Indigenous Cultural Safety Within Mainstream Health Systems

A Rapid Review of the Literature and Considerations for Indigenous Canadian Armed Forces Members Accessing Military Health Services

8 April 2025

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Author's Note
This rapid review was conducted by the Collaborative Applied Research for Equity in Health Policy and Systems (CARE) Research Lab, led by Dr. Stephanie Montesanti. The review was conducted to profile evidence and experiences drawing on an approach that is similar to a five-day rapid evidence profile conducted by the McMaster Health Forum. The review included a scan of programs, strategies, and best practices to enhance cultural safety for Indigenous people in both military and civilian health systems. Due to a lack of evidence regarding cultural safety initiatives in military health systems, we broadened our focus to encompass civilian healthcare systems.

About the CARE Research Lab
CARE is an applied health policy and systems research program at the University of Alberta's School of Public Health. It focuses on transdisciplinary research and engagement to tackle complex health system challenges, as well as social and structural issues that affect population health. The program aims to reorient health systems and services towards equity and integration. The CARE team works in collaboration with policy- and decision-makers, practitioners, and communities to support evidence-informed decisions and applied interventions that promote health and health equity by drawing on qualitative insights, implementation science, and systems analysis.

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Key Messages

- Cultural safety does not have a single definition; instead, it encompasses a set of competencies, actions, or behaviours that lead to more culturally safe healthcare encounters, as defined by the Indigenous patient.
- Efforts to enhance cultural safety must be implemented at the provider, organizational, and systems levels, with the active engagement of Indigenous peoples and leaders in their design to ensure maximum impact.
- There is limited evidence on the best practices for implementing cultural safety training specifically. Moreover, most evaluations of cultural safety training did not measure changes in patient's experiences of care, and those that did demonstrate limited impact.
- Health system interventions must be adapted to local contexts, avoiding a pan-Indigenous approach while ensuring meaningful engagement with Indigenous communities.

Questions

1. What practices within civilian health systems of Five Country Ministerial nations (Australia, Canada, New Zealand, the United Kingdom, and the United States) enhance cultural safety for Indigenous patients?
2. What are the key barriers and facilitators to implementing cultural safety strategies in civilian health systems, and how can these insights be adapted to enhance cultural safety within military health systems?

What We Did

We conducted a rapid review to identify and synthesize evidence related to the review questions (Appendix A). Our process involved defining the review questions, searching for research evidence, critically appraising sources, synthesizing findings, and identifying gaps and transferability considerations.

On January 15th, 2025, we searched Scopus and Medline with a health sciences research librarian (Appendix B). Initially, we aimed to examine cultural safety initiatives within military health systems. However, after finding no relevant studies, we expanded the focus to include civilian healthcare systems.

We included systematic, scoping, and other reviews that demonstrated clear methodological transparency relevant to the questions. We excluded sources that were not specific to Indigenous populations or the countries of interest, did not clearly state their methods, and failed to provide sufficient detail to address the questions.

Instead of conducting a formal quality appraisal, we rated sources by high, medium, and low relevance using an organizing framework. This was subjective and done iteratively through discussion between the reviewers. Given the broad scope of the questions and lack of findings related to military health systems, we deemed conducting a formal quality appraisal inappropriate for this review.

Two reviewers collaboratively extracted data, synthesizing findings from highly relevant sources. The final evidence profile includes findings synthesized by the organizing framework's domains, identified gaps, and transferability considerations to the military health system context. Tables in Appendices C-E categorize sources by type, relevance, and key findings, providing hyperlinks to each source.

What we found

Organizing framework

We screened and rated the relevance of all sources using the following organizing framework:

- **Concepts of cultural safety and patient experiences:** The source provides a definition or describes Indigenous people's perspectives on culturally safe care.
- **Cultural safety practices:** The source identifies and describes practices to increase cultural safety at one or more levels.
    - **Provider-level:** The source identifies and describes competencies or practices at the individual provider level to increase culturally safe care.
    - **Organizational-level:** The source identifies and describes an initiative to either increase providers' capacity to provide culturally safe care or increase the cultural safety of programs, services, or environments within the organization (e.g., cultural safety training and program and service design).
    - **Systems-level:** The source identifies and describes policies or regulations at the systems level to increase access to culturally safe care.
- **Facilitators for implementing cultural safety practices:** the source identifies factors that increase an organization's capacity to implement cultural safety practices.
- **Barriers to cultural safety:** The source identifies factors that decrease an organization's capacity to implement cultural safety practices.
- **Audit tools and evaluation:** The source identifies audit tools, evaluation frameworks, methods, or tools to measure the cultural competency of healthcare providers or the effectiveness of cultural safety practices, or the source presents findings from evaluating cultural safety practices.

- **Gaps in research and practice:** The source identifies gaps in evidence-informed approaches to increasing access to culturally safe care for Indigenous peoples.

Characteristics of included sources

We identified 48 reviews relevant to the review questions: 20 with high relevance, 11 with medium relevance, and 10 with low relevance. Seven sources were removed after the final extraction because the reviewers could not differentiate between results specific to Indigenous versus non-Indigenous populations, and the source did not sufficiently answer the review questions. We have hyperlinked these sources by title in Appendix F.

The highly relevant sources include:

- 4 systematic reviews; 11 scoping reviews; 1 critical synthesis; 2 rapid reviews; 1 narrative review; and 1 literature review.

All highly relevant reviews were published between 2011 and 2024, with 19/20 sources published after 2017. These reviews synthesized evidence on cultural safety across 412 primary studies. Below, we outline our key findings from highly relevant sources.

Key findings from highly relevant sources

Concepts of cultural safety and patient experiences

Six sources either provided definitions of cultural safety (1, 2) or elements of culturally safe care (e.g., reflexivity, culturally safe communication) (3, 4), highlighted patient perspectives (5) on cultural safety and their care experiences, or defined models relevant to cultural safety training (6).

A consistent theme in the sources was that cultural safety did not have a single definition but was instead described as a set of competencies, behaviours, or actions, which we have synthesized in forthcoming sections of the profile. One scoping review found that cultural awareness was generally highlighted as a critical first step in the continuum of knowledge, behaviours, and attitudes toward culturally safe practices (1).

One qualitative systematic review synthesized Indigenous patients' perspectives on the unique characteristics of Aboriginal Community Controlled Health Organizations (ACCHOs) that facilitated culturally safe care (2). **In this review, Indigenous patients defined culturally safe care as:**

- Care delivered by providers who were understanding, respectful of culture, and took the time to meet clients' needs.
- Care provided in an environment that made clients feel comfortable and supported.

- Care provided in a welcoming environment that includes both relational (e.g., seeing familiar faces fostering a sense of belonging) and emotional (e.g., ACCHOs as a place to connect, offer, and receive support) dimensions.

One systematic critical synthesis aimed to define reflexivity, a characteristic of culturally safe practice, finding a lack of conceptual clarity on what reflexivity means (3). The authors' findings informed the presentation of reflexivity as a spectrum of reflexive practice ranging from basic reflection to critical reflection and then reflexivity, where true reflexivity requires critical reflection of one's own held beliefs, the context that has shaped them, and how this impacts one's practice.

One scoping review exploring Māori experiences of physical rehabilitation services in Aotearoa, New Zealand, reported that patients voiced entering healthcare services with distrust due to previous unsafe experiences (5). Patients recalled experiences of culturally unsafe care, which included cold and impersonal communication delivered from a Eurocentric model that fails to recognize the broader determinants of health. A different systematic review exploring Indigenous patients' experiences of care emphasized the power of cultural communication to support patient engagement with healthcare services and adherence to treatment plans (4). Patients also reported that informal and formal communication with providers where they feel valued and equal contributed to culturally safe healthcare experiences.

Cultural safety practices: provider-level

Fourteen reviews identified and described competencies or practices at the individual provider level to increase culturally safe care (1-5, 7-15).

The competencies and practices have been categorized into the following themes:

1. **Self-reflection and accountability**: Non-Indigenous providers must recognize and challenge personal and systemic biases, assumptions, stereotypes, attitudes, and beliefs toward Indigenous people (1, 3, 8, 9). This includes understanding how these factors impact the provision of care and patient engagement (3, 9, 12). Strategies identified to enhance reflexivity include taking time to practice reflexivity, journaling and participating in group discussions (14). Additionally, non-Indigenous providers must be accountable for setting and achieving goals to drive change related to culturally responsive practice and aligning outcomes with what is important to Indigenous peoples (12, 15).
2. **Person- and family-centred care**: Person-centred care was described as care delivered based on the patient's wants, needs, strengths, and preferences (11, 15). This includes one-on-one discussions between patients and providers to align care priorities and using a strengths versus deficits-based approach to conversation and goal setting (12, 13). Care should also be holistic, addressing physical, emotional, cultural, spiritual, and social determinants of well-being (1, 11). A strong referral network was considered essential to facilitate holistic care (2). Finally, providers should explore patients' interests in including their families in their care (8). This involves recognizing the family as a member of the care

team, ensuring shared decision-making among families, providers, and patients, and encouraging feedback from patients/families to ensure understanding and active participation (5, 9, 10, 15). Family-centred care requires safety within emotional, cultural, and physical environments as determined by the patient to be impactful (11).

3. **Relationships and power-sharing:** Providers must build relationships with patients to enhance trust and comfort (5). Providers sharing their own cultural and personal context and attending community events can facilitate connection and trust-building (12). There also needs to be equality in relationships between providers and patients through power sharing and shifting (8, 9, 13). This can be done by allowing patients to share in decision-making, viewing their strengths as resources, having patients define what culturally safe care looks like to them, and empowering patients to confirm the cultural safety of an interaction through patient feedback forms (8, 9). Providers must understand and acknowledge power differentials between providers and patients, and how they are inherently embedded in colonial structures (1, 8).
4. **Incorporating traditional ways of knowing and healing into practice**: Sources consistently recommended that providers incorporate culturally meaningful activities into care plans and educate themselves on Indigenous peoples' cultural protocols and practices in their area (5, 12, 15). Providers need to recognize that not all Indigenous patients wish to share their spiritual beliefs (12). Instead, they should seek permission and follow the client's lead before exploring spirituality (12). Further, when possible, providers should use culturally grounded models of care rooted in the social determinants of health while also recognizing the diversity of Indigenous communities and rejecting pan-Indigenous approaches to care (13, 15).
5. **Recognizing racism and colonialism as Indigenous determinants of health**: Although intertwined with the theme of self-reflection, it is imperative that providers educate themselves on colonization and recognize present-day racism and colonialism as Indigenous determinants of health (8, 9, 12). This includes understanding the effects of intergenerational trauma, cultural genocide, oppression, and grief on ill health and how racism and colonialism manifest in everyday life to impact Indigenous health status, among other social, political, and economic factors (12).
6. **Culturally safe communication:** How providers communicate with patients is a key element of culturally safe care. This includes avoiding disempowering and humiliating language, avoiding medical jargon, ensuring respectful dialogue, using clear, relatable language and using cultural translators/interpreters when appropriate (1, 9, 15). Collaborative communication that involves patients can support power-sharing by encouraging feedback from patients and keeping them actively engaged in their care (5). Open, informative, and regular communication that includes informal conversations for relationship building can help reduce patient fears and anxieties while playing a critical role in encouraging patients to access healthcare (9, 10, 15). Providers should also be aware of the importance of using plain language in patient interactions without being patronizing (4).

Cultural safety practices: organizational-level

The sources that informed this evidence profile primarily discussed cultural safety practices at the organizational level, with sixteen out of the twenty highly relevant sources covering this domain of the organizing framework (2, 3, 5, 7-19).

These sources emphasize that strengths-based approaches should serve as the foundation for program design (8), ensuring that programs align with the cultural values and practices of the populations they serve. Approaches to cultural safety must avoid the notion that Indigenous people "need to be helped" while viewing non-Indigenous people as "change agents" (12). Program designers must recognize that a single initiative cannot be culturally safe for all Indigenous patients (8). Furthermore, engaging with Indigenous peoples is critical within health systems to effectively integrate cultural safety into their practice (14).

All remaining practices and approaches to delivering culturally safe care at the organizational level have been categorized into the following themes:

1. **Creating Culturally Safe Environments**: It is essential to establish supportive spaces free from racism where Indigenous people feel welcomed, respected, and heard (8). Promoting Indigenous cultural practices through dedicated spaces and organizational policies can enhance culturally safe environments (8, 9). This includes using meaningful colours, images, Indigenous artwork, landmarks, and culturally specific music when appropriate to counter cold and unwelcoming settings (8, 10, 15). Additional actions to consider include participating in events such as Indigenous Peoples' Day and incorporating culturally appropriate food into hospital menus (13). However, these actions should be combined with other elements of cultural safety to avoid tokenism (10).
2. **Recognizing the role of family and caregivers**: Support Indigenous patients in staying connected with their families throughout their healthcare journey and enable family participation in shared decision-making by providing large spaces to accommodate family involvement (10, 13). Programs and services should also recognize the role of family and caregivers as advocates and social-emotional support for patients (5, 7, 15). Additionally, caregivers should be provided support when possible (14).
3. **Honouring and embracing traditional healing approaches**: Programs should integrate Indigenous knowledge and traditional healing practices to balance biomedical approaches, going beyond mere acceptance of traditional medicine to recognize its intrinsic value in Indigenous care (5, 8, 9, 13). This can involve providing access to Elders and Traditional healers as paid care team members, creating spaces for traditional healing ceremonies and spiritual care, and respecting smudging as a spiritual practice (7, 12, 14, 15). Traditional approaches should be incorporated in collaboration with Indigenous communities, recognizing their unique values, traditions, and practices (8, 9).

4. **Training providers to deliver culturally safe care:** Three reviews specifically recommended that organizations should provide cultural safety training for staff as a strategy to overcome racism, disrespectful stereotypes, and poor communication practices across all healthcare settings (7, 10, 14). Additional features of cultural safety trainings highlighted in the sources are described below.
    a. The curriculum should include content about Indigenous culture and historical injustices, encourage learners to reflect on individual and systemic racism, and include cases related to Indigenous patients' healthcare journeys (8, 9, 13, 14).
    b. The training modalities varied across the sources, and there was no clear evidence on which were most effective or whether they should be mandatory (see Gaps in Research and Practice). Examples of modalities include offering training on a shorter, more regular basis during work hours through online, self-directed formats, in-person workshops, interactive group discussions, workshops, simulations, reflections, and podcasts with or without supportive materials (9, 16, 17).
    c. There was recognition of the need for Indigenous involvement in developing and facilitating course material, either in person or virtually (14). Innovative approaches include storytelling and talking circles with Elders, community-based placements, podcasts developed and voiced by Elders, simulation training facilitated by Indigenous community members, including case studies relating to patients' journeys, cultural mentorship, and education on traditional healing programs (3, 9, 14, 17). Additional Indigenous approaches include field visits and yarning circles[1] to challenge deficit-based discourses and legitimize Indigenous knowledge (3). Further, Indigenous people, specifically Elders, must be compensated for the time involved in training non-Indigenous health workers (14).
    d. One review emphasized applying purposeful and evidence-based pedagogical theory and practices to advance knowledge, self-awareness, and skills through cultural safety training. Highlighted frameworks include transformative learning theories, social-constructivist frameworks, diffusion of innovation theory, public health frameworks, the educating for equity framework, and participatory action or community-based approaches in development and delivery (17). The authors also emphasized that a pan-Indigenous approach is not appropriate, and that content should reflect the populations they serve (17).
5. **Growing an Indigenous Workforce**: Growing an Indigenous workforce is vital to ensure culturally safe care. This can include developing new roles like Indigenous health workers, cultural helpers, cultural navigators, or Indigenous liaison workers (1, 2, 7, 9, 14). These employee groups provide cultural and communication support, listening, reassurance, systems navigation, and communication assistance, while forming cultural bridges between

[1] A Yarning Circle is a process used by Aboriginal and Torres Strait Islander peoples to learn, share, build respectful and caring relationships, pass on cultural knowledge through storytelling, and come together as a community.

systems (1, 2, 7, 10, 15, 19). However, it is essential that these workers have the capacity and involvement in decision-making to use their roles effectively (14). Additionally, Indigenous representation across all health professions helps patients feel like their culture is reflected and positioned in their care, increasing trust and engagement with health services (2, 5, 7, 10, 13, 15, 19). One rapid review highlighted a study where Indigenous Elders were hired as part of the primary care team and participated in patient rounds, allowing for the integration of traditional medicine into care plans (19). See **Table 1** for more examples of Indigenous health workforce interventions.

6. **Fostering integrated care and envisioning new models of care**: Integrating services across community, health, and social sectors is essential for holistic and culturally safe care. This can be done through clear referral pathways, knowledge of referral and support options, use of multidisciplinary teams, and forming partnerships with Indigenous communities and organizations (7, 9, 11, 12). Examples include reduced caseloads allowing time for patient interactions, and case conferences to discuss culturally safe care and improve collaboration across sectors (15). Additionally, several sources emphasized that organizations should develop culturally responsive practice frameworks, adopt a post-colonial framework to care and use care models grounded in an understanding of Indigenous culture based on the social determinants of health (7, 12, 13, 15). For example delivering health information through alternative models like storytelling and bush trips (15).
7. **Language and communication**: Use translators, bilingual staff, or cultural interpreters when needed (9, 12-15). Other ways to reduce language barriers and improve communication include pictorial images, culturally informed consent, and oral consent when necessary (9, 13).

Table 1. Initiatives Aiming to Enhance Access to Culturally Safe Care for Indigenous Peoples

Review	Focus	Patient population	Initiative for improvement of cultural safety	Outcomes
Cultural Education Initiatives				
Tremblay et al. (18)	Increase self-efficacy and reduce intercultural anxiety of 3rd and 4th year nursing students	Indigenous patients with diabetes in Canada	Educational video and a handout informed by Social Cognitive Theory	Self-reported increased cultural self-efficacy and cultural sensitivity Did not measure patient outcomes
Tremblay et al. (18)	Modifying programs and clinical practices	Indigenous patients with diabetes in the United States	Three sequential interventions: (1) diabetic health education; (2) group medical care for diabetes with other Indigenous patients; and (3) shared collaborative care with medical, psychological and spiritual care simultaneously	Greatest improvement in diabetes management with shared collaborative care followed by group care, then regular care. Participants expressed satisfaction regarding the cultural component of intervention the shared collaborative care model.
Workforce Initiatives				
Tremblay et al. (18)	Community health worker upskilling and outreach	Indigenous patients with diabetes in Australia	Indigenous health workers were trained to support patients in self-management skills, medication advice, foot care, nutrition, smoking cessation, follow-up referrals for other health service providers, and scheduling tests.	Intervention group patients was more likely to have seen a dietitian and dentist, slightly more likely to have seen a diabetes educator, be taking insulin and to have received a flu vaccine. Decrease in glycated hemoglobin of 1% compared with the waitlist group's decrease of 0.2%.
Tremblay et al. (18)	Expand the role of community health workers	Indigenous patients with diabetes in Australia	Quality Assurance for Aboriginal and Torres Strait Islander Medical Services (QAAMS) program: Aboriginal health professionals provide culturally sensitive point-of-care testing (POCT) for diabetes management.	QAAMS relevant to raising diabetes awareness in communities, improving clinical outcomes, increasing motivation for change, and improving relationships between patients and point-of-care testers. Outcomes based on perceptions of the QAAMS Indigenous Leaders Team and POCT operators.
Tremblay et al. (18)	Expand access to Aboriginal health workers	Indigenous patients with diabetes in Australia	Increased employment of Aboriginal health workers for diabetes care in remote community health centers.	Progressive increase in diabetes care with an increased number of Aboriginal health workers per 1,000 residents.

				Patients in health centers with 10 Aboriginal health workers per 1,000 residents received more services than those in health centers with fewer than 5 Aboriginal health workers per 1,000.
Tremblay et al. (19)	Expand the role of Indigenous healthcare professionals	Indigenous patients accessing Aboriginal Community Controlled Health Services in Australia	Cultural telehealth consultation between patients and an Indigenous healthcare professional with the same culture and language. Drew attention to the social determinants of Indigenous health so that professionals involved in service delivery could better address them. Required human and financial resources, telehealth, and logistics.	Not specified
Tremblay et al. (18)	Expand the role of Indigenous healthcare professionals	Not specified	Incorporating Indigenous Liaison Officers in the multidisciplinary team. Strong executive leadership, a commitment to cultural safety, a proactive employment strategy, professional development opportunities, and a supportive work environment that respects Indigenous cultures were required.	Not specified
Mixed Initiatives				
Tremblay et al. (18)	Increase competency of rural registered nurses and expanded role of Aboriginal Health Workers	Indigenous patients with diabetes in Australia	Accredited diabetes course to expand the role of Aboriginal Health Workers and increase diabetes competencies of registered nurses.	Increased perceived empowerment of trainees; perceived empowerment of patients; improved health plan for patients. Results regarding patients are based on registered nurses' and Aboriginal health workers' perceptions and should be interpreted in this context.
Tremblay et al. (18)	Modifying clinical practices and integrating an Indigenous workforce	Indigenous patients with diabetic retinopathy in Canada	Hiring of nurses fluent in Cree; spiritual/cultural artifacts included in clinic screening protocols; nurses provided snacks, as traditional healers would; smudge ceremonies held with a spiritual leader from the community;	Increased appointment attendance from 25% to 85%; increased patient satisfaction, trust toward the healthcare team and improved communication among participants.

			traditional medicinal practices; open discussions; social gatherings and cultural activities in a teepee outside of the clinic.	
Maloney et al. (19)	Multicomponent quality improvement to improve emergency department experiences	Indigenous patients accessing emergency department care in Australia	Aboriginal Identification in Hospitals Quality Improvement Program (AIHQIP) which involved staff upskilling, education, site visits, and ongoing support. Goal to improve data on Indigenous peoples' emergency department experiences.	Did not impact the accuracy of recording Indigeneity in health system databases. Led to organizational changes, including improved waiting areas, visit management, and identification processes.
Tremblay et al. (19)	Promote cultural safety and improve communication between Aboriginal patients and non-Aboriginal staff	Not specified	Cultural mentorship from Aboriginal members to non-Aboriginal staff. Provided mentorship, cultural guidance, and cultural safety training to physicians with the goal of enhancing their understanding of local history, patient backgrounds, community resources, and networks.	Not specified
Tremblay et al. (19)	To enhance organizational capacity to provide equity-oriented healthcare and increase cultural competence of staff	Not specified	Employed education program coordinated by a practice consultant and delivered over 8-12 months. The consultant also supported staff and leaders in the development of an organizational integration and tailoring process.	Not specified
Tremblay et al. (19)	To build team capacity and increase access to care	Indigenous patients with respiratory disorders	Travelling multidisciplinary teams, including Indigenous project officers, provided respiratory outreach services. The officers sat in the street and connected with people walking past, performing clinical assessments and providing referrals. The intervention also combined two-way learning between Indigenous workers and multidisciplinary teams about community protocol and practices.	Not specified

Cultural safety practices: systems-level

Cultural safety practices at the systems level were identified in eight reviews (7-10, 12-14, 17) and were categorized into three themes: 1) Accountability and engaged leadership, 2) Governance and engagement, and 3) Policies and regulations:

1. **Accountability and engaged leadership**: To increase access to culturally safe care, self-reflection and accountability are required at the systems level (7, 9). Examples include embedding cultural responsiveness within health services and creating accountability for achieving culturally responsive goals (12). Institutional leadership should act as change agents and clinical champions to encourage participation in cultural safety training (17). They should also engage providers in their development journey by identifying provider knowledge gaps through tools like surveys and interviews (12).
2. **Governance and engagement**: Indigenous people need to be included in governance and decision-making structures to improve care for Indigenous peoples (13). This may consist of Indigenous input to improve healthcare services, partnerships with local organizations, and supporting community ownership which can increase engagement in health prevention activities (14). An example intervention identified in the literature is developing an Elders' Council to guide strategic processes and health planning (9). Additionally, initiatives must engage care recipients and their families in health planning to ensure services reflect their needs and values and support increased opportunities for engagement in health services planning (9).
3. **Policies and regulations**: Examples of policies and regulations identified to increase access to culturally safe care include:
    a. Creating physical spaces that accommodate families and groups (10).
    b. Mandating cultural safety training within organizations and health authorities and requiring evidence of cultural safety training as a requirement for accreditation and certification at organizational and provider levels (9, 17).
    c. Evaluating policies, procedures, and practices to achieve cultural safety (e.g., conducting cultural safety audits) (10, 14).
    d. Shifting existing power structures to distribute power and decision-making authorities to Indigenous peoples (8).
    e. Unpacking the Western foundations of healthcare by applying a human rights-based approach to change policies, work practices, systems and structures that cause harm and restrict the self-determination of Indigenous peoples (12).

Facilitators for implementing cultural safety practices

Given that the other categories of the organizing framework describe facilitators to increasing access to culturally safe care, this section only includes studies that identified process factors that facilitate the implementation of cultural safety practices. One of the two reviews identified both process facilitators as well as process barriers, which are highlighted in the proceeding section of this profile.

The first scoping review on cultural safety initiatives in Australian hospitals generally found that various staff were included in the initiatives, including nursing, medical, allied health, management, and clerical staff (16). One study included in the review reported implementation strategies that facilitated the uptake of the Aboriginal Identification in Hospitals Quality Improvement Program (AIHQIP) in Australian emergency departments. The program included tailored strategies at each site with the goal of Aboriginal patients self-identifying in the emergency department, improving the cultural competence of staff, improving collaborations between emergency departments and local Aboriginal community-controlled organizations, and reducing incomplete emergency department visits among Aboriginal patients. Implementation strategies included a 1.5-day workshop to design the implementation process with unspecified working group members, site visits from project officers, resource sharing, and communication across working group members, as well as having working groups oversee implementation with representation from Aboriginal Liaison Officers and local Aboriginal community-controlled organizations.

A second scoping review aimed to identify toolkits that guide the implementation of culturally responsive care, trauma-informed care, or continuity of care(r) in the perinatal period for Aboriginal and Torres Strait Islander people in Australia (11). The authors collated an extensive list of process facilitators across the project lifecycle, which are highlighted on pages 10 and 11 of the published manuscript and can be openly accessed through the link provided above.

Barriers to cultural safety

Barriers to cultural safety were grouped into two overarching themes: barriers to implementing cultural safety initiatives and barriers to accessing culturally safe care.

Two scoping reviews identified barriers to implementing cultural safety initiatives (16, 20). The first scoping review aimed to synthesize existing evidence for implementing cultural safety initiatives in Australian hospitals for Aboriginal and Torres Strait Islander peoples (16). Only one of the nine studies in the review identified barriers to implementing a cultural competency training program for emergency physicians. The authors cited varying levels of baseline knowledge, particularly with international physicians, and challenges scheduling training physicians as factors that got in the way of delivering the training.

The second scoping reviews specifically evaluated the implementation of audit tools for cultural safety and culturally responsive practices with Aboriginal and Torres Strait Islander Peoples (20). Barriers and facilitators to the implementation of audit tools were described for only one of the fifteen articles included, which covered twelve audit tools; this was the Koolin Balit Aboriginal Health Cultural Competence (KB-HCC) audit tool. Participants in the evaluation identified several barriers to implementing the KB-HCC audit tool. These barriers were related to the structure and comprehensiveness of the tool, as well as the perception that using it was too time-consuming and

inflexible. There was also confusion about the differences between the KB-HCC audit tool and other cultural competency tools or projects that had been utilized in the past. Additionally, participants noted the burden of time and responsibility associated with implementing the tool, a tendency for teams to deprioritize cultural competence in favour of other organizational responsibilities, and a lack of accountability for implementation since teams were not required to use the tool.

Three scoping reviews (1, 7, 15) and one systematic review (10) identified barriers Indigenous patients face in accessing culturally safe care at the patient, provider, organizational and systems levels:

- Patient-level barriers:
    - Unmet cultural and psychological needs (1)
    - Mistrust of the medical system and previous bad experiences (7, 15)
    - Differences in communication and language barriers (1, 15)
    - Alienation or feeling far from home (7)
    - Intergenerational trauma (1)
    - Financial constraints (7)
    - The perception that health professionals are not interested in Indigenous peoples' perspectives on health, illness, and treatment (10)
    - Experiences of perceived and actual racism (1, 7)
- Provider-level barriers:
    - Overuse of medical jargon, lack of communication and differences in communication (10)
    - Staff not being fully aware of the greater context of Indigenous peoples' lives (7, 15)
    - Racist and disparaging remarks, the perception that patients are stupid, careless, intoxicated (1, 10)
    - Excluding patients and families from care plans (7, 10)
    - Lack of time and capacity to provide culturally safe care including competing priorities (15)
    - Low patient engagement (15)
    - Low cultural awareness of healthcare providers (15)
- Organizational level barriers:
    - Lack of integrated social services (7)
    - Lack of alternative care options (7)
    - Concerns over organizational policies (e.g., prescription policies, policies on mental health and confinement) (7)
    - Lack of support and insufficient resources for providers and organizations to implement cultural safety and care for Indigenous patients (7)
    - Lack of professional interpreters (10)
    - Lack of respect for Indigenous beliefs, knowledge, and customs during care (10)
    - Conflicts between biomedical and holistic approaches (1, 10, 15)

- Systems level barriers:
    - Institutional policy constraints (7)
    - Lack of Indigenous staff workforce capacity (10)
    - Inequitable access to the social determinants of health (1)
    - Systemic racism (1, 15)
    - Poor care continuity (7, 15)
    - Hospital rooms are not designed to accommodate large families, an essential element of culturally safe care (1)
    - Insufficient resources (7)
    - Lack of support for culturally responsive practices (15)

All reviews included perspectives from Indigenous patients. The scoping review on Indigenous cultural competency in Canadian emergency departments (7) also included perspectives from patients, staff, Indigenous knowledge holders, and health organization representatives, which have been segmented in **Table 2**.

Table 2. Stakeholder perspectives on barriers to culturally safe care in Canadian emergency departments.

Patients	Staff	Knowledge Holders	Organizations
Concerns over stereotyping and discrimination Differences in communication styles or lack of adequate communication Lack of alternative care options Alienation or feeling far from home Lack of integrated social services Financial constraints Mistrust of the medical system Not being involved in care plans Concern over institutional policies	Ongoing discrimination and trauma experienced by patients Insufficient resources Policy constraints Poor care continuity	Staff not being fully aware of the greater context of Indigenous peoples' lives Historical distrust between Indigenous communities and the health care system Tacit and overt discrimination	Racism and stereotyping experienced by Indigenous patients seeking care Lack of access to primary care Presence of health disparities

Audit tools and evaluations

Only two (16, 20) of the twenty highly relevant sources included specific details related to evaluations of the implementation of cultural safety initiatives or audit tools for assessing cultural safety practices in healthcare settings.

Of the nine studies included in one scoping review on implementing and evaluating cultural safety initiatives in Australian hospitals (16), only two used a validated tool, a questionnaire developed by Mooney et al. (2005). The other included studies conducted evaluations using self-developed evaluation tools tailored to specific initiatives consisting of qualitative and quantitative methods. Evaluations primarily measured self-reported changes in provider perceptions, attitudes, and behaviours toward First Nations people. See Gaps in research and practice for recommendations specific to evaluation.

Another scoping review examined cultural safety audit tools aimed at providing culturally safe and responsive healthcare services to Aboriginal and Torres Strait Islander people (20). The authors identified twelve distinct tools, which are listed in the open-access paper. They found that the audit tools differed in length, terminology, assessed domains, and validation status. The tools included between 4 cultural responsiveness indicators and 36 self-rating cultural capability questions. Six of the fourteen included articles concerning the 12 tools assessed tool reliability and validity, with all tested tools demonstrating strong reliability and validity. Only one study qualitatively evaluated the implementation of an audit tool, specifically the Koolin Balit Aboriginal Health Cultural Competence (KB-AHCC) Audit Tool. These findings are reported in the facilitators and barriers sections of this profile.

Gaps in research and practice

Three reviews (6, 8, 9) referenced the lack of consistent evidence on the content of cultural training programs, how they should be delivered and evaluated, and their overall effectiveness in improving practice or patient experiences.

A different set of three reviews (5, 17, 18) described a significant limitation of evaluations on existing cultural safety initiatives: they do not measure patients' outcomes or perspectives on changes in the perceived cultural safety of their interactions with providers. For example, in a systematic review of Indigenous cultural safety training interventions for healthcare providers in Australia, Canada, New Zealand, and the United States , the authors found that only 3 out of 13 studies evaluated patient experience. Those that did were unable to establish an observable change in culturally safe care or clinical guideline adherence for Indigenous patients. Further, the authors found that although Indigenous people and communities were involved in developing and delivering cultural safety training, few were involved in the evaluations.

Transferability Considerations

Transferability is an important stage in determining whether a policy or program will be relevant and successful in the local context for which it is designed (21). The findings in this evidence profile should be interpreted with this in mind. The highly relevant findings in this review were implemented in countries such as Australia, Canada, the United States, and New Zealand, all of which have Indigenous populations with similarities and face significant health inequities compared to the general population (22). It is essential to recognize the diversity of Indigenous communities and reject a pan-Indigenous approach when designing health systems interventions.

Moreover, the reviews exhibited considerable variation in patient populations, spanning from the general population to those with diabetes, perinatal needs, and kidney care, suggesting that experiences may not be universally applicable. Nevertheless, the findings can still inform initiatives designed to enhance access to culturally safe care for Indigenous peoples, emphasizing the importance of extensive local engagement and the unique context of the Canadian Armed Forces Military Health System.

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Appendix A: Methodological Details

We applied a modified rapid review methodology outlined by the National Collaborating Centre for Methods and Tools(21) to prepare this evidence profile. The steps are to 1) Define the review questions, 2) Search for research evidence, 3) Critically appraise the information sources, 4) Synthesize the evidence, and 5) Identify applicability and transferability issues for further consideration.

1. Defining the Review Questions

We initially met with the requestors during a scoping meeting to discuss their expectations for the review and what they hoped to achieve. This meeting assisted us in drafting the proposed review questions. The primary goal of the review was to identify programs or case examples of initiatives aimed at enhancing the cultural safety of military health services for Indigenous service members.

After the initial literature search, we retrieved zero studies relevant to the review question on the military health systems. Because of this, we met with the requestor, who agreed to revise the review questions to include evidence synthesis on culturally safe healthcare for Indigenous peoples. See **Table 1** for the first and second drafts of the review questions.

Table 1. Review Questions

Proposed Review Questions	Revised Review Questions
What practices within the military health systems of Five Country Ministerial nations (Australia, Canada, New Zealand, the United Kingdom, and the United States) enhance cultural safety for Indigenous members?	**[Updated]:** What practices within civilian health systems of Five Country Ministerial nations (Australia, Canada, New Zealand, the United Kingdom, and the United States) enhance cultural safety for Indigenous patients?
What are the key barriers and facilitators to implementing cultural safety strategies in civilian health systems, and how can these insights be adapted to enhance cultural safety within military health systems?	**[No Change]:** What are the key barriers and facilitators to implementing cultural safety strategies in civilian health systems, and how can these insights be adapted to enhance cultural safety within military health systems?
What are the barriers Indigenous Canadian Armed Forces members face in accessing culturally safe care within the Canadian Forces Health Services Group?	**[Removed]**

2. Searching for Research Evidence

We worked with a Health Sciences Research Librarian at the University of Alberta to draft and refine the search terms and conduct the searches. We searched Medline and Scopus using two search strings (See Appendix B). The first search was for primary studies on military health systems and cultural safety. The second search was for scoping, systematic, rapid, and literature reviews on civilian health systems and cultural safety, which captured more relevant results.

We uploaded all search results to Covidence[1] for abstract and full-text screening. One reviewer completed the screening for all retrieved studies. We reviewed the articles at the second scoping call with the requestor to confirm the relevance of the reviews.

We included sources if they were in English, targeted at least one of the five countries in the review questions, specific to Indigenous populations (Aboriginal and Torres Strait Islanders for Australia, Māori for New Zealand, American Indian or Alaskan Native for the United States, and First Nations, Metis, and Inuit for Canada), and relevant to the organizing framework. We considered reviews that included studies on non-Indigenous populations or countries other than those specified if we could easily separate country or population-specific data during data extraction.

We excluded sources if they applied no transparent methodological approach to searching and screening the literature, if it was impossible to extract country or population-specific data from the results for those that included countries and populations not of interest, if they targeted children and youth, and were not relevant to the organizing framework.

3. Critically Appraising the Information Sources

The purpose of the review was not to inform direct program decisions but to review the literature on cultural safety and military health systems to inform future engagements on the topic. Because of this, we did not use a critical appraisal tool to assess the quality of the retrieved sources. Instead, two reviewers worked collaboratively to rate each source as having high, medium, or low relevance to the review questions using the organizing framework as a guide.

Sources were rated as "high" if they provided sufficient information in their results in response to one or more areas of the organizing framework. Sources were rated as "medium" if they offered moderate detail or if the results and discussion were so specific to a condition or setting that they could not be generalized to other conditions or settings within the health system (e.g., end of life care). Sources were rated as "low" if they were highly specific to cultural safety interventions in

[1] Covidence systematic review software, Veritas Health Innovation, Melbourne, Australia. Available at www.covidence.org.

educational settings (e.g., course curriculum) or the results were highly conceptual and did not provide enough specificity to answer the review questions. Rating the relevance of the articles was done collaboratively and iteratively. Information extracted from all sources is included in Appendices C-E. However, we only used results from highly relevant sources to synthesize the main findings in preparing this evidence profile.

4. Synthesizing the Evidence

We developed a data extraction tool using Google Sheets to chart the characteristics of each included source. Columns in the data extraction sheets included Authors, Titles, Years, Aims/Objectives, Population, Study Design/ Methods, Years of Publication, Results, Conclusions, Relevance Rating, and a column for reviewer notes and comments. Two reviewers extracted the data, with one reviewer assigned to each source. Reviewers interacted through an online messaging system to discuss any questions or reflections related to the process.

We condensed the data extraction tables into the following categories: relevance to the question by domains of the organizing framework, key findings, and recency. We then took the highly relevant sources and synthesized them by each domain of the organizing framework.

5. Identifying Applicability and Transferability Issues

Analyzing the applicability and transferability of the findings was out of the scope of this rapid review as this stage requires systematically engaging with knowledge users through a collaborative process. However, we did include transferability considerations and an overview of key gaps and challenges identified during collecting and synthesizing the evidence.

Preparing the Profile

We included a hyperlink to each source and a summary of the main findings for all included sources in Appendices C-E organized by relevance to the review questions, organizing framework and the source's recency. We only used highly relevant sources to write the main findings and key messages. Finally, we drafted a table summarizing the sources by each domain of the organizing framework.

Appendix B: Search Details

Search: Cultural Safety and Military Health Systems
Date: January 15, 2025
Databases: Medline and SCOPUS

Ovid MEDLINE(R) ALL <1946 to January 14, 2025>
Date searched: Jan 15, 2025
Results search #1- Primary studies on Military Health Systems and Cultural Safety (line 18) = 19
Results search #2- Reviews on Civilian Health Systems and Cultural Safety (line 24) = 251

1 indigenous peoples/ or "american indian or alaska native"/ or exp indians, north american/ or "australian aboriginal and torres strait islander peoples"/ or maori people/ or "native hawaiian or other pacific islander"/27234
2 exp Oceanians/ 6220
3 ((Native* adj1 (American* or Canadian* or Alaska* or Indian*)) or (Natives not "digital natives") or Tribes or Indigenous or Aborigin* or Inuit* or Inuk or Inupiat* or "First Australian" or "First Nation" or "First Nations" or Metis or Eskimo* or Aleut* or Amerindian* or (Indian* adj3 America*) or "American Samoan*" or "Canadian Indian*" or "first people*" or "autochthonous people*" or "Torres strait" or Maori* or oceanian*).mp. 103743
4 1 or 2 or 3 105618
5 Culturally Competent Care/ 2406
6 cultural characteristics/ or cultural competency/ or cultural diversity/35969
7 ((cultur* or transcultural or multicultural or cross-cultur) adj6 (safe* or competen* or aware* or sensitiv* or understanding or diversity or needs or knowledge or expertise or skill* or responsiveness or respect)).mp. 83261
8 6 or 7 97791
9 exp health facilities/ or exp health workforce/ or exp health personnel/ or exp health services/ or exp "delivery of health care"/ or exp patient care team/ or exp point-of-care systems/ or "quality of health care"/ 4154201
10 (care or healthcare or "health services" or "health* resources" or "care resources" or "medical resources" or "medical services" or specialist* or "specialty care" or "physician* or doctor*" or "primary care" or "general practitioner*" or "home care" or telecare or telehealth or telemedicine or telerehab* or hospital or hospitals or clinician* or health personnel* or health professional* or health provider* or health practitioner* or doctor* or nurse*).mp. 5024428
11 9 or 10 6415808
12 8 and 11 53944
13 5 or 12 53944
14 4 and 13 4714
15 Military Personnel/ 46722

16 (Military or paramilitary or armed-force* or armed-service* or servicewomen or servicemen or service member* or air-personnel or defense-force* or defence-force* or service-personnel or army or navy or air-force or marine* or sailor* or soldier* or infantryman or Civil-defense or Troops or ranger* or "medic" or "coast guard" or submariner* or active duty or enlisted personnel or reserve personnel or reservist* or uniformed personnel).mp. 270967
17 15 or 16 270967
18 14 and 17 19
19 (review* or "systematic review" or "scoping review" or "rapid review" or evidence synthes* or overview or meta-anal* or metaanal*).pt,ti. 3908195
20 14 and 19 742
21 ((cultur* or transcultural or multicultural or cross-cultur) adj6 (safe* or competen* or aware* or sensitiv* or understanding or diversity or needs or knowledge or expertise or skill* or responsiveness or respect)).ti,kf. 13732
22 *Culturally Competent Care/ or *cultural characteristics/ or *cultural competency/ or *cultural diversity/ 18241
23 21 or 22 28455
24 20 and 23 251

Scopus (advanced search)
Date searched: Jan 15, 2025
Results Search #1 (48 studies)
Results Search #2 (99 studies)

Search #1 for Primary studies on Military Health Systems and Cultural Safety
TITLE-ABS-KEY((Native* W/1 (American* or Canadian* or Alaska* or Indian* or Hawaiian)) or (Natives AND NOT "digital natives") or Tribes or Indigenous or Aborigin* or Inuit* or Inuk or Inupiat* or "First Australian" or "First Nation" or "First Nations" or Metis or Eskimo* or Aleut* or Amerindian* or (Indian* W/3 America*) or "American Samoan*" or "Canadian Indian*" or "first people*" or "autochthonous people*" or "Torres strait" or Maori* or oceanian*) AND TITLE-ABS-KEY((cultur* or transcultural or multicultural or cross-cultur) W/6 (safe* or competen* or aware* or sensitiv* or understanding or diversity or needs or knowledge or expertise or skill* or responsiveness or respect)) AND TITLE-ABS-KEY(care or healthcare or "health services" or "health* resources" or "care resources" or "medical resources" or "medical services" or specialist* or "specialty care" or "physician* or doctor*" or "primary care" or "general practitioner*" or "home care" or telecare or telehealth or telemedicine or telerehab* or hospital or hospitals or clinician* or "health personnel*" or "health professional*" or "health provider*" or "health practitioner*" or doctor* or nurse*) AND TITLE-ABS-KEY(Military or paramilitary or armed-force* or armed-service* or servicewomen or servicemen or "service member*" or servicemember* or air-personnel or defense-force* or defence-force* or service-personnel or army or navy or air-force or marine* or sailor* or soldier* or infantryman or Civil-defense or Troops or ranger* or "medic" or "coast guard"

or submariner* or "active duty" or "enlisted personnel" or "reserve personnel" or reservist* or "uniformed personnel")

Search #2 for Reviews on Civilian Health Systems and Cultural Safety

TITLE-ABS-KEY((Native* W/1 (American* or Canadian* or Alaska* or Indian* or Hawaiian)) or (Natives AND NOT "digital natives") or Tribes or Indigenous or Aborigin* or Inuit* or Inuk or Inupiat* or "First Australian" or "First Nation" or "First Nations" or Metis or Eskimo* or Aleut* or Amerindian* or (Indian* W/3 America*) or "American Samoan*" or "Canadian Indian*" or "first people*" or "autochthonous people*" or "Torres strait" or Maori* or oceanian*) AND TITLE((cultur* or transcultural or multicultural or cross-cultur) W/6 (safe* or competen* or aware* or sensitiv* or understanding or diversity or needs or knowledge or expertise or skill* or responsiveness or respect)) AND TITLE-ABS-KEY(care or healthcare or "health services" or "health* resources" or "care resources" or "medical resources" or "medical services" or specialist* or "specialty care" or "physician* or doctor*" or "primary care" or "general practitioner*" or "home care" or telecare or telehealth or telemedicine or telerehab* or hospital or hospitals or clinician* or "health personnel*" or "health professional*" or "health provider*" or "health practitioner*" or doctor* or nurse*) AND (KEY(review* or "systematic review" or "scoping review" or "rapid review" or "evidence synthes*" or overview or meta-anal* or metaanal*) OR TITLE(review* or "systematic review" or "scoping review" or "rapid review" or "evidence synthes*" or overview or meta-anal* or metaanal*

Appendix C: Key findings from source documents with high relevance to the review questions

Relevance to Question	Key Findings	Recency
Literature reviews (n= 1)		
• Concepts of cultural safety and patient experiences	**Indigenous cultural training for health workers in Australia (6)** This literature review did not provide details on the number of documents retrieved or when they were published. The aim of the review was to identify Indigenous cultural training for health workers and assess how effectively they have been translated into training programs within Australia. The review identified six major models for conceptualizing cultural training, placed along the axes of 'knowledge' to 'process' and 'individual health worker; to 'health system.' **1. Cultural Awareness** - Increase participants' awareness of the cultural, social, and historical factors affecting Indigenous people and communities and promote self-reflection on one's own culture and tendencies to stereotype. - This training assumes that increasing cultural knowledge will help health workers become more 'tolerant' and adjust their practices accordingly. - The literature suggests that cultural awareness training often overlooks the broader health service or system, focusing more on the development of cultural knowledge than on practicing cultural safety. - In Australia, most Indigenous cultural training for health workers focuses on developing cultural awareness. **2. Cultural Competence** - A 'set of congruent behaviours, attitudes, and policies' designed to prevent negative effects from disregarding culture in healthcare services. - Aim to improve health workers' awareness, knowledge, and skills so they can effectively manage cultural factors in health service interventions. - Growing emphasis on stimulating self-reflection and addressing 'organizational values, training, and communication. - Commonly used in the US.	2011

	3. Transcultural Care - A formal field of study and practice focused on providing culture-specific or culture-universal care, emphasizing power relations, racism (both institutional and interpersonal), and the conceptualization of identities. - Focuses on self-awareness and the acceptance of cultural differences rather than simply developing practice based on a 'catalogue of [cultural] knowledge.' **4. Cultural Safety** - Aim to address the effects of colonialism within the dominant health system by focusing on the cultural safety felt by individuals seeking healthcare. - The health service is responsible for recognizing and protecting individuals' cultural identities. - Developed in New Zealand's Indigenous healthcare context to address the impacts of colonial processes on Māori health. - Encourages health workers to become more aware of the social, political, and historical processes that shape health practice and to self-reflect on their identity and its impact on care. - Gaining recognition in Canada and Australia. **5. Cultural Security** - Acknowledges the effect of culture on access to health services and aims to incorporate cultural considerations in service delivery. - The responsibility for providing culturally secure health services lies with the health system as a whole, not individual workers. - Advocates for Indigenous cultural training to develop health workers' knowledge. - Currently, there is a lack of clear guidance on achieving cultural security in practice. **6. Cultural Respect** - Upholds the rights of Indigenous peoples to maintain, protect, and develop their culture, aiming for equitable health outcomes. - Focuses on system-wide change. - Advocates for Indigenous cultural training to develop health workers' knowledge. **GAP:** The evidence for the effectiveness of Indigenous cultural training programs in Australia is poor, and it is not yet clear to what extent Indigenous cultural training for health professionals improves practice or which factors (in terms of content, setting, or duration) make for effective training.	

	SOURCE	
Narrative reviews (n=1)		
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Cultural safety practices: systems-level	**Furthering Cultural Safety in Kidney Care Within Indigenous Communities: A Systematic and Narrative Review (14)** This narrative review included 15 studies published between 2011 and 2020 that explore cultural safety within care for Indigenous people with kidney disease in Australia, Canada, and New Zealand. The authors assembled their findings into three broad clusters, which are summarized below. **Addressing legacies of colonialism for health care providers:** - Self-reflective journey through journaling as a way to address harmful assumptions and stereotyping - Intensive listening conveys respect for both cultural and traditional worldviews - Having Indigenous health workers within dialysis units - Paid Elders, inclusive of family/community, cultural training of non-Indigenous health workers - Include case studies relating to patient journeys in healthcare education - Need for ongoing Indigenous involvement in reviewing the overall course and framework - Respect for smudging supporting the use of meaningful symbols in prayer in dialysis care - Approaching with an open mind; establishing trust and a sacred space; assessing belief systems; ongoing education for the provider **Solutions for relationality, engagement and health care self-determination:** - Incorporating translators, traditional approaches, Elders, peer support, attention to funding and advocacy - Individualized education - Support for caregivers - Learning from and listening to Elders - Sharing stories that voice ways of knowing and being inclusive of Indigenous art - Cultural Safety audits and continuity of service - Culturally appropriate social workers and cultural support personnel - Indigenous engagement within health care education and administrative and organizational systems sectors	2021

	Solutions for systemic issues, barriers, and access: - Recognition of the significance of land and cultural attachments to the place of origin - Increase Indigenous health workers capacity and involvement in decision-making - Supporting community ownership furthers engagement in health prevention SOURCE	
Rapid reviews (n=2)		
• Cultural safety practices: organizational-level • Gaps in research and practice	**Improving Cultural Safety of Diabetes Care in Indigenous Populations of Canada, Australia, New Zealand and the United States: A Systematic Rapid Review (18)** This rapid review included seven studies published between 2006 and 2016 to identify interventions that improve cultural safety for Indigenous people living with diabetes in healthcare settings and their potential impact on patients and healthcare professionals. Studies included in the review were published in Australia, Canada, and New Zealand. The results are broken down by intervention type. **Cultural Education (n=1):** - Nurses who received a video and handout to decrease intercultural anxiety and increase cultural self-efficacy self-reported higher cultural self-efficacy and sensitivity. - Limitations: No measurement of patient outcomes; Lack of blinding and limited sampling. **Culturally Safe Practice (n=1):** - Sequential interventions: (1) diabetic health education; (2) group medical care for diabetes; and (3) shared collaborative care with medical, psychological and spiritual care simultaneously. - Glucose control best with shared collaborative care, followed by group care and then conventional education. - Lack of control group and did not account for confounders. **Indigenous Workforce (n=3):** 1: Indigenous health workers trained to support patients in self-management skills, medication advice, foot care, nutrition, smoking cessation, follow-up referrals for other health service providers, and scheduling tests. - Intervention group patients were significantly more likely to have seen a dietitian and dentist, slightly more likely to have seen a diabetes educator, be taking insulin and to have received a flu vaccine.	2020

	- Decrease in glycated hemoglobin of 1% compared with the waitlist group's decrease of 0.2%. 2: Quality Assurance for Aboriginal and Torres Strait Islander Medical Services (QAAMS) program: Aboriginal health professionals provide culturally sensitive point-of-care testing for diabetes management. - Found QAAMS relevant to raising diabetes awareness in communities, improving clinical outcomes, increasing motivation for change, and improving relationships between patients and point-of-care testers. - However, the survey results are based on perceptions of the QAAMS Indigenous Leaders Team. 3: Increased employment of Aboriginal health workers for diabetes care in remote community health centres - Found progressive increase in diabetes care with an increased number of Aboriginal health workers per 1,000 residents. - Patients in health centres with 10 Aboriginal health workers per 1,000 residents received more services than those in health centres with fewer than 5 Aboriginal health workers per 1,000. **Mixed Interventions (n=2):** 1: Accredited diabetes course delivered to registered nurses and Aboriginal health workers working with Indigenous clients - Resulted in perceived empowerment of those who received training; perceived empowerment of patients; health organizations can capitalize on the expertise of their employees instead of relying on outside educators; improved health plan for patients - Results regarding patients are based on registered nurses' and Aboriginal health workers' perceptions and should be interpreted in this context 2: A Culturally sensitive model of health care, including: - Hiring of nurses fluent in Indigenous languages; spiritual/cultural artifacts included in clinic screening protocols; nurses provided snacks, as traditional healers would; smudge ceremonies held with a spiritual leader from the community; traditional medicinal practices; open discussions; social gatherings and cultural activities in a teepee outside of the clinic - Resulted in increased appointment attendance from 25% to 85%; increased patient satisfaction, trust toward the healthcare team and improved communication among participants SOURCE	

• Cultural safety practices: organizational-level • Cultural safety practices: systems-level	**Cultural safety involves new professional roles: a rapid review of interventions in Australia, the United States, Canada and New Zealand (19)** This rapid review included 23 studies published between 2010-2020 to explore fundamental characteristics of cultural safety interventions that involved the creation or transformation of professional roles. Interventions took place in Australia, Canada, New Zealand, and the United States. The included studies are synthesized into three main categories of professional roles: supporting health care system navigation, providing a new or improved service offering, and building organizational capacity to provide culturally safe health care. **Providing a new or improved service offering:** Partnerships between a mainstream health organization and an Indigenous health organization. 1. An Indigenous health professional with an expanded role - Consultation with Indigenous HCP with the same culture and language as the patient via telehealth - Indigenous HCPs drew attention to the social determinants of Indigenous health so that other health professionals could better address them. 2. An Indigenous Elder who offered spiritual guidance and enabled traditional health practices in a clinical setting. - Holistic health care in combination with Western medicine. • Elder offered traditional health practices, including spiritual rituals. • Specific resources for spiritual rituals, such as a ceremonial room or sacred space. • Cultural competency training for the staff. • Mobilization of Elders and development of meaningful partnerships between Indigenous community leaders and institutional stakeholders. **Building the capacity to provide culturally safe health care: Training, orientation and continuing education for non-Indigenous HCPs, as well as recruiting, supporting and retaining more Indigenous HCPs.** - Based on social justice and collaborative governance. 1. Cultural mentor - mentorship and cultural safety education/training for GPs and registrars. - Aim to increase awareness of local history, patient backgrounds, community resources, and networks to promote cultural safety and improve communication between Aboriginal and non-Aboriginal staff.	2023

	2. Integration of Indigenous Elders as part of the health care team. - educating HCPs about the pre-colonial and colonial background of the communities served. - fostering adaptation of community-centred health care. - encourage inclusion of Indigenous knowledge and language in health care. 3. Practice consultant coordinating employee education program (8–12 months). - Aim to enhance organizational capacity to provide equity-oriented health care by reducing the effects of structural inequities, the impact of discrimination in services, and mismatches between the dominant ways of providing services and the needs/realities of people affected by health/social inequities. **Supporting Indigenous people's access to and navigation of the healthcare system:** 1. Peer facilitators who support Indigenous individuals/families in overcoming multiple systemic/organizational barriers to health services access. - Usually involve one or more Indigenous people from local or urban communities who speak the local language and have a good knowledge of socio-economical contexts and cultural codes. - Roles include connecting patients with health/social services, coordinating appointments, facilitating communication with HCPs, patient follow-up, culturally safe outreach via home visits, insurance support, transportation, health education and prevention activities, and referrals. **Mixed Interventions: Combined service-centred roles, capacity building and navigation roles; In addition to patient navigation, Indigenous staff provided new services and were fully integrated into the health services and health care teams where they were deployed.** 1. Elders worked in direct partnership with the primary care team, participated in clinical rounds and shared access to the patient's digital medical records at the clinic. Allowed addition of traditional medicine to services. 2. Indigenous project officer sitting in the street in the community and yarning* with people walking past, performing clinical assessment with portable diagnostic tools, and providing referrals—two-way learning between Indigenous project staff and multidisciplinary health team staff. 3. Indigenous Liaison Officer care coordinators are integral to the multidisciplinary care team. - Supported at the organizational level by strong executive leadership and commitment to cultural safety, proactive employment and recruitment strategy, professional development, and supportive work environment with respect for Indigenous cultures. *Yarning is a way of connecting and purposefully sharing knowledge through narrative. It can include anecdotes, stories and experiences, and humor.	

	SOURCE	
Scoping reviews (n= 11)		
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Cultural safety practices: systems-level • Gaps in research and practice	**Culturally Safe Health Initiatives for Indigenous Peoples in Canada: A Scoping Review (8)** This scoping review included 30 studies published between 2007 and 2017 on culturally safe health initiatives for Indigenous Canadians, which include medical care, health promotion programs, or health interventions. The review identified six core themes as elements of culturally safe health initiatives: collaboration/partnerships, power sharing, addressing the broader context of the patient's life, safe environment, organizational and individual-level self-reflection, and training for healthcare providers. **Collaboration/partnerships:** - Collaboration with Indigenous communities should inform health program design. - Mutual trust and respect are essential in relationships between providers and patients, and they should be developed over time. - Programs should incorporate Indigenous knowledge, guided by community members, to balance Indigenous and biomedical approaches. **Power sharing:** - Acknowledge power dynamics and shift power to patients by allowing them to share in decision-making, viewing their strengths as resources, and allowing clients to define whether an interaction is culturally safe. - Providers must acknowledge their power and privilege and how they are embedded and inherent within post-colonial structures. - Strengths-based approaches should be the foundation of program design. **Address the broader context of the patient's life:** - Recognize that a single intervention will not be culturally safe for all Indigenous peoples. - Recognize colonialism as a key determinant of Indigenous health, among other social, political, and economic factors that impact care. - Providers should explore the patient's interest in including family or community members in their care. - Health initiatives should align with or incorporate the cultural values and practices of the target population.	2018

	Safe environments: - Healthcare providers should be non-judgmental and use culturally relevant resources. - Create supportive spaces free from racism and stereotyping, where Indigenous identities are respected and voices are heard. - Culturally safe physical and emotional environments make participants feel welcome and discourage behaviours that cause rejection or harm (e.g., Support Indigenous cultural practices through dedicated spaces and organizational policies; Use culturally meaningful colours, images, symbols, and themes while adapting resources to the diversity of Indigenous populations) **Organizational and individual level self-reflection:** - Individual self-reflection to recognize personal and systemic biases toward Indigenous peoples and challenge personal biases, including those within healthcare institutions and systems. - Organizations must evaluate policies, procedures, and practices to achieve cultural safety, including shifting existing power structures. - To provide equitable care, healthcare standards must be altered to support Indigenous cultural values and norms. **Training for healthcare providers:** - Training in cultural competency or cultural safety is crucial for non-Indigenous healthcare providers. - Training should include learning about Indigenous culture and self-reflection. - **Challenge:** Few details are provided on the specific content of training programs in the literature reviewed. SOURCE	
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Cultural safety practices: systems-level • Gaps in research and practice	**Indigenous-specific cultural safety within health and dementia care: A scoping review of reviews (9)** This scoping review included 17 studies published between 2011 and 2020 to identify key elements, conceptualizations, and interventions of cultural safety to improve health services and dementia care for Indigenous People. The included studies were published in Australia, Canada, and New Zealand. The review identified themes at three levels: person-centred/individual level, health practitioner/student level, and healthcare organizational level.	2022

	Person/Patient Level *Empowerment and redistribution of power:* - Need for equality in relationships between healthcare providers (HCPs) and patients. - Providers should advocate for empowering Indigenous patients to influence care and improve outcomes. - Empowerment example: Patient feedback (e.g., evaluation forms) to confirm the cultural safety of an interaction *Culturally appropriate and respectful communication:* - Reduce language barriers by using translators, bilingual staff, pictorial images, patient navigators, and certified medical interpreters and avoid medical jargon. - Providers should avoid disempowering or humiliating language and ensure respectful dialogue. - Disrespectful communication plays a critical role in reducing accessibility to healthcare for Indigenous Peoples • Address this through avoiding discrimination, person-centred care, and recognizing colonialism as an Indigenous determinant of health. *Culturally responsive/appropriate/tailored resources:* - Healthcare resources must reflect the unique values, traditions, and practices of First Nations, Inuit, and Métis communities. - Programs should include Indigenous ways of knowing and traditional healing practices. - Examples: Creation of an Elders council to develop a traditional medicine program for culturally safe care, patient support provided by elders, family-based decision making in addition to individualized care, spiritual care, cultural helpers, space for traditional ceremonies, creating safe care environments **Provider level** *Training and education:* - Cultural safety education should include understanding historical injustice and partnerships with Indigenous communities. - Training should extend beyond the classroom and involve self-introspection to understand biases better. - Examples: educational pamphlets, cross-cultural awareness programs, cultural mentorship, education on traditional healing programs, and Indigenous health curriculum for medical students.	

	Critical self-reflection, awareness, and reflexivity: - Reflexivity is essential for providers to examine personal biases, attitudes, and assumptions about Indigenous peoples. - Requires time to reflect on assumptions and judgments within the profession and community. - Self-reflection and accountability for delivering culturally safe care are necessary at both provider and organizational levels, as defined by the individuals receiving the care and their communities and as measured by outcomes in health equity. **Organizational level** *Indigenous leadership, decision-making, and governance:* - Indigenous leadership is essential for addressing systemic racism in healthcare and developing culturally safe policies and practices. - Current power structures must shift to embrace Indigenous cultural values and eliminate inequities. - Indigenous Peoples must have decision-making power to improve care quality and health outcomes. - Support local capacity-building and community ownership to meet the healthcare needs of Indigenous Peoples, especially in rural areas. *Collaboration and partnership with Indigenous communities:* - Partnerships with Indigenous Peoples are essential for developing cultural safety initiatives in healthcare. - Initiatives must actively engage care recipients and their families in health planning to meet local needs. - This may include Indigenous input to improve healthcare services, partnerships with local organizations, and supporting Indigenous engagement in decision-making. - Example intervention: Elders' Council guiding strategic processes and health planning, incorporating tribal and community values. *Organizational mandates, monitoring, and evaluation:* - Cultural safety training and education should be mandated within all healthcare organizations, health authorities, and across government levels. - Evidence of cultural safety should be a requirement for accreditation and certification at both organizational and practitioner levels. - Healthcare systems must evaluate cultural safety through systematic monitoring of health inequities.	

	- Challenge: There is limited knowledge on how to assess, operationalize, and evaluate cultural safety initiatives; more focus is needed on improving evidence to guide future health policy. SOURCE	
• Cultural safety practices: organizational-level • Barriers to cultural safety • Audit tools and evaluation	**Implementation and Evaluation of Cultural Safety Initiatives in Australian Hospital Settings: A Scoping Review (16)** This scoping review included nine studies published between 2005 and 2022 to identify existing evidence for implementing and evaluating Cultural Safety initiatives in Australian hospitals for Aboriginal and Torres Strait Islander peoples. The review identified five themes: the process of implementation, the process of evaluation, change in health professional behaviour, change in patient experiences, and future recommendations. **Process of implementation:** - Involve a variety of staff (nursing, medical, allied health, clerical, management) in the implementation. - Most trainings were in-person workshops facilitated by Aboriginal and Torres Strait Islander facilitators. Other modes of delivery include independent e-learning modules and podcasts. Only some trainings included supportive materials. - Implementation protocols (strategies) included a 1.5-day workshop to design the process with working group members, site visits, resource sharing, and communication across working group members; having working groups oversee implementation with representation from Aboriginal and Torres Strait Islander staff/interest holders. - Only one study included in the review used a theoretical framework to guide implementations - Barriers to implementation include challenges in scheduling training and varying levels of baseline knowledge among physicians. **Process of evaluation:** - Evaluation primarily conducted among health professionals, focusing on self-reported changes in perceptions, attitudes, and behaviours toward First Nations patients. - Only two studies used an evaluation framework	2024

	- Evaluations included qualitative (written reflections and free-text comments) and quantitative methods to measure perceptions and attitudes - Two studies used a questionnaire by Mooney et al. (2005) to measure perceptions and attitudes and compare pre- and post-training results. - Other studies used self-developed survey tools tailored to specific initiatives. - No validated evaluation tools were used beyond Mooney et al.'s questionnaire. - **Challenge**: Only one study evaluated patient experience, focusing on the identification of Aboriginal and Torres Strait Islander patients and incomplete ED visits. However, the indicators used were considered not sensitive enough to measure cultural safety accurately. **Change in health professionals' behaviour:** - Three studies showed minimal or no change in health professionals' practice after participating in the Cultural Safety initiative - The remaining studies found improvements in attitudes, awareness, skills, confidence, and self-assessed knowledge related to Aboriginal and Torres Strait Islander health and patient care. - Two studies reported that participants found the Cultural Safety training highly relevant and valued. - Insufficient information provided on mechanisms for change. **Change in patient experiences:** - Evaluation of patient experience was not assessed in eight of the nine studies. - One study analyzed changes in incomplete ED visits by Aboriginal and Torres Strait Islander patients, reporting minimal change. **Recommendations:** - Provide cultural safety training for hospital staff on a shorter, regular basis during work hours or through an online, self-directed format to increase engagement. - Ensure rigorous evaluation, utilizing both qualitative and quantitative methods for both hospital staff and patients - Conduct further research on appropriate wording and sensitivity of survey questions to ensure accurate evaluation SOURCE	

• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Barriers to cultural safety	**Culturally responsive, trauma-informed, continuity of care(r) toolkits: A scoping review (11)** This scoping review included 13 studies published between 2010 and 2018 to 1) Identify existing toolkits to support services in implementing culturally responsive, trauma-informed, and/or continuity of care(r) models of care across the perinatal period and first 1,000 days and 2) identify the principles, components, and key processes underpinning these models and their implementation. **Principles of toolkits:** These were the most prevalent principles in the toolkits; additional principles are included in the publication - Continuity of care(er) – Seeing the same provider over time. - Collaboration: was discussed concerning various groups, including care teams, service users, communities, interdisciplinary teams, and external support agencies. • Facilitates participation in decisions affecting individuals' lives. • Based on partnership and sharing power - Family-centred care • Requires safety within the environment: emotional, cultural, and physical • Cultural safety is self-determined by the service user. - Holistic care – Addresses physical, emotional, cultural, spiritual, and social well-being. **Core model components:** These were the most prevalent core components in the toolkits; additional principles are included in the publication - Provision of individualized care: Care delivered based on recipients' wants, needs, strengths, and preferences - Effective interdisciplinary teams: essential for the provision of safe care; Clear referral pathways, knowledge of referral and support options, and integrated services are crucial and noted in toolkits across the three concepts - Services that are flexible, welcoming, and safe: Several toolkits highlighted the aspect of programs and servings being community-based and integrated with other community or health services as a contributing towards this; services should create an environment that respects and encourages cultural values and practices • Ensuring this cultural safety also entails having staff who are culturally competent and respectful - Continuity of carer and care: having the same provider over time that coordinates care across the system **Key processes:** - An extensive list of process factors across all stages of project planning, implementation, development, evaluation, and sustainability are included with descriptions on pages 10-11 of the published manuscript	2024

	SOURCE	
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Cultural safety practices: systems-level • Barriers to cultural safety	**Culturally responsive occupational therapy practice with First Nations Peoples—A scoping review (12)** This scoping review included 41 studies published between 2002 and 2023 that explore features of culturally responsive occupational therapy (OT) practice and examine their alignment with the Indigenous Allied Health Australia (IAHA) Cultural Responsiveness in Action Framework. Included studies were published in Australia, Aotearoa, Canada, South Africa and the United States, with only one source being published in South Africa. **Theme: Respect for the centrality of cultures (IAHA capability)** - identifying, respecting and valuing cultures as central to the health and well-being of First Nations Peoples. **Sub-theme: Culturally responsive environments** - Provide flexible services in appropriate locations (e.g., home, schools, community). - Follow cultural protocols, especially in home settings. - Enhance therapeutic spaces with music, art, clothing, and dance. - Use culturally based introductions to build rapport. - Build trust through mutual sharing of backgrounds and where one comes from. **Sub-theme: Respecting Traditional Ways of Knowing and Healing** - Access to Elders and Traditional Healers – Important for culturally responsive care. - Spirituality – Recognizing differences between Western individualism and First Nations' holistic perspectives. • First Nations view health as interconnected with spirituality, family, community, and the land. • A holistic, community-wide definition of health is essential for cultural responsiveness. - Recognize that not all clients wish to share spiritual beliefs. • Providers should seek permission and follow the client's lead before exploring spirituality. **Theme: Self-Awareness (IAHA capability)** - Recognizing how one's own culture, assumptions, and beliefs influence practice. - Engaging in reflexivity and self-reflection. - Recommendations: • Acknowledge Personal Biases – Discuss one's own culture and worldview limitations.	2024

	• Understand Broader Systems – Learn about colonization, Western dominance in education and healthcare, and how these structures create privilege or marginalization. • Build Authentic Relationships – Share personal cultural context with clients. • Engage with Community – Attend community events and traditional activities. • Address Racism – Learn how racism manifests in everyday life and contributes to privilege. • Recognize Bias – Increase awareness of how attitudes shape biases in practice. **Theme: Proactivity in Taking Responsibility for their own Development in Culturally Safe Practice (IAHA Capability)** - Integrate spirituality and culture into practice. - Use community-led, population-based approaches. - Identify provider knowledge gaps through surveys and interviews. - Center First Nations perspectives in practice development and evaluation. **Theme: Inclusive Engagement (IAHA Capability)** - Ensure shared decision-making among clients, providers, and families. - Establish long-term, continuous relationships. - Collaborate with key community members, including Elders, First Nations health workers (for cultural brokerage), and Traditional Healers. **Sub-theme: Partnerships** - Partnerships between First Nations Peoples and providers were essential for culturally responsive practice. - In individual sessions, partnerships involved: Shared decision-making between the client, their family, and the therapist; Establishing long-term relationships with clients and their families. - At the program level, partnerships included developing therapy programs that incorporate the social, cultural, and spiritual values of the client's community and genuine investment by therapists in reflecting on and integrating community values. - Community partnerships were crucial for OT service development and evaluation, involving Local services, First Nations colleagues, community organizations and key community members such as Elders, First Nations health workers and traditional healers **Sub-theme: Voices and Perspectives of First Nations People** - First Nations people should guide culturally responsive practices.	

	- Recommendations: Use First Nations languages in sessions (with interpreters if needed); Engage cultural interpreters or liaison professionals.; Align therapist and client priorities; Emphasize strength-based rather than deficit-based discourse; respect and increase cultural knowledge, including knowing the individual cultural protocols and cultural practices that could facilitate appropriate and effective treatment **Theme: Leadership (IAHA Capability)** - Develop culturally responsive practice frameworks. - Use of a First Nations healthcare model to explore First Nations' perspectives. - Address environmental, social, and political contributors to health inequities. - Innovate through flexible service delivery. **Theme: Responsibility and accountability (IAHA Capability)** - Responsibility and accountability involve setting and achieving culturally responsive practice goals and aligning outcomes with what is important to First Nations Peoples. - Organizational accountability includes embedding cultural responsiveness within health services and ensuring accountability for achieving culturally responsive goals. **Sub-Theme: Recognizing and unpacking the Western foundations of healthcare** - Without an examination of Western voices and perspectives and acknowledgment of this biased lens, there is a risk of perpetuating harm to First Nations Peoples. - Unpack a Western lens by applying a human rights-based approach to change policies, work practices, systems, and structures that cause harm and restrict the self-determination of First Nations Peoples. - Approaches must avoid the belief that First Nations Peoples "need to be helped," that non-Indigenous providers are "change agents," and that First Nations Peoples should improve culturally responsive practices without compensation. - Emphasis on allowing adequate time for decision-making in collaboration with First Nations Peoples and when recruiting First Nations Peoples into teams. - Providers must recognize how non-Indigenous and First Nations Peoples are positioned to avoid perpetuating harm caused by colonization. - To understand First Nations Peoples' health, providers must first understand the effects of oppression, racism, trauma, grief, and cultural genocide on health or ill health. SOURCE	

• Concepts of cultural safety and patient experiences • Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Facilitators to implementing cultural safety practices • Barriers to cultural safety	**Healthcare professionals' cultural safety practices for indigenous peoples in the acute care setting – a scoping review (1)** This scoping review included 16 studies published between 2009 and 2022 across Australia, Canada, and New Zealand to explore what is known about cultural practices in caring for Indigenous Peoples in acute care settings. **Definitions and frameworks of cultural safety:** - Requires the individual to acknowledge and address their own biases, assumptions, stereotypes, attitudes, and practices that may affect their culturally safe healthcare delivery for Indigenous Peoples - Cultural awareness is the beginning of a continuum of knowledge, attitudes, and behaviours leading to cultural safety practices - Culturally appropriate communication and the use of cultural translators/interpreters to ensure that there was no miscommunication regarding Indigenous Peoples' healthcare needs - Involves understanding and acknowledging power differentials between providers and Indigenous Peoples and ensuring Indigenous People's needs are met holistically **Highlighted** De Zilva et al. (2022) **four interdependent aspects of cultural safety:** - Personable two-way communication – Open and respectful dialogue between healthcare providers and Indigenous Peoples. - Well-resourced Indigenous health workforces – Ensuring Indigenous healthcare workers have adequate support and resources. - Trusting relationships – Building strong, respectful connections between providers and Indigenous communities. - Supportive healthcare systems – Organizational structures that uphold and integrate Cultural Safety principles. - Enablers: • Indigenous health liaison officers as cultural bridges • A healthcare system that supports providers in developing skills and knowledge in culturally safe practices. **Barriers to cultural safety in practice:** - Communication barriers: Language barriers resulting in increased fear and previous negative healthcare experiences (e.g., disparaging, patronizing, and condescending behaviour from healthcare providers).	2023

	- Relationship barriers: Perceived and actual racism, unmet cultural and physiological needs, and conflicts between biomedical and holistic approaches. - Health inequities: Limited healthcare access due to intergenerational trauma, systemic racism, and negative attitudes from healthcare professionals. • Compounded by inequitable determinants of health (e.g., access to education, lower-paying jobs), which increase the potential for living in poverty - Institutional barriers: Lack of support for providers and organizations to implement Cultural Safety. • Could be improved through coordinated care approaches to improve communication and increase staff skills in providing culturally safe care through education and training. **Interventions:** - Only one intervention was reported among the sixteen studies - The Aboriginal Identification Program followed a nine-step plan based on the Plan-Do-Study-Act cycle. - Focused on staff upskilling, further education, site visits, and ongoing support. - Aimed at solution planning, information gathering, and improving data on Indigenous Peoples' ED experiences. - Did not impact the accuracy of recording Indigeneity in health system databases. - Led to organizational changes, including improved waiting areas, visit management, and identification processes. - Critique: Strategies were ad hoc and failed to assess barriers to Cultural Safety practices. **CHALLENGE:** Some cultural safety practices (e.g., larger hospital rooms to accommodate families) are antithetical to current practices SOURCE	
• Facilitators to implementing cultural safety practices • Barriers to cultural safety • Audit tools and evaluation • Gaps in research and practice	**Audit tools for culturally safe and responsive healthcare practices with Aboriginal and Torres Strait Islander people: a scoping review (20)** This scoping review included 15 studies published between 2006 and 2023 to identify and examine existing audit tools and their implementation barriers and/or facilitators for cultural safety and culturally responsive healthcare practices with Aboriginal and Torres Strait Islander people. All included studies were conducted in Australia.	2024

	Features of the 12 different tools identified: - Cultural Competency Scale; Organisational Cultural Competence Assessment Tool; Ganngaleh nga Yagaleh (GY) Cultural Safety Assessment Tool (previously named the Cultural Capability Measurement Tool); Cultural Safety Survey Scale; Awareness of Cultural Safety Scale - Revised; 'Meeting People in Their Own Reality' Guidelines; Koolin Balit Aboriginal Health Cultural Competence (KB-AHCC) Audit Tool; Self-audit of knowledge and skills on; Indigenous perspectives and health; Checklist for culturally competent general practitioners (GPs); Cultural Responsiveness Audit Tool; Best Practice Framework; Continuous Improvement Cultural Responsiveness Tool (CICRT) – Audit Tool - Audit tools varied in length, terminology, assessed domains, and validation status. - Tools ranged from 4 cultural responsiveness indicators to 36 self-rating cultural capability questions. - 6 out of 14 articles examined tool reliability and validity - All tested tools showed strong reliability and validity. - Only one study qualitatively evaluated tool implementation (KB-AHCC audit tool) through interviews with health and community representatives **Barriers and facilitators to audit tool implementation were only identified in one article (KB-AHCC audit tool)** - *Barriers:* • Tool structure and comprehensiveness: Some users saw it as too time-consuming and inflexible. • Confusion between tools: Participants struggled to differentiate the KB-AHCC audit tool from other cultural competency tools, hindering implementation. • Limited organizational engagement: Implementation was often assigned to a small team or single staff member, making it vulnerable to staff turnover. • Competing priorities: Cultural competence is risked being deprioritized, among other organizational responsibilities. • Lack of accountability: Tool use was not mandated, leading to inconsistent implementation. - *Facilitators:* • Positive perception of tool structure and comprehensiveness: Some users saw it as beneficial. • Action-oriented approach: Helped identify areas for improvement for healthcare workers • Organizational involvement: Enabled engagement across different levels of healthcare organizations.	

	SOURCE	
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Cultural safety practices: systems-level	**Cultural safety strategies for rural Indigenous palliative care: a scoping review (13)** This scoping review included 22 studies with no clear documentation of when they were published. The aim of the review was to explore what a culturally safe, palliative approach to care looks like in a rural Indigenous context. The studies included were published in Australia, Canada, and New Zealand. Seven themes were identified to facilitate cultural safety, which are summarized below. **Anticipate Barriers to Care:** - Use translation services when appropriate to improve communication. - Ensure culturally appropriate informed consent, including oral consent when necessary. **Active Involvement of Family and Patient:** - Recognize clients, families, and communities as equal partners in decision-making. - Shift power dynamics to align care with cultural values and goals. - Examples of strategies: • One-on-one discussions to prioritize direct, meaningful conversations ("speak less about, and more with"). • Encourage feedback from patients/families to ensure understanding and active participation. • Use culturally appropriate, family-centered communication approaches. • Implement Aboriginal health advocate programs to support patient involvement and address power imbalances. • Recruit providers, volunteers, or family members from the same cultural background to enhance trust and engagement. **Respectful, Clear, and Culturally Appropriate Communication:** • Incorporate local Elders in cultural safety training, using informal, conversational methods (e.g., tea-room style discussions) to enhance relevance. • Encourage reflection on individual and systemic racism in cultural safety training to promote healthy communication.	2019

	Symbolic or Small Gestures: - Use care models grounded in an understanding of Indigenous culture. - Reject a pan-Indigenous approach, recognizing the diversity of Indigenous communities. - Examples of culturally inclusive strategies: • Creating welcoming spaces with Indigenous art and participation in events like National Aboriginal Day. • Incorporating culturally appropriate food in hospital menus. • Respecting spiritual practices, even in the absence of culturally specific spiritual care services. **Shared Decision-Making:** - Enable client and family participation in decision-making to align care with Indigenous family priorities. - Examples of shared decision-making strategies: • Providing large spaces to accommodate family involvement. • Ensuring information is given to the culturally appropriate person within the family. • Using family meetings to communicate care plans and involve patient-identified support persons. **Empower Cultural Identity, Knowledge, and Traditions:** - Develop educational programs that explore Indigenous models of care and critically assess Western healthcare assumptions. - Move beyond merely accepting traditional medicine to acknowledging its inherent value in Indigenous approaches to care. **Policy and Governance:** - Including Indigenous peoples in governance and decision-making structures - Culturally appropriate service and certification protocol The authors emphasized that while individual clinicians must be open to change in order to enact principles of cultural safety and develop trust with their clients, relationships of trust and knowledge sharing must also be demonstrated at an institutional level. SOURCE	

• Concepts of cultural safety and patient experiences • Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Gaps in research and practice	**Māori experiences of physical rehabilitation in Aotearoa New Zealand: a scoping review (5)** This scoping review included 11 studies aiming to synthesize what is known about Māori experiences of physical rehabilitation services in Aotearoa New Zealand. The authors did not describe when or where the included studies were published. Overall, the studies encouraged rehabilitation professionals to be self-aware and self-reflective, particularly in relation to their culture and biases. Culturally safe clinicians were described as those who were conscious of the power relationship that inherently existed between themselves and Māori patients. Culturally safe clinicians actively incorporated and validated Te Ao Māori me ōna tikanga, as discussed in the previous theme. Several of the studies discussed the tendency to assume that health systems and the services they provide are culturally neutral. The studies advised that culturally safe clinicians recognize the historical impact of colonization on the setup of the health system in Aotearoa, New Zealand, and the instilled institutional racism that accompanies this. The thematic analysis of the results is presented in four themes below. **Theme 1: Māori Expectations of Culturally Unsafe Healthcare Become Reality in Rehabilitation** - Enter rehabilitation with distrust of health and social systems. - Experience culturally unsafe care, including cold, impersonal communication; Highly individualized services lacking holistic approaches; Eurocentric healthcare models that fail to connect with Māori; Incorrect assumptions about Māori by healthcare providers; lack of recognition of the wider determinants of health **Theme 2: Whānau Are Crucial for Navigating Cultural Collisions** - Whānau (immediate and extended family) act as advocates and provide emotional, social, and spiritual support. - Services fail to recognize whānau's collective well-being and their need for healing. **Theme 3: Culturally Safe Rehabilitation Through Te Ao Māori me ōna tikanga** - Incorporate Māori healing approaches and traditional medicine. - Increase Māori workforce to ensure culturally competent care. - Build meaningful connections between patients and healthcare providers to enhance comfort and trust. **Theme 4: Mana-Enhancing Rehabilitation Services** - Recognize whānau as active members of the care team. - Use collaborative, patient-centred communication. - Identify barriers and facilitators to rehabilitation with patients.	2024

	- Integrate culturally meaningful activities into rehabilitation plans. * Mana refers to prestige, power, and status-enhancing mana empowers Māori and respects Māori ways of doing things. **GAP:** Recommended cultural safety training for clinicians while highlighting they only evaluate learner experiences. SOURCE	
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Cultural safety practices: systems-level • Barriers to cultural safety	**Perspectives on Indigenous cultural competency and safety in Canadian hospital emergency departments: A scoping review (7)** This scoping review included six studies on identifying barriers and facilitators to cultural safety in Canadian emergency contexts from the perspectives of Indigenous knowledge holders, staff, patients, and health organizations. The results are summarized by each group's perspective below. **Patient perspectives on barriers and facilitators:** - Facilitators: cultural helpers (support with cultural or linguistic background), brief supportive interactions with hospital staff, spiritual support and mental support (e.g., decision-making) from family. - Barriers: concerns over stereotyping and discrimination, differences in communication styles or lack of adequate communication, lack of alternative care options, alienation or feeling far from home, lack of integrated social services, financial constraints, mistrust of the medical system, not being involved in care plans, and concern over institutional policies (e.g., prescription policies, policies on mental health and confinement). **Staff perspectives on barriers and facilitators:** - Facilitators: staff training, trust and relationships, cultural support for patients, family inclusion, community partnerships, organizational commitment to cultural safety. - Barriers: ongoing discrimination and trauma experienced by patients, insufficient resources, policy constraints, and poor care continuity.	2019

	Indigenous knowledge holder perspectives on barriers and facilitators: - Facilitators: adopting a post-colonial framework, appreciation for Indigenous culture, acknowledging the family's role, brief and supportive interactions, Indigenous staff employed, staff education on cultural safety, partnerships with Indigenous communities. - Barriers: staff not being fully aware of the greater context of Indigenous peoples' lives, historical distrust between Indigenous communities and the health care system, tacit and overt discrimination. **Health organization perspectives on barriers and facilitators:** - Facilitators: providing cultural competency training, use of multidisciplinary teams, enhancing referrals and access to primary care and specialist services. - Barriers: racism and stereotyping experienced by Indigenous patients seeking care, lack of access to primary care and the presence of health disparities SOURCE	
Systematic critical synthesis (n= 1)		
• Concepts of cultural safety and patient experiences • Cultural safety practices: provider-level • Cultural safety practices: organizational-level	**Reflexive Practice as an Approach to Improve Healthcare Delivery for Indigenous Peoples: A Systematic Critical Synthesis and Exploration of the Cultural Safety Education Literature (3)** This systematic critical synthesis included 46 studies published between 1992 and 2021 examining how reflexivity is conceptualized, taught or assessed within cultural safety curricula. Included studies were published in Australia, Canada, and New Zealand. The synthesis focused specifically on reflexive practice as an approach to improving healthcare delivery for Indigenous peoples. The results are broken down by definitions, conceptualizations, pedagogical approaches to facilitating reflexivity, and assessments of reflexivity. **Definitions of reflexivity:** - Reflexivity is inconsistently defined - Terms identified include reflexivity or self-reflection, self-awareness, critical reflection, and self-examination. - Most descriptors suggest a passive identification, observation, and awareness process.	2022

	- Some descriptors, however, call for action, such as using new self-knowledge to enact attitude changes or challenge previous understandings. **Conceptualizations of reflexivity:** - Self-identity: learners reflect on their identity, culture, worldviews, and values. • Purpose is to develop an understanding that identity, culture, worldviews, and values are not universal and that their identity shapes and influences their understanding, attitudes, and behaviours. - Held beliefs: Learners identify and articulate their knowledge, attitudes, biases, power, and privilege, particularly in relation to Indigenous peoples. • Documents often framed held beliefs in neutral terms, glossing over systemic racism that underpins beliefs and attitudes. - Relationality: Learners reflect on how self-identity and held beliefs impact engagement with and care for others, contributing to poor health and social outcomes. - Context: A process of reflecting on how self-identity, held beliefs, and relationality have been shaped by historical, social, political, and economic forces. Reflexivity ranges from basic reflection on self-identity at one end to more critical reflection on self-beliefs and relationality in the middle and reflexive analysis of the self as contextually situated at the other end. **Pedagogical approaches:** - Reflexivity was facilitated through various approaches, using reflexive catalysts to challenge learners' lived experiences and worldviews. Objects: These were most often used in small or large group discussions, where new knowledge was co-produced through shared beliefs, experiences, and interpretations. - People: Exposure to difference through simulations, community-based placements, and engaging with Indigenous educators, offering opportunities to challenge stereotypes. - Indigenous pedagogical practices: Practices like Yarning circles* and field visits challenged deficit-based understandings and legitimized Indigenous knowledge. **Assessment of reflexivity:** - Of the 46 educational interventions analyzed, only 22 provided information on the assessment of reflexivity and most were only a brief description - Assessments included journals, portfolios, reflexive questions, presentations	

	*A Yarning Circle is a process used by Aboriginal and Torres Strait Islander peoples to learn, share, build respectful and caring relationships, pass on cultural knowledge through storytelling, and come together as a community. SOURCE	
Systematic reviews (n= 4)		
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level • Cultural safety practices: systems-level • Barriers to cultural safety	**Culturally safe health care practice for Indigenous Peoples in Australia: A systematic meta-ethnographic review (10)** This meta-ethnographic systematic review included 34 studies published between 2012 and 2019 on the meaning of culturally safe healthcare practice from the perspectives of Indigenous Peoples in Western high-income countries, focusing on Aboriginal and Torres Strait Islander healthcare users in Australia. Although the review initially included studies from high income countries, the final analysis only included studies set in Australia. The analysis revealed four inter-relatable metaphors to characterize the elements of culturally safe healthcare practice: personable two-way communication, well-resourced Indigenous health workforce, trusting relationships and supportive healthcare systems. The elements of communication, relationships and value of Indigenous health staff were situated within and influenced by the wider health care system. **Responsible two-way communication:** - Facilitators: Families assist with communication by talking directly with health professionals to bridge barriers and advocate for patient needs; Open, informative, and regular communication, including casual conversations for relationship building (informal yarning); Yarning* to de-medicalize formal clinical encounters and reduces fear/anxiety; Use of a soft tone and quiet speech enhances communication. - Barriers: Overuse of medical jargon; Perception that health professionals are not interested in Indigenous peoples' perspectives on health, illness, and treatment; Exclusion of family from interactions with providers; Lack of professional interpreters. **Well-resourced Indigenous health workforce:** - Include liaison officers and Aboriginal and Torres Strait Islander Health Workers	2021

	- Interacting with Indigenous health staff helped patients feel their culture was reflected and positioned at the center rather than on the fringe. - Patients and families reported that Indigenous health staff understood, took seriously, and acted on their holistic needs and concerns. - Indigenous health staff served as a conduit for communication, bridging systemic miscommunication between health professionals and patients/families. - These staff members were viewed as trustworthy, and relationships with them were highly valued. **Trusting relationships:** - Require adequate time, communication, and continuity of care. - Key element: Support Indigenous patients in staying connected with their families during their healthcare journey. - **Barriers:** Health professionals making stereotypical assumptions and judgments about patients and families (e.g., being perceived as stupid, careless, intoxicated); Not recognizing the need for patient choice in the gender of healthcare provider. **Supportive healthcare systems:** - Facilitators: Developing family visitation policies; Creating physical spaces that accommodate family groups; Delivering care closer to home with innovative models.; Health systems that offer flexibility to meet patient and family needs, including enough time for health professionals to build relationships.; Increasing workforce representation by Indigenous health staff; Cross-cultural training for healthcare professionals; Enhancing health environments with Indigenous artwork, flags, clear signage, and physical meeting spaces to counter cold and unwelcoming settings [*should be combined with other elements of cultural safety to avoid tokenism] - Barriers: Biomedical models of care that are inflexible and disease-focused; Lack of Indigenous staff workforce capacity; Lack of respect for Indigenous beliefs, knowledge, and customs during care. Cross-cultural training was identified as a strategy to overcome racism, disrespectful stereotypes, and poor communication practices across all healthcare settings. Details about how the training would be delivered included being locally developed and facilitated. *Yarning is a way of connecting and purposefully sharing knowledge through narrative. It can include anecdotes, stories and experiences, and humor.	

	SOURCE	
• Concepts of cultural safety and patient experiences • Cultural safety practices: provider-level • Facilitators to implementing cultural safety practices	**What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence (2)** This systematic review included 10 studies published between 2004 and 2014 to understand how Aboriginal Community Controlled Health Organization (ACCHO) clients in Australia perceive the characteristics and value of care provided by ACCHOs compared to care provided in mainstream primary health care (PHC). ACCHOs are community-governed PHC organizations which provide care to Aboriginal and Torres Strait Islander people in Australia. **There were three main findings relevant to the research questions.** **Culturally safe care and environments were described as:** - Care delivered by providers who were understanding, respectful of culture, and took the time to meet clients' needs. - Provided in an environment that made clients feel comfortable and supported. - ACCHOs' welcoming environment included both emotional and relational dimensions: • Relational Dimension: Clients felt welcome because they saw familiar faces who understood them, both in the waiting room and clinical spaces, fostering a sense of belonging. • Emotional Dimension: ACCHOs were described as social meeting places where friends could connect, offer, and receive support. **How care was developed in a culturally safe way:** - Increased feelings of belonging and confidence when accessing services. - Taking the time to get to know clients. - Providing personalized care tailored to clients' self-perceived needs as identified by them. - Ensuring continuity of care over time. - Using appropriate and effective communication. - Holistic care, which included a strong referral network to non-clinical programs and services	2017

	Qualities of Staff: - Indigenous identity and representation within the care team. - Inclusion of Aboriginal health workers, who provided: • Listening and reassurance. • Navigation support. - Key behaviours: • Respectful and non-judgmental; Taking the time to understand clients' backgrounds and needs; Demonstrating sensitivity, kindness, reassurance, and trustworthiness—helping clients feel at home. SOURCE	
• Cultural safety practices: organizational-level • Cultural safety practices: systems-level • Gaps in research and practice	**Systematic review of Indigenous cultural safety training interventions for healthcare professionals in Australia, Canada, New Zealand and the United States (17)** This systematic review included 13 documents published between 2014 and 2022 to identify characteristics and any associated impact of cultural safety trainings in Australia, Canada, New Zealand, and the United States. **Participation and Theoretical Frameworks:** - Participation in all programs was voluntary. - Studies referenced various theoretical frameworks, including Transformative learning theories, Social-constructivist frameworks, Diffusion of innovation theory, public health frameworks, and the Educating for Equity framework (developed by a research team at the University of Calgary). - Some training programs used participatory action or community-based approaches in development and delivery. • Interventions developed for specific communities or cultures are not generalizable. Specificity is essential, and a pan-Indigenous approach is not recommended. **Training Delivery:** - Delivery methods varied and included: Online modules; Didactic lectures; Interactive group discussions; Workshops; Simulations; Reflections. - One study included cultural mentors. - Most programs were co-delivered by a mix of Indigenous and non-Indigenous facilitators or solely by Indigenous facilitators.	2023

	- Innovative approaches included Storytelling and talking circles with Elders; Podcasts developed and voiced by Elders; Simulation training facilitated with Indigenous community members. **Outcomes and Evaluation:** - Most studies reported self-reported shifts in knowledge and attitudes toward Indigenous people. - **CHALLENGE:** Only 3 out of 13 studies evaluated patient experience, with minimal impact observed. - **GAPS:** • While Indigenous people and communities were involved in curriculum development and delivery, their involvement in evaluation was minimal. • None of the studies were able to establish an observable shift toward more culturally safe or clinical guideline-adherent healthcare for Indigenous patients. • The lack of evaluation of patient experience/outcomes impacted the ability to determine the effectiveness of existing cultural safety training. **Recommendations and Challenges:** - Institutional leadership should act as change agents and clinical champions to encourage participation in cultural safety trainings. - Long-term incentives were not always effective. Training should be compulsory or obligatory, with organizational commitment and team involvement. - Indigenous cultural safety must be determined by Indigenous communities and individuals receiving care. - The application of purposeful, evidence-based, pedagogical theory and practices that advance prerequisite knowledge, self-awareness, and skills is critical to the success of cultural safety training. SOURCE	
• Concepts of cultural safety and patient experiences • Cultural safety practices: provider-level • Barriers to cultural safety	**The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication (4)** This systematic review included 65 documents published between 1995 and 2014 aimed to examine Aboriginal and Torres Strait Islanders perspectives on their healthcare experiences to understand culturally safe Indigenous healthcare communication.	2018

	Two key components of culturally safe healthcare communication emerged: the power of talk and power differentials within talk. The power of talk refers to the esteem in which Indigenous respondents held talk. This power was mediated by the power differentials experienced through talk. **Power of Talk:** - Speaking with providers is central to the healthcare experience. - Clients feel valued when talk is shared and hurt when it is withheld - Clients also valued talk in informal or social contexts beyond the usual health provider role. This conveyed to Indigenous clients a sense of genuine care and compassion, fostering trusting relationships with their care providers. - Conversations with other Indigenous clients in health settings are also valuable. Many describe mainstream health spaces as quiet and lonely, preferring health spaces that encourage social interaction. - The quality of communication influences: • Adherence to treatment plans. • Whether clients continue to engage with the health service or provider. **Consequences of Withholding Talk:** - The absence or perceived withholding of communication was described as a discriminatory experience - The Australian healthcare system is historically tied to colonization and control—one poor experience can impact interactions for years. - Example: Indigenous patients observed that white women received more frequent check-ins from midwives (e.g., "How are you doing? Do you need anything?"). **Power Within Talk:** - Dominance, power, and exclusion can be reinforced through communication. - Examples include: • Bullying and racist behaviour • Disbelief in Indigenous patients' medical history (e.g., assumptions about alcohol and drug use). • Overuse of medical jargon, making conversations inaccessible. • Authoritarian discussions where patients feel unheard and excluded.	

	Bringing it Down - Minimizing Power Differentials: - Indigenous clients valued health professionals who minimized power imbalances. - This was expressed through: • Status – "Come down to our level." • Terminology – "Bring it down" (simplifying language). • Physical position – "Sitting down" with patients. - Demonstrating care and respect involved: • Reducing hierarchical barriers. • Using clear, relatable language. • Approaching interactions with humility and equality. - Clients preferred providers who: • Used an informal, warm, 'yarning*' approach to build trust. • Balance the use of plain language without being patronizing *Yarning is a way of connecting and purposefully sharing knowledge through narrative. It can include anecdotes, stories and experiences, and humor. SOURCE	

Appendix D: Key findings from source documents with medium relevance to the review questions

Relevance to Question	Key Findings	Recency
Environmental Scans (n= 1)		
• Cultural safety practices: organizational-level	**Indigenous Cultural Safety Trainings for Healthcare Professionals Working in Ontario, Canada: Context and Considerations for Healthcare Institutions (23)** The authors conducted an environmental scan to identify existing Intercultural Safety Trainings (ICST) in Ontario, Canada. The goal of the scan is to use the findings inform the development and delivery of ICST within and across healthcare settings in the City of Toronto, Ontario. A full list of the identified ICSTs can be found in the environmental scan hyperlinked below. A synthesis of common features across the identified ICSTs is provided. **Content:** - Co-develop with Indigenous communities - Include local Indigenous histories, worldviews, and policies (past & present) - Address systemic colonialism, racism in healthcare - Encourage reflexivity and worldview challenges **Delivery:** - Preferably in-person, with hybrid/virtual options for wider reach - Facilitate long-term relationships for ongoing learning & accountability - Mandatory for all staff, not just providers **Learning Environment:** - Safe space led by Indigenous leaders, Knowledge Keepers, and Elders - Multi-day format to allow for reflection between sessions - Allocate time for personal reflection, questions, and group discussions - Test methods and protocols to ensure engagement and accountability	2023

	SOURCE	
Integrative Reviews (n=2)		
• Concepts of cultural safety and patient experiences • Facilitators to implementing cultural safety practices • Barriers to cultural safety	**Occupational Therapy Roles in an Indigenous Context: An Integrative Review (24)** The integrative review included 25 sources with no clear publication dates to explore how occupational therapists can improve their work with Indigenous peoples. Included articles were published in Australia, Canada, and New Zealand. The results are synthesized by actions to improve occupational therapy practice at the provider and organizational levels. **Culturally Safe Healthcare Practice - Provider Level** *Communication and Relationships:* - Power imbalances create barriers that take time and effort to overcome. - Building trust requires multiple visits, which conflicts with fast-paced healthcare systems. - Patient voices must be valued equally in care decisions to avoid cultural imperialism. *Tools and Concepts:* - Focusing on individual independence overlooks Indigenous communal ways of being. *Reciprocity and Collaboration:* - Respectful dialogue before action fosters stronger relationships. - Healthcare providers should shift from "experts" to allies, learning with and from communities. - A strength-based approach is essential; 'empowerment' language overlooks that Indigenous peoples are already powerful. - True collaboration means supporting communities in achieving their own visions, not imposing solutions.	2020

	Culturally Safe Healthcare - Organizational Level *Service provision:* - Barriers: Lack of services in communities, lack of trust - Relationality; important to take more time with each patient. • However, increased time and flexibility not be adequate if operating with Eurocentric expectations and assumptions. Recommendation to work with and employ Indigenous health workers. SOURCE	
• Cultural safety practices - individual-level • Cultural safety practices - program-level • Barriers to cultural safety	**Culturally Relevant Palliative and End-of-Life Care for U.S. Indigenous Populations: An Integrative Review (25)** The review included 17 sources published between 2001 and 2014 with the aim of ascertaining the state of the science on culturally acceptable palliative and end of life care options for Indigenous persons in the United States. Six main themes relevant to the review questions are outlined below. **Communication:** - Healthcare providers should understand their own and patients' communication styles. - Allow opportunities for patients to ask questions. - Be attentive to verbal/nonverbal cues, tone, pace, and word choice. - Use patient's language when discussing illness, slow speech and allow silence. - Include family in decision-making and use interpreters when needed. **Trust & Respect:** - Build trust by taking time to know patients, learning cultural nuances, and involving bilingual team members. **Cultural Awareness & Competence:** - Recognize diverse Indigenous beliefs on health and illness.	2018

	- Approach interactions with empathy, compassion, and patience. **Cultural Sensitivity Training:** - Making mandatory for healthcare providers may help prevent biased decision-making. **Engaging Indigenous Communities:** - Involve Elders, tribal leaders, community health workers, and families in program development. - Integrate traditional medicine, spirituality, and tribal values into care. - Assess individual cultural needs, as all tribes and individuals are different. - Collaborate with tribal entities, academic institutions, and community groups. **Barriers to Care:** - Limited time to build trust with Indigenous patients. - Mistrust of healthcare due to discrimination, poor funding, and past exploitation. - Fear of stereotypes affecting pain management and treatment quality. SOURCE	
Rapid Reviews (n= 1)		
• Audit tools and evaluation • Gaps in research and practice	**Self-assessment tools for assessing cultural competency: a rapid review of literature (26)** The rapid review aimed to evaluate the characteristics of self-assessment tools used to assess cultural competency and ascertain the context and outcomes of their use. The six included studies published between 2014 and 2018 took place in Australia and New Zealand. Overall, the authors found significant variability in characteristics of the tools and highlighted several gaps in their uses outlined below. **Gaps in evaluation of cultural safety interventions:** - Self-assessment tools are subjective and prone to bias. - They reflect practitioners' views, while cultural safety is defined by patients. - Improved self-assessed competence may not translate to better patient experiences or outcomes.	2022

	- Few studies assess healthcare impacts from First Nations patients' perspectives. SOURCE	
Scoping Reviews (n=5)		
• Cultural safety practices: provider-level • Cultural safety practices: organizational-level	**Cultural safety in telehealth consultations with Indigenous people: A scoping review of global literature (27)** The scoping review included 17 articles published between 2006 and 2021 to explore the attributes of culturally safe telehealth consultations with Indigenous people globally to identify strategies to improve the cultural safety of telehealth. Included studies were published in Australia, Canada, and the United States. Recommendations for fostering cultural safety within telehealth environments are outlined below. **Cultural and Community Knowledge:** - Understand cultural communication styles, colonial histories, and traditional healing. - Gather cultural history during consultations for holistic care. - Build relationships with Elders and community members through visits. **Communication:** - Use respectful, culturally appropriate communication. - Be open, transparent, and seek feedback. - Use simple language, culturally adapted resources, and allow time for trust-building. - Adapt to local communication preferences (eye contact, gestures, tone). **Building and Maintaining Relationships:** - Reflect on cultural roles and assumptions in care. - Allow time for trust-building, including through telehealth, which may reduce fear of judgment. **Technology & Telehealth:** - Assess if telehealth is appropriate for each patient. - Build face-to-face relationships before transitioning to virtual care.	2023

	- Create a welcoming, soundproof telehealth space with cultural elements. - Ensure privacy and confidentiality. **Support Staff:** - Utilize Indigenous Health Workers to enhance cultural connection and communication. For some individuals, telehealth is not a comfortable or acceptable form of care. However, if strategies are undertaken to make telehealth more culturally safe, it has the potential to increase opportunities for some individuals to access care and, in so doing, contribute to reducing health inequalities faced by Indigenous peoples. SOURCE	
• Cultural safety practices: provider-level	**How is cultural safety understood and translated into midwifery practice? A scoping review and thematic analysis (28)** The aim of this scoping review was to identify Australian midwives understanding of cultural safety and how this is translated into their practice when caring for First Nations women and families. The 12 articles included in this review were published between 2014 and 2021. Findings were excluded in the overview below if they were overly specific to midwifery care and lacked transferability to other patient populations. **Healthcare Practitioner Understanding of Cultural Safety:** - Recognize First Nations culture as vital (history, communities, practices, family structures, and health connections). - Provide personalized care that respects individuality, choice, and self-determination. - Build strong relationships with patients, families, and communities. - Acknowledge power imbalances in healthcare. - Collaborate with First Nations colleagues and Aboriginal Support Workers. **Translating Cultural Safety into Practice:** - Work in partnership with community leaders and community organizations.	2023

	- Ensure clear role definitions within the care team. - Empower patients and families to guide their own care. - Recognize the impact of colonization and intergenerational trauma on trust in healthcare. - Foster respectful communication by understanding health within a community context. - Engage in community immersion for deeper cultural learning. SOURCE	
• Cultural safety practices: systems-level • Gaps in research and practice	**Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature (29)** This scoping review included 15 articles published between 2003 and 2015 on the impact of health system approaches on cultural competence. Studies were published in Australia, Canada, and the United States. Of the seven studies published in the United States, only one targeted Indigenous populations. The remaining focused on other racial and ethnic minorities. The most common health system approaches to increase cultural competence include those that engaged Aboriginal people in the development of interventions, having committed organizations and leaders that were ready for change, and those that were implemented across multiple sites. Audit and quality improvement approaches and service-level policies and strategies were the most common approaches to implementing cultural competence interventions. The authors highlighted several gaps in the research which are outlined below. **Gaps in Systems-Level Cultural Competence Research:** - Few studies assess the impact of systems-level cultural competence. - Limited evidence on its effectiveness in improving client experiences and health outcomes. - Unclear guidance on which strategies work, how to implement them, or their overall impact on client experiences and health outcomes. SOURCE	2017
• Concepts of cultural safety and patient experiences	**Culturally safe health and social service access for urban Métis women: a scoping review (30)** This scoping review identified 12 sources on the experiences of Métis women seeking to access culturally safe health and social services in urban settings across Canada.	2024

	The results are categorized by four main themes outlined below. **Racism, Discrimination, and Marginalization:** - Experienced in both mainstream and Indigenous-specific services. - Métis identity questioned; perceived as "not Indigenous enough." - Lack of recognition of cultural diversity within Indigenous groups. - Fear of racism leads to avoidance of services and non-disclosure of identity. - Denial of pain medication and racist assumptions. **Jurisdictional Barriers to Services:** - Métis excluded from First Nations-specific health programs. - Lack of federally funded Indigenous health benefits. - Many Métis struggle with affordability due to lack of coverage. - Limited funding for Métis-specific services creates gaps. **Lack of Culturally Safe Care:** - Few Indigenous healthcare providers and holistic care options. - Service gaps in mental health, maternal care, legal aid, and elder support. - Métis-specific services are under-resourced, leading to long wait times or denial of care. - Services mostly located in downtown areas, limiting broader access. **Recommendations from Métis Women:** - More Métis staff in healthcare settings. - Clinic interiors incorporating Métis cultural elements. - Dedicated space within clinics for Métis people. - Friendly, culturally-informed, trauma-informed staff. - Métis-specific cultural training instead of a general Indigenous approach. - Indigenous/Métis-specific clinics. - Holistic, culturally safe approach to care. SOURCE	

• Cultural safety practices: program-level • Gaps in research and practice	**Building Collaboration: A Scoping Review of Cultural Competency and Safety Education and Training for Healthcare Students and Professionals in Canada (31)** This scoping review identified 26 articles published between 2010 and 2014 describing educational curricula and training programs being implemented for healthcare students and professionals to improve cultural safety practices across Canada. The review primarily provided examples of institutions and regulatory bodies that have developed curricula or training programs with limited description of the programs content. However, the authors did identify several challenges, recommendations, and gaps in the research which are outlined below. - Despite growing awareness of cultural competency and safety in healthcare, few programs have been effectively implemented in Canada. - Increasing demand for standardized training and ongoing education, particularly experiential learning and community involvement. - Literature emphasizes that cultural safety training must be mandated across healthcare organizations and government levels to be effective. - Improvements in health inequities difficult to measure. - Challenges in integrating cultural safety into everyday healthcare interactions and broader societal norms. SOURCE	2017
Narrative Reviews (n= 1)		
• Audit tools and evaluation • Gaps in research and practice	**Improving cultural competence of healthcare workers in First Nations communities: a narrative review of implemented educational interventions in 2015–20 (32)** This narrative review identified 13 studies published in Australia, Canada and the United States on interventions to increase cultural competence of healthcare workers providing care in First Nations Communities. The synthesized findings were very limited and are outlined below. **Positive Outcomes:** - Improved attitudes, knowledge, and confidence in culturally safe practices.	2022

	- Better understanding of social policies affecting Aboriginal people. - Self-reported improvements in professional behavior and skills. - Higher cultural strategic thinking (cultural quotient). - Increased cultural competence scores. **Other Findings:** - Participants generally enjoyed the experience. - One study noted slight improvements in patients' health risk factors. - Knowledge and attitude gains sometimes declined over time. **Limitations:** - Few studies had a long follow-up period. The quality of the papers was generally weak or moderate, with no studies using a control group, most used convenience samples, and few following up participants after the intervention period. **GAP:** There remains limited evidence for impact of cultural education alone on patient outcomes. Cultural education training by itself may not be adequate to deliver better patient outcomes. SOURCE	
Systematic Review (n= 1)		
• Facilitators to implementing cultural safety practices	**Improving the efficacy of healthcare services for Aboriginal Australians (33)** The systematic review aimed to identify enablers of effective healthcare delivery for Aboriginal Australians. Fourteen papers published between 2000-2014 were included in the review. **Cultural Competence Training:** - Ongoing staff training to build cultural competence. - Zero tolerance for racism. - Involve Indigenous people in program design, delivery, and evaluation. - Integrate local customs, language, and beliefs into healthcare programs.	2019

	Tracking Participation Rates: - Monitor attendance and track when individuals seek care (prevention, early intervention, chronic disease, emergency). - Implement strategies to encourage and facilitate participation. **General Healthcare Recommendations:** - Clinical Governance: Standardized assessment, treatment, and follow-up with strong leadership and audits. - Organizational: Effective leadership, clear governance, ongoing staff training, and strategies to manage turnover. - Healthcare Access: Improve health literacy so individuals understand what services they need and how to access them. SOURCE	

Appendix E: Key findings from source documents with low relevance to the review questions

Relevance to Question	Key Findings	Recency
Literature Reviews (n= 3)		
• Cultural safety practices: organizational-level	**Decolonizing and Indigenizing pharmacy education in Canada (34)** The purpose of this literature review was to describe decolonizing and/or Indigenizing approaches taken in other healthcare educational programs in order to inform decolonization and Indigenization of pharmacy education in Canada. **Privileging Western Knowledge:** - Western medicine is prioritized, with Indigenous medicine seen as "alternative." - White lived experiences are privileged. **Holistic (Indigenous) vs. dissected (Western) knowledge:** - Western medicine divides the body; Indigenous medicine is holistic. - Education doesn't prepare students for culturally safe interactions with Indigenous patients. - Learning should be mutual, not one-sided. **Need for Métis and Inuit Visibility:** - Decolonization efforts often focus on First Nations, leaving Métis and Inuit perspectives out. **Need for Indigenous Staff and Faculty:** - Progress requires more Indigenous staff and faculty. - Faculty should reflect on their worldviews to transform education. **Challenges with Curricular Change:** - Indigenous studies often follow colonial processes. - Education delivery needs to be decolonized and Indigenized. **Student and Patient Impacts:**	2020

	- Western education disconnects Indigenous professionals from their cultural roots. - Decolonized education benefits both students and patients. **Structural Challenges with Elder Engagement:** - Cultural protocols must be followed. - Policy changes needed for fair honoraria, catering flexibility, smudging allowances. SOURCE	
• Concepts of cultural safety and patient experiences • Barriers to cultural safety • Gaps in research and practice	**Strategies that support cultural safety for First Nations people in aged care in Australia: An integrative literature review (35)** The purpose of this literature review was to detail key aspects relevant to Cultural Safety for First Nations peoples supported by aged care services in Australia. Thirteen Australian studies published between 2011 and 2020 were included in the review. The results were synthesized into the themes outlined below. **Barriers to Healthcare:** - Complex systems, lack of transport, long waits, ineffective virtual services. - Shame, stigma, past negative experiences, language barriers. - Poor provider communication (jargon, unclear care plans). **Racism and Discrimination:** - Common in healthcare, worsens mental & physical health. - More pronounced in rural areas, affects provider attitudes & cultural understanding. **Health Impacts:** - Poor access and care quality lead to care avoidance. - Aboriginal Medical Services provide better outcomes. - Cultural connections essential for well-being. **Workforce Gaps:**	2023

	- Limited provider knowledge, shortage of First Nations workers. **Recommendations:** - Recruit and retain First Nations staff, involve family/community. - Provide Cultural Safety and spiritual well-being training. - Ensure First Nations input in health care improvement strategies. - Support well-being through cultural events, family access, and culturally responsive staff. SOURCE	
• Concepts of cultural safety and patient experiences	**Indigenous Australians' Experiences of Cancer Care: A Narrative Literature Review (36)** This literature review explored Indigenous patient's experiences of cancer care in the Australian healthcare system from the patient's perspective. The review included 23 studies published between 2000 and 2022. The findings were synthesized into three themes described below. **Communication:** - Language and literacy barriers reduce understanding, lead to missed appointments. - Rural patients face confusion and anxiety in unfamiliar hospital environments. - Lack of discharge and medication information; more support needed for families/carers. **Cultural Safety:** - Poor continuity of care and alienating hospital environments reduce trust. - Concerns over privacy, medical staff intrusion. - Racism, unsympathetic communication, and absence of cultural practices worsen cultural safety. **Access to Services:** - Long wait times and delays in diagnosis, especially for rural patients. - Follow-up care issues due to staff turnover and lack of coordination. - Poor coordination between primary and tertiary care, ignoring rural living challenges. SOURCE	2022

Scoping Reviews (n= 4)		
• Facilitators to implementing cultural safety practices • Barriers to cultural safety	**Understanding and responding to racism and the provision of culturally safe care by interdisciplinary health professionals in the aged care sector in regional, rural and remote areas: a scoping review (37)** This scoping review included 10 articles published in Australia, Canada, the United States, England, and Norway with only one articles published in England and Norway. The aim of the review was to obtain conceptual clarification about how racism and cultural safety are understood by interdisciplinary health professionals in the aged care sector in regional, rural and remote areas. However, the authors also identified barriers and facilitators to providing culturally safe care which are highlighted below. **Although the review includes discussion of First Nations' people, it is unclear how many of the included studies focused on Indigenous populations.** **Barriers to Culturally Safe Care:** - Limited cultural education for healthcare providers. - Minimal integration of Indigenous culture in daily practices. - Reluctance to discuss cultural matters due to confidentiality concerns and fatigue. - Language barriers. - Lack of cultural competency among providers. **Facilitators of Culturally Safe Care:** - Patient-centered goals focused on quality of life. - Care plans acknowledging traditional and transient lifestyles. - Trust, authenticity, respect, and sensitivity in provider-patient relationships. - Providers representative of the served population. - Effective communication between health services, staff, families, and communities. - Cultural brokers facilitating mutual understanding. - Positive relationships with healthcare services increase care-seeking behavior. SOURCE	2024

• Cultural safety practices: organizational-level • Audit tools and evaluation	**Indigenous Cultural Safety Training for Applied Health, Social Work, and Education Professionals: A PRISMA Scoping Review (38)** This scoping review included and extracted 134 studies published between 1996 and 2020 to synthesize the academic literature on how CST programs are developed, implemented, and evaluated in the applied health, social work and education fields in Canada, United States, Australia, and New Zealand. The findings are highlighted below. **Education Methods:** - Multi-modal; common sources include lectures, discussions, and community visits. - Less common: storytelling, online practice, case studies, and workbooks. **Duration:** - Varied from months-long immersion to semester-based courses; details often missing. **Instructors:** - Professors (36%), health professionals (30%), Indigenous elders/community (28%). Half of programs involved Indigenous educators. **Evaluations:** - 45% assessed, mainly learner experiences (31%); rarely examined Indigenous perspectives (2%) or care outcomes. **Gaps:** - Few papers had Indigenous authors or specified the relevant Indigenous population. Indigenous roles in training development and delivery were often unclear. Greater inclusion of Indigenous voices is needed in cultural safety training design. SOURCE	2023
• Cultural safety practices: organizational-level	**Identifying methods to best integrate indigenous knowledge and perspectives within the radiation therapy undergraduate curriculum (39)**	2023

• Audit tools and evaluation	This scoping review identified 21 studies published between 2017 and 2021. The synthesized findings highlighted various assessment tools for measuring cultural capabilities in Indigenous Australian contexts and several recommendations for integrating Indigenous knowledge and perspectives into undergraduate radiation therapy curriculum at Queensland University of Technology. Included studies were from practice-based medical professions including mix of undergraduate students and qualified practitioners from the disciples of nursing, midwifery, podiatry, dentistry, medicine and social work. Three assessment tools (Cultural Capability Management Tool (CCMT), Trans-Cultural Self Efficacy Tool (TSET) and a Cultural Competence Clinical Evaluation Tool (CCCET)) measured cultural capability in Indigenous Australian contexts, tracking student progress and guiding curriculum development. **Recommendations:** - Use Indigenous patient scenarios to identify barriers/enablers to culturally safe care. - Contrast culturally safe vs. unsafe care examples to deepen understanding. - Invite guest Indigenous patients for first-hand experiences in workshops. - Create environments where students can express uncertainty and learn culturally informed strategies. - Recognize the role of student emotion and discomfort in transformative learning. - Implement yarning circles* for professional development and clinical learning. - Collaborate with Indigenous education consultants for development and quality control. - Offer reflective practice opportunities and discussions on power, privilege, racism, and disparities. - Use pre-post tools for ongoing reflexive practice. *A Yarning Circle is a process used by Aboriginal and Torres Strait Islander peoples to learn, share, build respectful and caring relationships, pass on cultural knowledge through storytelling, and come together as a community. SOURCE	
• Cultural safety practices: organizational-level	**Curriculum Indigenization in oral health professions' education worldwide: A scoping review (40)**	2024

• Facilitators to implementing cultural safety practices • Barriers to cultural safety • Recommended actions and gaps	The scoping review identified 23 documents published between 1964 and 2021 (95% of which were published after 2007) on the content, delivery, assessment methods, and barriers and facilitators of on Indigenization of post-secondary education curricula for oral health professions across all post-secondary education levels. **Curriculum content:** - Primarily Indigenous culture, Indigenous oral health, and Indigenous peoples' health. - Other topics included oral health education, models of health service provision for Indigenous people, and effect of racism and colonization. **Curriculum delivery method:** - Primarily rural and clinical placements in Indigenous communities followed by lectures and seminars - Others: case based learning, group discussion, group projects, workshops **Curriculum assessment method:** - Primarily evaluation surveys - Other: written reports, assignments, reflective journals, and written examinations. - Less common: formative feedback, Objective standard clinical examination (OSCE), clinical logs **Curriculum barriers/disadvantages:** - Student disinterest as they place higher focus on building clinical skills at the expense of broader learning experiences. - Community placement challenges: lack of interaction with Indigenous peoples, isolation and separation from family. - Logistical problems, lack of Indigenous dental facilities, curriculum is already saturated with content, lack of Indigenous instructors. **Curriculum facilitators/advantages:** - Real-life experience and cultural immersion during placements and supportive mentorship. - Other factors that facilitated Indigenous training included appreciative patients and friendly communities, the voluntary nature of the program, motivated students, Indigenous guest. speakers, and having Indigenous students and students from different cultural backgrounds.	

	Gaps and key areas for improvement: - Prioritizing Indigenous perspectives. - Fostering community partnerships. - Developing standardized assessment tools. - Identifying best practices for curriculum development and delivery. - Evaluating long-term impact of programs on health outcomes for Indigenous populations. SOURCE	
Systematic Reviews (n= 3)		
• Cultural-safety practices: Organizational-level	**Deep-Structure Adaptations and Culturally Grounded Prevention Interventions for Native Hawaiians: a Systematic Review of the Literature (41)** This systematic review identified 14 studies published between 205 and 2020 pertaining to the development and/or evaluation of prevention interventions for Native Hawaiians in the United States. The evaluated studies developed using deep-structure adaptation or culturally grounded procedures, and primarily focused on prevention of substance use, obesity/diabetes, and pregnancy/sexually transmitted infections. Most studies were in their development and implementation phase, and did not provide evaluation data. The main finding of the review was that Native Hawaiian interest groups were engaged in adapting mainstream interventions to culturally adapt them for Native Hawaiian populations. SOURCE	2021
• Concepts of cultural safety and patient experiences	**What Is the Evidence Globally for Culturally Safe Strategies to Improve Breast Cancer Outcomes for Indigenous Women in High Income Countries? A Systematic Review (42)** This systematic review identified fifteen articles published in unspecified dates in Australia, Canada, and the United States on the role of culture in improving breast cancer outcomes for Indigenous women. The results were organized into three themes outlined below.	2021

	Cultural Conceptions of Cancer: - Some Indigenous cultures lack a word for cancer, linked to fear and denial. - Cancer discussions are avoided to prevent inviting illness. - Isolation prevents cancer conversations and care access. - **Recommendation:** develop culturally appropriate language for screening and treatment. **Service Access:** - Lack of knowledge, shame, and mistrust hinder service access. - Education tailored to culture and literacy is key to improving participation. - Financial, childcare, and transport barriers limit preventive care. **Family and Community Support:** - Families need information to encourage screening. - Negative family views can prevent participation. - Viewing screening as beneficial for future generations can drive engagement. - Family involvement increases support and health literacy. SOURCE	
• Cultural safety practices: Organizational-level	**Teaching Cultural Competence in Dental Education: A Systematic Review and Exploration of Implications for Indigenous Populations in Australia (43)** This systematic review identified 12 studies published in the United States and Canada between 2004 and 2015 on teaching cultural competence in dental education and to explore the particular relevance of that teaching for the oral health care of Indigenous populations in Australia. The five themes identified in the review are briefly summarized below. **Curriculum Content:** - Focus on cultural competence, biases, health disparities, and diversity in healthcare. - Students should understand diverse needs and communicate across cultures.	2021

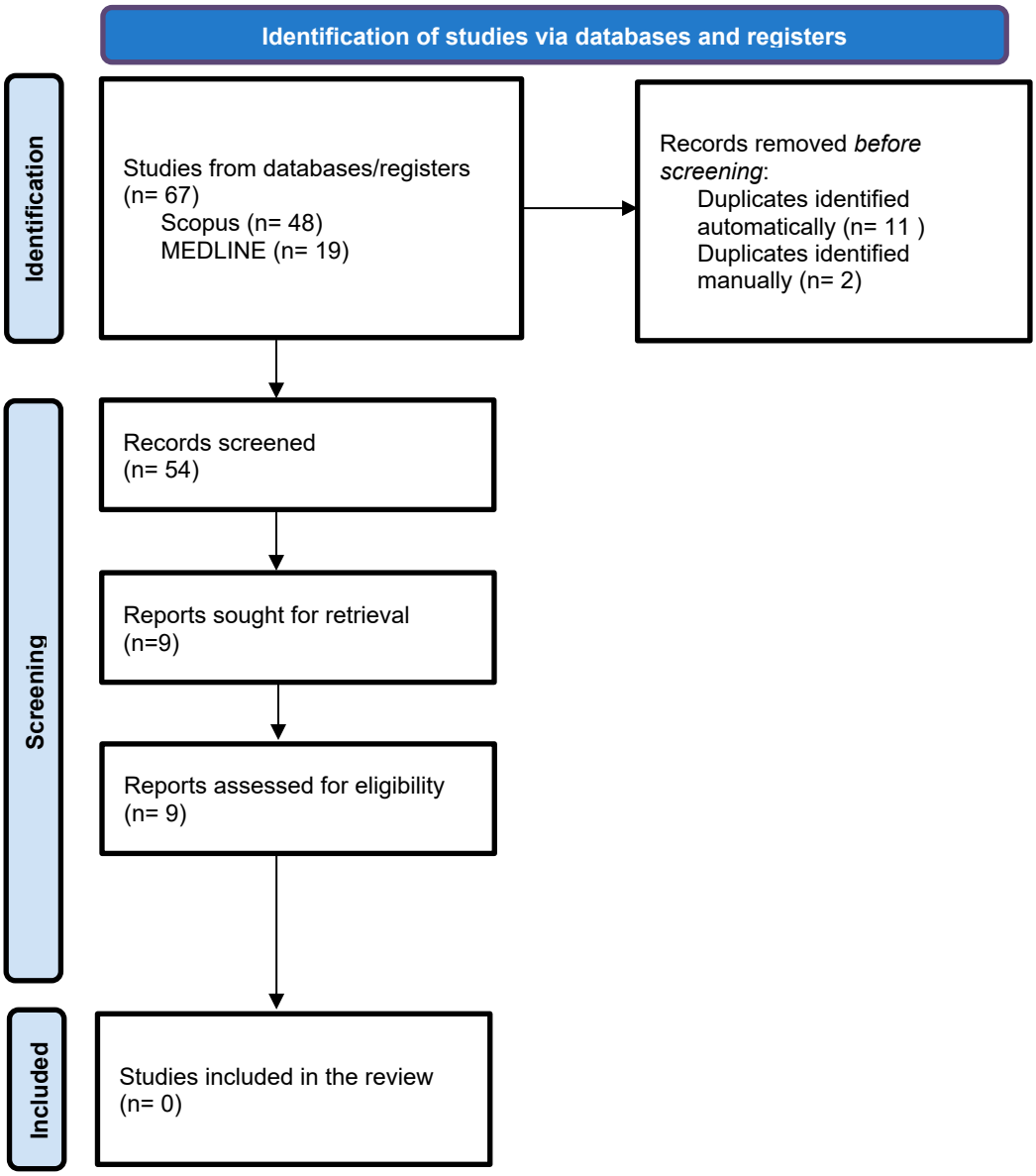
	Curriculum Delivery: - Web-based: Flexible, self-paced, solid content, but lacks peer interaction. - Seminar-based: Interactive, co-learning, but uneven participation. - Delivery Time: Shorter, more frequent sessions preferred. **Community Service Learning:** - Clinical-focused: Tension between altruism and practice in underserved areas. - Non-clinical-focused: Improved cultural competence but reduced willingness to treat public patients. **Reflective Writing:** - Raises awareness of privilege and culture, challenging stereotypes and beliefs. **Evaluation:** - Focuses on student perceptions, not patient care. - Lack of consensus on cultural competencies limits measurement tools. SOURCE	

Appendix F: Documents Excluded at the Final Stage of Reviewing

Type of Document	Hyperlinked Title
Systematic Review	Experiences of the HIV Cascade of Care Among Indigenous Peoples: A Systematic Review
Systematic Review	Systematic review of interventions for Indigenous adults with mental and substance use disorders in Australia, Canada, New Zealand and the United States
Scoping Review	The Role of Cultural Safety Within a Human Rights-Based Approach to Improve Indigenous Peoples' Health: A Scoping Review
Scoping Review	The Implementation and Evaluation of Health Promotion Services and Programs to Improve Cultural Competency: A Systematic Scoping Review
Scoping Review	Indigenous Peoples and Occupational Therapy in Canada: A Scoping Review
Scoping Review	Health workforce cultural competency interventions: a systematic scoping review
Narrative Literature Review	Investigating the processes used to develop and evaluate the effectiveness of health education resources for adult Indigenous people: A literature review

Appendix G: PRISMA Diagrams Populated by Covidence

Search #1 for Primary Studies on Military Health Systems and Cultural Safety



Search #2 for Reviews on Civilian Health Systems and Cultural Safety