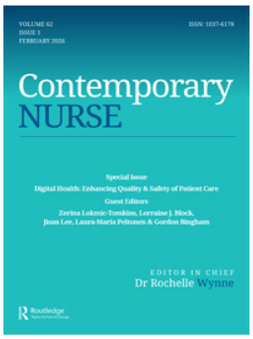

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REVIEW ARTICLE

Understanding nurses' perspectives on Māori health equity: a systematic scoping review

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Background: Nurses have professional, ethical and legal obligations to address health inequities for Māori.
Objective: To investigate and synthesise the literature available on nurses' views of health equity for Māori to inform future research, policy and practice.
Design: Informed by kaupapa Māori methodology, the systematic scoping review was conducted with the JBI approach and reported with the PRISMA Extension for Scoping Reviews (PRISMAScR). Database searches included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus, EMBASE, Psychinfo, Ovid MEDLINE and Google Scholar with 634 articles screeded.
Methods: Data were extracted and charted by author SH and reviewed by VE and EG. The JBI framework was used to guide data charting, followed by thematic analysis.
Results: Three key themes were identified in the literature. For Māori nurses, health equity for Māori was seen as an obligation; non-Māori nurses often viewed health equity for Māori as optional. Barriers to achieving health equity for Māori were identified by both Māori and non-Māori nurses. Three subthemes were identified for Māori nurses: te ao Māori and tikanga Māori, dual clinical–cultural role and lived experiences of racism. For non-Māori nurses, two subthemes were identified: non-Māori nurses demonstrating both an understanding and a lack of understanding of health equity.
Conclusion: Due to culture, Māori nurses had a greater commitment to addressing health equity. Conversely, non-Māori nurses appear to show greater ambivalence over whether to address health inequities. This study was limited by a small sample of non-Māori participants in the literature. Future research could focus on barriers and enablers for non-Māori nurses' commitment to health equity, valuing Māori nurses' cultural contribution and monitoring, education and action of NCNZ, nursing education institutions and professional leadership in addressing health equity.

Keywords: health equity; nursing; racism; policy; nurses; New Zealand; indigenous peoples; health inequities

Impact statement

At present, the burden of responsibility to address health equity sits on the shoulders of Māori, which is in itself inequitable. Steps can be undertaken in individual workplaces and at larger national levels like the Nursing Council of New Zealand to address this imbalance.

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Plain language summary

Nurses are the largest health workforce in Aotearoa New Zealand and have professional, ethical and legal obligations to address health inequities for Māori. This review examines nurse perspectives on health equity for Māori. Non-Māori tended to view addressing health equity as optional, whereas Māori typically saw it as an obligation associated with culture. This review highlights important areas for future research considerations regarding non-Māori enablers and barriers to showing a commitment to addressing health equity for Māori.

Introduction

Background

Nurses make up the largest body of healthcare professionals in Aotearoa New Zealand (referred to simply as Aotearoa from here) (Health New Zealand, 2024). They are reported as the most trusted healthcare profession (Oruche & Zapolski, 2020), often the first point of contact when accessing healthcare, and provide 80% of direct patient care (Alexander et al., 2023; Oruche & Zapolski, 2020; Theunissen, 2011). This positions them in a unique position to address Māori health inequities.

Māori are the indigenous people of Aotearoa. Being indigenous is an inherited right to sovereignty, which was reaffirmed by He Whakaputanga, the declaration of independence of New Zealand, in 1835 (Moewaka Barnes & McCreanor, 2019). Te Tiriti o Waitangi – a treaty between Pākehā (European descendants) and Māori written in the Māori language – was signed by over 500 Rangatira (Chiefs), further enshrining sovereignty for Māori over their taonga (treasures) (Came-Friar et al., 2019; Walker, 1990). However, in the act of establishing colonial dominance in Aotearoa, agreements such as te Tiriti o Waitangi were violated (Walker, 1990). This colonial violation resulted in cultural knowledge and language loss, together with forced land forfeiture, displacing Māori sovereignty and undermining Māori health, wealth, wellbeing, autonomy and authority (Moewaka Barnes & McCreanor, 2019; Walker, 1990). That colonially enforced subjugation reverberates into the present, reflected in political systems of dominance and Eurocentric attitudes (des Forges, 2024; Stewart, 2023). These political systems are influenced by the societal values of the majority via an imported democracy disguised as 'fairness' (des Forges, 2024; Reidy et al., 2025; Stewart, 2023). This 'fairness' has been described as a façade and used as part of maintaining colonial control while perpetuating marginalisation and racism towards Māori which in turn contributes to health inequities (Came-Friar et al., 2019; des Forges, 2024; Reidy et al., 2025; Stewart, 2023). For instance, Māori life expectancy is approximately 7 years shorter than Aotearoa Europeans, a direct result of historical, past and present colonial violence (Statistics New Zealand, 2021; Sullivan et al., 2023)

Equity is defined as an absence of health disparities between groups or populations of varying socioeconomical advantages or disadvantages (Braveman & Gruskin, 2003; Came-Friar et al., 2019). This comparison can then be used as a measurement of the existence of key colonial characteristics, such as racism, socioeconomically, politically and within our health system (Came-Friar et al., 2019; Jones, 2000; Kendi, 2019).

Approximately 7% of Aotearoa's nursing workforce is Māori, a stark underrepresentation given Māori make up around 17.1% of the overall population (Statistics New Zealand, 2024; Wilson, Barton et al., 2022). Low representation adds to the challenges Māori face, including enduring racism and discrimination in a predominantly colonial and Eurocentric society. A stronger Māori nursing workforce is a powerful lever for Māori health equity (Curtis et al., 2012; Wilson, Barton et al., 2022). Māori nurses bring a lived understanding of racism and

colonisation, relational trust with whānau (family) and communities, and culturally grounded care shaped by tikanga (correct procedure) and kaupapa Māori (Māori way of being), including aroha (empathy), manaakitanga (caring) and mātauranga Māori (Māori knowledge) (Wilson, Barton et al., 2022).

Registered nurses in Aotearoa New Zealand are guided by ethical, professional and legislative frameworks that collectively require them to advance health equity for Māori and practise in culturally safe ways (New Zealand Nurses Organisation, 2019; Nursing Council of New Zealand, 2011; Nursing Council of New Zealand, 2012; Nursing Council of New Zealand, 2025; Health & Disability Commissioner, n.d.). Across these, common expectations include culturally safe and Tiriti-responsive practice, active partnership with Māori, respect for Māori values and rights, and a professional duty to identify and address inequities. These obligations are underpinned by the Health Practitioners Competence Assurance Act 2003, which requires regulators to set standards of clinical, cultural and ethical practice. Recent NCNZ updates in 2025 strengthen and make more explicit responsibilities for nurses in addressing Māori health equities (Nursing Council of New Zealand, 2025). Despite the responsibilities nurses have in addressing health equity for Māori, Māori continue to experience disparities in access to health and health outcomes when compared to non-Māori (Hobbs et al., 2019).

Objectives

The aim of this scoping review is to investigate and synthesise the literature presenting nurses' views on health equity for Māori. This will be used to address the research question: *What are nurses' views on health equity for Māori* ? This review is timely and much needed to inform policy and practice in a rapidly changing political and professional landscape when it comes to equity for Māori (Nursing Council of New Zealand, 2025; Pitama et al., 2024; New Zealand Government Education and Training Amendment Bill (No 2), 2025; New Zealand Government Principles of the Treaty of Waitangi Bill, 2025). Results will also inform future research on health equity in nursing in Aotearoa.

Methods

The scoping review's objectives, inclusion criteria and methods were registered with Open Science Framework (OSF) (Hughes et al., 2025). The scoping review was conducted with the JBI approach, which is a comprehensive framework for reviews that aims to strengthen academic rigor (Peters et al., 2020; Pollock et al., 2021). The scoping review was reported with the PRISMA Extension for Scoping Reviews (PRISMAScR) checklist (Tricco et al., 2018).

Kaupapa Māori methodology underpinned the review. Kaupapa Māori methodology challenges Eurocentric research that portrays deficits or misrepresentation of Māori. It reclaims the research space for Māori (Smith, 2021; Wilson, Mikahere-Hall, et al., 2022). The review was designed by Māori to place Māori health advancement in the centre of decision making. It was led by a Māori researcher (SH) with a Māori mentor (JH). Non-Māori authors guided the review from an allyship and supervision perspective.

Positionality

The lead author (SH) is of Ngāi Tahu and European descent. The research team's ethnicity/whakapapa includes Māori (JH), kailoma – iTaukei Fijian (AA), German (VE) and European (EG,

AA, VE) ancestry. All are academic-based health researchers with varied experience in health equity. SH and JH are Māori nurses who have experience in the Aotearoa healthcare systems.

Search methods

No date restrictions, publication restrictions or other restrictions were placed. The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus, EMBASE, Psychinfo, Ovid MEDLINE and Google Scholar databases were searched to identify publications on nurses' views of health equity for Māori. All pages and references were downloaded and screened from Google Scholar. The search was undertaken in August 2025. The Boolean string used the logic combinations 'AND' and 'OR'. A librarian was involved with the development of the terms to strengthen the quality. The full search strategy for all databases can be found in Table 1.

Study selection

Eligibility criteria for scoping study inclusion are presented in Table 1. A broad and inclusive approach was utilised using the keywords and criteria to search peer-reviewed publications. The aim was to identify the perceptions and experiences of registered nurses regarding health inequities affecting Māori. Only peer-reviewed literature was included in the review due to higher quality data being suitable to reflect views and experiences (Butler et al., 2016).

A total of 817 articles were identified from the databases. 183 duplicates were manually removed using Rayyan.ai (Ouzzani et al., 2016), leaving 634 articles for title and abstract screening. Title and abstract screening was undertaken by one reviewer (SH) due to the focused scope of the review and the relatively small anticipated evidence base. To mitigate the risk of selection bias, inclusion and exclusion criteria were clearly defined a priori and applied consistently. 619 articles were excluded after title and abstract screening. Two reviewers (SH and VE) independently reviewed all full text articles against the inclusion criteria. Any disagreements were resolved through discussion and consensus was reached in all cases.

This resulted in nine articles to be included in the review. Reference lists of the included articles were screened by one reviewer (SH) to identify additional eligible studies, resulting in one further article meeting the inclusion criteria. Eligibility of this article was confirmed through team discussion.

Data extraction and analysis

A data template was created in Microsoft Excel by two reviewers (SH and VE). Data was extracted and charted by one reviewer (SH) and reviewed by two other reviewers (VE and EG). Articles that were original research, only the methods and results sections went forward into the analysis stage. For the auto-ethnographic articles, the full text was included. The JBI framework was used to guide charting data (Peters et al., 2020). Data charted included authors, year published, objectives, population, concept, context, study type and main findings. The charted data was then used after analysis to relate themes coded in each article.

Using an inductive approach, Braun and Clarke (2022) thematic analysis was used to guide the analysis of the data to identify themes. This approach was suitable as only qualitative studies met the inclusion criteria. Thematic analysis is a qualitative analysis method that allows the identification of codes and patterns within data that can be formed into themes (Braun & Clarke, 2022). The research team applied Braun and Clarke (2022) methodology by following

Table 1. Full search strategy.

Medline	1. exp nurses/ or nurs*.ti,ab,kf.
	2. view*.ti,ab,kf.
	3. Perspective*.ti,ab,kf.
	4. opinion*.ti,ab,kf.
	5. belief*.ti,ab,kf.
	6. understand*.ti,ab,kf.
	7. perception*.ti,ab,kf.
	8. perceive*.ti,ab,kf.
	9. attitude*.ti,ab,kf.
	10. experience*.ti,ab,kf.
	11. "implicit bias*".ti,ab,kf.
	12. knowledge.ti,ab,kf.
	13. 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12
	14. maori people/ or (Maori People or Maori).ti,ab,kf.
	15. Zealand.ti,ab,kf.
	16. Aotearoa.ti,ab,kf.
	17. "tangata whenua".ti,ab,kf.
	18. 14 or 15 or 16 or 17
	19. (health* adj3 (inequit* or equit* or disparit* or gap* or equal* or inequal*)).ti,ab,kf.
	20. health inequities/ or health status disparities/ or healthcare disparities/ or socioeconomic disparities in health/
	21. 19 or 20
	22. 22. 1 and 13 and 18 and 21
Embase	1. exp nurses/ or nurs*.ti,ab,kf.
	2. view*.ti,ab,kf.
	3. Perspective*.ti,ab,kf.
	4. opinion*.ti,ab,kf.
	5. belief*.ti,ab,kf.
	6. understand*.ti,ab,kf.
	7. perception*.ti,ab,kf.
	8. perceive*.ti,ab,kf.
	9. attitude*.ti,ab,kf.
	10. experience*.ti,ab,kf.
	11. "implicit bias*".ti,ab,kf.
	12. knowledge.ti,ab,kf.
	13. 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12
	14. maori people/ or (Maori People or Maori).ti,ab,kf.
	15. Zealand.ti,ab,kf.
	16. Aotearoa.ti,ab,kf.
	17. "tangata whenua".ti,ab,kf.
	18. 14 or 15 or 16 or 17
	19. (health* adj3 (inequit* or equit* or disparit* or gap* or equal* or inequal*)).ti,ab,kf.
	20. health inequities/ or health status disparities/ or healthcare disparities/ or socioeconomic disparities in health/
	21. 21. 19 or 20 22. 1 and 13 and 18 and 21
Psychinfo	1. exp nurses/ or nurs*.mp.
	2. view*.mp.
	3. perspective*.mp.
	4. opinion*.mp.
	5. belief*.mp.
	6. understand*.mp.
	7. perception*.mp.
	8. perceive*.mp.
	9. attitude*.mp.
	10. experience*.mp.
	11. exp Implicit Bias/ or "implicit bias*".mp.
	12. knowledge.mp.
	13. 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12
	14. Maori.mp.
	15. Zealand.mp.
	16. Aotearoa.mp.
	17. "tangata whenua".mp.
	18. 14 or 15 or 16 or 17
	19. (Health* adj3 (inequit* or equit* or disparit* or gap* or equal* or inequal*)).mp.
	20. exp Equity/ or exp Health Disparities/
	21. 19 or 20
	22. 1 and 13 and 18 and 21

CINAHL	1. MH nurses OR nurs* 2. (View* OR perspective* OR opinion* OR belief* OR understand* OR perception* OR perceive* OR attitude* OR experience* OR "implicit bias*" OR knowledge) OR MH Attitude 3. Māori OR Zealand OR Aotearoa OR "tangata whenua" 4. (Health* AND (inequit* OR equit* OR disparit* OR gap* OR equal* OR inequal*)) OR MH health inequity 5. XB (S1 AND S2 AND S3 AND S4)
Scopus	(nurs*) AND (view* OR perspective* OR opinion* OR belief* OR understand* OR perception* OR perceive* OR attitude* OR experience* OR "implicit bias*" OR knowledge) AND (māori OR "tangata whenua" OR aotearoa OR zealand) AND TITLE-ABS-KEY (health* W/3 inequit* OR equit* OR disparit* OR gap* OR equal* OR inequal*)
Google Scholar	("nurse view" OR "nurse perspective" OR "nurse opinion" OR "nurse belief" OR "nurse understand" OR "nurse perception" OR "nurse perceive" OR "nurse attitude" OR "nurse experience" OR nurse "implicit bias" OR "nurse knowledge") AND (Māori OR "tangata whenua" OR Zealand OR Aotearoa) AND ("health equity" OR "health inequity" OR "health gap" OR "health disparity" OR "health equality" OR "health inequality")

the six phases of reflexive thematic analysis. Kaupapa methodology underpinned the analysis with whiriwhiri (discussions) and wānanga (collective learning) being held throughout the analysis process (Wilson, Mikahere-Hall, et al., 2022). One of the ways we respectfully put into practice the Kaupapa Māori methodology was applying the give way rule. Where in instances of disagreement, the voices of the Māori team members were prioritised (Naepi, 2015). Kaupapa Māori methodology also placed Māori health advancement at the centre of decision making when deciding on themes, while acknowledging and affirming the various authors' and participants' contributions (Onwuegbuzie & Frels, 2016; Smith, 2021). The primary author (SH) familiarised themselves with the data and generated codes (Braun & Clarke, 2022, phase 1: familiarising the data set and phase 2: coding). The first (SH) and third (JH) authors discussed the codes and verified these together. The research team then met and discussed the codes and possible patterns (Braun & Clarke, phase 3: generating initial themes). These patterns led to the development of themes, which were continuously discussed collaboratively with all members of the research team, and full consensus was met (Braun & Clarke, 2022, phase 4: developing and reviewing themes and phase 5: refining and naming themes). Throughout the manuscript preparation, themes were reflected on, reviewed and refined further (Braun & Clarke, 2022, phase 6: writing).

Results

Selection of sources of evidence

Refer to Figure 1. PRISMA flow diagram for details on article screening and sources. Of the 15 reports sought for retrieval, six did not meet the eligibility criteria due to opinion pieces ($n = 2$), conference presentation ($n = 1$), not related to health equity ($n = 1$), not related to Māori ($n = 1$) and not nurses' views or experiences ($n = 1$). This resulted in 10 articles eligible for data extraction and analysis.

The extracted data is presented in Table 2. All studies were based in Aotearoa. Publication date ranges from 2020 to 2025, with one from 2014 (Huria et al., 2014). All studies were qualitative empirical studies. Three focus groups (Kidd et al., 2020, 2022; Komene et al., 2025), five semi-structured interviews (Hunter & Cook, 2020; Huria et al., 2014; Taylor et al., 2024; Walker et al., 2024; Watkins et al., 2024), one narrative approach (Davis et al., 2021) and one wānanga (Komene et al., 2023). Seven studies reported kaupapa Māori or Māori centred research (Davis et al., 2021; Hunter & Cook, 2020; Huria et al., 2014; Kidd et al., 2020; Komene et al., 2025; Taylor

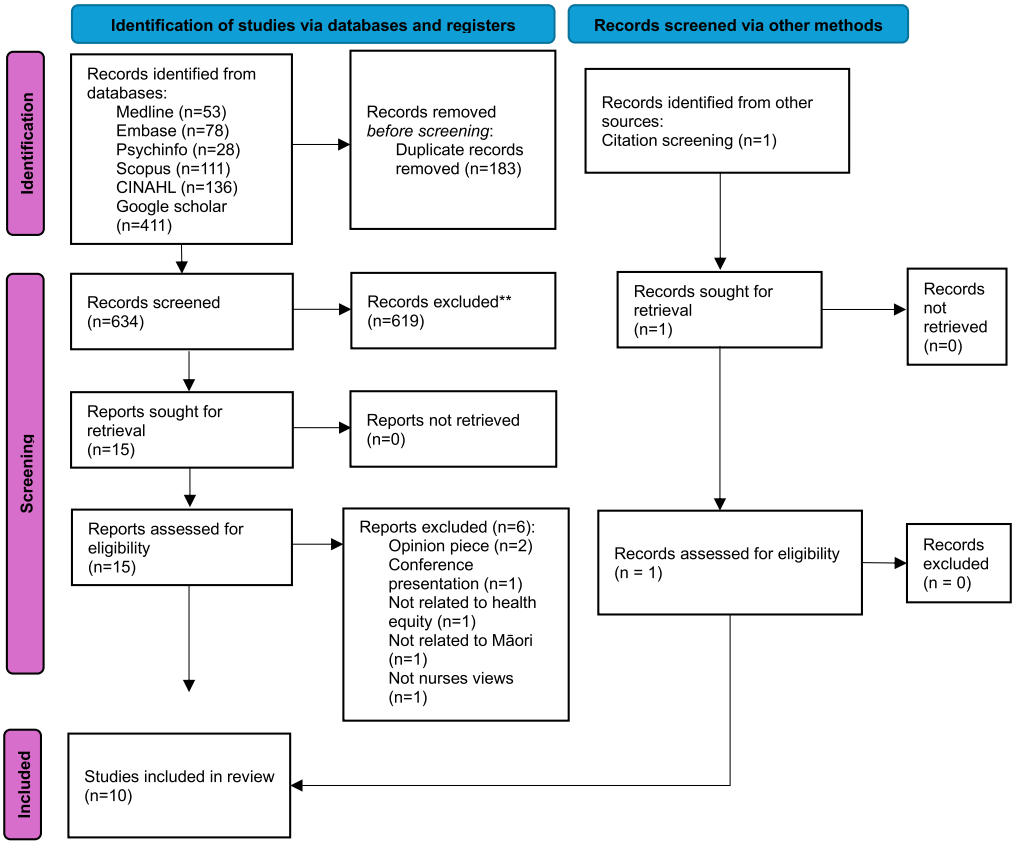

Figure 1. PRISMA 2020 flow diagram.

et al., 2024; Watkins et al., 2024). All studies had at least one Māori author. The total participant sample across all papers was 90 nurses, nurse practitioners and nurse/midwife specialists. Of the 90 nurses, 61 identified as Māori, 13 as non-Māori and 16 did not identify the ethnicity (Walker et al., 2024; Watkins et al., 2024). Walker et al. (2024) and Watkins et al. (2024) sampled other health professionals, including nephrologists and transplant nephrologists (Walker et al., 2024), and 25 parents and 13 specialist doctors (Watkins et al., 2024). The studies reporting experience (Hunter & Cook, 2020; Huria et al., 2014; Kidd et al., 2022; Taylor et al., 2024) indicated that participants' nursing experience ranged from 2 to 40 years.

Three dominant themes were identified in the literature (Figure 2); summarised, these were Māori nurses: addressing health equity for Māori is obligatory, non-Māori nurses: optional. Both Māori and non-Māori nurses identified several barriers to health inequities inclusive of a lack of resources, structures and adequate processes.

An additional three subthemes were identified specific to Māori nurses': the importance of te ao Māori and tikanga Māori, the challenge of dual clinical–cultural roles and their lived experiences of racism. For non-Māori nurses, two additional subthemes were noted: non-Māori nurses demonstrated both an understanding and a lack of understanding of health equity. These themes will now be discussed at length.

Table 2. Charted data.

Authors (year)	Year	Population	Concept	Context	Study type	Objectives	Findings	Themes coded in this article	Full reference
Kidd, J., Came, H., & McCreanor, T.	2022	4 tauiwi nurses and 5 Māori nurses.	Perceptions beliefs and attitudes.	Anti-racism praxis.	Focus group.	To examine racism to generate interventions.	Mono-cultural practice, everyday micro-aggressions; complexity and the costs of racism, Pākehāprivilege and employment discrimination.	Māori nurses: Addressing health equity for Māori is obligatory. Non-Māori nurses: Addressing health equity for Māori is optional. Barriers to health equity for Māori.	Kidd et al. (2022)
Huria, T., Cuddy, J., Lacey, C., & Pitama, S	2014	15 Māori registered nurses.	Identify the effects of racism.	Racism.	Semi-structured interviews. Kaupapa Māori.	To explore the experience and impact of racism on Māori registered nurses within the New Zealand health system.	Māori nurses experience racism, before and during theirnursing career. Institutional, interpersonal, and internalised racism was present.	Māori nurses: Addressing health equity for Māori is obligatory. Barriers to health equity for Māori.	Huria et al. (2014)
Komene, E., Davis, J., Davis, R., O'Dwyer, R., Te Pou, K., Dick, C., Sami, L., Wiapo, C., & Adams, S.	2024	5 Māori Nurse Practitioners and 1 Māori nurse researcher.	Perceptions.	Patient safety.	Focus group. Kaupapa Maori.	To describe Māori NPs perspectives on patient safety when caring for Māori and understand how Māori NPs deliver safe health care.	Dual cultural clinical role, knowledge systemsand living in Māori and Pākehā worlds.	Māori nurses: Addressing health equity for Māori is obligatory.	Komene et al. (2025)

Kidd, J., Came, H., Herbert, S., & McCreanor, T.	2020	5 Māori and 4 Tauiwi nurses.	Perspectives.	Anti-racism.	Pilot study. Two focus groups – one Māori and one Tauiwi. Kaupapa Māori.	To explore Māori and Tauiwi nurses' perspectives of anti-racism.	Challenging actions, irregular application, positive behaviour.	Māori nurses: Addressing health equity for Māori is obligatory. Non-Māori nurses: Addressing health equity for Māori is optional.	Kidd et al. (2020)
Walker, R. C., Palmer, S. C., Abel, S., Jones, M., Walker, C., & Tipene-Leach, D.	2024	18 clinicians: 9 nephrologists, including 2 transplant nephrologists, and 9 nurses, including 6 transplant coordinators	Clinicians' experiences of barriers to delivery of kidney transplantation for Māori.	Kidney transplantation for Māori.	Qualitative interviews.	To explore the perspectives of clinicians in the delivery of kidney transplantation for Māori.	Three structures: Society, Health care system, Health care services. Nine themes.	Non-Māori nurses: Addressing health equity for Māori is optional. Barriers to health equity for Māori.	Walker et al. (2024)
Davis, J., Wiapo, C., Rehana-Tait, H., Clark, T. C., & Adams, S.	2021	3 Māori nurse leaders.	Stories, insights, frustrations, and solutions.	COVID-19 first lockdown in 2020.	Narrative approach.	To describe the activities and experiences of Māori nurse leaders during the first COVID-19 lockdown in 2020.	Māori nurse leaders have multiple clinical cultural roles.	Māori nurses: Addressing health equity for Māori is obligatory. Barriers to health equity for Māori.	Davis et al. (2021)
Taylor, E., Moeke-Maxwell, T., & Anderson, N, E.	2024	4 Māori nurses and 5 non-Māori nurses.	Perspectives.	Māori end-of-life care in the intensive care unit.	Qualitative research. Semi structured interviews. Kaupapa Māori.	To characterise nursing experiences of end-of-life care for Māori in the ICU. To identify barriers to and facilitators of confident, competent culturally responsive care. To highlight opportunities to improve preparation and support.	Positive and negative experiences in caring for Māori at the end of life. Internationally trained nursesneed cultural support and education.	Māori nurses: Addressing health equity for Māori is obligatory. Non-Māori nurses: Addressing health equity for Māori is optional. Barriers to health equity for Māori.	Taylor et al. (2024)

(*Continued*)

Table 2. Continued.

Authors (year)	Year	Population	Concept	Context	Study type	Objectives	Findings	Themes coded in this article	Full reference
Komene, E., Gerrard, D., Pene, B., Parr, J., Aspinall, C., & Wilson, D.	2023	12 Māori registered nurses.	Experiences.	Māori patients and their whānau in acute hospital services.	Qualitative Māori-centred research methodology. Kaupapa Māori.	To identify the experiences of Māori nurses and priorities for a Māori model of relational care working with Māori patients and their whānau in acute hospital services.	Cultural-clinical dual role has negative effects due to increased workload. Māori nurses experience institutional racism.	Māori nurses: Addressing health equity for Māori is obligatory. Non-Māori nurses: Addressing health equity for Māori is optional. Barriers to health equity for Māori.	Komene et al. (2023)
Watkins, S., Ward, K., Brown, R., Crengle, S., Wm de Laat, M., Percival, T., Sadler, L., Cloete, E., Gorinski, R., & Gentles, T.	2024	25 parents and 20 health professionals (7 specialist midwifes/nurses, and 13 Specialist doctors).	Experiences.	Critical congenital heart disease in New Zealand to advance health equity.	A prospective qualitative study using grounded theory methods utilising semi-structured interviews.	To understand how to mitigate disparity by investigating the parent and healthcare professional experiences' of critical congenital heart disease healthcare in New Zealand.	Persisting inequities occur, with European families being privileged. Under-resourced healthcare systems.	Non-Māori nurses: Addressing health equity for Māori is optional. Barriers to health equity for Māori.	Watkins et al. (2024)
Hunter, K., & Cook, C.	2024	12 Māori registered nurses and nurse practitioners.	Cultural and clinical practice realities/ insights.	The emotional labour of Indigenous nurses.	A qualitative Indigenous narrative inquiry. Semi-structured interviews. Kaupapa Māori methods.	To explore how Māori nurses navigate delivering culturally responsive care Māori across different healthcare settings.	Māori nurses' burnout with dual cultural clinical role. Institutional racism present.	Māori nurses: Addressing health equity for Māori is obligatory. Barriers to health equity for Māori.	Hunter & Cook (2020)

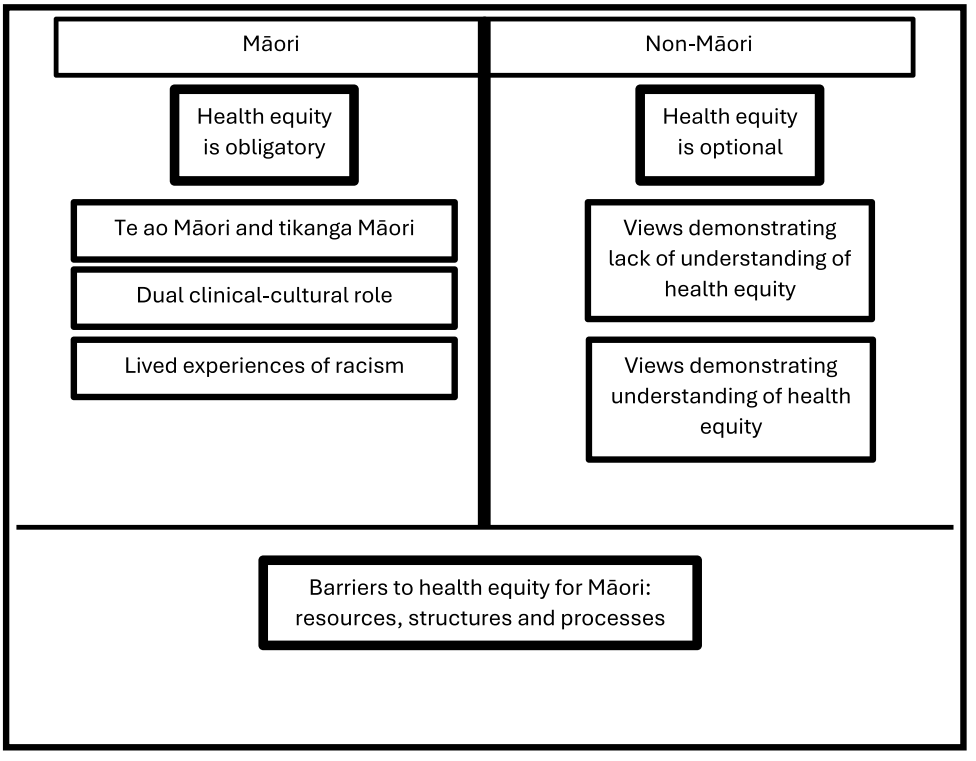

Figure 2. Themes and subthemes.

Māori nurses: addressing health equity for Māori is obligatory

This theme has been termed to represent the strong views and experiences of Māori nurses representing an obligation to address health equity for Māori, particularly through te ao Māori informed practice, their dual cultural–clinical roles of being Māori and a nurse, and their lived experiences of racism. Māori nurses articulate those experiences of obligation in personal statements within a number of the analysed studies (Davis et al., 2021; Hunter & Cook, 2020; Huria et al., 2014; Komene et al., 2023; Komene et al., 2025). For instance, Huria et al. (2014) quote a participant who stated:

> It never surprises me, when you walk into a hospital and there are very few Māori nurses and you go onto the ward and there is a Māori patient and you are the first person they make a bee-line for. It's powerful to be able to help but also it's really hard work … the minute you say yes I am a Māori health worker within a non-Māori all the Māori patients that come through are directed to you. (p. 368)

This was further reinforced by Komene et al. (2023)

> When you see someone that has brown skin as well, you're like I got you, you're with me" (p.2589) and "he [Māori patient] demanded to speak to somebody only in Māori and I only got involved to de-escalate because he was very angry. The nurses told him that I spoke fluent Māori, I don't speak fluent Māori, just laughed when he laughed. (p. 2590)

Te ao Māori and tikanga Māori

Māori nurses can bring a unique worldview to the nursing profession, often grounded in kaupapa and tikanga Māori customs and practices (Davis et al., 2021; Hunter & Cook, 2020; Komene et al., 2023, 2025). Tikanga Māori incorporates a wide range of practices and processes that can be inherent for Māori nurses. Tikanga by Māori nurses was reported to heighten feelings of obligation to address health inequities for Māori (Davis et al., 2021; Hunter & Cook, 2020; Komene et al., 2023, 2025). Upholding tikanga kept Māori patients and staff safe physically, spiritually and emotionally with the use of karakia and protocols informed by tikanga (Davis et al., 2021). Tikanga also led Māori nurses to view the room of a long-term Māori inpatient as their 'whare' (place of residence), with appropriate respect and deference observed (Hunter & Cook, 2020).

The use of whanaungatanga (connectedness) was reflected across multiple studies (Davis et al., 2021; Hunter & Cook, 2020; Kidd et al., 2020; Komene et al., 2025). Whanaungatanga was a vital aspect of kaupapa and tikanga Māori. This goes beyond an individualistic relationship vista to include the wellbeing of whānau – the patients' family – which is strengthened through trust and the use of whakapapa (genealogy) (Hunter & Cook, 2020). Komene et al. (2025) describe how this is a natural and inherent process for Māori nurses and represents the importance of reciprocal relationships. Whanaungatanga allowed continuity of relationships that have been established through trust and whakapapa that can result in life-long relationships with whānau (Davis et al., 2021; Kidd et al., 2020; Komene et al., 2025). It is also common for Māori nurses to have whakapapa connections a patient's community or whānau, which aids trust that allows relational barriers to be broken down (Davis et al., 2021).

Manaakitanga (taking care of) is a prominent term in te ao Māori. The principle of Manaakitanga was reflected in the way many of the Māori nurses showed care and love to Māori health consumers and whānau (Davis et al., 2021; Hunter & Cook, 2020; Komene et al., 2025). Manaakitanga was used first and foremost to care for Māori health consumers and their whānau holistic wellbeing and safety (Komene et al., 2025). Māori nurses also used manaakitanga to ensure Māori health consumers and their whānau were prioritised and understood, even if that made the Māori nurses late to their next meeting (Hunter & Cook, 2020).

Dual cultural–clinical role

Māori nurses rarely identified solely as a nurse, describing themselves as first and foremost Māori (Davis et al., 2021; Hunter & Cook, 2020; Huria et al., 2014; Kidd et al., 2020; Komene et al., 2023; Komene et al., 2025; Taylor et al., 2024). Māori nurses also reported seeing themselves as members of communities with shared whakapapa and experiences that encouraged obligation to care for other Māori health consumers, driven by tikanga, whanaungatanga and manaakitanga values (Davis et al., 2021). These concepts were used to care and protect the communities, whānau and Māori health consumers, demonstrating the dual cultural–clinical role of Māori nurses (Davis et al., 2021; Huria et al., 2014; Kidd et al., 2020)

Kidd et al. (2020) present a comment from a Māori nurse that expands on this concept:

> I am given the hardest of the hard; like my nickname used to be 'the too hard box nurse' … the ones that were 'nah we can't do anything with them', they'd give them to me. (p. 390)

This comment illustrates non-Māori nurses avoiding responsibility, leaving that responsibility of caring to Māori nurses who are expected to advance Māori health within their respective

workplaces (Kidd et al., 2020). This role also extended to the education of non-Māori nurses on Māori health topics, adding to Māori nurse workloads (Komene et al., 2023; Taylor et al., 2024). These dual roles added additional burdens to Māori nurses, often not experienced by non-Māori colleagues, resulting in extra hours worked, shorter breaks and increased likelihood of burnout (Komene et al., 2023).

Lived experiences of racism

Many Māori nurses reported lived experiences of racism before becoming a nurse, during nurse training, and in their role as a Māori nurse while working in predominantly colonially influenced healthcare institutions. This encompassed all forms of racisms: interpersonal, internalised and institutional (Davis et al., 2021; Hunter & Cook, 2020; Huria et al., 2014; Kidd et al., 2020, 2022; Komene et al., 2023, 2025). Lived experiences of racism resulted in Māori nurses having depth of understanding of Māori health consumers and their whānau experience, both in the community and western healthcare system (Huria et al., 2014). Māori nurses also reported witnessing racism directed at Māori patients (Hunter & Cook, 2020). This compounded prejudice-based stress for Māori nurses and perpetuated a commitment to caring for and protecting Māori patients and advancing health equity for Māori, which in turn added an additional emotional burden and workload to Māori nurses (Hunter & Cook, 2020; Komene et al., 2023).

Non-Māori nurses: addressing health equity for Māori is optional

For nurses who identified as non-Māori and those who did not state an ethnicity, they expressed views and described experiences where addressing health equity for Māori was often an optional part of their role. In many of the included studies, non-Māori nurses were able to 'opt out' of caring for Māori health consumers/whānau (Kidd et al., 2020; Kidd et al., 2022; Komene et al., 2023; Walker et al., 2024). There are also examples in the included literature of non-Māori nurses making assumptions that Māori nurses would complete the care plans for Māori patients, stating Māori health and racism were too difficult to address. This expressed instances of a lack of knowledge about how to reduce health inequities, Kidd et al (2020) reports:

> Tauiwi nurses reported Pākehā paralysis can manifest as opting out of caring for complex Māori patients. (p. 390)

Despite non-Māori nurses having access to resources such as 'tikanga best practice', many of those included in this review were still able to ignore basic tikanga protocols such as touching the head without permission (Hunter & Cook, 2020).

Non-Māori demonstrating a lack of knowledge on health equity

Non-Māori nurses expressed views that demonstrated a lack of understanding of health equity, racism, tikanga Māori and te ao Māori (Kidd et al., 2020; Kidd et al., 2022; Komene et al., 2023; Taylor et al., 2024; Watkins et al., 2024). Some non-Māori nurses expressed racist views toward the 'special treatment' Māori receive from society, victim-blaming discourses toward Māori patients and expressing scepticisms towards Māori nurses such as 'what are Māori nurses actually doing?' (Kidd et al., 2020). There are examples where some non-Māori nurses demonstrated a lack of understanding of Māori culture and tikanga, resulting in misinterpreted assessments of Māori health consumers, contributing to the discrimination experienced by Māori (Kidd et al., 2020; Kidd et al., 2022; Komene et al., 2023; Taylor et al., 2024).

Perpetuating and contributing to this cycle of discrimination, some non-Māori nurses looked the other way when faced with racism (Kidd et al., 2020).

Non-Māori demonstrating knowledge on health equity

Non-Māori nurses demonstrated that they had varying levels of understanding of te ao Māori, health inequities and strategies on how to address health inequities for Māori, demonstrating the ability to 'opt in' to advancing health equity for Māori (Kidd et al., 2020; Taylor et al., 2024; Walker et al., 2024; Watkins et al., 2024). In a couple of the included studies, non-Māori nurses expressed the need to involve whānau in care and listen to what the patient and their whānau had to say (Kidd et al., 2020; Watkins et al., 2024). Failures of the health system were acknowledged and described as individualistic, capitalistic, racist and westernised (Kidd et al., 2020; Walker et al., 2024; Watkins et al., 2024). This emphasised the role of institutional racism in the enduring perpetuation of health inequities of Māori (Walker et al., 2024). Several non-Māori nurses were able to describe the social determinants of health and how that influenced health outcomes (Kidd et al., 2020; Walker et al., 2024). Non-Māori nurses also emphasised the need to engage in reflective practices, address biases, apply cultural safety, support Māori nurses in the work place, increase the amount of Māori nurses in the workplace and dismantle racist structures within the health system to contribute to health equity for Māori (Kidd et al., 2020; Walker et al., 2024; Watkins et al., 2024). Links were made between historical colonisation, marginalisation and mistrust in the health system to the inequities that are seen today (Walker et al., 2024).

Barriers to health equity for Māori: resources, structures and processes

Both Māori and non-Māori expressed that limited resources, and racist system structures and processes were barriers to supporting or achieving health equity for Māori (Davis et al., 2021; Hunter & Cook, 2020; Huria et al., 2014; Kidd et al., 2022; Komene et al., 2023; Taylor et al., 2024; Walker et al., 2024; Watkins et al., 2024) Interestingly, Māori emphasised the maldistribution of resources (Davis et al., 2021; Hunter & Cook, 2020; Kidd et al., 2020). Examples of resources that were limited or maldistributed ranged from 'Māori nurses' as resources (Huria et al., 2014; Taylor et al., 2024), inappropriate assessment resources for Māori such as body mass indexing (Walker et al., 2024), information pamphlets not in different languages (Watkins et al., 2024), through to lack of funding and racist funding allocation (Kidd et al., 2022; Walker et al., 2024).

Discussion

Authors acknowledge this framing appears binary and over generalised, and as such, should be seen as a way to frame the literature instead of a definitive categorisation. Despite having professional, ethical and legal obligations to address health inequities for Māori, non-Māori were able to 'opt out' of caring and addressing health inequities for Māori. This finding suggests that the nursing profession continues to contribute to the racism and discrimination that Māori experience when they access the health care system (Wilson, Barton et al., 2022). This racism and discrimination is perpetuated by the NCNZ's inadequate monitoring of nurses' competence, nursing education that fails to dismantle institutional racism or provide meaningful health equity training, and professional leadership apathy or inaction towards racism, resulting in ongoing harm to Māori communities (Barton, 2018, 2025; Heke et al., 2018; Komene et al., 2023; Wilson, Barton et al., 2022). This is a breach of the legal requirements under the Health

Practitioners Competence Assurance Act 2003: "The principal purpose of this Act is to protect the health and safety of members of the public … " (Parliamentary Counsel Office, 2003). This experience is supported by Māori who access the public health system and experience racism and discrimination at higher rates than non-Māori (Barton, 2018; Ministry of Health, 2023; Wilson, 2018). Conversely, non-Māori were also able to 'opt-in', demonstrating some commitment to health equity. How this decision was made by non-Māori is not clear. The solution to non-Māori views in addressing health equity is multifaceted. There are multiple models to guide non-Māori nurses in understanding the realities of Māori, apply cultural safety, antiracist praxis, address biases and advance health equity (Barton, 2025; Heke et al., 2018; Pitama et al., 2017; Wepa, 2015; Wiapo et al., 2024). However, the application of these models requires personal agency and the ability to 'opt out' remains an option.

As has been explained, the processes and consequences of colonisation have led to multiple challenges for Māori. To assume that it is Māori's responsibility to address health inequities would be to victim blame (Wilson, Barton et al., 2022). This contrasts with the key findings where Māori nurses did not feel the privilege of 'opting out' was extended to them, and they had no other option but to care for Māori and address health inequities. Māori nurses' commitment to health equity is grounded in whakapapa, tikanga, manaakitanga and lived experiences of racism. This commitment goes above and beyond the professional, ethical and legal obligations and is an authentic commitment. However, with the stark underrepresentation of Māori nurses and the deeply racist culture that exists in nursing, Māori nurses find themselves having to assimilate to the dominate white culture or risk being alienated or marginalised (Barton, 2025; Hunter & Cook, 2020; Huria et al., 2014; Komene et al., 2023; Wilson, Barton et al., 2022). Equally, being a cultural educator for non-Māori colleagues and fierce guardians of Māori and whānau health, also leads to burnout due to the increased workload which is also misunderstood and undervalued from non-Māori colleagues (Barton, 2025; Wilson, Barton et al., 2022). These experiences by Māori nurses reinforce the concept of 'optional' by being the recipients of the workload left by non-Māori nurses 'opting out', leading to increased workloads and burnout.

Māori may have an inherited or innate understanding of te ao Māori that can be applied in practice to provide culturally competent care for Māori (Wilson, 2018; Wilson, Barton et al., 2022). Due to the lack of Māori nurse representation, the implementation of te ao Māori concepts and tikanga Māori into practice can result in burnout and ultimately loss of Māori nurses due to the increased, unrecognised and inequitable workload (Came-Friar et al., 2019; Wilson, 2018; Wilson et al., 2022a). These inherited strengths and experiences can be powerful tools in shifting culture in nursing (Barton, 2025; Wilson, 2018; Wilson et al., 2022a). Having an equitable Māori nursing workforce and equitable Māori in nursing leadership positions will likely result in the needed culture change in the nursing profession and resulting in improved health equity for Māori (Came-Friar et al., 2019; Wiapo & Clark, 2022; Wilson, 2018; Wilson et al., 2022a). However, the increase of Māori nurses is not a simple task of recruitment into a profession that is inherently racist (Wilson et al., 2022a). It will require a full dismantling of the colonial system and an ultimate removal of institutional racism (Wilson, 2018) and requires multiple organisational, educational, professional and political action that is meaningful and impactful (Wilson, 2018; Wilson et al., 2022a).

In both Māori and non-Māori nurses' views, barriers to health equity for Māori were resources, structures and processes. Māori nurses, however, were also concerned about the maldistribution of resources. Racist structures, policies and processes have been well defined as the most impactful contribution to health inequities (Jones, 2000). Despite this concept being well defined, government inaction has been well documented and institutional racism has failed to be meaningfully dismantled (Came et al., 2018; Came-Friar et al., 2019; Walker, 1990). The distribution of resources is controlled by power and is embedded in political structures (Came et al.,

2018; Reidy et al., 2025). Fundamental societal values are reflected politically (Reidy et al., 2025). Aotearoa has a neoliberal democracy (Came et al., 2018) which is characterised by privatisation, erosion of public services and deregulation (Barnett & Bagshaw, 2020; McCartney et al., 2019). Neoliberalism is a profoundly racist political structure that negatively impacts Māori health and wellness, driving further discrimination towards Māori (Barnett & Bagshaw, 2020; McCartney et al., 2019; Wilson et al., 2022a). When nurses are talking about the lack of resources, they are likely feeling the impacts of neoliberalism on the healthcare system (Barnett & Bagshaw, 2020). When Māori nurses talk about the maldistribution of resources, they are likely feeling the impact of institutional racism that is compounded on top of neoliberalism (Barnett & Bagshaw, 2020; Came et al., 2018; Wilson, Barton et al., 2022).

Strengths and limitations

Underpinned by kaupapa Māori methodology, a systematic and rigorous scoping review methodology was followed throughout this review and drew on well-established and justified frameworks. Title screening was conducted by a single reviewer (SH), which may introduce a risk of selection bias. This review was limited to peer-reviewed publications and did not include grey literature; thus limiting its application and implications for policy. The studies included in this study often included a small number of non-Māori and unidentified ethnicities, which may limit strength comparisons.

Implications for future research

Many opportunities exist to conduct research addressing the aforementioned limitations. Specifically, (1) we should undertake a further review of the grey literature to provide actionable first steps towards closing the research gap and improving policy recommendations in relation to health equity for Māori. (2) Prioritise the inclusion of non-Māori voices in future research into the barriers faced by nurses undertaking steps towards health equity for Māori. Plans are in place for this research team to conduct this in the future. (3) For Māori nurses, future research could explore ways to ease the burden of the dual clinical–cultural role. For non-Māori nurses, future research could seek to understand the barriers and enablers to preventing greater action towards health equity for Māori within their scope of practice. (4) Opportunities exist for all nursing organisational bodies and workplaces to undertake research to understand what barriers and enablers there are for nurses to address health equity for Māori within their unique contexts, this will lead to evidence-based implications for policy and practice.

Implications for policy and practice

The NCNZ has specific competencies that outline the role of nurses in addressing health equity for Māori (Nursing Council of New Zealand, 2025). This review shows that despite the existence of these competencies, work still needs to be done to dismantle the barriers and support the enablers leading to better health equity outcomes for Māori from all nurses. This needs to occur at both large organisational levels and within small nursing team opportunities. This review has highlighted that the solution to addressing health equity for Māori is multifaceted. However, multiple models exist to support non-Māori nurses to better understand Māori realities, apply cultural safety and antiracist practice, address bias, and advance health equity in concrete ways. Further opportunities exist for the NCNZ to monitor nurse competence, nursing education and institutional racism in ways that meaningfully advance health equity for Māori.

Conclusion

This systematic scoping review synthesised the available peer-reviewed literature in Aotearoa exploring nurses' views on health equity for Māori. Overall, the review found that Māori nurses view health equity as an obligation that typically went beyond the expected professional, legal and ethical obligations. This was supported by whakapapa, te ao Māori and tikanga Māori, dual clinical–cultural role and lived experiences of racism. Non-Māori nurses view health equity as an option that is supported by conflicting views on the topic. This ambivalence appears to show the nursing profession as continuing to contribute to health inequities for Māori and is perpetuated by inadequate monitoring, education and action by NCNZ, tertiary nurse educators and professional leadership. Both Māori and non-Māori nurses expressed barriers to health equity as resources, structures and processes, whereas Māori nurses also emphasised that the maldistribution of resources was also a barrier to health equity. These views can be explained by the neoliberal democracy in Aotearoa that acts to erode public services and institutional racism, impacting the equitable distribution of resources. This study was limited by a small sample of non-Māori participants in the literature. Future research into the barriers and enablers that exist for non-Māori to commit to addressing health inequities for Māori, research into easing the burden of the dual cultural–clinical role of Māori nurses whilst harnessing their authentic commitment to addressing health inequities for Māori and research into NCNZ, educational institutions and professional leadership is recommended.

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No potential conflict of interest was reported by the authors.

Data availability statement

All data used in review is available publicly as journal articles.

Glossary

Glossary of te reo Māori terms used in this paper (in order of appearance). An important note is that te reo Māori is not easily translated into English, and these terms are to guide readership rather than to provide a definitive definition.

Aotearoa: Māori name for New Zealand
He Whakaputanga: Declaration of Independence
Te Tiriti o Waitangi: Original treaty signed by Māori chiefs
Māori: Indigenous to New Zealand
Whānau: Family
Rangatira: Chief
Taonga: Treasure
Tikanga: Correct protocol
Kaupapa: Māori way of being
Wānanga: Shared learning and discussion
Whanaungatanga: Connectedness
Whakapapa: Genealogy
Manaakitanga: To take care of
Tauiwi: Non-Māori

Supplemental data

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