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Acknowledging and Promoting Indigenous Knowledges, Paradigms, and Practices Within Health Literacy-Related Policy and Practice Documents Across Australia, Canada, and New Zealand

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Abstract
Enhancing health literacy can empower individuals and communities to take control over their health as well as improve safety and quality in healthcare. However, Indigenous health studies have repeatedly suggested that conceptualisations of health literacy are confined to Western knowledge, paradigms, and practices. The exploratory qualitative research design selected for this study used an inductive content analysis approach and systematic iterative analysis. Publicly available health literacy-related policy and practice documents originating from Australia, Canada, and New Zealand were analysed to explore the extent to which and the ways in which Indigenous knowledges are recognised, acknowledged, and promoted. Findings suggest that active promotion of Indigenous-specific health knowledges and approaches is limited and guidance to support recognition of such knowledges in practice is rare. Given that health services play a pivotal role in enhancing health literacy, policies and guidelines need to ensure that health services appropriately address and increase awareness of the diverse strengths and needs of Indigenous Peoples. The provision of constructive support, resources, and training opportunities is essential for Indigenous knowledges to be recognised and promoted within health services. Ensuring that Indigenous communities have the opportunity to autonomously conceptualise health literacy policy and practice is critical to decolonising health care.

Keywords
Aboriginal, Australia, Canada, health literacy, health policy, health promotion, Indigenous, Indigenous knowledges, New Zealand

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Acknowledging and Promoting Indigenous Knowledges, Paradigms, and Practices Within Health Literacy-Related Policy and Practice Documents Across Australia, Canada, and New Zealand

The health promotion sector is increasingly recognising that developing and improving individual, population, and provider health literacy (HL) is an important and effective strategy to enhance health and wellbeing, as well as to improve safety and quality in healthcare (Australian Commission on Safety and Quality in Health Care [ACSQH], 2014; Centre for Literacy, 2011; Johnson, 2014). Integral to HL is the capability of individuals and the wider community to take active control and participate in addressing their healthcare needs (ACSQH, 2014, Johnson, 2014, Nutbeam, 2008). Health outcomes can be improved through HL competencies that enable self-care and self-advocacy, development of mutual trusting relationships with health professionals, more effective access to and navigation of the healthcare system, as well as the ability of service providers to communicate effectively (Paasche-Orlow & Wolf, 2007, Sørensen et al., 2012). Recent studies have highlighted that inclusion and promotion of Indigenous health knowledges within health promotion practices can enhance overall Indigenous health outcomes through mutual recognition of differing worldviews (Smylie, Kaplan-Myrth, McShane & Métis Nation of Ontario-Ottawa, 2008; Vass, Mitchell, & Dhurrkay, 2011), improved health communication (Lowell et al., 2012), and through strengthening cultural safety within culturally diverse healthcare systems (Rowan et al., 2013; Nielsen, Alice Stuart & Gorman, 2014).

However, representation of Indigenous health knowledges and practices within health literacy-related policy and practice documents does not appear to have been investigated in previous research. The overall purpose of this paper is to present selected findings of a larger study (Boot, 2016), which has sought to address this knowledge gap by exploring the extent and means by which Indigenous knowledges, paradigms, and practices are recognised, acknowledged, and promoted within HL-related documents across Australia, Canada, and New Zealand. This article focuses on two themes from the findings that have particular relevance: acknowledging cultural beliefs, practices, and norms, and promotion of Indigenous cultural health knowledges, paradigms, and practices (Boot, 2016).

The next section of this article explores definitions and context encompassing Indigenous health and health literacy. The Methods section describes in detail the exploratory research approach, document selection, and content analysis process. The Findings section illustrates prominent examples from within the two themes that are represented within this article. The relevance and implications of these findings are further explored in the concluding discussion, and recommendations for future research are presented.

Background

Many countries, including Australia, Canada, and New Zealand, are considered to have world-class healthcare systems (Organisation for Economic Co-operation and Development, 2017). Extensive efforts are made by governments and the health promotion sector to improve overall health and quality of life outcomes within these populations (Organisation for Economic Co-operation and Development, 2017). The majority of people living within these countries have reasonably good health and enjoy an average life expectancy of 78 to 82 years of age (Australian Bureau of Statistics [ABS], 2015b; Statistics Canada, 2015; Statistics New Zealand, 2015). All three countries have a similarly rich history of

Indigenous cultures, knowledges, and languages, but life expectancy for many Indigenous people within these countries remains significantly lower, ranging from 69 to 80 years of age, in comparison with the national average (ABS, 2015a; Statistics Canada, 2015; Statistics New Zealand, 2015).

The health inequities Indigenous people experience today are predominantly linked to the effects of colonisation and persistently unfavourable social determinants (Dudgeon, Milroy & Walker, 2014; Griffiths, Coleman, Lee & Madden, 2016; Sherwood, 2013). Governments and frontline health services aim to overcome these inequities by developing and implementing a variety of policies, strategies, and evidence-based approaches.

Defining Health Literacy

The concept of health literacy originates from the field of education and has in recent years expanded to include a wide range of skills and knowledges. Health literacy is commonly defined as the abilities and skills of an individual or community to access, appraise, and communicate health-related information, to navigate and engage with the healthcare system, and to advocate and maintain personal and community health and wellbeing (Centre for Literacy, 2011; Nutbeam, 2000; Sørensen et al., 2012; World Health Organisation, 2016a). Governments and scholars advocate that developing and enhancing HL within populations supports the process of empowerment thereby enabling the individual, community, and society to take control over their healthcare needs and engage in collective action to promote health (ACSQH, 2014; Estacio, 2013; Freedman et al., 2009; Johnson, 2014; Kickbusch, 2009; Ministry of Health, 2015; Mitic & Rootman, 2012; Nutbeam, 2008; Sykes, Wills, Rowlands, & Popple, 2013).

Health literacy skills develop across the lifespan, are context specific, and influenced by social, cultural, and political contexts (Centre for Literacy, 2011; Kickbusch, Wait, & Maag 2006; Mitic & Rootman, 2012; Paasche-Orlow & Wolf, 2007; Vass et al., 2011; Zarcadoolas, Pleasant, & Greer, 2005). Zarcadoolas et al. (2005), for example, asserted that *cultural health literacy* needs to be inherent within health literacy models. This is defined as having "the ability to recognize and use collective beliefs, customs, world-view and social identity in order to interpret and act on health information" (p. 197). In addition, Ewen (2011) argued that health professionals need to obtain and effectively utilise *cultural literacy* skills in order for them to be culturally competent in their service delivery. Cultural literacy is considered a skill-set that encompasses awareness, respect, and responsiveness to cultural differences and needs (Ewen, 2011). These abilities become critical within culturally diverse healthcare environments where worldviews, values, approaches to communication, and conceptualisations of health and wellbeing differ significantly from those endorsed by the dominant culture.

More recent conceptualisations of HL are increasingly recognising the significance and complexity of the health literacy environment: That is, "the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way in which people access, understand, appraise and apply health-related information and services" (ACSQH, 2014, p. 10). The Global Conference on Health Promotion in Shanghai in 2016 also identified HL as a critical social determinant of health that needs to be developed and strengthened within populations (World Health Organisation, 2016b). Enhancing HL skills within Indigenous populations, however, requires sophisticated cultural literacy and a collaborative, comprehensive, and empathetic approach

due to the diversity in worldviews, perceptions of health and wellbeing, as well as complex sociocultural factors (Ewen, 2011; Smylie, Williams & Cooper, 2006; Vass et al., 2011).

Indigenous Concepts of Health and Wellbeing

Indigenous populations across and within each of the three countries that are the focus of this article (Australia, Canada, and New Zealand) are diverse in terms of languages and their physical environment (urban, rural, level of remoteness, and climate), as well as political and social relationships, ancestral heritage, and cultural knowledges and practices (Dudgeon et al., 2014; Greaves, Houkamau & Sibley, 2015; Stephenson, 1995). Although Indigenous Peoples share some common health beliefs, their health knowledges and healing practices are diverse due to the unique social, cultural, political, and environmental circumstances within which they have developed and continue to exist (Dudgeon et al., 2014; Durie, 1994).

Despite this diversity, Indigenous people across all three countries tend to regard health and wellbeing as a holistic, multidimensional, and interconnected concept that cannot be separated from other aspects or fragmented into distinguishable individual units (Durie, 1994; Morgan, Slade & Morgan, 1997; Stephens, Porter, Nettleton & Willis, 2006). Health and wellbeing incorporates physical, psychological, social, ecological, spiritual, and cultural aspects and is sustained by nurturing and attending to all these relational aspects regularly in an appropriate and meaningful manner (Campbell, 2002; Durie, 1994; Morgan et al., 1997; Vukic, Gregory, Martin-Misener & Etowa, 2011; Wilson, 2008). Individual studies within all three countries similarly highlight how positive strengthening and maintaining of those inter-related aspects can provide preventative and long-lasting health benefits (Colles, Maypilama & Brimblecombe, 2014; Dockery, 2010; Hopkirk & Wilson, 2014; Lambert et al., 2014; Lowell, Kildea, Liddle, Cox & Paterson, 2015; Smylie et al., 2008; Wilson, 2008).

Previous research addressing Indigenous health concerns have identified HL-related barriers and challenges including racism, communication and language barriers, poor relationships, and culturally associated misconceptions (Durey & Thompson, 2012; Lambert et al., 2014; Lowell et al., 2015; Vass et al., 2011). Such challenges can significantly obstruct access to and provision of effective primary healthcare services, inevitably influencing health outcomes (Lambert et al., 2014). The need for healthcare systems to adequately acknowledge and incorporate Indigenous health knowledges within health promotion practices has also been identified (Hopkirk & Wilson, 2014; Liaw et al., 2011; Lowell et al., 2015; Nielsen et al., 2014; Priest, MacKean, Davis, Briggs & Waters, 2012; Rowan et al., 2013; Vass et al., 2011).

Incorporating and promoting Indigenous knowledges within an Indigenous healthcare environment has the potential to strengthen culturally safe practices and opportunities for self-determination, enhance health communication, and to foster relationships that are built on trust and mutual respect (Colles et al., 2014; Dockery, 2010, Hopkirk & Wilson, 2014; Lambert et al., 2014, Lowell et al., 2015). However, the majority of current conceptualisations of HL are commonly confined to Western pedagogies and paradigms. As such, they frequently disregard the significance of Indigenous cultures, languages, and knowledges as strengths, with potential health benefits (Akena, 2012; Barwin, 2012; Durey & Thompson, 2012; Lambert et al., 2014; Priest et al., 2012; Sherwood, 2013; Smylie et al., 2006; Vass et al., 2011).

Ingleby (2012) suggested that every person has some form of HL that is intrinsic to their personal and cultural beliefs. Enhancing HL within diverse populations can therefore only be achieved when distinctive personal and cultural beliefs are taken into account and appropriately acted upon (Ingleby, 2012). Indigenous concepts of holistic health and associated knowledges and practices have developed over millennia, ensuring individual and community survival, health, and well-being prior to colonisation and beyond. For example, Indigenous-specific HL includes knowledges and practices related to bush medicines and sourcing traditional food (Ewen, 2011) and the interconnectedness of language, physical, emotional, environmental, and spiritual aspects that as a whole contribute to health and wellbeing among First Nation people (Smylie et al., 2006).

Methods

Research Approach

The aim of this study was to explore the ways in which Indigenous knowledges and practices are recognised, acknowledged, and promoted within HL-related policy and practice documents originating from Australia, Canada, and New Zealand. As no previous studies on this topic were identified, an exploratory qualitative research design was considered appropriate to achieve the aim of this study. The research approach was informed by critical theory (Denzin & Lincoln, 2011) and used inductive content analysis methods (Cho & Lee, 2014; Mayring, 2000).

The aim of inquiry from a critical theory perspective, used within this study, is to identify and critically consider existing culturally dominant structures that may influence the ways in which Indigenous knowledges, paradigms, and practices are acknowledged and promoted within HL-related policy and practice documents. Critical theory emphasises that the present reality needs to be understood within context of historical events (such as the history and legacy of colonisation) as these have shaped the current existing social, political, cultural, economic, ethnic, and gender values and power relationships (Denzin & Lincoln, 2011). These existing values significantly influence how social determinants, including HL, are perceived by individuals and cultural groups within culturally and linguistically diverse environments, and which affect overall health and wellbeing.

Data Selection

Publicly available health literacy policy and related practice documents originating from Australia, Canada, and New Zealand were identified from a 10-year period, ranging from January 2005 until December 2015. The majority of these documents were sourced through the broader public internet domain, using search engines Google and Yahoo, in addition to websites from governments and relevant primary healthcare organisations. This approach was appropriate for identifying relevant policy documents and resources that are less likely to be located through searches of academic databases. The search terms used were "Australia," "Canada," or "New Zealand" combined with "Health Literacy" AND "Policy" OR "Framework" OR "Guidelines" OR "Action Plan" OR "Position Statement." A systematic screening of the first 200 search results was conducted. An additional search specific to Australia and Canada was also conducted in order to capture region-specific HL relevant documents. Within this process the countries were replaced with either a state, province, or territory, such as "Western Australia" or "Northern Territory," and "British Columbia" or "New Brunswick," and the first

100 search results were reviewed. From these reviews additional relevant documents were also identified.

Documents were purposefully selected when these influenced, explicitly articulated, or implied concepts and approaches related to HL in health services and programs in Australia, Canada, and New Zealand. Selected documents included strategic plans, policies, frameworks, initiatives, guidelines, policy-related reports, and discussion papers. HL-related promotion materials for service providers were only included when these were specifically cited or promoted within policy and related documents, and they considered relevant to the research question. Health promotion materials needed to provide references on aspects such as Indigenous knowledges, practices, and languages, or service-provider cultural competencies within an Indigenous health context in order to be included within the study.

The selected documents were divided into two groups. The first group comprised governance documents, as in policies, strategic plans, frameworks, action plans, or guidelines that explicitly influence operational processes of health services. Supportive documents, such as discussion papers, reports, resources, and promotion materials, comprised the second group. These were included when they connected to relevant governance documents and specifically addressed HL concerns of Indigenous Peoples. The majority of documents within the selected study sample originated from Australia, followed by Canada and New Zealand (see Table 1). Additionally, the majority of selected documents addressed Indigenous populations either directly or had substantial chapters or references on Indigenous-specific health topics. Documents addressing the general population, for example national strategies and frameworks, were also included to broaden and diversify the study sample (see Table 2).

Data Analysis

An in-depth analysis of 107 systematically selected documents was conducted in order to explore the extent and ways in which Indigenous health knowledges are recognised, acknowledged, and promoted within key HL-related policy and practice documents. The number and type of documents selected for this study are highlighted in Table 3.

These documents were analysed with the assistance of QSR (2012) NVivio10 software. This study applied an inductive qualitative content analysis approach (Cho & Lee, 2014; Mayring, 2000) using a systematic iterative analysis of HL-related documents included within the study sample. All relevant documents were analysed and coded to identify emerging themes, and illustrative quotes were selected related to key themes (Cho & Lee, 2014; Mayring, 2000). The frequent implementation of feedback loops when reviewing the data made certain that the emerging codes, categories, or themes were revised and if necessary amended (see Figure 1), and it also ensured accuracy and trustworthiness within the process (Mayring, 2000).

Table 1. Number of Documents by Country of Origin

Total	Australia	Canada	New Zealand
$N_0 = 107$	$N_1 = 47$	$N_2 = 32$	$N_3 = 28$
100%	44%	30%	26%

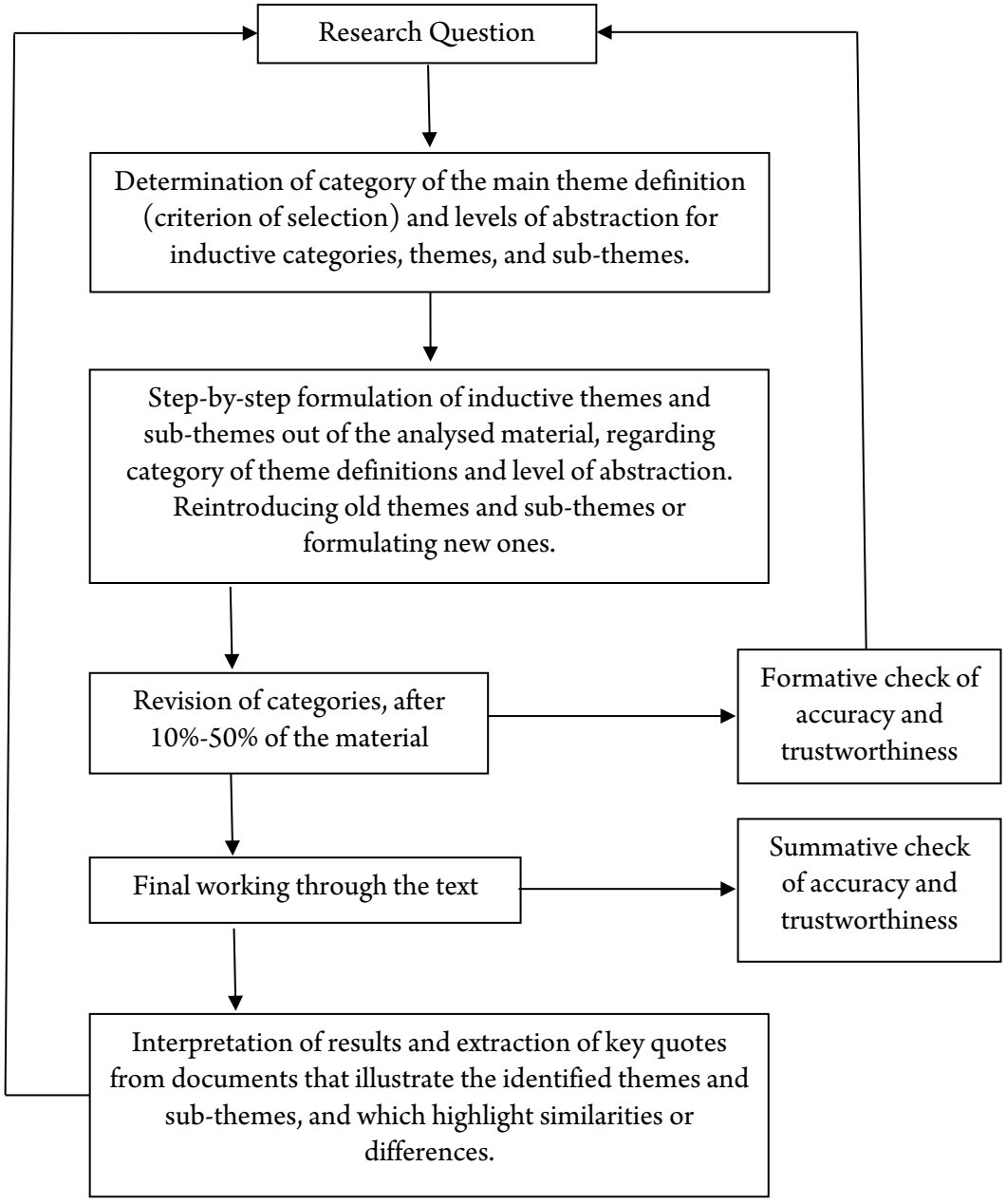

Figure 1. Step model of inductive theme development adapted from Mayring (2000).

Table 2. Number of Documents by Population Group

Total	Specific to Indigenous Populations	General Population with Substantial Reference to Indigenous People	General Population
$N_0 = 107$	$N_1 = 39$	$N_2 = 27$	$N_3 = 39$
100%	36%	28%	36%

Table 3. Number of Documents Within the Study Sample by Type

Type of Document	Number of Documents ($N = 107$)
Strategic plan	13
Policy	5
Frameworks	29
Action plan	7
Guidelines	7
Initiatives or interventions	13
Report or discussion paper	20
Position statement	4
Promotion materials or resources	8
Curriculums	1

The process consisted of three distinctive coding waves with the second and third wave including all selected documents. The first wave of coding reviewed one-third of documents within the study sample in order to identify and extract phrases, common topics, themes, and considerations relevant to the research question. The second wave of coding included all selected documents, reviewing and where necessary amending initially identified themes and topics, as some were considered too broad, inconclusive, or irrelevant. The third wave of coding aimed to review the selected themes with regard to consistency and accuracy. This stage also conducted a final clustering of codes into sub-themes and border key themes. Expert and peer advice was sought from a number of academics with experience in Indigenous health and research practices. One of the advisors identifies as an Indigenous person from Australia (Far North Queensland) with a background in psychology and clinical sciences. All advisors provided support and feedback during the research process through discussion of the emerging themes and sub-themes and their meaningful presentation, in response to which revisions were made.

Findings

After an in-depth analysis of the 107 systematically selected HL-related policy and practice documents from Australia, New Zealand, and Canada, six main themes were identified:

1. Acknowledging cultural beliefs, practices, and norms;
2. Promotion of Indigenous cultural health knowledges, paradigms, and practices;
3. Accommodating language diversity;
4. Cultural responsiveness;
5. Participation, self-determination, and sovereignty; and
6. Approaches to measuring health literacy (Boot, 2016).

Table 4 highlights the total number of documents for each theme with reference to the intended population group. This article focuses on two of these themes: acknowledging cultural beliefs, practices, and norms; and promotion of Indigenous cultural health knowledges, paradigms, and practices. These two themes were selected as examples that best illustrate how Indigenous knowledges, paradigms, and practices are recognised, acknowledged, and promoted within HL-related policy and practice documents across the countries investigated.

Table 4. Number of Documents by Intended Population and Theme

Main Themes	Specific to Indigenous Populations	General Population with Substantial Reference to Indigenous People	General Population
Theme 1: Acknowledging cultural beliefs, practices, and norms	26	11	2
Theme 2: Promotion of Indigenous cultural health knowledges, paradigms, and practices	19	3	2
Theme 3: Accommodating language diversity	17	16	15
Theme 4: Cultural responsiveness	32	24	19
Theme 5: Participation, self-determination, and sovereignty	33	27	39
Theme 6: Approaches to measuring health literacy	3	5	3
Total	39	29	39

Note. $N = 107$.

Theme 1: Acknowledging Cultural Beliefs, Practices, and Norms

Acknowledgement of cultural beliefs, practices, and norms was evident within 39 documents from across all three countries (see Table 5). Governance documents originating from Australia and New Zealand in particular acknowledge and demonstrate substantial recognition of Indigenous cultural diversity. In contrast, limited acknowledgement of Indigenous cultural diversity was found in governance documents originating from Canada. Supportive documents, such as reports and discussion papers addressing HL, were instead more likely to highlight issues of Indigenous cultural diversity within Canada's population. Within this theme, four sub-themes emerged, illustrated in Table 6.

Table 5. Number of Documents by Type and Country of Origin for Theme 1: Acknowledging Cultural Beliefs, Practices, and Norms

Document Type	Australia	Canada	New Zealand
Strategic plan	5	1	3
Policy	1	0	1
Frameworks	3	2	2
Action plan	0	0	1
Guidelines	0	0	2
Initiatives or interventions	0	0	2
Report or discussion paper	2	3	5
Position statement	0	1	0
Promotion materials or resources	2	2	0
Curriculums	0	1	0
Total within theme ($n = 39$)	13	10	16

Note. $N = 107$.

Table 6. Number of Documents by Sub-Theme for Theme 1: Acknowledging Cultural Beliefs, Practices, and Norms

	Sub-Theme	Number of Documents (n = 39)
1.1)	Recognition of Indigenous holistic health	34
1.2)	Indigenous social networks and support systems considered a health resource	14
1.3)	Indigenous culture and languages considered a health asset	10
1.4)	Recognition of cultural protocols	4

Note. N = 107.

Sub-theme 1.1: Recognition of Indigenous holistic health. The most prominent sub-theme identified was the recognition and acknowledgement that many Indigenous people view health and wellbeing as a holistic concept (Sub-theme 1.1). All levels of health governance from Australia, Canada, and New Zealand are increasingly acknowledging that holistic health concepts are pivotal to many Indigenous people and, when integrated within health service delivery, can potentially enhance Indigenous health outcomes. Recognition of the interconnectedness of physical, social, cultural, emotional, and environmental factors, including language and spiritual connections or relationships, are illustrated by examples below. The *Framework for Comprehensive Primary Health Care Services* originating from South Australia Health (2011) illustrates this recognition:

> The importance of a holistic approach to health (i.e. attending to the physical, spiritual, mental, cultural, emotional and social wellbeing) and their role in contributing to health outcomes for Aboriginal peoples; including the environmental determinants of health such as food, water, housing, and unemployment; including the social determinants of health and wellbeing, such as racism, marginalisation, history of dispossession and loss of land and heritage. (South Australia Health, 2011, p. 5)

The example above also indicates a gradual acceptance that Indigenous holistic health concepts may extend beyond the commonly identified social determinants to include, for example, deeper spiritual aspects and ancestral connections to a particular country or place of significance. Such statements can prompt service providers to consider essential aspects of Indigenous health and wellbeing. However, further scrutiny of the core elements within this document revealed no further promotion, support, or guidance on how integration of such Indigenous health concepts can be implemented in practice.

Similar evidence of recognition of comprehensive holistic health concepts can be found within the New Zealand government document: *Rauemi Atawhai: A Guide to Developing Health Education Resources in New Zealand* (Ministry of Health, 2012).

> Māori perceive health in a holistic way where good health is dependent on a balance of factors affecting wellbeing. Wairua (the spiritual), hinengaro (mental), tinana (physical), te reo rangatira (language) and whānau (family) elements interact to produce actual wellbeing. The

> wellbeing of te ao tūroa (environment) contributes also. This approach requires that Māori health be understood in the context of the social, economic, and cultural position of Māori. (p. 28)

The Canadian report, *Evaluation of the First Nations and Inuit Home and Community Care Program 2008-2009 to 2011-2012* (Health Canada & the Public Health Agency of Canada, 2013), illustrates how Indigenous community-controlled health services recognise and include holistic health aspects within their service delivery.

> Home and community care services that are delivered and managed by communities are more likely to appropriately reflect cultural aspects such as language, holistic nature of services, access to both mainstream and traditional care, and emphasis on traditional diet, lifestyle and relationship to the land. (p. 13)

The majority of documents, however, present simplistic, brief, or selective definitions of what comprises Indigenous holistic conceptualisations of health. For example, the Australian government discussion paper, *Health Literacy: Taking Action to Improve Safety and Quality,* states: "Key to addressing health literacy within Aboriginal and Torres Strait Islander communities is ensuring that strategies to address literacy and health literacy build on Indigenous understandings and perspectives, including language and worldview" (ACSQHC, 2014, p. 25). Such broad statements provide limited guidance on how to effectively identify and integrate these concepts within services.

Sub-theme 1.2: Indigenous social networks and support systems considered a health resource. The second sub-theme related to the increasing recognition of Indigenous social networks and support systems as a beneficial health resource (Sub-theme 1.2). Documents at all levels of health governance from Australia, Canada, and New Zealand were identified that promote the inclusion of Indigenous family and social networks within healthcare. The majority of these documents refer to Indigenous family and social networks within the context of understanding health holistically, for example:

> Family and community connectedness are some of the most important factors enabling individuals to recover from the damaging affects (*sic*) of adversity. Family and community connectedness are acknowledged strengths of Aboriginal communities. (New South Wales Health, 2007, p. 5)

> The role of the doula is to build on the more traditional role of Aunty; a lay woman recruited from the community who bridges language and cultural barriers and provides the woman, her partner and family with continuous emotional support, physical comfort and assistance in obtaining information before, during, and just after childbirth. (Ministry of Health British Columbia, 2012, p. 14)

> Involving whānau in support for self-management increases the likelihood that healthy behaviour will be adopted. Since family and whānau members are likely to have similar risk factors to the person with the chronic condition, involving family/whānau is a sound preventative approach. (Health Improvement and Innovation Resource Centre, 2010, p. 8)

However, these documents rarely elaborate on how these relationships and social networks influence health and wellbeing within families, communities, or populations. Documents that do cite the significance of family and social relationships acknowledge that a sharing of health-related information is common practice within these relationships and considered important by many Indigenous people across all three countries.

Sub-theme 1.3: Indigenous culture and languages considered a health asset & Sub-theme 1.4: Recognition of cultural protocols. Consideration of Indigenous culture and languages as a health asset (Sub-theme 1.3) was infrequent and recognition of cultural protocols (Sub-theme 1.4) was rare within governance and associated supportive documents. However, the importance of a strong cultural identity for Indigenous people's health and the value of local Indigenous languages were recognised in some governance documents from all three countries. Statements within these documents demonstrate the significance and relevance of cultural awareness with regard to health and wellbeing. In turn, they prompt health services to recognise and accommodate social, cultural, and language factors at a local level, for example:

> Services at the local level should recognise the protective factors of culture, and the strong connection between culture and positive wellbeing, to help improve Aboriginal and Torres Strait Islander people's access to timely and culturally appropriate mental health care. (Australian Government Department of Health, 2015, p. 21)

> The Northwest Territories attaches a strong value to self-identity, traditional culture, and language, as being important and integral to lifelong learning. It is reasonable and obvious in the minds of the elders that language is very much a part of who Aboriginal people are as people and can only enrich the learning environment as an important asset. (Government of the Northwest Territories, 2008, p. 65)

> Māori perceive health in a holistic way where good health is dependent on a balance of factors affecting wellbeing. Wairua (the spiritual), hinengaro (mental), tinana (physical), te reo rangatira (language) and whānau (family) elements interact to produce actual wellbeing. The wellbeing of te ao tūroa (environment) contributes also. This approach requires that Māori health be understood in the context of the social, economic, and cultural position of Māori. (Ministry of Health, 2012, p. 28)

> The premises were blessed by our kaumatua before it re-opened. (Cultural literacy is an important contributor to health literacy). (New Zealand Guidelines Group, 2011, p. 30)

Theme 2: Promotion of Indigenous Cultural Health Knowledges, Paradigms, and Practices

Active and consistent promotion of Indigenous cultural health knowledges, paradigms, and practices was found to be less substantial within HL-related policy and practice documents when compared to the acknowledgement of cultural beliefs, practices, and norms. Only 24 documents within the sample promoted an inclusion of Indigenous knowledges, paradigms, and practices in health services, acknowledging their significance to culturally competent health literacy environments as well as potentially having long-term health benefits. Table 7 highlights the number of documents by country of

origin. The theme Promotion of Indigenous Cultural Health Knowledges, Paradigms, and Practices is comprised of five sub-themes (see Table 8).

Table 7. Number of Documents by Country of Origin for Theme 2: Promotion of Indigenous Cultural Health Knowledges, Paradigms, and Practices

Document Type	Australia	Canada	New Zealand
Strategic plan	2	0	1
Policy	1	0	0
Frameworks	3	0	0
Guidelines	1	0	1
Initiatives or interventions	0	1	0
Report or discussion paper	1	3	4
Promotion materials or resources	1	5	0
Total within theme ($n = 24$)	9	9	6

Note. $N = 107$.

Table 8. Number of Documents by Sub-Theme for Theme 2: Promoting Indigenous Cultural Health Knowledges, Paradigms, and Practices

	Sub-Theme	Number of Documents ($n = 24$)
2.1)	Acknowledgment and promotion of Indigenous paradigms	9
2.2)	Indigenous healing and medicinal practices	10
2.3)	Indigenous food practices	8
2.4)	Indigenous traditional and contemporary cultural practices	7
2.5)	Indigenous birthing and childrearing practices	2

Note. $N = 107$.

The majority of documents represented within these sub-themes were supportive documents, as in reports, discussion papers and resources, and they originated predominantly from Canada and New Zealand. In contrast, governance documents originated mostly from Australia and to some extent from New Zealand, but they were underrepresented within this theme. Acknowledgment and promotion of Indigenous paradigms (Sub-theme 2.1) and Indigenous healing and medicinal practices (Sub-theme 2.2) were identified as the most prominent sub-themes across all types of documents. The promotion of Indigenous food-related knowledge and practice (Sub-theme 2.3) and traditional and contemporary

cultural practices (Sub-theme 2.4) were less frequent. Promotion of Indigenous birthing and childrearing knowledge and practice (Sub-theme 2.5) was only evident within discussion papers: These stated that policies should give more consideration to the issue.

Sub-theme 2.1: Acknowledgment and promotion of Indigenous paradigms. Some governance documents from Australia and New Zealand explicitly suggested that service providers working in Indigenous healthcare environments should consider incorporating Indigenous paradigms and approaches within service delivery. The need to incorporate and build on Indigenous worldviews, knowledges, and concepts of health and wellbeing within HL was highlighted within some documents (illustrated in examples provided above). Approaches that embrace the principles of self-determination, autonomy, and sovereignty, and that focus primarily on consumer needs rather than provider concerns were also sometimes advocated:

> Key to addressing health literacy within Aboriginal and Torres Strait Islander communities is ensuring that strategies to address literacy and health literacy build on Indigenous understandings and perspectives, including language and worldview. (ACSQH, 2014, p. 25)

> Māori community development models offer another route to wellbeing. These approaches use Māori strengths and assets to develop their own initiatives tailored to meet their own health needs. This includes support to develop programmes and interventions that incorporate Māori models of health and wellbeing, rongoā (traditional healing) and innovation. Services should also be organised around the needs of Māori consumers and their whānau rather than the needs of providers. (Ministry of Health, 2014a, p. 10)

Sub-theme 2.2: Indigenous healing and medicinal practices. Inclusion and promotion of Indigenous healing and medicinal knowledges and practices were explicitly suggested within some governance documents (strategic plans and frameworks) from Australia and New Zealand. These documents recognised the importance of such practices and their need to be considered as an integral part of an Indigenous holistic view of health and wellbeing. In contrast, emphasis on the utilisation of Indigenous healing and medicinal practices was identified only in supportive documents from Canada. Examples illustrated below highlight the similarity across all three countries with some excerpts providing examples of different Indigenous healing and medicinal practices:

> Ngangkari traditional healers have been practising for thousands of years, and are respected by Aboriginal communities throughout Australia as traditional doctors. Ngangkaris play a vital role in shaping the lives of Aboriginal people and influencing and managing a person's spiritual and physical wellbeing. This skill has been passed down to them through their ancestors and in by practising traditional health healing. Where Aboriginal people request the support of a Ngangkari SA Health staff must respect the wishes of a patient and facilitate access to a Ngangkari. (South Australia Health, 2010, p. 20)

> An example of a community-based approach utilizing cultural and spiritual methods as healing practices can be found in Alkalki Lake, British Columbia. Dances, ceremonies, and spiritual practices, such as pow-wows, sweetgrass ceremonies, sweat lodges, and drumming circles were used by traditional healers to try and treat the substance-abuse issues of some of its members. (Centre for Suicide Prevention. 2013, para. 4)

> Several of the GPs and nurses acknowledged the preference Māori often express for natural herbal remedies or traditional Māori medicines (rongoā). Several provider staff noted the role that such traditional therapies may play in their patients' wellbeing and were able to negotiate taking Western medicines alongside rongoā. (Jones et al., 2015, p. 50)

> Includes support to develop programmes and interventions that incorporate Māori models of health and wellbeing, rongoā (traditional healing) and innovation. (Ministry of Health, 2014a, p. 10)

Sub-theme 2.3: Indigenous food practices. The promotion of traditional food-related knowledge (Sub-theme 2.3), such as traditional food sources, hunting, gathering, and processing, was limited or absent within governance documents. Health promotion materials and resources, predominantly from Canada, were the main documents that included such knowledges and practices.

> Through a partnership with the Canadian Diabetes Association and Dietitians of Canada, a tool kit was developed to assist with disseminating the products, including adapted resources for use with Inuit populations in the North and First Nations communities. This tool kit included the development of picture-based nutrition fact sheets that incorporate traditional "country" foods and cooking practices. (Canadian Public Health Association, 2006, p. 4)

Documents from Australia rarely acknowledged the value that traditional Indigenous food knowledges and practices may have for health and wellbeing. Nonetheless, some documents identify that traditional food practices are intrinsic to the holistic concept of health for some Indigenous people and can potentially provide food security and physical, spiritual, and environmental health and wellbeing, for example:

> Traditional foods still require some physical effort to obtain (fishing, hunting, gathering fruit) but assisted by outboard motors, cars, guns and thus not as active – however these activities are often considered to also contribute significantly to spiritual, physical, mental and social wellbeing as well as providing food. (Colles et al., 2014, p. 35)

The only reference found to Māori food-related knowledge and practices from New Zealand was in a document related to cultural competence of health services that suggested that denying Māori people traditional foods may create a culturally unsafe environment for some.

> Table 4: Search #1 Identify barriers that inhibit utilisation of palliative care services for Māori: Not being permitted to bring traditional food to comfort the dying person. (Kidd et al., 2014, p. 85)

Sub-theme 2.4: Indigenous traditional and contemporary cultural practices. The promotion of traditional and contemporary cultural practices (Sub-theme 2.4) was infrequent within HL-related documents across all three countries. Recognition of the significance of incorporating and promoting such practices to ensure a more responsive health literacy environment was evident only in supportive documents. Cultural practices and interconnected relational aspects, for example the ancestral and spiritual connection Indigenous people may have to a specific part of the country or the interpersonal

and spiritual relationship between people, are commonly recognised and promoted within Australia and New Zealand in association with palliative care:

> Aboriginal people are to be supported to 'return to country' to die if requested. (South Australia Health, 2011, p. 28)

> Kinship groups are to be permitted to remain with a person during inpatient care and management and recognition of post-death practices are to be permitted. (South Australia Health, 2011, p. 28)

> Whānau participating in the Waikato project described the last days and hours spent with a dying whānau member or friend as a spiritual experience, and emphasised the critical role of tikanga (cultural practices). They specifically discussed the importance of waiata (song) and karakia (prayer) in managing pain and facilitating the dying person's spiritual journey through making connections between the spiritual and material worlds. These cultural practices were an expression of Māori beliefs and values and often involved strengthening interpersonal relationships (including spiritually) between the person dying and whānau members, and among whānau members. (Ministry of Health, 2014b, p. 50)

In contrast, documents from Canada promote the utilisation of cultural practices more broadly in order to develop culturally safe environments for interaction and to establish new, or maintain existing, important relationships:

> A more formal approach involves a traditional talking circle where a sacred object (such as a feather or rock) is passed from grandmother to grandmother. The one holding the object speaks without interruption by others, creating a respectful and safe environment for all. Teachings are based on the four domains of the traditional Medicine Wheel and the alignment with aspects of human behaviour: mental, emotional, physical and spiritual. (Canadian Public Health Association, 2014, p. 20)

Sub-theme 2.5: Indigenous birthing and child rearing practices. Similarly, the recognition and promotion of Indigenous traditional childrearing and birthing practices (Sub-theme 2.5) as beneficial appears to be rare. Only two supportive documents originating from Australia and Canada were found to explicitly endorse or promote Indigenous approaches to birthing and childrearing practices. The discussion paper from Australia in particular details the potential benefits of traditional Indigenous childrearing and birthing practices. It also recognises the development of Indigenous family and social networks in supporting the development of a healthy and strong Indigenous cultural identity across the lifespan:

> Birthing on country [is defined as] . . . maternity services designed and delivered for Indigenous women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by, or with, Indigenous people. The term BOC should be understood as a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families, an

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> appropriate transition to motherhood and parenting for women, and an integrated, holistic and culturally appropriate model of care for all. (Thoms, Mohamed, & Grant, 2015, p. 13)

This discussion paper, addressing the *National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families*, proposes that more consideration be given towards women living in remote areas with regard to giving birth on country. Having to relocate mothers well in advance of giving birth in larger, sometimes unfamiliar, urban areas may disrupt traditional cultural birthing practices and can result in an emotional and spiritual disconnect from the wider community, their homelands, and cultural identity and affecting the emotional and physical health of mothers and their babies (Thoms et al., 2015).

In summary, the findings from this study illustrate that a wide range of Indigenous knowledges and practices are acknowledged within many HL-related documents to varying degrees. Indigenous knowledges and practices related to birthing and child development, traditional foods, healing, and medicine, as well as understanding of the relationship between health and cultural strength, identity, and language can be considered legitimate elements of HL. The study findings suggest, however, that recognition of such Indigenous knowledges within conceptualisations of HL rarely goes beyond acknowledgement. Little practical guidance on how Indigenous knowledges and practices could be integrated within service delivery and models of care was identified in the documents analysed in this study, even though many of the documents addressed issues of service delivery, health communication, and community engagement.

Discussion

The findings of this study suggest an important distinction between passively recognising and acknowledging the existence of Indigenous diversity, knowledges, paradigms, and practices and actively promoting these within HL-related documents across Australia, Canada, and New Zealand. Health knowledges, and the methods of disseminating and communicating health-related information, are predominantly confined to those derived from Western pedagogies, paradigms, and practices in governance documents (e.g., policies, strategic plans, frameworks, action plans, and guidelines) from all three countries. Those documents that do acknowledge and, less often, promote Indigenous health knowledges were more likely to refer to these unobtrusively by providing marginally descriptive or generalised references.

Promotion and advocacy for inclusion of Indigenous knowledges and practices based on Indigenous ontologies, epistemologies, and values were rare and occurred mostly within supportive documents (e.g., discussion papers, reports, resources, and promotion materials). These documents were more likely to provide practical examples or detailed descriptions of specific local Indigenous knowledges and customs, including traditional healing, food, cultural practices and to elaborate on holistic health concepts. Not surprisingly, it has been suggested that services and agencies working specifically within an Indigenous healthcare environment are more inclined to advocate and presumably incorporate and promote such knowledges and practices as they are more likely to recognise their significance and value (Health Canada & the Public Health Agency of Canada, 2013).

The significance of holistic health concepts and understandings within Indigenous cultures in Australia, Canada, and New Zealand is becoming increasingly acknowledged across all levels of health governance;

this was evident within approximately one-third of all HL-related policy and practice documents. Recognising and incorporating Indigenous understandings of holistic health has been persistently advocated within relevant research literature (Colles et al., 2014; Dudgeon et al., 2014; Durey & Thompson, 2012; Vukic et al., 2011). Healthcare providers delivering services to Indigenous people are increasingly prompted by policy, frameworks, action plans, and guidelines to reflect on existing paradigms and approaches, and the need to consider alternative approaches that are deemed meaningful, relevant, and culturally safe, to enhance HL skills of Indigenous populations. Despite an increase in promotion of Indigenous holistic health conceptualisations within governance documents, which nonetheless is a positive and necessary step forward, the study findings suggest that Indigenous knowledges, understandings, and practices are rarely recognised and promoted as legitimate elements of HL.

Whilst it is justifiable for the majority of HL-related documents to broadly acknowledge the diverse languages, cultural practices, and views on health that many Indigenous Peoples share without detailing specifics, more specific guidance and resources are needed when aiming to enhance the cultural competence of services and service providers. Numerous studies from Australia, Canada, and New Zealand have cited similar culturally associated misconceptions, communication and language barriers, and prevailing poor relationships between Indigenous people and the health service sector as common and persisting challenges (Colles et al., 2014; Durey & Thompson, 2012; Freeman et al., 2014; Lambert et al., 2014; Lowell et al., 2015; Lowell et al., 2012; Richardson, 2012; Vass et al., 2011). Disregarding, diminishing, or discrediting Indigenous health knowledges and practices within an Indigenous health literacy environment by another culture can be perceived as maintaining structures of cultural bias and dominance (Connell, 2014; Durey & Thompson, 2012).

Incorporating Indigenous holistic views of health and wellbeing within an Indigenous healthcare environment, as well as within mainstream services that frequently provide care and services to Indigenous people, is essential in order to address the extensive and complex health problems many Indigenous people face (Dudgeon et al., 2014; Durey & Thompson, 2012; Keleher & MacDougall, 2016). Considering Indigenous-specific social determinants is critical (Dudgeon et al., 2014; Keleher & MacDougall, 2016), and culturally sensitive and safe practices need to be evident within the wider health literacy environment, including policies, service providers, processes, and resources (Durey & Thompson, 2012; Lambert et al., 2014; Lowell et al., 2012; Vass et al., 2011). However, language barriers, poor use of interpreter services, inadequate or no cross-cultural health education for service providers resulting in culturally inappropriate care jeopardise improving HL and health outcomes for many Indigenous people (Durey & Thompson, 2012; Lowell et al., 2012; Vass et al., 2011). Consequences may include Indigenous patients refusing and abandoning treatment, having a limited understanding of prescribed medications, and receiving inequitable treatment regimes compared to non-Indigenous people (Durey & Thompson, 2012; Lowell et al., 2012). A study by Lambert et al. (2014) recommended the development and provision of adequate HL training for healthcare professionals and illustrates that implementation of government frameworks and policies needs to be supported through provision of constructive resources, guidelines, and training opportunities.

Considering Ingleby´s (2012) proposition that every person develops varying concepts, understandings, and levels of HL throughout the life-span, then Indigenous Peoples will have developed unique forms of HL throughout their history. Taking such understandings into account will likely enhance both provider

and consumer HL skills (Ingleby, 2012) and contribute to developing culturally safe spaces as relationships and health communications are improved. For example, adopting the concepts of holistic health that are a key element of HL therefore supports the process of establishing culturally safe healthcare environments for Indigenous Peoples, an issue that has also been frequently raised (Colles et al., 2014; Dudgeon et al., 2014; Durey & Thompson, 2012; Hopkirk & Wilson, 2014; Vukic et al., 2011).

A prerequisite to establishing culturally safe environments is the identification, acknowledgment, and elimination of institutional and personal cultural biases or prejudices (Dudgeon et al., 2014; Durey & Thompson, 2012; Lambert et al., 2014). This also requires a decolonisation of conceptualisations of HL as well as the healthcare environment and the development of strong and trusting relationships between providers and service recipients (Durey & Thompson, 2012; Richardson, 2012). There is a risk that Indigenous people will potentially avoid healthcare environments that are considered culturally unsafe, due to fear of discrimination and culturally insensitive treatment (Barnett & Kendall, 2011; Durey & Thompson, 2012; Lambert et al., 2014). As a result, the effectiveness of health promotion, health communication, and disease prevention efforts are diminished and treatment for acute or existing health conditions can be compromised (Barnett & Kendall, 2011; Colles et al., 2014; Lambert et al., 2014). However, health services that recognise, value, promote, and incorporate Indigenous knowledges and practices are more likely to establish culturally safe and supportive environments as they mitigate the risks of misinterpretations, misunderstandings, confusion, and potentially adverse outcomes (Colles et al., 2014; Dudgeon et al., 2014; Lowell et al., 2012; Vass et al., 2011; Wilson, 2008).

Culturally safe and supportive environments are fundamental to enable empowerment, self-determination, and autonomy. Durey and Thompson (2012) and Richardson (2012), for example, assert that it is imperative to acknowledge and address existing power differentials within these relationships. According to these authors, this process requires critical reflection, cultural competencies, and a genuine commitment to change (Durey & Thompson, 2012; Richardson, 2012). Many of the current definitions of, and approaches to, HL endorse concepts of empowerment, self-determination, and self-efficacy with an overall aim to enable populations to take control over their healthcare needs (ACSQHC, 2014; Estacio, 2013; Kickbusch, 2009; Ministry of Health, 2015; Mitic & Rootman, 2012; Nutbeam, 2008; Sørensen et al., 2012). The concept of empowerment is concerned with the removal of formal or informal barriers within existing political, social, economic, cultural, and personal environments (Hennink, Kiiti, Pillinger & Jayakaran, 2012; Wallerstein, 2006).

In order for Indigenous people to become genuinely empowered and to take control over their own health concerns, they need to be able to negotiate and determine what comprises a culturally safe environment: One that they perceive as providing a sufficient and culturally responsive physical and psychological space (Akena, 2012; Huia, 2014). Decolonisation of conceptualisations of HL is a necessary first step in the process of ensuring the value of Indigenous knowledges, paradigms, and practices is fully realised in health policy and practice. It is therefore critical that governments, policymakers, and health services acknowledge and integrate Indigenous health knowledges and practices within the health literacy environment.

Conclusion and Implications

Acknowledging and promoting Indigenous knowledges and practices as legitimate elements of health literacy is imperative and integral to cultural literacy. It provides the foundation for governments, Indigenous communities, academics, and service-providers to work collaboratively within a culturally diverse healthcare system, and to explore, develop, and enable avenues for Indigenous self-determination and greater control at a local level. Findings from this study, supported by other research, suggest that there is limited support, guidance, or provision of effective resources and training for services to effectively incorporate Indigenous health knowledges, paradigms, and practices.

Effective identification and removal of the formal and informal barriers to incorporating Indigenous health-related knowledges and practices would support decolonisation efforts and contribute towards establishing culturally safe environments. Culturally safe and supportive environments are compromised or unachievable without recognition and integration of Indigenous health knowledges, paradigms, and practices. Consequently, any attempts to enhance health literacy of both health professionals and consumers are jeopardised, and opportunities for Indigenous Peoples to drive the change they consider positive and beneficial will remain limited.

Limitations

A limitation of this study was the sole focus on analysis of documents, without the opportunity to investigate the formal and informal processes that develop and influence the construction of such documents. As such the study was unable to shed light on the underpinning processes and power-relationships that affect the construction of knowledge and current policy outcomes.

Although this study comprised of only one research method, which may have restricted the interpretation, discussion, and conclusions drawn, the study was strengthened through investigator triangulation. Three experts and one peer advisor individually provided critical feedback as they assessed and evaluated the research process and content, as well as data readability, trustworthiness, and credibility in response to which revisions were made. Additionally, extensive and detailed authentic illustrative references have been presented throughout this article to support subsequent interpretations.

A further constraint was that the study was only able to include readily accessible documents. Although a thorough and systematic search was conducted within the most common and popular internet search engines and government databases, it is likely that some key documents may have been missed. For example, discussion papers that significantly debate and influence the inclusion of Indigenous knowledges within policy, as well practice-related documents are not necessarily accessible through publicly accessible databases. Such documents could provide additional valuable insight into the current discourse on how Indigenous knowledges are portrayed and valued, and potentially highlight any contrasting viewpoints on the issue. Policy and practice documents from local Indigenous and non-Indigenous community-controlled health organisations are also commonly not available to the general public. However, accessing and analysing such documents could provide valuable knowledge on how Indigenous languages, knowledges, and practices are valued, acknowledged, integrated, and promoted at the grassroots level and may be significantly stronger than in those documents that are readily accessible within the public domain. In order to mitigate these risks, a large and diverse sample of publicly available

sources was chosen which is believed to accurately reflect of the current progress on incorporating Indigenous knowledge practices within the health literacy environment.

Suggestions for Future Research

Future studies could consider a distinctions-based approach whereby specific Indigenous cultural and language groups, as well as different geographical regions, are examined to explore whether local distinct health literacy strengths and needs are addressed within health systems through incorporation of locally relevant Indigenous knowledges and practices. Such clarification could be achieved by conducting case studies. Additionally, such research could be supported by conducting a mixed-method approach using statistical text analysis combined with more conventional qualitative methods. For example, interviews with health delivery providers and healthcare users would gain a broader and deeper sense of how Indigenous knowledges, paradigms, languages, and practices are incorporated and promoted within the local health literacy environment.

The limited acknowledgement and promotion of Indigenous knowledges and practices within HL policy and related practice documents, also raises questions regarding the involvement and influence of Indigenous communities and peak organisations in the process of their development. An investigation into these processes could help identify systemic barriers and challenges as well as draw attention to personal opinions, perceptions, and experience of the significance of Indigenous knowledges and language within current policy discussions and the health literacy environment. Similar suggestions for additional research have also been proposed by Smylie et al (2008). Such studies could collectively contribute towards decolonising healthcare systems, improving cultural respect, and could provide practical constructive guidance for effectively enhancing health literacy within culturally and linguistically diverse populations and healthcare systems.

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