McMaster University | Health Forum

Rapid evidence synthesis

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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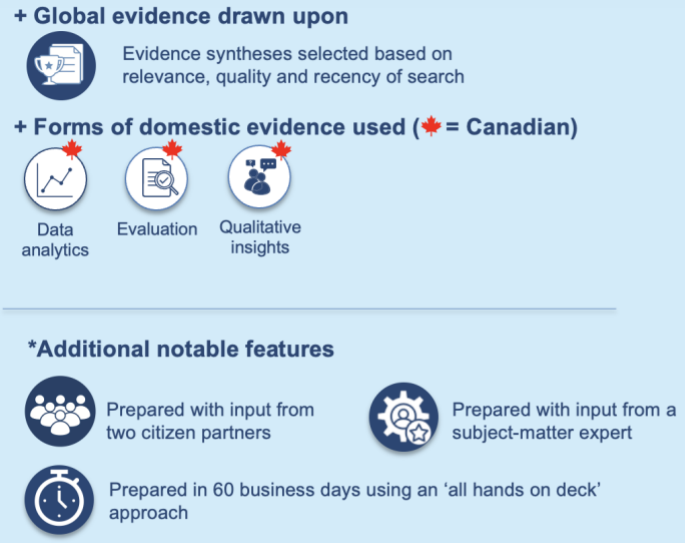
Context

In Canada, equity-deserving communities (e.g., Black, Indigenous, and racialized peoples, 2SLGBTQIA+ populations, those of low socioeconomic status, people with disabilities, women, rural residents) are underrepresented among the trainees, faculty, and leadership within health sciences institutions.(1-7)

Systemic barriers (e.g., financial costs associated with professional school admissions, discrimination during and beyond hiring, lack of accommodations, workplace violence) hinder them from joining and meaningfully engaging within health sciences institutions.(1-7) Such barriers have implications for patient and community well-being, contributing to patient experiences of discrimination within healthcare institutions and hindering their needs and perspectives from being recognized.(8) Addressing these barriers can thus support the inclusion and well-being of current and prospective trainees, faculty, and leadership, and mitigate inequities in health-service access and outcomes (e.g., by enhancing trainee capacity to support diverse patient groups and mitigating providers' implicit biases).(1;2;8;9)

Box 1: Evidence and other types of information



In recent decades, there have been efforts focused on advancing equity, diversity, and inclusion (EDI) within health sciences institutions, including EDI integration in high-level decision-making, the enhancement of admission and hiring processes, efforts to cultivate inclusive curricula and climates, and the provision of disability-related accommodations.(7) While these initiatives have strengthened EDI on some fronts (e.g., increased representation of women in the physician workforce), efforts to improve EDI in the health workforce are ongoing.(2;7) Empirical evidence about the processes and outcomes for initiatives can inform the development and refinement of future efforts.(10)

This rapid evidence synthesis assesses the best-available evidence on the features and impacts of EDI-focused training and leadership initiatives within health sciences institutions, alongside the experiences and perceptions of those engaged with these initiatives. Please note that we employ the EDI definitions proposed by McMaster University's Equity and Inclusion Office. We define health sciences institutions as encompassing health-focused academic departments and faculties, teaching hospitals with links to academic faculty, health anchor institutions (e.g., hospitals or universities supporting population health efforts in surrounding areas), and health networks (e.g., public health units, regional health authorities, hospital networks).

Questions

1. What are the features and impacts of EDI initiatives focused on training and/or leadership in health sciences institutions on individual-, organizational-, community-, and systems-level outcomes?

2. How do trainees, faculty, staff, health professionals, and institutional leaders experience and perceive the value and effectiveness of EDI initiatives focused on training and/or leadership in health sciences institutions?

High-level summary of key findings

- We identified 134 evidence documents, which include 14 evidence syntheses and 120 single studies that largely focused on strengthening knowledge of and/or skills in cultural competency and safety, followed by establishing formal structures and processes supporting EDI, integrating EDI into strategic planning and decision-making, and community engagement or partnerships with external actors with the aim of promoting EDI.
- Given the large volume of literature identified, we focused our in-depth analysis of key findings about features and any reported impacts of EDI training and leadership initiatives from the 14 existing evidence syntheses that we identified and the five single studies that were conducted in Canada to provide local contextualized evidence from Canada (where this rapid evidence synthesis was requested) alongside the global evidence in the evidence syntheses.
- These evidence syntheses and Canadian studies underscored the need for multi-level, intersectional EDI-focused training and leadership initiatives that are continuously evaluated, formally supported, and embedded in institutional structures.
- Evaluations of EDI-focused training and leadership initiatives were often limited to self-reported confidence or satisfaction metrics; only a few studies incorporated longer-term, multi-method assessments that measured outcomes such as faculty retention, promotion rates, and climate change, highlighting a key gap in evaluating structural impact.
- EDI training and leadership initiatives in health science institutions can improve individual-level outcomes (e.g., confidence, knowledge, and cultural responsiveness) and community-level outcomes, especially when co-developed with community members and delivered using interactive and reflexive methods (e.g., lived-experience panels, role-play, participatory reflection).
- Programs targeting underrepresented groups in health and academic research (including racialized persons, Indigenous peoples, individuals with disabilities, 2SLGBTQIA+ people, and those from lower socioeconomic backgrounds) at the organizational-level demonstrated improved retention, grant success, and advancement when supported by mentorship, skill-building, financial supports, and institutional infrastructure (e.g., community partnerships, inclusive admissions practices).
- Several evidence documents identified the need for formal institutional commitment to equity (e.g., dedicated EDI plans, EDI committees with legislative power, leadership training, and accountability structures), which were associated with increased underrepresented in medicine faculty representation and sustained organizational change.
- Faculty delivering emotionally intensive content – particularly decolonial or intersectional pedagogies – reported emotional and spiritual burden, citing the need for structural support (e.g., protected time, cultural safety policies, workload accommodations) to prevent burnout and enable sustainability.
- Common implementation barriers included limited leadership support, insufficient training capacity, lack of protected time, and curricular constraints (e.g., content overload, lack of mandate).
- Key enablers included mentorship networks, community engagement, interactive formats, and culturally inclusive pedagogical approaches.
- However, several studies noted that long-term systemic change (e.g., shifting institutional culture, restructuring leadership norms) remains difficult to achieve without sustained support from senior leadership and clear strategic goals.

Framework to organize what we looked for

- 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 (e.g., anti-discrimination laws, legislated accessibility requirements, funding incentives for diversity programs, accreditation standards for professional programs)
  - Regional or global EDI standards or frameworks (e.g., UN Declaration of Human Rights, UN Sustainable Development Goals, International Labour Organization conventions)
- Population of focus for the EDI training or leadership initiative
  - Currently enrolled health-related trainees (e.g., graduate-level students in health services and methodology, medical students, nursing students, residents, allied health students)
  - Current or prospective faculty
  - Existing staff
  - Existing health professionals
    - Physicians (e.g., generalists, specialists)
    - Nurses
    - Dentists
    - Allied health professionals
    - Lay/community health workers
    - Citizen/patient partners
  - Existing institutional leaders (e.g., health sciences department chairs, deans, division chiefs, medical directors, senior health scientists, healthcare administrators)
- Equity, diversity, and inclusion initiatives focused on training and/or leadership
  - EDI overall
    - Formal governance structures and processes supporting EDI (e.g., creation of committees tasked with strengthening EDI, appointment of EDI leads)
    - Integration of EDI into strategic planning and decision-making processes (e.g., embedding EDI goals in institutional mandates, policies, terms of references and evaluations, dedicated funding for EDI)
    - Strengthening leadership competencies in EDI (e.g., fostering inclusive leadership through implicit bias training)
    - Community engagement or partnerships with external actors with the aim of promoting EDI (e.g., cultural safety training embedded within community outreach programs)
  - Diversity-centred initiatives
    - Training to enhance admission and recruitment processes (e.g., implicit bias training for application reviewers)
    - Strengthening hiring processes and career progression (e.g., training of reviewers to mitigate unconscious bias and conflicts of interest, accessible professional development, mentoring, and training opportunities)
  - Equity-centred initiatives
    - Providing accommodations for trainees or leaders (e.g., for trainees living with disabilities)
    - Promoting fairness in recognition and treatment (e.g., implicit bias training for tenure committees)
  - Inclusion initiatives
    - Fostering inclusive participation and meaningful involvement in different environments (e.g., access to resources and opportunities for equity-deserving trainees, training climate assessments, creating a disability-inclusive learning environment)
    - Ensuring psychological safety (e.g., provision of emotional support for equity-deserving trainees, reporting mechanisms, mechanisms for conflict resolution or management)
    - Strengthening knowledge of and/or skills in cultural competency and safety (e.g., developing inclusive curricula, global training opportunities aiming to promote cultural awareness)
- Knowledge mobilization and capacity building
  - Dissemination and uptake of EDI-related knowledge and best practices (e.g., integration of findings into institutional policies and programs, sharing of evidence-based strategies across institutions and sectors)

    - Capacity building to sustain EDI initiatives over time (e.g., leadership development programs, mentorship networks, creation of communities of practice)
    - Scalability and adaptability of EDI efforts (e.g., expansion of successful initiatives across different disciplines, institutions, or jurisdictions, flexibility to accommodate evolving needs and priorities)
    - Institutional learning and continuous improvement (e.g., iterative refinement of EDI initiatives based on evaluation data and stakeholder feedback)
- Groups or communities of focus
    - Intersectionality-grounded approach (e.g., initiatives for addressing the impacts of intersecting identities)
    - Dimensions of equity (adapted from Cochrane's PROGRESS-Plus)
        - Place of residence
        - Race/ethnicity
        - Culture/language
        - Gender
        - Sex
        - Age
        - Religion
        - Socio-economic status
            - Level of income
            - Education level
            - Occupation
        - Disability
        - Sexual orientation
        - Indigenous identity
        - Immigration and/or refugee status
        - Citizenship
        - Time-dependent relationships (e.g., caregiving responsibilities)
- Outcomes
    - Outcomes related to the broader communities serviced by institutions
        - Physical and mental health outcomes (e.g., patients, broader community)
        - Development of high-quality trusting relationships with local organizations
        - Research (e.g., socially relevant research, shared decision-making)
        - Collaboration across sectors (e.g., policy, economy, social sector) to produce socially relevant research, mobilize knowledge, and co-create solutions that address community needs and promote shared decision-making
    - Organizational outcomes
        - Reputation
        - Innovation and competitive advantage
        - Body of trainees (e.g., diversity of health-related trainees, learning outcomes of trainees)
        - Workforce (e.g., employee recruitment and retention, workforce diversity, productivity, career progression such as tenure and promotions, team-based outcomes)
    - Individual-level outcomes
        - Views and experiences with the EDI initiative
        - Views and experiences with respect to institutional climate (e.g., perceptions about sense of belonging, relatedness, autonomy, competence, degree to which individuals feel meaningfully involved, empowerment, employee satisfaction)
    - Cost-related outcomes (e.g., cost savings from reduced discrimination-related complaints, increased benefits from improved staff productivity)

- Implementation barriers and facilitators (e.g., difficulty accessing EDI training opportunities)

What we found

We identified 134 evidence documents (14 evidence syntheses and 120 single studies relevant to the research questions).(1;8;11-143) Given the large volume of literature, we mapped the evidence documents in a table to highlight the coverage and gaps of the existing research on this topic (Appendix 2). We provide a high-level summary of our general observations from the evidence mapping below.

Of the 134 evidence documents, we focused our in-depth analysis on the 14 existing evidence syntheses and the six single studies that were conducted in Canada to provide local evidence alongside the global evidence in the evidence syntheses. We summarize the key findings from these 20 evidence documents in narrative form below. Additional details about each identified EDI training and leadership initiative organized by its features and any reported impacts are provided in Appendix 3. Data extractions from each of the included evidence documents are provided in Appendix 4 and 5. Protocols for evidence syntheses that are underway are provided in Appendix 6.

Key observations from mapping all included evidence documents (n=134)

In general, the most significant coverage across the evidence documents relates to EDI-focused training and/or leadership initiatives for strengthening knowledge of and/or skills in cultural competency and safety. Most of the reported outcomes related to individual-level changes among trainees, including their views and experiences of the trainings. Given the focus of this rapid evidence synthesis, this finding is not surprising. However, we see evidence documents clustered around three additional initiatives: 1) establishing formal structures and processes supporting EDI; 2) integrating EDI into strategic planning and decision-making; and 3) community engagement or partnerships with external actors with the aim of promoting EDI. This may suggest a growing interest in formalizing and

Box 2: Approach and supporting materials

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.

We identified evidence addressing the question by searching AMED, APA PsycINFO, CINAHL, EDM Reviews, Embase, Global Health, Ovid Emcare, Ovid Healthstar, and Ovid MEDLINE to identify evidence syntheses, protocols for evidence syntheses, and single studies. All searches were conducted on 17 March 2025. The full methodology is described in Appendix 1.

In contrast to our rapid evidence profiles, which provide an overview and insights from relevant documents, this rapid evidence synthesis provides an in-depth understanding of the evidence. Additionally, due to the large volume of literature, an evidence map was developed to highlight the coverage and gaps of the existing research on this topic.

We appraised the methodological quality of evidence syntheses that were deemed to be highly relevant using the first version of the AMSTAR tool. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality, medium-quality evidence syntheses are those with scores between four and seven, and low-quality evidence syntheses are those with scores less than four. The AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to evidence syntheses pertaining to delivery, financial, or governance arrangements within health systems or implementation strategies.

This rapid evidence synthesis was prepared in a 60-business-day timeline.

A separate appendix document includes:
1) methodological details (Appendix 1)
2) a summary table of evidence mapped to the organizing framework (Appendix 2)
3) key findings from included evidence syntheses and Canadian-based single studies on EDI training and leadership initiatives (Appendix 3)
4) findings from each evidence synthesis organized by document type (Appendix 4)
5) findings from each single study organized by document type (Appendix 5)
6) protocols for evidence syntheses that are underway (Appendix 6).

institutionalizing EDI-focused training and leadership initiatives. The reported outcomes were well distributed across individual, organizational, and community levels, with limited attention to system-level outcomes. There was also notable coverage of the experiences and perceptions of EDI-focused training and/or leadership in international contexts. Related to evidence gaps, we identified only one single study that examined the return on investment of cultural competency leadership training in academic hospitals. The rest of the literature did not describe costs or other financial outcomes, highlighting a key area for future research.

Key findings from evidence syntheses and Canadian-based single studies (n=20)

The evidence documents primarily focused on the features and impacts of EDI-focused training initiatives implemented in health sciences institutions across different levels (i.e., individuals, organizations, communities, health systems). Generally, there was limited information on EDI-focused leadership initiatives. Some evidence documents also reported on the experiences and perceptions of those engaged in training and/or leadership-focused EDI initiatives. When reported, evaluations of these EDI-focused training and leadership initiatives were often limited to self-reported confidence or satisfaction metrics, with only a few evidence documents incorporating longer-term, multi-method assessments. Overall, the evidence supports the need for multi-level, intersectional EDI-focused training and leadership initiatives that are continuously evaluated, formally supported, and embedded in institutional structures.
Details of the identified EDI-focused training and leadership initiatives (including descriptions on their features, knowledge mobilization or capacity building, reported experiences and/or impacts, and other implementation considerations) are provided in Appendix 3.

Below we summarize high-level key findings from the identified 20 evidence documents (14 evidence syntheses and six Canadian-based single studies), which are organized according to the research questions.

What are the features and impacts of EDI initiatives focused on training and/or leadership in health sciences institutions on individual-, organizational-, community-, and systems-level outcomes?

We identified three medium-quality evidence syntheses and two single studies that described the features and impacts of EDI-related training initiatives on individual-level outcomes.(56;64;89;126;129) The trainings assessed focused on cultural competency with respect to the 2SLGBTQIA+ community, gender-affirming care, and inclusive clinical skills for trainees (e.g., medical, nursing, dental students and residents). Specifically, these trainings featured co-developed content, community voices and/or facilitators with lived experiences (e.g., experiences relevant to the training topics), and interactive formats (e.g., didactic teaching, group learning, mentorship).(29;89) Trainees commonly reported increased knowledge, comfort, and confidence following participation. Additionally, positive changes in individual self-awareness and social responsibility were also reported in global and community-based placements, where learners engaged directly with equity-deserving populations or trainees in other country contexts and confronted real-world inequities.(56;79) However, sustained shifts in attitude and behaviour were harder to achieve and required repeated and reinforced exposure over time.(29) Finally, training initiatives that included reflexive components (e.g., encouraging learners to examine power, positionality, and systemic inequities) were associated with stronger learner engagement and self-awareness, with the reported outcomes limited to trainees.(56;126)

We identified 11 evidence syntheses (seven medium-quality and four low-quality) and one single study that examined the features and impacts of EDI-related training, mentorship, and leadership development initiatives on organizational-level outcomes.(8;10;13;34;49;51;56;58;66;97;119;129) Key features of these initiatives included:

- integration of EDI content into curricula
- implicit bias training for admissions and hiring committees
- development of inclusive leadership capacity (e.g., leadership training focused on adaptability, mentoring for underrepresented faculty to improve hiring and career progression, strategic planning support, promotion of inclusive recruitment)

- investments in mentorship and skills development programs (e.g., grant writing, networking, and clinical skills training).(8;51;129)

These initiatives were associated with stronger professionalism and improved equity-related competencies among trainees from a range of disciplines (e.g., medicine, nursing, allied health). A subset of the identified evidence documents focused on the features and impacts of mentorship and leadership development programs for underrepresented groups (including racialized persons, Indigenous peoples, individuals with disabilities, LGTBTQIA+ people, and those from lower socioeconomic backgrounds) in health research and academic medicine. These programs included tailored training (e.g., grant-writing and clinical skill-building workshops for early-career researchers), mentorship models (e.g., peer and group mentoring networks), and structured leadership pipelines (e.g., national faculty development programs such as the Amos Medical Faculty Development Program and the PRIDE Institute).(34;51;58;61;97) These programs led to increased workforce retention, greater faculty representation, and stronger research capacity,(34;51;58;119) particularly when supported by institutional commitment, longitudinal support models, and structured networks.(34;51;61;129) These impacts were further reinforced when programs were implemented within institutions that had formal commitments to equity, including dedicated EDI plans, EDI committees with legislative authority, structured leadership development, and accountability mechanisms.(13;34;49;51;58;97;119)

We identified two evidence syntheses (one medium-quality and one low-quality) and one single study that reported on the features and impacts of EDI-related training and leadership initiatives on community-level outcomes.(49;79;129) Evidence documents highlighted how outreach and engagement contributed to broader health and education goals such as improving learner preparedness, increasing awareness of systemic inequities, and strengthening commitment to accessible care.(49;79;129) For example, a low-quality evidence synthesis described a physician assistant training program that involved inclusive sexual and gender minority health content. The training program was associated with improved learner preparedness and awareness of personal bias, which contributed to more inclusive care in the community.(49) A medium-quality evidence synthesis described how community-based participatory research and culturally responsive training designs contributed to impactful EDI programs aimed at increasing the diversity of researchers studying marginalized populations.(129) A qualitative study reported that dental students in Quebec who participated in social justice education (i.e., using participatory methods like role-play and reflection to foster awareness of systemic inequities) and outreach rotations reported increased awareness of health inequities and a strengthened commitment to accessible, population-specific care.(79) In particular, outreach clinic rotations helped to expose students to marginalized groups and emphasize non-judgmental care.(79)

We identified two medium-quality evidence syntheses that focused on system-level features that shaped the development and implementation of EDI training initiatives.(49;97) These included formal governance structures (e.g., EDI committees), integration of EDI into mission statements and strategic plans, and policies mandated by professional regulators.(49;97) These initiatives often involved academic leadership teams and faculty who played key roles in strategy design, committee participation, and curriculum integration.(49) Overall, there was limited information on system-level impacts of EDI-focused training and leadership initiatives.

How do trainees, faculty, staff, health professionals, and institutional leaders experience and perceive the value and effectiveness of EDI initiatives focused on training and/or leadership in health sciences institutions?

We identified six evidence syntheses (five medium-quality and one low-quality) and three single studies that examined how stakeholders experience and perceive EDI training and/or leadership initiatives in health sciences institutions.(1;8;18;49;51;58;61;66;89) Trainees consistently reported valuing EDI-related content for enhancing preparedness and confidence, but also noted gaps in curriculum duration and delivery format.(64;89) Faculty delivering decolonial and intersectionality content described significant emotional and spiritual strain, citing limited institutional support, lack of protected time, and isolation in their roles.(18) They emphasized the need for institution-wide support to embed EDI across programs and departments, highlighting that without clear timelines, leadership involvement, and structural backing, efforts can lead to burnout, isolation, and limited progress.(58;79) Common barriers to implementation included limited leadership support, a lack of institutional training capacity, insufficient protected time,

and curricular constraints (e.g., content overload, absence of mandate).(18;58) These challenges were offset in part by key enablers such as mentorship networks, community-engaged models, interactive learning formats, and pedagogical approaches that reflect diverse cultural contexts.(8;49;51;64) Institutional leaders who participated in national career-development programs (e.g., Executive Leadership in Academic Medicine, Mid-Career Women in Medicine, Early-Career Women in Medicine) reported increased leadership skills, confidence, and career advancement, but emphasized that broader institutional transformation typically depended on the initiative of individual program graduates rather than systemic supports.(61)

Next steps based on the identified evidence

Based on the coverage and gaps within the identified evidence documents, next steps for strengthening the implementation and evaluation of EDI-focused training and leadership initiatives in health science institutions could include:

- moving future evaluations beyond self-reported satisfaction or confidence measures, and adopting longitudinal, multi-method approaches that assess behavioural change, institutional climate, costs, and structural outcomes (e.g., retention, promotion, grant acquisition)
- revising curricula to incorporate inclusive definitions of professionalism and EDI competencies, especially in settings where current standards are perceived as restrictive or non-reflective of equity-deserving groups
- investing in faculty development and well-being to ensure lasting change in health science institutions (e.g., practices such as faculty clustering, cohort-based hiring, and workload protections can help advance equity and improve faculty retention)
- addressing gaps in evidence about EDI-focused leadership initiatives by evaluating their long-term effects on representation, institutional culture, and career progression
- strengthening the evidence base on co-development by assessing how involving community partners and equity-deserving groups in the design and delivery of EDI initiatives influences uptake, relevance, and outcomes
- co-developing training content with community partners and individuals with lived experience where possible
- designing EDI programs to respond to intersecting forms of inequity (e.g., race, gender, income, disability, Indigenous identity).

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