McMaster University | Health Forum

Rapid evidence synthesis appendices

Features, impacts, and views and experiences of equity, diversity, and inclusion training and leadership initiatives in health science institutions on individual-, community-, and organizational-level outcomes

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Appendices

Appendix 1: Methodological details

Background to the rapid evidence synthesis

This rapid evidence synthesis mobilizes both global and local research evidence about a question submitted to the McMaster Health Forum's Rapid Response program. Whenever possible, the rapid evidence synthesis summarizes evidence drawn from existing evidence syntheses and from single research studies in areas not covered by existing evidence syntheses and/or if existing evidence syntheses are old or the science is moving fast. A systematic review is a summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select, and appraise research studies, and to synthesize data from the included studies. The rapid evidence synthesis does not contain recommendations, which would have required the authors to make judgments based on their personal values and preferences.

The Forum produces timely and demand-driven contextualized evidence syntheses such as this one that address pressing health and social system issues faced by decision-makers (see our website for more details and examples). This includes evidence syntheses produced within:

- days (e.g., rapid evidence profiles or living evidence profiles)
- weeks (e.g., rapid syntheses that at a minimum include a policy analysis of the best-available evidence, which can be requested in a 10-, 30-, 60-, or 90-business-day timeframe)
- months (e.g., full evidence syntheses or living evidence syntheses with updates and enhancements over time)

This rapid evidence synthesis was prepared over a 60-business day timeframe and involved four steps:

1) submission of a question from a policymaker or stakeholder (in this case, McMaster University's Faculty of Health Sciences)
2) engaging subject matter expert and citizen partners
3) identifying, selecting, appraising, and synthesizing relevant research evidence about the question
4) drafting the rapid evidence synthesis in such a way as to present concisely and in accessible language the research evidence.

Engaging subject matter experts and citizen partners

At the beginning of each rapid evidence synthesis and throughout its development, we engage a subject matter expert and citizen partners, who help us to scope the question and ensure relevant context is taken into account in the summary of the evidence.

Identification, selection, quality appraisal, and synthesis of evidence

For this rapid evidence synthesis, we collaborated with a Health Research Librarian from McMaster University to develop a search strategy to help us identify:

1) evidence syntheses
2) protocols for evidence syntheses that are underway
3) single studies (when no guidelines or evidence syntheses are identified or when they are older).

The Health Research Librarian conducted the search on 17 March 2025 in the following databases: AMED, APA PsycINFO, CINAHL, EDM Reviews, Embase, Global Health, Ovid Emcare, Ovid Healthstar, and Ovid MEDLINE. The search strategy combined controlled vocabulary and free-text terms related to health professionals, academic settings, and EDI-related interventions focused on training and leadership (e.g., anti-racism, diversity training, inclusive leadership). Filters were applied to include relevant study designs such as cohort studies, case series, randomized controlled trials, systematic reviews, and qualitative research. Editorials, letters, comments, and case reports were excluded. We limited the search to publication dates between 2015 and 2025. The full search strategy is available by request. We retrieved 3,654 evidence documents from the search.

We imported the search results into Covidence, which automatically removed 1,233 duplicates, leaving 2,421 evidence documents for title and abstract screening (level one, single reviewer), during which 1,439 references were excluded based on the eligibility criteria. During full-text screening (level two, single reviewer), 981 evidence documents were assessed, 845 of which were excluded, with 134 evidence documents ultimately included in the rapid evidence synthesis. During the screening process, we conducted multiple calibration exercises with five research team members to ensure consistency in applying our inclusion and exclusion criteria. Any disagreements were resolved by consensus or with the input of a reviewer on the team. We excluded evidence documents for one or more of the following reasons: 1) did not explicitly discuss an EDI training or leadership initiative; 2) was not an empirical study; 3) ineligible publication type (e.g., conference abstract); 4) did not address health-related trainees, faculty, staff, or leadership in health sciences institutions; 5) focused only on low- and middle-income country settings; 6) no full-text available; and 7) published before 2015. The excluded list of evidence documents is available by request.

Given the high volume of literature identified for the rapid evidence synthesis, an evidence map was developed to highlight the distribution of the existing research on this topic. This mapping approach provided a breadth and scope of the available evidence, showcasing key areas of research concentration and gaps where evidence is limited. The evidence documents were organized in Appendix 2 by the features of the EDI training or leadership initiative (according to the dimensions of the organizing framework), outcomes assessed, whether the literature focused only on a description of the EDI training or leadership, literature with an explicit focus on knowledge mobilization efforts and capacity building efforts, and corresponding citations. An evidence document may have been categorized more than once as they often described multiple features. An excel version of the evidence map is available by request.

Additionally, for each evidence synthesis we included, we documented the dimension of the organizing framework with which it aligns, declarative title (e.g., hyperlinked to the evidence source) and key findings, living status, methodological quality (using AMSTAR), last year the literature was searched (as an indicator of how recently it was conducted), availability of GRADE profile, and equity considerations using PROGRESS-Plus.

Two reviewers independently appraise the methodological quality of evidence syntheses that are deemed to be highly relevant using the first version of the AMSTAR tool. Two reviewers independently appraise each synthesis, and disagreements are resolved by consensus with a third reviewer if needed. AMSTAR rates overall methodological quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. High-quality evidence syntheses are those with scores of eight or higher out of a possible 11, medium-quality evidence syntheses are those with scores between four and seven, and low-quality evidence syntheses are those with scores less than four. It is important to note that the AMSTAR tool was developed to assess evidence syntheses focused on clinical interventions, so not all criteria apply to those pertaining to health-system arrangements or implementation strategies. Furthermore, we apply the AMSTAR criteria to evidence syntheses addressing all types of questions, not just those addressing questions about effectiveness, and some of these evidence syntheses addressing other types of questions are syntheses of qualitative studies. While AMSTAR does not account for some of the key attributes of syntheses of qualitative studies, such as whether and how citizens and subject-matter experts were involved, researchers' competency, and how reflexivity was approached, it remains the best general quality-assessment tool of which we're aware. Where the denominator is not 11, an aspect of the tool was considered not relevant by the raters. In comparing ratings, it is therefore important to keep both parts of the score (i.e., the numerator and denominator) in mind. For example, an evidence synthesis that scores 8/8 is generally of comparable quality to another scoring 11/11; both ratings are considered 'high scores.' A high score signals that readers of the evidence synthesis can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the evidence synthesis should be discarded, merely that less confidence can be placed in its findings and that it needs to be examined closely to identify its limitations. (Lewin S, Oxman AD, Lavis JN, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 8. Deciding how much confidence to place in a systematic review. *Health Research Policy and Systems* 2009; 7 (Suppl1): S8.)

For Canadian-based single studies, we documented the dimension of the organizing framework with which it aligns, publication date, jurisdiction studied, methods used, a description of the sample and intervention, declarative title and key findings, and equity considerations using PROGRESS-Plus. We then used this extracted information to develop a synthesis of the key findings from the included syntheses and Canadian-based single studies.

During this process we include published, pre-print and grey literature. We do not exclude documents based on the language of a document. However, we are not able to extract key findings from documents that are written in languages other than Chinese, English, French, Portuguese, or Spanish. We provide any documents that do not have content available in these languages in an appendix containing documents excluded at the final stages of reviewing. We excluded documents that did not directly address the research questions and the relevant organizing framework. All of the information provided in the appendix tables was taken into account by the authors in describing the findings in the rapid evidence synthesis.

Appendix 2: Mapping of all the identified evidence syntheses and single studies

Features of EDI initiatives	Outcomes assessed					Literature focused only on description of training or leadership initiative (i.e., no outcomes assessed)	Literature with an explicit focus on knowledge mobilization and capacity building for EDI initiatives
	Outcomes related to broader communities serviced by institutions	**Organizational outcomes**	**Individual-level outcomes**	**Cost-relative outcomes**	**Implementation barriers and facilitators**		
EDI overall							

Formal governance structures and processes supporting EDI	Physical and mental health outcomes
	• Single studies (1)
	
	Development of high-quality trusting relationships with local organizations
	• Evidence syntheses
	  ○ Low quality (2)
	• Single studies (3)
	
	Collaboration across sectors
	• Evidence syntheses
	  ○ Medium-quality (4)
	
	Research
	• Evidence syntheses
	  ○ Medium quality (4)
	  ○ Low quality (2)
	• Single studies (5)
		Innovation and competitive advantage
		• Single studies (3)
		
		Reputation
		• Evidence syntheses
		  ○ Low quality (2)
		
		Body of trainees
		• Evidence syntheses
		  ○ Low quality (2; 6)
		• Single studies (1; 3; 7-11)
		
		Workforce
		• Evidence syntheses
		  ○ Medium quality (4; 12)
		  ○ Low quality (2)
		• Single studies (1; 8; 13-17)
		
		Research
		• Evidence syntheses
		  ○ Low quality (2)
		• Single studies (3; 5)
			Views and experiences with the EDI initiative
			• Evidence synthesis
			  ○ Medium quality (4)
			  ○ Low quality (2; 6)
			• Single studies (1; 3; 5; 8; 11; 13; 16; 18-25)
			
			Views and experiences with respect to institutional climate
			• Evidence synthesis
			  ○ Low quality (2; 6)
			• Single studies (5; 8; 11; 15; 17; 19; 22; 26)
				• Single studies (27)	• Evidence syntheses
					  ○ Medium quality (4)
					  ○ Low quality (6; 12)
					• Single studies (1; 3; 7; 8; 11; 16; 18-24)
						• Single studies (28-30)	• Evidence syntheses
							  ○ Medium quality (4)
							  ○ Low quality (2; 12)
							• Single studies (1; 3; 5; 7; 10; 14; 15; 21; 23; 26; 28; 30)

Integration of EDI into strategic planning and decision-making processes	Physical and mental health outcomes
	• Single studies (31)
	
	Development of high-quality trusting
		Innovation and competitive advantage
		• Single studies (31; 34-36)
		
		Reputation
		• Evidence syntheses
			Views and experiences with the EDI initiative
			• Evidence syntheses
			  ○ Low quality (6)
			• Single studies (5; 13; 21; 23; 31-33; 37-39)
				–	• Evidence syntheses
					  ○ Low quality (6; 12)
					• Single studies (7; 21; 23; 32; 33; 38)
						• Evidence syntheses
						  ○ Low quality (40)
						• Protocol for evidence syntheses(41)
							• Evidence syntheses
							  ○ Low quality (6; 12)
							• Single studies (5; 10; 13; 15; 19; 21;

Features of EDI initiatives	Outcomes assessed					Literature focused only on description of training or leadership initiative (i.e., no outcomes assessed)	Literature with an explicit focus on knowledge mobilization and capacity building for EDI initiatives
	Outcomes related to broader communities serviced by institutions	**Organizational outcomes**	**Individual-level outcomes**	**Cost-relative outcomes**	**Implementation barriers and facilitators**		

	relationships with local organizations
	• Evidence syntheses
	  ○ Low quality (2)
	• Single studies (32)
	
	Collaboration across sectors
	• Single studies (31; 32)
	
	Research
	• Evidence syntheses
	  ○ Low quality (2)
	• Single studies (5; 33)
		○ Low quality (2)
		
		Body of trainees
		• Evidence syntheses
		  ○ Low quality (2; 6)
		• Single studies (7; 10)
		
		Workforce
		• Evidence syntheses
		  ○ Low quality (12)
		• Single studies (13; 15; 17; 31; 36; 37)
			Views and experiences with respect to institutional climate
			• Evidence syntheses
			  ○ Low quality (2; 6)
			• Single studies (17; 33)
						• Single studies (28; 30; 42)	23; 28; 30-33; 35-37; 39; 42-44)

Strengthening leadership competencies in EDI	Physical and mental health outcomes
	• Single studies (1; 31; 45; 46)
	
	Development of high-quality trusting relationships with local organizations
	• Evidence syntheses
	  ○ Low quality (2)
	
	Collaboration across sectors
	• Evidence syntheses
	  ○ Medium quality (4)
	• Single studies (31)
	
	Research
	• Evidence syntheses
	  ○ Low quality (2)
		Innovation and competitive advantage
		• Single studies (31; 34)
		
		Reputation
		• Evidence syntheses
		  ○ Low quality (2)
		
		Body of trainees
		• Evidence syntheses
		  ○ Medium quality (47)
		  ○ Low quality (2)
		• Single studies (1; 8; 46)
		
		Workforce
		• Evidence syntheses
		  ○ Low quality (2)
		  ○ Medium quality (4)
		• Single studies (1; 17; 31; 45; 48; 49)
			Views and experiences with the EDI initiative
			• Evidence syntheses
			  ○ Medium quality (4; 47)
			• Single studies (1; 8; 23; 33; 34; 45; 48-52)
			
			Views and experiences with respect to institutional climate
			• Evidence syntheses
			  ○ Low quality (2)
			• Single studies (8; 17; 31; 33; 46)
				–	• Evidence syntheses
					  ○ Medium quality (4; 47)
					• Single studies (1; 8; 23; 33; 34; 45; 46)
							• Evidence syntheses
							  ○ Medium quality (4; 47)
							  ○ Low quality (2)
							• Single studies (1; 4; 8; 23; 31; 33; 51)

Features of EDI initiatives	Outcomes assessed					Literature focused only on description of training or leadership initiative (i.e., no outcomes assessed)	Literature with an explicit focus on knowledge mobilization and capacity building for EDI initiatives
	Outcomes related to broader communities serviced by institutions	**Organizational outcomes**	**Individual-level outcomes**	**Cost-relative outcomes**	**Implementation barriers and facilitators**		
	○ Medium quality (4) • Single studies (33)						
Community engagement or partnerships with external actors with the aim of promoting EDI	Physical and mental health outcomes • Single studies (53; 54) Development of high-quality trusting relationships with local organizations • Evidence syntheses ○ Low quality (2) • Single studies (3; 54) Collaboration across sectors • Evidence syntheses ○ Medium quality (4) • Single studies (55-58) Research • Evidence syntheses ○ Low quality (2) ○ Medium quality (4) • Single studies (3; 56; 59)	Innovation and competitive advantage • Single studies (3; 43) Reputation • Evidence syntheses ○ Low quality (2) Body of trainees • Evidence syntheses ○ Medium quality (47; 60) ○ Low quality (2) • Single studies (3; 54-59; 61-72) Workforce • Evidence syntheses ○ Medium quality (4) ○ Low quality (2) • Single studies (17)	Views and experiences with the EDI initiative • Evidence syntheses ○ Medium quality (4; 47; 60) • Single studies (3; 55-57; 61; 64; 66-73) Views and experiences with respect to institutional climate • Evidence syntheses ○ Low quality (2) • Single studies (17; 26; 59; 62)	–	• Evidence syntheses ○ Medium quality (4; 47; 60) • Single studies (3; 59; 62; 70-73)	• Single studies (29; 44; 74-77)	• Evidence syntheses ○ Medium quality (4; 47) • Single studies (3; 26; 43; 56; 57; 59; 68; 71-73; 77)
Diversity-centred initiatives							
Training to enhance admission and recruitment processes	Physical and mental health outcomes • Single studies (45) Development of high-quality trusting	Innovation and competitive advantage • Single studies (3) Reputation • Evidence syntheses	Views and experiences with the EDI initiative • Evidence syntheses ○ Medium quality (78)	–	• Evidence syntheses ○ Medium quality (12) • Single studies (3; 7; 38; 45)	• Single studies (29; 30; 42; 77; 83)	• Evidence syntheses ○ Medium quality (12) ○ Low quality (2)

Features of EDI initiatives	Outcomes assessed					Literature focused only on description of training or leadership initiative (i.e., no outcomes assessed)	Literature with an explicit focus on knowledge mobilization and capacity building for EDI initiatives
	Outcomes related to broader communities serviced by institutions	**Organizational outcomes**	**Individual-level outcomes**	**Cost-relative outcomes**	**Implementation barriers and facilitators**		

	relationships with local organizations
	• Evidence syntheses
	  ○ Low quality (2)
	• Single studies (3)
	
	Research
	• Evidence syntheses
	  ○ Low quality (2)
	• Single studies (3)
		○ Low quality (2)
		
		Body of trainees
		• Evidence syntheses
		  ○ Low quality (2)
		  ○ Medium quality (78)
		• Single studies (3; 7; 9; 10; 79-82)
		
		Workforce
		• Evidence syntheses
		  ○ Low quality (2)
		  ○ Medium quality (12)
		• Single studies (14; 45)
			• Single studies (3; 38; 45)
			
			Views and experiences with respect to institutional climate
			• Evidence syntheses
			  ○ Low quality (2)
			• Single studies (79)
							• Single studies (3; 10; 30; 42; 77; 81)

Strengthen-ing hiring processes and career progression	Physical and mental health outcomes
	• Single studies (45)
	
	Development of high-quality trusting relationships with local organizations
	• Evidence syntheses
	  ○ Low quality (2)
	
	Collaboration across sectors
	• Evidence syntheses
	  ○ Medium quality (4)
	
	Research
	• Evidence syntheses
	  ○ Low quality (2)
	  ○ Medium quality (4)
		Innovation and competitive advantage
		• Evidence synthesis protocol (84)
		• Single studies (35; 43)
		
		Reputation
		• Evidence syntheses
		  ○ Low quality (2)
		
		Body of trainees
		• Evidence syntheses
		  ○ Medium quality (78)
		  ○ Low quality (2; 6)
		
		Workforce
		• Evidence syntheses
		  ○ Medium quality (4; 85)
		  ○ Low quality (2)
		• Single studies (13; 15; 37; 45; 48; 49)
			Views and experiences with the EDI initiative
			• Evidence syntheses
			  ○ Medium quality (78)
			  ○ Low quality (2; 6)
			• Single studies (13; 21; 37; 45; 48; 49; 86)
			
			Views and experiences with respect to institutional climate
			• Evidence syntheses
			  ○ Low quality (2; 6)
			• Evidence synthesis protocol (84)
			• Single studies (15)
				–	• Evidence syntheses
					  ○ Medium quality (4)
					  ○ Low quality (6)
					• Single studies (13; 21; 37; 45)
						• Single studies (29; 30; 42; 74; 87)	• Evidence syntheses
							  ○ Medium quality (4)
							• Single studies (15; 21; 30; 35; 42; 43)

Features of EDI initiatives	Outcomes assessed					Literature focused only on description of training or leadership initiative (i.e., no outcomes assessed)	Literature with an explicit focus on knowledge mobilization and capacity building for EDI initiatives
	Outcomes related to broader communities serviced by institutions	**Organizational outcomes**	**Individual-level outcomes**	**Cost-relative outcomes**	**Implementation barriers and facilitators**		
Equity-centred initiatives							
Providing accommodations for trainees or leaders		Innovation and competitive advantage • Single studies (35) Workforce • Single studies (15)		–		• Single studies (77; 83)	• Single studies (15; 35; 77)

Promoting fairness in recognition and treatment	Physical and mental health outcomes
	• Single studies (31; 45)
	Development of high-quality trusting relationships with local organizations
	• Evidence syntheses
	  ○ Low quality (2)
	
	Collaboration across sectors
	• Evidence syntheses
	  ○ Medium quality (4)
	• Single studies (31)
	
	Research
	• Evidence syntheses
	  ○ Low quality (2)
	  ○ Medium quality (4)
		Reputation
		• Evidence syntheses
		  ○ Low quality (2)
		Innovation and competitive advantage
		• Single studies (31; 35; 43)
		
		Body of trainees
		• Evidence syntheses
		  ○ Low quality (2)
		• Single studies (81; 88)
		
		Workforce
		• Evidence syntheses
		  ○ Medium quality (4)
		• Single studies (15; 31; 45)
			Views and experiences with the EDI initiative
			• Evidence syntheses
			  ○ Medium quality (4)
			• Single studies (24; 45; 50; 86; 88; 89)
			Views and experiences with respect to institutional climate
			• Evidence syntheses
			  ○ Low quality (2)
			• Single studies (31)
				–	• Evidence syntheses
					  ○ Medium quality (4)
					• Single studies (45)
						• Single studies (24; 29; 30; 87)	• Evidence syntheses
							  ○ Medium quality (4)
							  ○ Low quality (2)
							• Single studies (15; 30; 31; 35; 43; 81)

Inclusion initiatives							
Fostering inclusive participation and meaningful involvement in	Physical and mental health outcomes • Single studies (46) Development of high-quality trusting	Innovation and competitive advantage • Single studies (3; 34; 35; 43) Body of trainees	Views and experiences with EDI initiatives • Evidence syntheses • (6; 47; 60; 93) • Single studies (3; 8; 11; 21; 32; 34; 37;	–	• Evidence syntheses (6; 12; 47; 60) • Single studies (3; 7; 8; 11; 21;	• Single studies (29; 30; 42; 46; 74; 83)	• Evidence syntheses (2; 8; 12; 21; 35; 47) • Single studies (3; 8; 30; 32; 42; 56; 71)

Features of EDI initiatives	Outcomes assessed					Literature focused only on description of training or leadership initiative (i.e., no outcomes assessed)	Literature with an explicit focus on knowledge mobilization and capacity building for EDI initiatives
	Outcomes related to broader communities serviced by institutions	**Organizational outcomes**	**Individual-level outcomes**	**Cost-relative outcomes**	**Implementation barriers and facilitators**		

different environ-ments	relationships with local organizations
	• Evidence syntheses
	  ○ Low quality (2)
	• Single studies (3; 32)
	
	Collaboration across sectors
	• Single studies (32; 55; 56; 58)
	
	Research
	• Evidence syntheses (2)
	• Single studies (3; 56)
		• Evidence syntheses
		  ○ Medium quality (47; 60)
		  ○ Low quality (2; 6)
		• Single studies (3; 7-9; 11; 46; 55; 56; 58; 71; 90-92)
		
		Workforce
		• Evidence syntheses
		  ○ Low quality (2)
		  ○ Medium quality (12; 85; 93)
		• Single studies (15; 17; 37; 48; 49; 94)
			38; 48; 49; 52; 55; 56; 71; 86; 90; 92; 94-96)
			
			Views and experiences with respect to institutional climate
			• Evidence syntheses
			  ○ Low quality (2; 6)
			• Single studies (8; 11; 15; 17; 46; 92)
					34; 35; 37; 38; 46; 71; 92)		

Ensuring psychological safety	Research
	• Single studies (33)
		Body of trainees
		• Single studies (97; 98)
		
		Workforce
		• Evidence syntheses
		  ○ Medium quality (12; 93)
			Views and experiences with EDI initiatives
			• Evidence syntheses
			  ○ Medium quality (93)
			• Single studies (23; 33; 38; 39; 86; 97-99)
			
			Views and experiences with respect to institutional climate
			• Evidence syntheses
			  ○ Medium quality (100)
			• Single studies (26; 33)
				–	• Evidence syntheses
					  ○ Medium quality (12)
					• Single studies (23; 33)
						• Single studies (29; 87)	• Evidence syntheses
							  ○ Medium quality (12; 100)
							• Single studies (23; 26; 33; 39)

Strengthening knowledge of and/or skills in cultural	Physical and mental health outcomes
	• Evidence synthesis protocol (101)
		Innovation and competitive advantage
		• Single studies (3; 31)
		
		Body of trainees
			Views and experiences with EDI initiatives
			• Evidence syntheses
				• Single studies (130)	• Evidence syntheses
					  ○ Medium quality (4;
						• Evidence syntheses
						  ○ Low quality (40)
							• Evidence syntheses
							  ○ Medium quality (4; 47; 103)

Features of EDI initiatives	Outcomes assessed					Literature focused only on description of training or leadership initiative (i.e., no outcomes assessed)	Literature with an explicit focus on knowledge mobilization and capacity building for EDI initiatives
	Outcomes related to broader communities serviced by institutions	Organizational outcomes	Individual-level outcomes	Cost-relative outcomes	Implementation barriers and facilitators		
competency and safety	• Single studies (1; 31; 53) Development of high-quality trusting relationships with local organizations • Single studies (3) Collaboration across sectors • Evidence syntheses (4) • Single studies (31; 32; 55; 57) Research • Evidence syntheses ○ Medium quality (4) • Single studies (3; 5; 33; 59)	• Evidence syntheses ○ Medium quality (47; 60; 97; 102) ○ Low quality (103) • Evidence synthesis protocol (101) • Single studies (1; 3; 8; 10; 11; 49; 55; 57; 59; 61-73; 78; 90; 91; 98; 104-114) Workforce • Evidence syntheses ○ Medium quality (4) • Single studies (1; 17; 31; 94; 106)	○ Medium quality (4; 47; 60; 97; 102) • Evidence synthesis protocol (101) • Single studies (1; 3; 5; 8; 11; 18-20; 23-25; 32; 33; 39; 47; 51; 52; 55; 57; 61; 62; 64; 66-73; 78; 89; 90; 94-96; 98; 99; 103-106; 108-110; 113-129) Views and experiences with respect to institutional climate • Evidence syntheses ○ Medium quality (100) • Single studies (8; 11; 17; 19; 26; 31; 33; 59)		47; 60; 101; 102) • Single studies (1; 3; 8; 11; 20; 23; 24; 32; 33; 59; 62; 70-73; 105; 108)	• Single studies (28-30; 42; 44; 74-76; 87; 131-134)	• Single studies (1; 3; 5; 8; 10; 23; 26; 28; 30-33; 39; 42; 51; 57; 59; 68; 71; 72; 104; 105; 131; 133) (73)

Appendix 3: Key findings from included evidence syntheses and Canadian-based single studies on EDI training and leadership initiatives (n=20/134)

Features of EDI initiatives	Description of training or leadership initiative	Knowledge mobilization and capacity building	Outcomes				
			Outcomes related to broader communities serviced by institutions	Organizational outcomes	Individual-level outcomes	Cost-relative outcomes	Implementation barriers and facilitators
EDI overall							

Features of EDI initiatives	Description of training or leadership initiative	Knowledge mobilization and capacity building	Outcomes				
			Outcomes related to broader communities serviced by institutions	Organizational outcomes	Individual-level outcomes	Cost-relative outcomes	Implementation barriers and facilitators
• Formal governance structures and processes supporting EDI	DEI committees and academic leadership teams were used to coordinate institutional strategies (e.g., faculty recruitment, mentorship, inclusive curricula) (2; 4; 6; 12; 49)	Committees were informed by surveys, scoping reviews, and interviews with faculty, students, and staff to guide racial equity planning (6)	Some strategies promoted shared decision-making with community partners (e.g., involving Indigenous Elders in course design and evaluation) (56)	Institutions reported improved faculty retention and representation through structured governance and inclusive planning processes (2; 4)	Governance-supported initiatives led to mentoring, peer networks, and student supports that enhanced retention and academic experience (2; 4; 6)	Formal governance work required resource investment (e.g., funding for leadership, mentoring programs) and was limited by lack of sustainable funding (2; 4; 6; 49)	Facilitators included senior leadership support and inter-departmental collaboration Barriers included unclear mandates, time constraints, and under-recognition of EDI workload (2; 4; 6; 12)
• Integration of EDI into strategic planning and decision-making processes	EDI strategies were embedded into institutional planning through policies, revised professionalism frameworks, curriculum changes, and faculty development strategies (e.g., inclusion of EDI principles in admissions and hiring policies) (2; 4; 6; 78; 100)	Planning was guided by evidence from scoping reviews, stakeholder interviews, and literature syntheses that shaped curricula and leadership program design (4; 6)	Community-informed planning (e.g., through consultation with racialized students or Indigenous partners) helped align program objectives with broader health equity goals (56; 66; 69)	Inclusion of EDI in strategic frameworks contributed to improved retention, leadership diversity, and alignment between institutional priorities and equity goals (2; 4; 12)	Strategic alignment supported leadership training and equity-promoting practices, contributing to increased confidence, satisfaction, and inclusion among participants (4; 12)	While costs were not quantified, several articles highlighted the need for sustained institutional commitment to resource EDI efforts as part of long-term planning (2; 4; 6; 49)	Facilitators included leadership involvement and use of strategic frameworks Barriers included limited resources, institutional resistance, and lack of dedicated accountability structures (2; 4; 6; 49)
• Strengthening leadership competencies in EDI	Several programs focused on developing leadership among underrepresented groups, particularly women in academic medicine (e.g., Executive	Programs incorporated structured tools (e.g., 360-degree evaluations, Myers-Briggs) to build self-awareness and	Participants of these programs often became leaders of EDI initiatives or mentors to others, thereby supporting broader cultural change within	Improved institutional visibility and promotion of women into leadership roles were attributed to program alumni driving	Participants reported enhanced confidence, self-awareness, academic advancement, and development of professional	Institutional sponsorship or external funding was necessary to support registration and release time for participants; some cited financial and time	Barriers included institutional gender bias and lack of sustained organizational support post-program Facilitators included strong mentorship, institutional nomination, and peer networks (4; 12; 49; 93)

Features of EDI initiatives	Description of training or leadership initiative	Knowledge mobilization and capacity building	Outcomes				
			Outcomes related to broader communities serviced by institutions	Organizational outcomes	Individual-level outcomes	Cost-relative outcomes	Implementation barriers and facilitators
	Leadership in Academic Medicine, Mid-Career Women in Medicine, Early-Career Women in Medicine), with content on negotiation, strategic career planning, self-promotion, and conflict resolution (4; 49; 93)	leadership capacity (49)	institutions (4; 6; 12; 93)	organizational EDI changes (4; 12; 49; 93)	networks (4; 12; 49; 93)	constraints as barriers (4; 12; 49; 93)	
• Community engagement or partnerships with external actors with the aim of promoting EDI	Several initiatives were co-designed with community partners to promote equity (e.g., Indigenous Elders co-developing cultural safety training, sexual and gender minority community members co-developing inclusive curricula) (40; 56; 66; 69)	Programs emphasized collaborative knowledge sharing (e.g., participatory curriculum design, integration of lived experience into training) to enhance cultural relevance (56; 66; 69)	Initiatives led to improved responsiveness to community-identified needs (e.g., addressing the effects of colonization, reducing health disparities, strengthening cultural safety) (56; 66; 69)	Engagement with communities supported curriculum reforms, staff education, and strengthened partnerships between institutions and external stakeholders (56; 66; 69)	Trainees developed stronger empathy, self-reflection skills, and understanding of their positionality in relation to communities (e.g., public health professionals reporting increased reflexivity) (56; 66)	Programs required dedicated resources (e.g., time, honoraria, coordination) and were more effective when funding supported ongoing community collaboration (56; 66; 69)	Facilitators included community leadership, existing relationships, and co-learning approaches Barriers included institutional silos, limited time, and lack of cultural readiness or training among staff (56; 66; 69)
Diversity-centred initiatives							
• Training to enhance admission and recruitment processes	Training was provided to admissions and hiring committees to address unconscious and/or implicit bias and promote	These efforts were supported by strategic planning, mentorship programs, and feedback mechanisms	Inclusive recruitment strategies helped attract applicants from marginalized communities (e.g., racialized groups,	Organizational benefits included increased recruitment and promotion of underrepresented faculty and	Participants of training and mentorship programs reported increased competitiveness	Training programs were supported by funding mentors, project management assistance, and travel or	Facilitators included inclusive leadership, peer support, and tailored training Barriers included insufficient protected time, recruitment

Features of EDI initiatives	Description of training or leadership initiative	Knowledge mobilization and capacity building	Outcomes				
			Outcomes related to broader communities serviced by institutions	Organizational outcomes	Individual-level outcomes	Cost-relative outcomes	Implementation barriers and facilitators
	inclusive recruitment (e.g., grant writing and diversity hiring strategies targeting underrepresented faculty) (4) (2; 12)	designed to guide fair and effective admissions and hiring processes (4) (2; 12)	sexual and gender minority individuals), thereby addressing historical underrepresentation in academic health institutions (4) (2; 12)	stronger EDI mandates in recruitment practices for trainees (4) (2; 12; 14)	and skill development for academic and research roles (e.g., leadership training, grant writing) (4; 49; 93)	registration support (e.g., conference registration) (4)	challenges, and limited mentorship capacity (4; 12)
• Strengthening hiring processes and career progression	Several programs focused on improving hiring and career progression for underrepresented faculty through leadership development, skills training (e.g., grant writing, clinical research), and peer or group mentoring (4; 12; 49)	Programs used strategic planning and career development frameworks, often informed by stakeholder consultation and participant evaluations (e.g., surveys on retention, academic advancement) (4; 6; 49)	More diverse and representative hiring was seen as a pathway to improving the quality and inclusivity of care for marginalized communities (2; 4; 12)	Institutions that implemented structured support for career advancement saw improved retention, promotion, and leadership representation among underrepresented faculty (4; 12; 49; 93)	Participants reported enhanced confidence, academic productivity (e.g., publications, grants), and stronger networks (e.g., leadership pipelines, peer support groups) (4) (49; 93)	Many programs offered financial support (e.g., travel funds, research assistance), but sustainability depended on consistent investment from institutions or funders (4) (49; 93)	Barriers included insufficient mentorship availability, lack of faculty with community-based experience, and challenges recruiting participants from underrepresented backgrounds Facilitators included tailored training and network-building supports (4) (49; 93)
Equity-centred initiatives							
• Providing accommodations for trainees or leaders	Some programs integrated accommodations into training and leadership structures, including academic and emotional supports (e.g., peer tutoring, reflexive practices, mentorship for	Programs used participant feedback and institutional evaluations to identify accommodation needs and adapt training formats (e.g., asynchronous	Culturally responsive accommodations (e.g., land-based learning, trauma-informed content) helped ensure safer engagement for marginalized communities (56; 66; 69)	Institutions that embedded accommodations into curricula and faculty development supported improved retention and inclusion of	Trainees reported improved well-being, learning outcomes, and reduced emotional burden when accommodations were responsive to their social and	Accommodations such as tailored delivery models or culturally safe programming required time and financial investment (e.g., Elder involvement, small-group	Barriers included inflexible institutional structures and under-resourced implementation Facilitators included trauma-informed approaches, flexible design, and sustained cultural support (56; 69)

Features of EDI initiatives	Description of training or leadership initiative	Knowledge mobilization and capacity building	Outcomes				
			Outcomes related to broader communities serviced by institutions	Organizational outcomes	Individual-level outcomes	Cost-relative outcomes	Implementation barriers and facilitators
	equity-deserving students) (6; 97)	modules for flexibility) (56)		equity-deserving trainees (4; 6; 97)	cultural needs (6; 56)	learning formats) (56)	
• Promoting fairness in recognition and treatment	Several initiatives called for structural reform to address inequities in how faculty and trainees are evaluated and recognized (e.g., addressing the "minority tax" in workload expectations and promotions) (12; 49)	These strategies were supported by literature reviews and expert consensus processes (e.g., Council of Residency Directors review) that identified best practices in inclusive faculty evaluation (6; 12)	Greater fairness in recognition of EDI labour contributed to more inclusive environments for underrepresented communities served by the health workforce (4; 12; 49; 93)	Institutions that recognized and compensated EDI contributions (e.g., mentoring, outreach) reported improved retention and promotion of underrepresented faculty (12; 49; 93)	Faculty reported increased satisfaction, reduced burnout, and improved career progression when their contributions to EDI were formally acknowledged (e.g., in promotion processes) (12; 49; 93)	Formal recognition and protected time for EDI responsibilities were recommended to offset unpaid labour and failure to do so was associated with attrition risk (12; 49)	Barriers included systemic bias in promotion and evaluation, and lack of formal credit for diversity work Facilitators included strategic planning, chief diversity officers, and institutional accountability mechanisms (12; 49)
Inclusion initiatives							
• Fostering inclusive participation and meaningful involvement in different environments	Programs emphasized co-creation and shared leadership with underrepresented groups (e.g., 2SLGBTQIA+ people, Indigenous Elders) in curriculum design, mentorship, and training delivery (6; 56; 69; 97)	Training was shaped through qualitative interviews and participatory approaches that elevated lived experience and integrated it into institutional processes (6; 56; 69)	Community members' involvement in curriculum and evaluation led to more relevant and inclusive content (e.g., teaching about intergenerational trauma, cultural safety) (6; 56; 69)	Inclusion of diverse voices strengthened institutional culture, built credibility in EDI initiatives, and enhanced the reach of academic programs (4; 6; 56)	Trainees reported greater engagement, self-awareness, and empowerment when given space to meaningfully contribute to training environments (6; 56)	Programs that enabled co-leadership required investment in relationship-building, facilitation support, and often financial honoraria for community partners (56; 66)	Barriers included limited institutional readiness, time constraints, and unequal power dynamics Facilitators included relational approaches, shared values, and commitment to ongoing collaboration (6; 56; 69; 97)
• Ensuring psychological safety	Trainings were designed to create safe learning environments through reflexive practices, trauma-informed pedagogy,	Programs were shaped by faculty and community member experiences, with many prioritizing co-design and	Programs that emphasized safety helped address historic and ongoing harm experienced by marginalized	Institutions that supported psychological safety saw improved engagement in EDI training and	Participants reported increased comfort, sense of belonging, and ability to engage critically with	Some programs required funding to enable culturally safe delivery formats (e.g., asynchronous learning, in-person	Barriers included emotionally taxing content for faculty, limited institutional protections, and uneven delivery quality Facilitators included trauma-informed approaches, space

Features of EDI initiatives	Description of training or leadership initiative	Knowledge mobilization and capacity building	Outcomes				
			Outcomes related to broader communities serviced by institutions	Organizational outcomes	Individual-level outcomes	Cost-relative outcomes	Implementation barriers and facilitators
	and small group-based engagement (e.g., Indigenous cultural safety training, Global Health Practicum) (49; 56; 69; 97)	ongoing reflection to address emotional impact and identity-based harm (56; 69)	communities in health education (e.g., colonization, racism, heteronormativity) (6; 56; 66; 69)	deeper organizational understanding of equity issues (6; 56; 69)	power and privilege (e.g., moral uncertainty, cultural dissonance, emotional processing) (6; 49; 56; 69; 97)	dialogue circles, Elder support) (56; 66)	for reflection, and land-based or peer-supported learning (49; 56; 69; 100)
• Strengthening knowledge of and/or skills in cultural competency and safety	Programs aimed to improve cultural competency and safety through anti-racism education, 2SLGBTQIA+ health training, Indigenous-led content, and international learning (e.g., micro-credential courses, panel-based training, online global health collaborations) (40; 47; 56; 66; 69; 97; 100; 103; 133)	Programs incorporated co-developed materials, participant evaluation (e.g., pre/post surveys, reflections), and long-term planning to embed cultural knowledge in curricula (40; 56; 97; 100; 103)	Culturally responsive content improved awareness of health disparities and promoted affirming care for equity-deserving communities (e.g., 2SLGBTQIA+ people, Indigenous groups, international learners) (56; 69; 97; 100)	Institutions strengthened their capacity to provide inclusive training, address equity gaps, and improve the cultural safety of care delivered by their graduates (40; 47; 103)	Participants showed increased knowledge, self-confidence, comfort, and reported improved skills in providing culturally safe, inclusive care (e.g., understanding pronouns, navigating bias, addressing history-taking barriers) (97; 100; 103)	Programs ranged in cost and delivery intensity (e.g., 20-minute modules to 8-week seminars, virtual and in-person formats) and often required resources for faculty training, guest speakers, and online platforms (40; 97; 100; 103)	Barriers included lack of institutional readiness, inconsistent engagement across faculty, time constraints, and emotional burden for both learners and instructors Facilitators included co-design, peer mentorship, and community involvement (40; 56; 69; 97; 100)

Appendix 4: Detailed data extractions from evidence syntheses

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Population of focus for the EDI training or leadership initiative
  ○ Current or prospective faculty
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ EDI overall
  ▪ Formal governance structures and processes supporting EDI
  ▪ Integration of EDI into strategic planning and decision-making processes
  ▪ Strengthening leadership competencies in EDI
  ▪ Community engagement or partnerships with external actors with the aim of promoting EDI
  ○ Diversity-centred initiatives
  ▪ Training to enhance admission and recruitment processes
  ▪ Strengthening hiring processes and career progression
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Race/ethnicity
	Leadership and training strategies to improve racial equity in health research institutions should be transparent and multifaceted, guided by policies and frameworks, and include mentorship, financial supports, shared decision-making, processes for accountability, and regular outcome monitoring (6)
	• This review looked at the use of the Robert Wood Johnson Foundation learning assessment for building strategies to address institutional racism in health science institutions
	• This study had three parts: an online survey, scoping review, and qualitative interviews
	  ○ The online survey asked students, faculty, and staff from the Robert Wood Johnson Foundation about their experiences to improve racial equity outcomes
	  ○ The scoping review looked for strategies to advance racial equity, reduce intuitional racism, and increase recruitment, retention, and promotion of underrepresented individuals
	  ○ Interviews were conducted with 60 faculty, students, and staff to understand what changes should be implemented to improve racial equity
	• Results from all three parts of the study were integrated to provide key strategies to improve racial equity in institutions
	  ○ Over half of participants believed that race-based affirmative action was helpful for improving racial equity in institutions
	  ○ Holistic frameworks for recruitment and admissions can help admissions teams consider different aspects that may impact the performance of underrepresented students and recognize untraditional examples of success
	  ○ The development of pathway programs can help increase interest in educational programs for students from different backgrounds
	  ○ Program leads should develop partnerships with organizations that provide supports for underrepresented populations
	  ○ DEI committees should be formed at the local and larger systemic levels, there should be communication across different committees, and committees should be permitted the legislative power to enact change
		No	3/9	23 February 2024	N/A	• Race/ ethnicity

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Outcomes
  ○ Outcomes related to the broader communities serviced by institutions
  ▪ Collaboration across sectors
  ○ Organizational outcomes
  ▪ Body of trainees
  ▪ Workforce
  ○ Individual-level outcomes
  ▪ Views and experiences with the EDI initiative
  ▪ Views and experiences with respect to institutional climate
	○ Mentorship programs were described in most of the literature and survey responses; they can be used to increase grant funding and retention
	○ Academic (e.g., peer tutoring) and emotional supports were needed for retaining students
	○ Strengthening scholar networks can help create a sense of community and welcoming
	○ Overall, there was a need for multipronged anti-racism strategies embedded at multiple levels across the institution
	• Strategies should be continuously evaluated to determine the successes and possible barriers
	○ Possible types of outcomes to be collected include understanding experiences, admission rates, retention rates
	○ Data should be disaggregated by sociodemographic factors (e.g., language, race) and success indicators
	• Strategies to advance racial equity cannot be supported without sufficient financial resources
	• The authors provided additional recommendations
	○ Admission processes, policies, and outcomes of policies should be transparent
	○ There needs to be a level of accountability across different levels to promote progress
	○ Power in decisions should be shared with community partners and persons from underrepresented groups					

• Population of focus for the EDI training or leadership initiative
  ○ Currently enrolled health-related trainees
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ Inclusion initiatives
  ▪ Strengthening knowledge of and/or skills in cultural competency and safety
• Groups or communities of focus
	Only some existing undergraduate medical anti-racism curricula are mandatory, and gaps exist in the assessment of established curricula on medical student behaviour change (103)
	• The synthesis identified current literature on undergraduate medical education (UME) anti-racism curricula, including its implementation, assessment, and evidence gaps
	○ 20 studies were included, with 18 having been conducted in the last five years
	• Anti-racism was the central theme in 35% of included studies, with 65% of anti-racism curricula being mandatory for medical students
	• Tools used to evaluate the curricula included surveys, focus groups, and direct observations
	• Future directions for curricula included further integration into established UME curriculum, using longitudinal effectiveness
		No	3/9	April 2023	N/A	Not reported

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus) ▪ Race/ethnicity • Outcomes ○ Organizational outcomes ▪ Body of trainees	assessments, increasing the amount and duration of sessions, and delivering the content in different formats (e.g., virtual, hybrid) • Assessment of implemented curricula involved learner's reactions (90% of included studies) and behaviour change (10% of included studies) ○ There is an identified gap in literature surrounding effectiveness and assessments of anti-racism curricula • The authors suggest using explicit definitions of anti-racism, using longitudinal learning opportunities, and longitudinal effectiveness assessments when designing and implementing UME anti-racism curricula					
• Broader policy environment in which the EDI training or leadership initiative was implemented ○ Domestic laws, regulations, or standards related to EDI, including those put forward and/or enforced by health profession regulators • Population of focus for the EDI training or leadership initiative ○ Currently enrolled health-related trainees • Equity, diversity, and inclusion initiatives focused on training and/or leadership ○ Inclusion initiatives ▪ Strengthening knowledge of and/or skills in cultural competency and safety • Groups or communities of focus ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus) ▪ Race/ethnicity ▪ Culture/language ▪ Religion	EDI interventions are associated with improved professionalism and EDI competencies, but current standards of professionalism should be revised to include needs and values of equity-deserving groups (100) • The scoping review investigated how EDI can be incorporated into education programs and professionalism assessments for healthcare trainees ○ 48 studies were included examining medical trainees (n=18) and other medical professions including nursing, social work, midwifery, dentistry, and physical therapy ○ Methods of qualitative evaluation included participant interviews, surveys, written responses, and literature reviews and methods of quantitative evaluation included Likert scales, but few studies employed validated tools ○ 21 studies included an EDI training intervention consisting of either educational courses or clinical placements • The review found that EDI interventions (courses and clinical placements) are associated with improved professionalism of trainees across all included healthcare professions ○ Topics of courses included health advocacy and cultural/spiritual competency/advocacy ○ Settings of clinical placements included rural and international placements • The review identified that EDI training and professional identity development are both essential for professionalism and acquiring EDI competencies ○ Included studies indicated that adaptability and humility are essential components of both professionalism and EDI competency • The reviewers identified a theme of perceived non-inclusive standards of professionalism	No	5/9	March 2023	Not available	• Race/ ethnicity/ culture/ language

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Outcomes
  ○ Organizational outcomes
  ▪ Body of trainees
	○ Included studies showed that equity-deserving groups experience professionalism as being culturally and ethnically restrictive
	• There is a call to redevelop and revise professionalism frameworks to express the values and needs of healthcare trainees and professionals					

• Population of focus for the EDI training or leadership initiative
  ○ Currently enrolled health-related trainees
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ EDI overall
  ▪ Community engagement or partnerships with external actors with the aim of promoting EDI
  ○ Inclusion initiatives
  ▪ Fostering inclusive participation and meaningful involvement in different environments
• Knowledge mobilization and capacity building
  ○ Dissemination and uptake of EDI-related knowledge and best practices
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Sexual orientation
• Outcomes
  ○ Individual-level outcomes
  ○ Views and experiences with the EDI initiative
	Medical trainees reported improved self-confidence and comfort towards patients from the 2SLGBTQIA+ community after completing training to improve their knowledge and attitudes; these training strategies were often described as being multifaceted (including didactic and group learning strategies), and those with better individual-level outcomes involved co-developed training materials and mentorship opportunities with individuals with lived experiences from the community; however, the meta-analysis did not report significant improvements (97)
	• This systematic review and meta-analysis looked at the effectiveness of training strategies for medical students' knowledge and attitudes regarding 2SLGBTQIA+ people
	• Regardless of the duration or type of intervention, students reported increased comfort and confidence in treating 2SLGBTQIA+ people
	• The review highlighted that:
	  ○ most training strategies were multifaceted, involving different components
	  ○ topics covered in these trainings included describing the biological basis of gender, lived experiences of interactions with healthcare professionals, importance of using correct pronouns, biases that may occur in healthcare, teaching how to appropriately gather information on sexual history, different types of medical needs specific to 2SLGBTQIA+ persons (e.g., hormone therapy), and an overview on health disparities and how they affect access to care
	  ○ some training strategies included a panel of persons with lived experiences after the lecture was taught
	  ○ one course was taught by a researcher, psychologist, and a person with lived experience
	  ○ many interventions included didactic and group learning
	  ○ interventions ranged from 20-minute modules to 2.5-hour long lectures to eight-week-long seminar courses
	• The level of knowledge about the needs of 2SLGBTQIA+ persons varied across studies, and no significant improvements were seen in the meta-analysis
	• Training strategies that included moderators from the 2SLGBTQIA+ community had better outcomes than other types of strategies, emphasizing the importance of collaboration with community partners
		No	6/11	2023	N/A	• Sexual orientation

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
	for creating safe learning environments, developing educational materials and providing mentorship to trainees					

• Population of focus for the EDI training or leadership initiative
  ○ Current or prospective faculty
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ EDI overall
  ▪ Strengthening leadership competencies in EDI
  ▪ Community engagement or partnerships with external actors with the aim of promoting EDI
  ○ Diversity-centred initiatives
  ▪ Training to enhance admission and recruitment processes
  ○ Inclusion initiatives
  ▪ Fostering inclusive participation and meaningful involvement in different environments
  ▪ Strengthening knowledge of and/or skills in cultural competency and safety
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Race/ethnicity
  ▪ Gender
	EDI initiatives for hiring, retaining, and promoting underrepresented persons in health research may include strategies to increase diversity at the leadership level, build inclusive cultures, increase community engagement, and support capacity for skill training, mentorship, and networking at both organizational and community levels (4)
	• The purpose of this scoping review was to characterize and evaluate 62 diversity, equity, and inclusion leadership and training programs for retaining, hiring, and promoting underrepresented persons in health services research
	  ○ Most of the programs focused on research training skills, followed by mentoring, leadership (e.g., leadership culture and funds and resources), social networking, and community engagement
	  ○ Programs generally included three core strategies: 1) increasing supportive leadership and inclusive workplace culture, 2) increasing funding, and 3) promoting community engagement
	  ○ Most of the trainings were focused on unconscious bias addressing certain behaviours in the workforce (e.g., bullying and bias), inclusive excellence, and skills training (e.g., contribute to their competitiveness in academic and research sectors such as grant development training and clinical and methodological skills)
	  ○ The types of underrepresented groups included racialized persons, women and gender diverse persons, those from lower socioeconomic status, persons with disabilities, and persons of diverse sexual orientations
	• Skills training was described as a helpful step to promote retention of persons from underrepresented groups in research and seen across all reported programs (n=62)
	  ○ Didactic and grant writing training were the most common types of training
	  ○ Lack of teaching abilities to reinforce certain skills was seen as a barrier to skill training
	  ○ Facilitators may include building a support network of persons from underrepresented groups or using a tailored training approach
	• A total of 23 programs looked at increasing funding and resources for increasing equity, diversity, and inclusion
		No	4/9	2023	N/A	• Race/ ethnicity
						• Gender
						• Sex
						• Age
						• Socioeconomic status
						• Level of income
						• Disability
						• Sexual orientation

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
▪ Sex ▪ Age ▪ Socioeconomic status ▪ Level of income ▪ Disability ▪ Sexual orientation • Outcomes ○ Organizational outcomes ▪ Innovation and competitive advantage ▪ Body of trainees ▪ Workforce ○ Implementation barriers and facilitators	○ Strategies to increase funding included having funding mentors, grant writing workshops, data support, and project management support ○ Challenges of implementing these strategies included recruiting underrepresented populations and providing them with resources to be successful in obtaining funding • A total of 10 studies looked at leadership and inclusive culture, and describe this as essential to shape long term goals ○ Most programs derived from strategic planning meetings ○ Strategies to promote a positive culture included training workshops (e.g., on unconscious bias), considering diversity in recruitment, and using assessments to track progress • A total of seven studies looked at community engagement to recruit research staff and form relationships with community partners ○ Barriers included lack of time, commitment, and faculty with experiencing working within the community • Mentorship was a core theme implemented across all three strategies ○ Mentoring could include peer mentoring, group mentoring, or multiple mentoring ○ Finding engaging mentors was a challenge across programs, possibly due to lack of time and funding • Social networking was described as a helpful strategy in 11 articles • Social networking may include funding conference registration for early career researchers and developing support groups ○ Outcome measures used to track success of programs included: increasing hiring, promotion, and retention, number of grants awarded, number of manuscripts and conferences published, and acquired research skills • Gaps in sustainable programs included lack of leadership in larger roles and few long-term goals to evaluate the success and next steps of programs					
• Population of focus for the EDI training or leadership initiative ○ Currently enrolled health-related trainees • Equity, diversity, and inclusion initiatives focused on training and/or leadership	Conceptualization, pedagogical techniques, methods of outcomes, and evaluation are essential approaches to consider in the development of anti-racist educational interventions for postgraduate medical education (47) • The synthesis assessed the current literature on educational anti-racist interventions in postgraduate medical education that employ a systemic or structural view of racism	No	4/9	2022	Not available	None identified

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
○ Inclusion initiatives ▪ Strengthening knowledge of and/or skills in cultural competency and safety • Groups or communities of focus ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus) ▪ Race/ethnicity • Outcomes ○ Organizational outcomes ▪ Body of trainees	○ 23 studies were included that assessed anti-racism education interventions on postgraduate residency programs • The main type of education intervention employed were didactic sessions and interactive workshops; interventions were led by faculty, residents, or working groups (mix of faculty and residents) • The review identified three major components across interventions ○ Conceptualization: Across interventions, there were different clusters of racism conceptualization, with interventions utilizing different curricular content with differing levels of community engagement in curriculum development ○ Pedagogical issues: Interventions used differing pedagogical techniques including one-time workshops vs. integrated anti-racism curriculums, and systemic vs. structural framed teachings ○ Outcomes and evaluation: Most of the interventions (n=19) used quantitative evaluation employing Likert scale surveys, with nine studies also using qualitative evaluation components • Self-report evaluation was critically questioned as a reliable method for intervention effectiveness, as it may not directly translate to skill development, and two included studies used a multi-pronged evaluation method that included measuring residency performance by individual mentors					
• Broader policy environment in which the EDI training or leadership initiative was implemented ○ Domestic laws, regulations, or standards related to EDI, including those put forward and/or enforced by health profession regulators • Population of focus for the EDI training or leadership initiative ○ Currently enrolled health-related trainees ○ Current or prospective faculty ○ Existing institutional leaders	Key features of EDI training and leadership initiatives in nursing schools include formal governance, integration into institutional goals, community engagement, faculty training, inclusive hiring, and embedding EDI in curricula and faculty development (2) • Formal governance structures, such as EDI committees and academic leadership teams that visibly support and promote EDI, help recruit diverse faculty • These efforts should be embedded in strategic planning through dedicated EDI plans, the integration of EDI principles into mission statements, and institutional policy changes related to recruitment, acceptance, and progression of faculty and students • Community engagement is pursued through partnerships that expand recruitment pipelines for underrepresented minority faculty and students and incorporate cultural safety training • Diversity-centred initiatives involve implicit bias training for admissions and faculty search committees, along with establishing diverse hiring committee and recruiting underrepresented minority faculty • Inclusion initiatives focus on integrating EDI concepts into curricula, providing faculty education, and building knowledge capacity	No	1/9	2022	N/A	• Place of residence • Race/ ethnicity • Culture/ language • Gender • Sex • Age • Religion • Socioeconomic status • Disability • Sexual orientation • Immigration and/or

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  o EDI overall
  ▪ Formal governance structures and processes supporting EDI
  ▪ Integration of EDI into strategic planning and decision-making processes
  ▪ Community engagement or partnerships with external actors with the aim of promoting EDI
  o Diversity-centred initiatives
  ▪ Training to enhance admission and recruitment processes
  ▪ Strengthening hiring processes and career progression
  o Inclusion initiatives
  ▪ Strengthening knowledge of and/or skills in cultural competency and safety
• Knowledge mobilization and capacity building
  o Capacity building to sustain EDI initiatives over time
  o Institutional learning and continuous improvement
• Groups or communities of focus
	• Capacity-building strategies support long-term sustainability through mentorship programs and leadership development, while continuous improvement is achieved by collecting data on recruitment, retention, and institutional climate to inform the refinement of EDI strategies
	• Outcomes:
	  o Organizational outcomes of EDI initiatives include improved workforce diversity, retention, and reduced attrition
	• Barriers such as limited leadership support and difficulty accessing EDI training can hinder their implementation
						refugee status

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus) ▪ Place of residence ▪ Race/ethnicity ▪ Culture/language ▪ Gender ▪ Sex ▪ Age ▪ Religion ▪ Socioeconomic status - Level of income - Education level - Occupation ▪ Disability ▪ Sexual orientation ▪ Immigration and/or refugee status • Outcomes ○ Organizational outcomes ▪ Workforce ○ Implementation barriers and facilitators						
• Broader policy environment in which the EDI training or leadership initiative was implemented ○ Domestic laws, regulations, or standards related to EDI, including those put forward and/or enforced by health profession regulators • Population of focus for the EDI training or leadership initiative ○ Currently enrolled health-related trainees	Integrating EDI into physician assistant education requires collaborative curriculum reform and inclusive teaching strategies that address sexual and gender minority health across all relevant coursework (40) • Integrating EDI into the curriculum for physician assistant trainees involves a collaborative approach that includes administrators, faculty, students, and sexual and gender minority (SGM) community partners • Inclusion strategies combined with community engagement involve developing inclusive curriculum modifications, such as embedding sexual health content, incorporating diverse simulated patient encounters, and addressing SGM topics within various cultural and social contexts throughout the curriculum • Incorporating foundational language for sexual history taking is important to enhance trainee comfort and fluency, providing comprehensive faculty training before leading SGM-related discussions, and integrating sexual health content across all relevant courses	No	2/9	2022	N/A	• Gender • Sex • Sexual orientation

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ EDI overall
  ▪ Community engagement or partnerships with external actors with the aim of promoting EDI
  ○ Inclusion initiatives
  ▪ Strengthening knowledge of and/or skills in cultural competency and safety
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Gender
  ▪ Sex
  ▪ Sexual orientation
• Outcomes
  ○ Outcomes related to the broader communities serviced by institutions
  ▪ Physical and mental health outcomes
  ○ Individual-level outcomes
  ▪ Views and experiences with the EDI initiative
	• Outcomes:
	  ○ Perceived outcomes of incorporating sexual and gender minority health into the physician assistant curriculum include increased knowledge, greater comfort with sensitive clinical skills such as sexual history taking, and improved ability to recognize and address personal biases
	  ○ At the broader community level, these initiatives are seen to contribute to reducing health disparities, particularly in areas like disease prevention, mental health, and substance use					

• Broader policy environment in which the EDI training or leadership initiative was implemented ○ Domestic laws, regulations, or standards related to EDI, including those put forward and/or	Most studies focused on funded, research-specific programs, while fewer examined institution-wide initiatives or addressed institutional culture (i.e., the shared rules, values, beliefs, behaviours, and customs that influence behaviour within an organization) and climate (i.e., individuals' perceptions of that culture) (85) • Efforts to diversify the physician workforce have progressed, but less focus has been placed on increasing minority physician representation at the faculty level in Academic Medical Centres (AMCs)	No	4/9	2021	N/A	• Race/ ethnicity

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

enforced by health profession regulators
• Population of focus for the EDI training or leadership initiative
  ○ Existing health professionals
  ▪ Physicians
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ EDI overall
  ▪ Strengthening leadership competencies in EDI
  ○ Diversity-centred initiatives
  ▪ Training to enhance admission and recruitment processes
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Race/ethnicity
● Outcomes
  ○ Organizational outcomes
  ▪ Innovation and competitive advantage
  ▪ Body of trainees
  ▪ Workforce
	• This review aims to update the literature on outcomes and components of programs designed to enhance racial/ethnic diversity among AMC faculty
	• 10 papers were included, describing eight programs
	• Four studies measured changes in underrepresented in medicine (URiM) faculty representation
	• Six studies focused on retention indicators: Promotion, leadership roles, grant acquisition, and scholarly productivity
	  ○ Program: Diversity Initiative at Medical University of South Carolina (MUSC)
	  ▪ Scope: Local (one site), 10 years
	  ▪ Aim: Develop a diverse academic physician workforce
	  ▪ Intervention: Institutional-wide commitment, diversity plans, financial support
	  ▪ Outcome: URiM faculty increased from 4% to 6%, sustained over time
	  ▪ Finding: Multifaceted, mission-integrated strategies led to durable URiM increases
	  ○ Program: UC San Diego National Center of Leadership in Academic Medicine (NCLAM)
	  ▪ Scope: Local (one site), 10 years
	  ▪ Aim: Improve faculty climate
	  ▪ Intervention: Demographic data sharing, policy changes, faculty development
	  ▪ Outcome: URiM increased from <1% to 7% (tenure track), 5% to 8% (all faculty); higher retention for program participants
	  ▪ Finding: Institutional climate changes enhanced both representation and retention
	  ○ Program: Robert Wood Johnson Foundation (RWJF) Harold Amos Medical Faculty Development Program (AMFDP)
	  ▪ Scope: National (sites not reported), five years
	  ▪ Aim: Increase minority healthcare professionals
	  ▪ Intervention: Funded research, mentorship
	  ▪ Outcome: Leadership higher among scholars (28%) vs. non-scholars (10%)					

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
	▪ Finding: Research funding linked to leadership but not to other career outcomes o Program: National Institutes of Health (NIH) Minority Medical Faculty Development Program (MMFDP) ▪ Scope: National (sites not reported), 31 years ▪ Aim: Enhance URiM academic medicine retention ▪ Intervention: Research support and mentorship ▪ Outcome: 80% of alumni in academic roles, many in senior leadership ▪ Finding: Long-term research support correlates with high URiM retention and rank o Program: Mentored Career Development (KL2) Program at University of Puerto Rico-Medical Sciences Campus (UPR-MSC) and Morehouse School of Medicine-Master of Science in Clinical Research (MSM-MSCR) ▪ Scope: Local (two sites), 10 years ▪ Aim: Train URiM junior faculty for research careers ▪ Intervention: Post-doctoral degree and mentored research phases ▪ Outcome: Grant funding: 74% (UPR-MSC), 68% (MSM-MSCR) ▪ Finding: Research training programs led to high grant success among URiM scholars o Program: PRIDE Institute – Programs to Increase Diversity Among Individuals Engaged in Health-Related Research ▪ Scope: National (one site), five years ▪ Aim: Boost URiM recruitment and retention in sleep/behavioral medicine ▪ Intervention: Summer program, courses, mentoring, research project ▪ Outcome: Promotions and NIH award rates higher among participants ▪ Finding: Program improved academic outcomes and grant success o Program: PRIDE-CVD (cardiovascular disease) ▪ Scope: National (two sites), 12 years ▪ Aim: Develop URiM faculty in CVD research					

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
	▪ Intervention: Summer programs, mentoring, networking, grant strategy ▪ Outcome: 27% promoted to associate professor; 66% grant success rate ▪ Finding: Comprehensive research support yielded higher promotion and grant rates o Program: PRIDE-Functional and Translational Genomics of Blood Disorders (FTG) ▪ Scope: National (six sites), three years ▪ Aim: Increase URiM faculty in heart/lung/blood/sleep research ▪ Intervention: Summer training, mentorship, grant writing, networking ▪ Outcome: Participants averaged 0.28 grants/person vs. 0.16 in comparison group ▪ Finding: Modest gains in research productivity; limited by control group differences • Two successful programs at UC San Diego (UCSD) and at MUSC demonstrated increased URiM faculty representation through institution-wide initiatives; despite using different multimodal approaches, both programs shared key elements: o institutional support and funding o institution-wide scope • The MUSC study emphasized that: o broad institutional efforts can address the lack of a critical mass of URiM faculty o insufficient critical mass can hinder progress and lead to higher attrition o fewer URiM faculty members often face the "minority tax" – a disproportionate expectation to serve on committees and represent diversity, which detracts from career-advancing activities and can lead to burnout • The UCSD study highlighted the importance of: o clearly communicated timelines for diversity initiatives o leadership involvement and committed stakeholders as essential to engaging the community and demonstrating genuine commitment to diversity					

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Population of focus for the EDI training or leadership initiative
  ○ Currently or prospective faculty
  ○ Existing staff
  ○ Existing institutional leaders
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ Diversity-centred initiatives
  ▪ Training to enhance admission and recruitment processes
  ▪ Strengthening hiring processes and career progression
  ○ Inclusion initiatives
  ▪ Fostering inclusive participation and meaningful involvement in different environments
• Knowledge mobilization and capacity building
  ○ Dissemination and uptake of EDI-related knowledge and best practices
  ○ Capacity building to sustain EDI initiatives over time
• Groups or communities of focus
  ○ Intersectionality-grounded approach
• Outcomes
  ○ Organizational outcomes
	Evidence-based strategies that improve recruitment, retention, and leadership advancement of underrepresented faculty in academic medicine emphasize the importance of institutional commitment, inclusive policies, mentorship, and accountability structures to advance equity, diversity, and inclusion (12)
	• The paper is a narrative literature review and expert consensus developed by the CORD Best Practices Subcommittee
	• It used a systematic search of MEDLINE/PubMed and selected 70 relevant articles on faculty recruitment, retention, and leadership diversity
	• Faculty who are underrepresented in medicine (UIM) remain underrepresented across academic ranks and leadership, with slower promotion and higher attrition than non-UIM peers
	• Inclusive recruitment strategies, like holistic review and diverse hiring committees, improve the diversity of faculty candidates
	• Mentorship, sponsorship, and development programs specifically for UIM faculty are essential for retention and advancement
	  ○ UIM faculty often lack access to mentorship and sponsorship networks critical for career advancement
	  ○ Structured programs that provide mentoring, leadership training, research support, and career guidance have been shown to improve faculty retention, increase promotion rates, and foster a sense of belonging and purpose among UIM faculty
	• Institutions should address the “minority tax” by fairly recognizing and compensating UIM faculty for diversity work and mentorship
	  ○ UIM faculty are frequently asked to serve on diversity committees, mentor UIM students, and engage in outreach work without adequate recognition or support; this “minority tax” can limit their time for research and scholarly work
	  ○ Institutions should formally acknowledge this labour through compensation, protected time, and credit in promotion decisions
	• Leadership commitment and accountability, including Chief Diversity Officers and strategic diversity plans, are key to sustained progress
	• Bias in promotion, tenure, and evaluation systems must be regularly assessed and addressed to ensure equity
	• Institutional climate should be improved through cultural competency training, anti-discrimination policies, and supportive environments
		No	4/9	January 2021	N/A	Not reported

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
▪ Body of trainees ▪ Workforce	• National programs (e.g., Harold Amos Medical Faculty Development Program or AMFDP, Research in Academic Pediatrics Initiative on Diversity or RAPID) are effective models for scaling equity and inclusion efforts in academic medicine • The study suggests that institutions implement sustained, evidence-based EDI strategies, including inclusive recruitment, mentorship, leadership accountability, and structural reform					
• Population of focus for the EDI training or leadership initiative o Currently enrolled health-related trainees • Equity, diversity, and inclusion initiatives focused on training and/or leadership o Inclusion initiatives ▪ Strengthening knowledge of and/or skills in cultural competency and safety • Outcomes o Organizational outcomes ▪ Body of trainees	While online international learning in occupational therapy aims to enhance cultural awareness and global health understanding, its effectiveness remains unclear; success depends on culturally and technically appropriate course design with measurable outcomes, as well as prepared, motivated students who benefit from small group support (102) • The aim of this review was to determine what is known from the existing literature on the use of online international student collaboration in occupational therapy curricula • Following screening and review, 10 papers met the inclusion criteria and were included in the review • Online international collaborations involve students from different countries (in this case, occupational therapy students) working together online toward shared learning goals o These collaborations typically use video conferencing platforms (e.g., Microsoft Teams, Zoom), social media (e.g., Facebook, WhatsApp), and email o When facilitated effectively, they promote cultural exchange and understanding of occupational therapy across diverse contexts • These online experiences offer international exposure to all students, especially those who may be unable to travel due to financial, personal, or pandemic-related reasons, promoting inclusive education • Students value small group, collaborative learning spaces with both synchronous and asynchronous interactions • There is currently weak evidence on whether online international learning effectively achieves its intended outcomes (e.g., cultural competence, civic awareness, understanding of global occupational therapy practice) • Curriculum design needs included: o clear expectations, training, and cultural preparation o alignment of learning outcomes, teaching methods, and assessments (constructive alignment)	No	5/9	2020	N/A	None reported

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
	○ involvement of both students and staff from all participating universities in the design process to avoid cultural or linguistic bias • Challenges included: ○ technical issues (e.g., connectivity, platform failures) ○ time zone and scheduling differences between institutions ○ language barriers and need for additional support when working in a second language ○ varying levels of digital fluency among students and staff • Future research directions included: ○ more rigorous research and validated assessment tools ○ greater focus on evaluating learning outcomes and improving pedagogical strategies ○ digital fluency development and structural barrier removal should be prioritized to future-proof education					
• Population of focus for the EDI training or leadership initiative ○ Currently enrolled health-related trainees • Groups or communities of focus ○ Intersectionality-grounded approach ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus) ▪ Gender ▪ Sex ▪ Sexual orientation • Outcomes ○ Individual-level outcomes ▪ Views and experiences with the EDI initiative	Several training approaches effectively improved student knowledge and confidence in providing affirming care for sexual and gender minorities; however, lasting attitude and belief changes required interactive exposure, with practice-based methods proving more effective than didactic learning alone (60) • The review examined the effectiveness of teaching medical students and residents on knowledge, attitudes, and skills in addressing the health of SGM persons and the strength of the research sample, design, and methods used • It identified a total of 36 articles that assessed the impact of medical student and resident education on knowledge, comfort, attitudes, confidence, and skills in working with SGM patients • Positive outcomes included increased knowledge, comfort, skills, attitudinal improvements, and high satisfaction with training ○ High satisfaction with training was common, often measured via Likert-scale surveys ○ Satisfaction is tied to student engagement and perceived value, which support knowledge acquisition ○ Most interventions assessed knowledge (26 studies) ○ Most studies reported significant knowledge gains, though one showed only minor improvement ○ Attitudes were harder to shift than knowledge ○ Eight studies assessed attitudinal change; only a few showed sustained or significant improvements	No	5/10	2020	N/A	• Sex/gender

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations
	○ One study showed loss of attitude improvement at 90-day follow-up, emphasizing the need for repetition and reinforcement ○ All seven studies that measured comfort showed significant post-training increases ○ All studies showed increased confidence in providing care post-training ○ Effective confidence methods included patient panels, student-led interventions, online modules, and multimodal workshops ○ Confidence gains occurred at various training stages (M1–M4, residency, fellowships) ○ Six studies assessed skill acquisition, most via self-reported preparedness rather than direct observation • Recommendations included: ○ Increasing curricular time dedicated to affirming/inclusive care ○ Conducting long-term follow-up to assess sustained impacts and generalize training to other health professions					
• Broader policy environment in which the EDI training or leadership initiative was implemented ○ Domestic laws, regulations, or standards related to EDI, including those put forward and/or enforced by health profession regulators • Population of focus for the EDI training or leadership initiative ○ Current or prospective faculty ○ Existing staff • Equity, diversity, and inclusion initiatives focused on training and/or leadership ○ Diversity-centred initiatives ▪ Strengthening hiring processes and career progression	Mentoring programs for women academics in medicine are often seen as strategies to address gender disparities in career advancement and to promote awareness of diversity and equity policies (93) • Effective mentoring schemes involve clearly defined goals, such as enhancing knowledge, skills, attitudes, and fostering professional relationships • Key components include the identification and training of mentors, the selection of mentees, and the matching process between mentors and mentees • There is no clear consensus on the necessity of gender-matching, even within programs designed exclusively for women mentees • Outcomes: ○ At the community level, mentoring has supported research capacity through sessions on teaching, grant writing, and publication ○ At the organizational level, mentoring has contributed to improved workforce outcomes, including promotion, retention, and academic performance of women staff ○ At the individual level, mentoring has enhanced participants' experiences of academic life, job satisfaction, well-being, and perceived career progression	No	4/9	2019	N/A	• Gender

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Gender
• Outcomes
  ○ Outcomes related to the broader communities serviced by institutions
  ▪ Research
  ○ Organizational outcomes
  ▪ Workforce
  ○ Individual-level outcomes
  ▪ Views and experiences with the EDI initiative
  ▪ Views and experiences with respect to institutional climate						

• Population of focus for the EDI training or leadership initiative
  ○ Currently enrolled health-related trainees
  ○ Currently or prospective faculty
  ○ Existing institutional leaders
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ Diversity-centred initiatives
  ▪ Strengthening hiring processes and career progression
  ○ Inclusion initiatives
  ▪ Fostering inclusive participation and meaningful
	Mentorship and training interventions to diversify aging and Alzheimer's researchers are reported to be effective when culturally responsive, theory-driven, and supportive across career stages (78)
	• The study conducted a scoping review of 14 peer-reviewed empirical articles on mentorship and training programs for underrepresented minorities (URMs) in aging and Alzheimer's disease and related dementias (ADRD) from 1999 to 2019
	  ○ All programs reviewed were based in the United States and focused on increasing diversity in the ADRD research and practice workforce
	  ○ Programs targeted various URM groups, including Black/African American, Hispanic/Latino, American Indian/Alaska Native, and Asian American populations
	• A majority of the programs focused on students or early-career trainees, including undergraduates, graduate students, medical students, and postdoctoral scholars
	• Only a few programs specifically targeted faculty or clinical professionals, indicating a gap in ongoing professional development for existing staff
		No	4/9	August 2019	No	• Race/ ethnicity
						• Age
						• Socioeconomic status
						• Culture/ language

Dimension of organizing framework	Declarative title and key findings	Living status	Quality (AMSTAR)	Last year literature searched	Availability of GRADE profile	Equity considerations

involvement in different environments
• Knowledge mobilization and capacity building
  ○ Capacity building to sustain EDI initiatives over time
• Groups or communities of focus
  ○ Intersectionality-grounded approach
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Race/ethnicity
  ▪ Age
  ▪ Socioeconomic status
  ▪ Culture/language
• Outcomes
  ○ Organizational-level outcomes
  ▪ Body of trainees
  ▪ Workforce
  ○ Individual-level outcomes
  ▪ Views and experiences with the EDI initiative
  ○ Views and experiences with respect to institutional climate
	• Just five out of 14 programs were guided by theoretical frameworks, highlighting a lack of theory-informed design in most initiatives
	• Many programs emphasized culturally relevant and representative mentorship, a key factor valued by participants and associated with greater retention and success
	• Career development support across multiple stages of training was identified as essential to sustaining URM engagement in aging research
	• Some programs demonstrated positive outcomes, including increased URM recruitment, graduate school enrolment, and publication rates
	• Programs that included community-based participatory research, cultural competency, and leadership training were particularly impactful
	• Few studies provided systematic evaluations or standardized outcome measures, limiting broader comparison and scalability
	• Barriers identified included limited access to mentorship, lack of institutional support, and inadequate funding or resources
	• Facilitators of success included mentorship networks, structured program design, and longitudinal support models
	• The review revealed a need for institutionalization of EDI efforts, with consistent funding, leadership commitment, and integration into academic culture
	• The findings emphasize the importance of developing systematic evaluation standards and incorporating equity-focused, theory-driven designs in future EDI training and leadership programs					

Appendix 5: Details about each identified single study

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Broader policy environment in which the EDI training or leadership initiative was implemented
  ○ Domestic laws, regulations, or standards related to EDI, including those put forward and/or enforced by health profession regulators
• Population of focus for the EDI training or leadership initiative
  ○ Currently enrolled health-related trainees
  ○ Current or prospective faculty
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ EDI overall
  ▪ Community engagement or partnerships with external actors with the aim of promoting EDI
  ○ Inclusion initiatives
  ▪ Strengthening knowledge of and/or skills in cultural competency and safety
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Race/ethnicity
  ▪ Gender
  ▪ Age
  ▪ Socioeconomic status
	Social justice education in an undergraduate dental program in Quebec, Canada emphasized community engagement, outreach clinics, and active teaching methods to raise student awareness and promote responsibility for addressing health inequities (133)
	• Involving communities in admissions may help recruit students committed to serving vulnerable populations
	• Outreach clinic rotations expose students to marginalized groups and emphasize non-judgmental care
	• Social justice education uses participatory methods like role-play and reflection to foster awareness of systemic inequities, integrated early and throughout the curriculum
	• Outcomes:
	  ○ At the individual level, social justice education fosters student awareness of systemic inequities, a sense of responsibility for change, and the importance of accessible, population-tailored care
	• Barriers and facilitators:
	  ○ Barriers to social justice education in dentistry include limited curricular time, varying student interest, financial constraints, and the need for trained educators to ensure consistent messaging
	  ○ Student awareness was seen as the most essential element for effective teaching
		High	Publication date: 2022
			
			Jurisdiction studied: Quebec, Canada
			
			Methods used: Qualitative design using semi-structured interviews
				• Race/ethnicity
				• Gender
				• Age
				• Socioeconomic status
				• Immigration status (i.e., new immigrants)

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations
▪ Immigration and/or refugee status • Outcomes ○ Individual-level outcomes ▪ Views and experiences with the EDI initiative ○ Implementation barriers and facilitators				
• Population of focus for the EDI training or leadership initiative ○ Currently enrolled health-related trainees ○ Current or prospective faculty ○ Lay/community health workers • Equity, diversity, and inclusion initiatives focused on training and/or leadership ○ EDI overall ▪ Formal governance structures and processes supporting EDI ▪ Integration of EDI into strategic planning and decision-making processes ▪ Strengthening leadership competencies in EDI ○ Diversity-centred initiatives ▪ Training to enhance admission and recruitment processes • Groups or communities of focus ○ Dimensions of equity ▪ Place of residence ▪ Race/ethnicity	Evaluation of a multi-pronged EDI approach—including implicit bias awareness training for evaluators, and implemented by Schulich Medicine admissions committee in its non-Indigenous admissions pathway with the goal of enhancing diversity of Canadian physician workforce—found an overall increase in the representativeness of the incoming medical school class within two years of implementation (14) • This study evaluated the effectiveness of a multi-pronged five-strategy approach to enhancing diversity of the incoming medical class to Schulich School of Medicine ○ Only one of the five initiatives focused on training ○ This training consisted of implicit bias awareness training for committee members, file reviewers, and interviewers, drawn from faculty, community members, and senior medical students ▪ The other four initiatives were more structural in nature, consisting of a) introduction of voluntary applicant diversity survey; b) addition of an Equity Representative on the admission committee and increasing diversity of the admissions committee and evaluator pool, with limits on term membership; c) introduction of biosketch component to admissions requirements; and d) introduction of ACCESS alternate admissions pathway for applicants with financial/socio-cultural/medical barriers that has more flexible MCAT requirements and evaluators with lived experience/expertise with applicant's barrier ○ Implicit bias awareness training focused on self-assessment of self and collective biases in relation to applicants, and methods to ameliorate implicit bias ○ Article did not go into detail as to how the implicit bias awareness training was being delivered ○ The goal of this training was to diversify the future of Canada's physician workforce • The outcome of the implicit bias awareness training was not evaluated independently of the four other, more structural changes to the admission process, initiatives • Study compared diversity data before and after implementation of the five initiatives and found general improvement in representation ○ Compared to the class of 2022 (pre-initiatives), the class of 2024 (post-initiatives) had increased representation of female students (10%, although this could be due to an	Medium	Publication date: June 2022 Jurisdiction studied: Schulich School of Medicine, southern Ontario Methods used: Comparison of diversity data of incoming cohort before vs. after initiatives; comparison of applicant pool vs. admitted class	• Race/ethnicity/ culture/language • Gender/sex • Education • Socioeconomic status • Personal characteristics associated with discrimination (e.g. age, disability)

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations
▪ Culture/language ▪ Gender ▪ Sex ▪ Age ▪ Socioeconomic status ▪ Disability ▪ Sexual orientation • Outcomes ○ Organizational outcomes ▪ Body of trainees ▪ Workforce	external trend and not the strategies), racialized students (18%), LGBTQ2S+ (24%), mature students (28%), and students with a disability (88%) ○ There were two statistically significant increases, regarding increase in representation of those struggling financially, and regarding representation of those with a first language other than English or French • From observing the class of 2024's diversity data at the first stage of admission and at the last stage (the pool of those admitted), there was similar representation; this suggests that no new barriers were introduced by the strategies, and that barriers were even potentially mitigated by the strategies • Reported limitations included: ○ Because this is a case study, results are not generalizable ○ Longer-term impacts are unknown ○ The multi-pronged design meant that study couldn't analyze which initiative had the most impact • Applicant data for gender identity, sexual identity, disability status, first-generation Canadian, and first-generation in university was not robust			
• Population of focus for the EDI training or leadership initiative ○ Existing health professionals ▪ Nurses ▪ Allied health professionals • Equity, diversity, and inclusion initiatives focused on training and/or leadership ○ EDI overall ▪ Community engagement or partnerships with external actors with the aim of promoting EDI • Groups or communities of focus ○ Dimensions of equity ▪ Indigenous identity • Outcomes ○ Outcomes related to the broader communities serviced by institutions ▪ Research	A three-hour micro-credential course co-designed by researchers and Indigenous Elders was provided to public health professionals (such as public health nurses) in Ontario; it involved reflexive practices to understand systemic power imbalances and the ongoing effects of colonization and self-reflection about the provider's individual power, privilege, and positionality (66) • The goal of this training was to address gaps in knowledge about Indigenous people within healthcare to decrease the frequency of anti-Indigenous racism in a public health organization • Participants included public health nurses, health promoters, managers, public health inspectors, and senior leaders • The course was delivered virtually through nine asynchronous modules due to the COVID-19 pandemic, though the program was designed to have synchronous and/or in-person components to create a dialogue and build relationships while learning this content, rather than a passive unilateral transfer of information • Since the publication of this study, there have been additional studies that relate to this program, including: ○ A longer cultural safety program called the New Respect Cultural Safety Program, which was based on the previous project and lessons learned, which the Indigenous Elders from local First Nations and Métis communities were involved in throughout the course design process and research period ○ An Indigenous Cultural Safety Evaluation Checklist, which was piloted through the study for public health managers to add to regularly scheduled performance evaluations (effectiveness is unknown at this time)	Medium	Publication date: May 2022 Jurisdiction studied: Ontario, Canada Methods used: Pre- and post-test surveys	• Race/ethnicity/ culture/language

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations
	○ An evaluation on the participation of the research, where they found higher course completion in the 2022 time period, compared to the 2021 period; the authors hypothesize that the workload during the COVID-19 pandemic may have influenced participation outcomes			
• Population of focus for the EDI training or leadership initiative ○ Currently enrolled health-related trainees ○ Current or prospective faculty • Groups or communities of focus ○ Intersectionality-grounded approach ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus) ▪ Race/ethnicity ▪ Indigenous identity • Outcomes ○ Individual-level outcomes ▪ Views and experiences with the EDI initiative ▪ Views and experiences with respect to institutional climate	Faculty members in nursing and medical education at several Canadian universities described their strategies to incorporate decolonial, intersectional pedagogies and training into existing curriculum and expressed the emotional and spiritual toll that may come with delivering this type of training (56) • The views and experiences of faculty members providing EDI (Indigenous cultural safety) lectures and training were documented, especially their experience within the institutional culture ○ Faculty expressed that their curriculum was already content-packed, pedagogy is based on the interests of individuals because of the Academic Freedom clause, and cultural safety for Indigenous Peoples is not part of the mainstream curriculum in Canada ○ They also reported that the influence of the Truth and Reconciliation Commission (TRC) Calls to Action have contributed to the popularization of mandatory 'diversity courses' • Faculty members expressed the emotional and spiritual toll when delivering this type of training • Faculty provided recommendations to incorporate Decolonial, Intersectional Pedagogies In Nursing And Medical Education in Canada, which included: (1) institutional features (e.g., cultivate inner conscious awareness, partnerships, pedagogies from multiple worldsenses of health and healing, provide departmental support to mitigate burnout such as half-day Fridays, designated professional time, paying honoraria); (2) classroom strategies (e.g., use terms such as ancestral lineage, teach and facilitate pedagogies that allows space to discuss intergenerational trauma, continue updating physical and virtual spaces with architects and designers on Indigenous knowledges, and integrate concepts of settler-colonialism, health equity, and social justice); and (3) emotional and spiritual health of faculty (e.g., share the load of teaching on topics such as racism and settler-colonialism, cluster faculty hiring to create a cohort from equity-deserving groups, and integrate land-based learning)	Medium	Publication date: August 2023 Jurisdiction studied: Canada (several universities) Methods used: Interviews and participant observation with critical ethnographic methods	• Race/ethnicity/ culture/language
• Broader policy environment in which the EDI training or leadership initiative was implemented ○ Domestic laws, regulations, or standards related to EDI, including those put forward and/or enforced by health profession regulators	The Global Health Practicum (GHP) is an EDI training for undergraduate nursing students, designed to enhance their understanding of health inequities and advance social justice in resource-deprived settings through reflective practices and practical experience, ultimately resulting in experiences of moral uncertainty, heightened social consciousness, and sense of connectedness (69) • The program includes preparatory training on issues such as power dynamics, privilege, and social determinants of health, followed by practical experience in varied healthcare settings under the supervision of local healthcare providers and a clinical instructor • During the GHP, students gain experience in a range of settings, such as acute care facilities, public health sites, non-governmental organizations, and educational institutions	High	Publication date: 2021 Jurisdiction studied: Canada and Africa Methods used: Qualitative design using semi-	• Culture/language • Socioeconomic status

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Population of focus for the EDI training or leadership initiative
  ○ Currently enrolled health-related trainees
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ Inclusion initiatives
  ▪ Strengthening knowledge of and/or skills in cultural competency and safety
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Culture/language
  ▪ Socioeconomic status
• Outcomes
  ○ Individual-level outcomes
  ○ Views and experiences with the EDI initiative
	○ Outcomes include experiences of moral uncertainty (i.e., difficulty determining the appropriate course of action), heightened social consciousness, and a sense of connectedness with the local community, clinical settings, or peer network
	○ Moral uncertainty is influenced by students' motivations, expectations, and reflective practices, and can be mitigated through comprehensive predeparture preparation, clearly defined program goals, and strong supervision and support
			structured interviews	

• Population of focus for the EDI training or leadership initiative
  ○ Current or prospective faculty
• Equity, diversity, and inclusion initiatives focused on training and/or leadership
  ○ Diversity-centred initiatives
  ▪ Strengthening hiring processes and career progression
• Groups or communities of focus
  ○ Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
  ▪ Gender
	Findings from interviews of cohorts that participated in national career development programs ELAM, MWIM, and EWIM from 1988–2010 show that these programs can facilitate career advancement of American and Canadian women biomedical faculty, when combined with a host of other individual-level, institutional-level supports (specifically with intentional support of institutional leaders and socio-cultural-level factors) (49)
	• Two of the three programs, Mid-Career Women in Medicine (MWIM) and Early-Career Women in Medicine (EWIM), are sponsored by the Association of American Medical Colleges, and were founded in 1988 with the goal of building the skills and confidence needed to enable advancement at each of the career stages of women pursuing academic career in medicine; these programs are three days long and run in medical schools across the U.S. and Canada, and were developed to achieve gender equity in success in academic medicine
	• The third program, the Hedwig van Ameringen Executive Leadership in Academic Medicine (ELAM) program, was founded in 1995 in order to increase the proportion and effectiveness of senior women executive leaders in health science organizations; the program accepts nominations from the dean or other leaders of academic health centres that can provide
		High	Publication date: April 2016
			
			Jurisdiction studied: Medical schools across the U.S. and Canada
			
			Methods used: Reconstructive thematic analysis of telephone interview data
				• Gender/sex

Dimension of organizing framework	Declarative title and key findings	Relevance rating	Study characteristics	Equity considerations

• Outcomes
  ○ Organizational outcomes
  ▪ Workforce
  ○ Individual-level outcomes
  ▪ Views and experiences with the EDI initiative
  ▪ Views and experiences with respect to institutional climate
  ○ Implementation barriers and facilitators
	evidence of their commitment to developing the nominee for advancement within five years of ELAM participation, and is delivered at the Drexel University College of Medicine
	• Narrative analysis of telephone interviews with women (n=45) currently holding faculty appointments in academic medical institutions in the U.S. or Canada who had participated in at least one of the three programs revealed promoters and barriers of program attendance and program impact, and also highlighted how these influences interacted with socio-cultural promoters/barriers:
	  ○ Pre-program individual-level promoters: All participants were motivated to attend to reduce isolation, develop network of women colleagues, and find women mentors; early and mid-career academics wanted to attend to prepare for promotion; full professors wanted to develop leadership skills; participants were ambitious
	  ○ Post-program individual benefits included skill-development (negotiation, interpersonal skills, conflict management, time management, goal setting, strategic career planning, self-promotion), self-awareness (Myers-Briggs and the 360 evaluations of leadership attributes activities facilitated greater self-awareness and confidence in ambitious efforts), academic advancement (because participants used these learned skills to attain promotion and career milestones), increased visibility at the organizational level, and a broader perspective of the institutional culture
	  ○ Post-program institutional impacts were minimal, and not the result of strategic planning by the institution to enhance its investment; any changes to the institution in the direction of increased gender equity and inclusion was the result of individual graduates of the program who, inspired by their program experience, initiated or joined campus programs (e.g., mentoring programs, women's interest groups, DEI committees, resident education groups) to promote diversity and gender equity; therefore, to achieve long-lasting gender equity and inclusion at the institutional level, it is important to have intentional support of institutional leaders, along with career development programs
	  ○ These programs took place within socio-cultural backdrop, interaction with which determined outcomes; socio-cultural promoters included family support and financial resources, possessing attributes of passion/patience/persistence, and, starting around the year 2000, the existence of women powerful enough to sponsor other women
	  ○ Socio-cultural barriers included demands from family responsibilities, gender bias (overt and covert devaluing of women's contributions, the belief women need more training to be successful in the workplace and must conform to male-dominated norms to survive), and uncertainty of funding in combination with changes in healthcare system financing models, which decreased institutional willingness to support these kinds of programs
	• Limitations of this study are possible recall bias and cohort effects; moreover, as with all qualitative studies, there is absence of external validity since these participants' experiences are not necessarily representative of the entire population of women in academic medicine			

Appendix 6: Protocols for evidence syntheses that are underway

Hyperlinked protocol
Improving gender equity in critical care medicine: A protocol to establish priorities and strategies for implementation
Strategies for equity, diversity and inclusion in geriatric healthcare professional curricula: A scoping review protocol
From the sticky floor to the glass ceiling and everything in between: Protocol for a systematic review of barriers and facilitators to clinical academic careers and interventions to address these, with a focus on gender inequality
Effect and outcome of equity, diversity and inclusion programs in healthcare institutions: A systematic review protocol

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