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Inequities in access to palliative care and community-based indigenous palliative care programs in Canada: a scoping review

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Abstract

Introduction Approximately two-thirds of deaths in Canada require palliative care. Indigenous Peoples continue to experience inequities in access to culturally safe, community-based palliative and end-of-life care. This scoping review examined experiences of care, barriers to access, and community-based palliative care programs among Indigenous Peoples in Canada to identify key gaps and inform future research and practice.

Methods This review was guided by the Arksey and O'Malley framework and reported in accordance with PRISMA-ScR guidelines. Searches of Medline, PubMed, Google Scholar, Indigenous Collections, and Indigenous Peoples of North America databases were conducted from inception to May 2026.

Results Thirty-four studies met the inclusion criteria, including studies on stakeholder experiences and community-based programs and interventions. Four overarching themes were identified: structural barriers and patterns in palliative care; cultural safety, communication, and misalignment with Western models of care; end-of-life preferences and experiences; and community-led approaches and capacity building. Indigenous Peoples have fewer home care nursing hours, physician home visits, and an increased likelihood of dying in an acute care setting. Indigenous participants consistently described preferences for home and community-based dying, family involvement, and integration of spiritual and cultural practices within care. Significant research gaps were also identified, including the absence of Métis-specific studies, limited research involving urban Indigenous populations, and lack of long-term evaluation of community-based programs. No identified studies were from Prince Edward Island or New Brunswick, despite the presence of Mi'kmaq and Wolastoqiyik communities in these provinces.

Discussion Current research exploring palliative care for Indigenous Peoples in Canada remains limited despite increasing attention toward health reconciliation. Community-led and culturally safe palliative care models have the potential to improve end-of-life experiences and align care with Indigenous values. Indigenous-led models show promise, but longer-term evaluations are needed to assess their effectiveness and applicability beyond small pilot settings.

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Keywords Indigenous, Palliative care, End-of-life, Health inequities, Cultural safety, Programs

Introduction

Palliative care is required in about two-thirds of all deaths in Canada [1–4]. Palliative care is a service used to prevent and relieve the suffering of those living with life-limiting illnesses [5], through early detection and treatment of physical, psychosocial, or spiritual problems [6, 7]. The goal of palliative care is to improve quality of life for patients and their families, and it extends beyond symptom management to include cultural and spiritual support throughout serious illness and at the end of life. Unlike hospice care, palliative care can be initiated at any stage of illness and may be provided alongside curative treatment. As individuals approach the end of life, palliative care increasingly focuses on communication about goals of care, advance care planning, and caregiver support. Unfortunately, Indigenous communities often lack autonomy in how they engage in both living and dying, owing to the legacy of settler colonialism [8, 9]. This legacy extends to the contemporary state of decreased life expectancy and higher rates of chronic diseases among Indigenous Peoples in Canada, underscoring the imperative for culturally safe care, including palliative medicine [10–14].

A growing issue in indigenous communities

The lack of culturally safe palliative care in Indigenous communities is a clear manifestation of health inequity [15–17]. Health inequity is defined as the presence of avoidable, unfair, and systemic differences in health outcomes because of historical injustices and ongoing systemic racism [18–20]. These inequities for Indigenous groups in Canada are rooted in the ongoing effects of colonization, including residential schools, forced displacement, cultural suppression, and systemic racism within systems of care, all of which continue to shape Indigenous experiences of illness and death. Despite federal and provincial commitments to improve access to palliative and end-of-life care for Indigenous groups, many communities still lack formally funded palliative care programs [21–23]. While progress is being made through investments from the Government of Canada, translation of recent research, for the most part, has yet to extend beyond pilot programs [24].

A decolonizing approach to palliative care

Colonial trauma continues to shape Indigenous Peoples' relationships with healthcare systems, contributing to persistent mistrust [25]. Colonial trauma also reinforces longstanding power imbalances and health inequities. This mistrust is grounded in documented harms, including the coerced sterilization of an estimated 1,200

Indigenous women between 1970 and 1975, often without informed consent and, in some cases, under the false belief that the procedure was reversible birth control [26]. It is also rooted in the operation of racially segregated hospitals from the 1930s to the 1980s, where Indigenous patients were isolated from their communities and frequently subjected to substandard care without informed consent [27]. By 1960, the Government of Canada operated 22 such hospitals with more than 2,200 beds, mostly across Ontario and the western provinces [27]. These harms occurred alongside colonial policies that suppressed Indigenous healing practices, the introduction of infectious diseases by European settlers, and imposed socioeconomic conditions, including inadequate housing, that continue to contribute to elevated rates of respiratory illness, mental health challenges, and type 2 diabetes [18]. A decolonizing approach to palliative care moves beyond efforts to rebuild trust within existing systems and instead supports Indigenous self-determination and control over how care is defined and delivered.

Guidelines for palliative care in indigenous communities

Importantly, there is no singular Indigenous approach to palliative and end-of-life care, and practices may vary between communities. However, there remains a lack of nationally and provincially adopted guidelines addressing culturally safe palliative care delivery within Indigenous communities in Canada. Guidelines of this kind may help protect safe practices, strengthen autonomy, improve equity in access to care, and support the integration of Indigenous knowledge systems within palliative care delivery. The development of such frameworks may also support advocacy efforts for sustained funding and guide the implementation of palliative care practices within a wide range of Indigenous communities. The earliest review on this topic was completed by Kelly and Minty in 2007, and the landscape of Indigenous palliative care has since evolved substantially [8]. Caxaj et al. subsequently examined Indigenous palliative care across Canada, Australia, New Zealand, and the United States. However, their review was restricted to rural, remote, on-reserve, and small-town populations and included a limited number of Canadian studies [28]. More recently, Weisgerber et al. focused on the palliative and end-of-life care experiences and needs reported by Indigenous Peoples in Canada [29]. The present review builds on this work by examining both experiences of care and the development, implementation, and evaluation of community-based Indigenous palliative care programs. In doing so, this review provides a more applied perspective by linking identified needs and barriers with existing

community-based responses and areas requiring further implementation.

Scoping reviews

A scoping review is particularly well suited to exploring complex and under-researched topics such as Indigenous palliative care [30]. Unlike systematic reviews, which aim to answer specific questions through rigorous inclusion criteria and quality assessments, scoping reviews are designed to map patterns, inconsistencies, and areas lacking adequate investigation. In such cases, scoping reviews inform future research directions and care practice [31].

Aims

This scoping review explores end-of-life experiences, barriers and inequities to access, and existing community-based palliative care programs and initiatives among Indigenous Peoples in Canada, while identifying research gaps to inform future research and promote better practices.

Authors' self-location and positionality statement

Self-location is a necessary and expected element of accountable and ethical inquiry in Indigenous research, as it allows readers to understand who the authors are and their relationships to Indigenous Peoples and communities [32, 33]. The author team consists of researchers and trainees affiliated with Canadian academic institutions and brings backgrounds in health sciences, medicine, and health research. The authors recognize that their academic training and institutional positions shape how the literature was selected, interpreted, and presented. The review team does not claim to speak on behalf of Indigenous Peoples or to represent the perspectives of First Nations, Inuit, and Métis communities.

M.S., H.K., M.D., and A.K. live, study, or work in Calgary, Alberta, on the traditional territories of the peoples of Treaty 7, including the Blackfoot Confederacy, the Siksika, Kainai, and Piikani Nations, the Tsuut'ina Nation, and the Îyârhe Nakoda Nations, and within the homeland of the Métis Nation of Alberta, Region 3. M.S. is a Pakistani Canadian who was born in Pakistan and immigrated to Canada with his family. The region now comprising Pakistan was governed under British colonial rule. His interests include health equity, Indigenous health, and palliative care, and he approaches this work with humility and a commitment to learning from Indigenous communities. H.K. is of Iraqi descent, and his family immigrated to Canada from Oman. Iraq's modern history was shaped by Ottoman rule and subsequent British occupation and administration, while Oman experienced periods of Portuguese occupation and extensive British imperial influence. He works as a research coordinator

and is interested in improving health outcomes for populations historically overlooked in healthcare. M.D. is an Ivorian Canadian who was born in South Africa and immigrated to Canada as a child. Côte d'Ivoire was subjected to French colonial rule, while South Africa's history was shaped by Dutch and British colonialism and the subsequent apartheid system. He recognizes the continuing effects of colonialism on Indigenous health and is committed to respecting Indigenous leadership in health research and care. A.K. is a Bangladeshi Canadian who was born in Bangladesh and immigrated to Canada during early childhood. The land now comprising Bangladesh was part of Bengal under British colonial rule and, following the 1947 partition, became East Pakistan before achieving independence in 1971. He acknowledges that contemporary Indigenous health inequities are rooted in historical and ongoing colonial structures and seeks to support change while respecting Indigenous community leadership. I.B. is of Indian descent and lives and studies in Surrey, British Columbia, on the traditional and ancestral territories of Coast Salish Peoples, including the Katzie, Kwantlen, and Semiahmoo First Nations. He approaches this work with a commitment to listening to Indigenous communities and respecting community-defined priorities. H.A. is a Pakistani Canadian who was born in Pakistan and immigrated to Canada as a child. He lives and studies medicine in Toronto, Ontario, which is situated on the traditional territories of the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, and the Wendat Peoples and is covered by Treaty 13. He recognizes the importance of Indigenous leadership, community partnership, and self-determination in health research and healthcare delivery. B.D.M. is a family physician of White settler ancestry. For more than three decades, he provided comprehensive primary care in the ceded and unceded territories of First Nations and Inuit Peoples in northern and remote settings across Canada. He currently resides in Winnipeg, Manitoba, within the National Homeland of the Red River Métis and in proximity to the traditional territories of the Anishinaabeg, Ininiwak, Anisininew, Dakota Oyate, and Dene Peoples. His current practice centres on relationship-focused care in pediatric and adult palliative medicine. The authors acknowledge that their families' experiences of colonialism are distinct from the histories and ongoing realities of settler colonialism experienced by Indigenous Peoples in Canada. These backgrounds are presented to situate the authors' perspectives rather than to equate different colonial experiences.

Method

Scoping review design

This review was guided by the methodological framework developed by Arksey and O'Malley [34] and reported

in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR), a reporting guideline available through the EQUATOR Network [35, 36]. No review protocol was developed or registered.

The initial database search was conducted on April 1, 2025, and included records published from the database's inception to that date. An updated search was conducted on May 1, 2026, to identify newly published eligible studies. Searches were conducted in MEDLINE via Ovid, PubMed, Google Scholar, Indigenous Collections, and Indigenous Peoples of North America. These databases were selected to provide biomedical, interdisciplinary, and Indigenous-focused coverage of the research topic [37]. Databases were searched using keywords and controlled vocabularies, such as MeSH, when available [38].

Search strategy

The search strategy was developed around three core concepts: (1) Indigenous Peoples and communities; (2) Canada; and (3) palliative and end-of-life care. Keywords and controlled vocabulary terms, including Medical Subject Headings where available, were identified for each concept and combined using the Boolean operators “AND” and “OR” [38]. Search terms included variations and related terms for Indigenous Peoples, First Nations, Inuit, Métis, Canada, palliative care, end-of-life care, terminal care, and hospice care.

The search syntax and controlled vocabulary were adapted to the indexing structure and requirements of each database. No publication-date restrictions were applied. Searches were limited to English-language records in accordance with the review eligibility criteria. Reference lists of included studies were manually screened, and backward and forward citation searching was conducted to identify additional eligible studies. The complete database-specific search strategies, including all search terms, Boolean combinations, controlled vocabulary terms, limits, and dates searched, are provided in Supplementary File S1.

Inclusion and exclusion criteria

Eligible studies were English-language, full-text, peer-reviewed Canadian studies reporting data from Indigenous patients, caregivers, healthcare providers, or communities. Eligible methodologies included qualitative interviews, focus groups, participant observation, chart reviews, narrative analyses, open-ended surveys, administrative data analyses, and mixed-methods approaches. Multiple papers involving the same study population were included only when they reported distinct findings.

Only Canadian studies were included because jurisdictional, historical, and service-delivery contexts differ across countries, including Australia, Aotearoa New

Zealand, and the United States. Studies that did not report findings specific to Indigenous Peoples were excluded to maintain a focused analysis [39–41]. Editorials, commentaries, grey literature, reviews, and other sources that did not meet the eligibility criteria were excluded from the primary evidence synthesis [42–46]. No publication-date restrictions were applied. The complete inclusion and exclusion criteria, along with their justification, are provided in Supplementary File S2.

Study screening

Results from the database searches were exported, and the synthesis review software, Covidence®, was used to deduplicate results and facilitate title/abstract and full-text screening of studies [47]. Titles and abstracts were screened for eligibility, and full texts were screened by two independent reviewers (M.S. and H.K.). Conflicts were resolved by a third reviewer (I.B.). We screened the reference lists of included studies for potentially eligible articles and conducted citation chaining of all included studies through the PubMed database. The study selection process through the PRISMA framework is in Fig. 1.

The database searches identified a total of 405 records across all databases. After removal of 209 duplicates, 196 records remained for title and abstract screening. Following screening, the full texts of 39 articles were reviewed for eligibility. According to the inclusion criteria, 34 articles were identified: 24 on stakeholder experiences and 10 on programs and resources. To maintain a manageable scope for tabular presentation, we included 17 studies published from 2015 onwards in tables, seven focused on programs or recommendations [48–54], and ten on stakeholder experiences [55–64]. The studies focused on perspectives in Table 1, and those that were primarily programming in Table 2 were used to identify study-specific research gaps from the existing literature. The other 14 included articles on experiences in palliative care [9, 39–42, 44, 53, 54, 65–70] and 3 on interventions [43, 45, 48] published prior to 2015 were included in the written results. The full list of studies used to synthesize our results is provided in Supplementary File S3.

Data extraction and thematic synthesis

A standardized extraction table was developed to systematically organize and analyze the included studies. Extracted information included study location, Indigenous population or community, methodological approach, sample size, participant group, key findings, research gaps, and characteristics of identified programs or resources.

Thematic synthesis was conducted manually by two reviewers (M.S. and H.K.) using the data-extraction table. The reviewers independently examined the extracted findings, developed preliminary codes, and grouped

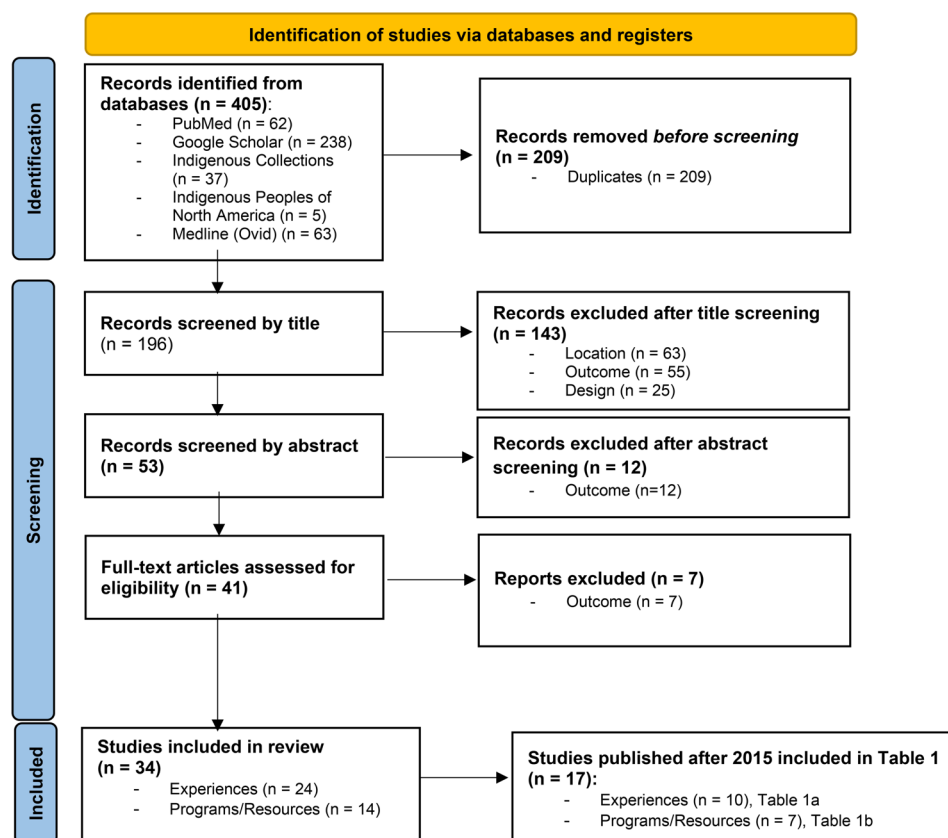


Fig. 1 PRISMA flow diagram illustrating the identification, screening, eligibility assessment, and inclusion of studies in this scoping review examining Indigenous palliative and end-of-life care in Canada. Indigenous populations included First Nations, Métis, and Inuit communities

recurring concepts into broader categories. Differences were resolved through discussion and consensus. The preliminary categories and themes were subsequently reviewed and refined in collaboration with an Alberta-based Indigenous physician with expertise in palliative and end-of-life care to strengthen their relevance and interpretation within an Indigenous healthcare context.

Included studies were also categorized according to whether they primarily examined stakeholder experiences or described programs, interventions, or resources. The final themes were reviewed against the extracted data to ensure that they accurately represented the findings of the included studies.

Excluded and contextual sources

Sources that did not meet the predefined eligibility criteria were excluded from data extraction, study characterization, coding, or thematic synthesis. During database screening, reference-list screening, and citation searching, additional sources relevant to the historical, policy, and service-delivery context of Indigenous palliative care were identified. These sources were retained for contextual purposes when they provided information directly relevant to understanding or interpreting the barriers, care models, and community-based programs identified

among the included studies. Contextual sources were used only to support the interpretation and discussion of findings generated from included studies and did not contribute to the development of themes reported in the formal evidence synthesis. Findings derived from included studies are presented in the Results. This approach is consistent with the exploratory and mapping-oriented nature of other scoping reviews on Indigenous health [49].

Results

Structural barriers and patterns in palliative care

Publication trends and geographic representation

The highest number of primary publications occurred in 2017, as shown in Fig. 2. The literature demonstrated substantial disparities in the representation of Indigenous populations and geographic settings, as well as shifts in research focus over time. Almost all studies concentrated on rural, remote and reserve-based communities. To examine changes in the literature over time, studies were grouped into those published up to 2015 and those published from 2016 onward. This timeframe was selected because changes in study type and in the diversity of Indigenous communities represented became more apparent after 2015. Although this period coincided with

Table 1 This table summarizes research on the perspectives, and research gaps for Indigenous Peoples in Canada

First Author (Year)	Province	Objective	Method	N	Findings	Research Gaps
Chan (2020) [63]	NU	to describe time intervals from symptom onset to the start of palliative radiotherapy in Inuit patients	QN	88	Median time from referral to flight was 4 days. Patients spent a median of 64.5 days away from home with a median survival of just 5.2 months.	Lack of accessible, culturally safe local palliative care services. Poor continuity of care and lack of use of virtual solutions for follow-up.
Funnell (2021) [56]	ON	to describe the places of care and death in Ontario who received provincially funded home care services	QN	223 363	Fewer home care services (1.9 fewer nursing hours and 5 fewer personal support hours). They were 28% less likely to receive a palliative physician home visit. Indigenous people were more likely to die in acute care settings.	Lack of access to home care and physician services. Hospital deaths that go against cultural preferences for community-based care.
Bablitz (2018) [57]	AB	to examine issues in palliative care for a terminally ill Indigenous patient	QL	1	A terminally ill man wished to die at home, but due to lack of home care, and a nearby pharmacy, he died in a rural hospital far from family. He was described as "lonely" at death.	Insufficient palliative care in communities, including limited home care hours, lack of 24/7 services.
Dawe (2024) [58]	NL	to describe the practices related to death and dying among the Innu in Sheshatshiu	QL	16	A peaceful death for the Innu involves family presence, dying at home or on the land with traditional practices.	Lack of culturally safe, community-based services, including limited access to indigenous-speaking care providers. Limited healthcare staff familiar with Innu traditions.
Galloway (2020) [64]	NU	to describe issues during cancer and end-of-life care in Inuit patients	QL	10	Inuit patients and families preferred care in their home, surrounded by family. Medical travel to cities caused emotional, financial, and logistical strain.	Communication barriers, lack of culturally appropriate care, and insufficient interpreter services.
Hordyk (2017) [61]	QC	to describe the role of Inuit interpreters involved in end-of-life care in Nunavik.	QL	24	Inuit interpreters are required in end-of-life care but often lack formal training, support, and culturally appropriate tools.	Lack of structured training and ethical guidance for interpreters in end-of-life care.
Hordyk (2017) [59]	QC	to describe factors that affect end-of-life care in Nunavik.	QL	103	Inuit families prefer care at home, supported by community.	Institutional mistrust, and colonial legacy persists. Family caregiving is affected by historical trauma, poor housing, and limited psychosocial support.
Hordyk (2023) [62]	QC	to explore Inuit grief, and impact of cumulative grief.	QL	103	Inuit caregivers experience layered and prolonged grief due to ongoing deaths, historical trauma, and cultural shifts.	Grief practices are evolving yet support structures remain limited. Insufficient formal support for caregivers and service providers.
Vincent (2019) [75]	NU	to describe health care providers' perceptions of palliative care in the Qikiqtaaluk region.	QL	13	Providers highlighted importance of culturally sensitive, holistic palliative care, the role of family, and the strong desire of Inuit patients to receive care at home.	Limited palliative resources, few Inuit interpreters, and lack of formal training.
Latcu et al. (2025) [95]	ON	to learn sensitive palliative and end-of-life care within First Nations communities and understand how families define a "good death."	QL	19	Five themes emerged: family caregiving, local provider support, dying at home, community involvement, and respecting individual wishes.	Lack of safe hospital policies; limited navigators and supports; insufficient provider cultural sensitivity training, and inadequate support for home-based palliative care and bereavement services in First Nations communities.

The study was designated to, indicating be qualitative (QL), quantitative (QN), or mixed methods (MM). Other abbreviations include N for the number of participants or cases, and provincial abbreviations such as AB Alberta, NL Newfoundland and Labrador, NU Nunavut, ON Ontario, QC Quebec, and MB Manitoba

Table 2 This table summarizes research on programs related to palliative care, and research gaps for Indigenous Peoples in Canada

First Author (Year)	Province	Intervention	Method	N	Findings	Research Gaps
Nadin (2018) [72]	ON	development and implementation of the Wiisokotaatiwin Program.	MM	35	The Wiisokotaatiwin program provided six clients culturally appropriate, coordinated palliative care at home. The pilot found improvements in client experience, service integration, and community satisfaction.	Lack of sustained funding and jurisdictional clarity.
Prince (2019) [73]	ON/MB	created education interventions to build palliative care capacity.	MM	94 + 185	Developed community-driven educational programs across four First Nations communities. These improved death literacy, palliative care capacity, and community readiness.	Lack of culturally appropriate palliative care education for patients, families, internal health providers, and external systems.
Fruch (2016) [71]	ON	created palliative care program integrating Haudenosaunee teachings.	QL	n/a	The Six Nations community developed a palliative care program. The program led to increased home deaths (55 vs. 22 hospitals, 6 hospice), improved provider education and mentorship.	Jurisdictional ambiguity and limited funding for palliative care in communities hinder program development and resource allocation, for 24/7 care, staff training, and equipment needs.
Gaspard (2021) [77]	BC	to evaluate an end-of-life doula course designed for Indigenous communities.	QL	86	The Indigenous Doula Course was designed to support culturally grounded care in their communities. Participants reported increased confidence in having conversations about death, planning for care, and sharing resources.	Lack of culturally safe education and support structures, including formal recognition of the doula role, sustainable training access.
Kelley (2018) [50]	ON/MB	development of community-based palliative care programs using community capacity approach.	QL	279	Four First Nations communities developed palliative care programs using a participatory action research and community capacity development approach.	Lack of sustainable policy support, and culturally safe training for both internal and external health providers.
Koski (2017) [51]	ON	created journey mapping workshops to develop a culturally appropriate pathway.	MM	42	Journey mapping effectively created a 9-stage culturally appropriate pathway. The process improved communication, built partnerships, and integrated services.	Lack of community-led care pathways and cross-jurisdictional service integration. Insufficient funding, fragmented services, and the absence of a guiding policy framework.
Stang (2022) [78]	ON/AB/NL	updating competencies for spiritual care professionals in palliative and bereavement care	MM	33	Developed and reached consensus on 9 advanced competencies for spiritual care professionals in palliative and bereavement care. Client input led to revisions in competencies.	Lack of development of competencies and training for culturally sensitive palliative care.

The study was designated to, indicating be qualitative (QL), quantitative (QN), or mixed methods (MM). Other abbreviations include N for the number of participants or cases; and provincial abbreviations such as AB Alberta, NL Newfoundland and Labrador, NU Nunavut, ON Ontario, QC Quebec, and MB Manitoba

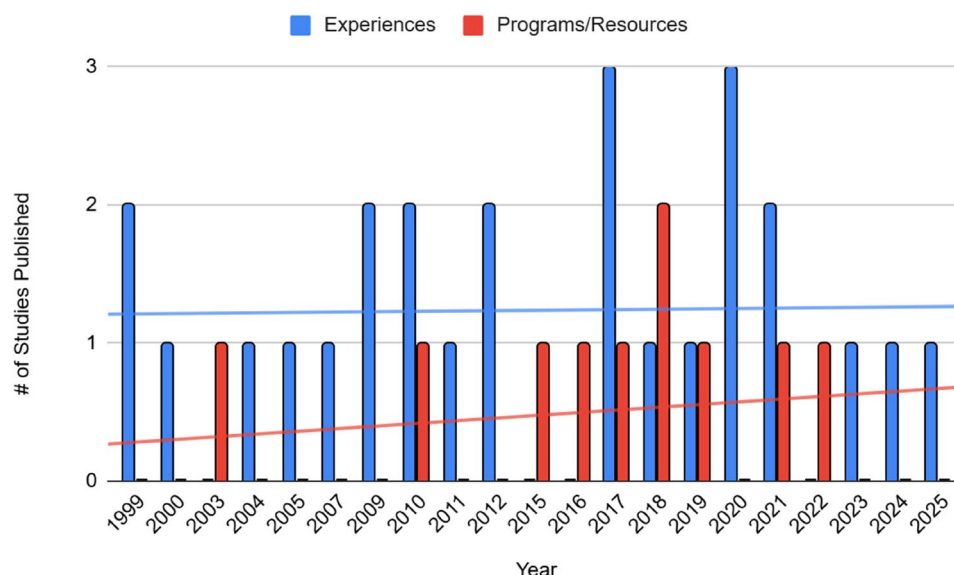


Fig. 2 Temporal distribution of included studies examining Indigenous palliative care in Canada from 1999 to 2025, categorized into studies focused on stakeholder experiences and those examining programs/resources

the release of the Truth and Reconciliation Commission of Canada's Calls to Action, the temporal overlap should not be interpreted as indicating that the TRC caused the observed publication trends. Before 2015, the literature consisted primarily of experience-based studies ($n=16$, 88.9%), with few intervention-focused studies identified ($n=2$, 11.1%). In contrast, from 2016 onward, there was a marked increase in program and resource-oriented literature ($n=7$, 41.2%), alongside continued growth in experiential studies ($n=10$, 58.8%).

Likewise, the literature was overwhelmingly focused on First Nations communities ($n=14$, 77.8%), with limited representation of Inuit populations ($n=4$, 22.2%). Studies during this period also frequently did not specify the participating Indigenous communities ($n=3$, 16.7%). In contrast, literature published from 2016 onward demonstrated greater Inuit representation ($n=4$, 23.5%), and an increase in First Nations-focused research ($n=7$, 41.2%). However, despite this expansion in the literature, no studies exclusively on Métis populations were identified in either time period, even though Métis-specific health research exists in other areas of health [89, 90]. This complete absence of Métis-specific peer-reviewed evidence represents a major gap in the Canadian palliative care literature.

We subsequently evaluated the geographic distribution of studies to understand regional representation within the literature better and identify gaps in research implementation (Fig. 3).

Jurisdictional fragmentation

Across studies, jurisdictional fragmentation emerged as a recurring structural determinant of palliative care

characterized by unclear responsibility for service delivery, funding gaps, limited accountability, and shortages of locally available healthcare providers and palliative care programs [50–52, 55, 65]. This is highlighted by fewer programs implemented in Canada, compared to Norway, New Zealand, Australia, and the United States for Indigenous palliative care [52]. This is also evident in Habjan et al. who found a shortage of healthcare providers and programs in select communities in Canada [65].

Cultural safety, communication, and western models of care

Misalignment between biomedical and indigenous understandings of death

It is also evident that there is a significant misalignment between the dominant Western biomedical models of death and dying and perspectives emanating from First Nations and Inuit communities. Western healthcare systems often conceptualize death primarily as a biomedical event focused on disease management, institutional care, and clinical decision-making. In contrast, many Indigenous participants described death as Wholistic, spiritual, and relational [55, 66, 69]. Participants across studies expressed concerns that institutional healthcare environments often failed to accommodate Indigenous cultural practices and traditions surrounding death and dying [55–59]. Restrictive hospital policies, limited flexibility surrounding ceremony and family gatherings, and insufficient provider understanding of Indigenous spiritual beliefs were identified as contributing to emotional distress and spiritual disconnection near the end of life [55]. This misalignment was also evident in understandings of cancer pain. Barkwell's qualitative grounded

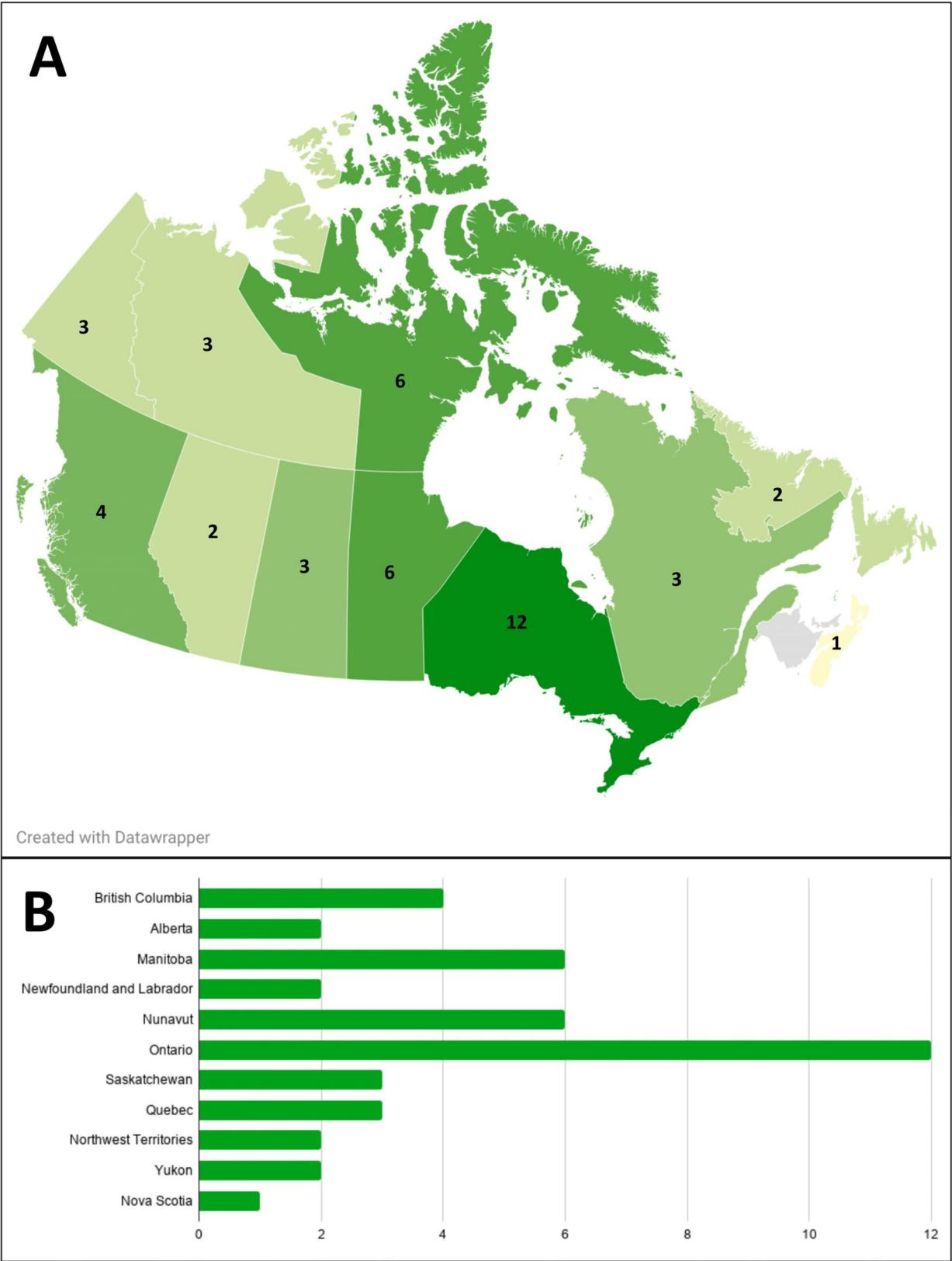


Fig. 3 Geographic distribution of Indigenous palliative care studies conducted across Canadian provinces and territories included in this scoping review. **A** Geographic representation of study locations across Canada. **B** Heat map of included studies by province or territory

theory identified substantial differences between Ojibway understandings of cancer pain and dominant biomedical conceptualizations [66]. Ojibway participants described cancer pain as inseparable from spiritual suffering, whereas healthcare professionals primarily focused on physical sensation and symptom control [66]. Participants emphasized that pain was deeply connected to family experiences [66].

Culturally unsafe care practices

Studies elucidated that Indigenous patients and families frequently experienced culturally unsafe environments, discrimination and offensive stereotypes within institutional healthcare environments, including a lack of respect for Indigenous beliefs and practices surrounding death and dying [8, 11]. Experiences such as these have been shown to cause greater mistrust between Indigenous patients and the medical system, leading to reduced engagement with palliative care services [60]. Cultural safety extends beyond culturally appropriate care and requires addressing systemic power imbalances, racism, and colonial structures embedded within healthcare systems [60]. This review found that to bolster cultural safety, institutions should partner with Indigenous communities to integrate Indigenous perspectives, provide cultural safety awareness training for care providers, and spread awareness of palliative services in Indigenous communities through cultural health education strategies, including oral stories [60].

Language and communication barriers

Two studies discussed patients' desire to receive information in their native language to further the provision of culturally safe palliative care [61, 62]. Chan et al. found that 73% of study participants did not speak English and continued to face significant language barriers [63]. As a result, interpreters were frequently identified as important supports for communication and end-of-life discussions [61]. Studies have also expressed concerns about the use of medical jargon when conveying "bad news" about prognosis or diagnosis, especially in hospital care [54, 60]. These findings demonstrate that language and communication barriers remain recurring challenges to the delivery of culturally safe care.

End-of-life preferences and experiences

Preferences for home and community-based dying

Among Indigenous communities, studies described a strong preference for at-home care and community-based end-of-life care, where individuals can remain surrounded by their families and loved ones [8, 59, 64, 68]. To receive palliative care, the majority of Indigenous Peoples are transferred to urban hospitals, isolated from the support of loved ones [63]. Chan et al. retrospectively

reviewed Inuit who received palliative radiotherapy in Ottawa between 2005 and 2014. Although the median time from referral to flight to Ottawa was only 4 days, patients spent a median of 64.5 days away from their home communities despite a median survival of only 5.2 months [63]. Another retrospective cohort study found that Indigenous Peoples in Ontario receiving provincially funded home care services experienced substantial inequities in end-of-life care access and were more likely to die in acute care settings rather than within their home communities [56]. Indigenous patients received fewer home care nursing hours (1.9 fewer hours), fewer personal support worker hours (5 fewer hours), and were 28% less likely to receive a palliative physician home visit during the final 90 days of life compared to the general public [56]. Hotson et al. identified Indigenous communities have fewer resources and equipment to support home-based palliative care [9]. Among Indigenous Peoples, those who received a palliative physician home visit reduced the odds of dying in acute care by approximately 50% [56]. Bablitz et al. shed light on the emotional consequences of inadequate community-based palliative care through a case study involving a terminally ill Indigenous man in rural Alberta [57]. Although the patient strongly wished to die at home, the absence of a nearby pharmacy resulted in him being transferred to a rural hospital far from family, where healthcare providers described him as "lonely" during the final stages of life [57]. The preference for at-home care and dying was also a common theme in the other studies [9, 64, 68, 71, 72]. However, not all caregivers feel confident with the training they receive to safely provide effective palliative care for a loved one at home [50, 68, 70, 73]. From our exploration of the literature, it was also clear that palliative care was not always available, and there was a limited understanding of local services available to some communities [28, 67, 71, 73, 74]. Indigenous Elders reiterated that community gatherings were important in the preparation leading up to death for Indigenous individuals [69]. Hordyk et al. reported that during the final stages of life, homes were often filled with family and friends, creating an emotionally and socially supportive environment [59]. Overall, these studies demonstrate a recurring preference among Indigenous Peoples to receive care within their home communities and remain close to family. However, limited access to home and community-based care frequently prevents these needs from being addressed.

Education and cultural safety training

Additional issues with care delivery are the consequences of a lack of interpreters [61, 63], and limited training related to Indigenous cultural practices and belief systems [58, 61–63, 75]. Interpreters themselves often lacked formal training and ethical guidance when

navigating emotionally difficult end-of-life conversations [61]. Concomitant with a lack of training, providers also faced uncertainty about how to provide culturally safe palliative care for their Indigenous patients [67]. Inuit interpreters in Nunavik frequently experienced moral distress when translating information, as Western approaches to disclosure seldom align with Inuit communication practices [61]. Interpreters routinely felt caught between institutional expectations for direct translation and responsibilities to communicate information in a sensitive manner [61]. Prince et al. and Hampton et al. emphasized the need for greater provider understanding of Indigenous cultural practices and belief systems surrounding end-of-life care [69, 73]. Collectively, these findings highlight gaps in training for healthcare providers and interpreters in navigating differences between Western and Indigenous approaches to care.

Community-led approaches and capacity building

Existing community-based programs and resources

Existing community-based programs and resources were also explored in our search. The Six Nations of the Grand River Territory Palliative Care Program was developed through the Improving End-of-Life Care in First Nations Communities initiative from 2010 to 2015 [71]. Using a participatory action research framework and a community capacity development approach, the program was led by a local Project Advisory Committee and Leadership Team composed of Indigenous healthcare providers, community leaders, Elders, and Traditional Knowledge Keepers. The program was marked by Indigenous governance, local decision-making, and community-defined aspirations throughout implementation. Fruch et al. note that the program integrated Haudenosaunee teachings, community values, and culturally grounded understandings of death and dying into care delivery [71]. An extension of the program was the development of a Palliative Shared Care Outreach Team consisting of a First Nations physician, a clinical nurse specialist, and a psychosocial-spiritual bereavement clinician, all of whom were community members [71]. Additional contributions included a detailed community-based care pathway, culturally grounded bereavement and grief programs, advanced care planning resources such as *Journey Back Home*, caregiver support materials, formalized palliative care guidelines, and partnerships with regional hospice and home-care organizations. Positive outcomes were reported following implementation. The reported outcomes included increased referrals from 30 in 2012 to 80 in 2013, and subsequently to 81 in 2014. Between 2013 and 2015, home deaths ($n=55$) substantially exceeded hospital deaths ($n=22$) and hospice deaths ($n=6$) [71]. The program provided access to 24/7 care, physician home visits, pain and symptom management,

psychosocial and spiritual support, and bereavement follow-up for families. They identified that lack of education represented a significant barrier to dying at home within First Nations communities [72]. Families often did not know what services were available, how to care for a loved one at home, or what to expect during the dying process. Internal healthcare providers also expressed the need for more palliative care training. Knowledge Carriers stressed that caregivers must provide care “feeling wise, loving wise,” rather than treating palliative patients impersonally [73]. Across communities, the project developed telehealth partnerships, grief and bereavement curricula, discharge planning protocols, planning resources, and formalized partnerships with external hospitals, hospices, and home-care providers [50]. This was similar to the four directions of the Medicine Wheel advocated by Clarke and Holtslander in the early 2010s [48, 70]. The Medicine Wheel represents a theoretical framework for healing and decolonizing death and is a commonly cited resource in the literature [76]. Orton found a similar framework in Mi'kmaq communities, which promoted the concept of “hospitality” as a framework for spiritual care, emphasizing relationship-building, trust, reciprocity, and the creation of welcoming environments for Indigenous patients and families within healthcare settings [45].

The Wiisokotaatiwin Program was developed in Naotkamegwaning First Nation in northwestern Ontario over a period of five years [72]. The program was created through a participatory action research framework and a community capacity development model. Unlike deficit-based approaches that focus on what Indigenous communities lack, the initiative emphasized building on existing community strengths, local leadership, and culturally grounded care practices. Community leadership was central to the development of the program, with a palliative care leadership team composed of local healthcare providers, Elders, Band council members, and administrators guiding implementation. The program was devised in accordance with Anishinaabe beliefs and traditions surrounding death and dying. Because discussing death directly was considered culturally inappropriate and there was no direct Anishinaabe translation for “palliative care,” Elders selected the name Wiisokotaatiwin, meaning “taking care of each other” or “supporting each other.” Journey mapping workshops were also included in this program [51]. The workshops developed strategies such as improved consent procedures, coordinated care conferences, culturally relevant communication practices, and telemedicine-supported collaboration. Researchers found that conventional “value stream mapping” approaches were inappropriate for most community participants and therefore adapted into a more relational storytelling-circle format grounded in Two-Eyed

Seeing [51]. All respondents agreed the workshops identified gaps in care delivery and effectively created a palliative care pathway; concurrently, participants reported stronger partnerships between community members and external healthcare providers. The resulting nine-stage Wiisokotaatiwin care pathway integrated community-based services with regional health systems. Six clients received services during the pilot, with clients receiving an average of 50.5 h of direct care per month [51]. Much of this support occurred outside regular working hours, including evenings and weekends. Families and healthcare providers reported high satisfaction with the initiative. However, these results should be interpreted with caution, as they were derived from a small pilot within a single community and may not be representative of other Indigenous communities or care settings.

Another project was the Indigenous End-of-Life Doula Program developed by the First Nations Health Authority in partnership with Douglas College in British Columbia [77]. The program was created in response to concerns that many Indigenous Peoples die in hospitals despite preferring to remain at home. In 2019, five training sessions were offered, and 72% of participants identified as Indigenous, representing 47 Indigenous communities [77]. The curriculum focused on communication skills, grief support, advocacy, advance care planning, and culturally grounded approaches to end-of-life care. Elders opened and closed sessions with ceremony, while local cultural teachings and practices were integrated throughout the training. No formal healthcare background was required, which allowed community members already engaged in caregiving roles to participate. Surveys found participants had increased confidence discussing death and dying, supporting families, and facilitating advance care planning within their communities. A similar project in Saskatchewan developed educational tools and videos, in which Elders created presentations for non-Indigenous healthcare professionals [69]. Similarly, Stang et al. attempted to identify competencies for spiritual care professionals working in palliative and bereavement settings in Canada [78]. They found, through interviews, focus groups, and surveys with 22 spiritual care experts, that the key areas of interest were communication, grief and bereavement, cultural humility, spiritual assessment, and quality of life [78].

In addition to improving education, the literature also focused on developing broader solutions. For example, Martin described determinants required for the development and implementation of a community-based palliative care program in the Kivalliq Region of Nunavut in 2003 [43]. Recommended strategies included expanding home-care services, improving pain and symptom management training for local providers, integrating interpreters and culturally relevant communication practices,

increasing telehealth use, and establishing stronger collaboration between communities, regional health centers, and southern tertiary hospitals.

Across the identified programs, Indigenous community leadership and governance were central to the development and implementation of palliative care services. Rather than applying standardized models of care, initiatives were developed around local cultural values, traditions, and community-defined needs while strengthening local capacity through education and caregiver support. Across the studies, we found that partnerships with external healthcare organizations and regional health systems provided additional resources and expertise while allowing communities to retain an active role in shaping care delivery. Collectively, these findings highlight a recurring emphasis on community-led approaches that combine Indigenous knowledge and decision-making with broader healthcare resources to support locally relevant palliative care.

Discussion

Literature on Indigenous palliative care began to appear in the 1990s [54]. Since then, palliative care has gained more attention and become a more established field of study [79]. Still, research in palliative care for Indigenous Peoples in Canada is limited. The findings from this scoping review indicate a strong consensus in the literature that culturally safe, community-led models of palliative care are needed for capacity development. The programs implemented [58, 71, 72] have suggested that when palliative care is grounded in community values, traditional teachings [71, 80], and Indigenous leadership, it may address the end-of-life needs of Indigenous communities [81–83]; however, more studies are needed. Our findings demonstrate that Indigenous resilience, existing community strengths, and successful community-led initiatives improved culturally safe palliative care delivery. Educational resources, workbooks, toolkits, videos, training initiatives, and caregiver manuals developed in collaboration with Indigenous communities may serve as important frameworks for the development of future community-based palliative care.

The programs most consistently described as effective in the included literature, such as the Six Nations of the Grand River Territory Palliative Care Program and the Wiisokotaatiwin Program, were characterized by Indigenous-led governance structures, including Project Advisory Committees, Leadership Teams, and Band council involvement, that gave communities direct authority over program design, priorities, and resource allocation [71, 72]. Improving palliative care access for Indigenous Peoples in Canada therefore depends not only on culturally safe clinical practice, but on decision-making authority, funding control, and jurisdictional accountability

remaining with Indigenous communities and governing bodies. Indigenous self-determination and governance should accordingly be understood as structural determinants of access to palliative care, rather than as features of individual programs alone.

Indigenous self-determination as a structural determinant of palliative care

Indigenous self-determination extends beyond participation and refers to the collective authority of First Nations, Inuit, and Métis Peoples to determine their health priorities and govern the systems through which care is funded, designed, delivered, and evaluated. Indigenous governance is the institutional expression of this authority through Indigenous governments, leadership bodies, and accountability structures [84, 85]. Indigenous health systems research indicates that community authority, service design, and meaningful control over resources are central characteristics of accessible and responsive healthcare models [86, 87]. Self-determination should therefore be understood as a structural determinant of health because it shapes the conditions under which services can be sustained for the populations they are intended to serve [88].

In the context of palliative care, governance determines whether communities can allocate resources towards appropriate care. It also determines whether Elders and Knowledge Keepers are recognized as integral components of care [89]. When authority remains divided among systems, gaps in responsibility can delay services and leave families uncertain about which institution is accountable for providing care. Canadian scholarship has identified these policy and jurisdictional divisions as persistent barriers to equitable Indigenous healthcare access [90]. Although Jordan's Principle applies specifically to First Nations children, it demonstrates the broader consequences of allowing disagreements to interrupt necessary care. It establishes the principle that services should be provided before governments resolve payment disputes [91].

Self-determination also requires authority over how palliative care success is defined and evaluated [84]. Conventional indicators may prioritize hospital utilization or clinical outcomes, while communities may also value remaining on the land, dying at home, family presence, relational continuity, and collective wellbeing [92]. Indigenous data-governance frameworks reinforce that Indigenous Peoples should have authority over the collection, interpretation, use, and ownership of information concerning their communities [93]. For First Nations, the principles of Ownership, Control, Access, and Possession (OCAP®) affirm that communities should exercise authority over how their information is collected, interpreted, accessed, used, and retained [94]. Accordingly,

culturally safe palliative care requires more than adapting mainstream services; it requires arrangements that enable communities to independently define priorities, control resources, and hold external healthcare systems accountable.

Gaps in the existing literature

The methodological approaches of the studies in Tables 1 and 2 consisted of eleven qualitative studies [50, 57–59, 61, 62, 64, 71, 75, 77, 95], four mixed methods studies [51, 72, 73, 78], and two quantitative studies [56, 63]. Existing research relies on qualitative methods, indicating a gap in mixed-methods or quantitative studies that could offer comparative data on care outcomes. However, Salvalaggio et al. indicate that this may be the most appropriate cross-cultural methodological approach. On the other hand, mixed-methods approaches are increasingly recognized in health research because they integrate quantitative and qualitative findings, allowing researchers to better understand not only clinical outcomes but also the cultural, social, and experiential dimensions of care delivery [96]. Such approaches may therefore provide a more comprehensive understanding of Indigenous palliative care needs or barriers.

In recent years, there has also been increasing migration of Indigenous populations toward urban centers, with approximately 50% of Indigenous Peoples in Canada now living in non-remote or urban areas [97]. Despite this shift, much of the existing Indigenous palliative care literature remains limited. Although urban areas have closer access to primary healthcare, social support, and specialist services, Indigenous Peoples do not have better healthcare compared to those First Nations on reserves or Inuit in Nunangat and Alberta. As a result, this represents a significant research gap in palliative care medicine [98].

A particularly critical gap is the complete absence of Métis-specific peer-reviewed studies on palliative or end-of-life care identified in this review, despite the existence of Métis-specific health research in other clinical areas [99, 100]. Given that Métis Peoples are one of the three constitutionally recognized Indigenous Peoples in Canada in Sect. 35 and comprise more than one-third of the Indigenous population, their absence from the existing evidence base is particularly notable [99]. Métis Peoples are a distinct rights-bearing Indigenous People with a unique and rich history. While they do have ancestral ties to First Nations of the Red River region and to fur traders in the late 18th century, their experiences should not be subsumed under a broad Indigenous categorization. Future research should be developed and governed in partnership with Métis communities and Métis-led health organizations, including urban Métis communities and Alberta's Métis Settlements. Such work is necessary

to identify Métis-specific end-of-life priorities, barriers to care, and appropriate models of community-based palliative care.

No studies were identified from Prince Edward Island (PEI) or New Brunswick (Fig. 3). This is important because the provinces are home to Indigenous communities, including Mi'kmaq and Wolastoqiyik peoples, with different languages and end-of-life traditions from those represented in the existing literature [101]. In general, research in these communities often does not meaningfully engage the community [102, 103]. If research is to be done in these communities, we recommend working with the Nunatsiavut Government, the Mi'kmaq Confederacy of PEI, and the Native Council of PEI, who have previously been involved in participatory research [101].

While jurisdictional fragmentation has been frequently noted, there remains limited research on how policies directly influence Indigenous palliative care accessibility, funding, coordination, and continuity of care. As a result, many studies relied on experiences of participants within the healthcare setting [65]. No studies have explored how disagreements over jurisdictional responsibility, funding allocation, or healthcare governance affect the implementation of community-based palliative care services in Indigenous communities. Jurisdictional barriers have been identified in other areas of Indigenous healthcare through Jordan's Principle, which was created to address delays in services for First Nations children [104]. Future research should therefore address this research gap.

In general, frameworks for developing palliative care in Indigenous communities did not translate to many programs or resources [68, 71, 72]. This suggests there remains a significant gap between knowledge creation and practical implementation of culturally safe palliative care practices for Indigenous groups. In addition, there is limited long-term evaluation of program implementation that goes beyond five years. Most of the programs identified were pilot programs and lacked longitudinal follow-up [77]. As a result, there remains limited understanding of which models are most sustainable, transferable, or effective over time. Future implementation-focused research should evaluate how Indigenous-led palliative care programs can be scaled while considering autonomy and local governance structures.

International perspectives on indigenous palliative care

Similar needs in Indigenous palliative care across Australia, New Zealand and the United States have been identified [52]. Although the histories and experiences of Indigenous Peoples in these countries and across the world are distinct, they have been shaped by related processes of settler colonialism, including land dispossession, forced relocation and assimilation, suppression

of Indigenous languages and healing practices, and the imposition of Western political and healthcare systems [105–107]. Colonialism should therefore not be understood solely as a historical event. Its ongoing structural consequences continue to influence the social determinants of health, the distribution of healthcare resources, relationships between Indigenous communities and healthcare institutions, and the extent to which Indigenous knowledge systems are recognized within care [108–110].

Similar to our findings, internationally, there was a preference for community-based dying, family involvement, culturally safe care, and integration of spiritual and cultural practices within end-of-life care [111–114]. Indigenous Peoples around the world expressed a desire for dying at home, surrounded by their loved ones [111]. Family engagement was an important part of palliative care and end-of-life. Across the studies, the barriers identified were like those in Canada, including mistrust towards healthcare systems, language barriers, lack of interpreters, and poor hospital policies, inadequate provider knowledge of Indigenous preferences surrounding death and dying [115, 116]. International literature also highlighted the importance of Indigenous healthcare workers and community leadership in improving trust, communication, and continuity of care within palliative services [117]. This was reflected in our review through programs that integrated Elders, Indigenous healthcare providers, spiritual care workers, and Knowledge Carriers into service development and implementation. In New Zealand, Māori-focused hospice services improved care delivery by creating flexible visiting spaces for large families, partnering Māori staff with non-Indigenous healthcare providers, and strengthening communication between agencies and families [111]. Similar culturally grounded adaptations were observed in Canadian Indigenous-led initiatives such as the Wiisokotaatiwin Program and the Six Nations of the Grand River Territory Palliative Care Program [71, 72]. Other countries have identified specific funding issues, but there is limited research in Canada on how funding affects delivery of care [13, 112, 113, 117, 118].

Contextual examples from grey literature

Although grey literature was excluded from the formal evidence synthesis, selected contextual sources identified during screening and citation searching illustrated additional community-based initiatives not represented in the peer-reviewed literature. One example was the Meno Ya Win Health Centre, a community-based initiative launched in 2005 with funding from the Government of Canada. The hospital includes a smudging room and a palliative care area designed to accommodate extended family members and has been recognized for supporting

trust and communication between Indigenous communities and healthcare providers [119]. This example demonstrates how culturally grounded service-delivery models may exist outside the peer-reviewed literature and therefore may not have been captured in our review. Future reviews formally incorporating systematic searches of grey literature may provide a more comprehensive account of Indigenous-led and community-developed palliative care initiatives. We have included a list of relevant grey literature in Canada for Indigenous palliative care providers seeking specific resources that would support care in their communities. This list is provided in Supplementary File S4 in collaboration with Indigenous scholars.

Strengths of this scoping review

A strength of this scoping review is the inclusion of studies that used qualitative and community-based research methodologies aligned with Indigenous ways of knowing. Specifically, studies used focus groups [39, 40, 58, 59, 61, 62, 65, 70, 83], storytelling [57], participant observations [54, 62, 120], semi-structured or open-ended interviews [9, 39, 41, 42, 46, 58, 62, 64, 66–69, 75], narrative inquiry [57], participatory action research [71, 72], and Elder sharing circles [58]. In particular, participatory research is a recognized and promising approach to achieving Indigenous self-determination through research [121, 122]. Another strength of this review is the inclusion of both stakeholder experiences and community-based programs or resources. This moves beyond a deficit-based model that focuses solely on barriers to exploring Indigenous resilience, local leadership, and successful culturally safe initiatives. Given the limited peer-reviewed literature available in Indigenous palliative care, our inclusion of contextual framework sources strengthened interpretation of our results and supported identification of broader systemic issues affecting palliative care delivery. We also included identified changes in publication trends, and the gradual shift from primarily experiential studies toward program development and resource-oriented initiatives.

On a methodological basis, as a scoping review, this study examined an emerging and under-researched topic [123]. Because Indigenous palliative care involves a varying range of paper types, a scoping review was appropriate for mapping the depth and breadth of evidence in the literature [124]. We believe this review fulfilled the objective of scoping reviews by identifying key knowledge gaps that require further investigation to guide future Indigenous palliative care research, policy development, and implementation efforts. We extended our search to Indigenous databases to capture literature that may not always be indexed within mainstream databases. Indigenous health literature is often underrepresented in traditional

academic indexing systems, making broad search strategies especially critical for reducing publication bias [125].

Solutions proposed in literature

To meet the ongoing need to monitor and support those in remote communities, digital technologies for virtual consultations were suggested to reduce the burden of travel and improve continuity of care and preventive care [97]. Telehealth and virtual palliative care models may support advanced care planning, follow-up care, and communication between communities and urban specialists. Another area of concern that requires a solution is funding. While Indigenous Peoples living in Canada are under federal jurisdiction, health services in particular, including access to specialist care in palliative care, are accessed from the provincial government. Few, if any, services are delivered on reserves and in remote communities. This dual funding system has created fragmented governance structures, leading to confusion over responsibility, delays in accessing care, and inequities in end-of-life support [126]. Our research has found that Indigenous Peoples are seeking accountability from the federal government and greater control over their healthcare services. In particular, the province of British Columbia has already entered into an agreement with the First Nations Health Authority to take over the responsibility for funding and the development of on-reserve services [127]. Greater funding allocation for at-home dying in Indigenous communities will make a meaningful difference in end-of-life care for these communities.

Limitations

As mentioned in our inclusion criteria, only English-language, peer-reviewed studies based in Canada were included, which may have excluded some relevant articles on experiences [9, 39–42, 44, 53, 65–70] and interventions [43, 45, 48]. The exclusion of grey literature, government reports, unpublished theses, and community documents may also have resulted in the underrepresentation of Indigenous-led knowledge and locally developed palliative care initiatives that are not well represented within academic databases. Grey literature was excluded to maintain a clearly defined and reproducible evidence base composed of peer-reviewed research and to ensure consistency in the identification and selection of included sources. However, we did use grey literature to inform the context and interpret our results in the discussion. Future reviews should consider systematic searches of grey literature and Indigenous organizational and community sources to provide a more comprehensive understanding of existing palliative care initiatives.

A potential limitation of the study design itself is the inability to conduct an exhaustive or fully comprehensive search. In contrast to systematic reviews, this scoping

review did not undergo a quality appraisal of included studies. However, only peer-reviewed literature was included in the primary synthesis to mitigate this limitation partially. Scoping reviews are inherently exploratory and are intended to map the breadth and nature of existing literature rather than determine the effectiveness or quality of evidence. The findings presented should not be interpreted as definitive evidence regarding the effectiveness of Indigenous palliative care interventions or programs. Another limitation is that scoping reviews are conducted predominantly within Western academic and methodological frameworks. There remains a broader need for decolonized and Indigenous-led approaches within health research methodologies. Although an Indigenous physician with expertise in palliative care contributed to the refinement and interpretation of the thematic categories, the review was not designed or conducted in formal partnership with Indigenous communities [128]. As a result, the review questions and recommendations may predominantly come from an academic and healthcare-system perspective and may not fully capture community-defined priorities among First Nations, Inuit, and Métis Peoples. Future reviews on this topic should work with Indigenous partners from the outset through community governance, co-development of research questions, interpretation of findings, and knowledge-sharing processes.

Despite these limitations, we still believe this review provides insight into the current state of Indigenous palliative and end-of-life care literature in Canada. This review may inform future research priorities, healthcare policy development, resource allocation, and clinical training for healthcare providers working with Indigenous Peoples.

Conclusion

To our knowledge, this is the first scoping review of Indigenous palliative care in Canada to examine barriers and experiences of care, as well as existing community-based initiatives, research gaps, and recommendations. The findings demonstrate that Indigenous Peoples continue to face substantial inequities in accessing palliative and end-of-life care, particularly in relation to geographic isolation, jurisdictional fragmentation, culturally unsafe care, and limited access to formal community-based services. Importantly, the literature also highlights that palliative care should not be understood solely as a formal program or clinical service. In many Indigenous communities, compassionate end-of-life care is already provided through families, Elders, cultural practices, and community relationships, even where formal palliative care programs are unavailable. Indigenous-led and community-based initiatives identified in this review offer promising approaches to addressing identified barriers

and supporting culturally grounded end-of-life care. Further research and long-term evaluation are needed to assess the effectiveness and sustainability of these initiatives. The absence of Métis-specific peer-reviewed research on palliative and end-of-life care represents a particularly important gap that requires urgent attention. Future efforts should prioritize Indigenous-led research, evaluation of community-based programs, sustainable and equitable funding models, and policies that support Indigenous governance and self-determination in the design and delivery of palliative care.

Abbreviations

AB	Alberta
BC	British Columbia
MB	Manitoba
MeSH	Medical Subject Headings
MM	mixed methods
N	number of participants or cases
NL	Newfoundland and Labrador
NU	Nunavut
ON	Ontario
PEI	Prince Edward Island
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews
QC	Quebec
QL	Qualitative
QN	Quantitative
U.S.	United States

Supplementary Information

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Supplementary Material 1.
Supplementary Material 2.
Supplementary Material 3.
Supplementary Material 4.
Supplementary Material 5.

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Authors' contributions

M.S. and H.K. contributed substantially to the conception and design of the study. M.S. and H.K. conducted the literature search, screening, data extraction, and preparation of figures and tables. M.S., H.K., and I.B. participated in the analysis and interpretation of the findings and drafted the original manuscript. H.A. and M.D. provided methodological guidance and critically revised the manuscript for important intellectual content. A.K. assisted with manuscript editing and literature interpretation. B.D.M. made substantial intellectual contributions during the revision process, including refinement of the conceptual framing and interpretation of Indigenous palliative care, critical revision of the manuscript in response to peer-review comments, and important revisions to the manuscript's intellectual content. All authors reviewed and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

Not applicable. This study was a scoping review of previously published literature and did not involve human participants, human tissue, or identifiable personal data.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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