ABSTRACT

Background: Culturally secure care is considered foundational for good perinatal outcomes for Indigenous women. It is unknown what literature reports on whether Indigenous women giving birth in urban areas receives appropriate cultural care. The aim of this scoping review was to examine and summarise relevant evidence which reports on culturally secure care for Indigenous women using urban maternity services at any time during the perinatal period.

Methods: Eleven journal databases plus grey literature and theses databases were searched for relevant material dated 1986-2018. Articles were included if these were about Indigenous women from Australia, New Zealand, Canada or the USA; care was provided anytime during the perinatal period and in an urban area; and, cultural security (or variations of this term) were used.

Results: 6856 titles and abstracts were screened, of these: 25 studies, 15 grey literature documents and 9 theses matched the search criteria. Studies were mostly qualitative (13/25) and from Australia (18/25). Studies showed women's access to and experiences of culturally secure maternity care in urban areas as variable. The grey literature originated from Australia (8/15); New Zealand (4/15); and Canada (3/15); while theses were from Canada (7/9) and Australia (2/9).

Conclusion: The scoping review results showed substantial qualitative evidence on Indigenous women's experience during the perinatal period in urban areas. In-depth analysis of these studies is required to inform future practice and policy on what works and what needs improvement. Culturally secure midwifery care shows promising results.

Keywords: Indigenous; cultural security; urban; perinatal; scoping review

STATEMENT OF SIGNIFICANCE

Issue: A number of reviews have investigated birthing on country models of care and/or culturally safe (culturally secure) midwifery care for Indigenous women. The variability of the terminology associated with cultural security and cultural safety and how this is applied differs by country, and within individual countries. The outcomes have often focussed on rural and remote Indigenous women, with scant attention on Indigenous women located or birthing in urban areas.

What is already known: As high proportions of Indigenous women give birth or live in urban areas, a focus on maternity services in urban locations that provide high quality and culturally safe childbearing support and/or culturally secure experiences for Indigenous women is needed to inform future practice and policy.

What this paper adds: This paper is the first attempt we are aware of that reviews the evidence related to the cultural needs of childbearing Indigenous women who relocate to or are located on Indigenous Country (ancestral lands) which has been urbanised in order to give birth, either on or off Country.

INTRODUCTION

The concept of cultural safety/cultural security in nursing and midwifery practice stems from work undertaken in New Zealand in the early 2000's by Ramsden[1] and further debated and refined by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).[2] Despite the passing of nearly two decades, the incorporation of these concepts into midwifery practice guidelines and service delivery frameworks and impact evaluation of cultural safety and/or cultural security on Indigenous women's experiences of maternity care has not been systematically reported in the countries included in this review. Whether Indigenous women receive culturally secure maternity care or not shapes their experiences of empowerment/disempowerment across the childbearing continuum. In Australia, as women are highly likely to have contact with midwives across the perinatal period, there is potential for midwives to influence Indigenous women's receipt of care and whether this influences how women experience culturally security during childbirth. To establish the evidence associated with culturally secure care for Indigenous women, this scoping review was undertaken as part of a large National Health and Medical Research Council of Australia funded study (Partnerships Project Grant xxxx) in Western Australia. *The (insert grant name here)* was conducted from 2014-2019. The (*grant name)* Project investigated questions associated with the cultural birthing practices and maternity experiences of Aboriginal women living *on country* (Noongar Boodjar), part of which occupies a large urban location in Western Australia, and, the knowledge of midwives who provide perinatal care. Two recent evidence reviews (2013 and 2017) had investigated birthing on country models of care and midwifery care for Indigenous women.[3,4] In these, the evidence focussed on rural and remote Indigenous women, with little attention paid to the needs of Indigenous women already located, or who travel from regional or remote areas, and give birth in urban locations. Due to overall poorer Indigenous maternal and infant health outcomes, there is an urgent need for high quality, accessible and culturally secure care to support Indigenous women during pregnancy and childbirth. The aim of this scoping review was to examine the available evidence on culturally secure care in urban maternity services

for Indigenous women during the perinatal period to inform future practice and policy in the development of maternity models of care of service programs.

METHODS

The methods by Arksey and O'Malley guided protocol development for the scoping review.[5,6] The five-stages are: 1] identifying the research questions, 2] identifying relevant studies, 3] study selection, 4] charting data, and, 5] collating summarising and reporting results.[5 7] We have provided the completed PRISMA checklist in Supplementary Materials (Table S1).[7] We also used the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) approach for the scoping review to account for inclusion of qualitative, mixed methods and theoretical papers.[8] The SPIDER tool was developed with qualitative research in mind, but offers an adaptable method to review all research designs, including theoretical papers. It has previously been used to develop search criteria for a scoping review on community participation in rural health.[9] A general definition of each component of the SPIDER tool is provided in Table 1.

Sample

Three sample populations of interest for the scoping review were:

1. Indigenous women (and their families) during antenatal, birthing period, and up to one year postnatally (perinatal period) from Australia, Canada, New Zealand or the USA. 'Indigenous' was defined using the World Health Organisation definition, "Indigenous populations are communities that live within, or are attached to, geographically distinct traditional habitats or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined. They generally maintain cultural and social identities, and social, economic, cultural and political institutions, separate from the mainstream or dominant society or culture."[10]
2. Individuals/groups caring for Indigenous women during perinatal period and who are providing maternal care within a formal organisation or structure. Such as, formal health

service providers (e.g. midwives or Health Workers), informal health service providers (e.g. volunteers or Aboriginal Liaison Workers) and anyone who may not fall into these two categories but identified as providing maternity care.

3. Service sectors which Indigenous women use (for example, antenatal clinics or maternity hospitals/wards) and with health service providers as described above.

Phenomenon of interest

Cultural security

Coffin describes cultural security as directly linking a health practitioner's *understanding* of cultural issues as the means of building their own cultural awareness, with the application of the knowledge acquired by health practitioner's to *actions* that support Aboriginal people to feel safe to access health care (described as culturally safe care); with the health practitioner's awareness and ability to provide culturally safe care concomitantly supported by organisation or system based *policies and procedures* designed to be 'automatically applied from the time when Aboriginal people first seek health care' (p. 23).[11] It is the incorporation of policies and procedures specific to Aboriginal people that create the circumstances for Aboriginal people to experience culturally secure health care.

Terms of interest related to the concept of cultural security may be used interchangeably in the literature due to the nature of the phenomenon, its interrogation by different groups and the contexts in which it is used. Hence, the phenomenon of interest was extended to encompass the following terms: 'cultural safety', 'cultural care', 'cultural humility', 'cultural awareness', 'cultural respect', 'cultural sensitivity', 'culturally appropriate', 'cultural sovereignty' 'cultural competence', 'cultural literacy', 'cultural framework', 'cultural value', 'cultural difference', 'inter-cultural', 'bi-cultural'.

Perinatal period

A number of definitions are used for the perinatal period within the literature [12,13]. To ensure the broadest inclusion possible for the review we included all studies from conception, the antenatal period and up to one year post-partum.

Geographic location

We used the definition of urban to include terms such as city, town, built up or inner city, metropolitan, municipal and suburban. We included studies if women from regional, rural and remote regions had attended urban maternity services during the perinatal period.

Research Design

We included all research designs (for example, qualitative, quantitative and mixed methods) service evaluations and theoretical papers; but excluded opinion pieces, editorials and conference abstracts.

Evaluation

We identified literature that explored patient or provider experiences/perceptions or which considered improving health and wellbeing outcomes. We specifically looked at the delivery and quality of antenatal and postnatal care including birth and time spent in hospital. We excluded articles specifically related to health promotion activities (i.e. smoking cessation) or were disease specific, for instance, gestational diabetes.

Search Strategy

The SPIDER criteria informed search criteria. Keyword searches for Indigenous, perinatal period and cultural security were developed. The MEDLINE keyword search has been provided in the Supplementary materials (Table S2). Databases searched were: MEDLINE, CINAHL, Plus Full Text, Embase, PsychInfo, Maternal and Infant Care, APAIS-ATSIS ATSI Health Collection, JBI CONNECT, Cochrane reviews, CENTRAL, and DARE.
Grey literature searches included: GreyLit.org, Dissertations and Theses PQDT, Australian Commonwealth and State Health Departments, Health Canada, Indian and Northern Affairs

Canada, Canadian Institute for Health Information, Statistics Canada, Indian Health Service (https://www.ihs.gov/), NZ Commonwealth Health Departments, and NACCHO.

All included papers had reference lists searched for any additional material. The reference lists of systematic reviews that did not meet our criteria, but may have articles relevant to the scoping review were also searched. Inclusion dates were January 1986-September 2018. Studies were searched from 1986 as this is when the term cultural security was first published in New Zealand.[1] Only studies published in English were included.

Study selection

Based on titles and abstracts, studies were initially removed when no relevance was identified. Following this, studies were removed if: non-Indigenous women sample; non-urban areas; phenomenon of interest was clearly not related to cultural security (or similar terms); or, was outside the perinatal period. This process was completed by two authors and a third author if disputes occurred. Once eligible studies were agreed, full-text articles were located, and the above process was repeated. Articles were retained which met a majority of inclusion criteria. Reference manager Endnote X7 (Endnote 2015) was used during the selection process. This resulted in identification of studies that referenced but did not detail or discuss the scoping review criteria, and these were also excluded.

Data extraction and analysis

Data from included studies were independently collected by two authors using a standardised data collection form created for the scoping review. Data included: study design, location of study, aim of study, population (including sample size), and perinatal period as defined in the study. We were also interested in whether culturally secure care was provided to women. To assess this, the following information was also extracted from each journal article:

1. Were Indigenous women's cultural needs in their pregnancy/birth journey identified or described?
2. Did Indigenous women express/identify any examples of feeling culturally unsafe during instances of perinatal care?

3. Were traditional birthing on country protocols identified and/or described?
4. Were Indigenous women's expectations of midwives cultural competence identified?
5. Were aspects of cultural competence of midwives identified?
6. Were standards for measuring evaluating the cultural security/safety of maternity organisations identified?

The information from each study was categorised as: 'yes' information was provided on the question; 'no' information was not provided on the question; or 'N/A' if the study design was not aligned with the question of interest. Data extraction from eligible studies was completed by two authors. If there were discrepancies, the authors discussed the discrepancy and if it could not be resolved, a third author was consulted.

Quality assessment

We completed the CASP (Critical Appraisal Skills Programme) for all qualitative studies in the review.[14] Two authors completed the risk of bias on such articles and a third author was consulted for any disputes. Responses to the CASP tool have been provided in the standardised format of 'Yes', 'No' and 'Can't tell'. We have revised the final question of the CASP tool 'How valuable was the research' to reflect a yes/no/can't tell answer and modified it to 'Was the research valuable?'. We did not provide a 'total' or summary indicator for each study as the CASP tool was not designed to do this.

Summarising and reporting results

Data are reported in descriptive tables (Tables 2-6). We examined the extent of the literature presented and grouped the information by journal articles, grey literature and theses. The tables provide details on aims, types of studies and when the data was collected (i.e. perinatal period) and a comprehensive overview of the available literature.

RESULTS

The scoping review search criteria identified 8763 articles for inclusion. After removal of duplicates, 6856 articles (title and abstracts) were screened. Using the exclusion process described above, we identified 25 studies (2 articles were for the same study)[15-40], 15 grey

literature documents[4,41-54] and nine theses.[55-63] Reasons for exclusion of all other publications are provided in Figure 1**.**

Characteristics of included studies

Details of 25 studies included in the scoping review are in Table 2. The majority of study designs were qualitative (n=13; 52%); followed by mixed methods (n=5; 20%), evaluations (n=3; 12%) and one each for randomised controlled trial, audit, narrative review and a case study consultation paper (4% each). Eighteen of the 25 studies were from Australia (72%), five from Canada (20%) and two from the US (8%). We did not find any publications from New Zealand that matched our criteria. A relatively even distribution of timing of care provided in the perinatal period was apparent: 18 studies during the antenatal period; 14 in the intrapartum; and, 15 during the postnatal period; with some studies including more than one period, hence being counted more than once. Across the qualitative and mixed methods studies, approximately 460 pregnant women/mothers were interviewed or surveyed.

Quality assessments

We completed CASP qualitative assessment on 20/25 (80%) that included a qualitative component (Table 3), with most studies positively assessed against ten CASP criteria. The most poorly reported CASP criteria were: if the recruitment strategy was appropriate (5/20 'can't tell'); and, whether the relationship between researcher and participants was adequately considered (6/20 'can't tell').

Cultural security

As described above, assessments were made for each study (see Table 4) to ascertain whether Indigenous women experienced culturally secure care during the perinatal period, in relation to each component earlier, with a summary provided below.

Were Indigenous women's cultural needs in their pregnancy/birth journey identified or described?

Nearly all studies (24/25) provided evidence that Indigenous women's cultural needs had been considered.[15-36,38-40] This was either through evaluating midwifery models of care for Indigenous women, highlighting the needs of women through justification for

the study, as information provided by women or community members or identified as needing cultural secure care within the discussion. Only one study did not discuss cultural needs of Indigenous women during the perinatal period, as the study was focused on supporting medical students and their delivery of care.[37]

Did Indigenous women express/identify any examples of feeling culturally unsafe during instances of perinatal care?

Ten studies reported Indigenous women as feeling culturally unsafe in the care they received through the perinatal period.[17,19,21,22,24,26,28,30,35,38] Some of these included physical and emotional stress during their time in hospital, not having a choice in birthing positions[19]; loneliness, fear, and isloation[21]; and being judged because of culture[17]. Other examples were: staff being abrupt and women feeling like they were wasting peoples time[30]; inadequate communication between hospital staff and mothers[24]; problems related to alienation and racism[24]; and, impersonal care and lack of connection with hospital staff[28]. One of the ten was a case study on care provided to a young Indigenous woman she discussed the inappropriate, threatening and 'bullying' care she received during her time in hospital.[22]

Were traditional birthing on country protocols identified and/or described?

One study referred to birthing on country principles for the adaptability of these to urban contexts. The principles were described as: community based and/or governed; incorporate traditional practices; involve connection with land/country; use a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by, or with, Indigenous people.[40]

Were Indigenous women's expectations of midwives' cultural competence identified?

Five studies referred to Indigenous women's expectation of midwives cultural competence.[16,17,23,25,26] Three of these studies were Australian Indigenous specific maternity programs: The Aboriginal Maternity Group Practice Program (Perth, Western Australia)[16], The Malabar Community Midwifery Link Service (Sydney, New

South Wales)[23] and the Murri Clinic (Brisbane, Queensland).[26] These studies identified that women who attended the services found midwives more likely to be culturally sensitive to their needs with common themes including improvements in continuity of care, communication and trust between women and midwives. In another study, Indigenous women supported by Indigenous midwives reported experiencing positive perinatal care; which included effective communication, improved relationships, and positive support and assistance from the midwives.[25] However, outside of the care women received from Indigenous midwives and/or specific programs for Indigenous women, women were faced with difficult and inflexible systems that did not support them through their journey. This resulted in mixed feelings about the level of culturally competent care provided by midwives.[17,25,26]

Were aspects of cultural competence of midwives identified?

The cultural competence of midwives was referred to in nine studies.[16-19,23,25-27,29] Important components of delivery of care from midwives to Indigenous women included: the communication skills of midwives; support midwives receive from other Indigenous health service providers and community members; and, building rapport with women during the perinatal period.

Identification of standards for measuring or evaluating cultural security of maternity organisations?

Two studies identified measures for assessing culturally secure care in maternity organisations.[16,34] Following an audit of 42 maternity services used by Aboriginal women in Western Australia, Reibel et al. (2010) used four key indicators to determine whether culturally appropriate, acceptable antenatal care was available for Aboriginal women. The indicators were: 1) service having an Aboriginal specific antenatal protocol; 2) confirmation of an Aboriginal specific program of antenatal care; 3) access optimised by location of service and availability of unbooked antenatal appointments and transport; and, 4) inclusion of Aboriginal Health Workers

as members of multidisciplinary antenatal care teams.[34] Bertilone et al. (2016) used an 'Organisational Cultural Competence Assessment Tool' to identify elements of an Aboriginal Maternity Group Practice Program that contributed to the provision of a culturally competent service.[16] Key findings against the nine domains of organisational cultural competence were described and included: creating a welcoming environment; developing, supporting and enhancing the cultural competence of new and existing staff; communicating effectively with Aboriginal people; improving service delivery; building relationships; leading and managing change; providing culturally responsive care; facilitating culturally inclusive and secure policies and practices; and monitoring and evaluating the effectiveness of strategies.[64]

Grey literature and theses

There were 15 grey literature documents and nine theses found regarding our topic. Of the grey literature nine were from Australia[4,41-45,47,51,54], four from New Zealand[48,49,52,53] and two from Canada. [46,50] The documents are described in Table 5, and included evaluations of programs, guidelines, reviews and reports related to the broader topic of culturally appropriate service delivery and culturally competent care for Indigenous women during the perinatal period. Common elements included: culturally appropriate services which are responsive to Indigenous women's needs, are community based, culturally and clinically safe, with practices and policies driving service delivery and care provided by culturally competent carers, with an emphasis on the availability of an Indigenous workforce, the inclusion of traditional practices and birthing on country models, with partnership, information and choice available. Of the nine theses six were from Canada[58-63], two from Australia[55,56] and one thesis included Indigenous women from Canada and USA.[57] These are described in Table 6 and were largely centred on exploring Indigenous women's experiences, perceptions and beliefs about birthing and care provided to them during the perinatal period.

DISCUSSION

The scoping review included 25 studies, 15 documents identified from the grey literature and 9 theses that met our criteria. The studies were mainly qualitative or mixed methods, with one RCT included. The RCT[34] was mostly concerned with medical student training and the impact of their cultural awareness on Native American women during pregnancy, rather than impacts or outcomes directly related to the women. While it is important to be aware of well-designed studies that can inform education and training of health professionals in cultural awareness and safety, any similar future studies would be more robust if women's views of their experiences are included in the study design to ensure a comprehensive assessment of impact.

In the remaining 24 studies, we found a range of definitions and understandings of cultural security and safety evident for different locations (countries) and Indigenous groups. Only one of the studies referred to traditional birthing on country models or practices, and this was concerned with incorporating birthing on country principles into urban models of care. The majority of the 24 studies in the main described how a maternity service addressed the needs of Indigenous women. Of concern was that many reported that women experienced culturally unsafe care; ranging from poor communication to bullying. This finding indicates a significant gap in the application of evidence to models of maternity care; specifically, that individual Indigenous women's pregnancy and birthing needs assessments are not always aligned with the culturally safe health care required to support a culturally secure birth experience. For example, if Coffin's (2007) definition of cultural security is applied to midwifery care for Indigenous women, this would require a midwife to develop *understanding* of Indigenous cultural birth issues (as a means of building the midwife's cultural awareness of these); and, incorporating cultural awareness into her midwifery practice by initiating *actions* that support an Indigenous woman to feel safe to access maternity care (as a means of developing culturally safe maternity care). Once a midwife combines cultural awareness and culturally safe care into her practice *and* this is supported by health service or system *policies and procedures* automatically applied from the time when an Indigenous woman first

seeks maternity care, the circumstances are created for the likelihood of an Indigenous woman's maternity experience to be culturally secure. Coffin's articulation of the building blocks of cultural awareness, cultural safety and cultural security in health care, can thus be applied in maternity care settings. For example, in Canada, the Toronto Birth Centre is a community-based, midwife-led centre located in downtown Toronto. It is dedicated to delivering a culturally safe place for Indigenous and non-Indigenous families and is the vision of the Indigenous led Seventh Generation Midwives Toronto.[65,66] This model of care is grounded in their Indigenous Framework that goes from governance to operation and has successfully birthed approximately 1900 babies since 2014.[67] While in Australia, the Birthing in Our Community Service launched in 2013, is a partnership with local Aboriginal Community Controlled Health Organisations, the Institute for Urban Indigenous Health, and the Mater Hospital in South East Queensland.[68] Although yet to be academically published, evaluations to date have shown significant improvements in preterm births, caesarean sections and low birth weight infants.[69] Therefore, culturally secure Indigenous led midwifery care can be implemented with success and have been shown to improve outcomes for both mothers and their infants.

Achieving cultural security in a setting where an Indigenous woman is pregnant, giving birth or caring for a baby in the first year, therefore requires *all* of Coffin's building blocks to be in place. Reibel and Walker's[31] (2010) audit of maternity services in Western Australia which provided care to Aboriginal women found that only nine of 42 services met the criteria for cultural safety or cultural responsiveness. One of the key criteria used by the authors, the application and use of culturally relevant protocols to define the delivery of culturally safe maternity care to Aboriginal women, was largely missing, or at best haphazard in the evidence considered in our scoping review. The absence of the available evidence applied to Indigenous specific guidelines in contemporary maternity settings might explain the obvious gap between health practitioner assessments of the care they provide and women's experiences of the care they receive.

As such, the scoping review demonstrated a need for health systems to create tools, models, frameworks and protocols capable of supporting quality improvements in the provision of culturally secure maternity care for Indigenous women and the means to gather Indigenous women's perceptions of their care. The engagement of Indigenous women in the design of such protocols would be a positive and culturally appropriate way forward to ensure that services provide guidance to all health practitioners, but particularly midwives, that is both evidence and experientially informed.

A further important factor promoting cultural security identified in our review was the presence of an Indigenous midwife and/or the setting in which care or birth takes place, being designed and managed as an Indigenous specific service. Four studies[13,20,2340] from Australia provide evidence of the importance of this approach. Further, these four studies suggest there is scope for further investigation of the impacts and outcomes Indigenous mothers experience when services tailored to their needs are available; with services expanded to cater to more Indigenous women than currently appears to be the case. Further, that services are aligned with appropriate guidelines, cultural protocols and practitioner education that promotes the individual health practitioner and health system competencies required for Indigenous women to experience cultural security. Furthermore, research that engages women from Indigenous communities and ensures that culturally specific methodology and experience is embedded in research processes, would improve the quality and outcome of future research to contribute to the evidence base for developing culturally secure maternity services for Indigenous women.

We note some limitations associated with the scoping review. Firstly, it was difficult to determine which studies to include. Some studies did not always report the stage of the perinatal period in which the research was undertaken or the geographical location. Unless these factors were explicitly reported, we did not include them in the study. Secondly, we were primarily interested in whether mothers' received culturally secure care from midwives for the specific purpose of providing maternity care and or support in the delivery of

maternity care. As such, our results largely reflect this even though many studies reported experiences of other health service providers. Thirdly, we did not find any journal articles from New Zealand that meet our criteria. We believe this may be due to a number of factors including most of the studies in New Zealand studies were conducted in regional areas and that many of the studies included Pacific Islander women with Māori women not the primary focus of those studies. As such these were excluded from the scoping review. Lastly, this is a scoping review and, by nature, not as extensive as a systematic review. However, we did search a number of databases and reference lists to ensure we captured the majority of the research related to our search criteria.

CONCLUSION

Having undertaken an extensive search of the literature identified by the scoping review criteria, we identified 25 studies that met our inclusion criteria in relation to what is known about culturally secure maternity care for Indigenous mothers in urban locations. Based on the number of studies we found on the experience of Indigenous women receiving care during the perinatal period, the next logical step would be to complete a qualitative systematic review or evidence synthesis to critically assess these experiences. As many of the studies reflected both positive and negative experiences; understanding what care is delivered well and where improvements need to be made is important to informing next steps. Other areas of research include future studies aimed at comprehensively measuring the outcomes of co-designed services in which Indigenous women and health services providers use culturally appropriate methodologies and incorporate culturally defined protocols. When this approach is taken, there is potential to inform and influence the development of specific culturally secure maternity services which will effectively support the self-determination of Indigenous women.

FIGURE LEGEND

Figure 1: Flow diagram of selected studies

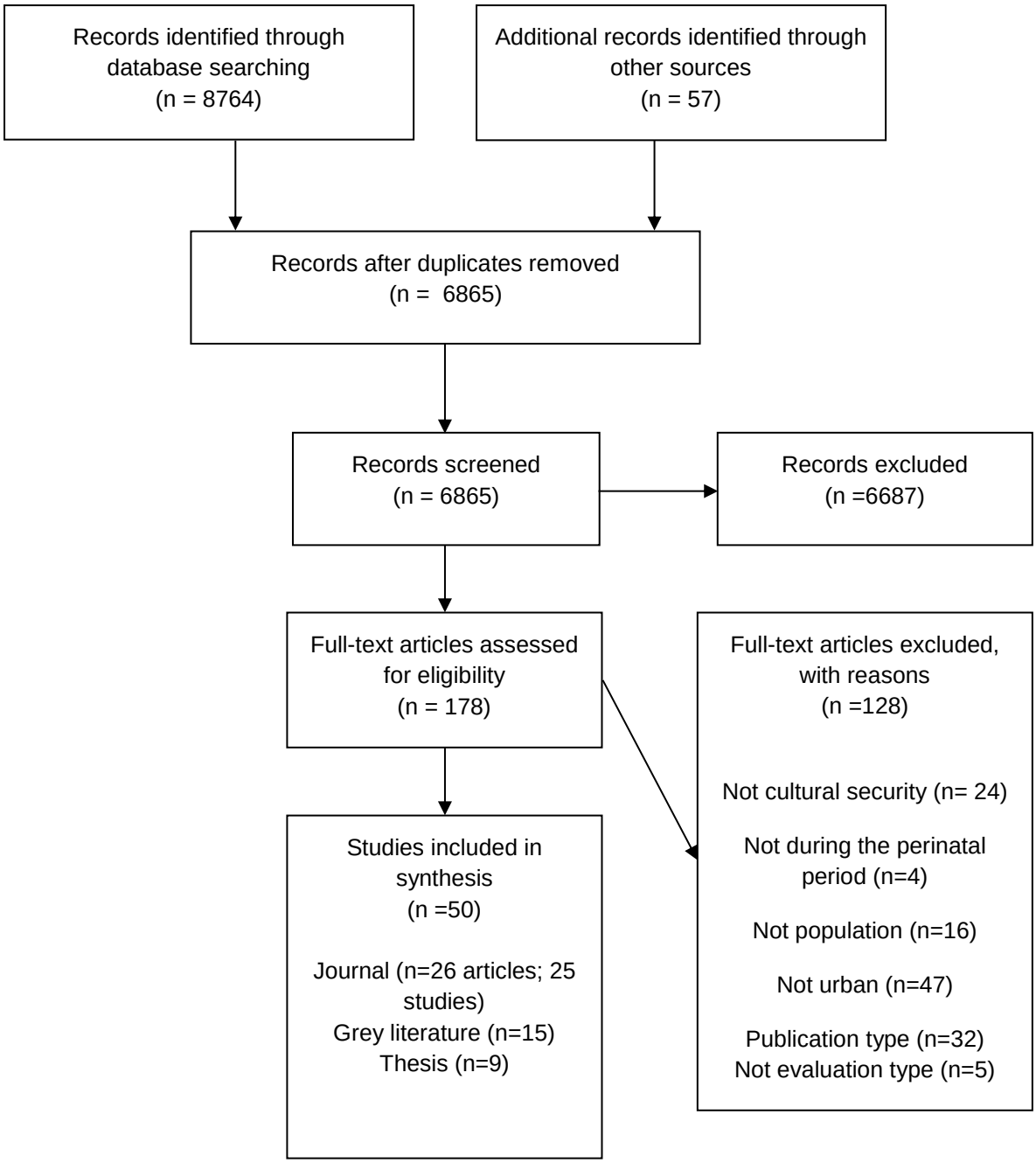
Records identified through database searching (n = 8764)
Additional records identified through other sources (n = 57)
Records after duplicates removed (n = 6865)
Records screened (n = 6865)
Records excluded (n =6687)
Full-text articles assessed for eligibility (n = 178)
Full-text articles excluded, with reasons (n =128)
Not cultural security (n= 24)
Not during the perinatal period (n=4)
Not population (n=16)
Not urban (n=47)
Publication type (n=32)
Not evaluation type (n=5)
Studies included in synthesis (n =50)
Journal (n=26 articles; 25 studies)
Grey literature (n=15)
Thesis (n=9)

Table 1: SPIDER acronym

Component	Definition
S - Sample	The sample/population of interest
PI - Phenomenon of Interest	Encompasses behaviours, experiences, and interventions
D - Design	Specific study designs within the research type
E - Evaluation	Experiences, perceptions, health outcomes
R - Research Type	Three research types could be searched for qualitative, quantitative, and mixed methods

Table 2: Characteristics of studies

First author and publication year	Study design	Qualitative methodology or study design	Country	Aim	Population and sample size	Perinatal period
1. Chamberlain (2000)[19]	Qualitative	Grounded theory	Canada	Describe the effect of transferring Canadian Inuit women out of their communities for birth	Mothers (n=20); Fathers (n=3); Community members (n=5)	Intrapartum (or birthing)
2. Davies (2001)[20], Prater (2002)[32]	Evaluation	N/A	USA	Determine the effectiveness of the program and implications for perinatal practice	Native American mothers (n=43); Lamaze class participants (n=11); and agency and program staff (n=17)	Antenatal; Postnatal
3. Minniecon (2003)[30]	Qualitative	Descriptive study	Australia	Identify barriers that exist for Aboriginal and Torres Strait Islander women accessing mainstream antenatal and postnatal services as well as existing barriers with hospital staff	Aboriginal and Torres Strait Islander women (n=5)	Antenatal; Intrapartum (or birthing); Postnatal
4. Jan (2004)[24]	Evaluation	Participatory study	Australia	Conduct a holistic economic evaluation of an Aboriginal community (Daruk)-controlled midwifery service in Western Sydney	Quantitative study: non-RCT of births between October 1990-December 1996 Intervention: Aboriginal women who were seen at Daruk (n=185) Control: Aboriginal women who received antenatal care at Nepean or Blacktown hospitals (n=195) Qualitative study: Aboriginal women who used the service (six focus groups of between 10 and 15 women), key stakeholders from Aboriginal and mainstream health services (n=35); meetings with Daruk programme providers (n=4)	Antenatal
5. Smith (2006)[35]	Qualitative	Case study	Canada	Determine community based stakeholder views on care during pregnancy and parenting	Community-based leaders, health service providers (not midwives), community members(Total n=73; Aboriginal (n=44); non-Aboriginal (n=66)	Antenatal; Intrapartum (or birthing); Postnatal
6. Smith (2007)[36]	Qualitative	Case study	Canada	Exploration of stakeholders and women's pregnancy and birth experiences	Community-based leaders, health service providers (not midwives), community members (Total n=57; Aboriginal (n=35); non-Aboriginal (n=22)	Antenatal; Intrapartum (or birthing); Postnatal
7. Valdez (2009)[37]	RCT	N/A	USA	Determine if medical students' attendance at specialized prenatal clinic would impact on their awareness of and comfort in discussing traditional and unique values of Native American women during pregnancy	Intervention: 3rd year medical students attended a urban (n=29) or rural (n=43) antenatal clinic at Indigenous health services Control: 3rd year medical students who only had contact with Native American families during hospital labour and delivery unit or obstetric triage (n=63)	Antenatal

8.	Dietsch (2010)[22]	Qualitative	Exploratory study	Australia	Explore the experience of women who are required to travel away from their communities to birth	Forty-two participants (six of whom identified as Aboriginal) were interviewed in 2007 and 2008 from all over rural and remote NSW. An in-depth case study of an Aboriginal mother in hospital was reported.	Intrapartum (or birthing); Postnatal
9.	Kornelsen (2010)[28]	Mixed methods	Participatory study	Canada	Understand the impact of rural maternity unit closures on First Nations Women required to be evacuated to other locations for childbirth	Quantitative study: Aboriginal women surveyed (n=55) Qualitative study: Aboriginal women (n=12)	Postpartum
10.	Reibel (2010)[34]	Audit	N/A	Australia	Ascertain the usage frequency and characteristics of antenatal services used by Aboriginal women in Western Australia	Health services (Total n=42; Aboriginal specific service (n=18); non-Aboriginal specific (n=24)	Antenatal
11.	Dietsch (2011)[21]	Qualitative	Descriptive study	Australia	Explore the mental health of postnatal Aboriginal women who leave their communities to birth	Aboriginal women (n=3); Father (n=1)	Postnatal
12.	Homer (2012)[23]	Mixed methods	Descriptive study	Australia	Determine whether the Malabar services was meeting the maternity needs of women and staff working within the service	Quantitative study: Cohort Aboriginal and Torres Strait Islander women who had attended the service during their pregnancy and gave birth during 2007 and 2008 (n=99) Qualitative study: Aboriginal mothers (n=7)	Antenatal; Postnatal
13.	Kildea (2012)[26]	Mixed methods	Comparative study	Australia	Identify the strengths and challenges of the Murri Clinic and make recommendations for future development.	Quantitative study: non-RCT Intervention: Indigenous women who participated in Murri Clinic (n=367) Control: Standard care (n=414) Qualitative study: Service users (n=46 total; n=38 completed surveys; n=8 interviews); Staff (n= 157 total; n=147 surveys; n=10 interviews); External stakeholders (n=17 interviews)	Antenatal; Intrapartum (or birthing); Postnatal
14.	Murphy (2012)[31]	Evaluation	N/A	Australia	Evaluate if the Aboriginal Maternal and Infant Health Service (AMIHS) Program is achieving its goals in its provision of antenatal and postnatal care	Aboriginal women attending AMIHS. Specific numbers not provided.	Antenatal; Intrapartum (or birthing); Postnatal
15.	Varcoe (2013)[38]	Qualitative	Ethnography	Canada	Understand rural Aboriginal women's experiences of maternity care	Individual interviews: First nation mothers (n=66) and father (n=1); Health care /community leaders (e.g. physicians, CEOs) (n=9) Focus groups: First nation 42 mothers (n=42 and fathers (n=5); First Nation elders (n=11); Youth (n=5) Community meeting and observations and invited participation at community events was also completed.	Antenatal; Intrapartum (or birthing); Postnatal

16.	Bar-Zeev (2014)[15]	Mixed methods	Comparative study	Australia	Assess adherence to antenatal guidelines by clinicians and identify factors affecting the quality of antenatal care delivery	Quantitative study: Cohort of Aboriginal mothers from two communities who gave birth between 2004-2006 (n=412) Qualitative study: Clinicians involved in the provision of antenatal care in the health centres: District Medical Officers; Remote area nurses; Midwives; Aboriginal health worker; Clinical service managers; Outreach visiting midwives; Obstetric doctors (n=27). Two participants were Aboriginal or Torres Strait Islander descent.	Antenatal
17.	Kelly (2014)[25]	Qualitative	Descriptive study	Australia	Explore the experiences of women who participated in a Continuity of Care journey with an Aboriginal and Torres Strait Islander Bachelor of Midwifery student	Aboriginal women (n=4)	Antenatal; Intrapartum (or birthing); Postnatal
18.	Reibel (2015)[33]	Qualitative	Descriptive study	Australia	Understanding women's views on pregnancy care	Aboriginal Pregnant or birth mothers (n=28); Senior women and community members (n=36; majority Aboriginal number not provided); Service providers (Total n=20; Aboriginal (n=12); Non-Aboriginal (n=8)	Antenatal
19.	Bertilone (2016)[16]	Qualitative	Participatory study	Australia	Identify elements of the Aboriginal Maternity Group Practice Program that contributed to the provision of a culturally competent service	Staff interviews (n=15), program partners completed surveys (n=22 individuals from 14 partner organisations), and clients completed surveys (n=16). Seven staff, all 16 clients, and 8 individuals from partner organisations were Aboriginal.	Antenatal; Intrapartum (or birthing)
20.	Brown (2016)[17]	Qualitative	Phenomenology	Australia	Explore the lived experiences of women accessing labour and birth care in the standard hospital care system	Indigenous women who have given birth in South Australia (n=14)	Intrapartum (or birthing)
21.	Brown (2016)[18]	Qualitative	Phenomenology	Australia	Explore the lived experiences of midwives providing care in the standard hospital care system	Midwives (n=13). Not reported whether any women were Aboriginal.	Intrapartum (or birthing)
22.	Kildea (2016)[27]	Narrative review	N/A	Australia	Review of the Australia's National Maternity Services Plan (2010-2015)	N/A	Antenatal; Intrapartum (or birthing); Postnatal
23.	West (2016)[39]	Qualitative	Narrative inquiry	Australia	To explore Indigenous students perceptions of providing continuity of midwifery care to Indigenous women whilst undertaking a Bachelor of Midwifery	Indigenous midwifery students (n=3)	Antenatal; Intrapartum (or birthing); Postnatal

24.	Middleton (2017)[29]	Evaluation	Descriptive study	Australia	Evaluate implementation and outcomes of the Aboriginal Family Birthing Program (AFBP)	Quantitative study: non-RCT Intervention: Aboriginal women attended the AFBP (n=486) Control: Aboriginal women who did not attend AFBP (n=1452) Qualitative study: Staff (Total (n=107); Aboriginal Maternal and Infant Care workers/trainees (n=20); Midwives (n=35); Medical practitioners (n=8); Health service managers (n=25), Health/allied health professionals (n=12); AFBP educators (n=4); Aboriginal support workers (n=3)); Aboriginal clients (n=20)	Antenatal; Intrapartum (or birthing); Postnatal
25.	Kildea (2018)[40]	Case study consultation paper	Case study	Australia	A demonstration of how Birthing on Country principles can be applied to the urban setting.	Workshop including service providers, researchers, and community members	Antenatal; Intrapartum (or birthing)

N/A = Not applicable; non-RCT = non randomised control trial

Table 3: Qualitative CASP assessments

First author and publication year	Was there a clear statement of the aims?	Is the qualitative methodology appropriate?	Was the research design appropriate?	Was the recruitment strategy appropriate?	Was the data collected in way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Was the research valuable?
1. Chamberlain (2000)[19]	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes
2. Davies (2001)[20], Prater (2002)[32]	Yes	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Can't tell	Yes	Yes
3. Minniecon (2003)[30]	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Can't tell	No	No
4. Jan (2004)[24]	Yes	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes
5. Smith (2006)[35]	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Smith (2007)[36]	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Dietsch (2010)[22]	No	Yes	Can't tell	Can't tell	Yes	Can't tell	Yes	Yes	No	Yes
8. Kornelsen (2010)[28]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9. Dietsch (2011)[21]	Yes	Yes	Can't tell	Can't tell	Yes	Can't tell	Yes	Yes	No	Yes
10. Homer (2012)[23]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11. Kildea (2012)[26]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12. Varcoe (2013)[38]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13. Bar-Zeev (2014)[15]	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
14. Kelly (2014)[25]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15. Reibel (2015)[33]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16. Bertilone (2016[16])	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17. Brown (2016)[17]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18. Brown (2016)[18]	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
19. West (2016)[39]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
20. Middleton (2017)[29]	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Total Yes	17	20	18	15	19	14	18	18	17	19
Total Can't tell	1	0	2	5	1	6	1	2	0	0
Total No	2	0	0	0	0	0	1	0	3	1

Table 4: Cultural security assessments

First author and publication year	Were Indigenous women's cultural needs in their pregnancy/birth journey identified or described?	Did Indigenous women express/identify any examples of feeling culturally unsafe during instances of perinatal care	Were traditional birthing on country protocols identified and/or described?	Were Indigenous women's expectations of midwives cultural competence identified?	Were aspects of cultural competence of midwives identified?	Were standards for measuring evaluating the cultural security/safety of maternity organisations identified?
1. Chamberlain (2000)[19]	Yes	Yes	No	No	Yes	No
2. Davies (2001)[20] Prater (2002)[32]	Yes	No	No	No	No	No
3. Minniecon (2003)[30]	Yes	Yes	No	No	No	No
4. Jan (2004)[24]	Yes	Yes	No	No	No	No
5. Smith (2006)[35]	Yes	Yes	No	No	No	No
6. Smith (2007)[36]	Yes	No	No	No	No	No
7. Valdez (2009)[37]	No	No	No	No	No	No
8. Dietsch (2010)[22]	Yes	Yes	No	No	No	No
9. Kornelsen (2010)[28]	Yes	Yes	No	No	No	No
10. Reibel (2010)[34]	Yes	N/A	No	No	No	Yes
11. Dietsch (2011)[21]	Yes	Yes	No	No	No	No
12. Homer (2012)[23]	Yes	No	No	Yes	Yes	No
13. Kildea (2012)[26]	Yes	Yes	No	Yes	Yes	No
14. Murphy (2012)[31]	Yes	N/A	No	No	No	No
15. Varcoe (2013)[38]	Yes	Yes	No	No	No	No
16. Bar-Zeev (2014)[15]	Yes	N/A	No	No	No	No
17. Kelly (2014)[25]	Yes	No	No	Yes	Yes	No
18. Reibel (2015)[33]	Yes	No	No	No	No	No
19. Bertilone (2016[16])	Yes	N/A	No	Yes	Yes	Yes
20. Brown (2016)[17]	Yes	Yes	No	Yes	Yes	No
21. Brown (2016)[18]	Yes	N/A	No	No	Yes	No
22. Kildea (2016)[27]	Yes	N/A	No	No	Yes	No
23. West (2016)[39]	Yes	No	No	No	No	No
24. Middleton (2017)[29]	Yes	No	No	No	Yes	No
25. Kildea (2018)[40]	Yes	N/A	Yes	No	No	Yes
Total Yes	24	9	1	5	10	3
Total No	1	9	24	20	15	22

N/A = not applicable

Table 5: Summary of reports and government documents related to cultural security in urban areas

First author and publication year	Location	Perinatal period	Aim of document	Involvement of cultural security in practice
1. NSW Health (2005)[51]	New South Wales, Australia (state-wide)	Antenatal, intrapartum and postnatal	Evaluate the NSW Aboriginal Maternal and Infant Health Strategy (AMIHS). The AMIHS aimed to improve the health of Aboriginal women during pregnancy and decrease perinatal morbidity and mortality.	The AMIHS teams provide holistic, culturally appropriate services within a primary health care model. The partnership of Aboriginal health workers and midwives is a crucial element of this.
2. Native Women's Association of Canada (2007)[50]	Canada (country-wide)s	Antenatal, intrapartum	To highlight issues related to reproductive health, midwifery, and birthing centres for Aboriginal women in Canada, and present examples of Aboriginal-women-specific policies and programs that are considered successful	Aboriginal midwifery is described which includes the need for support and respect so that women can deliver safely with empowerment and dignity in a culturally relevant way.
3. Reibel (2009)[54]	Western Australia (state-wide)	Antenatal	To report on outcomes of an audit of antenatal services used by Aboriginal women in Western Australia and review current curricular for undergraduate nursing, midwifery and medical education and continuing professional development activities with regards to the inclusion of Aboriginal health content	The cultural responsiveness of antenatal service delivery was examined, and a review of Aboriginal specific content in professional education and continuing professional development was conducted. Benchmarks for planning culturally responsive antenatal services were provided.
4. Department of Health and Ageing (2009)[42]	Australia (country-wide)	Antenatal, intrapartum and postnatal	To report on the Maternity Services Review, which aimed to elicit a range of perspectives on maternity services in Australia, identify gaps, determine what changes is needed, and inform the priorities for a national action plan.	A key issue discussed in the review was the need for culturally safe and community-centred models of care. Examples of culturally appropriate models of maternity services in Australia were provided.
5. Health Council of Canada (2011)[46]	Canada (country-wide)	Prenatal, antenatal, postpartum	To provide a commentary on Aboriginal maternal and child health issues across Canada.	Government initiatives that aim to integrate modern medicine and culturally relevant practices were discussed. Gaining access to culturally sensitive care was identified as an important theme from stakeholder meetings. Examples were provided
6. Ministry of Health (2011)[48]	New Zealand (country-wide)	Antenatal, intrapartum and postnatal	To outline a set of standards to guide the planning, funding and monitoring of maternity services by the Ministry of Health and District Health Boards.	Included in the set of standards is maternity services that are culturally safe and appropriate. This is measured by consumer feedback and District Health Boards are required to demonstrate in their annual reports how they have responded to consumer feedback.
7. Kruske (2012)[47]	Australia (country-wide)	Antenatal	To identify the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people.	The key components of culturally competent care were identified. They included the physical environment, specific programs, Aboriginal and Torres Strait Islander workforce, continuity, collaboration, communication, attitudes and respect, educational programs, relationships, informed choice, tools to measure cultural competence, specific guidelines, culturally appropriate health promotion and behaviour change activities, engaging consumers and governance.
8. Kildea (2013)[4]	Australia (country-wide)	Antenatal, intrapartum and postnatal	A review of 'Birthing on Country' models	This review provides important evidence which supports that a Birthing on Country model would provide improvements in maternal and infant outcomes for Aboriginal and Torres Strait Islander women.

9.	Moewaka (2013)[49]	New Zealand (country-wide)	Antenatal, intrapartum	To identify Māori life course research priorities, with a specific focus on wellbeing at the early stage of life, hapū ora (pregnancy health), covering the fetal/gestational and neonatal periods	Maternity services for Māori women were examined, which included the provision of services that are clinically and culturally safe, based on partnership, information and choice.
10.	Pacific Perspectives (2013)[52]	South Auckland, New Zealand	Antenatal, intrapartum and postnatal	To facilitate, collate, analyse and document information generated from Maternity Care Consumer Panel discussions convened by Counties Manukau Health, and interviews with Māori mothers facing barriers to accessing maternity care. The aim was to identify what is working well with the current maternity care system, and provide recommendations.	One of the key themes was culturally appropriate nutritional interventions to reduce pregnancy obesity. Barriers to nutrition were identified. Input from mothers was sought to assist Counties Manukau Health plan and implement actions to improve the cultural appropriateness of its maternity care services.
11.	CATSINaM (2014)[43]	Australia (country-wide)	Antenatal, intrapartum and postnatal	To report on the National Summit on Cultural Safety in Nursing and Midwifery. The aim of the Summit was to explore the strengths and weaknesses of current work on cultural safety in nursing and midwifery, and identify what needs to occur to collectively achieve cultural safety, recruitment and retention of Aboriginal and Torres Strait Islander students and graduates, and better health outcomes for Aboriginal and Torres Strait Islander peoples.	An overview of cultural safety is provided, how cultural safety is practised in different contexts, and how it is practised in Australia. A Leaders in Indigenous Nursing and Midwifery Education Network was proposed, to focus on supporting recruitment and retention of Aboriginal and Torres Strait Islander peoples in nursing and midwifery, and raising the profile of and increasing access to cultural safety for Aboriginal and Torres Strait Islander nurses and health service users.
12.	Department of Health (2015)[44]	Australia (country-wide)	Antenatal, intrapartum and postnatal	To provide an overview of the Implementation Plan for the Aboriginal and Torres Strait Islander Health Plan 2013-2023.	There is a focus on ensuring the health system provides culturally safe access to quality early intervention and treatment services and integrated clinical services.
13.	Ampersand Health Science Writing (2017)[41]	Australia (country-wide)	Antenatal, intrapartum and postnatal	To identify how holistic antenatal care can be provided to meet the needs of Aboriginal and Torres Strait Islander women.	Successful models of care were reviewed which had positive outcomes on the level of culturally appropriate and culturally sensitive care provided by health services staff, and cultural competency education and training was reviewed.
14.	Para (2017)[53]	Tairāwhiti region, New Zealand	Antenatal, intrapartum and postnatal	To inform the progress of the Tairāwhiti Maternity Quality & Safety Programme (MQSP).	A key aim of the programme is to provide evidence informed/based maternity services which are culturally-appropriate. This includes encouraging midwives to complete the Quality and Leadership Programme, engage consumers to identify barriers to access and/or engagement with services, and produce a curriculum and toolkit to grow the number and breadth of culturally appropriate pregnancy and parenting programmes.
15.	Department of Health (2018)[45]	Australia (country-wide)	Antenatal	To present the national Clinical Practice Guidelines on Pregnancy Care which provide evidence-based recommendations to support high quality, safe antenatal care in all settings.	A holistic approach to antenatal care is promoted that is woman-centred, culturally sensitive and enables women to participate in informed decision-making at all stages of their care. Recommendations for pregnancy care for Aboriginal and Torres Strait Islander women are reported which include cultural safety training for health professionals.

CATSINaM= Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

Table 6: Summary of theses related to cultural security in urban areas

Author and publication year	Location	Perinatal period	Aim of document	Involvement of cultural security in practice
1. Beale (1996)[55]	Sydney, Australia	Antenatal, intrapartum and postnatal	To discover what the cultural needs of urban Aboriginal women are when presenting to a hospital for confinement and postnatal care.	The cultural needs of Aboriginal women were explored, and recommendations for promoting culturally sensitive practices throughout the perinatal period are provided.
2. Hiebert (2003)[57]	Manitoba, Canada Ontario, Canada Texas, USA	Intrapartum	To integrate scientific investigation and action to develop a community-based childbearing model in Nisichawayasihk Cree Nation.	The findings suggest a loss of cultural childbirth practices in this population and a lack of safe, culturally-relevant practices in health centres due to colonisation. The integration of cultural knowledge and traditions into childbearing practices is recommended and ways of doing so discussed.
3. Smith (2006)[61]	British Columbia, Canada	Antenatal, intrapartum and postnatal	To describe community-based stakeholders' perspectives on their experiences improving care for pregnant and parenting Aboriginal women and families.	Cultural safety was raised as an important issue in the context of care during pregnancy and parenting. Participants' stories offer a prescription for action in bringing culture back, and greater stakeholder involvement in governance of care is recommended to achieve safe and responsive care.
4. Whitty-Rogers (2006)[62]	Nova Scotia, Canada	Antenatal, intrapartum	To provide new knowledge and a greater understanding about Mi'kmaq women's childbirth experiences.	The need for culturally competent care both during the prenatal and intrapartum periods was highlighted, with participants expressing a lack of personal knowledge about childbirth, communication barriers, and a lack of cultural awareness among nurses. Health facilities outside native communities were deemed to fail in providing culturally appropriate care and education and collaboration with stakeholders to improve care was recommended.
5. Woodman (2006)[63]	Nova Scotia, Canada	Antenatal	To explore Aboriginal women's experiences and perceptions of pregnancy in Nova Scotia in order to determine how these were influenced by social contexts.	A lack of cultural competence among health professionals was raised as a barrier to holistic pregnancy care. Prenatal classes were also a topic of interest as some women expressed they had not benefitted from them as they were not culturally appropriate. Culturally competent information is recommended, as well as training in cultural competence for health educators and physicians.
6. Payne (2010)[59]	Northwestern Ontario, Canada	Antenatal, intrapartum and postnatal	To explore whether the Sioux Lookout Meno Ya Win Health Centre (SLMHC) focus on birthing meanings, beliefs, attitudes, and practices as described by elders may contribute to the development of a more culturally safe hospital birth model.	A transcultural approach to maternal and newborn care, aimed at understanding and involving birthing beliefs, practices and meanings into the health care setting, is necessary in achieving cultural safety. The SLMHC is considered a good initiative to improve cultural safety for First Nations peoples.
7. Phillips-Beck (2010)[60]	Manitoba, Canada	Antenatal, intrapartum	To report on the childbirth experiences of women and their families from a northern isolated community in Manitoba – who had to leave or were about to leave home to give birth.	Culture was highlighted as a central component of care, and a framework for improving child birth care for First Nation women was developed. This family centred approach acknowledges the voice of women, and respects cultural beliefs and practices.

8.	Olson (2013)[58]	Manitoba, Canada	Intrapartum	To understand how risks are created and managed within multiple settings of maternity care for First Nations women in Manitoba.	Women's experiences of evacuation (giving birth in urban hospitals) were provided, which included risks about giving birth in their communities' vs a hospital setting. Such risks include medical risks, emotional risks and isolation (being away from family), and the role of traditional birthing ceremonies. Key issues were risk, responsibility and cultural safety.
9.	Brown (2016)[56]	Adelaide, South Australia	Intrapartum	To explore the lived experiences described by Aboriginal women who gave birth in the standard hospital care system. An additional aim included an exploration of the lived experiences described by midwives providing care in the standard hospital care system to Aboriginal women at a large tertiary teaching hospital in South Australia.	Some of the Aboriginal women's cultural needs were identified and culturally unsafe practices highlighted, in regards to giving birth in standard care. Potential threats to the cultural safety of Aboriginal women are identified and suggestions for improvements in midwifery understandings of cultural safety were provided, as well as how to support midwives in their practice.

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