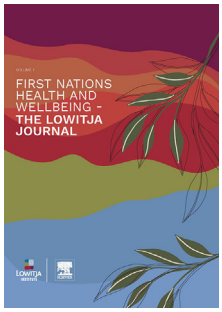

Review

Advancing health system accountability: A scoping review of cultural security and Indigenous health

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Abstract

Purpose Despite the countless frameworks emphasising the need for culturally safe provision of care, systemic racism persists and, in some cases, the gap between Indigenous and non-Indigenous health has widened. Cultural security is differentiated from cultural safety due to its demand of system-level changes that inform provision of care. Confusion with a myriad of other cultural terminologies has diluted the nuances between actions required to create culturally secure environments. Therefore, this scoping review was undertaken to explore existing evidence that contributes to the understandings and applications of cultural security for global Indigenous peoples across all health contexts, while recognising the potential overlap with systems-level definitions of cultural safety and the opportunity to clarify the distinctive contributions of cultural security.

Methods Two reviewers screened records from PubMed and then adapted for Scopus, Embase, Web of Science, ProQuest and Australian Indigenous HealthInfoNet. Inclusion in this review was not restricted by geographical location or language. Underscored by principles of critical realism and decolonising methodologies, principles related to the implementation and understanding of cultural security were extracted from each of the included articles and synthesised into common categories.

Main findings The systematic search identified 1,809 unique records, with 28 fulfilling the inclusion criteria. Twenty-four of the articles were related to Aboriginal and Torres Strait Islander health in Australia and four articles discussed Indigenous health globally. Evidence related to the understanding and implementation of cultural security was synthesised into 12 shared principles of cultural security. These principles focused on the importance of cultural identity, worldviews and values in healing, as well as the need for system level commitments and pathways of accountability for the creation of culturally secure environments.

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Principal conclusions Commitment to culturally secure provision of care at both an institutional and individual level is both an ethical and moral necessity for all healthcare providers. The balance of policy changes that incorporates space for living Indigenous cultures to ebb and flow necessitates a commitment to daily conversations, practices of reflexivity, and evaluation processes that measure service effectiveness for the Indigenous communities they serve.

Keywords: Indigenous health; Cultural security; Indigenous peoples

Highlights

- Cultural security goes beyond cultural safety awareness competency; by its demand for action at a systems level, the establishment of accountability frameworks is necessary to ensure sustainability of these changes.
- Infrequent training for non-Indigenous healthcare providers that solely focuses on knowledge acquisition of 'other' cultures risks oversimplifying understandings of Indigenous cultures and perpetuates cultural essentialism.
- Most of the work focused on cultural security within the context of Indigenous health has taken place in the Australian context; learnings from the findings can inform application of cultural security in global contexts.

Introduction

Colonial, neoliberal and racist policies entrenched within social economic and political systems persist, which maintain the marginalisation of Indigenous peoples[a] to peripheries of hegemonic society (Paradies 2016; Poirier et al. 2022). The persistent nature of colonial aspirations of assimilation have created an inequitable distribution of poor health outcomes, which is compounded by a failure of health services to prioritise accessibility and safety for Indigenous peoples (Anderson et al. 2016; Mitrou et al. 2014). Systemic racism manifests in healthcare through multiple mechanisms, including differential access, biased clinical decision-making and variable care quality (Fraser et al. 2021). Systemic racism prevents quality care provision and in extreme cases can result in death, as it did for Brian Sinclair in Winnipeg, Manitoba. Brian Sinclair was an Anishinaabe man from Sagkeeng First Nation on Turtle Island, who spent 34 hours unattended in an emergency department. He was checked on 17 times but never admitted, and the autopsy reported that he had been dead for between 2 and 7 hours before someone noticed. An inquiry into Brian Sinclair's passing was conducted to investigate the role of systemic racism, and recommendations were developed to try and prevent similar incidents from occurring (Lett 2013).

Seeking to challenge the operation of racism and power within healthcare settings, cultural safety has become a common goal within healthcare settings over the past 30 years. The assumption that all patients should be cared for in the same manner was first challenged by Māori nurse and scholar Irihapeti Ramsden in the 1990s. Ramsden's conceptualisation of cultural safety was primarily concerned with how the unequal distribution of power and resources (including information) impacted patient wellbeing.

[a]The term Indigenous peoples is employed throughout in alignment with the United Nations definition, which considers Indigenous peoples as those with pre-colonial societies who consider themselves distinct from populations now occupying their ancestral lands.

Within this definition, the nurse was understood as a bearer of their culture, attitudes and exercised conscious or unconscious power (Ramsden 2002). Since Ramsden's publication, many scholars and healthcare practitioners have evolved works based on the idea of power and cultural rights within healthcare contexts (Brascoupé et al. 2009; Kurtz et al. 2018). Cultural safety definitions have evolved from the individual level to organisational conceptualisation that encourage accountability for culturally safe care, as determined by patients and measured by progress towards health equity (Curtis et al. 2019).

Despite the countless documents and frameworks that emphasise the need for culturally safe provision of care for Indigenous peoples, the gap between Indigenous and non-Indigenous health has widened in some areas (Hernández et al. 2017) and systemic racism persists (Queensland Mental Health Commission 2020). In some countries, like Australia, there are funded models of care that are designed, implemented and accountable to Indigenous communities (termed Aboriginal community-controlled health organisations). These services are grounded in self-determination and are designed to provide anti-racist and culturally secure care by operating within community-oriented understandings of wellbeing that resist colonial and biomedical values that Western health systems operate within (Poirier et al. 2022). While there are health systems that have proven to optimally support wellbeing, the scale and resourcing of these services are unable to meet all health needs of Indigenous communities, and these services do not exist in all countries. As such, the need to strengthen provision of care for Indigenous peoples accessing Western health systems remains a high priority.

In response to the consistent failure of health systems to meet the needs of Indigenous peoples, the concept of cultural security was developed by Professor Juli Coffin (2007). Cultural security demands system-level changes, including monitored policies and processes, regarding the provision of care for Indigenous peoples, rather than relying on informal influence or unregulated 'best practice'. Coffin explains cultural security as requiring 'active conceptualisation' that emphasises 'behaviour over attitude' and 'actions over understanding,' applied by staff across entire health systems as a means of supporting better health outcomes for Indigenous peoples (Coffin 2007). While cultural awareness and cultural safety may be seen as building blocks for cultural security, they are insufficient without Indigenous-led co-design and brokerage between communities and institutions to embed cultural security into service protocols. Coffin asserts the need to understand cultural security as a service delivery outcome that should be monitored across time using metrics devised by Indigenous peoples that evaluate the effectiveness of services in meeting their needs (Coffin 2007).

However, the proliferation of overlapping and often inconsistently defined cultural concepts, described by Lock and colleagues as a 'cultural concept soup' (Lock et al. 2021), has contributed to definition confusion and also to conceptual dilution and implementation fatigue. This ambiguity hinders the ability of both practitioners and systems to enact genuine and sustainable change (Coffin 2007; Cox et al. 2022). More critically, the failure to implement cultural security often reflects not just confusion, but the unwillingness of institutional decision-makers to commit to meaningful resourcing, implementation and accountability for change that will support improved Indigenous health outcomes. These limitations are symptomatic of deeper structural racism embedded in health systems, where commitments to cultural safety, and similar concepts, are rhetorically made but

rarely operationalised or mandated in practice (Bainbridge 2023; Victorian Aboriginal Community Controlled Health Organisation 2023). Therefore, this scoping review was undertaken to explore existing evidence that contributes to the understanding and application of cultural security for global Indigenous peoples across health contexts, while also clarifying the distinctive contributions of cultural security as a system-wide enforceable standard.

Materials and Methods

As a type of systematic review, scoping reviews aim to identify all available evidence on a specified topic irrespective of methodological rigour (Munn et al. 2018; Peters et al. 2021). This scoping review sought to collate the existing evidence on the understanding and implementation of cultural security (Coffin 2007) within the context of healthcare provision for Indigenous peoples globally. Following a search of PubMed and PROSPERO it was determined that no similar studies were published or underway. This review was registered with the Joanna Briggs Systematic Reviews register, and in accordance with methodological recommendations for scoping reviews (Peters et al. 2021), the protocol was published with the Center for Open Science (Poirier et al. 2023). This review was conducted and reported in alignment with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (Page et al. 2021) (Supplementary File S1).

Positionality statement

The authors would like to position themselves in relation to the work presented herein, in recognition of the relational processes of learning that led them to this point (Gabrielle 2012; Wilson 2008; Yunkaporta 2019). They are a team based in Australia, comprising female settler (BP, LJ) and Indigenous (MC) academics from Canada (BP, MC) and Aotearoa New Zealand (LJ). They approached this work from a place of advocacy and gratitude. Either through lived experience or being entrusted with community stories, the inability of health systems to meet the needs of Indigenous wellbeing have become a centrality in their work. They acknowledge the immense honour it is to work in partnership with Indigenous communities across projects related to self-determination of Indigenous wellbeing.

Theoretical foundations

The metatheoretical perspective of critical realism informed the conduct of this scoping review (Archer et al. 2013; Bhaskar 2014). Critical realism acknowledges the different layers of reality that social phenomenon consist of and are constituted by (Blom et al. 2011). Therefore, critical realism demands exploration of causality on layers beyond the empirically observable, whereby contingencies that induce causal pathways for a given outcome can be identified and understood (Archer et al. 2013); which for this work is the provision of culturally secure healthcare for Indigenous peoples. Through the identification of aspects related to the outcome, opportunities to discern social complexities of decisions and occurrences that contribute to underlying structures of causal power are created, termed generative mechanisms (Bhaskar 2014; Blom et al. 2011). Generative mechanisms are observable in the social world but are considered tendential, requiring favourable conditions for their existence. As critical realism understands generative mechanisms as penetrating empirical surfaces to layers beneath the observable, it postulates that drawing conclusions regarding interacting generative mechanisms, even where circumstances prevent observable effects, remains possible (Blom et al. 2011).

This methodological approach was informed by decolonising theories, in alignment with the socially

focused tenets of critical realism. Decolonising theories foreground Indigenous realities and understand the continuous and deleterious impacts of colonisation and resultant marginalisation from hegemonic society (De Leeuw et al. 2017; Fanon et al. 1965; Hedges et al. 2023; Smith 1999). In the context of this work, hegemonic society incentivises the provision of biomedical care, rather than holistic care, that fails to understand, consider or meet the cultural rights and needs of Indigenous patients (Hole et al. 2015; Poirier et al. 2022; Sherwood et al. 2020).

Identifying articles for inclusion

Five databases were searched in June 2023 from database inception, using keywords and index terms related to 'cultural security', 'health' and 'Indigenous'. The search was initially developed for PubMed and then adapted for Scopus, Embase and Web of Science. ProQuest and Australian Indigenous HealthInfoNet were searched for grey literature using similar key words as the databases (Supplementary File S2). Evidence in any language, from any location and utilising any type of study design was eligible for inclusion in this review. To be considered for inclusion, evidence needed to discuss cultural security (Coffin 2007) within the context of Indigenous (United Nations 2007) health, defined as 'more than just the absence of disease or illness; it is a holistic concept that includes physical, social, emotional, cultural, spiritual and ecological wellbeing, for both the individual and the community' (Australian Institute of Health and Welfare 2020).

All records identified during the search were imported into Covidence (https://www.covidence.org/, Veritas Health Innovation Ltd, Melbourne, Australia) and, following the removal of duplicates, two independent reviewers (BP and MC) screened the titles and abstracts of records against the inclusion criteria.

Articles deemed relevant by either reviewer progressed to full-text review, whereby the independent reviewers screened the full text of articles against the criteria. Any uncertainties during the screening phase were resolved through discussion or with a third reviewer (LJ). In alignment with scoping review methodologies, critical appraisal was not performed on studies included in this review as it did not aim to produce critically appraised findings but rather provide an overview of existing evidence (Munn et al. 2018).

Data extraction and synthesis

Data were extracted into a piloted extraction form by two reviewers (BP and MC). Three articles were performed by both reviewers to ensure inter-rater reliability and reduce the introduction of selection bias (Ahmed et al. 2012). The data extracted included information about participants, study aim, context, methods and key findings, as well as conceptualisation and implementation of cultural security. Characteristics of each article were tabulated, conceptualisations of cultural security employed by authors of included articles were compared and narratively synthesised, and finally shared principles of cultural security were synthesised into categories.

Results

The systematic search identified 2,758 articles; after removal of 949 duplicates, 1,809 records were left for assessment against inclusion criteria. Following title and abstract screening, 69 articles were retrieved in full and assessed during the full-text review. Forty-one articles did not meet the inclusion criteria, primarily because they were not discussing cultural security within a health context or with an Indigenous population. Therefore, 28 articles were included in this review (Figure 1).

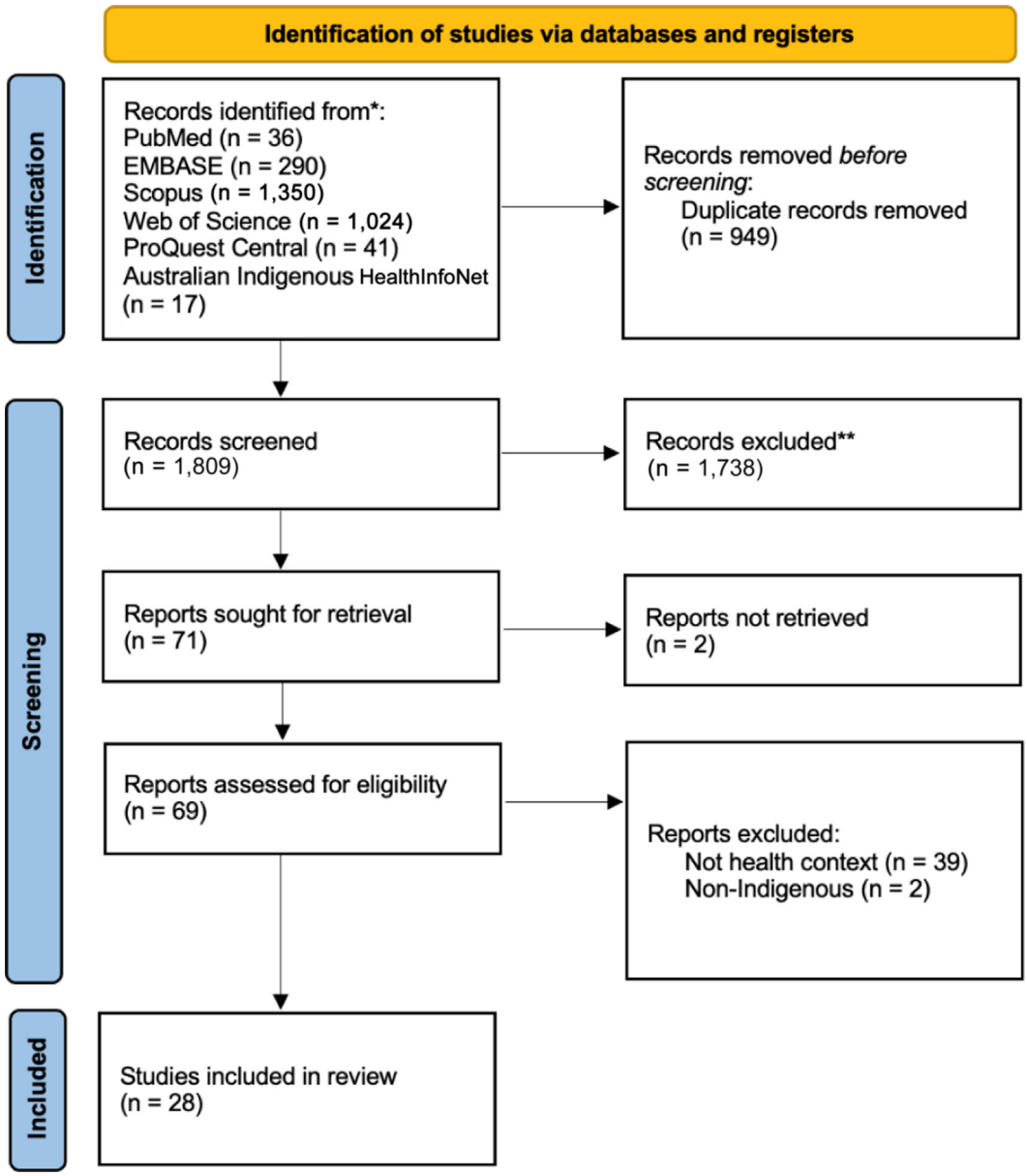

Figure 1: PRISMA 2020 flow diagram (Page et al. 2021).

Study characteristics

All of the included studies were conducted within Australia; 25 discussed cultural security in relation to Aboriginal and Torres Strait Islander communities in Australia (Armstrong et al. 2021a, 2021b; Bateup 2010; Bradley 2019; Downing et al. 2011; Gubhaju et al. 2020; Kimberley Aboriginal Health Planning Forum 2020; Liaw et al. 2011; Lin et al. 2014; Lin et al. 2017; Marriott et al. 2019a, 2019b, 2019c; Marriott et al. 2020; McRae et al. 2023; Northern Territory Health 2016; O'Brien

et al. 2021; O'Brien et al. 2023; Otim et al. 2015; Paki 2005; Paul et al. 2006; Sethi et al. 2022; Shahid et al. 2013a, 2013b; Skoss et al. 2021) and three discussed cultural security within the global Indigenous context (Gidgup et al. 2022; Lin et al. 2020; Marriott et al. 2019a, 2019b, 2019c). The study design and methodology ranged across the included studies: eight qualitative studies (including interviews and yarning) (Armstrong et al. 2021a, 2021b; Lin et al. 2014; Lin et al. 2017; Marriott et al. 2019a, 2019b, 2019c; McRae et al. 2023; O'Brien et al. 2023; Shahid et al. 2013a, 2013b); six literature reviews (including scoping, narrative and systematic) (Downing et al. 2011; Gidgup et al. 2022; Liaw et al. 2011; Lin et al. 2020; Marriott et al. 2019a, 2019b, 2019c; Taylor et al. 2011); four protocols (Armstrong et al. 2021a, 2021b; O'Brien et al. 2021; Sethi et al. 2022; Skoss et al. 2021); two process evaluations (Marriott et al. 2019a, 2019b, 2019c; Marriott et al. 2020); two descriptive surveys (Gubhaju et al. 2020; Paul et al. 2006); two policy frameworks (Kimberley Aboriginal Health Planning Forum 2020; Northern Territory Health 2016); two mixed methods studies (Bradley 2019; Paki 2005); one commentary (Bateup 2010); and one workshop-based study (Otim et al. 2015). Participants included community members, Elders, those with lived experience of a given health condition, care providers and medical students; sample sizes of participants ranged 20 to 207 (Table 1).

Synthesis of evidence

The concept of 'cultural security' is employed to convey several meanings; therefore, the review team sought to understand how authors of the included studies utilised the terminology of 'cultural security'. Two of the papers did not explicitly define cultural security in the context of their work (Gidgup et al. 2022; Marriott et al. 2019a, 2019b, 2019c), and 18 papers referenced Coffin's (2007) seminal piece on cultural security (Armstrong et al. 2021a, 2021b; Gubhaju et al. 2020; Liaw et al. 2011; Lin et al. 2020; Lin et al. 2014; Lin et al. 2017; Marriott et al. 2019a, 2019b, 2019c; Marriott et al. 2020; McRae et al. 2023; O'Brien et al. 2021; O'Brien et al. 2023; Sethi et al. 2022; Shahid et al. 2013a, 2013b; Skoss et al. 2021; Taylor et al. 2011). Other cited definitions or tools included the Northern Territory Health Aboriginal Cultural Security Framework (Northern Territory Health 2016), the Western Australia Aboriginal Health and Wellbeing Framework (Western Australian Department of Health 2015) and Reibel and Walker's audit tool for cultural security (Reibel et al. 2010). In addition to referencing established definitions, authors described cultural security as a concept operating at the policy and systems level, with quality assurance processes (Downing et al. 2011; Lin et al. 2020; Otim et al. 2015) that require active processes (Gubhaju et al. 2020) to ensure that the cultural rights of Indigenous peoples (O'Brien et al. 2021) are not compromised. Authors from one paper described cultural security as a concept that assures no one is 'afforded a less favourable outcome simply because they hold a different cultural outlook' (Wilkes et al. 2002). Another paper discussed the limited guidance that exists with regard to attaining cultural security (Downing et al., 2011).

Cultural security was discussed in relation to a number of health contexts for Indigenous communities, including brain injury (Armstrong et al. 2021a, 2021b; Skoss et al. 2021), acquired communication disorders (Armstrong et al. 2021a, 2021b), mental health (Bradley 2019, Kimberley Aboriginal Health Planning Forum 2020), amputation (Bateup 2010), physical activity (Gidgup et al. 2022), health service provision and research (Gubhaju et al. 2020; Northern Territory Health 2016; Paki 2005), chronic disease management (Liaw et al. 2011), low back pain (Lin et al. 2014; Lin et al. 2017), physical rehabilitation (Lin et al. 2020), birthing on Country (Marriott et al. 2019a, 2019b, 2019c; Marriott

Authors	Country	Aim	Design and methodology	Participants	Main outcome/results
Armstrong et al. 2021a, 2021b	Australia	To inform the development of appropriate, culturally secure adult brain injury rehabilitation service delivery models	Semi-structured interviews, thematic analysis	N = 50 (32 Aboriginal people with acquired communication disorders and 18 family members)	Increased appreciation of the health and social contexts of Aboriginal people after brain injury is needed to improve communication and accessibility of rehabilitation services. Cultural identity is key to ensuring cultural security and ultimately recovery; involvement of family and other Aboriginal people in recovery processes, access to Aboriginal languages, and proximity to Country* is central
Armstrong et al. 2021a, 2021b	Australia	To improve delivery of rehabilitation services to Aboriginal people post brain injury	Protocol, stepped-wedge cluster design	Eligibility: Aboriginal people aged >18 years who have suffered acute stroke or traumatic brain injury	N/A
Bateup 2010	Australia	To describe recommendations relating to cultural awareness of grief and loss for Indigenous and non-Indigenous patients after an amputation	Commentary	N/A	Recommendations include understanding the cultural security for Indigenous people because of the known factors contributing to health and hospitalisation. The lack of knowledge and/or ignorance of the psychosocial and emotional wellbeing promotes negativity with the doctors and social workers, which affect the individual
Bradley et al. 2019	Australia	To understand Aboriginal women's experiences of Top End mental health services	Mixed methods, database information and qualitative analysis of women's stories	N = 16 (Aboriginal women who have utilised the services)	Five broad and interconnected themes emerged from the analysis: social context (stressors and supports), connection (kin, culture and community), control (losing and regaining self-determination), caring (healing words and actions), communication (mutual understanding)
Downing et al. 2011	Australia	To review approaches to cultural training for health workers and the effectiveness of translation into program delivery	Literature review	N/A	Evidence for the effectiveness of Indigenous cultural training programs in Australia is poor. Critiques of cultural training from Indigenous and non-Indigenous scholars suggest that a 'cultural safety' model may offer the most potential to improve the effectiveness of health services for Indigenous Australians
Gidgup et al. 2022	Australia	To synthesise all evidence to understand the barriers and enablers for older Indigenous peoples engaging in physical activity	Qualitative systematic review	N/A	Cultural safety and security were key enablers, including developing physical activity programs led by Indigenous communities and prioritising Indigenous values. Colonisation was a key barrier that created mistrust and uncertainty. Social determinants of health, including cost, were addressed by successful programs, but if not, were demotivators of engagement
Gubhaju et al. 2020	Australia	To examine staff perspectives on the scope, reach, quality and cultural security of services targeted for Aboriginal people of Western Australia	Descriptive survey	N = 60 (staff from health or social services, 32% Indigenous)	Participants identified having Aboriginal staff and better cultural awareness training as methods to improve cultural security within the service. Much greater effort is required in improving knowledge through on-going training of staff in the practice of culturally safe care. Organisations must also be required to meet specific standards in cultural safety
Kimberley Aboriginal Health Planning Forum 2020	Australia	To support and guide Kimberley Aboriginal Health member organisations to improve cultural security in their organisation, for their employees and patients	Policy framework	N/A	Implement, monitor and evaluate progress across four areas to improve service provision to Aboriginal people: (1) professional development of the workforce; (2) the workplace environment; (3) work practices; (4) systems and processes

(Table 1 continues on next page)

Authors	Country	Aim	Design and methodology	Participants	Main outcome/results
(Continued from previous page)					
Liaw et al. 2011	Australia	To determine the attributes of culturally appropriate healthcare to inform the design of chronic disease management models	Literature review	N/A	Successful chronic disease care and interventions require adequate Aboriginal community engagement, utilising local knowledge, strong leadership, shared responsibilities, sustainable resources and integrated data systems
Lin et al. 2014	Australia	To examine communicative barriers and opportunities for improvement for Aboriginal people with chronic low back pain	Qualitative in-depth interviews	N = 32 (Aboriginal adults with chronic low back pain)	Barriers to communication related to content, information that was not evidence-based, miscommunication, communicative absence and the use of medical jargon. Enablers related to communication style described as 'yarning', a two-way dialogue, and healthcare practitioners with good listening and conversational skills
Lin et al. 2017	Australia	To develop culturally appropriate low back pain information for Aboriginal people in rural areas	Qualitative randomised crossover design	N = 20 (Aboriginal adults)	Participants valued seeing 'Aboriginal faces,' language that was understandable, visual formats, and seeing Aboriginal people undertaking positive changes. Similar processes are needed to develop pain information for other cultural groups, particularly those under-served by existing approaches to care
Lin et al. 2020	Australia	To examine the need for physical rehabilitation, barriers to rehabilitation and outline opportunities to improve physical rehabilitation for Indigenous peoples	Narrative review	N/A	A greater commitment to cultural security is needed, which would include improved funding of physical rehabilitation for Indigenous communities, building the Indigenous physical rehabilitation workforce, co-location within Indigenous health services, and cultural training for the existing physical rehabilitation workforce. For clinicians, a focus on cultural development and the quality of communication is needed
Marriott et al. 2019a, 2019b, 2019c	Australia	To review the applicability and cultural security of the program for Aboriginal women and midwives during childbearing	Process evaluation	N/A	By aligning with Indigenous methodologies, the research team was able to reach collaborative and meaningful interpretations while maintaining cultural integrity of the process and in interactions with community. This was integral to ensuring that the evidence would ultimately make a difference to the lives of Aboriginal women
Marriott et al. 2019a, 2019b, 2019c	Australia	To understand Aboriginal women's experiences of birthing on Country	Yarning	N = 74 (Aboriginal Elders or senior women with birthing experiences)	Findings highlighted that maternity care changes across time have failed to acknowledge and support Aboriginal women's cultural needs during childbearing. Women collectively expressed a strong desire to maintain cultural practices associated with childbirth, including birthing on Country, having family acknowledged and included throughout the perinatal period, and having access to Aboriginal midwives, nurses, doctors and other healthcare workers to support their cultural security

(Table 1 continues on next page)

Authors	Country	Aim	Design and methodology	Participants	Main outcome/results
(Continued from previous page)					
Marriott et al. 2019a, 2019b, 2019c	Australia	To examine the available evidence on culturally secure care in urban maternity services for Indigenous women	Scoping review	N/A	Substantial qualitative evidence on Indigenous women's experience during the perinatal period in urban areas exists. Culturally secure midwifery care shows promising results for women in these contexts; more in-depth analysis of these studies is required to inform future practice and policy on what works and what needs improvement
Marriott et al. 2020	Australia	To describe cultural security and associated concepts as related to the health system and maternity care	Process report/ reflection	N/A	Actions for change noted in the project recommendations include attracting more Aboriginal people into the health workforce, meaningful and regular participation by all healthcare providers in cultural education programs led by Aboriginal people, and systems and individual actions that confront racism in healthcare and enable mechanisms that challenge and stop this
McRae et al. 2023	Australia	To identify gaps in current treatment and prevention of skin infections and develop community-driven health promotion	Yarning	N = 56 (clinical and school staff, 29% Indigenous)	The strong knowledge of recognition, treatment and prevention of skin infections did not extend to the role skin infections play in causing acute rheumatic fever, rheumatic heart disease or kidney failure. Ongoing education for skin infections using culturally appropriate health promotion resources
Northern Territory Health 2016	Australia	To guide understanding of cultural security and provide guidance for embedding cultural security	Policy framework	N/A	This framework provides information about the domains of cultural security, priority areas within those domains and suggested strategies so that individuals, services and other stakeholders can use this document to further progress and embed cultural security in a systematic and sustainable way
O'Brien et al. 2021	Australia	To develop culturally appropriate arthritis resources	Protocol	Eligibility: Aboriginal people who experience arthritis	N/A
O'Brien et al. 2023	Australia	To understand the lived experience of Aboriginal and Torres Strait Islander people with osteoarthritis	Yarning	N = 25 (Aboriginal and Torres Strait Islander people with osteoarthritis)	Themes related to beliefs and knowledge, impact, coping and healthcare experiences. Multidimensional impacts were often experienced within complex health or life circumstances and associated with increased anxiety and depression that permeates all aspects of life and highlights the need for integrated, multidisciplinary care that is culturally informed

(Table 1 continues on next page)

Authors	Country	Aim	Design and methodology	Participants	Main outcome/results
(Continued from previous page)					
Otim et al. 2015	Australia	To develop an Indigenous-specific health metric that captures individual and community benefits for improving the priority setting process	Workshop-based approach	N = 40 to 60 (stakeholders from accessing cost effectiveness-prevention Indigenous steering committee and community members)	This study demonstrated how the objectives being pursued in Indigenous health can be captured for priority setting purposes. The results indicated that DALYs are an important measure of benefit, but account for a small proportion of what constitutes 'benefit' from an Indigenous perspective. It has further demonstrated that community health gain ought to be actively addressed in priority setting. It was possible to develop an instrument for measuring benefit in Indigenous health for priority setting purposes, which reflects Indigenous health constructs
Paki 2005	Australia	To develop a framework that informs the maintenance of cultural security for Aboriginal school children who participate in health research in Western Australia	Mixed methods (interviews and questionnaires)	N = 2 Aboriginal researchers (interviews) N = 7 Aboriginal (4) and non-Indigenous researchers (3) (questionnaire)	Findings indicate that practice-informed evidence supported the recommendations within the literature for maintaining the cultural security of Aboriginal health research participants. Content validation from an expert panel confirmed that the framework would assist a research project to demonstrate Aboriginal values relevant to health research and thus maintain the cultural security of Aboriginal participants
Paul et al. 2006	Australia	To describe the implementation of an integrated Aboriginal health curriculum into a medical course and the effect on students	Questionnaire	N = 207 (final year medical students)	Students who received the training were more likely to feel prepared and able to work with and care for Aboriginal and Torres Strait Islander people, to advocate and improve the health of Aboriginal people, and they were more likely to identify their social responsibility to work for change in Aboriginal health
Sethi et al. 2022	Australia	To improve access to culturally secure dental care for Aboriginal and Torres Strait Islander individuals with kidney disease	Protocol	Eligibility: Aboriginal and Torres Strait Islander people aged > 18 years, living with kidney disease	N/A
Shahid et al. 2013a	Australia	To explore care providers' experiences providing palliative care for Aboriginal people	In-depth qualitative interviews	N = 15 (palliative care providers)	The context of Aboriginal history and historical distrust of mainstream services influenced willingness and ability to accept care and support from palliative services. This needs to be understood at the system level. More cultural safety training was requested by care providers, but it was not seen as replacing the need for Aboriginal health workers on the palliative care team
Shahid et al. 2013b	Australia	To understand cancer service provider views about factors impairing communication with Aboriginal patients	In-depth qualitative interviews	N = 62 (Aboriginal and non-Aboriginal cancer service providers)	Individual cancer service providers identified challenges in cross-cultural communication and the willingness to accommodate culture-specific needs within the wider healthcare system. Participants indicated a lack of concerted effort at the system level to address Aboriginal disadvantage in cancer outcomes

(Table 1 continues on next page)

Authors	Country	Aim	Design and methodology	Participants	Main outcome/results
(Continued from previous page)					
Skoss et al. 2021	Australia	To determine whether the research was implemented as planned and investigate contextual factors at each different phase	Protocol	Eligibility: Aboriginal people aged >18 years, admitted to hospital for stroke or traumatic brain injury	N/A
Taylor et al. 2011	Australia	To understand the issues and strategies for enhancing cross-cultural and relational collaborations	Literature review	N/A	Although successful partnerships are crucial to optimise Aboriginal health outcomes, failed collaborations risk inflaming sensitive Aboriginal and non-Aboriginal relationships. Factors supporting successful partnerships remind us to develop genuine, trusting relationships that are tangibly linked to community

DALYs, disability-adjusted life years; N/A, not applicable. *Country is the terminology used to refer to traditional lands of Aboriginal and Torres Strait Islander peoples in Australia.

Table 1: Study characteristics

et al. 2020), perinatal health (Marriott et al. 2019a, 2019b, 2019c), childhood skin infections (McRae et al. 2023), arthritis (O'Brien et al. 2021; O'Brien et al. 2023), cancer (Shahid et al. 2013b), end stage kidney disease (Sethi et al. 2022), oral health (Sethi et al. 2022), palliative care (Shahid et al. 2013a), and cultural training (Downing et al. 2011; Paul et al. 2006; Taylor et al. 2011).

Shared principles of cultural security

All information related to the understanding, employment and reflections of cultural security among the included studies was synthesised into 12 shared principles of cultural security. Considering the overlapping nature of some elements identified during data synthesis with organisational understandings of cultural safety, Figure 2 depicts eight elements that are shared principles of both cultural security and cultural safety, and four elements that are unique to cultural security. Underscoring the 12 principles throughout the lived experiences and literature considered in this review was the central notion that *culturally insecure environments and experiences are a result of systemic racism* (Gubhaju et al. 2020; Lin et al. 2020; Lin et al. 2014; Marriott et al. 2020; Marriott et al. 2019a, 2019b, 2019c; O'Brien et al. 2021; Paul et al. 2006). Systemic racism as a consistent feature of culturally insecure care reflects the socio-political and historical contexts of Indigenous health (Lin et al. 2014) and has detrimental impacts on wellbeing (Gubhaju et al. 2020) and service accessibility (Lin et al. 2020; O'Brien et al. 2021; Paul et al. 2006). Systemic racism is reinforced by cultural awareness training, whereby clinicians learn about 'other' cultures, which further normalises deficit-focused differences between non-Indigenous clinicians and Indigenous patients (Lin et al. 2020; Marriott et al. 2020).

The most common shared principle across the included studies was that cultural security *considers cultural values, world views and determinants of health*

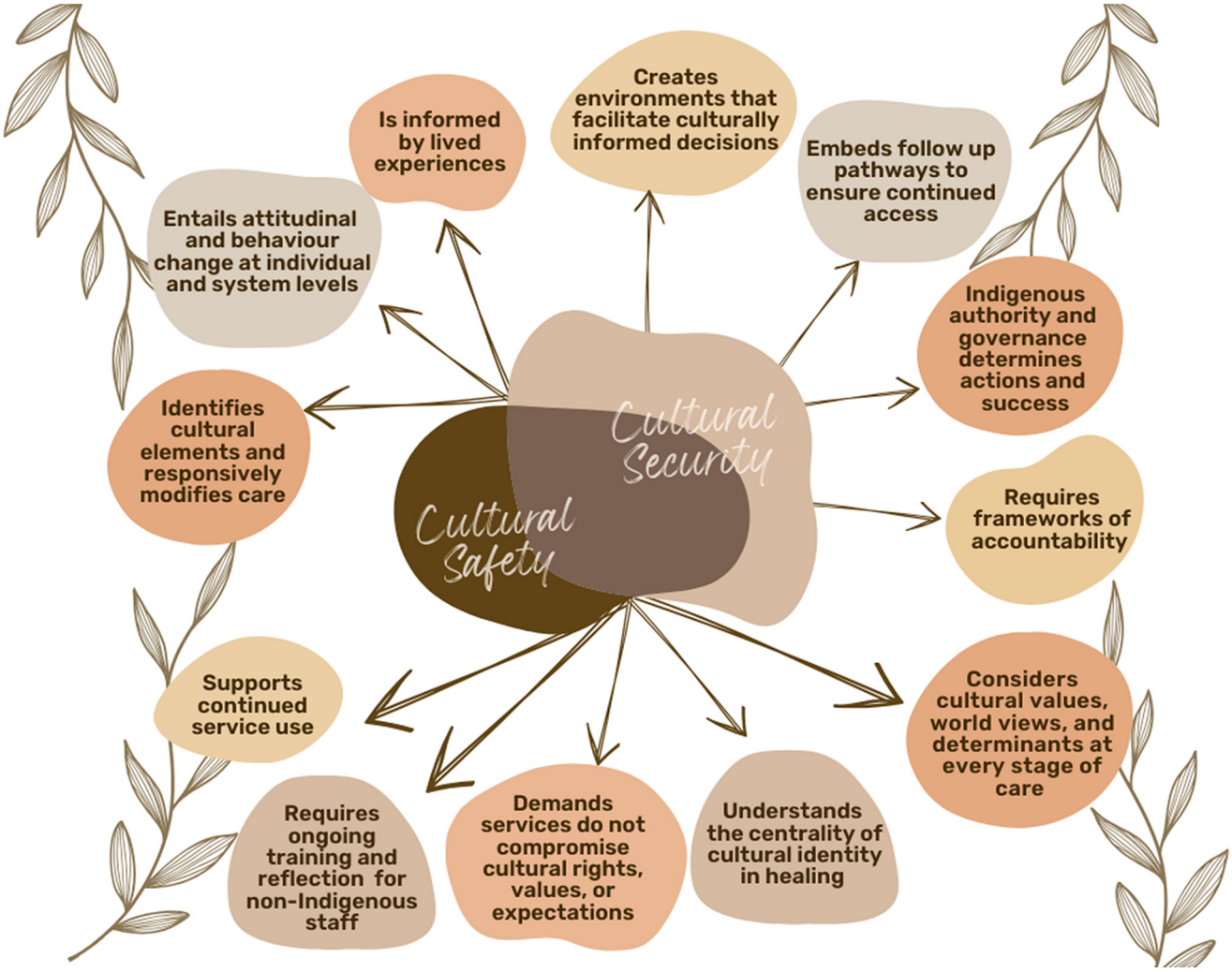

Figure 2: Shared principles of cultural security.

at every stage of care provision (Armstrong et al. 2021a, 2021b; Bateup 2010; Gidgup et al. 2022; Gubhaju et al. 2020; Kimberley Aboriginal Health Planning Forum 2020; Lin et al. 2020; Lin et al. 2014; Lin et al. 2017; Marriott et al. 2019a, 2019b, 2019c; Marriott et al. 2020; McRae et al. 2023; O'Brien et al. 2021; O'Brien et al. 2023; Otim et al. 2015; Paul et al. 2006; Sethi et al. 2022; Shahid et al. 2013a, 2013b; Taylor et al. 2011). Consideration of Indigenous worldviews and values means that cultural and social determinants of Indigenous wellbeing foreground the design, delivery and evaluation of services (Gidgup et al. 2022; Kimberley Aboriginal Health Planning Forum 2020; Lin et al. 2020; Marriott et al. 2019a, 2019b, 2019c; Otim et al. 2015; Paul et al. 2006; Sethi et al. 2022; Shahid et al. 2013b). Practitioners must understand the nuances of historical factors, racism, mistrust and tensions between Indigenous knowledges and biomedical knowledges to overcome communication barriers and ultimately provide culturally secure services (Lin et al. 2014; Shahid et al. 2013b). This also extends to Indigenous employment, the kinds of services and

resources available, incorporation of community feedback into services, as well as cultural and clinical platforms that support self-determined healthcare choices (Gidgup et al. 2022; Kimberley Aboriginal Health Planning Forum 2020; Lin et al. 2020; Marriott et al. 2020; McRae et al. 2023; Shahid et al. 2013b). Employing culturally secure research methods when engaging in Indigenous health research, such as clinical yarning, is required to maintain a culturally secure health environment (Lin et al. 2017; Marriott et al. 2020; Paki 2005). Considerations also must be supported by action because cultural security *demands services that do not compromise cultural rights, values or expectations* (Armstrong et al. 2021a, 2021b; Bradley 2019; Kimberley Aboriginal Health Planning Forum 2020; Marriott et al. 2019a, 2019b, 2019c; O'Brien et al. 2021; Paki 2005).

Lived experience must inform unique and contextual understandings of cultural security (Armstrong et al. 2021a, 2021b; Gidgup et al. 2022; Liaw et al. 2011; Marriott et al. 2019a, 2019b, 2019c; McRae et al. 2023; Northern Territory Health 2016; O'Brien et al. 2021; O'Brien et al. 2023; Paki 2005; Shahid et al. 2013a). Recognising the lack of consideration and integration of Indigenous perspectives in healthcare, many studies focused on gathering strategies and suggestion from Indigenous individuals with lived experience of a given health context, including brain injury (Armstrong et al. 2021a, 2021b), arthritis (O'Brien et al. 2021; O'Brien et al. 2023), physical activity (Gidgup et al. 2022), and birthing (Marriott et al. 2019a, 2019b, 2019c). Conversations identified areas for improved delivery of cultural security, including ineffective communication, health literacy skills, negative attitudes of healthcare practitioners, experiences of stigma, as well as social and cultural needs (Gidgup et al. 2022; McRae et al. 2023; Northern Territory Health 2016; O'Brien et al. 2021; O'Brien et al. 2023; Shahid et al. 2013a). The importance of communication was described by an Elder: 'One thing I always thought… when they talk medical terms… talk our kind of English not the medical English' (Marriott et al. 2019a, 2019b, 2019c). Culturally secure care *identifies cultural elements relevant to service delivery and responsively modifies care provision* (Bradley 2019; Kimberley Aboriginal Health Planning Forum 2020; Lin et al. 2017; Marriott et al. 2019a, 2019b, 2019c; Northern Territory Health 2016; Shahid et al. 2013b). Monitoring care (Bradley 2019) and identifying gaps (Shahid et al. 2013b) between services and cultural elements is critical for responsive care models and the delivery of culturally secure care. Examples of modifications to service provision include changing from written to visual information (Lin et al. 2017), including family members in the decision-making processes (Northern Territory Health 2016), providing information in traditional languages or in ways that meet patients' health literacy levels (Marriott et al. 2019a, 2019b, 2019c; Northern Territory Health 2016), as well as training of staff that develops understanding of cultural elements and how to incorporate these into care (Marriott et al. 2019a, 2019b, 2019c).

Culturally secure care *understands the centrality of cultural identity in healing* (Armstrong et al. 2021a, 2021b; Marriott et al. 2019a, 2019b, 2019c; Shahid et al. 2013b). Within the context of brain injuries, identity has always been considered an important part of recovery; however, acknowledging cultural identity for Indigenous patients has been described as necessary through its recognition of factors beyond medical impairments and related treatments to treatments that also support the reclamation of cultural identity (Armstrong et al. 2021a, 2021b). For mothers birthing on Country, intergenerational knowledge sharing provided the cultural basis for their understandings of childbearing, birthing and parenting. Incorporating these knowledges into birthing practices fosters

intergenerational spaces for healing and support, as described by one mother: 'For me, my grandmothers are very much my back bones. They're very wise, I think that it's very comforting to have them around. It's quite an honour for them to still be around (Marriott et al. 2019a, 2019b, 2019c).' In alignment with supporting one's cultural identity, cultural security *creates environments where people are in the best position to utilise their cultural resources to make culturally informed decisions* (Armstrong et al. 2021a, 2021b; Kimberley Aboriginal Health Planning Forum 2020; Marriott et al. 2019a, 2019b, 2019c; Marriott et al. 2020; McRae et al. 2023). Cultural resources can include involvement of family and community members in healing or treatment processes, access to traditional medicines and languages, as well as proximity to Country (traditional lands) (Armstrong et al. 2021a, 2021b; Kimberley Aboriginal Health Planning Forum 2020; Marriott et al. 2019a, 2019b, 2019c). Environments where Indigenous peoples are supported in making the best choices for their own health outcomes are necessary; culturally secure services can help facilitate productive dialogues when self-determination is foregrounded by healthcare practitioners (Kimberley Aboriginal Health Planning Forum 2020; McRae et al. 2023).

Cultural security entails both *attitudinal and behaviour change at the individual level as well as policy and practice change at the healthcare system level* (Bateup 2010; Bradley 2019; Downing et al. 2011; Kimberley Aboriginal Health Planning Forum 2020; Liaw et al. 2011; Lin et al. 2020; Lin et al. 2014; Marriott et al. 2019a, 2019b, 2019c; Northern Territory Health 2016; O'Brien et al. 2023; Paul et al. 2006; Sethi et al. 2022; Shahid et al. 2013a, 2013b). Methodological in nature (O'Brien et al. 2023), cultural security recognises the limitations of awareness and necessitates knowledge gain that informs practice and skills, as well as service design, delivery and evaluation (Downing et al. 2011; Kimberley Aboriginal Health Planning Forum 2020; Northern Territory Health 2016; Shahid et al. 2013b). Frameworks, protocols and models that support improvements in quality that ensure provision of culturally secure care must be informed by lived experiences and implemented across the health system so that all policies are sustainable (Liaw et al. 2011) and automatically applied from the moment of seeking care (Marriott et al. 2019a; Sethi et al. 2022). An example would be the welcoming of Indigenous family members in maternity units due to the crucial cultural role of families in supporting women during birthing (Marriott et al. 2019a). This commitment requires service providers value and understand the importance of providing culturally secure care to Indigenous peoples, whereby contexts affecting willingness and ability to participate in services are acknowledged and reflected in service design at a systems level (Lin et al. 2020; Shahid et al. 2013a). Intentional and critical thinking across teams to interrogate how different worldviews impact decision-making exemplifies how both attitudinal and systems level changes are necessary for the actualisation of cultural security within health systems (Lin et al. 2020; Marriott et al. 2019a). *Frameworks of accountability are needed for sustained cultural security* (Kimberley Aboriginal Health Planning Forum 2020; Liaw et al. 2011; Lin et al. 2020; Northern Territory Health 2016; Paki 2005). A whole of organisation approach and commitment to change is required for cultural security to be established, whereby frameworks of accountability are adhered to by all actors within a system (Lin et al. 2020; Northern Territory Health 2016). This can include Indigenous leadership structures, data and information systems that capture indicators of cultural security, and a shared responsibility that focuses on the sustainability of culturally secure care provision (Liaw et al. 2011; Northern Territory Health 2016).

Indigenous health services provide culturally secure care that optimises health outcomes (Lin et al. 2020); it is therefore unsurprising that *Indigenous authority and governance of establishment and evaluation over measures of success are necessary within culturally secure health systems* (Armstrong et al. 2021a, 2021b; Gidgup et al. 2022; Kimberley Aboriginal Health Planning Forum 2020; Liaw et al. 2011; Lin et al. 2020; Lin et al. 2014; Marriott et al. 2019a; Northern Territory Health 2016; O'Brien et al. 2021; Paki 2005; Shahid et al. 2013a; Skoss et al. 2021; Taylor et al. 2011). Indigenous leadership in this capacity was described as increasing accountability for changes across health systems (Liaw et al. 2011). Consistently, authors across included studies called for increased funding of Indigenous workforce development in their specific areas of health and wellbeing (Armstrong et al. 2021a, 2021b; Gidgup et al. 2022; Kimberley Aboriginal Health Planning Forum 2020; Lin et al. 2020; Lin et al. 2014; Northern Territory Health 2016; O'Brien et al. 2021). While Indigenous healthcare practitioners and community governance were identified as important across a number of studies, the need to ensure that Indigenous staff are themselves supported within culturally secure workplaces was also emphasised (Kimberley Aboriginal Health Planning Forum 2020; Marriott et al. 2019a; Northern Territory Health 2016). Culturally secure care *requires ongoing engaging training and reflection processes for non-Indigenous staff* (Armstrong et al. 2021a, 2021b; Kimberley Aboriginal Health Planning Forum 2020; Lin et al. 2020; Northern Territory Health 2016; Skoss et al. 2021; Taylor et al. 2011). Importantly, cultural awareness training where individuals learn about 'other' cultures was identified as potentially increasing stereotypes through reinforcement of racialised identities (Lin et al. 2020). Rather, a critically reflexive strengths-based approach to training, which acknowledges systemic racism that prioritises transferrable and practical skillsets, is needed to create culturally secure workforces. Training must be structured as an ongoing aspect of professional development, rather than one-off sessions, including both formal and informal experiences (Armstrong et al. 2021a, 2021b; Lin et al. 2020; Northern Territory Health 2016; Skoss et al. 2021; Taylor et al. 2011).

Culturally secure care *embeds follow-up pathways to ensure continuing access to services* (Armstrong et al. 2021a, 2021b; Kimberley Aboriginal Health Planning Forum 2020; Sethi et al. 2022). Upon discharge from hospital or completion of appointment, active follow-up systems need to be in place to provide ongoing accessibility to services, due to the complex contexts within which Indigenous peoples experience health and disease (Armstrong et al. 2021a, 2021b). This can include follow-up phone calls to provide space for discussion and reflection on previous experiences or new needs (Sethi et al. 2022). Further, the Kimberley Aboriginal Health Planning Forum described the notion of a 'No Wrong Door' principle, where clients who cannot be assisted by a service are provided warm referral options to access appropriate services (Kimberley Aboriginal Health Planning Forum 2020). Provision of culturally secure care *supports continued service use* (Bradley 2019; Gidgup et al. 2022; Gubhaju et al. 2020; Marriott et al. 2019a; Shahid et al. 2013a). Older Indigenous adults indicated that cultural security was a key consideration in attending and returning to physical activity programs (Gidgup et al. 2022). This connection between cultural security and service use was also described by pregnant mothers on Noongar Country in Australia (Marriott et al. 2019a), the follow on from positive experiences during pregnancy may contribute to family attendance to services in future.

Discussion

This review synthesised existing literature to understand how cultural security has been

conceptualised and applied in the health context and experiences among global Indigenous communities. To that end, the synthesis of evidence generated 12 shared principles of cultural security, reflecting a collective call for systems-level transformation grounded in Indigenous worldviews, values and governance. As demonstrated by this review, and indeed in the broader literature, culturally secure healthcare improves experiences and outcomes among Indigenous peoples by embedding cultural rights and accountability across health systems.

Central to any pursuit of cultural security and cultural safety is the recognition that effective care must be determined in partnership with local Indigenous communities, grounded in cultural values and worldviews. In action, this can look like place-based context-specific initiatives such as the Birthing on Country initiative, which has led to a 38% reduction in pre-term births compared with standard care (Gao et al. 2023) and is now recognised in national health policies as a model for culturally safe maternity care. There is no one size fits all for cultural security; therefore, cultural security processes cannot be narrowly understood nor diluted to a tick box exercise (Curtis et al. 2019). Cultures are dynamic, meaning that defining and prescribing elements of culture that need to be protected and secured within a given system (in this case, health) risks assumptions of permanence of these elements. Indigenous cultures are living cultures, whose nature has been described as a river: 'persistent in that the course of the river is relatively unwavering, but at the same time the water moving through it is always in motion' (Forrest 2006). Health systems must be equipped to adapt alongside this dynamic nature through embedded mechanisms that support cultural evolution rather than reinforce fixed notions of culture.

A risk to any cultural training that fails to centre critical reflexivity is the fostering of harmful 'othering' practices that increase experiences of alienation and oppression for Indigenous peoples (Curtis et al. 2019). In oversimplifying understandings of Indigenous culture, training can perpetuate cultural essentialism (Grosz 1990) and homogenise Indigenous peoples into a collective group based on cultural stereotypes (Dutta 2007; MacNaughton et al. 2001). Training of this nature leads healthcare practitioners to make unfounded assumptions about individuals, undermining quality of care provided (Truong et al. 2014) and reinforcing binary racialised discourses, which continue to obstruct Indigenous identity formation (McGrath 2017). This process directly contradicts findings presented in this review, which demonstrated the essential role of cultural identity in healing and the prioritisation of identity in culturally secure care (Armstrong et al. 2021a, 2021b; Marriott et al. 2019a; Shahid et al. 2013b); therefore, healthcare practitioners, organisations and health systems must challenge 'othering' practices within their contexts. Building environments that are equipped to responsively change with the dynamics of culture is needed, rather than narrowly securing certain aspects of cultures, which would place unjust (and culturally unsecure) conditions on how cultures can live, change and develop (Forrest 2006).

While both cultural security and cultural safety acknowledge the fluid and relational nature of cultures and call for responsive and anti-racist care, their operational differences are nuanced. Cultural safety definitions, particularly at the organisational and systems level, emphasise not only practitioner reflexivity, but also institutional accountability and equity-focused evaluation (Curtis et al. 2019). Cultural security complements and extends these frameworks by positioning accountability mechanisms as baseline requirements for sustained systems level change

(Kimberley Aboriginal Health Planning Forum 2020; Northern Territory Health 2016). Cultural security explicitly centres Indigenous leadership and authority, requiring enforceable policies, Indigenous-defined metrics and governance mechanisms to embed cultural rights across all levels of a health system (Coffin 2007). In this way, cultural security strengthens organisational cultural safety by defining success through collective, Indigenous-defined service outcomes that reflect community-determined standards of care. Unlike frameworks that seek to strengthen engagement or intent, cultural security demands measurable evidence of structural transformation, framed by rights-based and sovereignty-affirming standards (Givens et al. 2018).

Difficulties associated with understandings and applications of cultural security relate to the limited evidence available pertaining to the details of rigorous cultural security training, implementation pathways and actionable system-level change. Two pieces of evidence included in this review provided scaffolded policies and procedures at a regional level for implementing cultural security across a health system (Kimberley Aboriginal Health Planning Forum 2020; Northern Territory Health 2016). Both the Kimberley Aboriginal Health Planning Forum framework and the Northern Territory Aboriginal Cultural Security Framework articulate whole-of-system strategies, including leadership accountability, culturally governed service design, Indigenous workforce development and monitoring mechanisms (Kimberley Aboriginal Health Planning Forum 2020; Northern Territory Health 2016). The strength of these frameworks lies in the actionable strategies and measurable indicators that are embedded across each of their core pillars, lending the frameworks to transferable integration within health services. These frameworks demonstrate how cultural security can be operationalised through policy, professional development, culturally responsive infrastructure and co-governance models. While these documents provide a strong foundation, none of the included studies offered empirical evaluations of their implementation; this reflects broader limitations in the current policy and practice landscape. Current approaches often lack sustained funding, clear evaluation mechanisms and alignment with Indigenous-governed metrics. To address these gaps, it is proposed that future efforts prioritise the integration of cultural security into accreditation requirements, the development of Indigenous-led audit tools and inclusion of cultural accountability metrics in health service performance reporting. These strategies offer concrete pathways to move beyond aspirational commitments and toward tangible improvements in patient experiences, health equity and anti-racist system transformation.

Strengths and limitations

While the review team made all attempts to limit publication bias through the inclusion of grey literature, all languages and all locations, limitations exist. Although the search strategy was international in scope, most included studies originated in Australia, suggesting that the term ‘cultural security’ is largely geographically situated and not widely used in other Indigenous contexts. While search strategies were included to capture relevant grey literature, a systematic manual search of individual local health district websites and internal platforms was unfeasible within the scope of this review and was not part of the original protocol. As such, there may be relevant non-indexed local health district reports or internal documents that were not captured, which is acknowledged as a limitation. Further, the interchangeable use of terms related to cultural security (including cultural awareness, safety,

competency, etc.) means that initiatives aligning with cultural security principles but using a different terminology were not included in this review.

Conclusion

Healthcare practitioners have dedicated their careers to supporting the health and wellbeing of their communities. As such, a commitment to culturally secure care is not only an ethical and moral imperative but a structural obligation for all actors within health systems. This review identified 12 shared principles of cultural security that also relate to organisational conceptualisations of cultural safety, offering a consolidated foundation to guide policy and practice. However, the limited evidence on implementation valuation and transferability signals that cultural security remains underdeveloped as a systemic standard. The balance of policy shifts that allow for living cultures to ebb and flow requires continuous dialogue, organisational reflexivity and the use of Indigenous-governed metrics to assess service effectiveness. To move beyond symbolic commitments, health systems must embed cultural security into the core of how care is funded, delivered and evaluated, ensuring that Indigenous rights, knowledge and governance shape the systems intended to serve them.

Author contributions

B. Poirier and M. Cachagee contributed to the conceptualisation of this analysis. B. Poirier and M. Cachagee performed the search and screening. B. Poirier and M. Cachagee completed data extraction as well as interpretation and analysis of the data. L. Jamieson provided input into data analysis and interpretation. Writing and original draft preparation were performed by B. Poirier and M. Cachagee. Writing review and significant editing were performed by L. Jamieson. All authors read and approved the final manuscript.

Declaration of interests

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Supplementary material

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