

**CADTH RAPID RESPONSE REPORT:
SUMMARY WITH CRITICAL APPRAISAL**

Building Inclusive Health Care Services: A Rapid Qualitative Review

Service Line: Rapid Response Service
Version: 1.0
Publication Date: July 31, 2020
Report Length: 29 Pages

Authors: Elijah Herington, Andrea Smith, Deirdre DeJean, Charlene Argáez

Cite As: Building inclusive health care services: a rapid qualitative review. Ottawa: CADTH; 2020 Jul. (CADTH rapid response report: summary with critical appraisal).

ISSN: 1922-8147 (online)

Disclaimer: The information in this document is intended to help Canadian health care decision-makers, health care professionals, health systems leaders, and policy-makers make well-informed decisions and thereby improve the quality of health care services. While patients and others may access this document, the document is made available for informational purposes only and no representations or warranties are made with respect to its fitness for any particular purpose. The information in this document should not be used as a substitute for professional medical advice or as a substitute for the application of clinical judgment in respect of the care of a particular patient or other professional judgment in any decision-making process. The Canadian Agency for Drugs and Technologies in Health (CADTH) does not endorse any information, drugs, therapies, treatments, products, processes, or services.

While care has been taken to ensure that the information prepared by CADTH in this document is accurate, complete, and up-to-date as at the applicable date the material was first published by CADTH, CADTH does not make any guarantees to that effect. CADTH does not guarantee and is not responsible for the quality, currency, propriety, accuracy, or reasonableness of any statements, information, or conclusions contained in any third-party materials used in preparing this document. The views and opinions of third parties published in this document do not necessarily state or reflect those of CADTH.

CADTH is not responsible for any errors, omissions, injury, loss, or damage arising from or relating to the use (or misuse) of any information, statements, or conclusions contained in or implied by the contents of this document or any of the source materials.

This document may contain links to third-party websites. CADTH does not have control over the content of such sites. Use of third-party sites is governed by the third-party website owners' own terms and conditions set out for such sites. CADTH does not make any guarantee with respect to any information contained on such third-party sites and CADTH is not responsible for any injury, loss, or damage suffered as a result of using such third-party sites. CADTH has no responsibility for the collection, use, and disclosure of personal information by third-party sites.

Subject to the aforementioned limitations, the views expressed herein do not necessarily reflect the views of Health Canada, Canada's provincial or territorial governments, other CADTH funders, or any third-party supplier of information.

This document is prepared and intended for use in the context of the Canadian health care system. The use of this document outside of Canada is done so at the user's own risk.

This disclaimer and any questions or matters of any nature arising from or relating to the content or use (or misuse) of this document will be governed by and interpreted in accordance with the laws of the Province of Ontario and the laws of Canada applicable therein, and all proceedings shall be subject to the exclusive jurisdiction of the courts of the Province of Ontario, Canada.

The copyright and other intellectual property rights in this document are owned by CADTH and its licensors. These rights are protected by the Canadian *Copyright Act* and other national and international laws and agreements. Users are permitted to make copies of this document for non-commercial purposes only, provided it is not modified when reproduced and appropriate credit is given to CADTH and its licensors.

About CADTH: CADTH is an independent, not-for-profit organization responsible for providing Canada's health care decision-makers with objective evidence to help make informed decisions about the optimal use of drugs, medical devices, diagnostics, and procedures in our health care system.

Funding: CADTH receives funding from Canada's federal, provincial, and territorial governments, with the exception of Quebec.

Questions or requests for information about this report can be directed to requests@cadth.ca

Abbreviations

PHAC	Public Health Agency of Canada
MMIWG	Missing and Murdered Indigenous Women and Girls
TRC	Truth and Reconciliation Commission of Canada
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples

Context and Policy Issues

In her 2019 annual report on the state of public health in Canada, Chief Public Health Officer, Dr. Theresa Tam, opens by identifying Canada as a healthy nation that should be proud of its social and health care systems.¹ From this position of strength, however, she reminds readers of the persistence of health inequities that prevent many people living in Canada from being able to “achieve their full potential”(p5)¹, and identifies stigma as a primary driver of these inequities.

Stigma, she notes, is the “slow and insidious practice of dehumanizing others”(p5)¹ that is performed in discriminatory policies, behaviors or stereotypes, and reinforced across multiple levels of experience (e.g., individual, interpersonal, institutional, and population). It is operationalized as self-fulfilling prophecy that both adds to and supports stereotypes bolstered by unequal power dynamics across society.(p22) Stigma makes strange “the other” and draws on the multiple intersections of “identities, characteristics, behaviors, practices, and health conditions”(p22)¹ to label, categorize and exclude.

The point of these observations, as we see it, is not to claim novelty in identifying how stigma relates to health inequity (in fact, she draws on a few of the many others who participate in this identification work²⁻⁴), but rather to recognize and work toward remediating stigma’s expansive persistence in the Canadian health care system even in the face of these observations. This commitment to remediation is demonstrated both in the development of the “Stigma Pathways to Health Outcomes Model” and the subsequent “Action Framework for Building an Inclusive Health System.” Both the model and framework provide actionable advice on how to work toward addressing these presences rather than remaining at the level of observation.

As is evidenced in the name of the action framework, conversations around stigma and inclusivity are so entangled as to seemingly be one and the same. Indeed, in Luchenski et al.’s identification of “inclusion health” as an emergent health service, research and policy agenda, they mark the aims of this broad agenda as oriented toward a similar goal as Dr. Tam’s work on stigma – addressing “extreme health and social inequity.”(p1)⁵ Furthermore, they note that moves toward “inclusion health” have benefitted from at least two perspectives identified as similarly entwined in the process of stigmatization – social exclusion and intersectionality.^{5,6} While the terminology and conceptual use of “social exclusion” has become something of a catchall since Rene Lenoir original use of the expression in 1974,⁷ this review understands exclusion as that which marginalizes and places on the periphery – it denormalizes. In line with our understanding of intersectionality, exclusion is performed in the movement of power across gendered, racial, socio-economic, and cultural, among other, spaces.

This CADTH Rapid Response similarly aims to identify and describe some components of what it means to build inclusive health care services with Indigenous peoples living in what is now known as Canada. Whereas this aim follows the mode and tenor of both Dr. Tam's annual report¹ and broader calls toward "inclusion health,"^{5,6} we ground our work from a position that identifies stigma as one component of inclusivity and orient our focus specifically toward how inclusivity can shape Indigenous peoples' engagement with health care services in Canada.

Research Questions

How do people (e.g., community members, practitioners, funders) engaged with health care services (e.g., community health programs or private practice) that are situated within Indigenous communities, or largely oriented toward Indigenous peoples, conceptualize inclusive care?

- a. How did people describe the conditions of development, implementation and daily practice that contribute to the inclusivity (or not) of their health care services?
- b. How have these studies framed and engaged with the terminology of inclusivity (or related terminology of diversity, accessibility, cultural safety or awareness, etc.)?

Key Assumptions

We approach this project from a position aligned with the "Calls to Action" of the Truth and Reconciliation Commission of Canada (TRC),⁸ the "Calls for Justice" of the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG),⁹ and the UN Declaration on the Rights of Indigenous Peoples (UNDRIP).¹⁰ In particular, Call for Justice 7.1 (along with Call for Action #22⁸ and UNDRIP Article #23¹⁰) reminds all levels of health care institutions to:

recognize that Indigenous Peoples – First Nations, Inuit, and Métis, including 2SLGBTQQIA people – are the experts in caring for and healing themselves, and that health and wellness services are most effective when they are designed and delivered by the Indigenous Peoples they are supposed to serve, in a manner consistent with and grounded in the practices, world views, cultures, languages, and values of the diverse Inuit, Métis, and First Nations communities they serve.⁹

As such, this review recognizes that any conversation around building health care services must begin with (and be maintained by) the participation, direction and oversight (if not outright governance) of Indigenous peoples. Similarly, we take this to reinforce our decision to frame our review as informative to the work of other settler institutions or individual practitioners. We have chosen to center settler responsibility in inclusive health care services given our understanding that the full implementation of Call for Justice 7.1⁹ (among others) requires that settler institutions and practitioners first break down the structures of "whiteness and racism"¹¹ that reinforce inequity in Canada's health care system.

Key Findings

- Building inclusive health care services with Indigenous peoples is not the exclusive domain of settler service providers, but requires ongoing participation of, direction

and oversight from Indigenous peoples living in the locations where services will be or are currently located.

- Building inclusive health care services begins at the stage of identifying exclusion through the examination of assumptions and norms across all levels of service provision (e.g., individual, interpersonal, institutional, systemic) This process involves ongoing critical reflection on the part of leaders and practitioners of the ways in which individual behaviors and institutional or systemic attributes may reinforce and perform exclusion.
- Building inclusive health care services requires ongoing development and uptake of practices directed at addressing the specificity of these exclusions in health care service provision.
- Building inclusive health care services requires ongoing consideration of the external factors relevant to the specific service area and exploration of opportunities to reframe inclusion from “how can we bring or include Indigenous peoples into our care services” to “how can we participate and include our practice into the lived realities of the communities we are situated within.”

Methods

Literature Search Methods

A limited literature search was conducted by an information specialist on key resources including Ovid MEDLINE and PsycInfo. The search strategy was comprised of both controlled vocabulary, such as the National Library of Medicine’s MeSH (Medical Subject Headings), and keywords. The main search concepts were community health and cultural diversity or inclusion and Indigenous peoples. Search filters were applied to limit retrieval to qualitative studies. The search was also limited to English language documents published between January 1, 2010 and June 3, 2020.

Selection Criteria and Methods

One reviewer screened citations and selected studies. In the first level of screening, titles and abstracts were reviewed and potentially relevant articles were retrieved and assessed for inclusion. The final selection of full-text articles was based on the inclusion criteria presented in Table 1.

Table 1: Selection Criteria

Setting	People living in Western Settler states (e.g., Canada and the US/Turtle Island, Australia, New Zealand/Aotearoa) who are engaged with health care services providing care to Indigenous peoples (e.g., community members, practitioners, funders)
Phenomena of Interest	Health care services that are either situated within Indigenous communities or largely oriented toward Indigenous peoples
Design	Qualitative studies of any design (e.g., phenomenology, grounded theory, qualitative description) that use qualitative data collection and analysis methods; mixed methods designs that use robust qualitative data collection and analysis methods
Evaluation	Expectations, experiences, understandings, social relations and perspectives of people engaged with health care services oriented toward Indigenous peoples; framing, use of and

	engagement with terminology of inclusivity (or related terminology of diversity, accessibility, cultural safety or awareness, etc.) by people engaged with these programs
Research Type	Primary qualitative studies, mixed-methods studies with a robust qualitative component

Exclusion Criteria

Articles were excluded if they did not meet the selection criteria outlined in Table 1, they were duplicate publications, or were published prior to 2010. Additionally, once we began to review the literature, we made the decision to exclude the following types of studies:

- Studies focused around the cultural importance of wellness or lifestyle programs formed within Indigenous paradigms of health and wellbeing. This exclusion is not because we found these studies to be of little value or limited quality, but rather due to our recognition that as settler researchers trained and located within an institution that privileges settler modes of knowledge building, we are not equipped to analyze these studies or their included programming. Rather, given this very positioning, we see our role as focusing on the mobilization of inclusivity (or its related terminology) within health care services developed from a Western paradigm of health and wellbeing.
- Studies focused around health care services oriented toward behavioral modification along the lines of mental health, substance use or sexuality – even when formed within a Western paradigm of health and wellbeing. We chose to exclude these interventions/studies given their complex entanglements with racism, multiple layers of state sanction abuses of Indigenous bodies, and privileged position in historical projects of colonial assimilation and control.¹²⁻¹⁴ While we do believe Settler institutions must remain vigilant to the possibility that these types of interventions may perpetuate ongoing acts of assimilation and critique them when they do, a rapid response does not provide the time or space to do so.
- Studies that place the responsibility of inclusivity upon amending any individual perceived deficit of Indigenous peoples (e.g., not feeling as though an intervention is as important as public health practitioners do, poor rates of adherence to a chosen intervention that are framed as the “fault” of Indigenous peoples).

Critical Appraisal of Individual Studies

Critical appraisal was conducted by the primary reviewer and followed Krefting's¹⁵ interpretation model for assessing trustworthiness in qualitative research. Krefting's emphasis on and mode of exploring trustworthiness¹⁵ asks the reviewer to consider the interactions between research methods and results as a way of evaluating the process involved in arriving at a certain result or conclusion. This is done with a particular focus on four guiding questions: Were the study authors true to their participants (credibility)? Does the analysis make sense in light of the data presented (confirmability)? Is the analysis consistent across study findings (dependability)? Does the analysis found in one study resonate with both the analysis of other studies and the research question for this review (transferability)?¹⁵

As critique and analysis are often co-constitutive in qualitative research, this streamlined appraisal is consistent with disciplinary norms in which understanding aspects such as how

data are collected or where data sources are situated in relation to the researcher represent more than methodological considerations. Results of the critical appraisal were not used to exclude studies from this review; rather, they were used to understand the methodological and conceptual limitations of the included publications in specific relation to the research questions.

Data Analysis

Descriptive Analysis

The secondary reviewer extracted descriptive data of study characteristics including settler state in which the study was conducted, the stated study objectives, study design and data collection strategy, setting, inclusion criteria, and description of study participants. These have been presented in both tabular form in Appendix 2 and as a narrative summary.

Analytic Approach

Drawing on the tenets of thematic synthesis¹⁶ and grounded theory,¹⁷ data analysis followed an iteratively staged process that included several close readings of eligible studies, note making, descriptive and analytic memoing, and the construction of a synthetic analysis. The intent of the synthetic analysis has been to elucidate how participants within the included studies conceptualize inclusive care. The constant comparison method was adapted to include comparing notes or memos within and across studies. The synthetic analysis was done by the primary reviewer.

The primary reviewer began by reading and rereading eligible studies multiple times while making marginal notes and memos (in Word) to reflect preliminary thoughts, impressions and insights. While many of the notes were descriptive and referred directly to the content of a single line or paragraph, others critiqued and drew upon various study components (e.g. design or method, positioning of study authors, commentary in the discussion section) so as to be used as part of critical appraisal. The reviewer “coded” the data by underlining and bracketing lines or sections that seem particularly salient. Similar to the inductive logics of line-by-line and descriptive coding, this process allowed the reviewer to begin making connections throughout the empirical data found across the body of eligible studies.

These connections formed the basis of an outline of descriptive themes in Word and served as a skeleton for orienting and framing the synthetic analysis. At this stage the primary reviewer formally turned toward the construction of a synthetic analysis. Drawing on the primary reviewer's growing familiarity with the data set as built through (ongoing) iterative readings, successive layers of marginal notes, and outline development, the descriptive and analytic practice of memoing was used as a way of identifying links across descriptive themes and the research questions.

A second reviewer was engaged throughout this process and asked to read written memos and early drafts of the review. Their role was to probe for gaps in the primary reviewer's thoughts (as represented in memos and discussion) and to remain attuned to the purpose of the review and direction of the research questions. Ultimately, these memos served as the basis for the synthetic analysis and were incorporated with the descriptive themes at the time of writing.

Summary of Included Literature

Quantity of Research Available

A total of 1,031 citations were identified in the literature search. Following screening of titles and abstracts, 1,000 citations were excluded and 31 potentially relevant reports from the electronic search were retrieved for full-text review. Of these potentially relevant articles, 18 publications were excluded for various reasons, and 13 publications met the inclusion criteria and were included in this report. Appendix 1 presents the PRISMA¹⁸ flowchart of the study selection.

Summary of Study Characteristics

Additional details regarding the characteristics of included publications and their participants are provided in

Study Design and Data Collection Strategy

Of the 13 included studies, all were qualitative.¹⁹⁻³¹ Of those reporting study design, four described including elements of participatory action research.^{20,25,26,28} One each described using multi-sited ethnography,²³ health system assessment³¹ or a “co-operative inquiry that engaged community members in a collaborative interview process.”²² The remaining six did not report on study design.^{19,21,24,27,29,30}

Eight studies described collecting data using interviews alone^{19,20,22,25-28,30} two described using focus groups alone.^{21,31} Two more described using a mixture of focus groups, interviews and field observations.^{23,29} and one a mixture of interviews and yarning circles.²⁴

Location of Study – Settler State

Prior to identifying the location in which each included study was conducted, we would first like to acknowledge that the lands now occupied by Settler States (e.g., Canada, USA, Australia, New Zealand, etc.) are largely recognized by the names of the colonizers rather than those of the peoples indigenous to these lands. Given this reality, we must further acknowledge that we are complicit in this ongoing act of colonialism across Indigenous lands when we identify studies included in our review by their settler names.

Eight of the thirteen included studies were conducted in what is now known as Australia.^{20,24,27-31} Four studies were conducted in what is currently known as Canada.^{19,22,25,26} One each were conducted in the USA²³ and Norway.²¹

Description of Study Participants

For the purposes of narrative summary, participant descriptions were sorted into four categories: Indigenous health services worker, non-Indigenous health services worker, non-identified health services worker, and participant identifying as Indigenous participant speaking from a position of, among others, cultural mentor, community member or program participant. Full details are available in Appendix 2.

Three studies included people working in the health services sector (e.g., health care provider, health services board member, etc.) and identified as Indigenous^{19,25,28} Eight studies included people working in the health services sector who did not identify as

Indigenous^{19,25,28,30} or were not identified as either Indigenous or non-Indigenous.^{20,21,24,31} Six studies included participants who identified as Indigenous and spoke from positions including, but not limited to, cultural mentor, community member, and program participant.^{20,22-24,26,29} In total the included studies were comprised of six Indigenous people working in the health services sector, 148 non-Indigenous or non-Identified people working in health services sector, and 325 Indigenous participants speaking from positions such as cultural mentor, community member, and program participant.

Description of Programs or Inclusive Measures Taken

Given the diversity of programs and inclusive measures taken across included studies, we have sorted studies into three primary categories for this narrative summary: studies that are focused on a particular program or intervention; studies focused on general policy changes or development of oversight committees; studies that did not identify any particular policy, program, intervention or policy change. Full details are available in Appendix 2.

Six studies were not focused on any particular policy, program, intervention or policy change.^{19,21,23,25,29,30} Four studies focused on a particular program or set of interventions.^{20,22,27,31} The remaining three focused on general policy changes made or oversight committees developed.^{24,26,28}

Summary of Critical Appraisal

The studies included in this review were assessed to be of a moderate to high degree of trustworthiness overall.

We identified two studies that were of average credibility.^{20,22} While it is impossible to know what happened in the actual interviews, given the interview questions identified within each study's methods section we were concerned that study participants were constrained in the types of responses they could provide. In both studies there seemed to be a number of unexamined assumptions wrapped into the questions that could have prevented study participants from being true to their thoughts, feelings and experiences with the programs in question. For this same reason, both studies struggled with confirmability as well. None of the included studies were identified as being of limited dependability, as their internal logics and ways of framing seemed consistent across the entirety of analysis.

The primary factor affecting the trustworthiness of the included studies was their transferability. However, rather than this being the fault of any of the included studies in and of themselves, we identify our concern over transferability as located primarily in relation to the language of our own research questions and the diversity of programming, policy development and oversight structures across studies. While the primary object of our review was "inclusivity," this particular language is rarely identified as the object of our included studies. Rather, while studies may have identified inclusivity as a goal, most oriented their work around questions of what is "culturally appropriate care"^{23-28,31} or how to navigate cultural difference.^{19,21} As such, the difficulty for transferability was in identifying where the variability in languages employed articulated a shared movement toward inclusivity in health care services.

Summary of Findings

Taken as a whole, inclusive health care were described as a mode of practice and program design rather than a set of best practices that can accomplish the task of inclusivity. This is not to say that there were no specific action points identified, but simply that inclusivity is

best understood as a process rather than an endpoint or discrete actions. For the purposes of our review, we have organized these action points in a order that made sense when considering how to begin the process of building inclusive health care services: identification of exclusions, remediation of exclusions, and participation in the externalities of service provision.

While several studies noted the importance of Indigenous governance and/or oversight of health care services, given our attention to the MMIWG Calls for Justice,⁹ the TRC Calls to Action,⁸ and UNDRIP¹⁰ we have taken this for granted and frame our analysis with the assumption that all moves toward building (and maintaining) inclusive health care services begin at the participation, direction and oversight of Indigenous peoples.

Inclusive practice begins at the level of exclusion

Inclusivity as identifying interpersonal exclusion: attending to culture, racism and stigma

Discussions about improving how health care services are provided in Indigenous communities or with Indigenous peoples often circled around the importance of identifying and remediating exclusions. Exclusion can often be difficult to identify and may take place across multiple connected layers.

Consider the following description from a “white health professional” regarding how language becomes mobilized in a hospital setting.

[Staff] said they could see they had difficulties communicating with Aboriginal people but were trying hard. But they never think about getting a map to find out where this person comes from, what the local language from that area is. Separation from country [for Indigenous Australians] is a really big deal particularly at the end of life . . . [Staff need to be] asking the question ‘Who could we get to help talk with you in your language’?(p6/11)³⁰

Given that staff are already “trying hard” to communicate with Aboriginal people in their care, the reliance on English language performs one form of exclusion here. Exclusion identified, a fix can take place by pulling in an appropriate interpreter who can speak to and connect with the Indigenous person dying in hospital. However, this situation is further complicated when the speaker continues by describing the way in which previous requests for interpreters speaking various Aboriginal languages have been denied. The irony here, they note, is that several interpreters of various European languages are readily available in the same hospital. The participant continues:

Basically I think it is an issue of mistrust. Australians in an institutional setting (like a hospital) somehow have more confidence in interpreters from [Europe] than they do from an Aboriginal community . . . There is a sense of things being chaotic, disorganised, how would you know if you have the right answers, whereas there is a sense that other Europeans think like us and would probably know what it was all about. A vague unease.(p6/11)³⁰

So, what are the stakes of exclusion here? While they clearly lay at the level of the availability of interpreters, the exclusion being identified in the second quote is much more insidious. Mistrust, chaos, disorganization, unease – outside the norm. Given the ability for Europeans to “think like us,” they and their interpreters are considered worth including in the hospital care setting. What does this imply about the Indigenous person in that very same care setting? In this example, it is not enough to ask how to we move funds around to

include interpreters. Rather, the work of inclusivity here moves toward pinpointing why Indigenous interpreters have yet to be included in standard services. Racialized and stigmatizing representations of Indigenous peoples as chaotic or disorganised – not “like us” or “know[ing] what it was all about” – are identified as the drivers for the absence of interpretation services and resultant non-inclusive care.

The point is not to critique this particular hospital and their own practices of exclusion, but rather to draw out how an act like providing (or not) Indigenous interpreters can bely colonial understandings or frames (i.e., “not like us”, “disorganized that hamper inclusivity and support exclusion. It identifies the importance of digging beyond the obvious as a practice of inclusivity. What else, for example, might be caught up in a practitioner’s refusal to provide pain medication to an Indigenous person in their care,²⁶ or practitioner consternation over why their Indigenous patients simply do not take care of themselves?^{19,25,27,29,30} What about Indigenous people’s experiences of being feared by their care providers?²³

Inclusivity as identifying structural exclusions: critically engaging with the practices and norms of space

Health care technologies, institutional policies and physical spaces of health care provision are all structured with particular uses in mind. While these may often be considered banal, mundane or a-cultural, several participants across our included studies provided insight into how these policies or technologies could be considered exclusionary in their form.^{23,26,27,30} This could take the form of questioning the policies in place that enforce or prevent someone from feeling visible or as though they belong. For example, participants in Hole et al.’s study²⁶ provide a particularly salient walk through the exclusionary power of standard hospital visitation policy. Described by one participant as being “for everybody else. [That] doesn’t include us as Indian people,”(p1667)²⁶ visitation policies were identified as privileging non-Indigenous ideals of medical care. This is well captured in one woman’s frustration at the “stupid” rules.

I don’t think they’re effective. Like the whole two people in a room rule. They don’t get the fact that this is so significant for us. They have their idea of what is medically safe. And it’s more that they’re able to get to the patient and work with the patient than it is for the patient to have family support. We managed that. When they needed to come in and deal with grandma then we left. And then we went back [when they were done]. We’re out of your way. We’re not making things harder for you. So what’s your issue? . . . But they’ve got this rule and there’s no thought involved as to how effective it is. What’s the point in having the rule? Why do we continue using this rule? Should this rule be changed for certain situations? You know, especially in this life because when you think about somebody making that transition (dying), what is most important, your loved ones or some medical procedure? Well and it feels so arbitrary. The rules are just arbitrary.(p1668)²⁶

What is the exclusion here? The constraints of the encounter, that only two visitors are allowed in the room at a time, may seem to be the exclusion. At this level, the hospital could simply increase the number of individuals allowed to be in the room and be done with it. But we might argue that the stakes, while certainly about numbers, are also about the norms of care. How does one care for a dying relative – “what is most important, your loved ones or some medical procedure?”

While this participant ties (and understands) the enforcement of visitation rules to the hospital's "idea of what is medically safe," they still find themselves questioning "the point of having this rule." There is an obvious disconnect between the hospital policy and this individual's focus at the end of life. In this case, exclusion is a privileging of the cultural values of Western medicine over those of the Indigenous person speaking. The use of this particular example is not intended to essentialize Indigenous peoples' experiences or approaches to death and dying (nor deny that many non-Indigenous people may similarly want to be with their dying relatives), but rather to highlight the importance of questioning the way colonialism, in the form of a dominant European or Western ideology, can play out in health care facilities and their policies in clinical spaces.

We are not told by study authors or the speaker how to remedy this disconnect and exclusion in this instance. But drawing attention to and seeing how exclusion "works" can help begin to reorient toward inclusion. While it is fair to say that visitation policies restricting access to loved ones in hospital are rarely appreciated by anyone navigating them, it is important to consider, as one Indigenous man explained, "there's a whole different world when it comes to us, eh? And the oppression that our people have felt, smaller things, words, looks, movements, can insult us and make us feel powerless, and they don't even know they're doing that because they're not even aware of all the difference of our world."(p1670)²⁶

Colonialism's lineage and ongoing propagation of institutional exclusion across settler states is inevitably caught up within contemporary clinical encounters.^{23,26,27} Colonialism, by nature, privileges the norms and practices of the Colonial state at the expense, or exclusion, of the colonized. Relating her experience of clinical care in a town bordering a reserve to the history of colonialism a Yupik Elder said, "They come into the village and tell everyone what to do, 'I'm the boss' – the non-Native way – 'Our way is right and their ways are wrong' – like the missionaries, they turned you into whatever they were, Catholic or Episcopalian – they didn't give us a choice to be whatever we wanted."(p306)²³

Similarly, the physical space of the clinical encounter can be experienced as salient reminders of exclusion. As one Indigenous man noted, "To me when I look at the hospital, it's not different than looking at the residential school building. What they represent, it's not good things and so they're gonna have to work damn hard to convince me, and other folks like me, that they've changed."(p1668)²⁶

Put directly, the dispossession and disempowerment of colonialism is kin to the exclusion of health care. Given that Indigenous peoples are often pejoratively considered as ignorant to clinical practice,^{19,21-23,25,27-30} the work of inclusivity here might first be to consider the ways in which, in this case, hospital policy may be ignorant to the variety of Indigenous modes of being. Rather than situating the problem upon the other, the Indigenous person, settler health service providers may first look for it in their own norms.

Inclusivity as developing practices specifically oriented toward remediating exclusions

The dynamic movement of colonialism across settler states and the diverse focus of various health care service providers means that the particularities of exclusion identified in the previous two sections are neither exhaustive nor universally applicable. Rather, the aim of those two sections was to relate how participants across included studies identified how exclusions so easily slide into practice and embody colonial moves to dominate and control the narrative. For example, while visitation hours may not be a concern for private dental

clinics, standard practice around appointment scheduling and attendance policy may be reevaluated. In this section, we provide a few examples of practices that study participants described as working to remediate exclusions at both interpersonal and structural levels.

Inclusivity through addressing individual and interpersonal practices of exclusion

By and large, within the included studies, conversations about how to address exclusions tended to focus on individual or interpersonal measures.

As an individual, one can practice inclusive care by remaining attuned to and critiquing one's own cultural situatedness (i.e., how one's own cultural background and education frames thoughts and actions).³⁰ By moving the critical gaze inward, rather than onto the Indigenous person, care providers can work to "suspend disbelief and subjugate their own world views that may have discounted the client's understanding of health and illness, instead becoming attentive to such perspectives." (p9/11)³⁰ Working to know one's self in this way, can help a provider to acknowledge where their frames of health or health care interfere with the needs or desires of the person seeking their care.

In and of itself, however, this individualized practice of inclusion cannot fully address exclusions given that in a care setting, individual action is always caught within the interpersonal. If individual practice is specifically framed toward the inward gaze, interpersonal practice is how this inward gaze becomes mobilized in caring relations built on respecting differences, fostering trustworthy environments and acknowledging a shared humanity.^{23,25-27} For the studies included in our review, these mobilizations toward inclusive care tended to be couched in the language of "culturally appropriate care" (e.g., cultural safety, cultural sensitivity, cultural competency, etc.).^{19,26-28,30}

What qualified as culturally appropriate care varied across studies and ranged anywhere from participants describing cultural sensitivity as "never assum[ing] anything"²⁵ to a blurred line of cultural competency/sensitivity as "understanding how to approach things."²⁸ While the two points are not necessarily in complete opposition, parsing the difference between holding "knowing" as an assumption and "knowing" as confidence in one's capacity to engage with difference was difficult for the review author. This is likely due to the review author's limited engagement with concepts of competency, sensitivity and safety as well as the abbreviated timelines of rapid response to engage further with these concepts. Nonetheless, our analysis pursues and draws from the understanding of culturally appropriate care as "never assum[ing] anything."

Taken as such, culturally appropriate care works at the level of stereotypes and stigma that emerged from our analysis of interpersonal exclusions above. Assumptions were described as operating on at least two layers that can both work to essentialize indigeneity.^{23,25-27} On the one hand, good intentions can be caught up within stereotypes of "Indigenous" traditions, culture or beliefs and lead providers to assume they "know" what the Indigenous person in front of them will want in their care.²⁷ While it was important to be knowledgeable of cultural practices particular to the community you work in, it was described as important to remember if "you work in one community, you work in one community."^(p62)²⁷ Rather than identifying a singular and specific way of thinking, operating or being, terms like Indigenous and Aboriginal are used to categorize diverse peoples inhabiting lands prior to colonization. On the other hand, assumptions can reinforce negative stereotypes and prevent care providers from seeing the person in front of them.²⁶ Not only can this lead to detrimental health outcomes for the person seeking care,²⁵⁻²⁷ but it can also place an immense burden of emotional labour on the Indigenous person seeking care.²³

In their study examining how Aboriginal cultural mentors would describe cultural competency to general practitioners in what is now known as Australia, Abbott et al. lay out four categories that are helpful to think through when organizing care: “attitudes and approach,” “communication and consultation skills,” “culturally aware practices,” and “applied knowledge.”²⁷

Another way of supporting the move toward inclusive health care services is by providing financial and human resources that demonstrate the privileged position of this work.^{19,26,28-31} In some ways, this falls back on the notion of relationships needing to be built. Transiency of care providers in Indigenous communities can be damaging and felt as less than inclusive. What is it like to be felt like as a pit stop on the way to somewhere else? Furthermore, if there are Indigenous peoples who are hired as staff from within the community, there needs to be enough money to maintain high levels of staffing.^{28,28}

One of the particularly salient points to emerge from these discussions around culturally appropriate care and assumptions was the way in which training helped some participants learn to identify interpersonal practices of exclusion in their own lives. As one non-Indigenous hospital receptionist put it,

[I have had to ask] is my colleague suggesting the person’s being aggressive because they’re being aggressive or are they just a person in distress who doesn’t understand and who is frustrated and it is being perceived as aggression because of my colleague’s own personal views and values about that person’s race or ethnicity and I’ve seen situations where that’s occurred. . .and no-one really stopped to take the time to sort of think ‘is this an issue actually with the patient or is this actually an issue with my colleague?’ ‘Who owns this issue here?’(p548)²⁸

While we are not told whether this nurse intervened and spoke with the colleague about their behaviour or not, the point of “ownership” remains. Exclusion, by definition, is the refusal of belonging – the refusal of being seen as within the acceptable, the norm. In this nurses’ questioning of “who owns the issue here?” they identify (from our vantage point) is a need to reframe the stakes of the encounter. Does this persons’ distress, and, more importantly, their exhibition of this distress, belong? And who owns the right to determine which responses to distress belong in that space?

Exclusionary practices (such as racial profiling and stereotyping) are insidious in that they often go unaddressed, or worse, unseen. If cultural awareness or competency training offers trainees the opportunity to learn to identify the links between the seemingly abstract movements of colonialism or racism, and how these inform “on the ground” practices of exclusion , perhaps this helps foster spaces oriented toward inclusivity and are worth pursuing.

Inclusivity as considering the external factors and context of a particular health care service

Beyond rooting out exclusions already existing in health care services and finding ways to remediate these exclusions, the pursuit and building of inclusive health care practices can also involve considerations that are broader than specific clinical encounters.^{19,29,31} This practice turns the notion of inclusivity around to move attention away from how can Indigenous peoples be included into our services, to how do I make my practice something to be included into other lifeworlds? Not letting those “contextual factors” just sit as something “to be aware of.”

While this was not a view shared uniformly across studies, some participants drew attention to the importance of understanding the ways in which other material concerns may necessarily interfere with attending to or following through with care. For some this was as simple as finding a way to include transportation into the structure of care provision given that if people could not attend their appointments, it “defeats the purpose of us being here.”(p6/15)³¹ While this may not always be travel for every community, asking what the spaces around care that could work to defeat the purpose of being there is important.

This could be further supported by knowing what other health care services those participating your own services have already, or are likely to, engage.^{29,31} What is the pathway of care they are pursuing and how do your services tie or interact with those of other providers? “If no-one knows how long it is reasonable to wait for cataract surgery in the local public hospital, then the community just accepts whatever time is offered and the health services and optometrists are not empowered to remonstrate for change.”(p5/10)²⁹

Not only was it important to know the pathways of care those engaged in your services may be following, but this was also described as advocating for these people when they engage in other services and encounter exclusionary practices.³¹ While it is possible that one’s own health care services are undergoing fundamental changes oriented toward inclusivity, given that yours is not the only service being engaged it is important to consider where else people involved in your services may encounter systemic racism.

Folks who work at the AMS described having to deal with racism in hospitals that they had referred their patients to. One of the GPs even noted “that this involved, personally, a lot of advocating. . . ringing and cutting through the crap, the resistance and the verbal ‘rolling of the eyes’ and just keeping on pushing until the appointment happens’.”(p10/15)³¹

Study participants identified the risks involved in limiting care to the clinic as caught up with concerns of focusing on superficial solutions that do not address adequately the structural factors contributing patients’ health.^{19,20} For example, some study participants were concerned that focusing on clinical practices like prescription writing allows providers to remain ignorant of larger structural factors.¹⁹ Wrapped within the language of “social determinants of health,” some participants suggested that care providers and institutions develop relationships and establish agreements of support with Indigenous led/governed services located elsewhere within the community.³¹

Limitations

There are several limitations in the production of this report that concern both the included literature and the conduct of the research.

By and large, the terminology of inclusivity was absent from the included literature for this report. This is not to say that the word itself was missing, but rather that questions engaging with the meaning of inclusivity (e.g., how it ought to be defined) or how care becomes inclusive were rarely the explicit purpose of the included studies. Instead, many of the studies that met inclusion criteria were oriented around the language of cultural competency, safety and appropriateness. While this does not lessen the importance of the findings within this review, it may have led to a heavier focus on some components of inclusivity over others (e.g. individual responsibility over structural or system modes of exclusion).

In focusing our attention on the material, behavioral, and intellectual practices that settler providers or institutions should consider when working toward inclusive care services, we hope to have limited the possibility for harm that settler research has perpetuated for Indigenous peoples living in current settler nations. However, our privileged histories and movements through Canadian health care spaces (and life more generally) may have prevented us from identifying discussions within the included, international set of studies that could have provided more depth or grounding to our own analysis of those studies. While we were attentive to the ways in which our work could perpetuate harm (and have made conscious decisions to leave out various conversations from the included literature), it is possible that what we have presented above may preserve the norms of settler colonialism and the ongoing assimilation of Indigenous peoples into these norms.

And finally, given that several of the included studies conflated the meanings of “effective” care and “inclusive” care, we found it particularly challenging to parse through and remain attentive to the distinctions between what might make something inclusive versus what might make something effective. While the former certainly informs the latter, we focus here on finding the factors that *might* lead to effective programming but can *definitely* inform inclusive programming.

Conclusions and Implications for Decision or Policy Making

Building health care services with Indigenous peoples that are that are inclusive and safe is difficult. The findings presented in this review indicate that inclusivity is much more related to a mode of, or approach to, care that at the very least involves:

- ongoing participation, direction and oversight of Indigenous peoples living in the locations where services will be or are currently located;
- ongoing examination of assumptions and norms across all levels of service provision (e.g., individual, interpersonal, institutional, systemic) and critical reflection on the part of leaders and practitioners of the ways in which individual behaviors and institutional or systemic attributes may reinforce and perform exclusion.
- ongoing development and uptake of practices directed at addressing the specificity of these exclusions in health care service provision
- ongoing consideration of the external factors relevant to the specific service area and exploration of opportunities to reframe inclusion from “how can we bring or include Indigenous peoples into our care services” to “how can we participate and include our practice into the lived realities of the communities we are situated within.”

This is not to say that there are no other components to working in a mode of inclusivity, but rather to reiterate what were found as the most salient emerging from the literature included in this review. Similarly, the addition of “ongoing” to the beginning of every point is intentional and meant to articulate that it has become our understanding that inclusivity can never be completed, only worked toward.

Discussion

Commenting on the relationship between moves to reconciliation and Indigenous health research, Marcia Anderson calls on settler researchers (we will extend this to settler health

services workers) to move beyond “beneficent notions of allyship.”¹¹ While allyship can play a supporting role in the development of new regimes of care that are led by Indigenous peoples, she identifies a need for settlers in these positions of relative power to first “become active disrupters of systems of whiteness and racism that are the roots of historic and current harms to the health of Indigenous Peoples.”¹¹

We encourage readers to consider what Anderson’s call might mean in relation to the findings of this review. Consider the ways in which moves toward inclusivity could, at times, privilege performances of allyship over the work of systemic disruption. While allyship is certainly one component of building inclusive health care systems (by, for example, following and adhering to the “direction and oversight of Indigenous peoples living in the locations where services will be or are currently located”) there is a danger of decentering settler responsibility in this work. Furthermore, this may not only reinforce settler “moves to innocence,”³² but can also prompt partial solutions to far reaching exclusions.

In our reading, this is exemplified in the dissonance caught within the will to root out discriminatory practice (identification) and the desire to bring those experiencing exclusion into the fold (remediation). The question is, however, whose fold and at what cost?

When, for instance, a hospital decides to include Indigenous languages into their translation services, are the systems of whiteness, racism, and colonialism that reinforce their exclusion as a viable option being addressed? Perhaps, but we would suggest only partially. By reminding “us” that Indigenous peoples are often perceived as not “like us,” this study participant draws attention to the baked-in exclusivity of the health care services in question. It is not only that Indigenous peoples who do not speak English (or French) are prevented from fully communicating with their care providers, but also that the health care services were not created for “them” in the first place. The ease with which European travelers are perceived as moving through this Australian hospital given the right interpreter implies a privileging of Western ideals and norms. Without considering what it might do to disrupt these ideals and norms, it is possible that simply providing translation services for Indigenous peoples moving through hospital would reinforce the racialization of Indigenous peoples as untrustworthy, disorganized and chaotic.

Being disruptive

As these norms and exclusionary practices are being identified, how might one go about disrupting them? While options may be as varied and local as the services themselves, in our attempt to identify inclusive practices that could be taken at a generalized level and given a more deliberate form in local contexts, three primary practices stood out from the included literature: privileging oversight structures that reinforce Indigenous participation and direction of service provision; providing some form of training and ongoing education in what qualifies as “culturally appropriate” care; and engaging with factors external to one’s health care services. While the first of these three practices was identified in our assumptions described at the outset of this review, it was well supported throughout the literature and bears repeating.

The second asks both individual providers and health care institutions to engage with practices such as cultural competency training. To be disruptive when taken up as a mode of practice, this requires more than simply acknowledging the cultural difference of Indigenous persons participating in their care, but asks providers to understand their cultural situatedness and that of the system they work within as well. This is not to say that care providers should not be culturally knowledgeable (e.g., a settler midwife in a Cree

community should know local birthing customs); they should. Rather, much like the work of rooting out exclusions, we are identifying “cultural appropriate care” as an inclusive mode of practice that asks practitioners to constantly critique and interrogate the norms of their institutions and care practices.

The importance of this interrogation cannot be overstated. In her book, *Therapeutic Nations*, Dian Million describes the dangerous potential of moves toward multiculturalism across settler states like Canada. Working around the periphery of the politics of recognition and self-determination,^{13,33} Million points out the way in which “Canada can stall more autonomous self-determination efforts by Indigenous governments by negotiating their adaptive inclusions into its already expansive neoliberal multiculturalism.” (p 158)¹² The point here, while taken from a larger conversation on the politics of self-determination, is that inclusion can serve as a way of deflecting from more substantial stakes. Inclusion into the multicultural milieu, in this case, subsumes Indigeneity into the many. Disruptive work around “culturally appropriate” services then, might ask, how can we decenter settler norms and ideals in a way that privileges local Indigenous norms and ideals – how do our services become something to be subsumed?

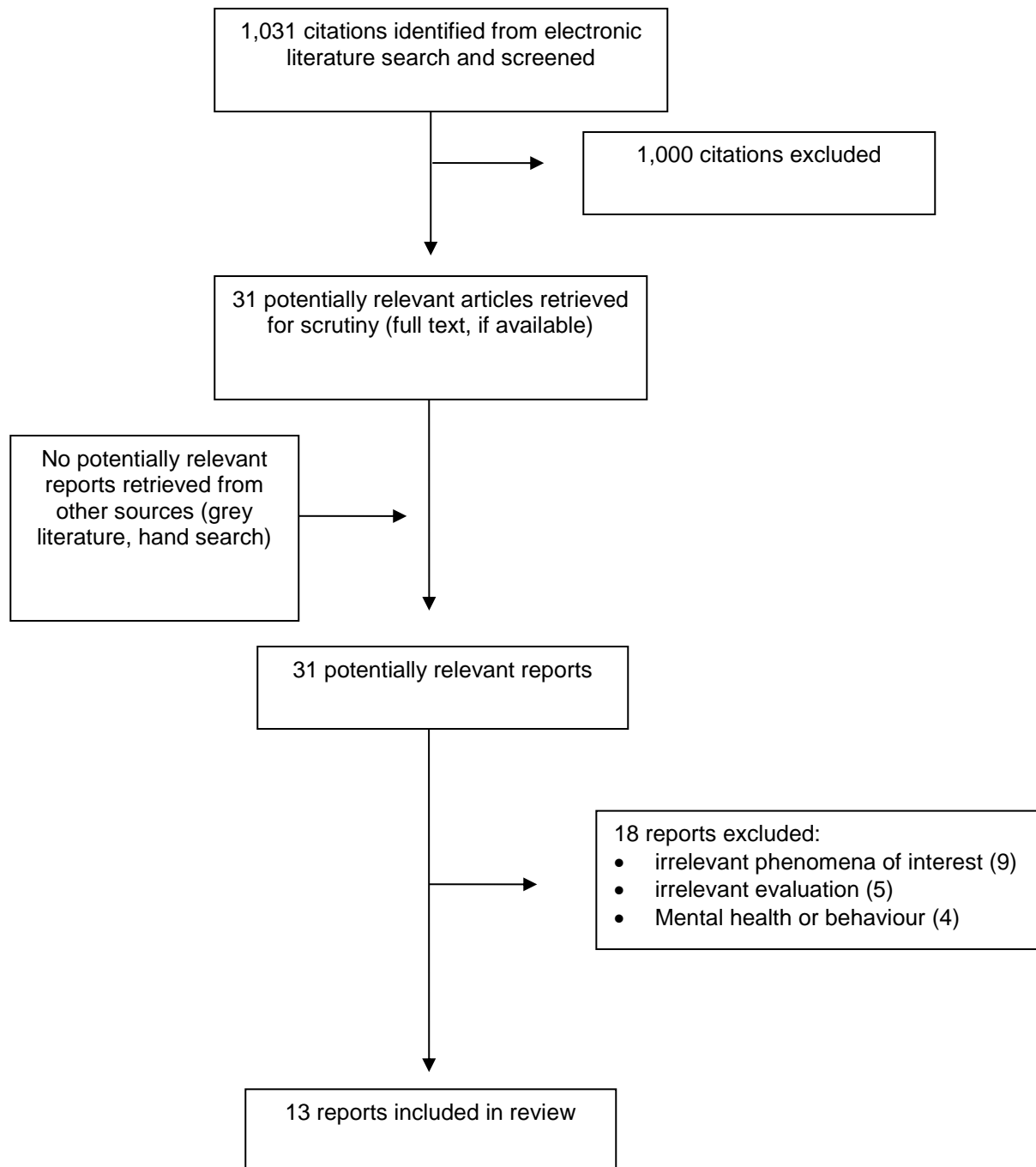
This leads to the third practice of inclusivity we have identified in our review – engaging with factors external to one’s health care services. This practice becomes disruptive, in some sense, when it is taken on in a way that decenters the clinic as the privileged location of care. In this way, health care services are positioned as another piece of in the lives of peoples engaging with them and asks providers to become invested members of the communities they work in rather than providers external to these communities. Inclusion here, takes on a stance that asks how does service provision come to be included into the community rather than the community included into service provision.

References

1. Public Health Agency of Canada. Addressing stigma: towards a more inclusive health system. *The Chief Public Health Officer's report on the state of public health in Canada 2019*. Ottawa (ON): PHAC; 2019 Dec: <https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf>. Accessed 2020 Jul 13.
2. Hatzenbuehler M, Phelan J, Link B. Stigma as a fundamental cause of population health inequalities. *Am J Public Health*. 2013 May;103(5):813-821.
3. Siddiqi A, Shahidi FV, Ramraj C, Williams DR. Associations between race, discrimination and risk for chronic disease in a population-based sample from Canada. *Soc Sci Med*. 2017;194:135-141.
4. Elias A, Paradies Y. Estimating the mental health costs of racial discrimination. *BMC Public Health*. 2016;16(1):1205.
5. Luchenski S, Maguire N, Aldridge RW, et al. What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *Lancet*. 2018 Jan;391(10117):266-280.
6. Freeman BJ, Bess G, Fleming CM, Novins DK. Transforming through leadership: a qualitative study of successful American Indian Alaska Native behavioral health leaders. *BMC Public Health*. 2019;19(1):1276.
7. Sen A. Social exclusion: concept, application, and scrutiny. Manila, Philippines: Asian Development Bank; 2000 Jun: <https://www.think-asia.org/bitstream/handle/11540/2339/social-exclusion.pdf?sequence=1>. Accessed 2020 Jul 22.
8. Commission of Canada. Truth and Reconciliation Commission of Canada: calls to action. Winnipeg (MB): Truth and Reconciliation Commission of Canada; 2012: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf. Accessed 2020 Jul 22.
9. The National Inquiry into Missing and Murdered Indigenous Women and Girls. Reclaiming power and place: the final report of the national inquiry into missing and murdered indigenous women and girls. Vol 1b. Ottawa (ON): Government of Canada; 2019 Jun: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1b.pdf. Accessed 2020 Jul 22.
10. United Nations General Assembly. United Nations declaration on the rights of indigenous peoples. New York (NY): United Nations; 2007 Sep: https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf. Accessed 2020 Jul 22.
11. Anderson M. Indigenous health research and reconciliation. *Can Med Assoc J*. 2019;191(34):E930-E931.
12. Million D. *Therapeutic nations: healing in an age of indigenous human rights*. Tucson (AZ): The University of Arizona Press; 2013.
13. Simpson A. *Mohawk interruptus: political life across the borders of settler states*. Durham (NC): Duke University Press; 2014.
14. Povinelli EA. *The empire of love: toward a theory of intimacy, genealogy, and carnality*. Durham (NC): Duke University Press; 2006.
15. Krefting L. Rigor in qualitative research: the assessment of trustworthiness. *Am J Occup Ther*. 1991;45(3):214-222.
16. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol*. 2008;8(1):45.
17. Charmaz K. *Constructing grounded theory*. Thousand Oaks (CA): Sage Publications Ltd; 2014.
18. Liberati A, Altman DG, Tetzlaff J, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *J Clin Epidemiol*. 2009;62(10):e1-e34.
19. Crowshoe LL, Henderson RI, Green ME, Jacklin KM, Walker LM, Calam B. Exploring Canadian physicians' experiences with type 2 diabetes care for adult Indigenous patients. *Can J Diabetes*. 2018;42(3):281-288.
20. Vallesi S, Wood L, Dimer L, Zada M. "In their own voice"- incorporating underlying social determinants into aboriginal health promotion programs. *Int J Environ Res Public Health*. 2018;15(7).
21. Blix BH, Hamran T. "They take care of their own": healthcare professionals' constructions of Sami persons with dementia and their families' reluctance to seek and accept help through attributions to multiple contexts. *Int J Circumpolar Health*. 2017;76(1):1328962.
22. Mathu-Muju KR, McLeod J, Donnelly L, Harrison R, MacEntee MI. The perceptions of first nation participants in a community oral health initiative. *Int J Circumpolar Health*. 2017;76(1):1364960.
23. Balestrery JE. Indigenous elder insights about conventional care services in Alaska: culturally charged spaces. *J Gerontol Soc Work*. 2016;59(4):296-315.
24. Durey A, McEvoy S, Swift-Otero V, Taylor K, Katzenellenbogen J, Bessarab D. Improving healthcare for Aboriginal Australians through effective engagement between community and health services. *BMC Health Serv Res*. 2016;16:224.
25. Oster RT, Bruno G, Montour M, et al. Kikiskawâwasow - prenatal healthcare provider perceptions of effective care for First Nations women: an ethnographic community-based participatory research study. *BMC Pregnancy Childbirth*. 2016;16(1):216.
26. Hole RD, Evans M, Berg LD, et al. Visibility and voice: Aboriginal people experience culturally safe and unsafe health care. *Qual Health Res*. 2015;25(12):1662-1674.

27. Abbott P, Dave D, Gordon E, Reath J. What do GPs need to work more effectively with Aboriginal patients? Views of Aboriginal cultural mentors and health workers. *Aust Fam Physician*. 2014;43(1):58-63.
28. Dwyer J, Willis E, Kelly J. Hospitals caring for rural Aboriginal patients: holding response and denial. *Aust Health Rev*. 2014;38(5):546-551.
29. Anjou MD, Boudville AI, Taylor HR. Local co-ordination and case management can enhance Indigenous eye care--a qualitative study. *BMC Health Serv Res*. 2013;13:255.
30. Durey A, Thompson SC. Reducing the health disparities of Indigenous Australians: time to change focus. *BMC Health Serv Res*. 2012;12:151.
31. Peiris D, Brown A, Howard M, et al. Building better systems of care for Aboriginal and Torres Strait Islander people: findings from the Kanyini health systems assessment. *BMC Health Serv Res*. 2012;12:369.
32. Tuck E, Yang K. Decolonization is not a metaphor. *Decoloniz Indigeneity Ed Soc*. 2012;1(1):1-40.
33. Coulthard G. *Red skin, white masks: rejecting the colonial politics of recognition*. Minneapolis (MN): University of Minneapolis Press; 2014.
34. Banfield MA, Morse AR, Gulliver A, Griffiths KM. Mental health research priorities in Australia: a consumer and carer agenda. *Health Res Policy Syst*. 2018;16(1):119.

Appendix 1: Selection of Included Studies



Appendix 2: Characteristics of Included Publications

Table 1: Characteristics of Included Publications

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
Crowshoe 2018, Canada ¹⁹	To describe the experiences of diabetes care by physicians with significant numbers of Indigenous patients to inform medical education and adapting care to address health inequities	NR; semi-structured interviews	Family practices and diabetes clinics	GPs or diabetes specialists who had 3 or more years of experience in providing care to Indigenous peoples and a minimum of 10% of one's patients being Indigenous	28 physicians: 24 family physicians and 4 diabetes specialists Three family physicians identified as Indigenous and 21 as non-Indigenous All 4 diabetes specialists identified as non-Indigenous	NA: Diabetes care in the practices of family physicians and diabetes specialists serving a significant number of Indigenous patients	
Vallesi 2018, Perth, Australia ²⁰	The overarching aim of the project was to capture through the eyes and voices of Aboriginal people, the barriers, enablers, and critical success factors to program participation and behaviour change	Participatory action research using photovoice; interviews	Heart Health program, cardiac rehabilitation program run by an Aboriginal Medical Service	Aboriginal participants of the Heart Health program Staff of the Aboriginal Medical Service and Heart Health program	13 Medical Service and Heart Health program staff and stakeholders 16 Aboriginal participants of the Heart Health program	Heart Health program, a culturally sensitive cardiac Rehabilitation program run at the Aboriginal Medical Service in Perth, Western Australia that provides a holistic approach to chronic disease management	
Blix 2017, Norway ²¹	To explore health care professionals'	NR; focus groups	Health care services within the 4	Nurses (RNs or LPNs)	18 nurses: 9 RNs and 9 LPNs who had	NA: Health care professionals	

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
	discursive constructions of Sami persons with dementia and their families' reluctance to seek and accept help from health care services		municipalities in the administration area of the Sami language law	involved in providing everyday care for users of local health care services	been working in the public health care sector for between 7-40 years Study authors did not request participants to identify as indigenous or not, but noted some participants self-identified as Sami (n = NR) during the focus groups	who care for patients who are Sami	
Mathu-Muju 2017, British Columbia, Canada ²²	To explore the experiences and opinions of First Nations families whose children had enrolled in the Children's Oral Health Initiative	Described as "a co-operative inquiry that engaged community members in a collaborative interview process"; semi-structured interviews	13 rural communities participating in the Children's Oral Health Initiative that were geographically isolated from year-round health services	First Nation families including Parents, grandparents and others who served as caregivers for children enrolled in the Children's Oral Health Initiative	141 participants: 111 parents; 18 other relatives; 12 grandparents 49 had two or more children either currently or formerly enrolled 50 had children who were 0–2 years old 42 had children who were 5–7 years old	Children's Oral Health Initiative, community-based preventive dental health programme for children and their caregivers living in remote communities in Canada, initiated and funded by Health Canada in 2004	
Balestrery 2016, Alaska ²³	To examine points of tension that characterize culturally	Multisite ethnography; formal and informal interviews, field notes,	Health care provided to Indigenous persons and communities across Alaska	Formal interviews: Alaska Native Elders	22 formal interviews with Alaska Native Elders	NA	

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
	pluralistic care services in the United States, specifically Alaska, within context of Indigenous colonial histories.	and documents		Informal Interviews: service providers, service recipients, and local community members comprised of Indigenous peoples and peoples from the wider community Ethnographic field notes and documents were collected from attendance at public events and venues, identified through public news media sources			
Durey 2016, Perth, Western Australia ²⁴	To evaluate a strategy of community engagement between local Aboriginal people and health providers across five districts in Perth, Western Australia and its impact on	NR; individual interviews and yarning circle (group discussion)	Five regional health districts in Perth, Western Australia	Four stakeholder groups: 1) Aboriginal District Aboriginal Health Action Group (DAHAG) members 2) Health providers of Aboriginal Services, including Aboriginal	30 Aboriginal District Aboriginal Health Action Group members 12 Aboriginal specific service users 4 Health providers of Aboriginal Services	Local Aboriginal community members formed District Aboriginal Health Action Groups to collaborate with health providers in designing culturally-responsive	

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
	health service delivery			and non-Aboriginal professionals who mainly provided care to Aboriginal people; 3) Aboriginal specific service users who were local Aboriginal people; and 4) Mainstream health service providers who worked in services that engaged in the DAHAG process	14 Mainstream health service providers	health care to improve local health service delivery for Aboriginal Australians	
Oster 2016, Maskwacis, Alberta, Canada ²⁵	To explore the characteristics of effective care with First Nations women from the perspective of prenatal care providers	Ethnographic community-based participatory research; semi-structured interviews	Parental health care services in and around the Cree community of Maskwacis	Health care providers (e.g., nurses, physicians, dietitians, mental health therapists) who deliver prenatal care to women from the community of Maskwacis	12 Health care providers: 7 nurses, 2 physicians, 2 dietitians, 1 mental health therapist 6 worked in the community and 6 worked off-reserve Three participants identified as Indigenous	NA; Prenatal care for women from the community of Maskwacis	
Hole 2015, Okanagan Valley, British	To engage with the perspectives of Aboriginal	Study authors describe their methodology as informed by	Community hospital	Participants self-identified	28 Indigenous community members (5 men and 23	The study authors note that there have been	Yes.

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
Columbia, Canada ³⁴	community members as a starting point for exploring how the principles of cultural safety could improve current practices in a community hospital, and to develop protocols and processes for uncovering and addressing culturally unsafe conditions in other contexts and jurisdictions	a combination of Participatory Action Research, Cultural Safety and Critical Race Theory; semi-structured interviews		as Indigenous, were 19 years of age or older, and were fluent in English	women) whose ages ranged from 19 to 75 years	<p>“explicit attempts and actions to promote culturally safe health care” at the local hospital, including designating a room that Indigenous peoples can use for traditional ceremonies</p> <p>The health authority within which the hospital is located had begun to implement an online “Indigenous Cultural Competency training Program” and hired six Indigenous Patient Navigators</p>	
Abbot 2014, Australia ²⁷	To explore the views of cultural mentors, Aboriginal health workers and Aboriginal health providers who support or teach GPs and GP registrars	NR; semi structured interviews	GPs providing care to Aboriginal people	Participants were selected from major cities or large rural towns, and included Aboriginal health workers and educators with explicit	14 participants who were Aboriginal cultural mentors, Aboriginal health workers, or Aboriginal health providers	NA: study participants were involved in training either their clients (as cultural educators) or mentoring their colleagues in notions of	

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
	working with Aboriginal patients as to what will assist GPs to work effectively with Aboriginal people			or implicit cultural mentorship roles with GPs	11 women and 3 men	"cultural competency"	
Dwyer 2014, Adelaide, Australia ²⁸	To investigate barriers against the implementation of legislation and policy work that requires the state's public health services to tailor care to the needs of Aboriginal peoples	Described as "part of a larger action research project"; interviews ."	Six clinical units across 5 major public health hospitals in Adelaide described as "admitting significant numbers of country Aboriginal patients." (p.547)	Staff in public hospitals with experience in providing care to rural Aboriginal patients and from a range of disciplines	26 staff members One was identified as Aboriginal Eight were identified as male	Policy measures (state legislation and policy work) being implemented that authorize or require "tailoring responses to the needs of Aboriginal patients"	
Anjou 2013, Australia ²⁹	To identify the barriers for effective organization of eye care and patient support at a local area level and propose sector-supported solutions to improve the co-ordination of eye care in Australia for Aboriginal and Torres Strait Islander peoples	NR; semi-structured interviews, focus groups and field work	Health care organizations and services involved in providing eye care to Indigenous Australians	Focus groups: NR Semi-structured interviews: staff working in Indigenous health, eye care, hospital, non-government organizations and government	Focus groups: 81 community member Semi-structured interviews: 289 participants including Aboriginal health service staff (n = 98), community health staff (n = 14), optometrists (n = 31), ophthalmologists (n = 25), hospital staff (n = 35),	NA	

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
					Division of General Practice staff (n = 10), non-government organization staff (n = 16), National Aboriginal Community Controlled Health Organisation affiliate staff (n = 12) and government staff (n = 29)		
Durey 2012, Perth, Australia ³⁰	To interview non-Indigenous medical practitioners experienced at working in the area of Indigenous health to identify institutional and interpersonal practices in mainstream health settings that compromised the health of Indigenous Australians, and highlight specific areas for improvement	NR; repeat interviews	Health care services in Perth, Western Australia providing care for Indigenous persons	Non-Indigenous medical practitioners with “long experience in service delivery in the Indigenous health sector” and who had “insights and reflective thinking located the problems of medical care for Indigenous clients within a health system which failed to adequately acknowledge	Three white, anglo-Australian medical doctors 2 female, 1 male	NA	

Lead Author and Year, Lands and/or Settler State ¹	Study Objectives	Study Design and Data Collection Strategy	Setting	Inclusion Criteria	Description of Study Participants	Description of program or measures taken	Met muster?
				and respond to their patients' needs"			
Peiris 2012, Australia ³¹	To explore staff perspectives on health systems issues that impact on access to optimal primary, specialist and hospital care; to determine organizational barriers and enablers to improved quality of care; and to explore the relevance of these findings to the Council of Australian Governments National Partnership Agreement on 'Closing the Gap in Indigenous health outcomes'	Health system assessment informed by candidacy theory, and the concept of kanyini, described as a term used largely by Aboriginal peoples living in what is now Central Australia that refers to the principle and primacy of caring for others - an obligation to nurture, protect and care for others; Focus groups	Six Aboriginal Community Health Services and one state government funded service "with a strong Indigenous management structure"	Staff from 7 health services	37 staff members across all seven health services from a range of positions from CEO to receptionists	This was a component of a larger project, the Kanyini Vascular Collaboration that aimed to improve health outcomes in Aboriginal and Torres Strait Islander people with chronic vascular and chronic kidney disease, through strategies of care that addressed health systems or service barriers	

NR = not reported; RN = registered nurse; LPN = licensed practical nurse; COAG NPA = Council of Australian Governments National Partnership Agreement; GP = general practitioner; AHW = Aboriginal health workers

¹ We acknowledge that the lands now occupied by Settler States (i.e., Canada, USA, Australia, New Zealand, etc.) are known by names other than those of the colonizers. As such, we give privilege to naming practices of the Indigenous peoples living on the land where possible (e.g., names noted within the studies). While the names of the Settler States will still be indicated, we hope that the juxtaposition of the two names serves as a reminder of the ongoing practices of colonial assimilation happening across Indigenous lands.