

SYSTEMATIC REVIEW

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Implementing healthcare decolonisation for Indigenous people: a systematic review

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Abstract

Background The Western biomedical system, rooted in colonialism, holds Western science as the only universally valid knowledge system. While it has been justified as an objective approach to improve health, it has failed to address health inequities for Indigenous communities. There is increasing recognition of the need to decolonise healthcare, but its practical application remains unclear. This study systematically reviewed global literature to explore what decolonising healthcare means in practice.

Methods A systematic search of published and grey literature was conducted across CINAHL, Embase, PubMed, Scopus, Google and reference lists for studies on decolonising health services for Indigenous peoples. Two reviewers independently screened and extracted data from eligible studies. Quality was appraised using the Joanna Briggs Institute's tool for systematic reviews and the Consolidated Criteria for health research involving Indigenous peoples. Data analysis and presentation followed an inductive thematic approach, refined through discussions with authors and external members who identify as Indigenous community members.

Results Fifteen studies from Canada, Australia, Aotearoa (New Zealand), the United States, Chile, and South Africa met the inclusion criteria, all reporting qualitative data. Key elements of decolonising healthcare included community governance, holistic care, relationality and trust, storytelling, reflexive practice, and colonisation-informed care. These were underpinned by cultural, ontological, axiological, and epistemic equity, along with shared power, essential for their decolonial nature. Studies identified barriers and facilitators to decolonising healthcare, reflecting broader structural factors. Reported outcomes included increased patient satisfaction, empowerment, and trust in services.

Conclusion Decolonising healthcare requires acknowledging colonialism within healthcare systems and fostering medical encounters with equity between Western and Indigenous ways of knowing, being, and doing. Genuine community-informed partnerships and leadership from Indigenous communities are essential for developing and evaluating services aligned with Indigenous health, well-being, and healing paradigms.

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Keywords Decolonisation, Health equity, Healthcare, Indigenous health

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Background

Colonial medicine – cultural genocide and epistemicide

Healthcare systems based on Western biomedicine are deeply rooted in European colonialism and imperialism [1]. Due to its association with imperial expansion and oppressive regimes, the term “colonial medicine” has been used to describe medical institutions and medical power relationships established by European colonial governments as part of colonial projects across Africa, Asia, Oceania and America [1, 2]. Medicine, humanitarian aid and welfare were equally used as a means to ensure European colonial expansion [2]. Tropical medicine knowledge and development were aimed at protecting colonial interests against high rates of death due to tropical diseases and lack of sanitary infrastructure [1, 2]. Medical visits and public health inspections enforced colonial authority and were key tools for ordering colonial space and resources [1, 2]. A French field marshal and first colonial administrator of Morocco exemplified the role of colonial medicine when he proclaimed that *“the one thing that ennobles it and justifies [the colonial project], is the action of the doctor”* and *“the physician, if he understands his role, is the most effective of our agents of penetration and pacification”* [2, p. 28, 3, p. 37].

To justify dispossession and forced subjugation, biological knowledge paired with pseudoscientific ideas of “superior species” resulted in dehumanisation and “othering” of non-white individuals. Through denial of humanity, Indigenous peoples’ intellectual virtue and knowledge systems were also denied, drawing an imposed, arbitrary, invisible line between truth and falsity described by Boaventura de Sousa Santos as “abyssal thinking” [4]. Dehumanisation of non-white people and Western medical hegemony privileged European “enlightenment” and scientific enquiry, permitting the conduct of unethical research experiments at the expense of non-white and Indigenous peoples [5–8]. Denial of Indigenous peoples’ humanity and intellectual virtue enabled the imposition of a hegemonic Western-European culture and knowledge system. These were made to prevail through laws and policies that criminalised any expression of Indigenous culture or knowledge and assimilation policies [9]. Such attempts to destroy a group’s culture and knowledge system are denominated as cultural genocide and epistemicide.

The legacy of colonial medicine continues to pervade concealed in modern healthcare systems. Abyssal thinking, which presumes Western science has universal validity of scientific truth, continues epistemicide by dismissing culturally diverse knowledge systems, worldviews and health paradigms [4, 10]. Racist narratives that associated Black, Indigenous and ethnic marginalised people with negative adjectives such as “uncivilized” and “unhygienic” are covertly perpetuated by Western

research and epidemiology through deficit-based discourses [11] and Indigenous people globally continue to face racism and discrimination within healthcare systems [12, 13]. Abuse of power, dispossession and exploitation are also still evident today through biopiracy or biocolonialism where Western researchers and pharmaceutical companies make profit through the use of traditional Indigenous knowledge [14–16].

Colonial health systems and Indigenous health inequities

The health gap between Indigenous communities and their non-Indigenous counterparts in several countries of the world is well known [17]. Ongoing expressions of colonialism within current systems such as racism and epistemic oppression, have been highlighted as shaping those inequities [12, 13, 18–26]. In a Western universalism logic, Western concepts of health and research are seen as universally applicable elsewhere, whilst other culture’s knowledge systems simply don’t measure up to the “superior” rational scientific thinking of Western culture [10]. Cemented ideas of Western science hegemony and white supremacy continue to result in experiences of racism, culturally unsafe healthcare delivery and demeaning attitudes against Indigenous peoples’ cultural values and understandings of health beyond physical ailment [27–30]. Such systemic racism and discrimination result in Indigenous people being less likely than non-Indigenous people to access primary health services and receive timely and gold standard care for multiple conditions such as pain management, cancer treatment and revascularisation following a coronary event [31–34].

Additionally, healthcare service delivery purely based on a Western biomedical model fails to meet the holistic health needs of Indigenous people. For instance, the biomedical model’s focus on illness often leads healthcare practitioners to dismiss aspects intertwined with Indigenous peoples’ health such as environmental health, community, spirituality and culture [35–37]. Within mainstream healthcare services, culturally safe practices which have proven to have a positive impact on health and wellbeing outcomes [38–41] are in many cases disregarded.

Healthcare systems are shaped under a colonial logic of Western universalism presuming that biomedical knowledge occurs outside of any cultural, ontological and epistemological context and is thus completely objective [42]. However, the core role that culture has on peoples’ perceptions and experiences of physical and psychological wellbeing, as well as on healthcare provider’s capacity to deliver culturally safe quality healthcare, is increasingly being recognised [43]. Napier et al. have asserted in a manuscript published in the *Lancet* that *“The systematic neglect of culture in health and healthcare is the single*

biggest barrier to the advancement of the highest standard of health worldwide” [43, p. 7].

Decolonising healthcare

Decolonising health has been recognised by multiple Indigenous and non-Indigenous academics as crucial to bridging health inequities between the Global North and Global South [44, 45] and between white populations and ethnic marginalised populations (i.e., Black, Indigenous and people of colour) [46, 47]. Decolonising health entails recognising colonialism as a key determinant of health and re-examining invisible preconceived ideas about culture, health, knowledge, and race that influence healthcare systems and shape inequities [19, 48, 49].

The term ‘decolonial’ has been used in some cases interchangeably with the words ‘postcolonial’ and ‘anticolonial’; however, the distinction between these and their correct use is a topic of discussion [50, 51]. The way the authors understand and use these concepts, as described in some literature, is summarised in Table 1 [51–53]. The use of the concept ‘decolonial’ in healthcare decolonisation does not mean denying or being in opposition to Western scientific concepts, nor intends to remove beneficial scientific advancements (i.e. vaccines, diagnostic or surgical techniques, etc.). It exposes and aims to dismantle hidden colonial structures that pervade healthcare systems, deny and oppress different knowledge systems and ultimately maintain health inequities [46, 48].

Decolonising health has gained momentum in the literature during the last decades, and efforts to decolonise academia and medical education continue to emerge [5, 54–56]. Decolonisation of research and education is a must to drive a change in discourse and paradigms, but is not enough to see widespread practical changes in

Table 1 Concepts and meaning of postcolonial, anticolonial and decolonial terminology

Concept	Meaning / connotation
Postcolonial	<ul style="list-style-type: none"> • The prefix “post” denotes a temporal period after the end of an event. Thus suggesting that colonialism is over. • Refers to approaches understood to be “deconstructive” inviting to interrogate rigorously Eurocentric theoretical inheritance. • Usually restricted to academia rather than action oriented.
Anticolonial	<ul style="list-style-type: none"> • The prefix “anti” denotes opposition to [direct rule and cultural domination]. • Evokes action demanding translation of reflexive critique to embodied praxis.
Decolonial	<ul style="list-style-type: none"> • The prefix “de” arises from “De-linking” a translation of the Spanish word “desprendimiento”. Denotes removal, deletion, emancipatory rupture. • Aims to expose underlying colonialism in modernity. • Rejects the conception of Western knowledge as superior or universal.

healthcare delivery [57]. Furthermore, among non-Indigenous practitioners, stakeholders and policy makers, the concept of healthcare decolonisation remains unclear and more so its practical application in healthcare delivery to address power imbalances. Further evidence and examples on the practical application of decolonisation in healthcare systems and services are needed to guide its widespread implementation in mainstream services [57]. This study aims to systematically review global literature to explore what decolonisation of healthcare means in healthcare settings, the elements or components that constitute healthcare decolonisation and its associated outcomes.

Methods

Standpoint statement

The author team includes: **CKS**, a non-Indigenous Colombian woman who currently lives on the land of the Bidjigal people of the Eora Nation in Australia. She has been living in Australia for over seven years and acknowledges that this is an occupied colonial state in which Aboriginal and Torres Strait Islander sovereignty has never been ceded. **BB and JC**, proud Gumbaynggir women and Aboriginal health researchers, and **CR**, a proud Narungaa woman and also an Aboriginal health researcher. **SE** is a Walbunja man with an executive managing position in healthcare, bringing extensive experience in providing healthcare for Aboriginal and Torres Strait Islander people. **KBB and BP** are Torres Strait Islander individuals and experienced researchers. **BC and PF** are Māori health researchers, **BC** has whakapapa connections to Ngāti Pūkeko, Ngāti Awa and Tainui iwi and **PF** has whakapapa connections to Ngati Kuia, Ngati Koata, Ngati Apa Ki te Rā Tō, Rangitane o Wairau. **UNY** is a Madhesi/Tharuman from Nepal with experience in Indigenous health and wellbeing research across multiple countries, including Australia, where he learned and contributed to evidence generation focusing Aboriginal and Torres Strait Islander people health and wellbeing. **KH** is a non-Aboriginal Australian of Irish descent and applies an Indigenist approach to her research. **IR** is of Chilean-Mauritian descent and aims to centre Indigenous epistemologies through her research. **SH** is of Eastern European descent and applies strengths-based practice in her work with Aboriginal and Torres Strait Islander people.

Study design

This review was prospectively registered in PROSPERO (CRD42024495407). The reporting guidelines and criteria set in Preferred Reporting Items for systematic review (PRISMA) [58] were followed and a PRISMA checklist was completed (Additional file 1).

Research questions

1. What is decolonising health in healthcare settings?
2. What elements or components are needed to talk about healthcare services being decolonised?
3. What are barriers and facilitators to decolonising healthcare?
4. Has healthcare decolonisation been evaluated?
5. What are outcomes associated with healthcare decolonisation?

Table 2 Inclusion and exclusion criteria

Include	Exclude
<p>Study characteristics</p> <ul style="list-style-type: none"> • Primary studies using Indigenous, qualitative, quantitative or mixed methods 	<ul style="list-style-type: none"> • Evidence synthesis¹ • Discussion papers • Editor's comments • Thesis
<p>Population</p> <ul style="list-style-type: none"> • Indigenous people from any country, sex, age and any health condition 	<ul style="list-style-type: none"> • Studies that include Indigenous people and non-Indigenous people but in which outcomes are not presented separately for Indigenous people
<p>Intervention / Exposure</p> <ul style="list-style-type: none"> • Studies describing the implementation of decolonisation or anticolonialism in health-care services to improve health outcomes of Indigenous peoples 	<ul style="list-style-type: none"> • Studies that describe implementation of potentially related aspects such as cultural safety or traditional healing but do not explicitly frame them within a decolonial or anticolonial approach
<p>Context/Setting</p> <ul style="list-style-type: none"> • Studies conducted in any country within the following settings: hospitals, mainstream health services, Indigenous community-controlled health services or primary health care services • Allied health professions such as occupational therapy or social work and other care providers such as midwives or doulas 	<ul style="list-style-type: none"> • Studies conducted at Indigenous Community Controlled Health Services but do not explicitly address health-care decolonisation • Studies applying decolonisation in research or medical education
<p>Outcome</p> <ul style="list-style-type: none"> • Defining healthcare decolonisation OR; • Establishing elements or components of healthcare decolonisation OR; • Reporting outcomes associated with health-care decolonisation such as patient experience, health outcomes and service efficiency, including impact on the workforce 	N/A

¹Evidence synthesis that met all other eligibility criteria were excluded from this systematic review but were full text reviewed to find primary sources that could potentially be included

Search strategy

A systematic search was conducted for published and grey literature. Published literature was searched through the databases CINAHL, Embase, PubMed and Scopus. A search strategy was developed using the Boolean operators “AND” and “OR” and a combination of key terms related to “decolonising”, “Indigenous people” and “healthcare”. These key terms were tailored to each database. The final search strategy used in each database is available in Additional file 2. Additional records were sought through a snowball approach (reviewing reference lists of selected studies) and through manual search using Google and Google scholar.

The topic of decolonising healthcare is relatively new in the literature and therefore without applying time limits, most databases showed results of records published after 1999. For Scopus, results were limited to records published after 1999 given the very high number of irrelevant records published before that year.

Study selection

All search results were exported to the data manager Endnote X9 where duplicates were removed [59]. Then, records were uploaded to the online tool Covidence to conduct screening [60]. Titles and abstracts were screened independently by two reviewers according to inclusion criteria in Table 2. Author CKS screened all titles and abstracts once, and then these were screened again by either JC, IR, BB, or SH. The concepts' meanings summarised in Table 1 were used to define inclusion criteria. Pre-selected abstracts were then full text assessed independently by two reviewers following the same process. Throughout the screening process conflicts were resolved through discussion until consensus was reached. Whenever consensus was not reached between two reviewers, a team that included all reviewers and senior researchers JC, KBB and KH met to discuss until consensus was reached.

Data collection

The team developed an Excel data extraction template based on the research questions and information read from the studies during the full text screening process. Manuscript data were extracted independently by two reviewers (once by CKS and a second time by either IR or SH) into two separate copies of the template. When available, data extracted included title, first author and year of publication, country, setting, study aim, authors' standpoint and methodological approach, methods, type of service or health condition of focus, sampling strategy and sample size, decolonising elements or components identified, or strategies implemented to decolonise health services, barriers and facilitators to decolonising healthcare and outcomes associated

to healthcare decolonisation. After all data had been extracted into both templates, CKS met with IR and SH to compare data and correct errors if any to ensure consistency. Discrepancies were resolved through meetings attended by all reviewers and authors (JC, KBB, KH, and BB) where the manuscript was reviewed and discussed until consensus was reached.

Data analysis

Data regarding decolonising elements or strategies, barriers and facilitators to implementation and associated outcomes were analysed using an inductive thematic approach. All other data were analysed and summarised following a descriptive synthesis process. The thematic analysis was conducted initially by CKS using NVivo [61]. Then, multiple meetings were held with the wider research team including Aboriginal and Torres Strait Islander Researchers (JC, KBB, BB, BP, CR, SE), one (UNY) Indigenous researcher (Madhesi/Tharu Nepal) with rich experience working with Indigenous populations in different settings of the world and two Māori researchers (BC and PF), as well as with external Aboriginal and Torres Strait Islander and non-Indigenous researchers. All members who attended the discussions have extensive experience on Indigenous health and research and many have clinical experience. During these meetings, preliminary codes were presented to discuss interpretation of findings and refine codes.

Quality assessment

Quality appraisal of all included papers was conducted independently by two reviewers. Authors CKS and either SH or IR appraised each paper using the Joanna Briggs Institute's critical appraisal tool for use in systematic reviews to assess methodological quality [62]. Given the focus of the included studies on First Nations peoples' health, these were also appraised using the Consolidated Criteria for strengthening the reporting of health research involving Indigenous Peoples (CONSIDER) statement [63]. This tool was used to assess the quality of the studies from the perspective of ethical conduct of research involving First Nations peoples. Although we note that the CONSIDER statement was published in August 2019, we used this tool to appraise all studies regardless of their publication year as it provides a general idea of relevant ethical research aspects such as First Nations governance, prioritisation of First Nations peoples' interests and participation of First Nations people throughout the conduct of the research. Once both reviewers had independently assessed all papers using both tools, they met to compare results. When discrepancies were found, these were resolved in a meeting with the wider team where the papers were revised and discussed until consensus was reached.

Results

A total of 2304 records were returned in searches, after 519 duplicates were removed 1785 records remained. Titles and abstracts of the remaining 1785 records were screened from which 1721 were excluded. Of the 64 records that were full text screened, 15 met the inclusion criteria and were included in this review. Two studies were found through Google and six through citation searching, however, none of these met the inclusion criteria. The results of the search and screening process and the reasons for exclusion are shown in Fig. 1.

General characteristics

Of the 15 included studies, six were conducted in Canada [64–69], five in Australia [70–74], one in Aotearoa (New Zealand) [75], one in U.S [76], one in Chile [77], and one in South Africa [78]. Although three of the studies reported collecting qualitative and quantitative data [66, 71, 72], all the included manuscripts focused on reporting qualitative data only. Two studies in Australia were conducted using Aboriginal research methods of yarning or yarning circles [70, 73], and the study conducted in Aotearoa employed a kaupapa Māori research approach. The studies' participant sample size ranged from $n = 5$ [65, 73] to $n = 183$ [64, 68]. Three studies employing a case study approach drew directly from health care providers' personal experiences without conducting formal data collection [72, 74, 77]. The total sample size across the studies was $n = 835$. Additional file 3 summarises the studies' general characteristics, including study aim, authors' standpoint, data collection and analysis methods, health setting, sampling method, and type of service or health condition of focus.

Quality assessment

From a methodological perspective, the quality of the majority of the studies ($n = 9$) was high [64–68, 70, 73, 75, 78] and the remaining studies ($n = 6$) were of medium methodological quality [69, 71, 72, 74, 76, 77]. The overall score from the ratings of each criterion and its rationale are available in Additional file 5. Due to the specific characteristics of each study, we decided not to calculate an overall score from the ratings of each CONSIDER criterion. Instead, the answers to each criterion and their rationales are displayed in Additional file 4.

Decolonising elements applied to healthcare delivery

Decolonising elements applied to healthcare delivery as described in the studies were organised into six main themes: (1) Community Governance and Ownership, (2) Holistic care, (3) Relationality and trust-based practice, (4) Storytelling, (5) Reflective practice and (6) Colonisation-informed care. Further quotes from the studies reflecting each theme are available in Additional file 5.

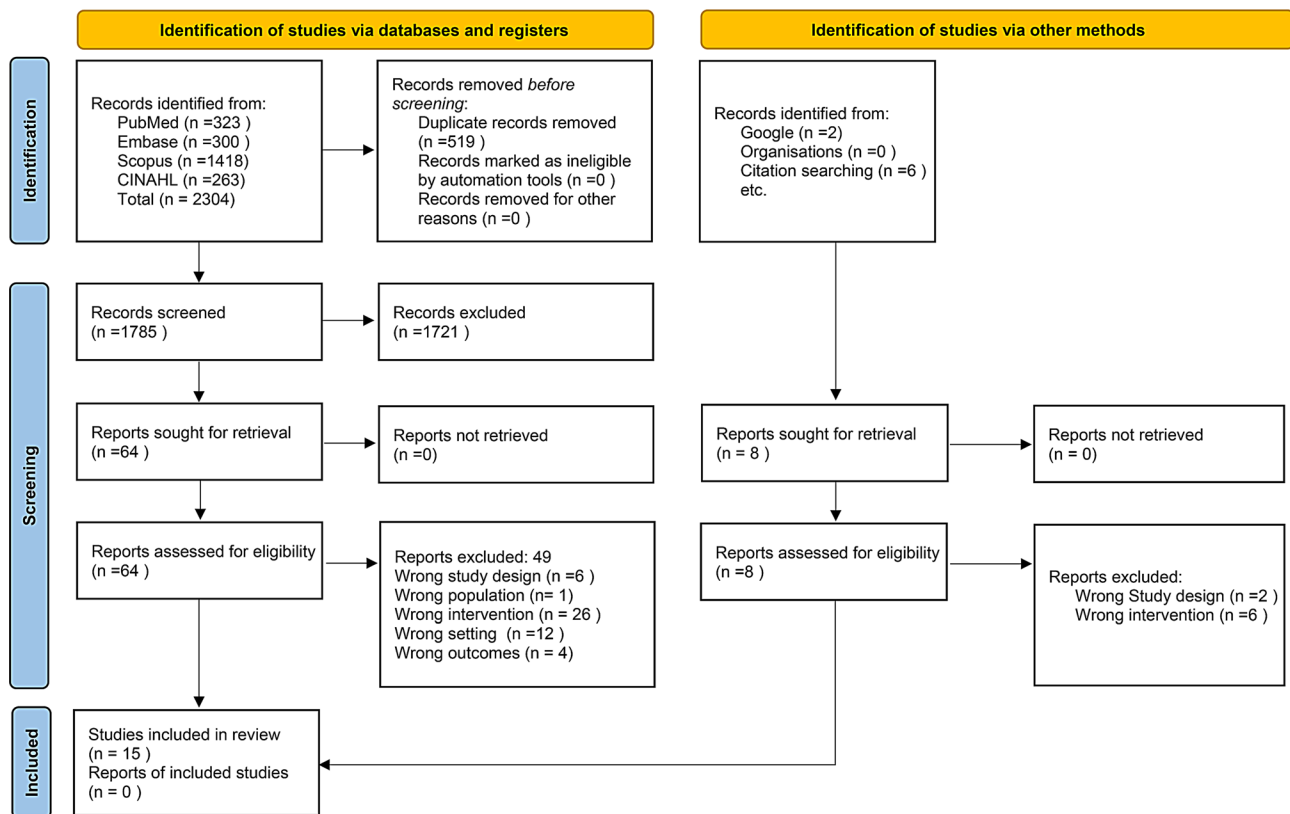


Fig. 1 PRISMA flow diagram

1. Community governance and ownership

Just over half ($n = 8$) of the studies described community governance on healthcare as a core aspect of decolonisation [64, 65, 67, 68, 71, 73, 75, 77]. This involved community control over decision making regarding service delivery models and frameworks and participation within execution. Studies stressed that community control entails adequate participation of all community members, ensuring two-way learning, representation of diverse voices and appropriate avenues for community members to voice ideas or concerns. Importantly, community control also included autonomy over the management of resources to be able to allocate them in a way that fits specific local needs.

...it became apparent that leaders were community members affected in the same way as other community members by colonial practices, etc.... Institutional hierarchies were not a part of the community-based leadership dynamic. Instead, community members, health administrators, providers, and the leadership lived and worked together within a circle of health. [68, p. 6]

We have to do things differently. I would like you

[non-Aboriginal social workers] to help us to write our own frameworks and help us to administer those frameworks. Make the way for us to write our own pieces of legislation, policies, and practices. Stand there with us and be our ally. Be our brothers and sisters in this journey. [73, p. 340]

Another key aspect of community governance was the delivery of healthcare locally by members of the community. This ensured healthcare providers were familiar with the cultural context and needs of the healthcare recipients and created a sense of cultural safety since health providers could identify with the community's cultural ways of knowing, being and doing.

We have all been subject to colonising practices and we know of ways of doing things differently. What you have done there,..., is allow people to speak. We do have the answers to practice in different ways. We don't need to interpret or translate. We have an understanding and knowledge that already exists. [73, p. 338]

Kai Manaaki [skilled case managers] were often described as drivers of culturally safe engagement in Mana Tū visits and during consultations between participants and their healthcare providers. Kai

Manaaki attending healthcare appointments alongside participants meant that cultural needs and aspirations could be communicated more effectively [75, p. 83]

2. Holistic care

All studies [64–78] discussed delivery of holistic care as a vital component of healthcare decolonisation. This component was further divided into four themes: (i) Integration of Indigenous knowledges and practices, (ii) Family and community centred care, (iii) Integration of physical, mental, spiritual, emotional, and environmental wellbeing, and (iv) Socioeconomic and cultural determinants of health.

i) Integration of Indigenous knowledges and practices

Studies ($n = 5$) stressed the role that culture has shaping health and wellbeing experiences and as a determinant of health, demonstrating multiple ways of integrating cultural health paradigms and practices into healthcare delivery as an essential element of decolonising healthcare [65, 67, 69, 72, 73]. Such integration requires respect for culturally different health and wellbeing paradigms, and healthcare delivery strategies that welcome cultural values and practices that are important for the patient contributing to their experience of wellbeing.

Indigenous practices are already being respected there. Saving the placenta is treated as a given when an Indigenous woman goes in, as well as having multiple family members present in the birthing room and a waiting room full of more family. Having a quiet birthing room is something that's respected as well. [65, p. 7].

...the psychologist adopted the Aboriginal concept of Social Emotional Wellbeing (SEWB)...The impact on psychological practice involved reducing the focus on the therapeutic connection and privileging the value of the client's cultural connections. The psychologist functioned as a facilitator, acting as a conduit between the client and the layers of connection; be that, facilitating the family sharing of a healing story, facilitating a connection between strong men and those who are unregulated or struggling, singing and dancing together, ladies group sharing and caring, intergenerational bush trips to hunt or gather pandanus for weaving [72, p. 140]

As part of respecting and welcoming cultural knowledges and practices, traditional healing and the use of

traditional medicines were highlighted in the studies as acts of decolonisation.

Resurgence of traditional spiritual practice was seen as strength, offering options for people to receive spiritual care when needed without fear or stigmatization. They have these people that seek traditional healing and traditional help and they know the history of it. [68, p. 10]

ii) Family and community centred care

Consistent with Indigenous health paradigms, decolonising models of care described by some studies ($n = 4$) [64, 65, 67, 75] included the delivery of health services that involve the patient's family and wider community, different to the traditional Western model that centres the individual.

Our model of care that we're creating together is really a family and community-centered model of care, which is very different from a Western patient centered model. So, when we are providing care, we have to take things into account that are not just impacting individuals but also the larger social context and their health. [65, p. 7]

Whānau ora (collective family wellbeing) was viewed by most participants as a critical success factor of the Mana Tū programme, as it allowed participants and their wider whānau to navigate health and wellbeing goals as a collective group. This collective navigation strengthened participant support systems, allowed for small and achievable changes over time and improved holistic wellbeing for the collective whānau. [75, p. 84]

iii) Integration of physical, mental, spiritual, emotional and environmental wellbeing

Broadening the biomedicine's focus on anatomical/physiological function, decolonising healthcare models ($n = 5$) addressed altogether the multiple domains of an individual/patient: cultural, physical, mental, spiritual and relationships with the natural world [64, 67, 68, 73, 75]. This is underpinned by Indigenous peoples' deep ontological connection to land, sky, and waterways.

Many Māori and Pacific participants valued the ability to explore and focus on domains of wellbeing beyond physical health in the Mana Tū programme through its Kaupapa Māori approach. This often included a focus on taha wairua (spiritual health),

taha hinengaro (mental health) and taha whānau (family health) [75, p. 84]

Many HCV-affected Indigenous participants and some treatment provider participants spoke about HCV treatment and cure as being a potential pathway toward enhanced spiritual, emotional, physical, and mental wellbeing. This informed their recommendation that HCV treatment providers align clinical teams and resources to be healing centered and wellness-based, paradigms that typically fall outside clinical models of care [67, p. 59]

iv) Socioeconomic and cultural determinants of health.

Studies ($n = 8$) described addressing socioeconomic determinants as part of healthcare delivery as an active act of decolonisation [64, 65, 67–71, 75]. This included advocating for clients with non-health services (e.g., employment, housing, etc.) or integrating such services within healthcare organisations [65, 75].

Their expansive vision of care reflects how Indigenous doulas are being attentive the many social determinants of health that can inform their clients' experiences of pregnancy, birth, and parenthood. Far from viewing patients as individualized, anonymous bodies, these Indigenous doulas are seeking to account for the various, intersecting systems and factors that disproportionately impact the people they support [65, p. 8]

A striking decolonising element described within this theme was healthcare providers' anti-racism activism. This included advocacy in cases of systemic racism and building cultural safety capabilities among non-Indigenous colleagues and other organisations [65, 67, 70].

ACCHO staff described acts of resistance in partnerships, which were frequently in response to unjust processes or treatment that were counter to decolonisation. At times, this meant having frank conversations and "pushing back" when ACCHOs felt that community was not at the centre of the partnership and that clients' needs were not being met. Often this process involved ACCHO staff challenging power differentials and confronting racism toward clients and staff, which represents resistance and is a key component to decolonisation and "pushing back" against structures of Whiteness and systemic racism. [70, p. 9]

Another example of a Western system that many Indigenous doulas are confronting in their work is

the crisis of Indigenous infant apprehension and child removal. Although the different doula initiatives we spoke with had varying levels of interaction with child welfare services, multiple participants stated that preventing infant and child removal is a defining feature of Indigenous doula care. [65, p. 8]

A focus on education and prevention, as well as fostering cultural determinants of health were described by studies as mechanisms through which healthcare is decolonised [67, 68].

Other treatment provider participants argued that with new DAA therapies, resources for managing side-effects of interferon ought to be redirected toward addressing barriers to care and restructuring clinics to be more wellness-focused. For example, treatment providers spoke about devoting resources to training staff to be trauma-informed; supporting peer-to-peer groups; offering drop-in hours; developing mobile HCV treatment units; and hiring Elders and Indigenous navigators [67, p. 59]

Another respondent echoed others in describing a thriving community with activities taking place, bringing people together for learning and socialization... 'That's another thing they do down there, it's kind of like a gathering place for different events like I said. a community-gathering place for our people... Our traditions are still alive. There's still caribou hunting, they are still dry meat making, there's still people fishing.' [68, p. 7]

3. Relationality and trust-based practice

Another prominent element of healthcare decolonisation was the establishment of relationships based on trust, respect, and reciprocity ($n = 5$) [65, 67–69, 73]. Ensuring that patients felt listened to and cared for was described to be opposite to the transactional-style relationship that often occurs in mainstream biomedical health encounters.

...several participants described the ways in which they worked to build trusting and deep connections with the people and families they work with. Their model of birthing support views relationships as a critical aspect of the birth, which stands in stark contrast to what one doula described as "just a transaction, like an OB-led birth can be." [65, p. 8]

Again, another system that says your way of knowing does not lead to a professional way of doing things. Within culture, it is the way that we do business.

We don't go to you thinking that we are above you. We go with the notion that we are going to walk a journey with you. This whole idea of professional or not professional is a colonising process...If you go with your position and not your story, then you will be shut off because that is not an Aboriginal way of knowing, being, or doing. [73, pp. 338–339]

Building authentic relationships and safe healthcare encounters were reported to be more important than the different interpersonal styles or approaches of health professionals [67]. The study by Pearce et al. (2019) described attitudes and actions that were perceived to create safe encounters:

Safe attitudes were demonstrated by providers who showed sincere caring/empathy (vs. pity), had a good sense of humor (vs. too serious, tense), acknowledged mistakes (vs. lacking humility), moved on quickly from disagreements and mistakes (vs. unforgiving, resentful), and took interest in getting to know patients (vs. indifferent). Safe attitudes were also demonstrated by doctors who respected patient autonomy and held non-judgemental, strengths-based perspectives on substance use [67, p. 56]

4. Storytelling

Storytelling as an Indigenous way of doing, was identified in some studies ($n = 3$) as an act of healthcare decolonisation [69, 72, 73]. Through valuing and employing storytelling, healthcare providers could connect deeper with healthcare recipients as well as understand and show respect for patients' contexts. By engaging in storytelling, healthcare providers acknowledged and showed respect for culturally diverse worldviews and ways of doing whilst sharing control over the medical encounter.

For the psychologist, the challenge was to accept the reality of not knowing the "full" story, recognising that the value placed on an individual linear narrative is culturally defined and that, in fact, a total story, is never fully knowable. As relationships and cultural awareness developed, the psychologist was able to broadly contextualise the narrative, holding complex backstories and effectively "guess" at the undercurrents, applying cultural themes of family obligation/stress, shame and jealousy. [72, p. 139]

Decolonising is about listening to the person's story. If, for example, we were thinking about keeping children safe, then we also need to keep parents safe. Their story is important, but it is not necessarily the story you hear first in social work. When you get a

referral, you are hearing someone else's interpretation, they put Aboriginal people into a box and it's not the real story. That box is really hard to work within. It does not represent what they or their family are needing or wanting, nor is it supporting their story...Getting their narrative is extremely important. ([73],336)

5. Reflexive practice

Results from four studies [72, 74, 77, 78] pointed practitioners' engagement in continuous self-awareness and reflectivity as a requirement for counteracting colonial practices. Decolonising healthcare requires healthcare providers reflecting on their standpoint (including culturally acquired ways of knowing, being and doing, as well as privileges gained through intersectoral attributes such as sex, sexual orientation, culture, ethnicity, education etc.) to be able to identify and address preconceived ideas, assumptions and power imbalances that will shape the medical encounter.

The psychologist was required to unpack her identity as a psychologist, reconfigure assumptions and create culturally respectful interventions for community members and Health Centre staff trained in the dominant paradigm [72, p. 139]

After a while, the women began to share stories of past colonization and negative healthcare practices, including children being removed from their families, young women being given injectable contraception without their consent, and Aboriginal people being denied access to equitable health care and treatment options. These stories were told with the understanding that I would listen deeply (Dadirri), reflect, and conduct my clinical practice accordingly (using Ganma) [74, p. 58]

In addressing preconceived ideas, assumptions and power imbalances, healthcare providers must create a safe space where diverse cultural knowledge systems (in this case Western biomedical and Indigenous knowledge and systems) engage in equitable and respectful dialogue to co-create new and better outcomes.

A second moment in the story is when the bio-medical biological model is questioned and opened to the dialogue of knowledge: 'When I got here (...) in the first instance, it was extremely challenging and difficult. One enters with a well-loaded profile towards biomedical and evidence-based medicine (...) as tools to support the behaviors one takes. One begins little by little, when meeting this knowledge, to

embrace other parameters. Realising that it cannot be measured based on these criteria [evidence, efficiency], but has to do with others. For example, how important it is for the person to use herbs [medicinal] or to resort to a traditional healer to assess the spiritual side. So, when you look at those things ... you start to open the door a little bit to that' [77, p. 337]

On reflection, I felt that this consultation had provided opportunities for my clinical nursing knowledge and the client's personal and cultural knowledge to swirl together in an intercultural knowledge exchange (Ganma). We had preserved and respected the integrity of our own and each other's knowledges while creating new mutual knowledge, or foam — in this case, the contraceptive options most suited to her physical, economic, cultural, and spiritual needs. [74, p. 59]

6. Colonisation-informed care

To decolonise healthcare, studies ($n = 4$) emphasised that recognising the impact of ongoing colonisation on health inequities experienced by Indigenous people and its pervasion into current health systems is essential [67, 69, 70, 78]. To counteract colonialism in healthcare, health providers must first understand colonisation as a determinant of health. Colonialism is an ongoing process that results in intergenerational trauma and shapes other socioeconomic determinants that contribute to poorer health outcomes for Indigenous peoples. Further, power sharing and engagement in respectful dialogue and co-creation with diverse knowledge systems requires acknowledging and challenging colonial systems of epistemic oppression.

The lamenting on the injustices is argued to be an important part of healing and preparing for the move to dreaming. The years of assault upon and damage done to the minds of indigenous people, their traditions, value and belief systems were evident in our discussions: 'AHPs [Allopathic Health Practitioners] should first acknowledge that we [Indigenous Health Practitioners] are there and accept us...We must first agree that we each have role to play in patients' health, and both sides are competent. Unless you accept that, collaboration will not be possible. [78, p. 5]

Key aspects of these clinics were acknowledgement of the effects of colonization as well as childhood physical, sexual, and emotional abuse and neglect on healthcare engagement...For example,

one explained why her clinic had shifted toward a trauma-informed, culturally based approach: 'To be honest, we have exhausted the Western way and it works for some but the (HIV) cascade of care hasn't changed that much as expected with the millions of dollars and millions of people working. I think partly it's because we don't address the trauma. We know that the trauma leads to drug use, drug use leads to HIV and hep C, and then we give methadone for addiction and we give medication for HIV and we treat the hep C but we don't actually treat the trauma so they continue to use...So, we're trying to break this cycle and we heard from the Indigenous women that an Elder can be helpful because a lot of them don't have families and they don't have a role model and they are torn by residential school history in their family, and they're torn between the Western and Indigenous ways [67, p. 57]

Throughout the meetings to review the interpretation of the findings and refine the themes, it was discussed that the principle bonding the 6 elements together and underpinning healthcare decolonisation is cultural ontological, axiological and epistemic equity. Through this, healthcare is decolonised by providing services that re-centre Indigenous ways of knowing, being and doing including health paradigms. Decolonising healthcare, thus, requires equitable power relationships between healthcare providers' cultural and educational background and patients' cultural worldviews and health paradigms. This enables space for empathetic and respectful dialogue and shared decision making. The six themes underpinned by this principle are depicted in Fig. 2.

Facilitators and barriers to decolonising healthcare

Findings reported in the studies also reflected barriers and facilitators to the decolonisation of healthcare. These are summarised in Table 3.

Outcomes associated with healthcare decolonisation

Of the 15 studies included, eight [65–69, 72, 75, 76] reported outcomes associated with implementation of healthcare decolonisation strategies. The most commonly reported outcome was patient satisfaction ($n = 6$) with health encounters, which were perceived as safe and positive [65–67, 69, 75, 76]. Further quotes from the studies reflecting each outcome theme are available in Additional file 4.

Participants also expressed how integration of Kānaka 'Ōiwi [Native Hawaiian] healing practices fills gaps in care that exist when culturally relevant care is not available. Patients expressed satisfaction and trust in the clinic when integration brings cul-

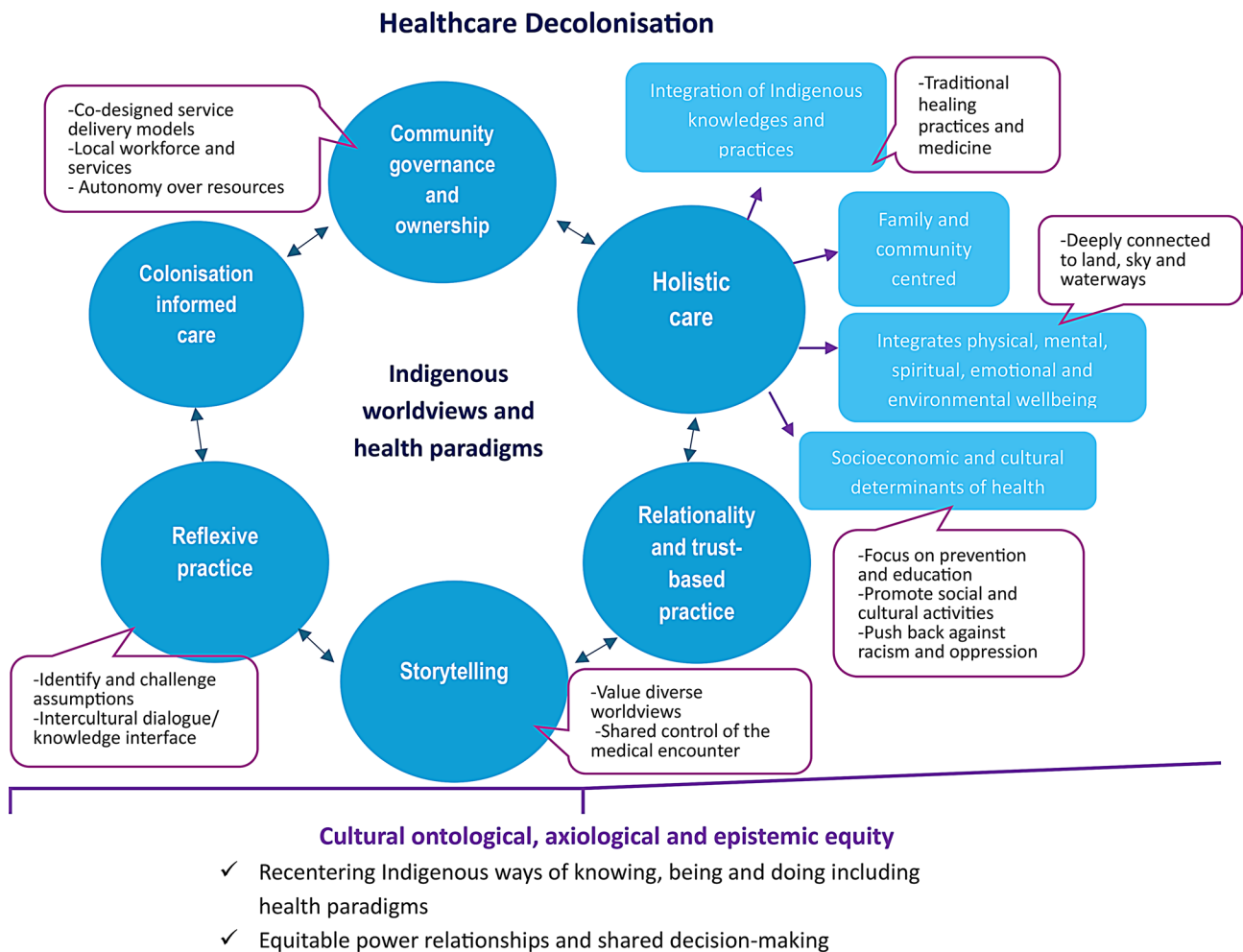


Fig. 2 Elements of healthcare decolonisation

Table 3 Barriers and facilitators to decolonising healthcare

Facilitators	Barriers
<ul style="list-style-type: none"> • Familiarity with the local community context • Integration of culturally safe practices within organisations (within and outside the health sector) • Local healthcare delivery and infrastructure • Culturally capable non-Indigenous workforce • Partnership and co-ordination among different services • Shared responsibility across all social levels • Promotion of education and training in local Indigenous knowledges and health practices 	<ul style="list-style-type: none"> • Epistemic hegemony and oppression • Lack of cultural safety within organisations (within and outside the health sector) • Complex and uncoordinated health systems • Limited resources and infrastructure locally/ lack of autonomy over control • High staff turnover within health services and other organisations

ture specific care to patients, as a patient responded: 'I get more than that when I come here.. It's just not take 2 [pills], they really show that they care for me.' [76, p. 75]

Clients who received such [Indigenous Birth Support Worker] assistance expressed gratitude acknowledging that it made them feel better; as one client stated, 'I smudged today, and it made me feel better.' Clients and families felt that their culture and tradi-

tions were recognized and respected, as evidenced by a client: 'I like she's thorough. She makes sure that we have the information we need. I like that she gave us pamphlets on the different traditional teachings and the little belly button pouch. And it was comforting to know those were offered services here at the hospital, 'cause I felt like it represented us as a family and what we would want in our baby's care.' [69, p. 7]

Some studies ($n = 2$) reported an increased sense of empowerment among patients and their families [66, 76].

In the study by Oneha et al. (2023), patients were also described by healthcare providers as making positive life changes [76]. An increase in acceptance and trust of service providers was also reported by two studies [67, 76].

In the interviews, multiple health providers reflected the excitement in seeing the positive changes patients are making to enhance the health status of both themselves and their families: 'I do see greater motivation. I see a lot of families make dramatic changes, they made this poultice, they tried it, and they are so excited. when you see families making these changes, it is so rewarding, and it's empowering for the families.' [76, p. 76]

Analysis of interview responses revealed that acceptance of and trust in Western medicine may increase when Western medical providers work in collaboration with already trusted, culturally familiar, Kānaka 'Ōiwi healers. One provider described observing this in patients: '... folks who not necessarily feel comfortable if we were just providing medicine or providing psychology, they feel really comfortable in talking and they see [the cultural practitioner] and they are almost immediately at ease, and are just more willing to just converse.' [76, p. 75]

Participants in the study by Kyoon Achan et al. (2022) reported shorter waiting times at the health facilities included in the study compared to those in other communities [68]. Castle (2021) reported that the implementation of their pilot program led to a 680% increase in psychology consultations compared to the previous month. Of these, 82% were Indigenous patients, and 8% were Health Centre staff [72].

Discussion

This review, to our knowledge, is the first to explore the practical elements associated with healthcare decolonisation. To date, most of the literature on healthcare decolonisation focuses on its theoretical underpinning [79]. We add to the current knowledge by showcasing pragmatic examples that can serve as a reference to help healthcare providers, organisations and policy makers begin to ground the concept of decolonisation within their practice.

The review identified strategies that contribute to pragmatic healthcare decolonisation for Indigenous people. It highlighted that decolonising healthcare demands an approach to care that is holistic and: (i) acknowledges ongoing colonialism, challenges racism, and considers environmental and socioeconomic determinants of health; (ii) respects and values culturally diverse

understandings and experiences of health and wellbeing; (iii) establishes genuine dialogue with people holding diverse conceptions of healing; (iv) prioritises treatment approaches that allow for the coexistence and integration of culturally diverse healing methods; and (v) shares power at the governance level to ensure that healthcare services and models of care design, implementation, and evaluation are shaped by culturally diverse perspectives, while also enacting Indigenous community sovereignty and self-determination.

Whilst many of the strategies identified in this review have been discussed in the literature for the last decades [80, 81], their implementation often reproduces colonial structures, privileging Western oppressive axiology, ontology and epistemology [82]. Implementation of any strategy without addressing underlying ideas of white supremacy, racism and capitalism, which have shaped today's health inequities, will invariably result in ineffective approaches [82]. Therefore, the key factors that underpin the elements identified in this review and characterise them as decolonial are the reclamation of equity between Western and Indigenous epistemology, ontology and axiology (ways of knowing, being and doing) and genuine power sharing to make decisions that enact Indigenous ways of knowing, being and doing.

For example, since the World Health Organization's (WHO) definition of health "as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" [83], many mainstream health services claim a "holistic focus". However, this is primarily shaped by Western ontological and epistemological assumptions and implemented as a one-size-fits-all model across diverse cultural contexts [84]. Findings of a systematic review of wellbeing frameworks indicated that whilst there is some degree of universality in the conceptualisation of wellbeing (similar clusters like physical health, psychological health, economic wellbeing), there is also evident cross-cultural variation in the deeper contextualisation of each of these wellbeing areas [85].

Similarly, since 1978, collaboration between Western and Indigenous traditional medicines and practitioners has been called for [86]. However, many attempts of collaboration have incorporated practices of epistemic oppression and assimilation. These include initiatives where traditional practitioners are taught by Western physicians, but not the other way around [77, 87, 88]. In addition, roles such as cultural brokers, intercultural navigators or Indigenous health workers are often undermined, as they experience racism and lateral violence in the workplace, and their role is scorned, undervalued and gradually relegated to administrative tasks [87–91]. Decolonisation entails genuine dialogue, collaboration, and power sharing between cultural ontologies, epistemologies, and approaches that can seem, at times, to

be in opposition to each other. The studies included in our review describe approaches where Western practitioners had to “let go” of their preconceived assumptions of health and disease paradigms and shift the focus from differences in opinion regarding health and treatment processes to finding opportunities of intercultural collaboration where the integrity of each knowledge is preserved whilst “swirling them together” to create new mutual knowledge and agreement [72, 74, 77, 78].

The use of storytelling within a medical encounter, for instance, brings to the meeting an act of colonial resistance to Western epistemic control over the interaction. In Australia, clinical yarning has been proposed as a way of prioritising Aboriginal and Torres Strait Islander ways of communication. Clinical yarning challenges the traditional biomedical closed style of questioning, contextualises the health issue within the patient’s life story and experience and shifts the narrative of the medical encounter to be patient-led therefore ensuring shared power [92]. In Aotearoa, the “Hui process” has translated Māori traditional principles of a meeting or coming together (Hui) into a framework that guides medical consultations [93]. Unlike the Western concept of meeting, this framework draws on traditional Māori cultural norms (tikanga), encouraging connection, relationship building and prioritising caring in a Te Ao Māori way that respects wairua (spirit) [94].

At a broader level, decolonisation requires transcending Euro-ethnocentricity [95]. This is recognising that multiple truths exist within culturally diverse ontologies and cosmologies [43]. System-change demands multi-leveled and unconditional openness to difference, where culturally diverse systems are engaged in decision making processes and granted equal merit and regard, irrespective of their presentation style [82]. This includes departure from Eurocentric formats that insist on “appropriate” or “professional” dress codes, or verbal and written structures to share ideas or arguments [82].

It is important to note that although many Indigenous communities share commonalities such as an inextricable relation to the natural landscapes and ecosystems, Indigenous worldviews are not homogeneous, and each community holds unique cultural beliefs and practices. Thus, the specific strategies described by the included studies respond to the cultural worldviews, values and traditions of the communities participating in the studies and do not reflect worldviews, values and traditions of all Indigenous communities. In opposition to imperial endeavours of cultural homogenisation, decolonial positions and approaches must be embedded in cultural, ontological and epistemic diversity and thus no specific approach should be used as a generalisable prescription [96]. Implementing approaches that ignore local context and communities (including local lived experiences,

health paradigms, community priorities and cultural values) is itself an act of colonialism [97]. Further, due to the deeply rooted colonialism in modern health systems, decolonisation implies a deep and continuous process of reflexion and transformation rather than a list of one-off actions [82, 98]. Thus, we strongly advise against the use of these findings by applying “tick the box” approaches. Instead, readers might use the findings as examples of practical approaches to embed elements of healthcare decolonisation and apply those elements adjusting them to local contexts.

It is essential to acknowledge that public health ultimately reflects broader social and political constructs [48]. Decolonising healthcare is intimately related at its core with wider contextual matters of social and epistemic justice. The barriers and facilitators to decolonising healthcare identified throughout the studies, reflect structural factors that exist outside of, but ultimately shape, healthcare delivery within a medical encounter and people’s experiences of health and wellbeing. Racism and other socioeconomic determinants of health must be understood within the context of colonialism, imperialism and capitalism that have shaped global capital and power dynamics across all systems [99]. Further, healthcare systems are shaped by the conceptualisations that academia recognise as truth, that in turn, influence medical education [54]. Decolonising healthcare is thus dependent on the decolonisation of the wider systems in which healthcare systems and health experiences exist including social, political, academic and education systems [5, 48]. This requires collective reflexivity and a “decolonising will” from individuals to enable change at various systems levels [5].

While decolonising healthcare requires a fundamental shift in power dynamics within broader social, political, and academic systems, the journey can progress with commitment from individuals across all healthcare system levels. Health organisations and practitioners are called to critically analyse where they exist within and contribute to Eurocentric structures of white supremacy, racism, and capitalism [82].

The main outcomes reported in this review are in line with evidence supporting the effectiveness of approaches grounded in respect for Indigenous sovereignty and knowledges in enhancing cultural safety, service uptake, and improving health and wellbeing outcomes [100–104]. System-wide implementation of approaches such as the ones applied by the studies, require further evaluation within each context. Local Indigenous-led research and monitoring are essential to ensure that implementation and outcome evaluation reflect local community’s health and wellbeing conceptualisations [105, 106]. Further investment in the implementation and evaluation of

Indigenous-led approaches to decolonise healthcare are required.

Strengths and limitations

The main strengths of this review include the systematic search strategy using different sources that included diverse databases, grey literature and reference lists. In addition, the methodological approach focused on Indigenous leadership and prioritisation of Indigenous peoples' voices and worldviews. This was conducted through leadership of Aboriginal and Torres Strait Islander researchers in the conceptualisation of the study as well as the search strategy building and screening process. In addition, the analysis of the findings was conducted in partnership with and prioritising the voices of the team members who identify as Indigenous people and Aboriginal and Torres Strait Islander people external to the study team.

One limitation of the study is the relatively new use of the term 'decolonial' and the lack of unanimity in the use of terminology. Due to this limitation, it is possible that studies using different terminology to refer to the concept of health decolonisation were missed. Although we attempted to locate grey literature, the studies that met inclusion criteria were retrieved through databases which increase the risk of publication bias. More so considering that to be published by journals, studies must abide by Western methodological and reporting quality benchmarks. The analysis of the findings prioritised the worldviews and experiences of the team members and other collaborators who identify as belonging to Indigenous communities, but these can't be generalised to the worldviews and experiences of all Indigenous communities. People from other Indigenous communities, including those involved in the studies, may have different interpretations.

Conclusions

Decolonising requires first acknowledging that the systems we live in are deeply rooted in colonialism, shaping social, political, economic, and health inequities. Decolonising health at its core requires a shift away from the arbitrary proclamation of Western science as the only knowledge system with universal validity and the forced generalisation of Western cultural values and wellbeing paradigms. Decolonisation of healthcare delivery entails medical encounters underpinned by reflexivity, respectful dialogue between Western and Indigenous ways of knowing, being and doing, and approaches that ensure shared power and decision making between both systems. Creating service delivery models that weave Western biomedical knowledge and approaches with diverse cultural knowledge systems and wellbeing paradigms requires genuine and equitable collaboration with local

community members and service users, ensuring that services and models of care are designed, implemented, and evaluated in a way that is meaningful for the target community.

Abbreviations

CONSIDER	Consolidated criteria for strengthening the reporting of health research involving Indigenous peoples
PRISMA	Preferred reporting items for systematic review
WHO	World Health Organization

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

Supplementary Material 3

Supplementary Material 4

Supplementary Material 5

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Author contributions

This study was conceptualised by CKS under the supervision of JC, KH and KBB. CKS built the search strategy under the supervision of JC, KH and KBB. Authors CKS, JC, IR, BB and SH screened the articles. Data was collected by CKS, IR and SH. Data was preliminarily analysed by CKS and then refined by JC, KH, KBB, BB, BP, CR, SE, UNY, BC and PF. The manuscript was drafted by CKS and reviewed and edited by KH, KBB, BP, UNY, BC and JC. All authors reviewed and accepted the final manuscript.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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