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Systematic Review

Interventions to improve Cultural Safety in healthcare in CANZUS countries: a systematic mixed studies review of First Nations Peoples' experiences

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Abstract

Background: **Assessing patient perspectives is fundamental to determining whether anti-racism and cultural training programs and services associated with an intervention achieve their intended outcomes, yet reviews frequently focus on health provider perspectives. This systematic review, therefore, aimed to investigate First Nations Peoples' experiences, as patients, of interventions to improve their Cultural Safety and experiences in secondary and tertiary healthcare settings.**

Methods: **American Psychological Association's PsycInfo (via EBSCOhost), Cumulative Index to Nursing and Allied Health Literature Complete (via EBSCOhost), PubMed, and Scopus (via Elsevier) were all searched from inception to 9 December 2025. Eligible intervention studies needed to report the experiences of First Nations' people as care recipients in secondary and tertiary healthcare settings. Eligible study countries were Australia, Canada, Aotearoa (New Zealand), and the United States of America (USA). General study quality was assessed using the Mixed Methods Appraisal Tool. Study quality was also examined with a modified version of the Aboriginal and Torres Strait Islander Quality Appraisal Tool to provide a First Nations perspective. Qualitative meta-aggregation was conducted to synthesize both qualitative and quantitative data.**

Results: **There were 22 reports (11 qualitative, 7 quantitative, and 4 mixed methods) of 20 eligible studies, including 2092 First Nations care recipients. Interventions and quantitative outcomes were heterogeneous, precluding meta-analysis. Four studies reported on cultural training for health professionals, with the remainder service-level interventions. The qualitative meta-aggregation resulted in six synthesized findings, which reflected the mechanisms by which these programs worked and their outcomes. Four synthesized findings described mechanisms. These included emotional and practical support; acknowledgement, respect, and support for culture; feeling accepted, heard, valued, safe, comfortable, and respected; and navigating treatment and the system. The two synthesized findings related to outcomes concerned perceptions of health services and, relatedly, impacts on health service access. Quality appraisal revealed no discussion of existing and newly created intellectual property considerations. Study limitations included undefined terminology, terms being used interchangeably, and a few studies from the USA and Aotearoa (New Zealand).**

Conclusions: **Published intervention studies assessing First Nations care recipients' experiences appear to be increasing. Future interventions must clearly define the terminology in the intervention, use mixed-methods approaches, and report intellectual property considerations.**

Trial registration: **Systematic review: PROSPERO, CRD42024521218 (prospective, available at https://www.crd.york.ac.uk/PROSPERO/view/CRD42024521218).**

Introduction

Australia, Turtle Island (Canada), Aotearoa (New Zealand), and the USA have similar settler-colonial histories [1, 2] and First Nations-specific health care services [3–8]. The suboptimal treatment in healthcare settings in these countries that First Nations people experience includes racism [9–13], discrimination [14], bias [15, 16], and prejudice [17], reflecting historical

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and ongoing colonization. Racism has been defined as organized systems in societies that cause avoidable and unfair inequalities in power, resources, capacities, and opportunities between racial or ethnic groups, manifesting through beliefs, stereotypes, prejudices, or discrimination [9]. In response, programs to reduce these negative experiences have tried to improve the cultural awareness [18], competence [19], respectfulness [20], safety [21], security [22], and appropriateness of health service staff and systems.

Several reviews of these concepts and programs have been published recently (2021–4). One meta-ethnographic review of qualitative studies focused on Culturally Safe healthcare practices for Aboriginal and Torres Strait Islander Australians [23]. Two reviews on Cultural Safety have focused on training interventions for healthcare professionals [21] and initiatives in Australian hospital settings [24]. One review assessed Indigenous health equity interventions in emergency departments [25]. Others have reviewed racism in healthcare [10] and anti-racism interventions in outpatient healthcare settings [11].

One limitation of these reviews was that none, to our knowledge, focused solely on First Nations' experiences of these interventions as patients. The only empirical studies of anti-Indigenous racism interventions [26–28] located in one review [11] collected data from healthcare staff. One review [10] located no anti-racism interventions assessing patient perspectives. Lastly, two reviews [21, 25] located only three studies [29–31] assessing patient experiences. However, this is an issue, as patients are the rightful determiners of the success of interventions. With the concept of Cultural Safety, for instance, care recipients, not caregivers, determine if Cultural Safety exists [32–34]. Clinician self-assessment is poorly correlated with observed measures of competence [35, 36]. To gain critical understandings of whether and how these interventions work, evaluations must include First Nations' patient perspectives.

Therefore, this review aimed to investigate First Nations patients' experiences of interventions to improve Cultural Safety and experiences of care in secondary and tertiary healthcare settings in these four countries. In addition to strengthening the literature, the rationale for this research emerged from priorities in multiple countries. In Australia, Priority eight of the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031—Framework* [37] is to improve the health system by identifying and eliminating racism. A sub-objective is to improve Cultural Safety training across mainstream health services and settings [37]. In Canada, Call 23iii. in the Truth and Reconciliation Commission requests that all levels of government provide cultural competency training for all healthcare professionals [38]. The Aotearoa *New Zealand Health Strategy 2023* [39] notes the need to tackle racism and discrimination at all levels in the health system. Addressing racism is also an outcome in four other Aotearoa (New Zealand) plans [40]. One strategic goal in the Indian Health Service's *Strategic Plan for Fiscal Years 2025–2029* was the need to ensure comprehensive, culturally respectful health care services [41]. One priority area in the National Indian Health Board's *2024 Legislative and Policy Agenda for Indian Health* [42] was increasing access to quality health care. Another was supporting an empowered and culturally informed health workforce. The studies included in this review will also inform an anti-racism intervention in an Australian hospital.

Methods

Study design: systematic mixed studies review

This review's protocol was registered on PROSPERO [43]. The abstract was reported per the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2020 extension for abstracts [44, 45] (Supplementary Table S1). This manuscript was reported per the PRISMA 2020 Statement [45] (Supplementary Table S2), and the PRISMA literature search extension, PRISMA-S [46] (Supplementary Table S3).

Eligibility criteria

Inclusion criteria for studies were as follows: Studies with First Nations participants that documented provider-, service-, or system-level interventions to improve Cultural Safety and the experience of care for First Nations patients in CANZUS countries. Eligible interventions needed to aim to reduce racism, bias, stereotypes, prejudice, or discrimination; or promote cultural awareness, competence, humility, respect, safety, security, sensitivity, or understanding. Any comparison group was eligible. Outcomes of interest were any patient-reported experiences. Interventions could be of any duration, published during any period. Settings could be secondary (e.g. specialist care) or tertiary (e.g. hospital), including outreach services or community-based facilities linked to these institutions.

Information sources

A.v.d.B. searched four databases without limits on 11–13 February 2024, and S.L. updated searches on 9 December 2025. Studies included in previously published reviews of the same concepts were also retrieved for screening. Databases and platforms included APA PsycInfo (EBSCOHost), Cumulative Index to Nursing and Allied Health Literature Complete (EBSCOHost), PubMed, and Scopus (Elsevier). https://osf.io/fbj6y/?view_only=351f3242aad84371989d3f826e94a8a3 lists all search terms. The search structure combined terms for First Nations populations, intervention content (e.g. anti-racism), interventions (e.g. intervention OR strateg*), and terms for the setting (e.g. hospital* OR 'secondary health centre*'), using both free-text searches of titles and abstracts and controlled vocabulary.

Search strategy

A university librarian reviewed the PubMed search terms, providing feedback (available at https://osf.io/fbj6y/?view_only=351f3242aad84371989d3f826e94a8a3) per the Peer Review of Electronic Search Strategies 2015 guideline statement [47]. A.v.d.B. translated the modified PubMed search manually to the other databases.

Study selection process

A.v.d.B., S.L., and S.S. independently screened titles, abstracts and full-text records in Covidence [48]. If conflicts emerged, screeners arrived at a consensus via discussion.

Data extraction process

A.v.d.B., S.L., and J.W. independently extracted data in Microsoft Excel [49]. Consensus over discrepant extractions was reached after discussion. General information extracted included the author(s). Information on participants extracted included group(s) of participants, population eligibility criteria, sample size, and percentage of First Nations patients. For interventions, information on intervention types, strategy (single- or multi-strategy), level (institutional and/or personally mediated), and the terminology describing the intervention was extracted. Information on outcomes extracted included the study outcomes and quantitative findings. Information on context included the country where the study occurred and the setting. A.v.d.B. also extracted, and S.L. checked data on the study aim, study design, and data collection method.

Quality appraisal

A version of the Aboriginal and Torres Strait Islander Quality Appraisal Tool (QAT) [50, 51] modified [52] for studies with First Nations people in other countries was used. The questions 'encompass setting appropriate research questions; community engagement and consultation; research leadership and governance; community protocols; intellectual and cultural property rights; the collection and management of research material; Indigenous research paradigms; a strength-based approach to research; the translation of findings into policy and practice; benefits to participants and communities involved; and capacity strengthening and two-way learning' [50].

Study quality was also appraised with version 2018 (3rd version) [53, 54] of the Mixed Methods Appraisal Tool (MMAT) [55]. Two authors of A.v.d.B., S.L., and J.W. independently applied both, reviewing discrepancies individually before meeting to resolve them. Findings from both appraisals were visualized using a Shiny application [56].

Qualitative synthesis methods

Following guidance for mixed-methods systematic reviews [57], a convergent integrated approach was used to combine qualitative and quantitative studies. This required 'qualitizing' the quantitative data by transforming the results of quantitative studies into textual descriptions [57]. One author of A.v.d.B. and S.L. qualitized the quantitative data in the included studies from the first and second searches, respectively, and the other checked these findings.

A.v.d.B. and S.L. independently used qualitative meta-aggregation [58], following recent guidance [59], to synthesize the data, resolving discrepancies via discussion.

The data synthesis involved three steps. A.v.d.B. and S.L. first extracted all findings from included studies with accompanying illustrations and assigned plausibility levels for each finding. Findings were then developed for categories, consisting of two or more findings per category. Synthesized findings comprising two or more categories were then developed.

Author-derived themes, metaphors, and observations were considered findings. Unsupported findings were removed from the synthesis. We grouped the categories into synthesized findings if concepts were similar. Where author-derived themes did not reflect the quotes (plausibility rating of equivocal), we categorized based on the quote to prioritize patient perspectives.

Results

Searches retrieved 6683 records and 22 reports [30, 60–80] of 20 studies met the eligibility criteria (Fig. 1). https://osf.io/fbj6y/?view_only=351f3242aad84371989d3f826e94a8a3 lists studies excluded at full text with exclusion reasons.

Table 1 reports the characteristics of included studies. There were 11 reports [61–63, 65–67, 73–75, 78, 79] of 10 qualitative studies, 7 reports [30, 64, 69–72, 80] of 6 quantitative studies, and 4 mixed-methods [60, 68, 76, 77] studies, including 2092 participants. Twelve studies occurred in Australia [60, 62–66, 68, 74, 76, 78–80], five in Turtle Island (Canada) [21, 30, 61, 66, 72], two in the USA [67, 70], and two in Aotearoa (New Zealand) [73, 77].

Types of interventions

Intervention types varied (Supplementary Table S5). The most common concepts mentioned were Cultural Safety ($n = 15$) [30, 60, 62, 64–66, 68–71, 74–76, 78, 79], cultural competence ($n = 8$) [60, 62, 64, 65, 70, 71, 74, 75], or cultural appropriateness ($n = 8$) [63, 73–78, 80]. Three studies each mentioned cultural awareness [65, 68, 76], sensitivity [61, 65, 78], and responsiveness [60, 65, 80]. Cultural security [65], cultural humility [66], and anti-Indigenous race bias [69] were each mentioned in one study. Seven studies [60, 62, 65, 71, 74–76, 80] mentioned multiple cultural concepts. Only one study [60] explicitly defined the concept studied.

First Nations patients' experiences after receiving interventions

Qualitative meta-aggregation produced six synthesized findings, comprising 28 categories, 131 findings, and 237 illustrations (Table 2). Three findings from one study [67] and 23 findings from two reports [74, 75] of another study were unsupported, as there were no accompanying quotes to serve as illustrations [67, 75], or it was unclear which theme the quote illustrated [74]. Eighteen were equivocal (findings open to challenge) and 114 were unequivocal (findings beyond reasonable doubt).

The 6 synthesized findings (Table 2) described program mechanisms and outcomes. The four describing program mechanisms covered support needs. They included (1) emotional and practical support; (2) acknowledgement, respect, and support for culture; (3) feeling accepted, heard, valued, safe, comfortable, and respected; and (4) navigating treatment and the system. The outcomes concerned (1) perceptions of health services and (2) impacts on health service access.

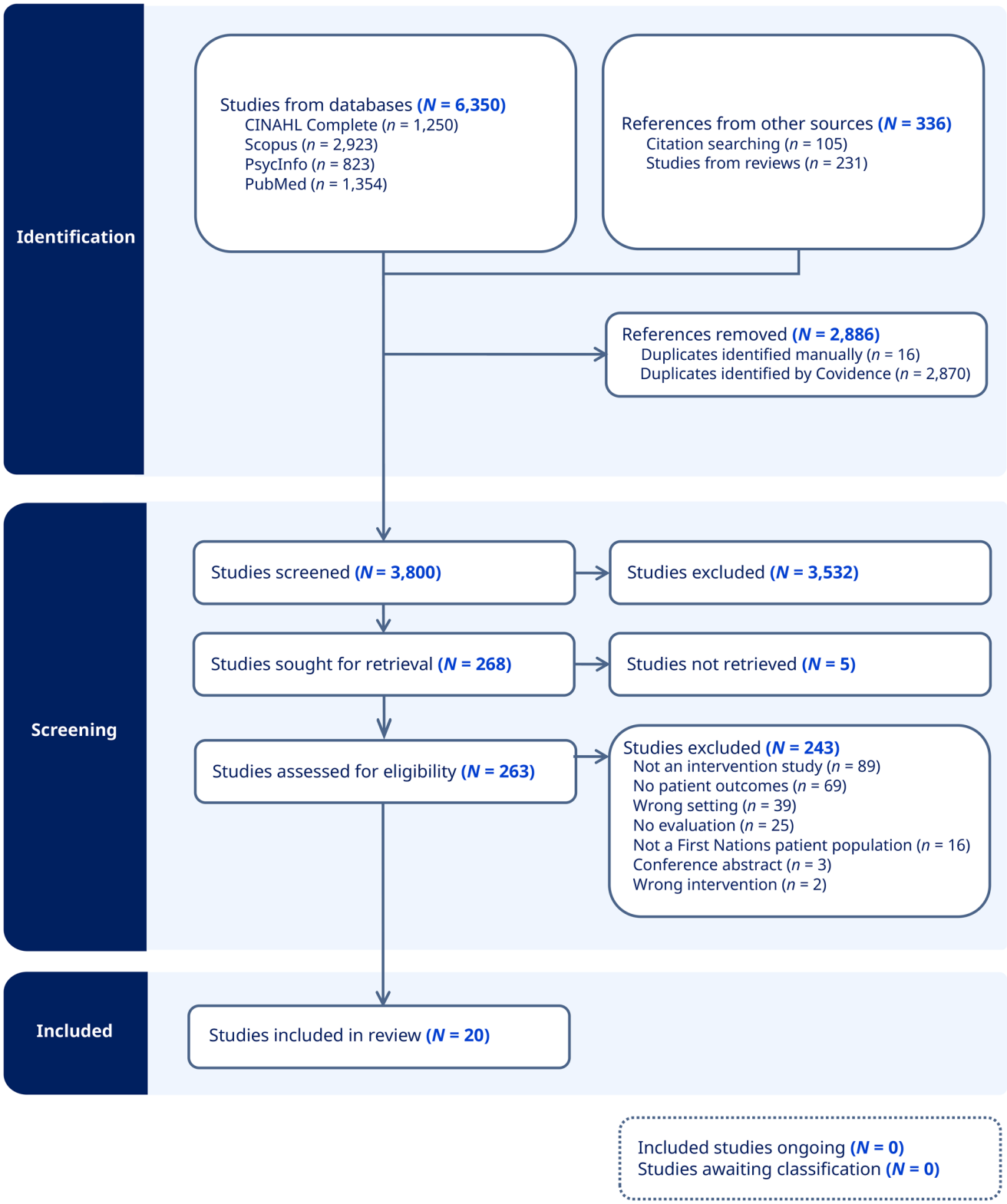

Figure 1 PRISMA flow diagram of study selection.
Source: Generated in Covidence, and adapted from Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

Emotional and practical support was evident in an Indigenous birth support worker program in a maternal care centre in a Children's hospital in Saskatchewan, Canada:

'*The girls [IBSW] are super friendly and easy to get along with, so that was nice. My husband wasn't able to be in the hospital much. So, they came in, so I wasn't alone as much. And they had taught me how to bead, so that was nice to have something to do while I was just sittin' around. Then they would run and grab me snacks and stuff if I needed it*'. [66, p. 5]

In contrast, it appeared the need for emotional support was sometimes unmet in an intervention of a pathway to address

Table 1 Characteristics of included studies.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Arora et al., 2013 [61]	Remote tele-ophthalmology clinic serving patients from Wood Buffalo, a Cree community in Northern Alberta, Canada	'to determine whether tele-ophthalmology services, provided to Aboriginal Canadians in a culturally-sensitive community-based clinic, could overcome social and cultural barriers in ways that would be difficult in the traditional hospital-based setting' [61, p. E57]	Qualitative, interviews	Aboriginal patients	5 patients; not reported—presumably 100%	Tele-ophthalmology clinic with a focus on educating Aboriginal people about diabetes, healthy lifestyle choices while providing medical screening tests. Nurses fluent in Cree were hired from the local communities. Religious/ cultural artefacts were included in clinic screening protocols. Before and after every clinic, ceremonies were held under the guidance of an invited spiritual leader from the community.
Bernardes et al., 2017 [63]	A major public hospital in Queensland, Australia	'to describe and reflect upon the experience of training an IPN [Indigenous Patient Navigator] and implementation of the intervention in the Australian context with Indigenous cancer patients' [63, p. 1]	Qualitative—survey with seven closed and five open-ended questions	Patients 18 years and over who had a cancer diagnosis and identified as Aboriginal and/or Torres Strait Islander	18 patients; 100%	The Indigenous Patient Navigator: the IPN combines patient navigation, cancer education, and communication coaching to improve patient outcomes for Indigenous people diagnosed with cancer.
Bertilone et al., 2017 [60]	Aboriginal Maternity Group Practice Program in south metropolitan Perth, Australia	'To identify elements of the Aboriginal Maternity Group Practice Program that contributed to the provision of a culturally competent service' [60, p. 121]	Qualitative—surveys with clients	Clients of the Aboriginal Maternity Group Practice Program	16 clients; 100%	Multicomponent 'Aboriginal Maternity Group Practice Program': grandmother role, Aboriginal online cultural learning package and cultural awareness training.

(Continued)

Table 1 Continued.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Blignault et al., 2021 [65]	An Aboriginal Transfer of Care model from hospital (Campbelltown and Liverpool Hospitals in Sydney, Australia) to primary care	'to explore patient, family and service provider experiences and views and to document and refine the model of care for Aboriginal adults with chronic conditions.' (p. 2) [65, p. 2]	Qualitative—semi-structured interviews	Aboriginal patients and their family/carers	8 patients; 100%	The Aboriginal Transfer of Care model: Transfer of care planning by a multidisciplinary team; Ensuring the patient and their family understand the follow-up care plan; ensuring patient's General Practitioner or Aboriginal Medical Service is aware of any follow-up arrangements; ensuring referrals are organised with community providers; ensuring the patient has the necessary medications, equipment and written patient summary information prior to transfer of care.
Brown et al., 2015 [80]	Metropolitan and regional Aboriginal Family Birthing Program services in South Australia	'1) to compare experiences and views of women attending standard (mainstream) models of antenatal care with those accessing care via the AFBP; 2) to assess factors contributing to early and continued engagement with antenatal care; and 3) to use this information to inform the strengthening of services for Aboriginal families' [80, p. 29]	Cross-sectional survey, conducted via interviews or self-completion of an interview booklet	All women who gave birth to an Aboriginal and/or Torres Strait Islander baby in South Australia between July 2011 and June 2013, excluding women under 14 years of age	344; 93% Aboriginal and/or Torres Strait Islander	Community consultation and engagement in the establishment of the program; creation of a new Aboriginal Maternal Infant Care (AMIC) worker position in a leadership role within maternity services; partnerships and skill exchange between AMIC workers and midwives; education and training for AMIC workers in antenatal, intrapartum, and postpartum care; and a commitment to providing both high-quality primary health care and continuity of caregiver for women and families [80, p. 28]

(Continued)

Table 1 Continued.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Conway et al., 2013 [62]	Mobile dialysis truck in remote north-west South Australia, Australia	'to qualitatively evaluate the South Australian Mobile Dialysis Truck program, its impact on the health and wellbeing of Indigenous dialysis patients, and the facilitators and barriers to using the service.' (p. 1) [62, p. 1]	Qualitative—yarning with patients	Indigenous haemodialysis patients	15 Indigenous patients; 100%	A mobile dialysis truck, allowing Indigenous dialysis patients forced to relocate for dialysis to visit or remain in their home communities for significant events (such as funerals and cultural ceremonies) and to spend time with family and friends.
Davison et al., 2024a [74] and 2024b [75]	Urban emergency department in Queensland, Australia	'primarily aimed to improve culturally competent care to reduce the number of First Nations patients presenting to a Queensland ED who 'Take own leave' (TOL). The secondary aim was to evaluate the implementation project.' [75, p. 554]	A pre-/post-test quasi-experimental study design using mixed methods, although patient-reported outcomes come just from the qualitative component—yarns (interviews)	Aboriginal patients in ED Information system presentation data	85; 100%	Care pathway: 1. Early, culturally safe engagement and information sharing. 2. Clinical screening of TOL patients (48–72 h Follow-up call). 3. Enhancing connections and supports through increased referrals to Indigenous Health Liaison Officers and community services.
Di Lallo, 2014 [71] and Aboriginal Prenatal Wellness Program, 2008 [72]	Clinic in Wetaskiwin, Alberta, Canada	Not reported	Uncontrolled before-after study, although only post-intervention findings reported—survey	Participants of the Aboriginal Prenatal Wellness Program	281; 100%	A team of nurses, physicians, support staff and workers from the local four Maskwacis Nations and nearby community agencies worked together to provide consistent and coordinated health care.
Druce et al., 2025 [76]	An Aboriginal and Torres Strait Islander Outpatient Clinic at a large metropolitan health service in Melbourne, Australia	To evaluate the clinic from the patient's perspective	Mixed methods: qualitative descriptive study and a cross-sectional survey	- Aged ≥18 years - Had attended the Clinic during 2024 or in the previous 12 months—had the cognitive capacity to engage in an interview	26 (11 qualitative, 15 quantitative); 100%	Tailored, inclusive, culturally safe and consumer-focused hospital outpatient service model of care specifically for Aboriginal and Torres Strait Islander clients

(Continued)

Table 1 Continued.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Guadagnolo et al., 2011 [70]	Rapid City Regional Hospital's Cancer Care Institute in Rapid City, South Dakota, USA	'To assess the impact of patient navigation (PN) on satisfaction with health care and medical mistrust among American Indians (AI) undergoing cancer treatment.' [70, p. 1]	Uncontrolled before-after study, survey	American Indian (Oglala, Rosebud, and Cheyenne River Sioux Tribes) patients presenting for cancer treatment	52; 100%	Culturally tailored patient navigation program
Hatcher et al., 2016 [77]	Emergency departments in seven hospitals in three District Health Boards in New Zealand	'to see if a package of interventions delivered in a culturally appropriate way improved outcomes at one year in Maori who presented with intentional self-harm to emergency departments.' [77, p. 885]	Zelen randomized controlled trial; self-rated scales and qualitative interviews	- Presented through the emergency department of one of the hospitals involved in the study following an episode of self-harm. Exclusion criteria: • Aged under 17 • Were still at school • Were unable to give informed consent to be part of the study	365; 100%	The intervention included regular postcards, problem-solving therapy, patient support, risk management, improved access to primary care and cultural assessment in addition to usual care.
Kerrigan et al., 2021 [79]	360-bed tertiary referral hospital in the NT capital city, Darwin	'to present Aboriginal language speaking patient experiences and perspectives of hospital care when access to interpreter-mediated communication is consistent'	Qualitative—interviews	Aboriginal patients who spoke an Aboriginal language as their first language were hospitalized for a minimum 5-day period and were able to consent to participate	4 patients; 100%	Access to interpreters

(Continued)

Table 1 Continued.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Kildea et al., 2012 [68]	Indigenous-specific antenatal 'Murri Clinic' in a tertiary hospital in Brisbane, Australia	'to identify the strengths and challenges of the Murri Clinic and make recommendations for future development. The objectives were to utilise a participatory approach to undertake a process and impact evaluation by performing a retrospective analysis of maternal and neonatal health data and seeking feedback from service users, staff and other stakeholders.' [68, p. 2]	Mixed-method post-intervention survey approach—individual and focus group interviews, surveys, mother and infant audit data and routinely collected data (from hospital databases)	Murri Clinic service users	Qualitative: 46 service users (38 completed surveys, eight interviews) Quantitative - 367 women attending the Murri Clinic and 414 (Indigenous) women attending standard care; up to 100% (some women attending the Murri Clinic had an Indigenous partner)	The 'Murri Clinic': a specialist antenatal Indigenous-specific clinic with a hospital-employed Indigenous midwife and Indigenous liaison officers
Masters-Awatere and Graham, 2019 [73]	Whānau (family) of Tamariki Māori (children of Māori heritage) admitted to Waikato Hospital regarding their experience of hospital care in Aotearoa (New Zealand)	'to explore the health-related experiences of whanau Māori with a child aged 0–5 years admitted to hospital during the research period (July–November 2018)' [73, p. 471]	Qualitative—in-depth interviews with participants from the mixed-methods randomised controlled trial	Whānau of tamariki Māori aged 0–5 years admitted to the hospital and whose hospital admission included experience of the Harti tool and whānau who experienced usual care; whānau had to meet at least one criterion for Aotearoa's (New Zealand) domains of deprivation	15: 7 whānau whose hospital admission included experience of the Harti Hauora Tamariki tool and 8 whānau who experienced usual care; not reported—presumably 100%	Utilization of the Harti tool (a whānau ora-based assessment instrument designed to reduce health inequities) during inpatient care and delivered by research assistants using a Kaupapa Māori-centred intervention.

(Continued)

Table 1 Continued.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Pandey et al., 2023 [66]	Jim Pattison Children's Hospital Maternal Care Centre in Saskatoon, Saskatchewan, Canada	'to explore the perspectives of the IBSWs [Indigenous Birth Support Workers] and program clients one year postimplementation.' [66, p. 2]	Qualitative—interviews and focus groups	Clients of Indigenous Birth Support Workers	10 clients; not reported, presumably 100% (or less if Indigenous babies born to non-Indigenous mothers)	The Indigenous Birth Support Workers Program provides Indigenous women with respectful, culturally safe, and trauma-informed care throughout labour, delivery and postpartum
Peake et al., 2024 [64]	The Operating Theatre of Royal Darwin Hospital, Northern Territory, Australia	To assess the acceptability and potential benefits of introducing personalized, Indigenous art-themed reusable theatre caps (including name and role) for staff in the Operating Theatre at Royal Darwin Hospital on the patient perioperative experience	Uncontrolled before-after-study with historical control group—surveys	Surgical patients	9 Indigenous patients completed the pre-intervention survey, and 14 Indigenous patients completed the post-intervention-survey; 100%	Personalized operating theatre caps with staff name and role and Indigenous artwork.
Reilly et al., 2018 [78]	Major metropolitan hospital in South Australia	'The qualitative component of CanDAD sought to understand the experiences of Aboriginal people as they interact with the health system. This included identifying gaps in care and exploring the impact of the various components of current cancer care provision (including care coordination) on Aboriginal patients' pathways from multiple perspectives.' [78, p. 929]	Qualitative study involving face-to-face semi-structured interviews	Aboriginal people with experience of cancer as patients	29 were Aboriginal patients or cancer survivors	Care coordination

(Continued)

Table 1 Continued.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Smylie et al., 2024 [69]	13 family medicine clinics and one emergency department across four large teaching hospitals in or near Toronto, Canada	'to compare the clinical impacts of intensive and brief ICS [Indigenous cultural safety] training to control, and to assess the feasibility of ICS training evaluation tools, including unannounced Indigenous standardized patient (UISP) visits' [69, p. 1]	Randomized controlled trial using surveys	Academic physicians, resident physicians, and nurse practitioners. Participants needed to identify as non-Indigenous and be committed to remaining in their current clinical setting for a minimum of 1 year post-recruitment. Exclusion criteria: Anyone who had already completed a San'yas Indigenous Cultural Safety training program. Physician leads at each site, who were unmasked to the study to facilitate its conduct.	58 health professionals and 9 Indigenous actors; 100% of evaluators	Intensive intervention: 'There are three purposefully sequenced content areas: history and current experiences of First Nations, Inuit, and Metis peoples; self-location; and cultural safety skills building. The brief anti-bias intervention is a 45-min interactive, computer-based education session focused on recognising and addressing anti-Indigenous race bias followed up with two re-enforcement/reminder emails that ask questions about strategy usage at six and eight weeks after the session'.

(Continued)

Table 1 Continued.

Author and year of publication	Setting and context	Study aim	Study design and data collection	Participants/ population eligibility criteria	Total sample size; percentage Indigenous	Intervention, tool or program
Varcoe et al., 2022 [30]	Emergency Departments at three hospitals: (1) serving an urban area, (2) serving a large suburban area, and (3) serving a region of rural, remote, and small urban communities in Canada	Not explicitly stated, but says: '"Equipping Health Care for Equity" is a study of an organisational-level intervention (in contrast to interventions aimed at individual service providers) to improve care quality at the point of care for those who face health inequities.' [30, p. 2]	Quantitative longitudinal panel design—patient and staff surveys and administrative data	Every consecutive patient over age 18 presenting to the emergency departments	560 Indigenous patients; 100% in the one subgroup analysis	Intervention activities varied in type and duration at each site. Examples include: work to improve patient way-finding, equity-oriented messaging in waiting room televisions, improving signage at triage, installing TV monitors with equity-oriented and anti-stigma messages, and partnering with the hospital's Indigenous health team and local Indigenous communities and an artist to commission and install artwork to create an improved patient environment in the waiting room.
Yukl, 1986 [67]	Indian Clinic in the Emergency Ward at Massachusetts General Hospital (MGH) in Boston, Massachusetts, United States of America	'The focus of this article will be on the author's experience as co-founder and director of the MGH (Native American) Indian Clinic'	Qualitative—case study	American Indian people attending the Indian Clinic	One group of initially 34 American Indian people; 100%	Indigenous-specific clinic

AFBP, Aboriginal Family Birthing Program; IPN, Indigenous Patient Navigator; MGH, Massachusetts General Hospital; PN, Patient Navigator.!

Table 2 Synthesized findings from the qualitative meta-aggregation.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'It's just hard. But the support worker last night, she stayed with me late, keeping me company. We talked, and she was very helpful' [66, p. 5]	**Clients' needs—expressed gratitude for the emotional assistance received during stressful times** [66, pp. 4–5]	Having company	Emotional and practical support
'Company during treatment…' [63, p. 4]	**Having someone to talk to and show compassion** [63, p. 4]		
'The girls [IBSW] are super friendly and easy to get along with, so that was nice. My husband wasn't able to be in the hospital much. So, they came in, so I wasn't alone as much. And they had taught me how to bead, so that was nice to have something to do while I was just sittin' around' [66, p. 5]	**Client's needs—Valued the one-on-one attention they received** [66, pp. 4–5]		
'It just makes me feel at ease, really at ease … I've got someone there to help me. I'm not on my own with the system' (P41, Campbelltown Hospital patient) [65, p. 8]	For many Aboriginal people living with chronic conditions, especially those with frequent hospital admissions, a sense of safety may be elusive. Two male patients admitted after a heart attack, both in their mid-30 s, were badly shaken. Having the ATOC team to provide support and the ALOs to explain what is happening and what will happen, including follow-up arrangements, is reassuring for patients and their families [65, p. 8]		
'I am going through a lot, and having some Elder support would be very effective for helping me get through this time' [66, p. 4]	**Cultural support would be valuable during difficult times** [66, p. 4]		
'So it was good having someone come in—especially if you don't have anybody up there and you are just stuck. I thought it was quite good' [Jodie] [73, p. 473]	**'This sense of "not wanting to disturb staff" left participants feeling isolated and alone. Having a RA spend time with whanau in a calm and relaxed manner while they engaged with the Harti tool was a welcome change. Participants repeatedly commented on their appreciation for such an approach'** [73, p. 473]		
'I came to the hospital alone, so it was nice to have them' [66, p. 5]	**Respectful, culturally safe, and trauma-informed care improved the quality of the patient experience** [66, p. 5]		
'[The care coordinator] is good. Especially in them first 7 weeks. She was here every appointment I come to. She come in when…they first said lymphoma. Cos sometimes you know, they'd talk and it would just go over your head… And, she come in there when they told me…12 months [pause] life expectancy. So [she] was there, she was really good'. [AP2] [78, p. 932]	Information about cancer and treatment [78, p. 932]		
'It's just hard. But the support worker last night, she stayed with me late, keeping me company. We talked, and she was very helpful' [66, p. 5]	**Clients' needs—expressed gratitude for the emotional assistance received during stressful times** [66, pp. 4–5]	Having someone to talk to	

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'Somebody to talk to who knows about it and who you don't know' [63, p. 4]	**Having someone to talk to** [63, p. 4]		
Clients stated that strengths of the Grandmother role included good communication, talking and yarning, being a role model or mentor, and providing support and education. [60, p. 126]	**Communicating effectively with Aboriginal people** [60, p. 126]		
'In my case it was more about having someone talking to me than helping with things. I'm satisfied with the support I have, I just want to talk and have a cuppa' [63, p. 4]	**Having someone to talk to and show compassion** [63, p. 4]		
'I felt like I really just had a friend to talk to' [Jodie] [73, p. 473]	**'This sense of 'not wanting to disturb staff' left participants feeling isolated and alone. Having a RA spend time with whanau in a calm and relaxed manner while they engaged with the Harti tool was a welcome change'** [73, p. 473]		
'They come and talk if I want to get something off my chest; they want to talk. They let me know they're there whenever I need them' [66, p. 8]	**'Communication—Clients expressed satisfaction with their interactions with the IBSW, who was approachable, empathetic, and assured that the clients' needs were addressed'** [66, p. 8]		
'It was pretty cool. I liked it because it was someone to help me get it off my chest sort of thing, but wasn't going to judge me for what I was saying, so it was cool. I liked it' [Anahera] [73, p. 472]	Appreciated receiving culturally appropriate, respectful interactions [72, p. 472]/'making people feel comfortable' [73, p. 473]		
'It's someone that's going to listen to you, then it don't matter what they look like' (Participant) [68, p. 7]	**'Although staff considered Indigeneity to be an important feature of the MC, their clients seemed less concerned about the Indigenous status of staff, stipulating that more important was access to the same care provider who was well qualified and experienced, with good listening skills'** [68, p. 7]		
'just them coming to have a yarn, that would be really good'. [75, p. 560]	**Listening to the patient** [75, p. 560]		
'and having someone who understands' [63, p. 4]	**Having someone to talk to and show compassion** [63, p. 4]	Attentive, compassionate and empathetic providers	
'Have someone show compassion on that day. Taking the time for me. Made me feel better about myself' [63, p. 4]			
'They're really helpful, and they're supportive. They check on me daily and make sure that I'm doing okay, they've been very helpful during my stay here' [66, p. 8]	**Cultural support—IBSWs were approachable and compassionate** [66, p. 8]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
AMIC worker always supported you with things happening in your life: 109/168 (65.1%) in the Aboriginal Family Birthing Program [80, p. 35] *Midwife* always supported you with things happening in your life: 110/171 (64.3%) in the Aboriginal Family Birthing Program, compared to 37/91 (41.1%) in mainstream public care, leading to an odds ratio of 2.6 (95% confidence intervals: 1.5, 4.4), $p < 0.001$ [80, p. 35] *Doctor* always supported you with things happening in your life: 74/155 (47.7%) in the Aboriginal Family Birthing Program, compared to 39/103 (37.9%) in mainstream public care, leading to an odds ratio of 1.5 (95% confidence intervals: 0.9, 2.5) [80, p. 35]	**Women's Views About Support from Health Professionals During Pregnancy** [80, p. 35]		
'*Analysis of survey data found that the majority of women (92%) felt "mostly understood and respected" by staff whilst attending the MC. Other hospital locations were less well rated, however, with only 47% of women feeling similarly about birth suite, 31% about the postnatal ward and the 31% about the Maternal Fetal Medicine unit. Relatively small percentages of women stated they felt "not at all understood" or "respected" in selected locations including; birth suite (14%), the Neonatal Intensive Care Unit (NICU) (6%), the postnatal ward (8%), the Maternal Fetal Medicine unit (8%), and the Home Care Program (6%)*' [68, p. 8]	Culturally responsive care [68, p. 8]		
'Very positive feedback (>80% provided a strongly agree response) was received for survey items related to interpersonal skills (… "I was happy with the emotional support I received") [76, p. 5]	**Interpersonal skills** [76, p. 5]		
'Then they would run and grab me snacks and stuff if I needed it' [66, p. 5] *'[The RA] even brought me lunch the next day…When you have kids in there you don't get fed at the hospital'*. [Jodie] [73, p. 473]	**Client's needs—Valued the one-on-one attention and assistance they received** [66, pp. 4–5] **'Even where participants did request assistance, they often had to wait some time before a health professional arrived. This sense of 'not wanting to disturb staff' left participants feeling isolated and alone. Having a RA spend time with whanau in a calm and relaxed manner while they engaged with the Harti tool was a welcome change. Participants repeatedly commented on their appreciation for such an approach'** [73, p. 473]	Practical support	

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'I really can't afford to get a brand new one and I've been asking on PIF [Pay It Forward, a Facebook page] and I was telling [name] about it, and the next minute she walks in with a car seat for me. I was gob smacked man. Not very many good things like that happen to us. It was awesome' [Aroha] [73, p. 473] *'I have told everyone– holy shit, when I went to hospital I got this and I got that. I got hooked up with all this! I have messaged my Mum and my cousin. Holy shit cuz, you know I got a free car seat when I was at hospital!'* [Jodie] [73, p. 473]	**Immediate practical support offered to those in receipt of the Harti tool was also valued** [73, p. 473]		
'My partner, he is more understanding in Māori than he is in English, so for her to take that length of time was good for him' [Mere] [73, p. 472]	**Mere particularly enjoyed the in-depth conversations regarding health-related matters without having to translate for her husband (partner). His first language is te reo Māori, and Mere often found herself needing to act as his interpreter. Being able to converse naturally provided much-needed respite** [73, p. 472]		
'I found them supportive, received a moss bag and beaded earrings. I came to the hospital in shorts and didn't have anything. They brought me shoes and shampoo…It was great that IBSW took me upstairs (NICU) to see my baby right after delivery. She didn't have to, but she did. I enjoyed my time with them' [66, p. 5]	**Respectful, culturally safe, and trauma-informed care improved the quality of the patient experience** [66, p. 5]		
'*They gave us a cup of tea and coffee, and a biscuit if we wanted it. And then when we were finished they gave us a meal voucher to go and get lunch.'* (P7) [76, p. 4] '*They gave me a cup of tea and a sandwich, while I was having the appointment and they asked me if I wanted to eat and drink and things like that, and I said "Well just a cup of tea would be okay". They brought me a sandwich as well, so that on its own was well-deserved and I felt well treated by that.* (P8)' [76, p. 4]	**Provision of refreshments** [76, p. 4]		
'*I was offered a taxi, which was just fabulous. I think being offered rather than asking … doesn't make me feel like I'm … asking for a handout'*. (P11) [76, p. 4] '*And when [the AHLO] was in the room with the doctor, she said to me when I needed to go home just to ring her and she'll organise a taxi to go home. So you know they're making sure you can get there.*' (P5) [76, p. 4]	**Organisation of transport** [76, p. 4]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'*And even when I got released from there, they walked me down to the car park to get a taxi. They got the taxi for me and everything. It was really good. I cannot say a bad word about it*'. (P8) [76, p. 4]	**Assistance with wayfinding** [76, p. 4]		
'*It's like-because we've been with the kids ever since. And now with this here happening, and we are all like coming up and down. And it's just like they -…I don't know—they mostly feel like lost or messed up inside, because we're here and they are back there. Because we've been all time together…*' [AP1] [78, p. 934]	**Family needs** [78, p. 934]		
'*My mum… received a lot of support from them [the care coordinators], but not so much me. I wasn't feeling very community minded or like I wanted any help or anything like that throughout it'*. [AP4] [78, p. 934]			
'It just makes me feel at ease, really at ease . … I've got someone there to help me. I'm not on my own with the system' (P41, Campbelltown Hospital patient) [65, p. 8]	'For many Aboriginal people living with chronic conditions, especially those with frequent hospital admissions, a sense of safety may be elusive. Two male patients admitted after a heart attack, both in their mid-30 s, were badly shaken. Having the ATOC team to provide support and the ALOs to explain what is happening and what will happen, including follow-up arrangements, is reassuring for patients and their families' [65, p. 8]	Perceived practical support	
'*They introduced themselves and told us who they were and what they were there for, and how, if we needed help or support or anything. That they were there to help us'*. (P6) [76, p. 3]	**Establishing rapport with the healthcare provider** [76, p. 3]		
'The nurses are all Aboriginal and so we can understand each other bettnber' [61, p. E60]	**Understand each other better** [61, p. E60]	Better intracultural understanding	Acknowledgement, respect and support for culture
'[The ALO] talks to you on a blackfella level, the way they should, especially in the city … He tells the ins and outs of everything, explained everything'. (P45, Liverpool Hospital patient) [65, p. 7]	**Resourcing and ways of working: (…) Ensuring that the patient and their family understand the follow-up care plan. For some patients and family/carers lack of communication was 'the biggest problem'. The ALO's role in helping people feel safe by providing reassurance and information was valued by everyone** [65, p. 7]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
In our discussions with the cultural liaison, Aboriginal people explained that they believe that *'when vision is lost, it is also a spiritual loss, because when one can no longer see the sun, the animals, and the trees, one gets disconnected from Mother Earth's elements'* [61, p. E61]	**Patients felt nurses of Aboriginal descent could better empathize about this than doctors could, and thereby provide culturally-relevant recommendations, for example citing ways to overcome this spiritual loss and better connect with nature** [61, p. E61]		
'I found it really relaxing. Questions I could relate to [the RA] … It was so refreshing to talk to somebody that knew where you were coming from …' [Mere] [73, p. 472]	**Participants specifically mentioned the ability of the RAs to engage with them as Māori. Subsequently, they felt treated with value, dignity and respect** [73, p. 472]		
'*At the program level, the employment of Aboriginal staff in the program was highlighted as a program strength (7/16 clients)*' [60, p. 124] '*Of the 16 clients surveyed, 15 stated that the Aboriginal Health Officers, Grandmothers and midwives worked together effectively*'. [60, p. 124] '*One client also stated that a strength of the Grandmother role was being able to work in partnership with the midwife*' [60, p. 124]	**3.3. Developing, supporting and enhancing the cultural competence of new and existing staff**	Cultural and clinical expertise combined	
'I like she's thorough. She makes sure that we have the information we need. I like that she gave us pamphlets on the different traditional teachings and the little belly button pouch. And it was comforting to know those were offered services here at the hospital, 'cause I felt like it represented us as a family and what we would want in our baby's care' [66, p. 7]	**Clients and families felt that their culture and traditions were recognized and respected** [66, p. 7]	Hospital acknowledges, recognizes, respects and promotes or facilitates traditional cultural practices	
'I would love more information and for [ceremonies] to be happening, for that to be arranged' [66, p. 4]	**Cultural support** [66, p. 4]		
I was happy with the cultural support I received. (86% reported 'strongly agree') [76, p. 6]	**Cultural support** [76, p. 6]		
One patient said *'the Smudge is part of our traditional healing methods and it helps us to openly discuss our health, and participate with each other'* [61, p. E61]	**Absence of cultural rituals and ceremonies** [61, p. E61]		
'I smudged today, and it made me feel better' [66, p. 7].[66, p. 7]	**Clients who received such assistance with cultural services expressed gratitude acknowledging that it made them feel better** [66, p. 7]		
P2: *'The bus is really good for us, it gives us a chance to get home so we can have a voice'* [62, p. 7] P6: *'it is really good to see the whole family and that place. That feeling make me happy'* [62, p. 7] P6: *'Last time I was at a funeral, I was in Pipalyatjara. and I saw the truck there. Nobody told me! The community nurse told me. She said 'hey that dialysis truck is there!' (laughing), I said 'hey, I never heard from there!', then I did four hours in the truck there I was really happy'* [62, p. 6–7]	**Happiness and quality of life** [62, p. 7]	Treatment on Country reduces shame and grief and increases happiness and quality of life through connection with Country, Community and Family	

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
P1: *'I say to them, you gotta eat right, you gotta look after yourself, or else you end up like me, stuck to the chair.'* [A patient describing talking to younger generations about his health] [62, p. 7]	Happiness and Quality of life [62, p. 7]		
P2: *'Some of us have grandchildren and we can't teach them in Port Augusta and Adelaide coz we're not in the right Country'* [62, p. 5] P3: *'I'll be happy to see my family because I miss them. That's what we always want … I had to move here. I used to get homesick'* [62, p. 5] P2: *'I miss out on hunting Kangaroo, showing kids the Country, teaching our children about our dreaming'* [62, p. 5] P4: *'I had 2 nieces on dialysis here. I knew the troubles. They both passed away. I'm older than both of them. They too young'* [62, p. 5]	**Grief and loss** [62, p. 5]		
P1: *'Here I am powerless, I have no say. It's not my Country. I need to get back to my own Country. There are other tribes running my Country. I feel like we're not part of the community here. I can't go to there'* [62, p. 6] P2: *'Here, we have taken someone else's chair. We feel shame because it is not our Country here. What is someone else is from here and they can't come back from Adelaide coz there's not chairs here. I've taken up that chair. [We] feel a lot of shame for that'* [62, p. 6] P1: *'The elder's like to go back home to die, our spirit. My spirit is happier in our Country. We End up in hospital and we want to run away. Our elder want to run away coz he's very spiritual. In spirit world, if you go to the wrong Country you're not welcome, and you gotta leave'* [62, p. 6]	**Not our country** [62, p. 5]		
Beck hopelessness scale change at 3 months (mean difference of −1.7 [95% CI = −3.4 to −3.4, *P* = 0.05) and 12 months (mean difference of -1.6 [95% CI = −3.4 to 0.3], *P* = 0.01) [77, p. 891]	**Hopelessness** [77, p. 891]	Proud identity	
'it was the hook that dragged me in' [77, p. 892]	**A theme that helped with engagement was the Maori emphasis** [77, p. 892]		
The cultural impact profile showed that at baseline in the intervention group there was a greater proportion of participants with a notional or compromised identity compared to the treatment as usual group (27 % compared to 17 %). In both groups at 12 months there was a decrease in the proportion of people identifying as having a notional or compromised identity with greater change in the intervention group although this was not statistically significant, [intervention group 17 % (change −10 %) compared to the control group 12 % (change −5 %)]. [77, pp. 891–892]	**Notional or compromised identity** [77, p. 891]		

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Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'Everyone in my family—my mother, her partners, brothers, sisters are all violent. Mum doesn't care—she's long gone—just carries on drinking and drugs and men. I told mum "you are living your same life" … But I am breaking that cycle of violence'. [77, p. 892]	'**overcoming shame about being Māori and increasing self-esteem**'. [77, p. 892]		
P11 described the staff *'like family'* [62, p. 7]	**All participants reported good relationships with the staff on the trip** [62, p. 7]	Positive perceptions of staff	Feeling accepted, heard, valued, safe, comfortable, and respected
'I feel like it's just warm welcoming with them. All of them came and introduced themselves' [66, p. 8]	**Communication—Clients expressed satisfaction with their interactions with the IBSW, who was approachable, empathetic, and assured that the clients' needs were addressed** [66, p. 8]		
'*She introduced herself twice, the doctor, and she was interested in family'*. (P5) [76, p. 3]	**Establishing rapport with the healthcare provider** [76, p. 3]		
'*You go to a doctor, and ordinary doctor, and it's like a production line you know. The doctor doesn't have time to actually get to know the patients anymore. Whereas at the Clinic … most of the nurses recognise you as soon as you walk in'*. (P1) [76, p. 3]			
'*And also you can build a rapport with them, because … we were talking and she asked me where I lived and where my son lived'*. (P5) [76, p. 3]			
Very positive feedback (>80% provided a strongly agree response) was received for survey items related to interpersonal skills ('Staff introduced themselves') [76, p. 5]	**Interpersonal skills** [76, p. 5]		
'In addition, very positive feedback was reported for items related to cultural safety (… "The appointment was free of racism and discrimination"' [76, p. 5]	**Cultural safety** [76, p. 5]		
'*In addition, very positive feedback was reported for items related to cultural safety (… "Staff spoke to me as an equal"*' [76, p. 5]			
'It was nice to know that if my husband couldn't come in, to make it had I gone into labor. If he couldn't make it in time, there would be someone I already had a relationship with who could come in and be a support if he couldn't be there. That helped my mental health, for sure' [66, p. 6]	**Clients expressed relief at the prospect of receiving assistance from IBSWs if their family members could not be present during delivery** [66, pp. 5–6]	Sense of safety	
'They were supportive, friendly…' [66, p. 5]	**Respectful, culturally safe, and trauma-informed care improved the quality of the patient experience** [66, p. 5]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'I had a lot of support there which was good because that's what you really need. You're in foreign place. You're scared. You don't know what's gonna happen' (P13, Liverpool Hospital patient) [65, p. 8]	**For many Aboriginal people living with chronic conditions, especially those with frequent hospital admissions, a sense of safety may be elusive. Two male patients admitted after a heart attack, both in their mid-30 s, were badly shaken. Having the ATOC team to provide support and the ALOs to explain what is happening and what will happen, including follow-up arrangements, is reassuring for patients and their families** [65, p. 8]		
'I really like this place; it seems like home to me'. [67, p. 228]	**With much of the world in a state of constant flux, the Indian Clinic has remained stable and therefore a source of security and comfort to the Indian patient** [67, p. 228]		
'In addition, very positive feedback was reported for items related to cultural safety (…"The physical environment was welcoming")' [76, p. 5]	**Cultural safety** [76, p. 5]		
'*I love the artwork. I read about the artwork over and over and over every time*'. (P3) [76, p. 5]	**Welcoming environment** [76, p. 5]		
'*[It is] welcoming when I walk in and see all the patients and the lady walking around with the Aboriginal clothing on*'. (P6) [76, p. 5]			
'*It was like you're just at home and you're talking to someone*'. (P11) [76, p. 5]			
'*This Aboriginal hospital [the Clinic] is absolutely tops and me being Aboriginal I can't say enough. I got cared for, I got well looked after, I got shown love and attention while I was there, you know. It's just a real top place*'. (P8) [76, p. 5]	**Feeling culturally safe** [76, p. 5]		
'*As for me being Aboriginal, I didn't have one moment where I was ill-treated or badly spoken to or anything*'. (P8) [76, p. 5]			
'*I felt OK to ask questions*'. (P11) [76, p. 5]			
'made me feel comfortable' [66, p. 5]	**Respectful, culturally safe, and trauma-informed care improved the quality of the patient experience** [66, p. 5]	Felt comfortable and cared for	
'I think the questions are a bit too personal, but [the RA] made me feel comfortable answering them. I suppose it depends on who is delivering it' [Penny] [73, p. 472]	**Appreciated receiving culturally appropriate, respectful interactions** [73, p. 472]/**'making people feel comfortable'** [73, p. 473]		
'*She [the RA] did tell me that… some people think they are intrusive questions before she asked them and stuff. She made me feel comfortable'* [Astra] [73, p. 473]			

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'I was up there by myself and going crazy in that little room… it [the Harti] was real good. Yeah. Like they actually cared' [73, p. 473]	Having a RA spend time with whānau in a calm and relaxed manner while they engaged with the Harti tool was a welcome change. [73, p. 473] The combination of listening work, self autonomy and genuine care for their well being as Māori left participants feeling valued, with a renewed sense of confidence for navigating additional services [73, p. 473]		
Aboriginal Maternal Infant Care (AMIC) worker always asked about things happening in your life: 103/168 (61.3%) in the Aboriginal Family Birthing Program Services Program [80, p. 35] *Midwife* always asked about things happening in your life: 119/171 (69.6%) in the Aboriginal Family Birthing Program Services Program, compared to 52/91 (57.1%) in mainstream public care, leading to an odds ratio of 1.7 (95% confidence intervals: 1.0, 2.9), $p < 0.05$ [80, p. 35] *Doctor* always asked about things happening in your life: 86/156 (55.1%) in the Aboriginal Family Birthing Program Services Program, compared to 55/103 (53.4%) in mainstream public care, leading to an odds ratio of 1.1 (95% confidence intervals: 0.7, 1.8)	**Women's Views About Support from Health Professionals During Pregnancy** [80, p. 35]		
Most Aboriginal and/or Torres Strait Islander patients surveyed reported the personalised theatre caps to be helpful (89%, 95% CI 69–100) and felt more comfortable because staff were wearing them (88%, 95% CI 65–100) [64, p. 4]	**Did you notice that staff were wearing their names and jobs on their hats today?** **– If yes, was this helpful?** **– If yes, did this make you feel more comfortable or less comfortable?** [64, p. 3]		
'*It was a really relaxed discussion, and it was around me, and that I think is really important'*. (P11) [76, p. 3] *'To me it felt like it was personalised, that they're caring about you'.* (P7) [76, p. 3] '*I just don't have any worries or concerns because they treat me with respect'.* (P3) [76, p. 3] '*He was actually treated like a human being, you know and not just a number'*. (P7) [76, p. 3]	**Treated with respect and individualised attention** [76]	Felt respected	
'*Staff treated me with respect*'. (80% yes) [76, p. 6]	**Respect** [76, p. 6]		
Lower ratings (<70% provided a strongly agree response) were received for statements relating to shared decision making ('Staff showed an interest in my ideas about my health'. [76, p. 5] Lower ratings (<70% provided a strongly agree response) were received for statements relating to shared decision making ….'I have a clear plan for my health condition') [76, p. 5] I had a say on decisions about my care (74% responded with 'strongly agree') [76, p. 5]	**Shared decision making** [76, p. 5]	Felt heard	

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'The load is on me—seeing so many people. It's overload, and I get depressed and stressed'. [77, p. 892]	'being overwhelmed' [77, p. 892]	Care continuity with providers with the appropriate qualifications, expertise and experience	Navigating treatment and the system
'I don't want to be told not to smoke over and over again' (Participant survey) [68, p. 5] *'All they do is ask you the same questions'* (Participant) [68, p. 6] *'It's good coming here too because you know you're going to see the same people all the time. It's not a different doctor or a different midwife everytime who's going to ask you the same questions over and over again […] she (midwife) knows your full-on history from the first visit to, you know, your last visit. She knows everything about you, which is good'* (Participant) [68, p. 6]	**Continuity of carer (midwife and obstetrician) was a major attraction, with women reporting that this reduced the likelihood of being asked the same questions** [68, p. 6]		
'I'm more concerned about their qualifications and how much experience they've had […]. I'm not really worried about whether they're Indigenous or not'. (Participant) [68, p. 7]	**Although staff considered Indigeneity to be an important feature of the MC, their clients seemed less concerned about the Indigenous status of staff, stipulating that more important was access to the same care provider who was well qualified and experienced** [68, p. 6]		
'*It's good because you know everything gets done. You know instead of having to make another appointment and go back, it's all handled in the 1 day*'. (P1) [76, p. 4] '*They're all on the same page. And that's what I like. I personally like everyone to be on the same page'.* (P3) [76, p. 4] '*When you go to the doctor's you've got 10 min, here you know I've just spent half an hour with her. You know before that I was with the nurse, and you know the Aboriginal lady comes up and everyone's there and you're not rushed'*. (P5) [76, p. 4]	**Consultation with multiple healthcare providers** [76, p. 4]		
'It wasn't a nurse that would write down notes and then the next nurse reads it and then asks you. So that is what made it easier for me' [Anahera] [73, p. 472]	Appreciated receiving culturally appropriate, respectful interactions [73, p. 473]/'making people feel comfortable' [73, p. 473]		
'*They're good at that. You know they really push things through for you. I guarantee you if the Clinic hadn't been pushing it, I'd still be sitting around waiting for another few years'.* (P1) [76, p. 4]	**Advocacy for healthcare needs** [76, p. 4]	Advocacy and Referrals	

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'Also, they put me in touch with a couple of people able to come and advocate for me, on my behalf, with the CFS, to help me get my daughter back into my care. So that was really good. They've been helpful for everything'. [66, p. 5]	**IBSW observed that many clients were unaware of their rights or their eligible services. IBSWs frequently assisted clients in obtaining additional services they required** [66, p. 5]		
'She [The RA] went through a lot of things with us, it was really good too. Like the house is one of them she went through. She made sure that we were up to date with everything that had to do with her, like assistance from everybody. Yeah …So we are really interested in that Tamariki Ora, and the Whare Ora. Yeah, she referred us to Quit Smoking … She was awesome. Really. I mean what took maybe was supposed to have been half an hour took us maybe two hours. It was awesome. Yeah, it was just cool. Made sure that we knew about this, we knew about that or if we were hooked onto this– right down to Work & Income, if we were getting that and if we knew that it was there. It was awesome. She was good'. [Mere] [73, p. 473]	**Appreciation for having a RA spend time with whanau in a calm and relaxed manner** [73, p. 473]		
'I have been thinking about it for a while but I've always been putting it off–man, I'm going to start going crazy and I've got the kids to look after by myself. No! But it has actually been really good, and I'm glad that she [the RA] gave me the push to do it [and] referred me to the Quit Smoking coach, so she comes around every week to talk to me as well, so that is cool for support …I mean, if yous were around at the first …I might be smoke free already'. [Aroha] [73, p. 474]	**Being treated in a culturally supportive and encouraging manner resulted in a positive uptake of services** [73, p. 474]		
'I could be in labour and he'd have to bring me here and not know where to go'. (Participant) [68, p. 7]	**Location—the hospital was also favoured for the opportunity it provided partners and family members to become familiar with the surroundings in advance of labour** [68, p. 7]	Confidence to navigate treatment and services	
'*It's just easy to find and it's convenient and it's comfortable*'. (P2) [76, p. 4]	**Assistance with wayfinding** [76, p. 4]		
'I figured out how it (the clinic appointment system) was working. So I would go up there like (at) nine (am) […] women would be waiting after me that were probably meant to be before me. (I felt) bad at first but, you know, that's the way they operate'. [68, p. 7]	**Operational issues: Women sometimes used the knowledge that they would be seen without an appointment to their advantage** [68, p. 7]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'*Several (n = 3) participants recommended allocation of a point of contact for assistance with outpatient appointments*'. [76, pp. 5–6] '*Respondents acknowledged the benefits of the AHLO role. AHLOs work in collaboration with other healthcare providers to support the cultural, spiritual, mental and physical wellbeing of Aboriginal and Torres Strait Islander patients. This role is important both in terms of referrals into the Clinic and support of patients during their Clinic journey. Patients valued the role that AHLO clinicians played in the continuity of their care, with scheduling of appointments*'. [76, p. 6] '*To further compliment their care, participants suggested an additional and final appointment after their plan of care is established. In their view, this final review would enable an evaluation of their health condition following the introduction of a new health plan*'. [76, p. 6]	**Recommendations were made regarding navigating the health service**		
'*… Because everything else takes precedence, if you've got no money, no food, your housing's up the creek, you've got people coming and going and family and, you know, things happening with kids. And then getting into the cancer business…if you don't know what they're talking about and you go in by yourself, it just goes straight over*'. [AP25] [78, p. 932]	**Information about cancer and treatment** [78, p. 932]		
'*… someone like [name of care coordinator]…saying, "You right there? You got somebody at home? Do you want me to come and visit you, or, do you want me to try and help family come and visit you?" because the family's too scared or they may not have ways and means to come and visit you*'. [AP19] [78, p. 934] '*Ultimately it would be great to have that 1 person come into your home and go off and sort it all out …someone…better equipped to give an objective view…to organise for your payslips to go to housing, and they sort out your new rent…*' [AP2] [78, p. 934]	**Facilitating appropriate treatment and support** [78, p. 934]		
'*Yes I was more forceful with my treatment and making decisions and also I had more choices ….I was more forceful, making decisions based on things I wanted*'. [Matthew, Yolŋu Matha speaker] [79, p. 8] '*the doctors said there is the same medication down there and here*' [79, p. 8] Afterwards, Matthew said he was relieved because he finally understood his situation. He said: '*I could hear clearly*'. [79, p. 8]	**Proactive confident patients** [79, p. 8]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'[The ALO] talks to you on a blackfella level, the way they should, especially in the city . … He tells the ins and outs of everything, explained everything' (P45, Liverpool Hospital patient) [65, p. 7]	**Resourcing and ways of working: (…) Ensuring that the patient and their family understand the follow-up care plan. For some patients and family/carers lack of communication was 'the biggest problem'. The ALO's role in helping people feel safe by providing reassurance and information was valued by everyone.** [65, p. 7]	Explaining and ensuring understanding	
'It was really awesome that [the RA] took that time to explain' [73, p. 472]	**Appreciation for having a RA spend time with whanau in a calm and relaxed manner** [73, p. 473]		
'*They certainly helped me clear my mind a lot and helped me realise what I had to do without just being told'*. (P8) [76, p. 4]	**Clear verbal and written information** [76, p. 4]		
'*They actually spent time with you and asked you more questions and explained things slowly instead of just you know like 'You've got this and this and we'll see you back here in three months'*. (P7)' [76, p. 4]			
'*If it's my health I want to know. So you know she took the time to explain it to me'.* (P5) [76, p. 4]			
'*[The care coordinator]'s been…She's been a rock.… She comes in with me just in case I miss something and explains everything to me … and then she'll say, "Well, I wouldn't worry about that," you know, she reassures you*'. [AP13] [78, p. 932]	**Information about cancer and treatment** [78, p. 932]		
Lower ratings (<70% provided a strongly agree response) were received for statements relating to … education ('I received enough information about my health condition' [76, p. 5]	**Education** [76, p. 5]		
Lower ratings (<70% provided a strongly agree response) were received for statements relating to … education (… 'I received enough information about my medications'). [76, p. 5]			
'*Very positive feedback (>80% provided a strongly agree response) was received for survey items related to interpersonal skills (… "I was asked if I have any questions"*' [76, p. 5]	**Interpersonal skills** [76, p. 5]		
'We had one Elder that came in that it took a while for him to get into hospital. However, once he was here and we did speak to him and we did support his progression here in the hospital. Once he was discharged, he went home happy and we got the feedback from [the ALO] that he has been trying to encourage other Aboriginals that he knows that are very sick to come in to hospital because we will help them and that we are providing a good service and acknowledging their culture and supporting their culture.' (P29, Campbelltown Hospital ATOC) [65, p. 8]	For Aboriginal patients, having a positive experience during and when leaving hospital can help build trust and relationships and over time lead to improved engagement with the health service and reduced self-discharge [65, p. 8]	Health clinic recommended	Perceptions of health services
- '*Clinicians in the intensive or brief ICS groups had higher adjusted odds of being highly recommended to friends and family by standardized patients (OR 6.88, 95% CI 1.17 to 40.45 and OR 7.78, 95% CI 1.05 to 58.03, respectively)*' [69, p. 1]	**Highly recommended to family and friends** [69, p. 1]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'*I highly recommend it and I'm hoping they can expand it*'. (P1) [76, p. 5] '*I love the artwork. I read about the artwork over and over and over every time*'. (P3) [76, p. 5] '*[It is] welcoming when I walk in and see all the patients and the lady walking around with the Aboriginal clothing on*'. (P6) [76, p. 5] '*It was like you're just at home and you're talking to someone*'. (P11) [76, p. 5] '*This Aboriginal hospital [the Clinic] is absolutely tops and me being Aboriginal I can't say enough. I got cared for, I got well looked after, I got shown love and attention while I was there, you know. It's just a real top place*'. (P8) [76, p. 5] '*As for me being Aboriginal, I didn't have one moment where I was ill-treated or badly spoken to or anything*'. (P8) [76, p. 5] '*I felt OK to ask questions*'. (P11) [76, p. 5] '*Although most participants appreciated organisational and staff efforts to ensure a culturally safe environment, suggestions were put forward that the Clinic could be based within the community*'. [76, p. 6]	**'cultural safety'** [76, p. 5]		
'*98% of women said that they would recommend the program to family and friends*' [71, p. 45,72] '*All 16 clients surveyed stated they would recommend the program to a family member or friend*' [60, p. 124]	**Recommend the program to family and friends** [71, p. 45,72] 3.2. Creating a welcoming environment [60, p. 124]		
'*Eight of the 18 patients (45%) who had been logged as TOL were satisfied their treatment had been completed when they left ED*'. [75, p. 560]	'patients comfortable informing staff they needed to leave' and appreciation of follow-up "shows that they care" if they TOL'. [75, p. 560]	Impacts on trust and satisfaction	
'*The mean scale score for satisfaction with health care increased from 4.12 pre-navigation to 4.53 post-navigation, an increase of 0.41 (95% CI, 0.22–0.60) in the mean scale score ($p < 0.0001$)*' (Table 2) [70, p. 11]	**Increased satisfaction with the health service** [70, p. 11]		
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: the hospital or clinic I usually go to provides me with good health care over all ($P = 0.04$) [70, p. 12] Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: The medical care providers I usually see treat me with dignity and respect ($P = 0.005$) [70, p. 12] Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: I feel comfortable talking to doctors when I have a health problem ($P = 0.7$) [70, p. 12] Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: Doctor or nurse made sure I understood what to do next to get treatment for my cancer ($P = 0.008$) [70, p. 12]			

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: PRE: The first doctor or nurse that told me I had cancer listened carefully to my concerns.			
POST: My cancer doctor listens carefully to my concerns. ($P = 0.01$) [70, p. 12]			
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: PRE: Before my first visit to the Cancer Care Institute, there was a doctor or nurse available by phone or in person to answer my questions about cancer.			
POST: There is a doctor or nurse available by phone or in person to answer my questions about cancer. ($P = 0.002$) [70, p. 12]			
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: If I have a question, my doctor will give me a straight answer ($P = 0.32$). [70, p. 12]			
Odds Ratios for Rating of Antenatal Care as 'Very Good' by Model of Care, South Australia, 2011–2013	**Quality of care**		
Aboriginal Family Birthing Program (AFBP) services metropolitan, unadjusted odds ratio vs mainstream public care: 3.0 (1.5, 6.0)**, adjusted odds ratio vs mainstream public care: 3.4 (1.6, 7.0)**			
AFBP regional, unadjusted odds ratio vs mainstream public care: 2.1 (1.2, 3.5)**, adjusted odds ratio vs mainstream public care: 2.4 (1.4, 4.3)**			
*p < 0.05, **p < 0.01. [80, p. 35]			
'*I was happy with the health care I received' (74% reported "strongly agree")*' [76, p. 6]	**Patient satisfaction**		
'I feel able to follow through with the plan for my health condition'. (64% reported 'strongly agree') [76, p. 6]			
'I have a clear plan for my health condition'. (60% reported 'strongly agree') [76, p. 6]			
'I have a clear plan for my health condition'. (60% reported 'strongly agree') [76, p. 6]			
'I feel able to follow through with the plan for my health condition' (64% reported 'strongly agree') [76, p. 6]			
'The physical environment was welcoming' (80% reported 'strongly agree') [76, p. 6]			
'It was easy to get to the hospital from where I live'. (74% reported 'strongly agree') [76, p. 6]			
'It was easy to find the Clinic once I got to the hospital'. (67% reported 'strongly agree') [76, p. 6]			
'I got reminders from Western Health about my appointment'. (74% reported 'strongly agree') [76, p. 6]			
'The appointment was free of racism and discrimination'. (93% reported 'strongly agree') [76, p. 6]			

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'Although 80% of participants strongly agreed that their experience with the Clinic was positive ("Overall, I would rate my experience with the Aboriginal and Torres Strait Islander [Outpatient] clinic as positive")' [76, p. 5]			
'*fewer (<70% provided a strongly agree response) reported a positive overall experience with the organisation ("Overall, I would rate my experience with Western Health as positive")*'. [76, p. 5]			
Staff had enough time for me. (74% reported strongly agree) [76, p. 6]			
Staff let me know what was happening during the appointment. (74% reported 'strongly agree') [76, p. 6]			
Reflecting on that first interaction with Yolŋu interpreter Carly, Matthew used the Yolŋu word '*latju*' (nice) to describe the experience. [79, p. 7]	**Building relationships of trust** [79, p. 7]		
He said having another Yolŋu person present made him feel at ease: '*that was nice because Yolŋu were helping Yolŋu, really helping me*.' [79, p. 7]			
'*Like, this Balanda [non-Aboriginal] person doesn't understand what this Yolŋu person is saying. So that's why the Yolŋu has to be there to explain it to you. To make better communication with the Balanda people*.' - Patricia, Yolŋu Matha speaker [79, p. 7]			
'*The trust is massive…I feel when they come here (interpreters), I feel really good not only because I'm related to them, but I feel like the flow of the conversation is going faster. We are all understanding each other…. It's just a good feeling when it's flowing and everyone understands.*' [Matthew, Yolŋu Matha speaker] [79, p. 7]			
'Two months after first having access to an interpreter Matthew reported he felt much more supported: "*Yeah heaps of them are helping me*". He added interpreters not only helped him understand; importantly they helped the health providers understand his perspective and priorities. Matthew said with interpreters, communication works both ways: "*None of us are stuck or confused*."' [79, p. 8]	**Satisfied patients** [79, p. 8]		
Matthew said before interpreters became involved in his care he was '*stuck*' but after consistent interpreter-mediated communication with staff he is '*satisfied*'. Yolŋu Elder Patricia wants to see the model of embedded interpreters in medical teams permanently: '*Balanda doctor and Yolŋu interpreter all the time. I need to see that happen*.' [79, p. 9]			

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
Medical mistrust reduced from 2.38 pre-navigation to 2.23 post-navigation, a decrease of −0.13 (−0.28 to 0.03), $P = 0.1$ (Table 2) [70, p. 11]	**Reduced medical mistrust** [70, p. 11].		
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: I usually trust doctors (increase from pre to post, $P = 0.18$) [70, p. 13]			
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: People should always follow the advice given to them at hospitals (increase from pre to post, $P = 1.00$) [70, p. 13]			
Proportionally less people reporting 'agree' vs 'Neutral/disagree' from pre to post on: At hospitals and clinics rich patients receive better care than poor patients do (decrease from pre to post, $P = 0.14$) [70, p. 13]			
Proportionally less people reporting 'agree' vs 'Neutral/disagree' from pre to post on: I worry that doctors and nurses will do experimental studies on me without telling or asking me (decrease from pre to post, $P = 0.14$) [70, p. 13]			
Proportionally less people reporting 'agree' vs 'Neutral/disagree' from pre to post on: I have put off getting medical care when I have had health problems because I do not trust doctors and nurses (decrease from pre to post, $P = 1.00$) [70, p. 13]			
Unchanged from pre to post: Hospitals and clinics often want to know more about your personal business than they really need to know ($P = 1.00$) [70, p. 13]	**Unchanged medical mistrust** [70, p. 11].		
Unchanged from pre to post: Hospitals are places where people go to die (unchanged from pre to post, $P = 1.00$) [70, p. 13]			
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: In the past, clinics and hospitals have done harmful things to patients without their knowledge (increase from pre to post, $P = 0.26$) [70, p. 13]	**Increased medical mistrust** [70, p. 11].		
Proportionally more people reporting 'agree' vs 'Neutral/disagree' from pre to post on: I have put off getting medical care in the past because I felt that I would be treated disrespectfully (increase from pre to post, $P = 1.00$) [70, p. 13]			
98% of women said the program met their needs [71, p. 45], [72]	**Program met their needs** [71, p. 45], [72]	Changes in perceptions of care	
- Adjusted mean item patient experience scores were 46% (95% CI 12% to 80%) and 40% (95% CI 2% to 78%) higher for clinicians enrolled in the intensive and brief training programs, respectively, compared to control [69, p. 1]	**Improved patient experiences** [69, p. 1]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
I went down to have x-rays and there was a whole heap of orderlies sitting there around their waiting area. And I heard a racist remark by one of the orderlies. And I ended up in tears…It's like, oh Jesus, you're here crook and you hear a racist joke. [AP2] [78, p. 933] [The care coordinator] said, 'Well, it's not acceptable' …And she didn't force me or anything, she said- 'You need to really consider doing an official complaint.' So I thought, yeah, no, bugger it, I've got […] cancer and I'm hearing shit like that! So, yeah, I did an official report. [AP2] [78, p. 933]	**Racism and mistrust** [78, p. 933]		
'At UHNBC people who identified as Indigenous (β = − 0.13, p < .001)… reported lower perceptions of quality of care at all time points' [30, p. 8] 'The same associations were found for SPH—Indigenous (β = − 0.10, p = .001) receiving lower quality of care' [30, p. 8]	**Lower perceptions of quality of care** [30, p. 8]		
'Felt like I could have dealt with it at home as no-one seemed to be in a rush' [75, p. 560] 'I was there for an urgent thing but I didn't want to stay because they had a lot going on so I wanted to rest in my own bed'. [75, p. 560]	**'poor waiting times' continued to impair access, acceptability and usability'.** [75, p. 560]	Waiting times	
'*Well, they work with you on the time, they ask you what time suits you; they don't just give you a time*'. (P1) [76, p. 4] '*It's different to other clinics where you've got to sit and wait forever*'. (P4) [76, p. 4] '*And with the Indigenous clinic, if they have to cancel their appointments, they actually physically ring up or send you a letter saying your appointments been cancelled. They don't ring you 10 min when you're half-way down the road to say your appointments [has]been cancelled*'. (P7) [76, p. 4] 'I had a say in the timing of my appointment'. (60% reported 'strongly agree') [76, p. 6] '*I wasn't rushed and I wasn't sitting in the waiting room with a million other people*'. (P11) [76, p. 4]	**Flexible scheduling of appointments** [76, p. 4]		
'*I found the Clinic involved a lot of waiting. I'm frustrated by the healthcare system in general, and wait for specialties and people not doing what they say they will do*'. (P9) [76, p. 4]	Flexible scheduling of appointments [76, p. 4]		
P2: *'It's really disheartening how the trips have gone from nine weeks [of the year] to only two. We just have to sit here on the machine, getting disheartened'* [62, p. 6] P14: *'When is it coming up though? Coz it's nearly Christmas time now and I wanna go to Christmas to see my family but no renal. I want to sit down with my happy family'* [62, p. 6]	Bus attendance [62, p. 6]	Limited service capacity or space	Impacts on health service access
'*Limited provision increased pressures on staff as the clinic was extremely busy on the one day it was in operation; women reported that their appointments rarely ran to time*' [68, p. 5]	Operational issues [68, p. 5]		

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'*It's a very fishbowl kind of situation. We're all in there looking at each other in a very small space and as soon as the woman comes in with her other two kids and they start playing in the middle of the space, we're all part of it you know? It's like the comfort zones might be pushed for some […] I think it definitely needs a better situation […] at least a more appropriate one*'. (Participant) [68, p. 8]	Physical space [68, p. 8]		
'*Yeah they (male partners) wait outside […] (they) don't feel comfortable. Like my partner didn't feel comfortable sitting in there […] sometimes I'd see just fathers just stroll past […] because they don't really want to go in there*.' (Participant) [68, p. 8]			
'*Pitjantjatjara, Yankunytjatjara, Pitjantjatjara—that's their first language… they don't understand what the doctor's saying because you haven't got a lot of people that speak our language in the hospital here… A lot of them go-go back and they end up passing on because they don't really understand it*'. [AP1] [78, p. 932]	**Interpreters**		
'*I don't think that they're utilising interpreters as well as they should. Well they're probably using the health worker. But I'm not sure how that's working and whether they're utilising them as they should be. And you know, are they trained? Are the nursing staff trained to work with Aboriginal interpreters to get the information across clearly? And to communicate with the client in a proper way?'* [AP29] [78, p. 932]			
'*I was finding it hard when it was just me talking. Finding it really complicated and I would think to myself, 'Oh who's going to help me?'.*' [Matthew, Yolŋu Matha speaker] [79, p. 4]	**The frustrated and misunderstood patient** [79, p. 4]		
'*I sometimes wonder to myself, are there simpler words they can use so maybe I can understand?*' [Matthew, Yolŋu Matha speaker] [79, p. 4]			
Matthew: *Half of it I don't understand and then a little bit, I understand it a bit*.			
SYM: *So when the interpreters came in, what did you think about that?*			
Matthew: *It's really nice…It really helps when Yolŋu are here and we both understand each other, and I understand. Sometimes I get confused and think 'How am I going to talk?' Really, I don't know what to say.*			
SYM: *Do you get angry alone?*			
Matthew: *Yeah, I get angry when I don't understand and sometimes, I think about praying and I pray to God about it because I'm so frustrated.* [79, p. 4–5]			
Yolŋu patient Sally explained she had not requested an interpreter before despite a) having seen them on the wards at Gove hospital and b) stating she would prefer to communicate in Yolŋu Matha because doctors *'use too many big words and the interpreter helps me understand'* [79, p. 6]			

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
'Matthew said before the pilot he did not have access to an interpreter in the hospital: "there was nobody (referring to interpreters) …It was complicated, and I didn't understand." He later added: "I was very upset at that time." Yolŋu speaker Sally shared a similar story: she had been receiving treatment at RDH and Gove Hospital for over 2 years and said the first time she experienced interpreter-mediated communication in either Top End hospital was when interpreter Carly appeared with the renal team during the pilot'. [79, p. 6]	**Diminishing Aboriginal cultures and disempowering patients** [79, p. 6]		
'At the start they didn't get me an interpreter because they assessed my English and they said it was understandable. But when they got into the concepts of what had happened to my leg and what the treatment was, that's when it got complicated and I didn't fully understand' [Matthew, Yolŋu Matha speaker] [79, p. 6]			
'Patricia said doctors assumed she was happy speaking English because she had previously worked as a lecturer at a Darwin college. Patricia explained, "English is her second language" and Yolŋu Matha is her "normal language"'. [79, p. 6]			
'During one bedside consult, Patricia declined an interpreter. From this single interaction, health providers extrapolated Patricia did not want an interpreter for any consult. The following day she explained to researcher SYM in Yolŋu Matha she was in pain the previous day and didn't want to talk to anyone. She made it clear her preference was to speak in her first language with an interpreter present: "First language is important to us, it's like growing up as a child into that language. That Yolŋu Matha it's very important our language. We were born with it, we live with it, we prefer it'. [Patricia, Yolŋu Matha speaker] [79, p. 6]			
'*I'm going back, but I'm only going back to my family. I'm not going back to any follow-up support people back there, because they don't exist …As much as I'm excited to go home…it's also scary…I'm going home to a farm. There's no supports'.* [AP8] [78, p. 933]	Communication between providers [78, p. 933]		
'*I'd love to see more of the Clinics. Even if they just run off in one big building and they're designated—an African Clinic, a Burmese Clinic—and everyone gets to know about your culture*' (P3) [76, p. 4–5]	'**cultural safety**' [76, p. 4]		
'*Also, some participants reported difficulties with access, with lower ratings for the following survey items: "It was easy to find the Clinic once I got to the hospital*"' [76, p. 5]	**Access** [76, p. 5]	Accessibility of the clinic location and time	
'*Also, some participants reported difficulties with access, with lower ratings for the following survey items: … "I had a say in the timing of my appointment"*'. [76, p. 5]			

(Continued)

Table 2 Continued.

Illustration	Finding (unequivocal findings are bolded)	Category	Synthesized finding
23% of women reported that they accessed prenatal care because of clinic [71, p. 45,72]	**Would not have accessed any prenatal care if it wasn't for the APWP clinic** [71, p. 45], [72]	Improvements in accessing care	
Accessed prenatal care earlier: 47% [71, p. 45], [72]	**The prenatal clinic helped them access prenatal care earlier** [71, p. 45], [72]		
97% of women would come back to program [71, p. 45], [72]	**Come back to the program with future** [71, p. 45], [72]		
9/16 stated that accessing antenatal appointments had become easier as a result of participating in the program, 3/16 disagreed [68, p. 126]	3.3. Developing, supporting and enhancing the cultural competence of new and existing staff [68, p. 124]		
'*She worried if the therapist would like her, and also expected the "usual psychotherapy", and the need to explain herself "a hundred times over"*'. [77, p. 892]	**Ambivalence about engaging in treatment** [77, p. 892]	Barriers to engaging in treatment	
'*anxiety about being judged*' [77, p. 892]			
'*bad past experiences*' [77, p. 892]			
'*I kept changing my mind—at least three times—on the pretext that I was busy*'. [77, p. 892]			
'*moving residence frequently*' [77, p. 892]	**Difficult to stay in contact** [77, p. 892]		
'*the postcards were pretty, but they don't work, are a waste of money, and signed by someone I have never met or heard of*'. [77, p. 892]	**Ambivalence about receiving postcards** [77, p. 892]		
'*The "little cards were neat"*' [77, p. 892]	**Ambivalence about receiving postcards** [77, p. 892]	Facilitators of engaging in treatment	
'*the postcards are all good*' [77, p. 892]			

ALO, Aboriginal Liaison Officer; APWP, Aboriginal Prenatal Wellness Program; ATOC, Aboriginal Transfer of Care; CFS, Child and Family Services; IBSW, Indigenous Birth Support Worker; ICS, Indigenous Cultural Safety; OR, odds ratio; NICU, neonatal intensive care unit; RA, research assistants; SPH, St. Paul's Hospital; UHNBC, University Hospital of Northern British Columbia.

events where patients took their own leave for First Nations peoples presenting for emergency care in Redcliffe, Queensland, Australia:

> *'just them coming to have a yarn, that would be really good'.* [75, p. 560]

The synthesized finding of *acknowledgement, respect, and support for culture* was often reflected through Indigenous peoples' representation in staffing. This quote from a study evaluating an enhanced transfer of care model from hospital to primary care for Aboriginal Australians with chronic disease in Liverpool, New South Wales, Australia, demonstrated:

> *'[The ALO] talks to you on a blackfella level, the way they should, especially in the city … He tells the ins and outs of everything, explained everything.'* (P45, Liverpool Hospital patient) [65, p. 7]

Support for culture was also expressed through ceremonies, and there was some unmet need for these to occur in the Indigenous Birth Support Worker Program mentioned above:

> *'I would love more information and for [ceremonies] to be happening, for that to be arranged'*. [66, p. 4]

Feeling accepted, heard, valued, safe, comfortable, and respected was reflected in the following quote of an Aboriginal and Torres Strait Islander outpatient in a large metropolitan health service in Melbourne, Australia:

> '*This Aboriginal hospital [the Clinic] is absolutely tops and me being Aboriginal I can't say enough. I got cared for, I got well looked after, I got shown love and attention while I was there, you know. It's just a real top place'*. (P8) [76, p. 5]

However, quantitative findings from the same study indicated that the need for shared decision-making posed more difficulty in being heard:

> '*Lower ratings (<70% provided a strongly agree response) were received for statements relating to shared decision making ('Staff showed an interest in my ideas about my health'*. [76, p. 5]

The theme of *navigating treatment and the system* was exemplified by this quote from a Kaupapa Māori-centred intervention at Waikato Hospital in New Zealand:

> *'She [The RA] went through a lot of things with us, it was really good too. Like the house is one of them she went*

through. She made sure that we were up to date with everything that had to do with her, like assistance from everybody. Yeah …So we are really interested in that Tamariki Ora, and the Whare Ora. Yeah, she referred us to Quit Smoking … She was awesome. Really. I mean what took maybe was supposed to have been half an hour took us maybe two hours. It was awesome. Yeah, it was just cool. Made sure that we knew about this, we knew about that or if we were hooked onto this– right down to Work & Income, if we were getting that and if we knew that it was there. It was awesome. She was good'. [Mere] [73, p. 473]

Despite the intervention, there was still an unmet need for navigating social care systems in a study evaluating Aboriginal Cancer Care Coordinators at a major metropolitan hospital in South Australia:

'*Ultimately it would be great to have that 1 person come into your home and go off and sort it all out … someone … better equipped to give an objective view…to organise for your payslips to go to housing, and they sort out your new rent …*' [AP2] [78, p. 934]

For the synthesized finding of *perceptions of health services*, more positive perceptions of health services occurred through word of mouth in the Aboriginal Transfer of Care Model from hospitals to primary care for Aboriginal Australians with chronic disease at Liverpool Hospital, in New South Wales, Australia:

'We had one Elder that came in that it took a while for him to get into hospital. However, once he was here and we did speak to him and we did support his progression here in the hospital. Once he was discharged, he went home happy and we got the feedback from [the ALO] that he has been trying to encourage other Aboriginals that he knows that are very sick to come in to hospital because we will help them and that we are providing a good service and acknowledging their culture and supporting their culture'. (P29, Campbelltown Hospital ATOC) [65, p. 8]

However, experiences of care were still affected by instances of racism and mistrust in the study evaluating Aboriginal Cancer Care Coordinators at a major metropolitan hospital in South Australia:

'*I went down to have x-rays and there was a whole heap of orderlies sitting there around their waiting area. And I heard a racist remark by one of the orderlies. And I ended up in tears … It's like, oh Jesus, you're here crook and you hear a racist joke*'. [AP2] [78, p. 933]

However, intervention components validated the traumatic experiences of Aboriginal patients in this study:

'[The care coordinator] said, "Well, it's not acceptable"… And she didn't force me or anything, she said- "You need to really consider doing an official complaint." So I thought, yeah, no, bugger it, I've got […] cancer and I'm hearing shit like that! So, yeah, I did an official report'. [AP2] [78, p. 933]

For the outcome of *health service access*, 23% of 281 women reported that they accessed prenatal care because of the Aboriginal Prenatal Access Program [71, p. 45], [72]. Access to services was impeded due to the limited capacity of services in five Australian studies [62, 68, 74–76]. For instance, in an evaluation of an antenatal clinic based at a large metropolitan hospital in Brisbane, Australia:

'*Limited provision increased pressures on staff as the clinic was extremely busy on the one day it was in operation; women reported that their appointments rarely ran to time*'. [68, p. 5]

Quality appraisal

Supplementary Figs S1–S3 show findings from applying the modified Aboriginal and Torres Strait Islander QAT. Findings were presented for the full dataset (Supplementary Fig. S1), by study (Supplementary Fig. S2) and by question (Supplementary Fig. S3). Supplementary Table S5 shows each question with the number of papers assessed as either 'yes', 'partially', 'no', or 'unclear'.

There was only one study [80] where the researchers negotiated agreements to protect Indigenous peoples' ownership of intellectual and cultural property created through the research. In contrast, 13 studies each adopted a strengths-based approach [60, 62, 64–66, 69–71, 75–79] or provided evidence that the research benefited the participants and Indigenous communities [30, 60–63, 65–71, 73].

Supplementary Figs S4–S6 show the results of applying the MMAT. These are reported for the full dataset (Supplementary Fig. S4), by study (Supplementary Fig. S5) and by question (Supplementary Fig. S6). Supplementary Table S6 shows each question with the number of papers assessed as either 'yes', 'no', or 'can't tell'.

Four [65, 66, 76, 78] of 11 qualitative studies received a 'yes' for all questions. One quantitative study [80] received a 'yes' on four of five questions. Reporting of qualitative studies was stronger than that for quantitative studies, both across studies and in three [60, 68, 76] of the four mixed-methods studies. Supplementary Table S7 provides full justifications for the determinations on both appraisal tools.

Discussion

Statement of principal findings

The six main findings generated from the qualitative meta-aggregation from the perspective of First Nations intervention participants concerned program mechanisms and outcomes. In terms of program mechanisms, they included (1) emotional and practical support; (2) acknowledgement, respect and support for culture; (3) feeling accepted, heard, valued, safe, comfortable, and respected; and (4) navigating treatment and the system. The outcomes were (1) perceptions of health services and (2) health service access. Most patients' experiences of interventions were positive, and some negative aspects (e.g. location, opening hours) concerned logistical challenges; not any culturally specific content.

These findings are not universally represented across all First Nations communities due to intersectionality with culture, history, contemporary political and social factors across the four

countries Indigenous' peoples and the hundreds of clan groups within these countries. In addition, the clinical settings of studies included were heterogeneous in nature which both strengthens the need for anti- racism and cultural safety interventions in health care for Indigenous peoples globally. Most reports assessed the patient-reported experiences of women in the perinatal period [60, 66, 68, 71, 72, 80] or those presenting to emergency departments [30, 67, 69, 74, 75, 77]. Fewer studies included patients diagnosed with [63, 78] or being treated for cancer [70], those admitted to the hospital [73, 79], haemodialysis patients [62], chronic conditions [65], surgical patients [64], or outpatients [76].

Strengths and limitations

The included studies had several limitations. While mixed-method studies may provide a richer and complementary understanding of intervention processes and outcomes, there were only four [60, 68, 76, 77]. Only two quantitative studies [21, 70, 77] assessed the same outcomes before and after the intervention. Doing so may assist in understanding whether interventions may be responsible for changes. All studies had at least one 'no' and one 'unclear' response to questions on the Aboriginal and Torres Strait Islander QAT, signalling the need to improve reporting. Few studies included quantitative patient-reported experience measures. No studies measured experiences of anti-racism or anti-prejudice interventions. One study assessed discrimination but did not report the findings of the impact of the intervention on discrimination for the Indigenous subgroup in the study [30], while another measured and reported anti-Indigenous bias [69]. Study strengths included that some focused on negative outcomes.

Several review limitations exist. Neither of the reviewers who screened reports and extracted most of the data were First Nations. They may thus have been overinclusive in the interventions included. No grey literature search occurred, and previous relevant grey literature exists [31]. Only one study author was contacted to clarify unclear information. This review did not include general practice settings, potentially missing some evidence that could be transferable to secondary and tertiary healthcare settings. However, a 2023 review of Cultural Safety interventions [21] located only two studies [29, 81] in general practice.

Interpretation within the context of the wider literature

Thematically, there is some overlap here between the elements of culturally safe healthcare for Indigenous Peoples in Australia, summarized in a systematic meta-ethnographic review of qualitative studies published in 2022 [23]. Emotional and practical support aligned somewhat with their theme of personable two-way communication. Acknowledgement, respect and support for culture aligned with their themes of a well-resourced Indigenous health workforce and health care systems that are responsive to Indigenous Peoples' cultural knowledge, beliefs and values. Feeling accepted, heard, valued, safe, comfortable and respected aligned with the themes in that review of personable two-way communication, trusting relationships and supportive health care systems. Navigating treatment and the system aligned with a well-resourced Indigenous health workforce and personable two-way communication.

Previous reviews of the literature that have discussed [21] or quantified [82] the number of studies with patient-reported experiences or impacts have focused on Indigenous Cultural Safety training interventions for healthcare professionals [21] or cultural safety strategies in Australia [82]. This review built on these studies by searching for studies of any type of interventions, mentioning concepts including discrimination, stereotyping, bias, prejudice, hostility, harassment, cultural understanding and culturally appropriate. Despite the priority of eliminating racism in all four countries, only one intervention study [76] was located, which set out to measure patient-reported experiences of racism in the context of the intervention. However, one foundational principle of anti-racism interventions in healthcare settings is to incorporate explicit and shared anti-racism language [11].

Implications for policy, practice, and research

This review informs policy and practice in several ways. First, it confirms that the implementation of interventions to improve the experience of care for First Nations people in secondary and tertiary healthcare settings was mostly a positive experience for First Nations patients, with negative experiences typically relating to logistical challenges and not culturally specific elements. This provides evidence for all policymakers and health care providers to privilege cultural safety and anti- racism training and interventions on a perpetual basis to improve Indigenous peoples' cultural safety and experiences when seeking health care. Second, the product of the qualitative meta-aggregation provides a high-level overview of the mechanisms by which these interventions can translate into improvements in health service access and health outcomes that can inform policy documents concerning capturing patient-reported experiences. The findings of this review also reinforce the importance of clinicians and services having the opportunity to acknowledge, respect and support culture through tangible actions.

Future programs and policies must make provision to capture the perspectives of First Nations patients alongside health professionals to assess agreement with and any bias in health professionals' assessments, and capture the impact from multiple perspectives. Mixed-methods approaches are recommended, using qualitative research methods such as Yarning [83] and recently validated quantitative measures such as the Cultural Safety Survey Scale [84], so findings from both data collection approaches can inform each other. Because health professionals or hospitals might be the unit of randomization in these interventions, mixed-methods randomized controlled trials may be a suitable approach. Studies comparing novel or untested interventions to existing training or services would strengthen this field.

Conclusions

This review located 22 reports of 20 studies assessing patient-reported experiences in initiatives to improve the quality of health care for First Nations people in secondary and tertiary

healthcare settings from across four countries. While navigating their shared enduring legacy of colonization, the self-determination of First Nations peoples can be prioritized by centring their voices when developing and evaluating community-informed and community-led programs. This review showed that First Nations' voices have been centred in these interventions predominantly through qualitative or mixed-method studies with qualitative components. Benefits accruing to First Nations' individuals in these studies included receiving emotional and practical support; having their culture acknowledged, respected and supported; feeling accepted, heard, valued, safe, comfortable and respected; and feeling more confident to navigate their treatment and the health system. These experiences translated into improved perceptions of health services, evident through recommending them, expressing satisfaction with care, improved trust; better patient experiences and higher ratings of quality of care in most studies. Increased health service access also resulted, and was mainly constrained by the limited operating capacity of services and the spaces they operated in. Centring First Nations voices in this review offers the opportunity for health systems and services to reflect on the progress made in assessing First Nations' patient-reported experiences, consider opportunities for improved interventions, and redouble efforts to implement interventions that assess the mechanisms and success of these interventions with the gold standard measurement approach–from First Nations patients' perspectives.

Any amendments to information provided at registration or in the protocol: Described and explained in Supplementary Table S8.

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Author contributions

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Supplementary material

Supplementary material is available at *IJQHC* online.

Conflicts of interest

No known conflict of interests.

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Data availability

Template data collection forms will be available at the Open Science Framework webpage for the project, and data extracted from included studies and data used for all analyses are available in the supplementary information.

Ethics and other permissions

As publicly available data were used, no ethical approval was sought.

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Systematic Review