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**Supporting Information**

**Supplementary material**

**This appendix was part of the submitted manuscript and has been peer reviewed.**
**It is posted as supplied by the authors.**

Appendix to: Coe LJ, Dimitropoulos Y, Mealings K, et al. Values in health and health care for Indigenous people globally: an umbrella review. *Med J Aust* 2025; doi: 10.5694/mja2.70027.

## Appendix A: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) reporting checklist

Note: The page and item numbers in this checklist refer to the submitted manuscript, not to the published article or its Supporting Information file

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| **TITLE** | | | |
| Title | 1 | Identify the report as a systematic review. | Title |
| **ABSTRACT** | | | |
| Abstract | 2 | See the PRISMA 2020 for Abstracts checklist. | Abstract |
| **INTRODUCTION** | | | |
| Rationale | 3 | Describe the rationale for the review in the context of existing knowledge. | Introduction |
| Objectives | 4 | Provide an explicit statement of the objective(s) or question(s) the review addresses. | Introduction |
| **METHODS** | | | |
| Eligibility criteria | 5 | Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses. | Methods – Search strategy |
| Information sources | 6 | Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted. | Methods – Search strategy<br>Figure 1 – PRISMA Flowchart |
| Search strategy | 7 | Present the full search strategies for all databases, registers and websites, including any filters and limits used. | Appendix A |
| Selection process | 8 | Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process. | Methods – Study selection |
| Data collection process | 9 | Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process. | Methods – Data extraction |
| Data items | 10a | List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect. | Methods – Data analysis |
| | 10b | List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information. | Methods – Search strategy |
| Study risk of bias assessment | 11 | Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process. | N/A |
| Effect measures | 12 | Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results. | N/A |
| Synthesis methods | 13a | Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)). | N/A |
| | 13b | Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions. | N/A |
| | 13c | Describe any methods used to tabulate or visually display results of individual studies and syntheses. | N/A |
| | 13d | Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used. | N/A |
| | 13e | Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression). | N/A |

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| | 13f | Describe any sensitivity analyses conducted to assess robustness of the synthesized results. | N/A |
| Reporting bias assessment | 14 | Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases). | N/A |
| Certainty assessment | 15 | Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome. | N/A |
| **RESULTS** | | | |
| Study selection | 16a | Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram. | Results – Characteristics of included reviews<br>Figure 1 PRISMA Flowchart |
| | 16b | Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded. | Figure 1 PRISMA Flowchart |
| Study characteristics | 17 | Cite each included study and present its characteristics. | Appendix B |
| Risk of bias in studies | 18 | Present assessments of risk of bias for each included study. | N/A |
| Results of individual studies | 19 | For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots. | N/A |
| Results of syntheses | 20a | For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies. | N/A |
| | 20b | Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect. | N/A |
| | 20c | Present results of all investigations of possible causes of heterogeneity among study results. | N/A |
| | 20d | Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results. | N/A |
| Reporting biases | 21 | Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed. | N/A |
| Certainty of evidence | 22 | Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed. | N/A |
| **DISCUSSION** | | | |
| Discussion | 23a | Provide a general interpretation of the results in the context of other evidence. | Discussion |
| | 23b | Discuss any limitations of the evidence included in the review. | Discussion – Limitations |
| | 23c | Discuss any limitations of the review processes used. | Discussion – Limitations |
| | 23d | Discuss implications of the results for practice, policy, and future research. | Discussion – Conclusions |
| | | | |
| Registration and protocol | 24a | Provide registration information for the review, including register name and registration number, or state that the review was not registered. | N/A |
| | 24b | Indicate where the review protocol can be accessed, or state that a protocol was not prepared. | Appendix A |
| | 24c | Describe and explain any amendments to information provided at registration or in the protocol. | N/A |
| Support | 25 | Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review. | Acknowledgments |
| Competing interests | 26 | Declare any competing interests of review authors. | Acknowledgements |
| Availability of data, code and other materials | 27 | Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review. | Appendix B |

## Appendix B: General search terms — OVID databases

(aborigin* or indigenous or first nation*).mp. AND (health adj3 (outcome* or primary or deliver* or access* or service* or hear* or public*)).mp. OR (hospital* or otitis media or disease* or illness*).mp. AND (equit* or social determin* or disparit* or attitude* or social justice* or decolonial*).mp. OR (cultur* adj2 (care or competen* or safety or divers* or determin*)).mp. AND Meta-analysis.mp,pt. or metaanalysis.mp,pt or review.pt. or search:.tw.

## Appendix C: Descriptive characteristics and brief summary of findings of included reviews

| *Author (year)* | *Author positioning* | *Aim of review / Research question* | *Country / Indigenous populations* | *Review* | *Studies included in review* | *Study type included in review* | *Analysis* | *Results* |
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| Augur, MD (2016)[13] | Two-eyed seeing | Describe and interpret qualitative research relating to cultural continuity for Indigenous peoples in North America. | Canada, United States | Qualitative meta-synthesis | 11 | Qualitative and mixed methods | Meta-synthesis | Five themes identified: 1) connection between cultural continuity and health and wellbeing; 2) conceptualisations of cultural continuity and connectedness; 3) the role of knowledge transmission; 4) journeys of cultural (dis)continuity; and 5) barriers to cultural continuity. |
| Gomersall, JS (2017)[14] | Not stated | Explore the unique characteristics and value of care provided in ACCHOs compared to mainstream/general practitioner services, and implications for improving access to quality, appropriate primary health care for Indigenous Australians. | Australia | Systematic review | 10 | Qualitative | Thematic analysis | Perceived unique valued characteristics of ACCHOs were: 1) accessibility, facilitated by ACCHOs welcoming social spaces and additional services; 2) culturally safe care; and 3) appropriate care, responsive to holistic needs. |
| Mbuzi, V (2017)[15] | Not stated | Review qualitative research that investigated Indigenous patients' and their families' experiences of hospitalisation, with the aim of gaining insight and understanding of their distinct perspectives. | Australia, Canada, Kenya, New Zealand | Meta-synthesis | 21 | Qualitative | Thematic synthesis | Three themes identified: 1) strangers in a strange land; 2) encountering dysfunctional interactions; 3) suffering stereotyping and assumptions. Difficulties when accessing health care in hospital settings were exacerbated by poor communication, environmental restrictions, superficial relationships, isolation, and ingrained negative attitudes towards them. |
| Jennings, W (2018)[16] | Not stated | Examine Indigenous accounts, unpacking the themes raised and prioritised by their own voice and experience, in order to illuminate our understanding of culturally safe Indigenous health care communication. | Australia | Systematic qualitative literature review | 65 | Qualitative | Thematic analysis | Two key components of culturally safe health care communication emerged: the power of talk, and power differentials within talk. |
| Shahid, S (2018)[17] | Not stated | What is known of the needs and preferences of Indigenous patients at the end of life, any barriers to quality care at this time and identify the key features of specific models of care and innovative strategies developed to address these needs, preferences and barriers. | Australia, New Zealand, Canada, United States | Systematic review | 39 | Qualitative methods only, mixed methods, quantitative, literature reviews and a palliative care model | Thematic synthesis | Effective models included community engagement and ownership; flexibility in approach; continuing education and training; a whole-of-service approach; and local partnerships among multiple agencies. |

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| Berg, K (2019)[18] | Not stated | What is known regarding barriers and facilitators related to Indigenous cultural competency and cultural safety within Canadian EDs? | Australia, Canada, United States, New Zealand | Scoping review | 43 | Unclear; inclusion criteria included systematic reviews, theoretical frameworks, individual studies, qualitative studies, practice guidelines and program resources | Qualitative content analysis | Cultural safety included patients feeling valued and respected through cultural helpers, support from another person with their cultural and/or linguistic background, or "brief supportive interactions" with hospital staff. Barriers identified by patients include concerns over stereotyping and discrimination, differences in communication styles or lack of adequate communication, lack of alternative care options, alienation or feeling far from home, lack of social services in ED setting, busyness and lack of privacy in ED, patient financial constraints, mistrust of the medical system, not being actively involved in care plans and concern over institutional policies. |
| Butler, TL (2019)[19] | Not stated | Identify and describe the domains of wellbeing relevant to Indigenous Australians. | Australia | Literature review | 95 | Peer reviewed studies, grey literature | Narrative synthesis | The review identified a range of wellbeing domains potentially important to Indigenous Australians, extending far beyond those typically measured in existing QOL and HRQOL instruments. Wellbeing domains showed a strong sense of interconnectedness, and the needs of important connections such as communities, families, and kinship ties were often prioritised over the needs of individuals. These characteristics speak to the importance of prioritising Indigenous Australians' values and worldviews in the development of wellbeing instruments. |
| Palmer, SC (2019)[20] | Authors have expertise in Māori health research | Explore how Māori consumer experiences of health services and programs in Aotearoa New Zealand are conceptualised within qualitative research. | New Zealand | Systematic review | 54 | Qualitative | Māori consumer experiences of health services were mapped to the WHO Commission of Social Determinants of Health (CSDH) conceptual | Recommended actions to improve Māori experiences of health care were aligned with reducing risk of exposure to health-damaging factors (such as integration of tikanga (cultural mores) in health services, health literacy interventions, increasing Māori workforce capacity and involvement in health service development, resources for cultural competency, accessibility of health services and clinician responsiveness to Māori consumers. Recommendations to reduce the |

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| | | | | | | | framework on health inequities | unequal consequences of included culturally relevant interventions, support for whānau (extended family)-based care and involvement in the health system, holistic models of care and reflexive clinical practices. Strategies aimed at reducing exposures to health-damaging factors included improved referral practices, reducing clinician bias, increased awareness of health determinants and provision of cultural competency frameworks and strategy. |
| Walker, RC (2019)[21] | Not stated | What are the experiences, perspectives and values of Indigenous peoples regarding kidney transplantation? | Australia, New Zealand, Canada, United States | Systematic review | 8 | Case studies, qualitative | Thematic analysis | Five themes identified: 1) strong desire for transplantation; 2) lack of partnership in shared decision making; 3) barriers to live kidney donation (difficulty asking, apprehension about impact on donor, avoiding additional financial burden and fear of complications); 4) cultural considerations; 5) experiencing lack of cultural competence in clinical care (struggling with prejudice and ignorance, mistrust of clinicians and health system). |
| Walker, RC (2019)[22] | Not stated | Explore Indigenous women's experiences, perceptions, and values related to stopping smoking in pregnancy. | Australia, New Zealand | Systematic review | 7 | Qualitative | Thematic synthesis | Three themes identified: 1) agency, pride, role models, and family support; 2) understanding the drivers for smoking; and 3) preference for culturally responsive approaches to smoking cessation, valuing accessible programs designed specifically for and by Indigenous people. |
| Graham, R (2020)[23] | Kaupapa Māori | Synthesise perspectives of Māori patients and their whānau of their treatment within the public health system. | New Zealand | Systematic review | 14 | Qualitative | Qualitative meta-synthesis | Facilitators within the public health system included enabling whānau (extended family) practical assistance, emotional support and support to navigate the health system. |
| Jones, B (2020)[24] | Not stated | What is known about the experiences of Aboriginal and Torres Strait Islander patients and carers in Australian health care settings? | Australia | Realist and meta-narrative evidence synthesis | 54 | Qualitative | Thematic analysis | Three themes emerged: 1) beliefs about wellbeing and health care provision; 2) their level of trust in the health care system; and 3) individual and community health system interactions. |
| Koea, J (2020)[25] | Not stated | Define the factors determining the optimal and most productive relationship among Indigenous | New Zealand, Australia, North | Systematic literature review | 33 | Qualitative | Thematic analysis | Six themes emerged: 1) accessible health services; 2) community participation and community |

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| | | communities, surgeons, and providers of surgical services. | America, Indigenous Latin Americans | | | | | governance; 3) continuous quality improvement; 4) a culturally appropriate and clinically skilled workforce; 5) flexible approach to care, 6) holistic health care. |
| Christie, V (2021)[26] | Not stated | Examine the role of culture when it comes to improving Indigenous women's health outcomes. | Australia, United States, Canada, New Zealand, Norway, Japan | Systematic review | 15 | Not clear - however eligible studies were limited to journal articles, observational studies, clinical studies and clinical trials | Thematic analysis | Four overarching themes were described: 1) silence; 2) service access; 3) cultural conception of cancer; and 4) family and community support. The literature finds that culture makes a real difference to Indigenous women on their breast cancer journey. |
| Espiner, E (2021)[27] | The data analysis was informed by a Kaupapa Māori positioning | What are the barriers and facilitators of access to hospital services for Māori? | New Zealand | Literature review | 23 | Qualitative, quantitative | Thematic analysis | Five themes captured the barriers for Māori accessing hospital services (practical barriers, poor communication, hostile health care environment, primary care barriers and racism) and five facilitatory themes were identified (practical facilitators, whakawhanaungatanga (relational interactions), whānau (family), manaakitanga (caring attributes of staff) and cultural safety) |
| Lord, H (2021)[28] | Not stated | Explore the perceptions of Indigenous Australians toward participation in cardiovascular primary prevention programs. | Australia | Systematic review | 11 | Qualitative | Thematic synthesis | Social and community support affect participants' experiences of prevention programs. Structural drivers and social determinants influence Indigenous Australians' experiences and participation in prevention programs and health risk behavioural change. Personal desire to change behaviours and participate in prevention programs requires development of knowledge. |
| Smith, M (2021)[29] | Research team included First Nations people (Canada) - interpretation was both holistic and reflective of the unique | How cultural safety occurs within contexts of care for Indigenous people with kidney disease. | Australia, New Zealand, Canada, United States | Narrative review | 15 | Qualitative, quantitative, reviews | Narrative review | Factors that aligned with cultural safety included relationality, engagement and health care self-determination; systemic issues, barriers, and access; and addressing legacies of colonialism for health care providers. |

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| | insights and experiences of reviewers | | | | | | | |
| Verbunt, E (2021)[30] | Not stated | Outline the current understanding of what cultural determinants of health are valued in the literature, and how they interact to improve health and wellbeing outcomes for Aboriginal people. | Australia | Narrative overview of reviews | 9 | Literature reviews (systematic, scoping), meta-synthesis of qualitative studies | Narrative overview | Four determinants were identified including: 1) family/community; 2) Country and place; 3) cultural identity; 4) self-determination. |
| Allice, I (2022)[31] | Not stated | Identify and describe the landscape of culturally safe strategies and recommendations for health care and social service encounters with Indigenous families who have experienced family violence. | Australia, Canada, United States, New Zealand | Systematic scoping review | 34 | Qualitative, mixed methods, quantitative | Narrative synthesis | Three overarching themes: creating conditions for cultural safety; healing for people and communities; and system-level change. |
| De Zilva, S (2022)[32] | Not stated | Explore culturally safe health care practice from the perspective of Indigenous peoples as recipients of health care in Western high-income countries. | Australia, New Zealand, Canada, United States, Scandinavian countries | Systematic meta-ethnographic review | 34 | Qualitative, mixed methods | Meta-ethnography | Four inter-relatable metaphors to characterise the elements of culturally safe health care practice were described: 1) personable two-way communication; 2) well-resourced Indigenous health workforce; 3) trusting relationships; and 4) supportive health care systems. |
| Puszka, S (2022)[33] | Indigenous standpoint theoretical framework, developed by disability scholars John Gilroy and Michelle Donnelly | To conduct a systematic review of the disability conceptualisations, practices and experiences of First Nations peoples of Australia. | Australia | Systematic review | 12 | Qualitative and mixed methods | Meta-synthesis | Inclusive attitudes and practices of caregiving in First Nations families facilitate the participation of First Nations people with disabilities in family and community life. Ableism and racism in broader society exclude many First Nations peoples with disabilities from public spaces and from labour markets. Disability services regularly fail to reflect First Nations values and social practices and lead to further disempowerment and marginalisation due to diagnostic processes; displacement from country and communities; gendered discrimination and poor relationships with service providers. |
| Sanjida, S (2022)[34] | Not stated | What are the experiences among Indigenous people with cancer | Australia | Narrative literature review | 23 | Qualitative | Thematic analysis | Three themes were identified: 1) communication; 2) cultural safety; and 3) access to services. |

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| | | progress through different sectors of the health care system in Australia. | | | | | | |
| Trounson, JS (2022)[35] | Not stated | Investigate the current literature regarding the experience of Aboriginal people living with a disability to identify factors that facilitate or impede engagement with disability services. | Australia | Systematic review | 17 | Qualitative, theoretical papers and theoretical reviews | Inclusive inductive thematic analysis | Themes included culture and Indigeneity; accessibility; engagement; and lack of support. |
| Deravin, LM (2023)[36] | Four reviewers - one First Nations, other non-Indigenous; collaborative yarning was used to reach decision making | Identify strategies that have been successful and thereby provide aged care service providers with an overview of what they can do to address these issues. | Australia | Literature review | 13 | Peer reviewed and non-peer reviewed articles and government documents | Thematic analysis | Barriers to health care and communication include racism, discrimination, prejudice and cultural impacts on health outcomes. The literature identified a need to recruit more First Nations peoples into the aged care workforce, involve more First Nations family and community members in aged care and retain a consistent workforce overall. Results from the review indicate that the direct involvement of First Nations people (from beginning) was paramount to ensuring the strategies identified or implemented were successful. |
| Graham, S (2023)[37] | Not stated | What are the barriers to and facilitators of access to health services for First Nations, Inuit and Métis peoples living in urban areas of Canada? | Canada | Systematic review | 41 | Qualitative, quantitative, mixed methods | Not stated | Barriers of accessing health care services for Indigenous peoples living in urban areas included difficult communication with health professionals, medication issues, dismissal by health care staff, wait times, mistrust and avoidance of health care, racial discrimination, poverty and transportation issues. |

**Abbreviations:**
ACCHO Aboriginal Community-Controlled Health Organisation
ED emergency department
HRQOL health-related quality of life
QOL quality of life
WHO World Health Organization

## Appendix D: Values in health care

| *Value in health care* | *Description* | *References* |
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| *Decolonised, comprehensive holistic systems of care* | ▪ Colonial-led health services impact on patient engagement and the provision of culturally safe care<br>▪ Services that embed culture to challenge power differentials between patients and clinicians are valued<br>▪ Services that are developed in partnership with Indigenous communities<br>▪ Services are welcoming and Indigenous-centred<br>▪ Service provision is proactive, comprehensive and holistic<br>▪ Aboriginal community-controlled health services are preferred (Australian context)<br>▪ Services are community-wide, provide outreach and health promotion to remote communities<br>▪ Community engagement<br>▪ Interagency collaboration and continuity of care | 13, 16, 17, 19, 20, 25, 27, 29, 31, 33, 34, 36, 37 |
| *Culturally safe health services and care* | ▪ Empower Indigenous people to make their own decisions about their health and support self-determination<br>▪ Enable people to question the health service provider or feel comfortable to complain<br>▪ Provide representation (Indigenous staff, artwork, flags, celebrating significant Indigenous events)<br>▪ Consider the diverse needs of different Indigenous communities<br>▪ Are on country and viewed as 'meeting places' for community<br>▪ Are based on respect<br>▪ Appointments are flexible and family can attend<br>▪ Consider gender of clinicians (opportunity for male patients with a male doctor for example)<br>▪ Support interactions between peers and other patients<br>▪ Good communication (clinicians providing non-judgemental care, making people feel valued, respected and heard)<br>▪ Interpreters are available when required or services are provided in Indigenous languages<br>▪ Support or provide traditional healing | 14, 15, 17, 19, 24, 25, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37 |
| *Indigenous and culturally aware non-Indigenous health workforce* | ▪ Indigenous workforce is preferred and adequately skilled<br>▪ Non-Indigenous clinicians are immersed in local Indigenous culture, culturally aware and understand the reality of Indigenous history, social, and political contexts<br>▪ Clinicians are caring, kind and open-minded<br>▪ Racist clinicians or clinicians who lack Indigenous knowledge and/or have judgemental attitudes are not valued | 17, 18, 19, 20, 23, 24, 26, 27, 29, 31, 33, 34, 35, 36, 37 |
| *Accessibility* | ▪ Local services (especially in rural and remote areas to minimise travel)<br>▪ Provision of practical support to access services including transport, accommodation<br>▪ Lack of local and accessible health services, particularly in rural and remote areas, impacts on health<br>▪ Long wait lists, financial barriers, travel and childcare impact on accessibility | 14, 23, 24, 26, 27, 31, 36, 37 |

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| *Communication, trust and rapport building* | ▪ Yarning types of communication style<br>▪ Good communication increases engagement in services<br>▪ Open transparent communication<br>▪ Communication which involves and includes family members or relatives is valued<br>▪ Language that is culturally acceptable and relatable (medical jargon is not valued)<br>▪ Taking time to build rapport and build trust<br>▪ Unhurried care<br>▪ Racist clinicians or clinicians who have poor communication are not valued, decrease engagement in services and negatively impact health outcomes | 14, 16, 17, 18, 23, 24, 26, 27, 29, 31, 32, 36, 37 |

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