Anti-Racism in SWSLHD: Scoping Review Summary

Background

Globally, evidence of institutional racism within healthcare settings and its impact on health and health inequities are well documented [1-5]. In Australia, the legacy of colonisation embeds institutional racism and intergenerational trauma into institutions, including the health system [6]. Systemic racism in healthcare settings manifests as the beliefs and attitudes of individuals to organisational policies and practices, with the impact felt across all levels [6]. Institutional racism in healthcare services can influence patient trust and harm both the patients who use these services as well as the people who work within them [6, 7]. In recent years the presence and impact of institutional racism has been well documented and attempts to address or ameliorate its impacts have been made across multiple levels.

Anti-Racism in SWSLHD

In 2020 the Anti-Racism and Discrimination Steering Committee was established in response to a request from the SWSLHD Board as to how SWSLHD addresses racism in the workplace, and feedback of racism experienced by SWSLHD staff as reported in the People Matters Employee Survey 2019. The District supports a suite of strategies and activities that aim to address racism and improve cultural competence across the organisation. In 2022, The Centre for Health Equity Training Research and Evaluation (CHETRE) was approached to develop a monitoring and evaluation plan for the impact of anti-racism work in the District.

This report describes the results of the scoping review component of the project focused on peer-reviewed literature and aims to identify articles that report approaches to monitor and/or evaluate anti-racism activities/interventions in health services including impact and outcomes. The peer reviewed literature was supplemented with a hand search of the grey literature and peer review literature not captured in the original search.

Throughout this report we refer to Culturally and Linguistically Diverse Communities (CALD) and Aboriginal and/or Torres Strait Islander Communities to refer to multicultural populations.

Research Questions

- Explore the approaches to monitor and evaluate anti-racism activities in health services
    - What type of interventions exist at different levels of health systems?
    - Have these interventions been evaluated?

Methods

A scoping review approach was taken to gain insight into the main concepts, theories, sources and knowledge gaps around anti-racism interventions in health care settings [8]. Peer reviewed articles were identified through an electronic search of January 2012 to September 2022 in 4 data bases: PUBMED, Web of Science, Scopus and CINHAL. A set of search terms (Box 1) were used. The database search results were exported to EndNote, duplications removed and underwent screening using Covidence systematic review software. Data included in the final synthesis was analysed using thematic techniques in Excel.

Box 1: Search term groups were combined with the Boolean operator 'AND'

SEARCH #1
racism OR "racial discrimination" OR "Anti-racis? Intervention" OR "systemic racis*" OR "institutional racism"
SEARCH #2
"health care" OR "health system" OR "health service" OR "Medical anthropology"
SEARCH #3
institutional OR organisational OR organizational OR behavior* OR behavioural OR individual OR "organi* culture" OR "systems change"
SEARCH #4
assess* OR evaluat* OR monitor* OR review
SEARCH #5
intervention OR policy OR program

The peer reviewed literature searches were supplemented by a hand search of grey literature including: snowballing from peer reviewed literature, google searches and relevant project reports.

Inclusion and Exclusion Criteria

Articles were included in the review if they were:

Table 1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
- Peer reviewed literature - Evaluated or monitored an anti-racism intervention, policy or program - High income context [9] - Published 2012- present - Language: English	- Low or middle income context [9] - Study protocols, commentaries, editorials, or books/theses - only describes 'the problem' no solutions/interventions described - No data on anti-racism intervention, policy or program using qualitative, quantitative, or mixed-methods - Does not evaluate or monitor an anti-racism initiative/program/policy - Does not report an outcome of any kind - Does not have the potential to contribute meaningfully to answering the research question, purpose, or objectives.

Data extraction and Synthesis

All of the sources included in the final synthesis were extracted in Excel. The data extraction included:

1. Descriptive data: (author, year, country, article type [review or intervention], population, focus [cultural competency, accessibility, bias etc.], approach [education, model of care, tool etc.] and level)
2. Narrative synthesis key findings related to interventions to address racism in health services

Synthesis of the data was informed by the Socio-ecological model (SEM) highlighting activities (Figure 1). The definitions [10] used for this review were:

- ***Individual level*** interventions were based around making individuals aware of stereotypes, bias of racial groups that are typically unconscious. Interventions targeted individual development of knowledge, attitudes and behaviour e.g. cultural awareness training focused on stereotyping

- ***Interpersonal level*** interventions focused on developing interactions between providers and patients to address health disparities through harmful practices. (e.g., workplace training on cultural awareness to improve interactions with culturally and linguistically diverse (CALD) patients)
- ***Community level*** interventions focused on developing relationships between health services and the community they serve. This is achieved through developing, maintaining and supporting meaningful partnerships with CALD and or Aboriginal and/or Torres Strait Islander groups with the aim to address racism in health services. (e.g. engaging the local community in the planning and implementation of services)
- ***Organisational level*** interventions focused on processes and structures within an organisational including human resources, workforce, advisory boards to effect organisational change. (e.g., developing a culturally appropriate model of care for CALD populations)
- ***Policy level*** interventions focuses on processes, policies, frameworks at a system level. The aim is to provide system level mandates or guidance for health services e.g. mandates and targets for the recruitment of CALD at all levels of health service.

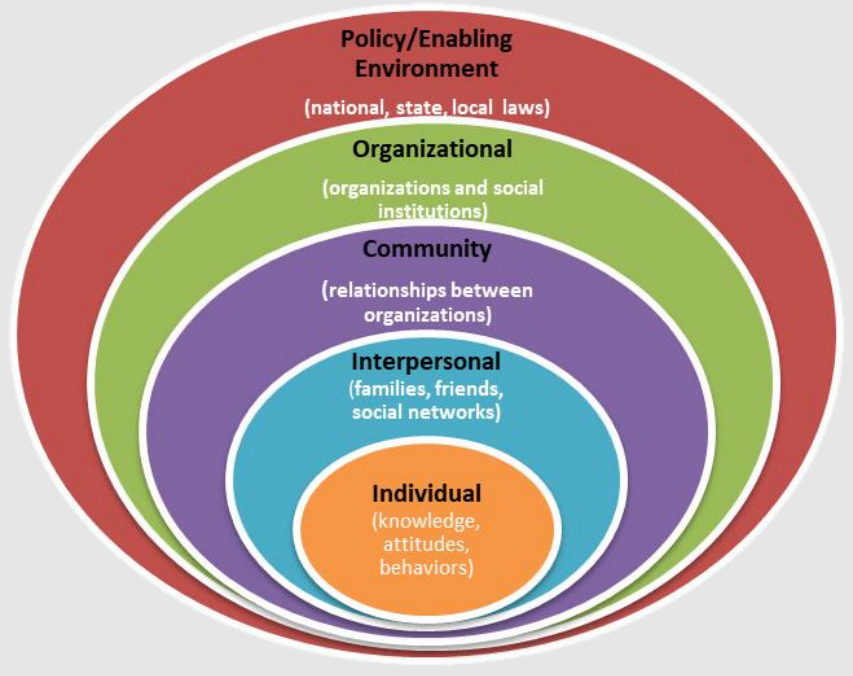

Figure 1: Social Ecological Model [10]

Results

A total of 24 papers were included in the final review, with an additional 6 included from the hand search. Figure 2 provides and overview of the database search. The table below (Table 2) provides a summary of the literature included in the scoping review. The full data extraction is provided in Table 3 (database search) and Table 4 (hand search). When combining the database and hand searches, a total of 10 (33%) of included papers were from the US, 9 (27%) from Australia and the remaining papers were from Canada, UK and New Zealand. Of the database search, 14 were review articles and 10 were empirical research.

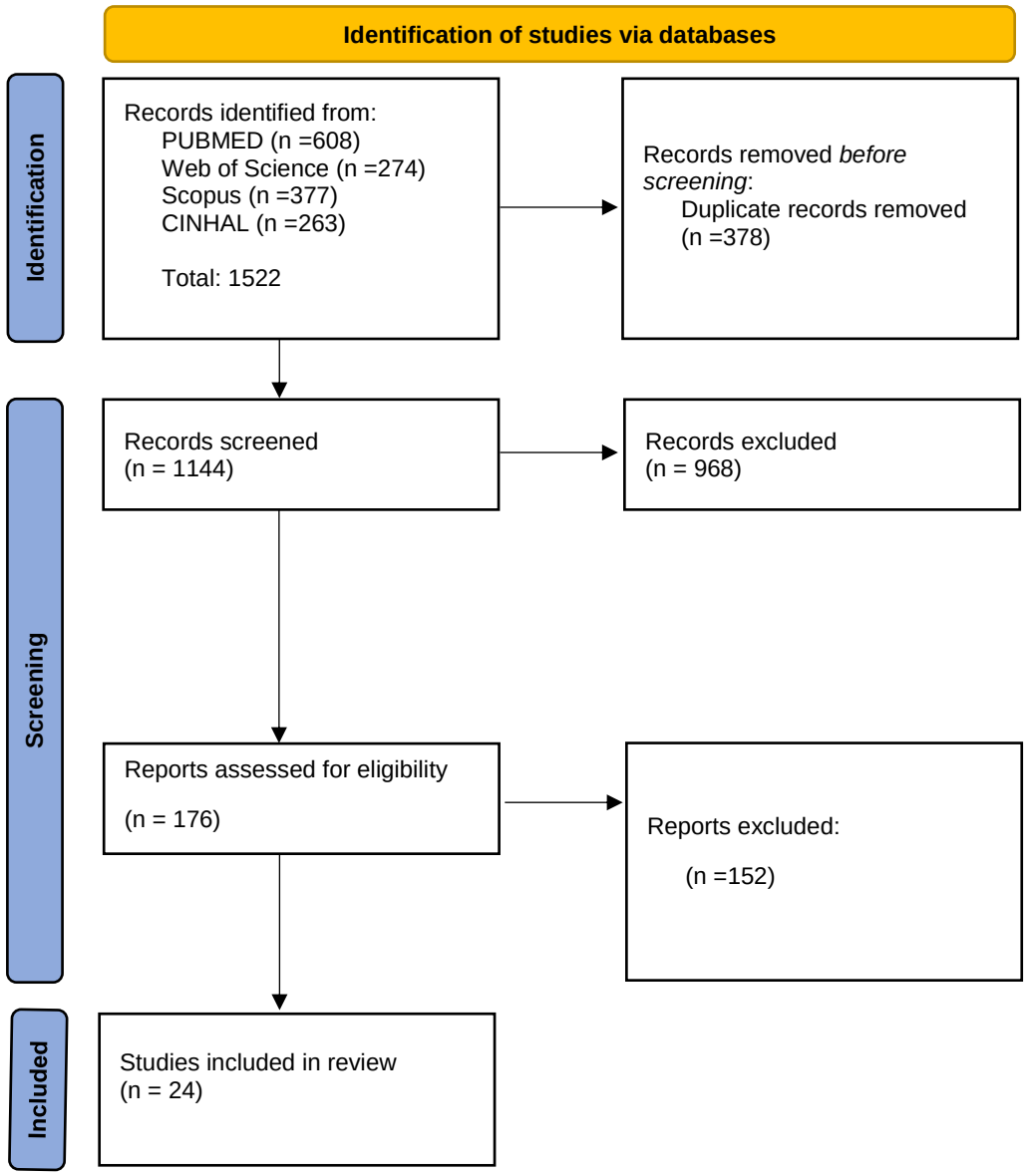

Figure 2: PRISMA Diagram of database search

The database search results (during screening) were overwhelmingly focused on cultural awareness/competency/safety/respect education models at the individual and interpersonal level. In order to ensure that the search captured diverse levels of intervention, we purposefully sampled a proportion of these education interventions until data saturation was reached (8 papers). A large proportion of the peer reviewed literature (58%) and hand search (83%) interventions were over multiple levels (two or more levels). Most interventions were targeted at the organisational (71%), individual (58%) and interpersonal levels (58%). Evidence was more limited for policy level action (21%) and community (25%).

Table 2: Summary of findings

Country	Database Search	Hand Search	Total
US	9 (38%)	1 (17%)	10 (33%)
Australia	7 (29%)	1 (17%)	9 (27%)
Canada	3 (13%)	2 (33%)	5 (17%)
UK	1 (4%)	1 (17%)	2 (7%)
New Zealand	1 (4%)	1 (17%)	2 (7%)
Multiple	3 (13%)		3 (10%)
Intervention approach			
Multiple	3 (13%)	3 (50%)	6 (20%)
Education	8 (33%)	1 (17%)	9 (30%)
Model of care	4 (17%)		4 (13%)
Tool/Framework	5 (21%)		5 (17%)
Workforce	2 (8%)	2 (33%)	4 (13%)
Advisory boards/Governance	3 (13%)		3 (10%)
Review	5 (21%)		5 (17%)
Level of intervention			
Multiple	14 (58%)	5 (83%)	19 (63%)
Individual	14 (58%)	2 (33%)	16 (53%)
Interpersonal	13 (54%)	2 (33%)	15 (50%)
Community	7 (29%)	2 (33%)	9 (30%)
Organisational	17 (71%)	5 (83%)	22 (73%)
Policy	6 (25%)	3 (50%)	9 (30%)

Key Findings from the Literature

An overview of the key findings from the literature is provided below, this is organized by level of intervention (using SEM) and by intervention approach. We then highlight the gaps in the literature and present implications for practice.

Level of Intervention

Individual level interventions were primarily educational tools and seminars which focus on delivering internal bias training which encourage participants to reflect on their personal knowledge, attitudes and practices [3, 4, 7, 11-18]. Although evidence of the effectiveness of individual level interventions is limited, just over half (N=16 53%) of the total included literature described interventions focused at an individual level.

Interpersonal level interventions were also primarily administered through an educational approach, focusing on relationships and interactions between healthcare workers and patients [7, 11-17, 19-24]. These training sessions primarily focused on developing cultural competence and cultural safety and relational skills such as using a trauma informed care approach [23]. Half of the literature described interpersonal level interventions (N=15).

Community level interventions involve building relationships between health services and the communities they serve through developing and maintaining partnerships with CALD and Aboriginal and/or Torres Strait Islander groups and community stakeholders [3, 4, 7, 14, 19, 20, 23, 25]. Community level interventions are usually attempts to reorganize power within health services, giving communities agency in service provision. Approaches at this level included engaging the local community in health service decision making and governance [3, 14, 25]. A third of included papers commented on interventions at this level (N=9).

Organisational level activities accounted for a large portion of included studies (N=22) and focused on policies, processes, norms and structures within organisations and generally required health services to acknowledge and confront institutional racism [26]. Organisational interventions include the establishment of internal committees [18, 23, 26, 27], adoption of culturally appropriate models of care [5, 19, 28], mandatory training [20, 29] and the development of monitoring tools for organisations to assess the effect of institutional racism in their service [20, 22, 27, 30, 31], assessment of internal protocols including the use of equity or racism focused improvement tools [30, 31] and the treatment of culturally diverse staff within the organisation [31, 32]. Organisational interventions are diverse in their effectiveness. Anti-racist organisational policies are dependent on stakeholder all levels of the service [26].

Policy level interventions address anti-racism at the system level through legislation and policies. A third (N=9) of included literature touched on policy level interventions. The small number of policy level could be a reflection of the search terms #3 being organisational focused. These interventions include mandating diversity targets in hiring [33], facilitating an enabling environment for systemic change including advocacy to address social determinants of health and racial discrimination from a legislative perspective [4, 17], formal complaint escalation procedures [34] as well as commitment to and implementation of interventions across multiple levels [3, 7, 20].

Intervention Approach

Education

Evaluation of the effectiveness of educational approaches were generally limited, often using short term self-assessment of a participant's confidence in superficial outcomes describing challenges providing care to diverse patients. Baseline data before the presentation of this kind of intervention were collected sporadically and the long-term impact of this level of intervention was not evaluated in any study. Training as an intervention is broadly criticised in the literature as ineffective in tackling institutional racism and allowing institutions to appear to be proactive in this space [24]. Education models that encouraged critical self-reflection and critical consciousness of one's values, beliefs and understanding of power and privilege [4, 11-13, 20, 29] were found to be more effective than those focusing purely on cultural awareness. Limiting education to 'learning about cultures' has the potential to perpetuate 'othering' and the idea that the problem (health inequities) lies within the 'differences' between seemingly homogenous cultures which in turn, perpetuates bias and stereotypes [3, 4, 13, 20, 23]

Model of Care

Culturally safe models of care were identified in this review, including active referral to services [5], implementation of a health service facilitator role to assist diverse clients to navigate health services[5, 19, 21], engaging community health workers to provide culturally appropriate health information and cultural consultation services in mental health [21]. This approach was effective in building trust in health services, increasing participant engagement and reducing health inequities [5, 21, 28].

Tools and Frameworks

Anti-racism tools and frameworks were implemented across all levels but were primarily identified at the organisational level. Frameworks were identified in the literature to self-assess institutional racism within an organisation. Another framework approach developed by Reichman and colleagues (2021) [30] assessed model of care quality improvement strategies for their impact on health equity to ensuring novel care initiatives did not perpetuate or entrench health disparities. These tools are an effective way to monitor impact of other approaches across multiple levels and to continually assess the service over time.

Workforce

Workforce approaches involved assessment of the workplace conditions of diverse staff in the health service workforce. A review by Topp and colleagues [32] investigated workplace conditions of Aboriginal and Torres Strait Islander health care workers in a health service, where these staff were employed under a different award than other medical staff. An accreditation system was developed for this workforce to transition into medical roles, but funding was limited which resulted in these staff being unable to secure the role. Many studies called for interventions that built and supported a workforce that is diverse and reflects the local community [22, 26, 31-33, 35] including ensuring diversity throughout the organisation for example in upper management, however the effectiveness of this was not tested in any literature identified in this review. Some literature achieved this through diversity and inclusion workforce targets/strategies including specified positions [18, 31, 33, 35].

Governance

Governance refers to the integration of CALD and Aboriginal and/or Torres Strait Islander representation across all aspects of health services. . Including the community in governance increased community engagement and trust in the health services, as well as increasing the responsiveness and appropriateness of services to community needs [25, 27]. Evaluation data was qualitative (1 study), making it more difficult to collect and analyse which may contribute to the relative under representation of interventions using this approach [25]. Much of the literature called for decentralisation of power within health service governance systems [19, 27, 29], however evidence of this having been successfully implemented and evaluated in a health service was relatively scant. A review by Hassen el al. 2021 [7] found that anti-racism work should be led by members of CALD and/or Aboriginal and/or Torres Strait Islander groups to ensure that any interventions are tailored to and reflect the communities they serve.

Gaps in Literature and Implications

The distribution of data over the SEM levels in this review is similar to that of previous reviews [3, 4, 7, 20, 22, 29-31] with interventions clustered at the individual, interpersonal and organisational, and primarily focused on education.

A significant proportion of the literature describes the problem of institutional racism in health care and recommends intervention across all levels which prioritises the redistribution of power and ensuring diversity throughout the governance structure. However, evaluation (and peer reviewed publications) of the impact of this approach is limited. While there is minimal impact data to support the implementation of systemic interventions that redistribute power in health services, the theory behind and benefit of this approach is well documented and this lack of impact data may speak to the difficulty or willingness of organisations to implement this kind of intervention rather than whether or not interventions are effective. Whilst there was evidence to support interventions at each level, comprehensive assessment of the impact of multilevel was limited. One paper, from Hunter New England Health provided an excellent example of how comprehensive, multilevel action can be planned/might look for a health service, however the entirety of this approach had not been evaluated.

A large proportion (N=19, 63%) of the literature included in the review described systemic interventions with action across multiple levels. Prioritisation of higher level interventions to elicit systemic change was frequently suggested [7, 20]. The literature broadly acknowledged that individual level change is important but cannot effect systemic change alone [17, 18, 20, 23, 30]. Evaluation and monitoring is essential for multi-level systems change [5, 7, 18, 20, 23, 29, 31] and is a key component of tools/frameworks [31]. Evaluation should cover multiple levels of action for example cultural competency of staff (individual/interpersonal) and evidence of health outcomes including changes to health inequities (organisational) [20, 29, 31]

Table 3: Data extraction database search

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
[19]	US	Intervention	Cancer treatment	Anti-racism	Model of care & Education	Individual	X	Accountability for Cancer Care through Undoing Racism and Equity (ACCURE) was an NIH-funded intervention that utilized an antiracism lens and community-based participatory research (CBPR) approaches to address Black-White disparities in cancer treatment completion. ACCURE emphasized change at the institutional level of healthcare systems through two primary principles of antiracism organizing: transparency and accountability. Project was successful in eliminating treatment disparities and improved completion rates for breast and lung cancer. Intervention includes electronic health records, nurse navigator, physician champion and healthcare equity training, a community based participatory research approach was used throughout the process. Community partners are community members, healthcare providers and academic researchers who are survivors of cancer, a member of an under-represented population or their professional work is focused on health equity. Core components of the project included: - Navigators: to assist patients through complex institutional procedures, navigators underwent anti-racism and patient-centred care training. Provided liaison between patients and providers from diagnosis to completion. - Champions: Cancer care physicians, advocated and promoted the intervention. Communicated study updates to care teams. - Racial equity training: anti-racism training for cancer centre providers and staff The project has been translated to the Maternal Health system and education system. Figures 1 & 2 are useful.
						Interpersonal		
						Community	X	
						Organisational	X	
						Policy		
[28]	UK	Intervention	Health Services	Cultural competence	Model of care	Individual	X	Paper reports on feasibility evaluation of a cultural consultation service (CCS) in mental health services. The service was designed to work at multiple levels of service provision and commissioning to tackle the complexities and structural and individual determinants of health inequalities. The CCS uses a broad understanding of culture in
						Interpersonal	X	
						Community		
						Organisational	X	

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
						Policy		the assessment, engagement and treatment of patients to ensure patient centred care is considered in the assessment and treatment of patients. The CCS aims to provide cultural consultations to improve diagnostic accuracy, culturally relevant planning and workforce satisfaction. The model also highlights the importance of strong clinical and managerial leadership, organisational commitment, engagement of family, friends and social systems. Evaluation of the CCS found: - Improvements in service user experience and recovery - Improvements in workforce development - cost savings for outpatient contacts (reduction of A&E services, psychiatrists etc.) - improved overall functioning for complex cases - reduction of work stress of staff - Clinician reports of improvements to treatment plans, medication compliance, levels of engagement and earlier discharge
[27]	Australia	Review Article	Hospital	Institutionalised racism	Tool/ Framework & Governance	Individual		This review outlines the application of a framework developed to identify, measure and monitoring institutional racism within public hospitals and health services. The tool uses publicly available information against a matrix across 5 indicators: 1) inclusion in governance 2) policy implementation 3) service delivery 4) employment 5) financial accountability. The tool was developed in response to ongoing-racial harassment of Aboriginal and Torres Strait Islander employees at a Queensland hospital. The tool was applied to the service in 2014 found that the total score was 14/140- an extremely high level of institutional racism (lower score=higher level of institutional racism). In 2017 his was repeated and the score increased to 39/140 (very high level). Externally observable changes at the service included: appointing an Aboriginal person to the Board, establishing an Aboriginal and Torres Strait Islander Health Community Consultation Committee, and re-establishing the Executive Director of Aboriginal and Torres Strait Islander Health
						Interpersonal		
						Community		
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								position. Key areas that were not addressed were financial accountability and employment.
[5]	Australia	Intervention	Aboriginal and Torres Strait Islander patients	Access to services	Model of care	Individual		Cultural Pathways programs designed and implemented in response to community identified need. Program is underpinned by Aboriginal and Torres Strait Islander ways of knowing, being and doing. Governance and leadership by the community. Figure 1 good. The program approach includes comprehensive screening utilising a specifically developed holistic screening tool to identify unmet social and emotional well-being needs. Referrals received through large population-based cohort study of Aboriginal and Torres Strait Islander South Australians. Once referred, Cultural Pathways facilitator (navigator) contact participant for participant lead case management process (flexible). Strength-based case management through goal setting, prioritisation and brokering connections to services. Stresses the importance of culturally relevant supervision. The Cultural Pathways Program is underpinned by an Indigenous methodological evaluation framework which utilises Developmental Evaluation, an approach to evaluation that supports innovation and adaptation in complex environment and is consistent with Indigenous methodology and participatory approaches requiring partnerships, trust and shared decision making. Key component of this evaluation is that the evaluator works directly with the team.
						Interpersonal		
						Community		
						Organisational	X	
						Policy		
[29]	Canada	Review Article	Indigenous Health Services (including dementia care)	Cultural safety	Review	Individual	X	Review of key elements, conceptualisations and interventions of cultural safety to improve health services and dementia care for Indigenous people. Results organised by three levels of supporting cultural safety: 1. Person centred/individual level: empowerments and redistribution of power from practitioner to individual receiving care. Culturally appropriate and respectful communication and culturally responsive/appropriate and tailored resources. 2. Health Practitioner/student level: cultural safety training and education (needs to acknowledge understanding of historical injustice and be in partnership with local communities). The need for critical
						Interpersonal	X	
						Community		
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								self-reflection, awareness and reflexivity (of personal bias, attitudes and actions) 3. Healthcare organisational level: Incorporate Indigenous leadership, decision making and health governance (vital in developing culturally safe healthcare policies, programs and practices) this might challenge existing power structures in organisations. Collaboration and partnerships with Indigenous communities (including recipients of care and their families) ensuring to meet local needs. Organisational mandates (mandatory cultural training and education healthcare and government), monitoring and evaluation (evidence of culturally safe practice and evidence of inequity outcomes)
[20]	New Zealand	Review Article	Health Services	Cultural safety	Tool/ Framework	Individual Interpersonal Community Organisational Policy	X X X X X	Review provides overview of cultural competency and safety. Proposes that cultural competency remains focused on developing individual competency rather than organisations/systemic processes. The focus is on cultural knowledge rather than reflective self-assessment of power, privilege and bias. Frequently uses 'other-focused' approach that is, cultures that are different than the dominant. Key difference in cultural safety is the acknowledgement of power. Proposes the following core principles when approaching cultural safety: - Focus on achieving health equity with measurable progress - centre on cultural safety and critical consciousness rather than narrow based notions of cultural competency - focus on developing cultural safety at an systemic/organisation level rather than individual (patient/provider) - apply cultural safety beyond learning about 'other cultures’', focus on addressing bias and stereotypes - cultural safety should focus on power relationships that reflect history - Not be limited to formal training but align across all training/practice environments, systems, structures and policies Also provides steps for health care organisations to take a more comprehensive approach:

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								- mandate evidence of engagement in cultural safety activities as part of training and professional development - Include evidence of CS (organisational and practitioners) as a requirement of accreditation - CS should be assessed by systemic monitoring of inequities (health workforce and health outcomes) - Require CS training and performance monitoring for all staff - acknowledge that CS is an independent requirement relating to competency in ethnic or Indigenous Health
[25]	US	Intervention	Paediatric primary care	Patient engagement (advisory)	Advisory board	Individual		Intervention describing the implementation of an advisory board of participants from limited English speaking Latina Mothers to engage families with health care improvement. Setting is an urban paediatric primary care clinic. Results: - Members had positive experiences with board participation. - Members felt the board provided an important opportunity to improve the clinic practices (and gave examples in how things had changed) - Increased trust with board members and clinic staff who participated - Participation on the board countered experiences of discrimination experienced at the clinic but also in the broader health system - board membership also facilitated learning and skill development for members, particularly around navigation and understanding of the health system
						Interpersonal		
						Community	X	
						Organisational		
						Policy		
[3]	Australia	Review Article	Health Services	Cultural safety	Education	Individual	X	Literature review of differentials in access to care, contributing factors and strategies to develop cultural competence/safety for Aboriginal and Torres Strait Islander patients and communities. Stresses the importance of the acknowledgement of systemic racism. Competence for culturally safe care: - evidence indicates that existing approaches (cultural awareness and cultural competence) have limited impact and that systematic multi-level approaches are needed. - the literature suggests that cultural awareness training frames
						Interpersonal		
						Community	X	
						Organisational	X	
						Policy	X	

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								Aboriginality as the difference that is causing the problem of health inequities. The approach focuses on Aboriginality and not the way the health system is discriminatory towards Aboriginal people. It also encourages stereotyping. - literature supporting cultural competence is developing and existing evidence is mixed. Most results in improved knowledge/skill of staff but positive impact to patient experiences are limited. - Literature suggests the existence of partnerships between Local Aboriginal communities as well as embedding cultural competence into governance, policies and programs to be an effective way to build cultural competence of an organisation. - Any cultural training needs to explicitly incorporate the ongoing impact of racism and colonisation. - cultural competence needs to be monitored using validated frameworks - Authors recommend for action to be coordinated across the organisation. Culturally safe practice between health care and patients is just the beginning, barriers to cultural competence exist and are perpetuated by policies, practices, protocols and programs (or the lack thereof). Whilst strategies should be developed locally, they should be evaluated and shared to inform others.
[7]	Canada	Review Article	Interventions in outpatient settings	Anti-racism	Review	Individual	X	Review includes findings from USA, Canada, UK, Australia and New Zealand. Review identified examples of anti-racism interventions in health care settings however these are limited. Identified gap in evaluated organizational and policy level interventions as opposed to individual and interpersonal level action of which there is an overemphasis on. Organises papers by socioecological model levels, found that most interventions targeted individual (54%) interpersonal (51%) organisational (57%). The least amount of articles were interventions at a community level (21%) and policy level (24%) Provides conceptual model of the principles and strategies for anti-racism interventions in healthcare settings (figure 2):
						Interpersonal	X	
						Community	X	
						Organisational	X	
						Policy	X	

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								- Foundational principles for anti-racism interventions in health care settings should include: 1) defining problem, setting clear goals and objectives 2) incorporating explicit and shared anti-racism language 3) leadership, buy-in and commitment 4) investment/resourcing 5) support and expertise 6) ongoing community and patient partnerships. - Institutional Racism: Interventions and strategies should be multi-level, multi-pronged for long term change. Broad (policy/organizational) interventions should be prioritised. - Personally-Mediated Racism: interventions and strategies should be ongoing, tailored staff education and training. - Evaluation and monitoring is a key component of system level change to dismantle racism. Other key findings: - Interventions need to be tailored to the communities they serve, this cannot be achieved without inclusion of the voices and experiences of racialized staff, patients and communities. - Leadership of all anti-racism must include racialized members.
[11]	Canada	Intervention	Medical students	Cultural safety	Education	Individual	X	Cultural safety exercise developed in collaboration between Aboriginal Rights Coalition and Indigenous Elders and teacher in 1996 (adapted in 2018). Training is holistic and immersive exercise that teaches Indigenous History thorough interaction, active participation and dialogue. Second year medical students participated in exercise and then completed evaluation following (evaluation focused on cultural safety and critical consciousness and were informed by Indigenous ways of knowing). Participants responses to the exercise included: - creating a space for dialogue: students found the debrief section of the exercise to be helpful in hearing the perspectives of their peers and that this strengthened and challenged their own perspectives. - Highlighting the socio-political context of Indigenous People's history: over 99% of participants agreed that the exercise increased their knowledge of Indigenous History in Canada. 97.7% agreed that it
						Interpersonal	X	
						Community		
						Organisational		
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								gave them a greater appreciation of the impact of colonization on Indigenous People. - Engaging in critical reflection: participants highlighted that they reflected on biases and stereotypes they held regarding Indigenous Peoples. Students also recognised their position of power and privilege within society. - Social action: Many students highlighted the realisation of their social responsibility and capacity to work towards Indigenous health equity. 79.2% agreed that they feel more capable of creating a culturally safe environment for Indigenous patients
[12]	Australia	Intervention	Health Services	Cultural safety	Education	Individual	X	Paper presents innovative approach to increasing cultural awareness of health service staff through a cultural education podcasts and discussion groups. The podcast called 'Ask the Specialist: Larrakia, Tiwi and Yolnu stories to inspire better healthcare' has Aboriginal leaders (known as the specialists) and doctors' questions about working with Aboriginal patients. The podcast content encourages critical consciousness, challenging racism in health care through a 'problem posing' education model. An evaluation of the podcast found: - Doctors developed their critical consciousness something that they felt was missing from other cultural training within the workplace, prompting listeners to consider how to improve the delivery of culturally safe care - From an organisational perspective, doctors expressed that a benefit of staff being culturally competent meant reduced self-discharge rates - The flexible format of the podcast (not interfering with clinical or administrative responsibilities was favoured by the doctors - Doctors felt that the podcast contributed to their professional development - Five major areas of learning indicated participants were developing their critical consciousness: importance of communicating in a culturally safe manner, creating partnerships with patients,
						Interpersonal	X	
						Community		
						Organisational		
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								awareness of spiritual practices, countering stereotypes and addressing racism. - Changes in behaviours were seen in 4 areas: investing time to build patient rapport, changing communication, working with interpreters differently and improving consent processes
[13]	Canada, Aus, US, Ireland, Sweden, Hong Kong	Review Article	Postgraduate medical and social science students	Cultural competence	Education	Individual	X	Review acknowledges the WHO recommendation for educational institutions to train clinicians in cultural competence. The review is focused on how postgraduate health and social science education approaches cultural competence and how it achieves its goals (or not). The review analysis highlighted 2 themes within the conceptualisation of cultural competence (CC) in postgraduate education: 1. Professional pedagogy: perpetuating ideas that culture is homogeneous, that culture can be applied to certain disease trends. The review also highlighted 'othering' and 'labelling', with CC teaching of difference leading to stereotyping of cultural groups and perceiving different cultures as risk for disease. 2. Becoming culturally competent: the second theme did not prescribe culture as the problem but a process of cultivating individual agency. Providing a safe CC teaching environment is important as well as critically reflecting on ones values and beliefs. Review concludes that CC in the postgraduate space seems to view cultural differences as the problem and cultural competence as a way to mitigate these differences. This places the focus on 'the other' rather than one self. Suggests that CC practice is an ongoing process, no something that someone 'becomes CC' after training.
						Interpersonal	X	
						Community		
						Organisational		
						Policy		
[14]	US	Intervention	Health Care Professionals	Cultural competence	Education	Individual	X	Using a community-based participatory research (CBPR) approach, researchers developed and evaluated a cultural competency training program for health care organisations. The training was developed using CBPR approach including a needs assessment to set an agenda to address local specific health disparities. Training was lead by a cultural competence professional, population specific models were presented by a community member. An internal champion at each of
						Interpersonal	X	
						Community	X	
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								the organisations were identified. Evaluation focused on learning and behaviour. Participants were surveyed at 2 time points- immediately after training and 6 months. Organisations were also contacted at 6 months so asses organisational level change. Results: - immediately post (53.8% RR), 91.2% reported increased knowledge, 86.6% increase in competence and 87.2% improvement in performance. - 6 months post (17% RR for participants and 28% RR for organisational reps). Participants reported learning, awareness and appreciation of cultural differences of their patient populations. Participants also reported changes to human resources at their workplaces- efforts to create more diverse applicant pool, hiring more demographically diverse employees to service the client population. Organisations agreed with this notion and also states that processes had changed to support cultural competency trainings. Participants and organisational reps also highlighted several changes to their materials and communication methods (providing translated materials, having interpreters available). Organisation reps also reported policies to ensure more culturally sensitive practice e.g. same sex interpreter and where possible for Marshallese patients. Intervention is an example of engagement of the effected communities in the development of cultural training.
[26]	US	Intervention	Health Care workers	Diversity, equity and inclusion	Governance	Individual		Establishment of a diversity, equity and inclusion (DEI) committee to oversee education, research, patient care and the workforce in a health department. Aligning DEI initiatives with existing departmental initiatives improves DEI message penetration. Commitment from leadership essential to improve DEI. Inclusion across different role groups across health department (e.g. medical staff/administrative/management) in planning, implementation and management increases stakeholder buy in.
						Interpersonal		
						Community		
						Organisational	X	
						Policy		
[30]	US	Review Article	Health Care worker			Individual		Review is focused on perinatal and neonatal care. Discusses that quality improvement has the capacity to mitigate, worsen, or

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
				Health equity and health disparities	Tool/ Framework	Interpersonal		perpetuate health disparities. Traditional QI has the potential to improve or worsen inequities through 1) improving outcomes for all equally (perpetuating existing disparities) 2) improving outcomes for all populations but particularly for more advantaged groups (widening disparities) 3) improve outcomes for all but particularly for the most disadvantaged (reducing or eliminating disparities). Introduces 'Equity-Focused Quality Improvement' EF-QI- EF-QI initiatives purposely integrate equity throughout the fabric of the project and are inclusive, collaborative efforts that foreground and address the needs of disadvantaged populations. EF-QI principles are applicable at every stage of project conception, execution, analysis, and dissemination. - interventions targeted at 'upstream' within policy, community levels of SEM are more likely to reduce disparities than 'downstream' factors including hospital processes and individual behaviour. - Socio-ecological principles are important in QI methodology Provides recommendations for putting EQ-QI into practice: 1. Foster a culture of equity: incorporate equity into all discussions (existing and future work), equity is everyone's work 2. To address disparity, it must first be identified: analyse data using variables including race/ethnicity, preferred language, country of origin, neighbourhood (PROGRESS-Plus example) and investigating how race/ethnicity and sociodemographic data are collected 3. Incorporate equity into the design of QI initiatives: incorporate equity into measures, root cause analysis, study design etc. 4. Families and community partners as stakeholders: have a seat at the table and provide input on project design and planning, qualitative research to tailor initiatives to need 5. Consider alternative comparator groups: e.g. size of group or performance 6. Focus- root cause and modifications of systems and processes: race-stratified data needs to be cautioned as to what 'race' is a proxy for (e.g. structural racism), approach disparities using systems
						Community		
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								thinking, root causes and systemic contributors- avoid focusing on individual behaviours 7. Adapt existing data visualization tools to emphasise disparity trends: Data should be presented as clearly as possible to capture and effectively communicate existing disparities 8. Approach dissemination of data from equity perspective: Disseminate data and findings to all involved stakeholders using plain language summaries to increase community capacity-building and Share lessons learned and best practices with other units and organizations.
[15]	US	Intervention	Medical students	Implicit racial attitudes	Education	Individual Interpersonal Community Organisational Policy	X X X 	Study uses a large multi-measure cohort of medical students (3959 students responded) from 49 U.S medical schools. Study aimed to describe differences in implicit racial attitudes between students who had been exposed to formal curricular (e.g. cultural competency) informal curricular (behaviour of faculty and organisational culture) and interracial contact (interactions with diverse staff, students and physicians). Study used validated Implicit Association Test (IAT) to measure implicit racial bias against African Americans during first and last semesters of medical school (year 1 ad year 4). Findings: - Formal curricula was associated with a significant decrease in implicit racial bias - Informal curricula: negative role modelling was associated with an increase in implicit racial bias whereas learning and orientation was associated with a decrease in implicit racial bias - Interracial contact: 'unfavourable' contact with African American faculty, medical students, allied health and administrative staff were associated with increases in bias, as was a lower amount of contact. Increased contact and favourable contact did not have a significant relationship with implicit bias. Findings are important given that small changes in implicit bias have been shown to affect behaviour and are notoriously difficult to change. Focusing on formal curricula alone is insufficient to address implicit racial bias.

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
[31]	US	Review Article	Community behavioural health (Psychiatry)	Anti-racism	Tool/ Framework & Workforce	Individual		Authors used a literature review to inform development of a 'Self assessment for Modification of Anti-Racism Tool' (SMART), a quality improvement tool that aims to facilitate organisational change in community behavioural health care. SMART has 5 domains, each with a questions and scales to assess (self-reported) whether an organisation has identified, tracked and addressed a target issue relevant to racism and disparity: 1. *Hiring, recruitment, retention and promotion*: building a CALD workforce is critical to proving responsive care. This domain encourages organisations to consider multiple facets of workforce development, including targeted efforts around recruitment and promotion as well as identifying and addressing disparities in hiring and retention 2. *Clinical care*: acknowledgement that there is a persistent and pervasive challenge of equity in access to mental health care, over diagnosis of certain mental disorders and disparities in treatment choices. This domain encourages organisation to examine disparity in a wide range of treatment access and choice areas. 3. *Workplace culture*: this domain is focused on the ways in which racism is explicitly addressed as it related to the impact on staff and patients. Stresses the importance of 'safe spaces' for staff and patients and need for formal structures to address racism in the workplace. 4. *Community advocacy*: encouraging health care providers to consider community-intervention and advocacy 5. *Population health outcomes/evaluation*: focused on the end point of health/outcomes e.g. how does your organisation track disparities?
						Interpersonal		
						Community		
						Organisational	X	
						Policy		
[16]	Australia	Intervention	Midwives	Cultural safety	Education	Individual	X	Article aims to improve knowledge between cultural safety training programs and its application to clinical practice. Study re-interviewed midwives who had previously attended midwifery training that aimed to increase cultural awareness and safety in healthcare. Interviews explored the impact of such programs on cultural capabilities, observations and experiences of racism in maternity setting.
						Interpersonal	X	
						Community		
						Organisational		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
						Policy		Participants were 14 non-Indigenous and 2 Aboriginal midwives that were drawn from 3 separate cohorts: cohort 1 had completed the new Indigenous unit in 2012, cohort 2 were former midwifery students who completed their final year clinical placement on remote Aboriginal Lands in WA, cohort 3 were former Aboriginal midwifery students who had completed the Indigenous unit. Results: - Casual racism (perception of prevalence): Almost all of the Non-Indigenous participants had witnessed casual racism in the clinical setting both towards Aboriginal women and multicultural women. Most participants felt they were in a positon to response and challenge such behaviour but acknowledged it would be awkward to raise such issues with colleagues. The Aboriginal participants had observed and experienced racism and were assertive in their efforts to identify it when it occurred. Both groups acknowledged that stereotyping was widespread and damaging. - Institutional racism (perceptions of prevalence): The non-Indigenous participants did not name any incidents of institutional racism but acknowledged that it can be subtle. The Aboriginal participants acknowledged the existence of institutional racism and were able to recognise when it occurred. Stereotyping and institutional/organisational level misunderstandings about Aboriginal cultural diversity and pressures placed on Aboriginal Health Professionals was common e.g. Aboriginal Health Professionals can respond to any situation involving Aboriginal patients. - Shifting attitudes: the non-Indigenous participants frequently referred back to the Indigenous Unit or remote placement as powerful influences in their practice. Aboriginal participants suggested a few educational opportunities based around stereotypes, racism and white privilege. The inclusion of Aboriginal Health Professionals in the delivery of this was seen to be essential. Participants acknowledged the need for more Aboriginal midwives and that Aboriginal mentors are essential in the recruitment and retention of students.

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
[4]	US	Review Article	Nursing profession	Institutionalized racism	Review	Individual	X	Review focused on the impact of institutionalized racism within the nursing profession. Relative to the number of peer-reviewed nursing journals, this review found very little that named institutionalised racism. Presents implications for: *Education and professional development* - most papers (10) presented recommendations for education in the academic setting and some (7) for education or professional development in other settings (health care agencies and professional organisations) - highlighted the importance of high level training for educators, reflection should occur at multiple levels e.g. at an individual level as well as organisational levels and that content to be very carefully considered and the need for it to explicitly include racism, privilege, history and critical race theory. *Implications for nursing practice* - 20 of the papers reviewed provided implications for nursing practice - Consistent acknowledgement that effectively combatting institutionalized racism in health care needs action across multiple levels; - individual patient level: taking a life course perspective approach to care, specific risk assessments and targeted interventions - organisational/ institutionalized level: focused on critically appraising organisational policies for perpetuating institutionalized racism and the development of explicit organizational goals, policies, and practices using a racial equity lens to avoid or minimize disparate impacts on communities of colour. - neighbourhood/community level: these were rare (only 3 papers) often describing partnership with stakeholders, communities and community based programs. - political or policy level: Advocacy and engagement with legislators to enact public health policies to increase access to social determinants of health e.g. education and employment. Government regulation to
						Interpersonal	X	
						Community	X	
						Organisational	X	
						Policy	X	

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								prevent racial discrimination in employment opportunities and employment.
[36]	US, Canada, Brazil, Aus, NZ	Review Article	Indigenous population	Access to services	Review	Individual		Focus on oral health but more broadly highlights significance of culturally sensitive and specifically tailored protocols to deliver the interventions. Key findings include: - Common challenges in conducting research in Indigenous communities include broad geographical location - Techniques that are effective in one community may not translate to outcomes in another community Fig 1. Effective methodologies for community intervention
						Interpersonal		
						Community		
						Organisational	X	
						Policy		
[32]	Australia	Narrative review	Aboriginal and Torres Strait Islander Health Workers (A&TSIHWs)	Governance	Governance & Workforce	Individual		Qualitative study of issues in governance of A&TSIHW: - A&TSIHW were categorised as operational staff, the same classification as cleaners and clerical staff. This classification came with fewer benefits than other health staff and as such the health care service was unable to attract and retain sufficient staff. - In 2012 a nationally recognised role Aboriginal and Torres Strait Islander Health Practitioner (A&TSIHP) with formal registration through APHRA was introduced however the corresponding roles have not been created in many settings. Lack of personal/professional development opportunities. - Minimal executive management of the workforce and no representation of A&TSIHW on decision making boards. - KPIs are outcome driven and don't reflect the nature and quality of the work done by A&TSIHWs. - Non indigenous staff were unclear on the scope of the role, hindering collaboration and leading to micromanagement and interpersonal conflict between A&TSIHW and medical staff. - No formal arrangements to gain cultural guidance. - No mental health support available. Racism is built into governance and formal and informal rules in different domains of the health system still constrain A&TSIHWs' opportunity and autonomy to carry out the role as intended.
						Interpersonal		
						Community		
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								"'owners' utilise leadership and management structures to protect certain groups while systematically excluding others".
[34]	Australia	Review Article	Health services	Reporting	Review	Individual		Escalating complaints of racism in healthcare setting is disparate, inconsistent across states and territories and costly to litigate if not escalated appropriately. Review recommends 1) complaint data should be published and disseminated more broadly and in detail. 2) existing reporting mechanisms should be evaluated to identify systemic issues. 3) data should be coordinated nationally.
						Interpersonal		
						Community		
						Organisational	X	
						Policy	X	
[21]	Various. US, UK, Aus etc	Review Article	Community health care workers serving black, asian and minority ethnic populations	Access to services	Model of care	Individual		Role of community health care workers in addressing disparities in health outcomes/engagement with programs during pandemic. 3 main goal from CHW programs: (1) to take action on socioeconomic inequities, (2) to provide linguistic and culturally tailored health information (3) to build trust in health provider. Common barriers to access across contexts were, living in poor, multigenerational and overcrowded housing, being an essential worker, low access to health insurance, immigration status and alienation from health and public institutions. Support services focused on addressing these needs including food and housing, medical supplies, legal assistance, and mental health services. CHW from the target communities critical to connect patients with services. CHW place a critical role in advocacy, encouraging policy change and promoting strategies to improve community health.
						Interpersonal	X	
						Community		
						Organisational		
						Policy		
[22]	US	Review Article	Health Services	Implicit racial attitudes	Tool/ Framework	Individual	X	Review focused on assessing the efficacy of interventions designed to reduce the explicit and implicit bias. Findings suggest that they can increase awareness of bias but this is not sustained. Such interventions are hampered by work and learning environments that perpetuate bias. Paper provides conceptual model that acknowledges role of health care providers but also stresses the importance of systemic change both internal and external to health services (figure 2). Paper provides recommendations for taking action:
						Interpersonal	X	
						Community		
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description (key findings)
								- action needs to be concurrent and multi-level and must address structural factors internal and external to health care - encourage and support diversity of health care workforce

Table 4: Data extraction hand search

ID	Country	Article Type	Population	Focus	Approach	Level		Description
[17]	New Zealand	Article	Indigenous population	Anti-racism	Multi strategic approach	Individual	X	Provides 4 'pathways' to transform racism in NZ and proposes that these pathways should be followed simultaneously to maximise interventions: 1. Address historical racism: in NZ context this would involve honouring the foundational document of Te Tiriti o Waitangi and its obligations. 2. Improving the racial climate: encouraging critical and reflective practice particularly around NZ colonial history and contemporary racism (this includes education). Public discourse around Maori needs to shift to be accurate, media also has a role to play in more equitable and progressive coverage of race. 3. Transform public institutions: focus on equity and utilizing systems change theory 4. Mobilise civil society: mobilise collective impact to bring together diverse anti-racism action and utilize human rights instruments
						Interpersonal	X	
						Community	X	
						Organisational	X	
						Policy	X	
[18]	Australia	Report	Health Services	Cultural safety	Multi strategic approach	Individual	X	Paper describes a large regional health service's multi-strategic approach to addressing individual and institutional racism. Achieving this requires sustained commitment and a comprehensive strategy including the active involvement of Aboriginal stakeholders. Hunter New England (HNE) has the largest Aboriginal population of any NSW LHD. The executive team are committed to closing the gap as a key objective and all parts of the service are responsible for this. The approach of this health service is underpinned by the objectives of: culturally competent staff, culturally safe workplaces and culturally respectful health services. Figure 1 provides overview of multi-strategic approach. Strategies include: Consultation negotiation and partnerships, use of evidence and evaluation, strategic service planning and policy review, broad organisational change programs, specific Aboriginal Health Initiatives, resource allocation and accountability, employment strategies, staff training and education,
						Interpersonal	X	
						Community		
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description
								performance monitoring and feedback and leadership. Three strategies are explored in depth: - Staff education and training: building culturally competent staff. Cultural safety training has been delivered since 2007 a challenging and confronting program focus is understanding the meaning of being part of the dominant culture, discussion of white privilege and racism (both individual and institutional) and the impact of dominant culture on the lives of Aboriginal Australians. The Program encourages participants to question their own beliefs, assumptions, life experiences and attitudes. Some staff have reacted negatively to this, and challenges to conform to the principles of the training have occurred- stresses the importance of a multi-strategic approach that extends beyond the training. - Leadership: active support at the highest levels is essential. The Aboriginal and Torres Strait Islander Leadership Committee has equal members who are Aboriginal and non-Aboriginal. HNE executive were the first to complete the cultural respect program (top down approach), no staff should attend unless immediate line manager has been trained in order for follow up, support and management of staff returning. Facility led Collaborative Groups involve health service management and Aboriginal staff to provide ongoing discussion and review of relevant policy, planning, service delivery and resource allocation. - Consultation, negotiation and partnerships: partnerships enabling health services to meet the needs of their community. There are formal partnerships with Aboriginal Stakeholders including HNE Aboriginal Health Partnership with ACCHS. There are also numerous collaborative groups including the leadership committee, specific committees and working groups for the initiatives in figure 1. Trust is important- HNE is committed to improving ongoing consultation internally with health staff and externally with Aboriginal communities and organisations. In addition to the Aboriginal Health Statement, consultation guidelines are also being developed engaging Aboriginal staff, community reps (including Elders and organisations) to ensure cultural appropriateness. All of this work is from a fundamental acknowledgement that racism exists

ID	Country	Article Type	Population	Focus	Approach	Level		Description
								within health services. Building a culturally safe and respectful organisation is long and complex.
[35]	Canada	Report	Workforce	Diversity, equity and inclusion	Workforce	Individual		Internal challenges: limited internal tracking of racial disparities in workplaces, lack of support for low income workers of colour, cultural disconnect between staff and clients. External challenges preventing advancement of WOC in HC: employer bias, discrimination, government restrictions and funding cuts, lack of training/education in clients of colour. Recommended solutions: data management, increase access to certification, race specific success indicators
						Interpersonal		
						Community		
						Organisational	X	
						Policy	X	
[33]	UK	Review	Health Services	Diversity, equity and inclusion	Workforce	Individual		In response to the lack of action since the NHS Race Equality Action Plan the NHS agreed to mandatory workforce race equality standard in 2015. The standard requires NHS organisations to collect baseline information on nine indicators of workforce equality for ethnic minority staff. Provides indicators for the workforce race equality standard which includes for example percentage of Black and Minority (BME) staff in bands 8-9 (very senior managers, including executive board members and senior medical staff compared with the percentages of BME staff in the overall workforce as well as monitoring e.g. percentage of staff experiencing bullying, harassment or abuse from patients and relatives or the public in last 12 months. Review then provides evidence for effective strategies: - Action needs to be multilevel (organisational, workplace, interpersonal, intrapersonal), multi strategy, mutually reinforcing and this needs to be over a long period. - Mandated policies are associated with better outcomes than non-mandated polices. Examples included mandatory diversity policies (quotas and numerical targets), resourcing and rewarding diversity - Beyond mandates, development of personal skills, ownership and commitment should be integrated alongside diversity interventions e.g. staff should be trained in strategies to reduce bias, discrimination and stereotyping as well as organisations needing to be safe environments that encourage open communication
						Interpersonal		
						Community		
						Organisational	X	
						Policy	X	

ID	Country	Article Type	Population	Focus	Approach	Level		Description
[23]	Canada	Review	Indigenous population	health equity/ disparities	Multi strategic approach	Individual		See Figure 1. Key dimensions of equity oriented care: 1. Culturally safe care: moving from cultural sensitivity to more actively address inequitable power relations, discrimination, racism and impact of historical injustices. Shifts focus away from cultural differences being the 'problem' 2. Trauma and violence informed care: both historic and ongoing, acknowledging and understanding impact. 3. Contextually tailored care: services that are specifically tailored to the local communities. Four general approaches to enact strategies to operationalise the key dimensions: 1. Develop partnerships with Indigenous Peoples 2. Take action at all levels (patient-provider, organisations, systems): individual health care level is insufficient to achieving health equity: Intrapersonal: all levels of staff values, beliefs, assumptions and capacity for reflexivity, interpersonal: optimise interactions providers and patients, staff, health and social organisations. Contextual: efforts by staff, managers and leaders to affect change within HC organisations and the wider community. 3. Attention to local and global histories: recognising the diversity within a cultural group through local understanding. 4. Attention to unintended and potentially harmful impact of each strategy: given dominant assumptions, policies and practices that are in place in health care systems. The paper then provides 10 strategies to guide equity-oriented services in Indigenous Peoples: 1. Explicitly commit to fostering health equity in partnership with Indigenous peoples in mission, vision, or other foundational policy statements 2. Develop organizational structures, policies, and processes to support the commitment to health equity e.g. structures polices and processes related to hiring 3. Optimize use of place and space to create a welcoming milieu: creating safe spaces where people feel welcomed 4. Re-vision the use of time: flexibility of use of time e.g. responsive action
						Interpersonal	X	
						Community	X	
						Organisational	X	
						Policy		

ID	Country	Article Type	Population	Focus	Approach	Level		Description
								balancing drop ins with scheduled appointments and time required to provide good care 5. Continuously attend to power differentials: recognizing that the dominant ideological doctrine of 'treating everyone the same' can actually reiterate inequities 6. Tailor care, programs, and services to local contexts, Indigenous cultures, and knowledge systems 7. Actively counter systemic and individual experiences of racism and intersecting forms of discrimination: Organizations that develop strategies to counter racism and discrimination need to push back against dominant, neoliberal discourses that reinforce misconceptions about people having equal access to health care and resources 8. Ensure opportunities for meaningful engagement of patients and community leaders in strategic planning decisions: addressing the root causes of health, social, and health care inequities requires partnerships with Indigenous peoples and community members. E.g. Community Advisory Committees, Elders Committee can ensure integration of Indigenous knowledge and aligns with culturally safe intentions. 9. Tailor care, programs, and services to address interrelated forms of violence: TVIC is one way of respectfully tailoring care to the impact of history, specifically histories of violence, on people's lives. 10. Tailor care to address the social determinants of health for Indigenous peoples: health issues must be understood and addressed within the context of SDOH. At an organizational level, structures and time allocation must support providers to address people's socio-economic needs, either through partnership arrangements with other agencies or by creating a network of multi-disciplinary team members to whom patients can be referred.
[24]	US	Survey	Health Care Professionals	Effectiveness of cultural competence and safety	Self-evaluation of cultural awareness in	Individual		Defence of clinicians, critique of effectiveness and evidence behind cultural awareness/competency/safety/humility training. Workshops are too short term with little follow up, focus only on surface level information. Promotes a "culture first" mentality where any misunderstanding
						Interpersonal	X	
						Community		

ID	Country	Article Type	Population	Focus	Approach	Level		Description
					service provision			is perceived to be culturally based. Culturally safety can reinforce group mentality where minority patients are distinct from majority clinicians. Can induce resentment and backlash if clinicians feel accused and can also increase bias. Implementation of knowledge gained in workshops is likely not supported in the workplace. Information in workshops is too generic to be applied so gives impression that the organisation is presenting workshops for optics purposes. Questions the significance of cultural health disparities.
						Organisational		
						Policy		

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