, few explore in-depth the distinctions between the concepts. Cultural competency involves acquiring knowledge and skills to work across cultures [15]. One study argued this framework should underpin culturally safe, Indigenous-led evaluations [16]. The Australian NSQHS Standards support cultural competence with Aboriginal and Torres Strait Islander people [4], but do not address systemic power dynamics and therefore Cultural Safety is unexamined. Only one study viewed cultural competency as sufficient [14], while 10 others in Australia advocated embedding Cultural Safety into all levels of care. Three studies positioned competency as a starting point, with safety achieved through reflection, anti-racism strategies, and Indigenous perspectives [17–19]. Others [3, 14, 20] critique Standards that stop at competency without progressing toward Cultural Safety.

Cultural Safety challenges structural inequities and power imbalances, demanding systemic change [1]. This aligns with Accreditation Canada's Indigenous Health Standards, which promote anti-racism, community engagement, and decolonizing practice. These values are also reflected in British Columbia's Cultural Safety and Humility Standard [5] and Ngā Paerewa HDSS [6]. A meta-synthesis of 14 studies by Graham and Masters-Awatere [17] called for reconceptualizing Māori health care delivery, linking cultural competency with deeper sociopolitical awareness. Without strong enforcement mechanisms, two studies argued Cultural Safety risks remaining aspirational [16, 17].

Across 27 studies, the enduring impacts of colonization were central to understanding inequities in health access and outcomes. Structural racism, intersectionality, and SDH must be addressed to institutionalize Cultural Safety [1, 19–23]. Scholars call for embedding Indigenous voices and accountability into national Standards and health pathways [24–28]. Although current research offers important perspectives on holistic health, equity and the significance of Cultural Safety, few studies examine the long-term effects of national Standards on Indigenous health outcomes, in some instances perhaps due to the short time periods the Standards have been in place.

Indigenous-led governance and self-determination

The centrality of Indigenous-led governance and self-determination is a recurring insight across the literature. Eighteen studies recognized that when Indigenous communities lead and control health services, outcomes significantly improve. Community-led approaches are consistently reported as more effective than top-down, government-imposed models. Governance models prioritizing self-determination, Cultural Safety, and local autonomy tend to result in more coordinated, culturally appropriate, and comprehensive service delivery [21–33].

Many studies advocate for community-led approaches and Indigenous decision-making across all levels of healthcare to support ground-level initiatives. In Canada, organizations must demonstrate an overarching commitment to Indigenous health equity in governance, strategy, and resource allocation [5]. In Aotearoa, Māori should be represented in governance and leadership roles to influence decision-making [6]. Despite these mandates being progressive, limited information is available from which to determine the success of these indicators. This highlights a need for closer monitoring to gather implementation data. In Australia, the Standards encourage Indigenous leadership as a strategic priority, rather than promote Indigenous governance (D) [4].

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

Table 3 Search strategy.

Search terms

Concept: Health sector standards		**Concept: Health experiences**		**Concept: Indigenous population**		**Concept: Colonization**		**Concept: Geography**
Health standards	AND	Impact	AND	Indigenous	AND	Colonialism	AND	Aotearoa
Health policies	OR	Effects	OR	Aboriginal	OR	Colonial	OR	Aotearoa New Zealand
Health regulations		Outcomes		Māori		Settlers		Australia
Healthcare standards		Influence		First Nations		Colonise		Canada
Healthcare policies		Effected		Inuit				
Healthcare regulations		Experience		Metis				
Standards of health		Consequence		Torres Strait Islanders				
Health needs		Shape		Native-born				
Healthcare needs		Ramifications		Ethnic				
		Implicate						
		Impinge						

PubMed
((“Health standards” OR “Health policies” OR “Health regulations” OR “Healthcare standards” OR “Healthcare policies” OR “Healthcare regulations”) AND (“Impact” OR “Effects” OR “Outcomes” OR “Influence” OR “Experience”) AND (“Indigenous” OR “Aboriginal” OR “Māori” OR “First Nations”) AND (“Colonialism” OR “Colonial”) AND (“Aotearoa” OR “Aotearoa New Zealand” OR “Australia” OR “Canada”))
Date Done: 10/09/2024
Results: 450
Reviewed: 15
Used: 4

Scopus
((“Health standards” OR “Health policies” OR “Health regulations” OR “Healthcare 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

(Continued)

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

Table 3 Continued.

Search terms
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

Integration of Indigenous knowledge and holistic approaches

Seventeen studies emphasize grounding health interventions in Indigenous knowledge systems and holistic wellbeing. Health is conceptualized as a dynamic interplay of physical, spiritual, cultural, and social dimensions. Three studies across Australia and Canada [34–36] advocate for co-designed healthcare approaches between Western healthcare and Indigenous stakeholders. Although these align with their respective health Standards, four studies [35–38] suggest a lack of integration, accountability mechanisms and formal policy infrastructures.

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

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

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 colonization. Four studies [21, 22, 30, 40] critique institutional structures and policies that disempower Indigenous communities by limiting autonomy and marginalizing 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 [19, 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 organizations 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 recognize 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 outcomes. Therefore, Standards provide mandatory expectations without dictating the process. Standards alone however will not transform health and social services [43]. Standards must be backed by rigorous audits to ensure there is continuous quality improvement in upholding Indigenous people’s rights. We concur with Ng *et al.* [44] that system learning is fundamental. A quantitative data-driven reporting process is required to operationalize improvement actions and progress towards expected outcomes. The current study also highlights the importance of the second strand of health system learning, which is a structured approach to education and problem-solving. In this context, health system learning entails Indigenous knowledges being integral to theory building and health systems’ evolution. Fundamental to this process is examining the systems that perpetuate health disparities [45]. The findings highlight that there are key areas pertaining to the transformation of health systems to better serve Indigenous communities where further institutional development is necessary.

Interpretation within the context of wider literature

In this study, key areas include Indigenous-led governance integrating Indigenous knowledge and community-led approaches as being essential for better outcomes. Racism is a central issue relating to colonization and systemic exclusion. This review

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

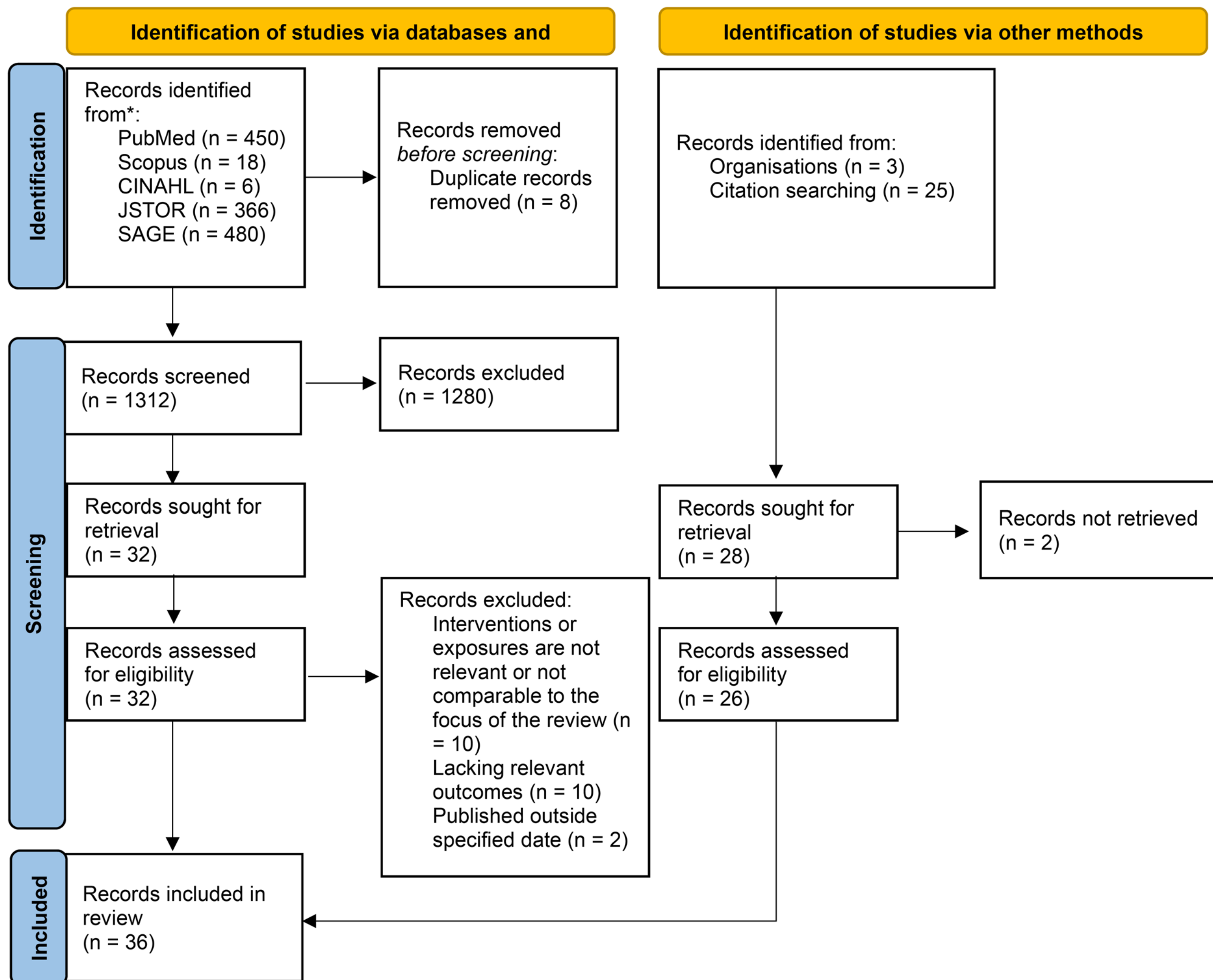

Figure 1 PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers, and other sources.

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

supports the argument that Indigenous people experience complex biopsychosocial harms from racism, and legal and health systems have a pivotal role in protecting rights [46]. Cultural competency is often treated as a technical requirement rather than a step toward deeper Cultural Safety. Cultural Safety requires systemic transformation, power-sharing, and anti-racism praxis [47]. The findings show persistent barriers remain, including limited insight into Indigenous definitions of Cultural Safety. Despite policy advancements, Cultural Safety is not consistently operationalized. Health systems still prioritize Eurocentric models, marginalizing Indigenous approaches [17, 18]. 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 politicization 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

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

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 recognize 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 colonization 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. Embedding Cultural Safety into governance structures, strengthening Indigenous leadership, and addressing broader SDH are essential to achieving equitable outcomes. The review recommends stronger accountability measures, sustained anti-racism initiatives, and the integration of Indigenous healing and holistic health models. By doing so, health Standards can move beyond symbolic inclusion and towards tangible improvements.

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.

Author contributions

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

Conflicts of interest

No known conflict of interests.

Funding

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

Data availability

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

Ethics

Ethics approval was granted by Auckland University of Technology Ethics Committee (AUTEC) on 29 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.

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. *Contemp*

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

Nurse 2022;**58**:33–42. https://doi.org/10.1080/10376178.2022.2027254
3. United Nations. *United Nations Declaration on the Rights of Indigenous Peoples*. United Nations, 2007. 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 edn. ACSQHC. https://www.safetyandquality.gov.au (20 April 2025, date last accessed).
5. *British Columbia Cultural Safety and Humility Standard* (HSO 75000:2022). Ottawa, ON: Health Standards Organization.
6. Standards New Zealand. *Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)*. 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**:e034302. https://doi.org/10.1136/bmjopen-2019-034302
8. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 2005;**8**:19–32. https://doi.org/10.1080/1364557032000119616
9. Levac D, Colquhoun H, O'Brien K. Scoping studies: advancing the methodology. *Implement Sci* 2010;**5**:69. https://doi.org/10.1186/1748-5908-5-69
10. Page MJ, Moher D, Bossuyt PM *et al.* PRISMA 2020 explanation and elaboration: updated guidance and exemplars for reporting systematic reviews. *BMJ* 2021;**372**:n160. https://doi.org/10.1136/bmj.n160
11. Harden A, Garcia J, Oliver S *et al.* Applying systematic review methods to studies of people's views: an example from public health research. *J Epidemiol Community Health* 2004;**58**:794–800. https://doi.org/10.1136/jech.2003.014829
12. Munn Z, Pollock D, Khalil H *et al.* What are scoping reviews? Providing a formal definition of scoping reviews as a type of evidence synthesis. *JBI Evid Synth* 2022;**20**:950–2. https://doi.org/10.11124/JBIES-21-00483
13. Tricco AC, Lillie E, Zarin W *et al.* PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med* 2018;**169**:467–73. https://doi.org/10.7326/M18-0850
14. Cullen T, Griffith M, Damodaran A *et al.* The First Nations experience of accessing rheumatology services in a metropolitan hospital: a qualitative study. *Health Expect* 2024;**27**:1–9. https://doi.org/10.1111/hex.14049
15. Ide Y, Beddoe L. Attitude or skills? Cultural competence development within an Aotearoa New Zealand bicultural framework. *Aotearoa N Z Soc Work Rev* 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. *Am J Eval* 2021;**42**:332–53. 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. *Aust N Z J 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. *Int Indig Policy J* 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 Serv Res* 2018;**18**:448–9. 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. *Med J Aust* 2017;**207**:15–6. 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. *Aust J Public Adm* 2021;**80**:239–60. https://doi.org/10.1111/1467-8500.12482
22. Zambas SI, Wright J. Impact of colonialism on Māori and Aboriginal healthcare access: a discussion paper. *Contemp Nurse* 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. *Int J Environ Res Public Health* 2022;**19**:13558–73. 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. *J Holist Nurs* 2017;**35**:185–97. 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 Prim Care* 2024;**25**:144–15. 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 Serv Res* 2021;**21**:493–15. 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. *Aust J Prim Health* 2024;**30**:NULL. https://doi.org/10.1071/PY22181
28. Masters-Awatere B, Cormack D, Graham R *et al.* Whānau experiences of supporting a hospitalised family member away from their home base. *Kotuitui N Z J Soc Sci* 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. *Hro-Ors* 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. *J Bioeth Inq* 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. *Can Public Adm* 2021;**64**:561–86. https://doi.org/10.1111/capa.12441

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026

32. Lavoie, JG, Kornelsen, D, Wylie, L *et al.* Responding to health inequities: Indigenous health system innovations. *Glob Health Epidemiol Genom* 2016;**1**:e14. 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. *Int J Health Gov* 2016;**21**:229–44. 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. *Aust Soc Work* 2022;**75**:165–79. 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 (NY)* 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**:2377–17. https://doi.org/10.1186/s12889-022-14580-0
37. Mack M. Integrating traditional practitioners within primary healthcare teams: development of an accreditation framework. *Healthc Manage Forum* 2024;**37**:7S–13S. 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 Hum 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. *Glob Health Promot* 2023;**30**:11–8. https://doi:10.1177/17579759221130948
40. Matthews R. Health ethics and Indigenous ethnocide. *Bioethics* 2019;**33**:827–34. 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. *Med J Aust* 2021;**214**:S12–S16. https://doi.org/10.5694/mja2.51020
42. O'Brien P, Bunzli S, Lin I *et al.* Addressing surgical inequity for Aboriginal and Torres Strait Islander people in Australia's universal health care system: a call to action. *ANZ J Surg* 2021;**91**:238–44. https://doi.org/10.1111/ans.16557
43. Hudson B, Hunter D, Peckham S. Policy failure and the policy-implementation gap: can policy support programs help? *Policy Des Pract* 2019;**2**:1–14. https://doi.org/10.1080/25741292.2018.1540378
44. Ng J, Chan J, Valencia J *et al.* Optimising the use of certification findings to support healthcare quality measurement and improvement. *N Z Med J* 2025;**138**:99–106. 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
45. Milligan C, Mantla R, Blake G *et al.* Health system learning with Indigenous communities: a study protocol for a two-eyed seeing review and multiple case study. *Health Res Policy Syst* 2022;**20**:65–10. https://doi.org/10.1186/s12961-022-00873-8
46. Dudgeon P, Bray A, Walker R. Mitigating the impacts of racism on Indigenous wellbeing through human rights, legislative and health policy reform. *Med J Aust* 2023;**218**:203–5. https://doi.org/10.5694/mja2.51862
47. Mohamed Shaburdin Z, Bourke L, Mitchell O *et al.* 'It's a cultural thing': excuses used by health professionals on providing inclusive care. *Health Sociol Rev* 2022;**31**:1–15. https://doi.org/10.1080/14461242.2020.1846581
48. Came H, O'Sullivan D, McCreanor T. Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy. *Ethnicities* 2020;**20**:434–56. https://doi.org/10.1177/1468796819896466
49. Came H, O'Sullivan D, Kidd J *et al.* Critical Tiriti analysis: a prospective policy making tool from Aotearoa New Zealand. *Ethnicities* 2024;**24**:985–1004. https://doi.org/10.1177/14687968231171651
50. Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand. *Standards of Competence for Registered Nurses.* Nursing Council of New Zealand, 2025. https://nursingcouncil.org.nz (20 December 2025, date last accessed).
51. Redvers N, Celidwen Y, Schultz C *et al.* The determinants of planetary health: an Indigenous consensus perspective. *Lancet Planet Health* 2022;**6**:e156–163. https://doi.org/10.1016/S2542-5196(21)00354-5

Downloaded from https://academic.oup.com/intqhc/article/38/1/mzag029/8510726 by Serial Acquisitions Edith Cowan University, Library - Level 2 user on 24 March 2026