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## Cultural competency in the delivery of health services for Indigenous people

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## What we know

- Cultural competency is a key strategy for reducing inequalities in healthcare access and improving the quality and effectiveness of care for Indigenous people.
- Cultural competence is more than cultural awareness—it is the set of behaviours, attitudes, and policies that come together to enable a system, agency, or professionals to work effectively in cross-cultural situations.
- Developing and embedding cultural competence in health services requires a sustained focus on knowledge, awareness, behaviour, skills and attitudes at all levels of service, including at the operational or administrative service level, health practitioner level, practitioner-patient level and student-training level.
- In Australia, past efforts to increase levels of cultural competence have been largely designed for particular situations. There has been an absence of a coherent approach to its inclusion or teaching and a lack of national standards for the provision of culturally competent health services.
- Research on cultural competence is overwhelmingly descriptive and there are few evaluation studies that are methodologically strong. In particular, there was a lack of Australian specific evidence about what strategies are most effective for improving culturally competent healthcare delivery to Indigenous Australians.

## What works

- The limitations in the evidence base meant that it was not possible to draw definitive conclusions about the effectiveness of culturally competent practices and frameworks in providing health care benefits for Indigenous people. But there was both international and Australian evidence of its potential in a number of studies.
- There were some studies that found that bringing together the cultures of health care organisations with Indigenous communities can improve access to health care for Indigenous Australians. This process involves health care organisations:
  - consulting with Indigenous Australian health services and communities
  - tailoring service delivery to the needs and preferences of specific communities
  - embedding cultural competence within the health care organisational culture, governance, policies and programs.
- Education for health care students that incorporates cultural perspectives and experiences can improve health students' preparedness for working in Indigenous health and their future commitment to working for change.



- It can lead to more open attitudes, increased awareness, more effective advocacy, a preparedness to engage with Indigenous people, and a better understanding of Indigenous health issues.
- Field experience can also make an important and positive contribution to health students' perspectives.
- Several studies suggested that key to reducing health disparities for Indigenous populations was health care workers developing partnerships, eliminating bias through self-reflection, and building relationships with Indigenous people.
- Embedding cultural competency principles within legislation or policy (as has been done in the United States and New Zealand) is a strategy that could be useful across Australia's health systems as part of an ongoing commitment to Indigenous Australians and delivering culturally competent care.
- Internationally validated instruments that measure health service access and use, service quality, perceived discrimination, language barriers and trust of practitioners could be useful if tailored to Indigenous Australian health services.

## What doesn't work

- Cultural awareness training is not enough in itself.
  - While such training might be expected to impart knowledge upon which behavioural change will develop, it has generally not been enough when it is delivered in isolation or rapidly delivered over short timeframes.
- Program transfer and implementation without cultural-tailoring are ineffective.
  - There are no homogenous approaches to developing and implementing cultural competence.
  - Cultural competency programs that are successful in one context cannot be assumed to work in another.
  - Programs need to be developed and delivered in partnership with and input from local Indigenous people.

## What we don't know

- There is neither a clear definition nor consistent terminology around cultural competence.
- There is inconclusive evidence on the effectiveness of culturally competent interventions and frameworks in relation to health care access and outcomes for Indigenous Australians.
- More needs to be done using validated indicators to measure what works in efforts to develop culturally competent health services for Indigenous Australians.
- More work is also required to determine the best combination of strategies to improve cultural competence in healthcare.



## Introduction

Concerns about inequalities in health care access, service provision and health outcomes for global Indigenous populations have prompted regulatory bodies and health services and professionals to examine how they can better meet the health care needs of Indigenous groups. There is ample evidence of inequalities in health status and health care between Aboriginal and Torres Strait Islander Australians (referred to as Indigenous Australians in this report) and non-Indigenous Australians. These inequalities are particularly apparent in chronic and communicable diseases, infant health, mental health, and life expectancy (AIHW 2013; AIHW 2015; ATSIJSC 2005; SCRGSP 2013). Many factors contribute to these inequalities, with perhaps the largest contributors being those related to social factors that lie outside the health care system (Osborne et al. 2013). There is also evidence that inequitable access to quality healthcare based on ethnicity has contributed to health disparities (Betancourt et al. 2003; SCRGSP 2013).

Globally, researchers and others have long reported the negative impacts that ethnocentric health service provision has on the health status of Indigenous populations (Downing et al. 2011). The lack of Indigenous health workers in health service delivery systems leads to Indigenous people delaying going to services and contributes to the under-use of healthcare services (LaVeist et al. 2003). There is increasing evidence that health disparities between Indigenous Australians and non-Indigenous Australians are linked to accessibility. Accessibility is influenced by economic and geographic factors and a variety of sociocultural factors (Thomson 2005). It is therefore important to increase efforts to improve the ability of all systems, services and practitioners to work with the diversity of patients.

In reporting on the state of the health of the world's Indigenous peoples, Cunningham (2009) stated that:

To improve the health situation of Indigenous peoples, there must thus be a fundamental shift in the concept of health so that it incorporates the cultures and world views of Indigenous peoples as central to the design and management of state health systems (Cunningham 2009:156).

In Australia, the Aboriginal community controlled health services movement has been central in driving new directions for Indigenous healthcare delivery that account for such shifts in leadership and design (Thomas et al. 2014). The movement started when the need for cultural competence was first prompted by civil rights movements across Western countries in the 1960s. This movement alerted administrators to the distinct identities and long histories of oppression of Indigenous people, ethnic groups, women, gays and lesbians, people with disabilities, and others. Aboriginal community controlled health services were set up in response to experiences of racism in the health system and the significant financial, cultural and social barriers to health care access experienced by Indigenous Australians (Anderson 2006). While there are now some 140 services Australia-wide (Thomas et al. 2014), the reach and capacity of these services to meet the needs of all Indigenous Australians is still limited. This shortfall means that the balance of services is provided by mainstream health systems that generally do not sufficiently account for Indigenous cultures or holistic notions of health (Thomson 2005).

Cultural competency is a key strategy for reducing inequalities in healthcare access and the quality and effectiveness of care received. This strategy works to enhance the capacity and ability of health service systems, organisations and practitioners to provide more responsive health care to diverse cultural groups, as discussed in the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Commonwealth of Australia 2013), which is also known as the NATSIHP. In the NATSIHP, cultural competency is described through the concept of respect: respect is described elsewhere as 'ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services' (NATSIHC 2003:2). As well as being consistent with a key result area in the NATSIP for achieving more effective and responsive health systems for Indigenous Australians, cultural competency strategies are supported by Australia's National Health and Medical Research Council:





All Australians have the right to access health care that meets their needs. In our culturally and linguistically diverse society, this right can only be upheld if cultural issues are core business at every level of the health system—systemic, organisational, professional and individual (NHMRC 2005:1).

Cultural competence interventions have developed in Australia and internationally in response to the now considerable research evidence pointing to the need for culturally responsive care. The argument for developing culturally competent services and workforces is positioned in a human rights framework: the basic human right to life and health (UN 2008; Walker et al. 2014):

The obligations of states [are] both to provide accessible, quality health care to Indigenous peoples and to respect and promote Indigenous health systems, each of which must be fulfilled in order to ensure the health of Indigenous peoples (Cunningham 2009:156).

There is also a local strategic priority in the reform agenda of the Closing the Gap policy, which aims to improve Indigenous life outcomes (COAG 2014). Although there is much evidence to suggest that cultural competence should work, health systems have little evidence about how to identify what mix of cultural competence strategies work in practice, and when and how to implement them properly. To better understand what is useful, this review examines the current evidence base in terms of strategies for improving cultural competency, measures and measurement instruments of cultural competency, and the relationship between cultural competency and health care outcomes.

## Aim and objectives

This review aims to examine available evidence on cultural competence in health care settings to identify key approaches and strategies that can contribute to improving the development and implementation of Indigenous health services and programs. The objectives are to:

1. define cultural competency
  - we consider the significance of cultural competence and how it has been defined in international and local literature, including the use of similar terms and meanings
2. report on the quantity, nature and quality of available evidence
  - we look at available evidence on cultural competency in Australia, New Zealand, Canada and the United States, including how cultural competence has been measured, and assess the quality of the evidence against basic methodological criteria
3. identify approaches and strategies that are effective in improving cultural competency among health services staff
4. examine the relationship between cultural competency and health outcomes
5. develop an evidence-informed conceptual framework of cultural competency.



## Defining cultural competency

This review used the definition of cultural competence by Cross et al. (1989). It is viewed as the most influential and most commonly cited work on the topic. They refer to cultural competence as:

Cultural competence... is... a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs (Cross et al. 1989:iv/7).

In Australia, cultural differences between service providers and Indigenous Australians have been referred to as the 'cultural chasm' (Thomson 2005:1). As far back as 1989, the National Aboriginal Health Strategy Working Party suggested that 'scant attention has been paid in the content of health related education programs to the relevance of cultural, traditional, political, and socio-economic factors of Aboriginal history and Aboriginal society to Aboriginal health and wellbeing' (NAHSWP 1989:90). It made recommendations toward closing the 'chasm' that included: (1) the need for appropriate education and training for health professionals and preparation to work in the field of Indigenous health; (2) the importance of relevant clinical experience as a part of formal studies; and (3) the need for cultural aspects to become part of continuing professional education (NAHSWP 1989).

Initially, education and training in Australia was mainly focused on bolstering the knowledge and experience of clinicians and other health service providers to deliver care (Thomson 2005). However, the notional concept of 'cultural awareness' represented by this kind of education and training shifted, initially, to place emphasis on individual behaviour as well as attitudes; and it was then extended to include system-wide factors (DHCS 2005). The term 'cultural security' was adopted to embrace this transition in the late 1990s.

In 2003, 'cultural security' was incorporated under the concept of 'cultural respect' and endorsed as the:

guiding principle in policy construction and service delivery for utilisation by jurisdictions as they implement initiatives to address their own needs, in particular mechanisms to strengthen relationships between the health care system and Indigenous peoples (SCATSIHWP 2004:3).

The Australian Health Ministers' Advisory Council developed the Cultural Respect Framework 2004–2009 (AHMAC 2004) as a guiding principle in policy construction and service delivery for use by different jurisdictions, and mechanisms to strengthen relationships between the health care system and Indigenous Australians. Bound by cultural respect, it has 7 guiding principles: a holistic approach, health sector responsibility, community control of primary health care services, working together, promoting good health, building the capacity of health services and communities, and accountability for health outcomes. The framework aimed to influence health services and their delivery to lead to:

- improved outcomes and quality
- more efficient and effective services
- expenditure reduction
- improved customer satisfaction.



The Cultural Respect Framework was informed by international developments around the notions of ‘cultural safety’ (New Zealand) and ‘cultural competence’ (United States). It was developed and endorsed for action by health ministers of all Australian jurisdictions with the intent ‘to ensure that Indigenous peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice’ (NATSIHC 2003:7). Cultural respect is defined by the Australian Health Ministers’ Conference as ‘ensuring that the cultural diversity, rights, views, values and expectations of Indigenous peoples are respected in the delivery of culturally appropriate health services’ (NATSIHC 2003:2). Key responses to this type of criterion have been to develop capacity of Indigenous Australians in the workforce, for example by training health workers, and providing cultural awareness training for those already working in Indigenous health care. See Appendix A for an expansion of the nomenclature around cultural competency.

## Approach used to review the evidence

### Scope of the review

**Types of literature:** The review included peer-reviewed and grey literature (including government and agency reports) relating to cultural competency in Australia, New Zealand, Canada and the United States published from January 2002 to December 2013.

**Study population:** In-scope publications focused on Indigenous Australians and Indigenous populations in countries with health care systems comparable to Australia, including New Zealand, Canada and the United States.

**Setting:** Studies included in the review related to cultural competence in a broad range of health care services (such as hospitals, primary health care settings, private practice and community health settings), and for both health care outcomes and population health outcomes.

**Interventions:** Interventions aimed at improving cultural competency for health systems, services or health professionals were included.

**Terms:** A broad range of terms was searched. Terms searched included cultural competence, cultural sensitivity, cultural safety, cultural security, cultural awareness, cultural literacy, cultural respect, cultural framework, cross-cultural, inter-cultural, cultural difference, inter-racial, racism, discrimination, cultural capability, bi-cultural and cultural inclusion. The exact combinations of search terms are identified in the search strategy (see Appendix B and Appendix C).

## Methods

### Locating the relevant literature

The search strategy for this review extended and updated a previous and more wide-ranging search on cultural competency. Appendix B summarises the earlier search; Appendix C summarises the extended search (from mid-2012 to the end of 2013). Both include the databases searched, the search terms used, the exclusion criteria applied, and the classification of included studies. Evaluation and indicator studies for Indigenous populations only were extracted from the original search. The original search captured a total of 37 studies. The second search strategy comprised 5 steps.



**Step 1:** The process began with the 37 studies identified in the original search.

**Step 2:** Consultation with representatives of relevant government portfolios, (Commonwealth and state) was facilitated by the Australian Institute of Health and Welfare to identify relevant grey literature sources and review and refine the objectives and methods. Five more publications were identified, increasing the total to 42 studies.

**Step 3:** Consultation with a qualified librarian had previously identified 17 relevant electronic databases to search: Indigenous Australia; Indigenous Studies Bibliography: AIATSIS; ATSIHealth; APAIS-ATSIS; FAMILY-ATSIS; Informit Indigenous Collection; Campbell Library; EBM Reviews/Cochrane DSR/ACP Journal club/DARE; PsycINFO; PsycEXTRA; Medline; Embase; CINAHL; Global Health; PAIS; Sociological Abstracts. The searches of the 17 databases (excluding duplicates) identified a further 103 references in the updated search to give a total of 145 references.

**Step 4:** To maximise search coverage of the grey literature, we also searched websites and clearinghouses related to Indigenous people of Australia, New Zealand, Canada and the United States. Five studies not identified in the electronic database search were located.

**Step 5:** A total of 150 references were examined.

## Classification of studies

The titles and abstracts of the 150 identified citations were categorised as:

**1. Indicators and measures of cultural competency:** defined as studies that described, developed or applied measures and indicators of cultural competence (n=14).

**2. Intervention evaluations:** defined as studies that evaluated the effectiveness of a strategy, program or policy designed to improve cultural competency. This included studies designed to address cultural awareness of health staff; Indigenous or ethnic minority peoples' access to health services, procedures, and culturally specific programs; the identification of Indigenous people or ethnic minorities in health service records; the provision of culturally respectful services; Indigenous health workforce participation and development (n=20).

Across the 2 classifications, there was an overlap of 6 studies (Wiley et al. 2009; Chong et al. 2011; Hearn et al. 2011; Mooney et al. 2005; Curran et al. 2005; Cook et al. 2010).

Studies that did not meet any of these 2 criteria were classified as 'other' (n=122) and excluded.

In total, 28 publications related to cultural competency in health care for Indigenous populations across Australia, New Zealand, Canada and the United States formed the basis for this review.

## Data extraction from indicator and intervention studies

Criteria for data extraction from both types of studies were adapted from the *Cochrane Collaboration Handbook for Systematic Reviews of Health Promotion and Public Health Interventions* (Jackson 2007). For indicator studies, the criteria shown in Appendix D relate to the type of indicator; measurement of the indicator; application of the indicator (country, population and healthcare setting); and quality of the indicator (reliability or validity). The full cultural competence indicator papers were read to extract these criteria. For intervention studies, the criteria shown in Appendix E relate to the intervention type; target population; sample size; study design; outcome measures and effects; and the overall methodological quality of the evaluation.





## Assessing the quality of research

Research evidence is commonly assessed by the quality of the methodology used in the study. For qualitative studies, the quality of original research publications was assessed and rated as 'strong', 'moderate' or 'weak' using the Critical Appraisal Skills Programme appraisal checklists for qualitative studies (CASP UK 2013). The indicator studies were rated using a quality assessment tool for quantitative studies (NCCMT 2008). Using the guidelines provided, the validity and reliability of the measurement instrument were rated as strong (evidence the instrument is valid AND reliable), moderate (evidence the instrument is valid OR reliable), or weak (no evidence the instrument is valid or reliable).

## Review findings

### Quantity and types of studies

This systematic search of studies conducted between 2002 and 2013 identified a total of 28 publications related to cultural competency in health care for Indigenous populations across Australia, the United States, Canada and New Zealand. The publications included (1) those that described the development or application of indicators and measures of cultural competence; and (2) those that evaluated intervention strategies designed to improve cultural competence. Indigenous people from Australia, Canada, United States and New Zealand were the focus of the 28 studies. Of these 28 studies, 12 (43%) were from the United States, 11 (39%) from Australia, 3 (11%) from New Zealand, 1 (3.5%) from Canada, and 1 (3.5%) was a combined cross-national study from New Zealand and Australia. Australian and United States studies constituted 82% of the identified studies.

Fourteen of the 28 (50%) relevant studies were classified as indicator or measurement studies; 20 (71.5%) studies were classified as evaluated intervention studies. Six studies (Chong et al. 2011; Cook et al. 2010; Curran et al. 2008; Hearn et al. 2011; Mooney et al. 2005; Wiley 2009) were intervention evaluations as well as indicator and measurement studies. Of the 28 studies, 14 (50%) reported significant health care outcomes. The summary of results and breakdown of study types is reported in Table 1.

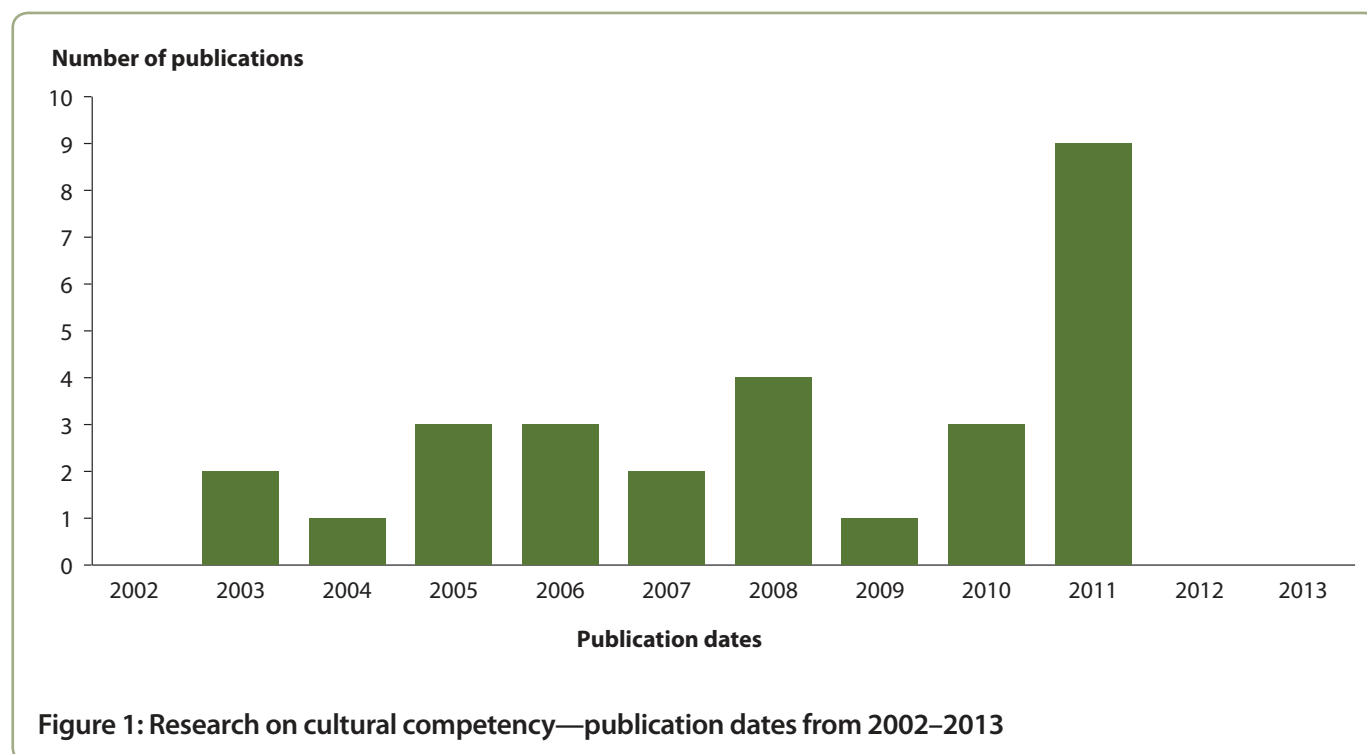
**Table 1: Summary of results by country of origin and type**

Country of origin	Indicator/ measurement studies	Evaluated intervention studies	Total no. of studies
Australia	7	6	11
United States	2	12	12
New Zealand	3	1	3
Canada	1	1	1
Cross-national	1	0	1
<b>Total</b>	<b>14</b>	<b>20</b>	<b>28</b>

Note: 6 studies were counted in both categories.



The output for cultural competency targeting Indigenous populations across 4 countries is poor. Only 28 eligible publications were extracted from a 12 year period (2002–2013 inclusive). There were no publications recorded in 3 of those years: 2002, 2012 and 2013. From 2003–2011, the number of publications varied; they peaked in 2011 with 9 publications (see Figure 1).



## Indicators and measures of cultural competence

Fourteen studies focused on measuring the cultural competence of health service provision specifically for Indigenous clients. They included 7 Australian studies (Chong et al. 2011; Coffin 2007; Hearn et al. 2011; Mooney et al. 2005; Muecke et al. 2011; Paul et al. 2011; Reibel & Walker 2010), 3 New Zealand studies (O’Brien et al. 2003, 2004; Wiley 2009), a comparative New Zealand–Australian study (O’Brien et al. 2007), 2 United States studies (Cook et al. 2010; Winderowd et al. 2008), and 1 Canadian study (Curran et al. 2008).

These studies developed or described indicators of cultural competence that could be used to identify examples of both good and poor cultural competence in health services, and to measure improvements in cultural competence. Overall, the type of indicators ranged from reliable, valid and objective indicators to non-validated subjective indicators, and from simple scales to complex instruments with multiple domains. Appendix D summarises the characteristics and quality of these 14 studies, 6 of which reported mixed levels of associated health care outcomes. Studies that did not report health outcomes included those that described the development or validation of cultural competence measurement tools, and those that described the process of applying the measurement tools to various settings.

A range of health care settings, health issues and health disciplines was covered in these studies. Included were health training courses for medical, nursing students (Curran et al. 2008; Paul et al. 2011); primary health care settings (Coffin 2007; Hearn et al. 2011; Muecke et al. 2011); and mental health settings (O’Brien et al. 2003, 2004, 2007; Winderowd et al. 2008). Clinical records, administrative benchmarks, national racial and ethnic categories, self-reported surveys, and qualitative interviews were used to measure the indicators of cultural competence. By far the most common measurement type was self-reported survey instruments.



## Quality of the research

Only 3 out of the 14 indicator studies were rated as 'strong' according to the criteria outlined in the methods section. This included 1 United States study (Winderowd et al. 2008), 1 New Zealand study (O'Brien et al. 2004), and 1 study from New Zealand and Australia (O'Brien et al. 2007). A further 3 indicator studies were rated moderate, and 8 were of weak quality (see Appendix D).

## Research findings

The indicator studies focused on 4 areas (some studies incorporated more than one focus, but they were reviewed according to their primary focus):

1. *Health service* (4 studies: O'Brien et al. 2003, 2004, 2007; Reibel and Walker 2010).
  - The studies demonstrated the considerable resources invested into developing and piloting instruments to audit service performance across sectors within health (O'Brien et al. 2003, 2004, 2007; Reibel & Walker 2010).
  - A cultural competence audit tool developed in New Zealand to measure the achievement of mental health nursing practice standards in New Zealand (O'Brien et al. 2003, 2004, 2007) was considered to be relevant to mental health nursing internationally by providing a framework for improving practice against standards of expected health care:
    - the Consumer Notes Clinical Indicators audit tool was based on identification of 'critical events' (events crucial to achievement of practice standards) from nursing notes in consumers' case notes
    - 25 valid and reliable indicators were considered crucial to the achievement of New Zealand standards.
2. *Healthcare practitioners' knowledge, attitudes and practice* (5 studies: Chong et al. 2011; Coffin 2007; Hearn et al. 2011; Mooney et al. 2005; Muecke et al. 2011).
  - Indicators were typically self-reported measures that looked at aspects of cultural awareness, cultural knowledge, cultural skill, cultural encounters, cultural sensitivity, culture shock or adaptability, and cultural desire.
  - Muecke et al. (2011) reviewed measures of culture shock (defined as the stress, anxiety, or discomfort a person feels when they are placed in an unfamiliar cultural environment and which is due to the loss of familiar meanings and cues relating to communication and behaviour). The study recommended two measurement instruments that could be applied to non-Indigenous Australian health workers in remote Indigenous communities to measure stages of culture shock and culture shock mid-employment and placement: the Culture Shock Profile and Culture Shock Adaptation Inventory.
  - In another Indigenous Australian study, Coffin (2007) provided a simple (unvalidated) scale that could be used by health practitioners to self-rate their own processes of change or those of health services towards attainment of the end goal of sustainable cultural security.
3. *Patients' satisfaction, behaviours or health outcomes* (3 studies: Cook et al. 2010; Wiley 2009; Winderowd et al. 2008).
  - Winderowd et al. (2008) used the validated American Indian Enculturation Scale to understand the traditional cultural experiences of American Indian and Alaskan native people and the connection between strong cultural ties and resilience, psychological wellbeing, substance abuse and substance abuse risk, and suicide attempts. This scale was found to be reliable, easily administered, and meaningful to individuals who completed it. The researchers encouraged the adaptation of the measure for use with Indigenous people from other nations.
  - Cook et al. (2010) has been included as a case study example (see Box 1). It had a moderate design rating and demonstrated healthcare outcomes for patient health, behaviour and patient and family satisfaction.



4. *Health curricula and students' knowledge, skills and attitudes* (2 studies: Curran et al. 2008; Paul et al. 2011).

- Paul et al. (2011) focused on developing a culturally competent health workforce as a key strategy in the struggle to provide quality healthcare services for Indigenous Australians. They implemented a comprehensive Indigenous health curriculum with medical students. A key shift in understanding and engagement occurred when students completed a comprehensive case history and discussion, including reflective comments, in relation to an Indigenous person they had seen during their rotation. Improvements were noted in students' preparedness to work with Indigenous people, play an advocacy role, and take responsibility to work for change in Indigenous health.
- Curran et al. (2008) considered the access barriers to nursing education for Aboriginal Canadian students. They found that access for students was improved by increasing the cultural relevance of the curriculum, including experiential and authentic learning, academic and social support and building of partnerships with health services and others.

**Box 1: Case Study of Cook et al. (2010)**

**Issue addressed:** The importance of closing the health disparity gap that affects the Native Hawaiian population initiated this study. It aimed to examine the process and outcomes of healthcare among Native Hawaiians with heart disease, and to evaluate the impact of a multidisciplinary, culturally sensitive effort to improve quality of care by providing patients with the education and tools for self-management of their health.

**Method:** Queen's Heart developed a program to address the cardiometabolic health disparities of hospitalised Native Hawaiians. Importantly, the program was supported by the Board of Trustees and chief executive officer of The Queen's Health Systems. The program focused on 3 intervention areas: education and self-care management, disease management, and stress reduction and wellness. An inpatient program was created by assembling a team of practitioners with an affinity for Native Hawaiian culture to address the healthcare needs of Native Hawaiian people. Patient educators and discharge counsellors delivered education and the tools that patients needed for self-care management as part of an Integrative Care Program that provided a holistic perspective of healing that was consistent with Native Hawaiians' conception of health. All Native Hawaiian patients who were admitted to The Queen's Medical Center from January 2007 to December 2008 became participants of the inpatient program. Baseline outcomes data (2006) for core cardiac measures, length of stay, 30-day re-admission rates, and adverse events were reviewed by the team before the study started and the results compared to other patient populations; data from 2008 were considered in follow-up.

**Results:** While the quality of cardiovascular care at baseline was excellent, core quality measures improved across the entire patient population. Significant improvements in healthcare outcomes included: less than 30-day re-admission rates for patients with acute myocardial infarction reduced by 2%; heart failure patients with less than 30-day re-admissions decreased from 33% to 17%; length of stay for patients decreased slightly; and patient and family satisfaction was enhanced. These data indicate levels very similar to that of non-Native Hawaiian populations. However, length of stay for heart failure patients was unchanged and remains a persistent issue. It was likely that length of stay was influenced by the severity of illness at the time of admission.

**Conclusion:** Culturally sensitive and patient-centred care, delivered by the team of specialists from Queen's Heart, has allowed patients to incorporate cultural preferences into their care and recovery. Re-admission rates decreased, mortality rates improved, and patient and family satisfaction was enhanced.

**Policy and program implications:** The multidisciplinary, patient-centred intervention demonstrated that a culturally informed, integrated approach to reducing disparities in cardiovascular disease can significantly raise quality of care, improve patient satisfaction, and promote the reduction of health care disparities. Cultural understandings of health must form the basis of engaging culturally diverse populations in their own care.





## Intervention strategies

Twenty studies (summarised in Appendix E) evaluated the effectiveness of interventions designed to improve cultural competence for Indigenous populations across Australia (7 studies), United States (11 studies), Canada (1 study) and New Zealand (1 study).

### Quality of the research

Of the 20 intervention studies, 3 (Barnett & Kendall 2011; Ka'opua et al. 2011; Wiley 2009) were rated as strong, 4 as moderate (Chong et al. 2011; Curran et al. 2008; Dignan et al. 2005; Paul et al. 2006), and the remaining 13 were rated as weak (see Appendix E).

Selection bias and poor attrition were common methodological deficiencies of studies using a weak or moderate study design. Selection bias and poor attrition also resulted in an overall weak rating for 1 of the 3 studies using a strong study design (D'Silva et al. 2011). Data collection methods were a common methodological strength of studies, with some studies using reliable or valid measurement instruments to measure outcomes. Four studies (20% of the intervention studies) were evaluated using qualitative methods (Barnett & Kendall 2011; Chong et al. 2011; Curran et al. 2008; Wiley 2009), and 1 used both qualitative and quantitative methods (Mak et al. 2006). Of the studies that reported on health outcomes, only 1 was rated as strong, and 2 were rated as moderate.

### Research findings

Among the 20 studies, there were 5 main types of intervention strategies and approaches aimed at improving culturally competent healthcare delivery to Indigenous populations and making systems more responsive:

1. *Reform health service and systems* to facilitate culturally competent healthcare delivery (Chong et al. 2011; Wiley 2009).
  - Chong et al. used a continuous quality improvement model to improve the cultural sensitivity and environmental culture at 5 Australian hospitals. The main objective was to produce tools and processes that could help hospitals engage with local Indigenous Australian communities in a collaborative exercise of cultural reform.
  - Chong et al. found that hospitals with improved cultural sensitivity shared key characteristics. These included having relationships with Aboriginal communities and commitment to supporting their Aboriginal workforce. They concluded that hospitals need senior management to prioritise and support these changes by ensuring that processes are Aboriginal-facilitated and that staff capacity to do so is supported. The inclusion of Aboriginal specific elements in the Australian Council of Healthcare Standards was also seen as key.
  - Wiley conducted an outcome evaluation of the New Zealand Disability Strategy.
    - Wiley found that adapting guidelines from the mainstream context to the Maori context reduced their effectiveness. It was considered that the strategy was fundamentally flawed for several reasons—some of which were reflected in the work of Chong et al. (2011). Key was that the strategy was not consumer-driven or explicitly developed on Maori views of health and wellbeing. Other reasons were need for collaboration across sectors, accountability structures and effective evaluation tools, as well as input based on the experiences of individuals and their families with the disability sector.
2. *Improve access to health care* for Indigenous populations (Dignan et al. 2005; Wetterhall et al. 2011).
  - In the study by Dignan et al. (2005), an attempt was made to increase Native American women's access to healthcare by improving communication between healthcare practitioners and patients through language immersion or communication enhancement programs.



- They tested the relative effectiveness of a tailored education program that was developed to address individual risk factors for breast cancer. It was delivered face-to-face or by telephone to urban Native American women with good results.
  - Self-reported mammograms registered from the previous year increased from 29% to 41.3% in the telephone group and from 34.4% to 45.2% in the face-to-face group at post-test. However, no difference was recorded from pre-test to post-test between the telephone and face-to-face groups.
  - The study by Wetterhall et al. (2011) employed a health-professional client-matching model of health care to enhance Native Alaskan residents' access to primary dental care.
    - This improved access to urgent care and was beneficial from a comprehensive cultural perspective.
3. *Improve the cultural competence of the health workforce* (Hearn et al. 2011; Ka'opua 2003; McCabe et al. 2006; McRae et al. 2008; Mooney et al. 2005).
- Mooney et al. (2005) found that half-day cultural awareness training workshops for non-Indigenous health workers had no significant effect in changing beliefs and attitudes towards Indigenous Australians. There was, however, a positive effect on familiarity or friendships with Indigenous people (see Box 2).
  - Hearn et al. (2011) reported on a program, SmokeCheck, developed specifically for Aboriginal Health Workers in New South Wales and which provided training to strengthen participants' knowledge, skills and confidence to deliver a smoking cessation intervention to Indigenous clients.
    - SmokeCheck training achieved some of its aims: confidence and ability to deliver the brief smoking cessation intervention increased significantly; participants' self-reported increased confidence in their knowledge and were able to reduce their tobacco use; and they reported improved skills in delivering brief intervention to their clients.
    - The intervention did not increase the motivation of Aboriginal Health Workers and other health professionals to quit smoking, and it did not influence their smoking status or readiness to quit.
4. *Train and educate health and medical students to be culturally competent practitioners* (Amundson et al. 2008; Curran et al. 2008; Mak et al. 2006; Paul et al. 2006; Steinfeldt & Wong 2010; Walton 2011).
- Typically, training and education interventions targeting health and medical students resulted in positive changes in participants' attitudes and intentions.
    - Paul et al. (2006) found that adding an integrated Aboriginal Australian Health Curriculum to an undergraduate medical course positively changed students' perceptions of their preparedness for, and future commitment to working for change in Indigenous health.
    - Curran et al. (2008) evaluated an access program that aimed to increase the number of Indigenous nursing students in Labrador, Canada. The researchers found that program effectiveness was influenced by a culturally relevant curriculum, experiential and authentic learning opportunities, academic and social support, and the level of partnership building between stakeholders.
5. *Develop culturally tailored health interventions to improve Indigenous groups' access to healthcare interventions* (Barnett & Kendall 2011; Braun et al. 2005; Cook et al. 2010; D'Silva et al. 2011; Ka'opua et al. 2011).
- Barnett and Kendall (2011) examined the tailoring and implementation of a health promotion program (the Stanford Chronic Disease Self-Management Program) that was implemented in 3 Queensland Indigenous communities (rural, regional and urban).
    - The impact of the intervention differed across regions, but the study highlighted the importance of paying attention to 'local' processes to ensure successful implementation.



- These included processes that: reflected the unique characteristics and profiles of individual communities; were responsive to local systems and structures; incorporated local cultural traditions and knowledge bases; used locally accepted forms of cultural communication; and facilitated local community participation and leadership in the program.
- These factors determined the experience of the program within each community, and they influenced its acceptability, effectiveness and sustainability.
- Cook et al. (2010) conducted a study related to culturally appropriate disease management as a strategy to improve service delivery for Native Hawaiians. It examined the process and outcomes of health care among Native Hawaiians with heart disease, and it evaluated the impact of a multidisciplinary, culturally sensitive approach to improving quality of care. The result was improvements across all quality indicators (see Box 1) to the degree recorded in other (non-Native Hawaiian) patient populations.
- Two American studies used culturally targeted education programs to improve the take up of particular health services: colorectal cancer screening for Native Hawaiians (Braun et al. 2005); and tobacco dependence treatment for Native Americans (D’Silva et al. 2011).
  - Both studies indicated that programs tailored to be culturally relevant can positively affect the acceptability of programs and engagement with them.

### **Box 2: Case study Mooney et al. (2005)**

**Issue addressed:** The impact of Indigenous cultural awareness training workshops in South Western Sydney Area Health Service on health professionals’ perceptions, familiarity and friendships, attitudes, and knowledge of Indigenous Australians and the health issues affecting them.

**Methods:** Non-Indigenous health professionals attended half-day workshops. Workshops were delivered by Aboriginal Australian Health Workers. Evaluation questionnaires were administered to intervention groups before and after completing the cultural awareness training workshops. Control groups also completed the same questionnaire on 2 occasions before attending the workshops.

**Results:** Few measures changed significantly in the intervention groups. There was no substantive evidence of influence on perceptions or attitudes of healthcare staff towards Indigenous Australians. There was a positive effect on familiarity or friendships with Indigenous people, with an increase:

- for respondents who ‘had friends who are Aboriginal’ from 37% to 48% ( $p < 0.05$ )
- in those who ‘worked with Aboriginal people’ from 37% to 52% ( $p < 0.05$ )
- in understanding the complexity of Aboriginal health problems—shift on a 5-point scale from 2.74 to 2.28 (1 = strongly agree) ( $p < 0.06$ )
- in relation to the statement that ‘Aboriginal health problems are largely due to changes in lifestyle and diet’—shift on a 5-point scale from 2.78 to 2.30 ( $p < 0.01$ ).

**Conclusion:** Half-day workshops do not have a significant effect in changing beliefs and attitudes. More effective strategies for increasing knowledge and changing attitudes among healthcare professionals require development.

**Policy and program implications:** Brief cultural awareness training alone is not an effective strategy in producing change or achieving better healthcare outcomes for Indigenous populations. While cultural understandings of health must form the basis of engaging culturally diverse populations to improve care and outcomes and are imperative policy directions, new strategies must move beyond current brief cultural awareness training interventions.





## Relationship between cultural competency and healthcare outcomes

Of the total 28 studies, 15 demonstrated a positive relationship between cultural competency and healthcare outcomes. Three of these were common to both indicator and intervention studies (Cook et al. 2010; Hearn et al. 2011; Mooney et al. 2005). Studies were distributed across the United States (8), Australia (6), and cross-nationally in Australia and New Zealand (1).

Outcomes were evidenced at 4 different levels: at the health service level, healthcare practitioner level, level of training and education, and patient level. Ten of the 15 studies demonstrated significant improvements in associated healthcare outcomes (Braun et al. 2005; Cook et al. 2010; Dignan et al. 2005; Hearn et al. 2011; Ka'opua 2003; McRae et al. 2008; Mooney et al. 2005; Paul et al. 2006; Steinfeldt & Wong 2010; Walton 2011).

In terms of the weight of evidence and quality of design, no high-quality studies demonstrated significant effects on healthcare outcomes. Only 3 studies with a moderately robust research design found significant effects (Cook et al. 2010; Dignan et al. 2005; Paul et al. 2006). See Appendix F 'Nature of healthcare outcomes ordered in terms of weight of evidence' for more detail.

### Health service level

Three studies reported healthcare outcomes associated with cultural competence at the health service level (Dignan et al. 2005; O'Brien et al. 2007; Reibel & Walker 2010).

- O'Brien et al. (2007) found that the bicultural nature of mental health indicators in New Zealand provided an example of how to involve patients in their own care and involve their kin and community. The culturally sensitive indicators also provided a quality mechanism for identifying areas of clinical nursing care where improvements could be made.
- Reibel and Walker (2010) showed that 42 services (18 Aboriginal specific and 24 general antenatal), reported use by Aboriginal women. Of these, only 9 were identified as providing culturally responsive service delivery that aligned with key indicators of cultural security, combined with highly consistent delivery of routine antenatal care. These 9 services increased access and frequency of visits for Aboriginal women from 3 to 5 visits.
- Dignan et al. (2005) tested the effectiveness of a tailored, culturally sensitive, educational Navigator intervention to increase adherence to guidelines for mammography screening among American Indian women. Navigator models are educational and include components of the care continuum. The intervention was delivered face-to-face or by telephone by lay health educators (trained local Native American women) to urban Native American women. They concluded that Navigators can be effective in increasing adherence to recommendations for screening mammography.

### Healthcare practitioner level

Six studies showed healthcare outcomes at the level of healthcare practitioners' knowledge, attitudes and practice (Braun et al. 2005; Hearn et al. 2011; Ka'opua 2003; McCabe et al. 2006; McRae et al. 2008; Mooney et al. 2005).

- As a result of a half-day training program for practitioners, Mooney et al. (2005) noted a significant increase ( $p < 0.05$ ) in understanding Indigenous Australian health issues and in forging better friendships and working relationships with Indigenous people. Even so, they concluded that half a day of cultural awareness training failed to bring about change in beliefs and attitudes. Resources would be better used in systematically identifying effective strategies than brief training interventions.





- Hearn et al. (2011), on the other hand, found that a culturally tailored SmokeCheck training program improved health practitioners' knowledge and competence to deliver smoking interventions to Indigenous Australian clients.
- McRae et al. (2008) evaluated a pharmacist-led medicines-education course delivered to Aboriginal Australian Health Workers. It was supporting an intensive pharmacist-education weekend to develop their cultural awareness and strengthen health professional networks by building partnerships between pharmacists and Aboriginal Australian Health Workers.
  - The combination resulted in achieving outcomes of some significance: pharmacists felt better equipped to deal with Indigenous health issues; they knew more Aboriginal Australian Health Workers in their area; they felt more confident as educators of Aboriginal Australian Health Workers; and they felt more confident that they had the necessary resources to deliver this education.
  - Qualitatively, pharmacists' interviews showed that the experience of delivering the education improved their confidence as educators and motivated them to develop sustainable relationships with Aboriginal Australian Health Workers. An important facilitator to achieving these outcomes was previously-existing relationships with local Indigenous health services.
- Generally, there was a consistent message that knowledge alone was insufficient to foster improvements. For Ka'opua (2003), for example, there was a focus on developing competence in intervention delivery as well as knowledge because both were regarded as essential to efficacy.

## Patient level

Two studies measured patients' satisfaction, behaviours or health outcomes (Cook et al. 2010; D'Silva et al. 2011). Both culturally competent initiatives resulted in improved client/patient satisfaction and ability to engage in treatment and recovery.

- Cook et al. (2010) noted significant changes (see Box 1): increased recovery rates from cardiac surgery, reduced re-admission rates and reduced mortality, and simultaneously high levels of patient and family satisfaction were reported.
- D'Silva et al. (2011) delivered a culturally tailored smoking cessation program for Native Americans. It resulted in increased program acceptability, more engagement, and improved use of medication.

## Training and education for students

The literature provided positive results for the healthcare outcomes that are associated with incorporating cultural competence training into medical courses (Paul et al. 2006, 2011), counselling courses (Steinfeldt & Wong 2010), and nursing student courses (Walton 2011).

- Steinfeldt & Wong (2010) tested the effectiveness of a training intervention that was designed to produce attitudinal change for postgraduate counselling students by raising awareness of their own and others' stereotypes about their Native American clients.
  - The intervention produced significantly more attitudinal change than a general training session on culturally sensitive counselling practices with Native American clients. This was particularly so for students who demonstrated attitudes that almost entirely failed to account for differences in considering their clients; particularly in ignoring the disadvantages of non-white populations for instance.
  - The results showed that the intervention increased students' awareness of societal racism.
  - Steinfeldt and Wong argued that educators should supplement their multicultural counselling curriculum with learning opportunities that raise awareness of the possible use of Native American-themed artefacts in an offensive way (mascots for example).



- Walton (2011) used pre- and post-surveys to assess change in cultural attitudes, beliefs, and knowledge of nursing students before and after receiving education about, and engagement with, Native Americans receiving dialysis.
  - There were statistically significant differences in the pre- and post-test. This change suggested that students could learn cultural awareness from Native Americans receiving home dialysis and that they could apply culturally aware interventions following an education session based on clinical research.
  - Walton concluded that cultural competency training alone is inadequate because the application of knowledge is often omitted.
- Paul et al. (2006), with a similar emphasis on the involvement of Indigenous Australians in curriculum development, found that cultural competence training significantly increased medical students' cultural knowledge, attitudes, skills and competence in Indigenous Australian settings.
  - Cultural competence training specifically increased medical students' preparedness to work with Indigenous people, play an advocacy role, and take responsibility for prompting change in Indigenous health.

### **Strength of evidence**

Of the 28 studies identified, only 10 demonstrated significant improvement in healthcare outcomes related to cultural competency. Although there is inconclusive evidence of the effectiveness of culturally competent practices and frameworks in providing healthcare benefits for Indigenous populations and in reducing health inequalities, there is some confirmation of its potential; higher-level outcomes and reduction in health disparities are particularly apparent in the study by Cook et al. (2010).

For health services, audits of clinical and cultural competence indicators resulted in measured improvements in patients' and families' involvement in health care, and ultimately the patients' recovery improved (O'Brien 2003, 2004, 2007). Audits also identified aspects of health care where improvements in cultural competence were needed (Chong et al. 2011; O'Brien et al. 2004, 2007).

For health practitioners, workforce participation and development initiatives resulted in improvements in communication and interaction, respect for recipients of care, improvements in team functioning, clarity of roles, and participation in decision making, and improvements in cultural knowledge, confidence, and the competence to apply skills in diverse cultural contexts (Hearn et al. 2011; McRae et al. 2008; Mooney et al. 2005).

For patients, cultural competence resulted in increased satisfaction with care and improved abilities to engage in treatment and recovery. As well, health outcomes were documented, including reduced risk of substance abuse and suicide attempts (Winderowd et al. 2008), increased recovery rates from mental health and cardiac surgery (Cook et al. 2010; O'Brien et al. 2004), and reduced re-admission rates and reduced mortality (Cook et al. 2010).

For medical, nursing and pharmacy students, cultural competence training resulted in increased cultural knowledge, attitudes, skills and competence, enthusiasm, and preparedness to work with Indigenous people. It also prompted change (Paul et al. 2006, 2011; Steinfeldt & Wong 2010; Walton 2011).

### **Implications for the Australian context**

This review found that promising, evidence-based strategies and initiatives could be combined into a coherent multi-dimensional approach. The review identified 5 intervention types, suggesting that cultural competence involves a sustained multi-strategy approach encompassing knowledge, awareness, behaviour, skills and attitudes, and the sustained embedding of a cultural shift towards cultural proficiency within organisations.



There was evidence in the literature for the following interventions:

1. Interventions to reform health service and systems using bi-culturally developed indicators and a continuous quality improvement model to facilitate culturally competent healthcare to benefit local Indigenous populations (Chong et al. 2011; O'Brien et al. 2004, 2007; Reibel & Walker 2010).
2. Interventions that improve access to health care for Indigenous populations by bringing together the cultures of the health care organisations with those of the targeted communities (Dignan et al. 2005; Wetterhall et al. 2011).
  - Useful measurement instruments included client perceptions of practitioners' cultural competency, and measures of clients' cultural identity (enculturation) or similarity (Winderowd et al. 2008).
3. Interventions that improve workforce participation and development for health professionals to nurture the development of cultural competence.
  - These increased communication and interaction, respect for recipients of care and individual assessments of cultural competence (Hearn et al. 2011; McRae et al. 2008; Mooney et al. 2005).
  - These strategies need to be evaluated to determine whether they have a flow-on effect to health outcomes for patients. At the level of health practice, relevant measurement instruments might include tools to measure culture shock (Muecke et al. 2011), expectations of health care provision (Chong et al. 2011), and knowledge and skills in cross-cultural health practice.
4. Interventions that embed cultural perspectives and experiences in the curriculum for students of health.
  - These resulted in significant shifts in preparedness for, and future commitment to working for change in Indigenous health (Paul et al. 2006) and showed that field experience made an important and positive contribution in participants' perspectives (Amundson et al. 2008; Mak et al. 2006).
5. Culturally tailored rigorous interventions that are evidence-based, culturally and linguistically appropriate, and that incorporate community collaboration and mechanisms for sustainability and evaluation.
  - These can be effective in improving health service delivery (Barnett & Kendall 2011).

Such strategies should be developed in consultation with Indigenous Australian health services and communities, tailored to the needs and preferences of specific communities, and embedded within organisational culture, governance, policies and programs of health services.

The embedding of cultural competency principles within legislation or policy in the United States and New Zealand suggests that this strategy could be useful across Australia's health system as part of an ongoing commitment to Indigenous Australians and delivering culturally competent care. Although the review did not find direct evaluations of legislative or policy approaches, the extent and nature of the United States literature suggested that the legislative approach potentially stimulated increased efforts for change (O'Brien et al. 2007).

Internationally validated measurement instruments of health service access and utilisation, service quality, perceived discrimination, language barriers and trust of practitioners are likely to be promising for specific settings if tailored to and piloted in Indigenous Australian health service contexts. Also relevant could be studies that measure the protective factors for equitable health service provision such as ethnic identity, resources and use of data to monitor and improve outcomes.





## Principles and strategies for developing culturally competent services

There are several strong national frameworks for working with Indigenous and other ethnic groups. These include, but are not limited to, the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003); the National Health and Medical Research Centre Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (NHMRC 2003); the National Health and Medical Research Centre Cultural Competency in Health Guide for Policy, Partnerships and Participation (NHMRC 2005); the NSW 'Two Ways Together' plan for working well together with Indigenous communities (NSW Audit Office 2011); and the New South Wales Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012–2016 (NSW Health 2012).

These frameworks highlight the importance of community ownership, the need to build capacity, and the importance of multi-sectoral partnerships, and recognition of holistic approaches to health. There is also a need for sustained investment in cultural competence interventions and robust measures to evaluate their effect.

Based on this review of the peer review and grey literature on cultural competence in health care for Indigenous people from Australia, the United States, Canada and New Zealand, the following principles and strategies for developing culturally competent services were developed:

- Make cultural competence and equity in health care an integral component of quality improvement in Australian health services.
- Identify disparities in the quality of care provided to Indigenous Australians to determine the most appropriate cultural competence strategies for improvements.
- Train healthcare practitioners to improve their knowledge, attitudes and skills to provide culturally competent health care.
- Integrate cultural competence education in medical and health curricula to improve knowledge and attitudes of health and medical students.
- Work with Indigenous Australian communities to culturally tailor interventions (customising content, approach or messaging) to improve the quality of care and patient satisfaction with care.
- Evaluate a systems-level intervention that combines best-evidence strategies to reduce disparities in healthcare delivery to Indigenous Australians and improve the cultural competency of healthcare services.

## Strengths and limitations of the review

This systematic review identified and examined 28 publications related to cultural competency in health care for Indigenous populations. The type of publications identified and examined included those that described the development or application of indicators and measures of cultural competence, and those that evaluated intervention strategies designed to improve cultural competence. Indigenous people from Australia, Canada, United States and New Zealand were the focus of the 28 studies: 12 were from the United States, 11 from Australia, 3 from New Zealand, 1 from Canada, and 1 was a combined study from New Zealand and Australia.

Most studies were located in the United States and Australia. One possible explanation for the high number of studies from the United States is that guidelines and standards for cultural competency are embedded in federal and state health policy and reporting requirements (New Zealand also has embedded cultural competency in its national legislation, but this has been a more recent addition). The United States also has dedicated resources and overarching bodies to spotlight cultural competence. One such body is the National Center for Cultural Competency (NCCC n.d.), in which a Cultural and Linguistic Competence Policy Assessment aspect was developed at the request of and thus investment by, the Bureau of Primary Health Care, Health Resources and





Services Administration, United States Department of Health and Human Service to assist community health centres to advance and sustain cultural and linguistic competence. Its explicit mandate is to 'increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity' (NCCC n. d.).

In Australia and Canada, cultural competency is not enshrined in policy so it is difficult to explain the high proportion of studies from Australia on that basis alone. While there is some evidence of a commitment to developing a culturally competent workforce that respects and values Indigenous Australian cultures and differences, there is no indication of the basis for this commitment.

What the results could suggest is that there is a high degree of engagement between researchers, health services, educational institutions and associated activism that recognises the need for cultural understandings to be included in policy development, service delivery and the people management practices of health services.

While there was a range of cultural competence literature available, both from Australia and internationally, the methods used to review this literature and establish the current findings have limitations. The publications in this review were identified with a non-exhaustive search strategy that was designed to produce the bulk of peer-reviewed and non-peer-reviewed (grey literature) health studies that described or evaluated cultural competence indicators and interventions (for studies published in 2002–13). It is possible that some relevant publications were missed, particularly those published in the grey literature and book chapters, which are more difficult to systematically search than the peer-reviewed journal articles. Given the two-step strategy of searching electronic databases and reference lists of reviews, the studies represented in this review are likely to be representative of published cultural competence research from the United States, Canada, New Zealand and Australia.

Relevant indicator and intervention evaluations may have been misclassified; however, a high level of agreement between blinded coders suggests not. Because evaluations with statistically significant findings are more likely to be published, it is possible that the published evaluations reviewed over-estimate the true intervention effectiveness (Easterbrook et al. 1991).

The review found that there was a lack of Australian specific evidence about what strategies are most effective for improving culturally competent healthcare delivery to Indigenous Australians; there is also a lack of validated indicators that have been applied to these settings to measure what works. Only 11 of the 28 evaluations of culturally competent interventions were in Indigenous Australian settings, and the evaluation designs of only 3 of these studies were rated methodologically strong or moderate (Barnett & Kendall 2011; Chong et al. 2011; Paul et al. 2006). Only 6 indicator studies reported measures of the effectiveness of cultural competence interventions targeting improvements in healthcare delivery for Indigenous Australians, 4 of which were rated methodologically strong or moderate (Chong et al. 2011; Hearn et al. 2011; Mooney et al. 2005; Muecke et al. 2011).

The state of the evidence for cultural competency measures and interventions indicates that, in Australia, it is imperative to develop more robust and methodologically adequate assessments of culturally competent interventions to more accurately inform the development of quality care for Indigenous Australian populations. It also points to gaps in the literature. Although understanding clients' cultural and linguistic background has been documented in the literature as preventative, in terms of risk of miscommunication between health services and their clients, no studies reported on interpretative services for Indigenous clients.

Finally, Greenhalgh (2012) critiqued systematic reviews in relation to today's complex and multifaceted health challenges because they leave many broad questions unanswered. She claimed that Cochrane reviews are boring and sometimes cannot be implemented in practice:



The technical process of stripping away all but the bare bones of a focused experimental question removes what practitioners and policymakers most need to engage with: the messy context in which people get ill, seek health care (or not), receive and take treatment (or not), and change their behaviour (or not) (Greenhalgh 2012:371).

Although this systematic literature search strikes a sensible balance between the highly technical, rigid, resource intensive but often inaccessible conventional systematic literature review on the one hand and the undisciplined non-transparent approaches on the other, Greenhalgh's comment suggests that the findings of searches such as this for cultural competency for Indigenous populations need to be carefully tailored to the discrete (messy) contexts in which they might be carried out.

## Gaps in the evidence

There is a need to improve the quality of evaluations of cultural competence interventions targeting health care delivery to Indigenous Australians. The quality of evidence derived from the majority of studies was insufficient to provide a strong basis for specific interventions. This is in line with the findings of a recent review by Paul et al. (2010:566) of the 'sorry state of the evidence base' for improving the health of Indigenous populations in Canada, the United States, New Zealand and Australia. They found only 19 out of 665 intervention studies sufficiently met rigorous quality criteria and allowed them to confidently establish the effectiveness of strategies for improving health outcomes.

There is an urgent need for future evaluations of interventions targeting improvements in cultural competence to employ more rigorous methods, in particular, stronger study designs and reliable and valid measures of outcome effects. Because the most rigorous study design, a randomised control trial, or even the inclusion of a control group, might not be possible in many settings, interrupted time-series designs may be a feasible option for evaluating interventions that aim to reduce health inequalities. These designs require the ability to reliably and objectively measure study outcomes multiple times before and after intervention.

## Conclusion

Other international jurisdictions have enshrined cultural competence requirements with legislation; they have also allocated responsibility for cultural competence to professional health associations. Policies and programs are most likely to be effective if they comprise multiple components at different levels of health care (across and within health services, by individual practitioners, to client groups and within health training curricula).

Promising evidence-based strategies are systems-reform interventions that incorporate the development and integration of cultural competence performance indicators with clinical indicators, auditing and continuous quality improvement approaches. At health practitioner levels of care, useful interventions are offered by assessments of practitioner cultural competence and cultural safety training, education, frameworks and guidelines. Interventions can be successfully culturally adapted and applied across a range of health issues with Indigenous Australian client groups so long as attention is paid to local processes, systems and structures, and knowledge bases, and provided local community participation and leadership are facilitated.

There is an urgent need to evaluate policies or programs, especially in terms of their costs and outcomes, because there were few outcome-oriented studies and no economic evaluations. Such evaluations can be designed with researchers with relevant skills and need not be expensive if they occur simultaneously with the development and implementation of a policy or program. To achieve effective outcomes through embedding cultural competency into health care contexts, there is little doubt that multi-level, integrated, locally-tailored approaches must be adopted. For successful implementation, cultural competency frameworks require the support of policy and constant quality assurance processes.



# Appendix A: Nomenclature around cultural competency

## Cultural awareness

Cultural awareness is defined as ‘a sensitivity to the similarities and differences that exist between 2 different cultures, and the use of (this) sensitivity in effective communication with members of another cultural group’ (Eisenbruch & Volich 2005). ‘Cultural sensitivity’ has also been used interchangeably for this kind of cultural education (Thomson 2005). Cultural awareness training aims to demonstrate how culture informs our values, behaviours, beliefs and basic assumptions. In the Australian context, for example, this training seeks to increase awareness of the inherent cultural, social and historical factors experienced by Indigenous Australians by promoting self-reflection about one’s own culture and biases (Downing et al. 2011).

The concept of cultural awareness, although an important part of developing cultural competency, is about raising a consciousness of difference. It is, therefore, not always complemented by the associated skills and behaviours that (1) are necessary to interact and communicate sensitively and effectively with Indigenous clients and (2) ultimately can lead to better health care and outcomes (Thomson 2005). Cultural awareness programs clearly focus on individual development rather than on changing systems. Yet, even with cultural awareness programs and skill development in place, it was found ‘that to be effective in delivering services to Indigenous people, the awareness and skills needed to be accompanied by the motivation of health professionals to be successful in their interactions with Indigenous clients’ (Thomson 2005:3). This acknowledgement prompted a shift to ‘cultural security’, which involved moving attention from the health professionals to the health system and the interactions between professionals and clients (Downing et al. 2011; Thomson 2005).

## Cultural security

The concept of ‘cultural security’ was developed in Australia. It is defined as upholding a commitment to the provision of services that do not ‘compromise the legitimate cultural rights, views, values and expectations of Aboriginal people’ (WA Health 2005:1). It speaks to the ‘recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administrations’ (WA Health 2005:3). This model advocates that responsibility lies with health services and the system rather than individual health professionals, and importantly, that culture affects healthcare access. As a result, cultural security focuses primarily on systemic change that seeks to assist systems and health professionals to integrate culture into their delivery of services (Thomson 2005). Few guidelines have been developed for carrying out these kinds of changes, and training is centred on improving the knowledge of health professionals and departmental staff. Despite its broader systemic underpinnings, cultural security relies on cultural training thus emphasising individual knowledge (Downing et al. 2011).

## Cultural safety

The cultural safety model was developed in an Indigenous Maori health care context and has been increasingly taken up in Canadian and Australian settings (Browne & Varcoe 2006; Johnstone & Kanitsaki 2007; Nguyen 2008; Walker et al. 2009). Cultural safety was developed to address the ways colonial processes and structures shape and negatively affect Maori health in the dominant health system (Downing et al. 2011). It focuses on the levels of cultural safety that individuals experience in accessing healthcare and the responsibility for maximising these levels that lies with the service. Emphasis is on professional empathy and reflective practice rather than





awareness of culturally specific beliefs—‘understand[ing] processes of identity and culture, and how power imbalances or relationships can be culturally unsafe’ in health care practice (Downing et al. 2011:249). Cultural safety highlights systemic and individual change.

## Cultural competence

Cultural competence education and training aims to improve health professionals’ ‘awareness, knowledge and skills so that they can “manage” cultural factors in relation to health service interventions’ (Downing et al. 2011:248). For this reason, the obligation of cultural competence lies with knowledge at the individual level (Downing et al. 2011). There is also evidence of an expanded focus in cultural competency training to stimulate processes of self-awareness and reflexivity alongside that of organisational values, training and communication (Downing et al. 2011). This trend moves closer to integrating systems and behavioural components. The trajectory along the cultural competence continuum needs to move beyond cultural competence toward holistic, culturally sensitive systems and service responses. This goal has been described by some as cultural proficiency (Gorringe & Spillman 2008). Health equity can be achieved only if organisations have clearly embedded defined and matching sets of values and principles, policies and structures. They should enable health professionals to work effectively in cross-cultural situations and facilitate individual knowledge and empathy so they can be translated into practice on the ground (See Figure 2). Coming to such a position involves adopting a multi-level integrated approach to healthcare.

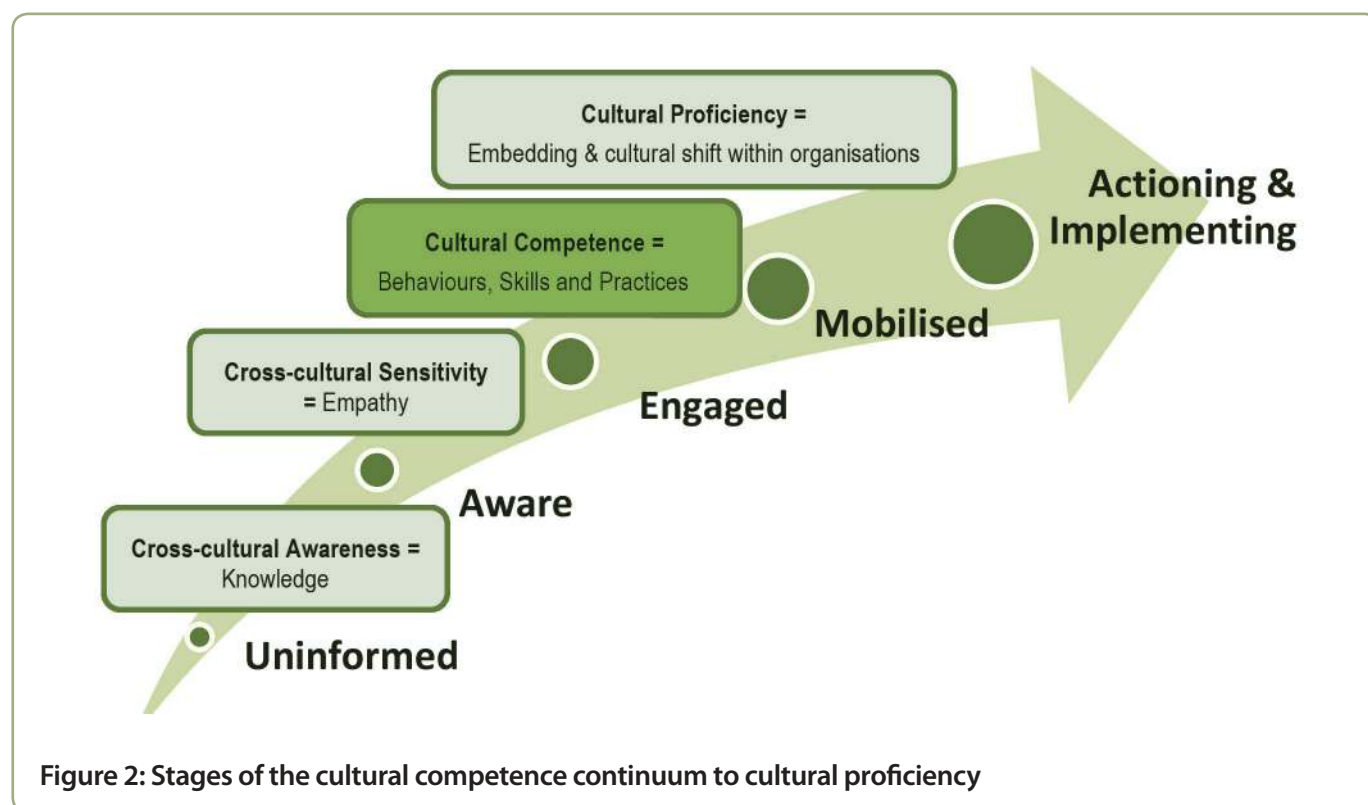


Figure 2: Stages of the cultural competence continuum to cultural proficiency

Source: Adapted from DET 2009; Gorringe & Spillman 2008



## Appendix B: Original search

### SEARCH 1

**A. Electronic Database search:** Indigenous Australia; Indigenous Studies Bibliography: AIATSIS; ATSIHealth; APAIS-ATSIS; FAMILY-ATSIS; Informit Indigenous Collection; Campbell Library; EBM Reviews/Cochrane DSR/ACP Journal club/DARE; PsycINFO; PsycEXTRA; Medline; Embase; CINAHL; Global Health; PAIS; Sociological Abstracts. (Searched on 19–20 June 2012)

Separate searches for each database for the time period, 2002–2012 (July) using database specific subject headings and keywords.

**Search strategy:** Search of databases using the appropriate subject headings in each database as well as keywords for the following search groups:

1. Health professionals OR health care providers OR health workers OR health administrators OR health workforce OR nurses OR doctors OR allied health workers OR medical practitioners OR health services OR primary care OR private practice OR community health OR hospitals.
2. Indigenous OR Aborigin\* OR Torres Strait Islander OR Native Americans OR Inuit OR Maori OR First Nations.
3. Cultural competence\* OR cultural sensitivity OR cultural safety OR cultural security OR cultural awareness OR cultural literacy OR cultural respect OR cultural framework OR cross-cultural OR inter-cultural.
4. Indicators OR measures OR intervention OR policy OR policies OR program\* OR evaluation OR training.
5. Health service outcomes OR population health outcomes OR equitable access OR health disparities OR patient satisfaction OR quality of health care.
6. Australia OR Canada OR USA OR New Zealand.
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6.

### B. Websites manually searched

- Australia: Indigenous HealthInfoNet; Closing the Gap Clearinghouse; NSW Ministry of Health. Aboriginal health.
- Canada: The National Collaborating Centre for Aboriginal Health; National Aboriginal Health Organization.
- New Zealand: Maori Health
- United States: American Indian Health.

### Web search strategy

Using keywords and the appropriate topic headings in each website:

- Cultural competency OR cultural
- Health
- 1 AND 2
- Web search engine MedNar to locate grey literature using the search terms 'cultural competency' AND (Indigenous or Aboriginal or native) AND health.

**Search 1 = 524 publications (after electronic removal of duplicates)**

### SEARCH 2

**Electronic Database search:** Indigenous Australia; Indigenous Studies Bibliography: AIATSIS; ATSIHealth; APAIS-ATSIS; FAMILY-ATSIS; Informit Indigenous Collection; Campbell Library; EBM Reviews/Cochrane DSR/ACP Journal club/DARE; PsycINFO; PsycEXTRA; Medline; Embase; CINAHL; Global Health; PAIS; Sociological Abstracts. (Searched on 24–25 July 2012).

Separate searches for each database using database specific subject headings and keywords.

**Search strategy:** Search of databases using the appropriate subject headings in each database as well as keywords for the following search groups:

1. Health professionals OR health care providers OR health workers OR health administrators OR health workforce OR nurses OR doctors OR allied health workers OR medical practitioners OR health services OR primary care OR private practice OR community health OR hospitals.
2. Aborigin\* OR Indigenous OR native OR Inuit OR Maori OR Torres OR first nation\* OR ethnic OR immigrant OR migrant OR "culturally and linguistically diverse populations" OR "vulnerable populations" OR "diverse".
3. Cultural competence\* OR cultural sensitivity OR cultural safety OR cultural security OR cultural awareness OR cultural literacy OR cultural respect OR cultural framework OR cross-cultural OR inter-cultural OR cultural difference OR inter-racial OR racism OR discrimination OR competence.
4. Indicators OR measures OR intervention OR policy OR policies OR program\* OR evaluation OR training OR assessment OR strategy OR strategies OR 'indicators of cultural competence'.
5. Health service outcomes OR population health outcomes OR equitable access OR health disparities OR patient satisfaction OR quality of health care OR delivery of health care OR clinical competence OR outcome assessment OR health indicators.
6. Australia OR Canada OR USA OR New Zealand.
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6.

**Years searched:** 2002–2012 (July)



## Appendix C: Updated search

### SEARCH STRATEGY

#### A. Electronic Database search by qualified librarian:

Indigenous Australia; Indigenous Studies Bibliography: AIATSIS; ATSIHealth; APAIS-ATSIS; FAMILY-ATSIS; Informit Indigenous Collection; Campbell Library; EBM Reviews/Cochrane DSR/ACP Journal club/DARE; PsycINFO; PsycEXTRA; Medline; Embase; CINAHL; Global Health; PAIS; Sociological Abstracts.

Separate searches for each database for the time period, 2002–2013 (October) using database specific subject headings and keywords.

#### Search strategy:

Search of databases using the appropriate subject headings in each database as well as keywords for the following search groups:

1. Health professionals OR health care providers OR health workers OR health administrators OR health workforce OR nurses OR doctors OR allied health workers OR medical practitioners OR health services OR primary care OR private practice OR community health OR hospitals.
2. Indigenous OR Aborigin\* OR Torres Strait Islander OR Native Americans OR Inuit OR Maori OR First Nations.
3. Cultural competence\* OR cultural sensitivity OR cultural safety OR cultural security OR cultural awareness OR cultural literacy OR cultural respect OR cultural framework OR cross-cultural OR inter-cultural OR bi-cultural\* OR cultural capability OR cultural inclusion.
4. Indicators OR measures OR intervention OR policy OR policies OR program\* OR evaluation OR training.
5. Health service outcomes OR population health outcomes OR equitable access OR health disparities OR patient satisfaction OR quality of health care.
6. Australia OR Canada OR USA OR New Zealand.
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6.

#### B. Websites manually searched

- Australia: Indigenous HealthInfoNet; Closing the Gap Clearinghouse; NSW Ministry of Health. Aboriginal health; NACCHO; Healing Foundation
- Canada: The National Collaborating Centre for Aboriginal Health; National Aboriginal Health Organization.
- New Zealand: Maori Health
- United States: American Indian Health.

#### Web search strategy

Using keywords and the appropriate topic headings in each website:

- Cultural competency OR cultural
- Health
- 1 AND 2
- Web search engine MedNar to locate grey literature using the search terms “cultural competency” AND (Indigenous or Aborigin\* or native) AND health.

#### Other

- Documents identified by the policy group and which met the inclusion criteria.

# Appendix D: Indicators of cultural competence ordered in terms of the strength of indicator quality

Author, year and type of publication	Country where developed and population	Indicator of cultural competence	Primary outcome measure	Measurement of indicator	Healthcare setting	Healthcare outcomes	Quality of indicator
O'Brien et al. 2007 Journal Paper	New Zealand and Australia Indigenous Australians and Maori people	Health service audit tool using bicultural indicators for clinical records and cultural competence	Health care delivery	Clinical indicators of critical events Consumer Notes Clinical Indicators audit tool	Mental health care	The way in which services were delivered affected patients' ability to engage in the treatment processes and ultimately in their recovery; patients became more involved in their own care; kin and community became more involved in care	Strong
O'Brien et al. 2004 Journal paper	New Zealand (includes Australian standards) Maori and non-Maori mental health clients	Health service audit tool using bicultural indicators for clinical records and cultural competence	Health care delivery	Health service Consumer Notes Clinical Indicators audit tool	Mental health services and mental health nursing	None reported or of significance	Strong
Winderowd et al. 2008 Journal paper	United States Native American clients and community members	American Indian enculturation	Patient health behaviours	Self-report survey using American Indian Enculturation Scale—this is related to protective factors of resilience and affects health care choices	Mental health—tribal counselling centre, university students and community members	None reported or of significance	Strong
Muecke et al. 2011 Journal paper	Australia Aboriginal Australian people	Culture shock and culture shock adaptation	Practitioner knowledge, attitude or behaviour	Self-report surveys using Culture Shock Profile, which tests comfort with social diversity, open-mindedness, role clarity and culture shock; and Culture Shock Adaptation Inventory, which tests feelings of control over the environment, getting along with others, emotional wellbeing and physical wellbeing	Primary health care—remote Indigenous Australian health services—for non-Indigenous practitioners	None reported or of significance	Moderate

(Continued)



Author, year and type of publication	Country where developed and population	Indicator of cultural competence	Primary outcome measure	Measurement of indicator	Healthcare setting	Healthcare outcomes	Quality of indicator
Chong et al. 2011 Report	Australia Indigenous patients	Expectations of culturally appropriate health care for Indigenous women with cancer	Expectations of health care by clinicians and Indigenous women	Qualitative interviews	Cancer—gynaecological care for women with cancer	None reported or of significance	Moderate
Cook et al. 2010 Journal paper	United States Honolulu Native Hawaiian population	Cultural preferences incorporated in patient quality care	Patient health behaviour and patient and family satisfaction	Clinical records and self-report survey	Inpatient hospital cardiac rehabilitation	Measurable reductions in adverse events following percutaneous coronary interventions and re-admissions for patients admitted with myocardial infarctions and heart failure Maintenance of high levels of family and patient satisfaction	Moderate
Hearn et al. 2011 Journal paper	Australia Health professionals working in Indigenous Australian health	Practitioners knowledge skills and confidence to deliver a culturally specific smoking intervention	Practitioner knowledge, attitude and behaviour	Self-report survey pre- and post	Primary health care—tobacco control	Significant increase (P<0.0001) in confidence to: <ul style="list-style-type: none"> <li>• talk about health effects (22%)</li> <li>• offer quit advice (27%)</li> <li>• assess readiness to quit (31%)</li> <li>• initiate a conversation about smoking (24%)</li> <li>• increase in access to culturally appropriate resources (19% p=0.001)</li> </ul>	Weak
Mooney et al. 2005 Journal paper	Australia (NSW) Health professionals Indigenous Australians	Health professionals' cultural awareness, perceptions, attitudes and knowledge	Practitioner perceptions, attitudes and knowledge	Health professionals' familiarity and friendships, attitudes and knowledge of Indigenous Australians and the health issues affecting them	Cultural awareness training	Non-significant (p>0.05) changes in perceptions and attitudes Significant increase (p<0.05) in friendships with Indigenous people; working with Indigenous people and an understanding of Indigenous health problems. Half-day cultural awareness training did not have a significant effect on changing beliefs and attitudes	Weak
Coffin 2007 Journal paper	Australia Indigenous Australian	Continuum of change toward cultural security	Health care delivery or practitioner knowledge, attitude or behaviour	Self-assessment against a continuum of change toward cultural security	Primary health care services	None reported or of significance	Weak

(Continued)



Author, year and type of publication	Country where developed and population	Indicator of cultural competence	Primary outcome measure	Measurement of indicator	Healthcare setting	Healthcare outcomes	Quality of indicator
Paul et al. 2011 Journal paper	Australia Medical students Indigenous Australia	Medical students' attitudes to Indigenous health and perceptions of preparedness to work in Indigenous health	Health curriculum	Comparative qualitative: questionnaire	Medical School Aboriginal Health Curriculum	Improvements in preparedness to work with Indigenous people, play an advocacy role and take responsibility to work for change in Indigenous health	Weak
O'Brien et al. 2003 Journal paper	New Zealand Maori and non-Maori mental health clients	Health service audit tool using bicultural indicators for clinical records and cultural competence	Health care delivery	Development of Consumer Notes Clinical Indicators for clinical records and cultural competence and Professional Practice Audit Questionnaire self-report survey	Mental health services and mental health nursing	None reported or of significance	Weak
Curran et al. 2008 Journal paper	Canada Aboriginal nursing students	Cultural relevance of nursing education curriculum for Aboriginal students	Health curriculum—student satisfaction with course	Interviews and questionnaires	Access to nursing education for Aboriginal students	None reported or of significance	Weak
Wiley 2009 Journal paper	New Zealand Maori who are disabled	Knowledge and attitudes to cross-cultural disability care	Consumers, carers, service providers and policy makers' knowledge and attitudes	Semi-structured interview instrument	Disability care and participation in services	None reported or of significance	Weak
Reibel & Walker 2010 Journal paper	Australia Indigenous Australian women	Patient access or utilisation (frequency of antenatal visits) of health service and cultural responsiveness; perception of cultural security	42 audited services, 18 Indigenous specific services, and 24 general antenatal services	Purpose-specific audit tool to measure access and quality of care of health services (general characteristics, risk assessment, treatment risk reduction and education, access and quality of care) administered through telephone interviews	Antenatal services in Western Australia	Variation across services; 9 of the 42 services provided culturally responsive service delivery, incorporating key indicators of cultural security combined with highly consistent delivery of routine antenatal care. Increased access and frequency of visits—reported 3 to 5 visits in the 9 culturally responsive services	Weak

# Appendix E: Evaluated cultural competency interventions ordered in terms of strength of design quality

1st author/ publication year publication type	Intervention type	Country developed/ target group	Sample size	Type of study	Outcome measures	Healthcare outcomes	Study quality
Barnett & Kendall 2011 Journal Paper	Educational health promotion program [Stanford Chronic Disease Self- Management Program]	Australia Leaders, Health professionals, Elders  Indigenous Australian	3 Indigenous Australian communities: 39 Elders, leaders, health professionals	Qualitative: participant- observation approach; [interviews and focus groups]	Program acceptability, effectiveness and sustainability	None reported or of significance	Strong
Ka'opua et al. 2011 Journal paper	Mammography— culturally tailored screening	United States Hawaii  Native Hawaiians		Randomised controlled trial	Protocols, procedures and processes; knowledge, attitudes and practice	None reported or of significance	Strong
Wiley 2009 Journal paper	New Zealand Disability Strategy	New Zealand  Maori		Qualitative: outcome evaluation	N/A	None reported or of significance	Strong
Paul et al. 2006 Journal paper	Aboriginal Health Curriculum	Australia  Australian medical students— Indigenous Australian health	224 students	Cohort, with historical control	Attitudes to Indigenous Australian health  Self-perceptions of readiness to work in Indigenous health	Significant improvements (p<0.05) in: preparedness to work with Indigenous people; play an advocacy role; and responsibility to work for change in Indigenous health	Moderate
Chong et al. 2011 Journal paper	Improving the culture of hospitals	Australia  Indigenous patients	5 hospitals	Qualitative: case studies—continuous quality improvement	Hospital environment  Cultural sensitivity	None reported or of significance	Moderate
Curran et al. 2008 Journal paper	Aboriginal nursing education access programs	Canada  Canadian Aboriginal nursing students	12 stakeholders	Qualitative study: responsive evaluation approach—focus groups, interviews, observations	Perceptions of program effectiveness and relevance	None reported or of significance	Moderate

(Continued)

1st author/ publication year publication type	Intervention type	Country developed/ target group	Sample size	Type of study	Outcome measures	Healthcare outcomes	Study quality
Dignan et al. 2005 Journal Paper	Face-to-face navigator intervention vs. telephone navigator intervention	United States Native American women	157	Randomised controlled trial	Self-reported mammograms	Significant within group increases in women reporting mammography screening: face-to-face, 34.4% to 45.2%; phone, 29% to 41.3%  No significant between group differences	Moderate
Wetterhall et al. 2011 Journal paper	Dental Care Model	United States Alaska  Alaskan Native people	233	Post-test	Patient satisfaction  Access to care	None reported or of significance	Weak
McRae et al. 2008 Journal paper	A culturally appropriate, pharmacist-led cardiovascular medicines education program for Aboriginal Australian Health Workers	Australia Pharmacists Aboriginal Australian Health Workers	12 Pharmacists 47 Aboriginal Australian Health Workers	Post-test with repeated measures	Confidence of pharmacists  Acceptability of program to Aboriginal Health Workers	Significant improvements in confidence with Indigenous health issues and educating Aboriginal Australian Health Workers (p = 0.002); access to resources to deliver education (p = 0.005)	Weak
Hearn et al. 2011 Journal paper	Culturally specific smoking cessation training program	Australia Health professionals working in Indigenous Australian health	165	Pre-post, with historical control	Knowledge, skills and confidence to offer an evidence-based quit smoking brief intervention to Indigenous clients	Significant increase (P<0.0001) in confidence to: <ul style="list-style-type: none"> <li>talk about health effects (22%)</li> <li>offer quit advice (27%)</li> <li>assess readiness to quit (31%)</li> <li>initiate a conversation about smoking (24%)</li> <li>increase in access to culturally appropriate resources (19% p=0.001)</li> </ul>	Weak
Mooney et al. 2005 Journal paper	Indigenous cultural awareness training	Australia Health professionals in urban setting— Indigenous Australian health	91	Pre/post, with historical control	Knowledge, perceptions, attitudes	Non-significant (p>0.05) changes in perceptions and attitudes  Significant increase (p<0.05) in friendships with Indigenous people; working with Indigenous people & an understanding of Indigenous health problems	Weak

(Continued)



1st author/ publication year publication type	Intervention type	Country developed/ target group	Sample size	Type of study	Outcome measures	Healthcare outcomes	Study quality
Cook et al. 2010 Journal Paper	Inpatient program—health care among Native Hawaiians with heart disease	United States Native Hawaiian population	Not Reported	Cohort, with historical control	Quality of care, patient satisfaction, and reduction of health care disparities: <ul style="list-style-type: none"> <li>percutaneous</li> <li>coronary interventions</li> <li>heart failure</li> <li>myocardial</li> <li>infarction</li> </ul>	Measurable reductions in adverse events following percutaneous coronary interventions and re-admissions for patients admitted with myocardial infarctions and heart failure Maintenance of high levels of patient satisfaction	Weak
Braun et al. 2005 Journal paper	Culturally tailored colectoral cancer screening	United States Hawaii Native Hawaiians	16 Hawaiian civic clubs 121 members	Randomised controlled trial	Knowledge, attitudes, intentions, self-efficacy, screening	Intervention vs control group significantly ( $p<0.05$ ) more likely to report improved knowledge; project was culturally appropriate; and enjoyment of program Screening rates increased from 59% to 67% in the experimental group and from 69% to 85% in the control group. Comparable improvements in knowledge and attitudes observed in both groups	Weak
D'Silva et al. 2011 Journal paper	Tailored smoking cessation group and individual programs	United States Native Americans	317	Pre-post	Demographic variables, program satisfaction; tobacco use quit rates	Increase in program acceptability, level of engagement and use of medication	Weak
Walton 2011 Journal paper	60-minute education presentation delivered by nurse	United States Native Americans	65 health science students 30 student nurses (aged 18–45; 70% female)	Pre/post survey, no control group	Knowledge, awareness, beliefs, attitudes and critical reflection	Significant changes in some knowledge and awareness domains ( $P<0.01$ )	Weak
Amundson et al. 2008 Journal paper	4-week summer internship on native American reservation: case-study presentations, team building exercises, discussions, community projects, mentors	United States Native Americans	46 health intern students (83% female)	Pre/post survey, no control group	Confidence to apply inter-professional and patient care skills	None reported or of significance	Weak

(Continued)





1st author/ publication year publication type	Intervention type	Country developed/ target group	Sample size	Type of study	Outcome measures	Healthcare outcomes	Study quality
Steinfeldt et al. 2010 Journal Paper	45-minute training presentation on culturally sensitive counselling practices with Native American clients vs 45-minute presentation addressing issues important to the use of Native themed mascots, to improve multicultural competence	United States Native Americans	46 counselling master's degree students (aged 22–50; mean age=25.71 years; 81% female)	Pre/post survey with parallel control group	Racial attitudes; awareness of offensiveness of Native theme mascots	Significant within group improvements in attitudes and awareness; no significant between group differences  Positive relationship between racial attitudes and increased awareness of offensive native mascots for intervention group	Weak
Ka'opua 2003 Journal paper	16-hour manual-based training, using adult pedagogical strategies infused with Native Hawaiian cultural practices	United States Native Hawaiians	11 community practitioners (10 female; age 30–61 years; mean age=50 years; 8 Native Hawaiian; 6 post-graduate qualification)	Pre/post survey, no control group	Knowledge of native healing practices and intervention protocols, and application of knowledge	Significant increases in knowledge (p<0.01); No significant improvement in application of knowledge	Weak
Mak et al. 2006 Journal paper	24-week clinical placement in remote area for prevocational medical practitioners (PMP)	Australia Indigenous Australians	4 prevocational medical practitioners (PMP)	Post-test only Qualitative: content analysis of PMP journals; structured phone interview Quantitative: questionnaire	Self-reported experiences, perceptions & knowledge	None reported or of significance	Weak
McCabe et al. 2006 Journal paper	2-day didactic workshop on implementing the Navajo English diabetes curriculum vs 40-minute video and study materials	United States Native Americans	22 health care workers from Indian health services: nurse aides; health educators; ambulance driver and physician assistant	Pre/post survey with parallel control group	Diabetes knowledge, frequency of patient interpreting, about diabetes, comfort level when interpreting, self-assessed ability in interpreting, and several topics, changes in interpreting	No tests of significance: some differences in improvements in knowledge and skills reported across both groups. Greater improvements in quality of interpretations in intervention group	Weak

# Appendix F: Nature of healthcare outcomes ordered in terms of weight of evidence

■ Denotes healthcare outcomes of significance

1st author/ publication year	Country and population	Healthcare outcome	Level targeted	Quality of indicator/ design
Paul et al. 2006	Australia Australian medical students—Indigenous Australians	Significant improvements ( $p < 0.05$ ) in: preparedness to work with Indigenous people; play an advocacy role; and responsibility to work for change in Indigenous health	Level of training and education for students	Moderate
Dignan et al. 2005	United States Native American women	Significant within group increases in women reporting mammography screening: face-to-face, 34.4% to 45.2%; phone, 29% to 41.3% No significant between group differences	Health service level—access	Moderate
Cook et al. 2010	United States Honolulu Native Hawaiian population	% reductions in adverse events following percutaneous coronary interventions and re-admissions for patients admitted with myocardial infarctions and heart failure Maintenance of high levels of family and patient satisfaction	Patients' level: satisfaction, behaviours or health outcomes	Moderate
Hearn et al. 2011	Australia Health professionals working in Indigenous health	Significant increase ( $P < 0.0001$ ) in confidence to: <ul style="list-style-type: none"> <li>talk about health effects (22%)</li> <li>offer quit advice (27%)</li> <li>assess readiness to quit (31%)</li> <li>initiate a conversation about smoking (24%)</li> <li>increase in access to culturally appropriate resources (19% <math>p = 0.001</math>)</li> </ul>	Healthcare practitioner level— knowledge, attitudes and/or practices	Weak
Mooney et al. 2005	Australia Health professionals Indigenous Australians	Non-significant ( $p > 0.05$ ) changes in perceptions and attitudes Significant increase ( $p < 0.05$ ) in friendships with Indigenous people; working with Indigenous people & an understanding of Indigenous health problems. Half-day cultural awareness training did not have a significant effect on changing beliefs and attitudes	Healthcare practitioner level— knowledge, attitudes and/or practices	Weak

(Continued)



1st author/ publication year	Country and population	Healthcare outcome	Level targeted	Quality of indicator/ design
McRae et al. 2008	Australia Pharmacists	Significant improvements in confidence with Indigenous health issues and educating Aboriginal Health Workers (p = 0.002); access to resources to deliver education (p = 0.005)	Healthcare practitioner level	Weak
Braun et al. 2005	Australian Aboriginal Health Workers United States, Hawaii Native Hawaiians	Intervention vs control group significantly (p<0.05) more likely to report improved knowledge; project was culturally appropriate; and enjoyment of program Screening rates increased from 59% to 67% in the experimental group and from 69% to 85% in the control group. Comparable improvements in knowledge and attitudes observed in both groups	Healthcare practitioner level	Weak
Walton 2011	United States College health science students Native Americans	Significant changes in some knowledge and awareness domains (P<0.01)	Level of training and education for students	Weak
Steinfeldt et al. 2010	United States Master's level counselling students Native Americans	Significant within group improvements in attitudes and awareness; no significant between group differences Positive relationship between racial attitudes and increased awareness of offensive native mascots for intervention group	Level of training and education for students	Weak
Ka'opua 2003	United States Native Hawaiians	Significant increases in knowledge (p<0.01); no significant improvement in application of knowledge	Healthcare practitioner level	Weak
O'Brien et al. 2007	New Zealand and Australia Indigenous Australians and Maori people	The way in which services were delivered affected patients' ability to engage in the treatment processes and ultimately in their recovery; patients became more involved in their own care; kin and community became more involved in care	Health service level	Strong
Paul et al. 2011	Australia Medical students	Improvements in preparedness to work with Indigenous Australians, play an advocacy role, and take responsibility to work for change in Indigenous health	Level of training and education for students	Weak
Reibel & Walker 2010	Indigenous Australian Australia Indigenous Australian women	Variation across services; 9 of the 42 services provided culturally responsive service delivery, incorporating key indicators of cultural security combined with highly consistent delivery of routine antenatal care. Increased access and frequency of visits—reported 3 to 5 visits in the 9 culturally responsive services	Health service level	Weak

(Continued)



1st author/ publication year	Country and population	Healthcare outcome	Level targeted	Quality of indicator/ design
McCabe et al. 2006	United States Native Americans	No tests of significance: some differences in improvements in knowledge and skills reported across both groups. Greater improvements in quality of interpretations in intervention group	Healthcare practitioner level	Weak
D'Silva et al. 2011	United States Native Americans	Some increase in program acceptability, level of engagement and use of medication	Healthcare practitioner level	Weak





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## Terminology

**Indigenous Australians:** ‘Aboriginal and Torres Strait Islander’ and ‘Indigenous’ are respectfully used interchangeably to refer to Australian Aboriginal and/or Torres Strait Islander people. The Closing the Gap Clearinghouse uses the term ‘Indigenous Australians’ to refer to Australia’s first people.

**Acculturation:** the degree to which an individual accepts and adheres to the majority dominant cultural values and their own cultural values (Winderowd et al. 2008).

**Clinical indicators:** statements describing pivotal health care behaviours that provide a practical and simple method of auditing important aspects of health care and have been used as a means of improving health care quality (O’Brien et al. 2004).

**Content validation:** the effectiveness of specific program components (Evans 2005).

**Critical event:** non-sentinel rate-based clinical indicators considered crucial to achievement of practice standards and that require a need for immediate rectification of the inherent practice.



**Cultural adaptation:** the possible positive outcomes of well-managed culture shock, such as personal growth and development (Muecke et al. 2011).

**Cultural awareness:** an understanding of a relevant cultural issue, not necessarily accompanied by a common or accepted practice or action (Coffin 2007).

**Cultural distance:** the degree of difference between the home culture and the host culture (Muecke et al. 2011).

**Cultural safety:** involves health providers working with individuals, organisations and the community to counter tendencies in health care that create cultural risk (or unsafety) through small actions and gestures, not usually standardised as policy and procedure. Cultural risk occurs when people from an ethnocultural group believe they are demeaned, diminished or disempowered by the actions and the delivery systems of people from another culture (Browne & Varcoe 2006; Coffin 2007).

**Cultural security:** links understandings and actions through policies and procedures which create processes that are automatically applied in health care (Coffin 2007).

**Cultural sensitivity:** an approach that avoids bias, prejudice and stereotyping (Crenshaw et al. 2011).

**Culturalism:** the process of viewing people through the lens of culture defined narrowly as shared values, beliefs and practices, and often conflated with ethnicity. In this process, 'culture' thus defined operates as the primary explanation for why certain people or groups experience various health, social or economic problems such as poverty, substance abuse or low birth weight (Browne & Varcoe 2006).

**Culture:** A system of beliefs, values and customs that are learned, shared, and transmitted through symbols (Evans 2005).

**Culture shock:** the stress, anxiety or discomfort a person feels when they are placed in an unfamiliar cultural environment, due to the loss of familiar meanings and cues relating to communication and behaviour (Muecke et al. 2011).

**Diversity:** accepting people who are different from oneself or being more inclusive and accepting of others regardless of colour, national origin, race, religion, sex or sexual orientation (Marra et al. 2010).

**Enculturation:** the process by which an individual learns about and identifies with his or her own cultural roots (Winderowd et al. 2008).

**Ethnicity:** a sense of group identification with beliefs, values and customs that are learned, shared and transmitted through symbols (Evans 2005).

**Indigeneity (Australian):** Involves a 3-part definition: being of Aboriginal and/or Torres Strait Islander descent, identifying as being Aboriginal or Torres Strait Islander, and being recognised by the community as being an Aboriginal or Torres Strait Islander person (Bourke 1998:175). However, Yin Paradies makes the point that Indigeneity does not require:

particular phenotypical traits, certain forms of cultural alterity, specific ethico-moral beliefs/actions, or a level of social disadvantage ... [instead] ... the poor and the rich Indigene, the cultural revival and the quintessential cosmopolitan, the fair, dark, good, bad and disinterested may have little in common, they are nonetheless all equally but variously Indigenous (Paradies 2006:363).

**Indigenous people globally:** The heterogeneity of Indigenous people globally is reflected in differing definitions across different countries. International forums have abandoned attempts to define Indigenous groups in favour of self-definition, due to the risk of excluding people because they do not fit in the definition (Ooft 2006). The United Nations Draft Declaration on the Rights of Indigenous Peoples states that 'Indigenous peoples have the collective and individual right to maintain and develop their distinct identities and characteristics, including the right to identify themselves as Indigenous and to be recognized as such' (UNHCHR 1994).





**Institutionalised racism:** the ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress various minority groups (Henry et al. 2004).

**Multiculturalism:** emphasises the need to respect and be sensitive to the cultures of different groups (Browne & Varcoe 2006).

**Rate-based indicators:** identify patient care events for which a certain rate of occurrence is acceptable and that may indicate a quality issue that requires review over a period of time (O'Brien et al. 2003).

**Sentinel events:** serious, rare, unacceptable and often avoidable aspects of health care (O'Brien et al. 2003).

**Traditionality:** an adherence to cultural values and behaviours that define a traditional perspective or way of life (Winderowd et al. 2008).

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