

1 **TITLE: Indigenous Cultural Safety Training for Applied Health, Social Work and Education Professionals:**  
2 **A PRISMA Scoping Review**

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25 **ABSTRACT:**

26 **Background:** Anti-Indigenous racism is a widespread social problem in health, social work, and education  
27 systems in English-speaking Colonized countries such as Canada, with profound negative impacts to the  
28 health and education of Indigenous peoples. In 2015, Canada's Truth and Reconciliation Commission  
29 recognized the legacy and impact of Colonization and recommended training programs for these  
30 professions on cultural competency and curricula, and on the colonial history of Canada. Yet there is little  
31 evidence on best practices for such training, highlighting the need to synthesize existing findings on how  
32 these training programs are developed, implemented, and evaluated. **Methods:** This scoping review  
33 explored the academic literature on Indigenous cultural safety and competence training in the health,  
34 social work, and education fields. Medline, EMBASE, CINAHL, ERIC and ASSIA were searched for articles  
35 published between 1996-2020 in Canada, United States, Australia, and New Zealand. The Joanna Briggs  
36 Institute's three-step search strategy was used as was the PRISMA extension for Scoping Reviews. Data  
37 was charted and synthesized in three stages. **Results:** 134 were included in this review. Data was extracted  
38 on four themes: 1) Article Characteristic; 2) Cultural Safety Concepts, Critiques and Rationale; 3)  
39 Characteristics of Cultural Safety Training; and 4) Evaluation Details of Cultural Safety Training. Findings  
40 suggest that research on cultural safety training programs in health, social work and education has grown  
41 significantly. Nursing and medicine professions have received a significant proportion of cultural training  
42 programs, compared with general/allied health, social work, and education. Across fields, professionals  
43 and students were targeted equally by training programs. Only half of evaluations of cultural safety and  
44 related intervention identified methodological limitations. **Implications:** Considering, comparing, and  
45 contrasting literature on cultural safety and related concepts and how they are applied in practice would  
46 advance this scholarly work, as would more robust evaluations of cultural safety and similar training  
47 interventions to understand their impact at the individual level. Finally, commitment to meaningfully  
48 engage Indigenous communities to develop, implement and evaluate such programs is urgently needed.

49 **1. INTRODUCTION**

50 **Rationale:**

51 There is substantial evidence to suggest that anti-Indigenous racism is a widespread health and social  
52 problem in Canada. While the term, Indigenous, refers to a variety of Aboriginal groups around the world  
53 (1), in Canada, Indigenous refers to the country's first inhabitants, namely First Nations, Inuit, and Métis  
54 peoples, as established in Section 35 of the Canadian Constitution (2). Racism may be understood as  
55 "racist ideologies, prejudiced attitudes, discriminatory behaviour, structural arrangements and  
56 institutionalized practices resulting in racial inequality as well as the fallacious notion that discriminatory  
57 relations between groups are morally and scientifically justifiable" (3). According to several population-  
58 based studies undertaken with Indigenous peoples across Canada, between 39% and 43% of respondents  
59 reported experienced racism (4-7). Systemic anti-Indigenous racism in health service organizations across  
60 the country is equally problematic. The investigations into the deaths of Brian Sinclair in Manitoba in 2008  
61 (8) and Joyce Echaquan in Quebec in 2020 (9), coupled with the alarming findings from the anti-Indigenous  
62 racism investigation in British Columbia's health care system in 2020 (10) collectively demonstrate the  
63 insidious nature of anti-Indigenous racism in Canada's health systems. Not only is racism a serious  
64 challenge for Indigenous peoples while accessing care, but also it has profound negative impacts on their  
65 likelihood of accessing future care (10-17).

66  
67 Beyond the health sector, research evidence also points to widespread anti-Indigenous racism in Canada's  
68 social work (18, 19) and Kindergarten to Grade 12 education systems (20, 21). Moreover, Indigenous  
69 peoples have been identified as the most disadvantaged with respect to accessing education in English  
70 speaking, colonized countries such as Canada, United States, Australia and New Zealand (20). Collectively,  
71 this evidence runs contrary to the inalienable rights established and set out within the United Nations  
72 Declaration on the Rights of Indigenous Peoples, including:

73 the right to be actively involved in developing and determining health [...] and social  
74 programmes affecting them [...] the right to access, without any discrimination, all social and  
75 health services [...], the right to enjoyment of the highest attainable standard of physical and  
76 mental health [...], [and] the right to all levels and forms of education [in the public system] [...]  
77 and that indigenous peoples, in the exercise of their rights, should be free from discrimination  
78 of any kind. (22)  
79

80 In 2015, Canada's Truth and Reconciliation Commission (TRC) recognized the legacy and impact of  
81 residential schools on Indigenous peoples across the country (23) and put forth 94 Calls to Action,  
82 including for the health, social work/child welfare, and education systems. These calls included providing  
83 cultural competency training for health professionals to address unconscious bias and systemic racism  
84 and developing culturally appropriate education curricula, while building student capacity for intercultural  
85 understanding, empathy, and mutual respect (24). The calls also set out the need to ensure that social  
86 workers who conduct child-welfare investigations to be properly educated and trained about the history  
87 and impacts of residential schools on children and their caregivers. In terms of education systems, the TRC  
88 recommended that resources be provided to ensure Indigenous schools utilize Indigenous knowledge and  
89 teaching methods in the classroom and that relevant teacher-training needs were identified to ensure  
90 such knowledge and methods were implemented.

91  
92 Initiatives such as Canada's TRC, along with similar federal government initiatives in Australia and New  
93 Zealand have led to the emergence of new training programs to facilitate cultural safety and competence,  
94 and ultimately, to eliminate anti-Indigenous racism and discrimination in health, social work and  
95 education systems (25, 26). However, given the nascency of the field of Indigenous cultural safety training  
96 combined with the need to expand the availability of such training to address anti-Indigenous racism,  
97 there is an urgent need to synthesize and understand existing evidence on how such training programs  
98 are conceptualized and developed, as well as how they are implemented in practice and evaluated for  
99 impact.

## 100 **1.2 Objectives**

101 Our team sought to explore the academic literature that conceptualizes and/or operationalizes  
102 Indigenous cultural safety training within the fields of health, social work, and education. The aim of this  
103 study was to answer the following three questions: 1) What is the general state of knowledge on  
104 Indigenous cultural safety training in the applied fields of health, social work, and education? 2) What  
105 methods are used to develop, implement, and evaluate Indigenous cultural safety training for students  
106 and professionals in the applied fields of health, social work, and education? And 3) What content is  
107 included in existing Indigenous cultural safety training program for students and professionals in the fields  
108 of health, social work, and education?

109

## 110 **2. METHODS**

111 **2.1 Protocol and registration:** A detailed research protocol for this scoping review is published in *Social*  
112 *Science Protocols* [doi.org/10.7565/ssp.2020.2815](https://doi.org/10.7565/ssp.2020.2815) (27), an open-access online journal platform. The  
113 authors of this paper chose not to register this study, both because of the rigid methodological  
114 requirements for registration, which do not align well with Indigenous research approaches, and because  
115 no other Indigenous studies were registered at the time. Indigenous cultural safety is a nascent area of  
116 research and practice, and the goal of this review was to achieve a comprehensive search. Our analysis  
117 sought to draw out insights that could inform Indigenous cultural safety training for professionals in the  
118 applied fields of health, social work, and education, which work with Indigenous peoples in Canada.

119

120 **2.2 Eligibility Criteria:** We reviewed the global academic literature on Indigenous cultural safety training  
121 that included but was not limited to Indigenous peoples in Canada. Inclusion criteria: This review was  
122 restricted to articles about Indigenous cultural safety in health, social work and education in British  
123 colonial settler nation states, including Australia, New Zealand, Canada, and the United States. All peer-

124 reviewed primary research articles on the topic of Indigenous cultural safety within the fields of health,  
125 social work, and education that were reported in the academic literature between 1996-2020 were  
126 included. The review dates were selected to ensure that the full history of the term “cultural safety”, first  
127 coined in 1996 (28), was captured. This review included all articles published in or translated into English.  
128 Exclusion criteria

129

130 **2.3 Information Sources:** To identify potentially relevant literature in health, social work, and education,  
131 the following five bibliographic databases were searched from 1996-2020: Medline, EMBASE, CINAHL,  
132 ERIC and ASSIA. These databases were selected to capture the fields of health, education, and social work  
133 as aligned with the focus of this review. The search strategies were developed by an experienced librarian  
134 from Gerstein Library at the University of Toronto and further refined through team discussion.

135

136 **2.4 Search Strategy:** A three-step search strategy (Aromatis & Munn, 2020) was utilized for this review.  
137 The first step involved a limited search of two initial databases, Medline and EMBASE, followed by an  
138 analysis of subject headings and search terms based on identified titles and abstracts. Table 1 (Search  
139 Strategy for MEDLINE AND EMBASE (Ovid)) outlines the keyword searches employed at this step. A second  
140 search was then conducted using all identified subject headings and keywords across all five databases.  
141 Table 2 and Table 3 detail the keyword searches employed to search CINAHL, and ERIC and ASSIA  
142 respectively (for details of this process, see section 2.5: Selection of Sources of Evidence). These searches  
143 were conducted in May 2020, and collectively resulted in 3600 studies, which were imported into  
144 Covidence for screening. The decision was made by our team to only search the literature prior to COVID-  
145 19.

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148 Table 1: Search Strategy for MEDLINE AND EMBASE (Ovid)

<b>Subject Heading Search: MEDLINE AND EMBASE (Ovid)</b>		
(Culturally Competent Care OR Cultural Competency) AND (exp Health Personnel OR exp Education OR exp Curriculum OR exp Teaching OR Social Work) AND (Indigenous Peoples OR exp American Native Continental Ancestry Group OR exp Oceanic Ancestry Group)		
<b>Keyword Search</b>		
Activity	ICS Training	(cultural* ADJ3 safe*) OR (cultural* ADJ3 competen*) OR (culturally ADJ3 appropriate) OR (cultural* ADJ3 sensitiv*)
Context	Indigenous	Indigenous OR (first nations) OR (Métis) OR (Inuit) OR (Aboriginal) OR (Maori) OR (Torres Straight)
Population	Health	(health care) OR (healthcare) OR (practitioner*) OR (health care provider*) OR (health ADJ3 professional*) OR (nurs*) OR (physician*) OR (public health)
	Education	(educat*) OR (teach*) OR (faculty)
	Social Work	(social ADJ2 work*) OR (child welfare) OR (criminal justice work*) OR (justice work*) OR (support ADJ2 work*) OR (employ* ADJ2 service*) OR (employ* ADJ2 support) OR (housing ADJ2 service*) OR (housing ADJ2 support) OR (family ADJ3 service*) OR (child* aid) OR (child* ADJ3 service*) OR (youth ADJ3 service*)

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151 Table 2: Search Strategy for CINAHL

<b>Subject Heading Search</b>		
(Cultural Safety) OR (Cultural Competence) OR (Cultural Sensitivity) AND (Indigenous Peoples) AND (Social Work) OR (Social Work Service) OR (Students, Social Work) OR (Education, Social Work) OR (Social Service Assessment) OR (Education) OR (Health Personnel) OR (Facilities, Manpower and Services) OR (Occupational Health Services)		
<b>Keyword Search</b>		
Activity	ICS Training	(cultural* N3 safe*) OR (cultural* N3 competen*) OR (culturally N3 appropriate) OR (cultural* N3 sensitiv*)
Context	Indigenous	Indigenous OR (first nations) OR (Métis) OR (Inuit) OR (Aboriginal) OR (Maori) OR (Torres Straight)
Population	Health	(health care) OR (healthcare) OR (practitioner*) OR (health care provider*) OR (health N3 professional*) OR (nurs*) OR (physician*) OR (public health)
	Education	(educat*) OR (teach*) OR (faculty) OR (curriculum)
	Social Work	(social N2 work*) OR (child welfare) OR (criminal justice work*) OR (justice work*) OR (support N2 work*) OR (employ* N2 service*) OR (employ* N2 support) OR (housing N2 service*) OR (housing N2 support) OR (family N3 service*) OR (child* aid) OR (child* N3 service*) OR (youth N3 service*)

152 Table 3: Search Strategy for ERIC and ASSIA (Proquest)

Keyword Search		
Activity	ICS Training	(cultural* NEAR/3 safe*) OR (cultural* NEAR/3 competen*) OR (culturally NEAR/3 appropriate) OR (cultural* NEAR/3 sensitiv*)
Context	Indigenous	Indigenous OR (first nations) OR (Métis) OR (Inuit) OR (Aboriginal) OR (Maori) OR (Torres Straight)
Population	Health	(health care) OR (healthcare) OR (practitioner*) OR (health care provider*) OR (health NEAR/3 professional*) OR (nurs*) OR (physician*) OR (public health)
	Education	(educat*) OR (teach*) OR (faculty)
	Social Work	(social NEAR/2 work*) OR (child welfare) OR (criminal justice work*) OR (justice work*) OR (support NEAR/2 work*) OR (employ* NEAR/2 service*) OR (employ* NEAR/2 support) OR (housing NEAR/2 service*) OR (housing NEAR/2 support) OR (family NEAR/3 service*) OR (child* aid) OR (child* NEAR/3 service*) OR (youth NEAR/3 service*)

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155 **2.5 Selection of Sources of Evidence:** The selection of studies for this review was performed in Covidence  
 156 independently by two reviewers and involved a four-stage process (see Image 1: Prisma Flow Diagram, in  
 157 Appendix). The first stage of screening involved identifying and removing 1117 duplicate studies from  
 158 Covidence (see results in Table 4: Scoping Search Results). The second stage of screening involved  
 159 reviewing the titles and abstracts of the 2483 remaining article and applying the inclusion and exclusion  
 160 criteria chosen for the study. The inclusions criteria include the following: 1) article focuses on an  
 161 Indigenous cultural safety training program (as defined above) for students/professionals in the fields of  
 162 health, education, or social work; 2) article pertains to investigations conducted in the English speaking,  
 163 colonial settler countries of Australia, New Zealand, Canada, or the United States; 3) published as peer  
 164 reviewed articles; 4) published in English; and 5) published since 1996. The exclusion criteria for the first  
 165 stage of screening included: 1) describes a training program other than Indigenous cultural safety; 2)  
 166 pertains to fields other than health, education, or social work; 3) published as literature reviews or



167 conference summaries; 4) published prior to 1996; and 5) published in a language other than English.

168 Applying the exclusion criteria resulted in removing 2163 articles from the study.

169

170 Table 4: Scoping Search Results

Source	Studies Imported	Duplicates Removed	Studies Selected
Ovid (MEDLINE, EMBASE)	1,372	5	1,366
CINAHL	1,608	820	788
Proquest (ERIC, ASSIA)	621	292	329
Additional articles retrieved from reviewing study reference lists	0	0	0
<b>Total</b>	<b>3,600</b>	<b>1,117</b>	<b>2,483</b>

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173 The third stage of screening involved reviewing the full text articles to the remaining 320 titles and

174 applying the same inclusion and exclusion criteria described in the previous screening stage. This process

175 resulted in the exclusion of 178 additional studies for the following reasons: not related to cultural safety

176 training and/or cultural safety concepts (n=126); not peer-reviewed (n=36); conference summaries (n=8);

177 duplicate content (n=2); literature reviews; (n=2) not focused on targeted professional groups (n=2); full

178 text not found (n=1); published before 1996 (n=1). As the removal of these articles, 142 titles were

179 selected for extraction. The reference lists of these remaining articles were then searched for additional

180 studies that met the inclusion and exclusion criteria, and no further studies were identified during this

181 process. Finally, an additional 3 articles were excluded during the extraction process for containing

182 duplicate content to that contained in studies already selected (n=2) and because a full text document

183 could not be located (n=1). A total of 134 articles were extracted for this study.

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## 186 **2.6 Data Charting Process**

187 A data-charting tool was developed for this study by AB with guidance from co-authors Dr. Mashford-  
188 Pringle, Dr. Erica Di Ruggiero, and a Librarian from Gerstein library, University of Toronto. The data-  
189 charting tool was developed in Google Spreadsheet by the first author of the published protocol paper for  
190 the study (27). While developing the data charting tool, several decisions were made to establish the  
191 focus, nature, and scope of data to be extracted. These decisions were: 1) to cut and paste entire ‘chunks’  
192 of text verbatim into the tool rather than paraphrasing the data; 2) to include article page numbers  
193 associated with data on cultural safety concepts and critiques; and 3) to include both the study aim, along  
194 with the research question if explicitly stated and relevant to the study. The data-charting tool was then  
195 piloted by all members of the review team based on two pre-selected articles. Several procedural  
196 decisions were made during the pilot stage to further articulate the scope of data to chart, both for  
197 existing data points and for two new data points added during this stage. These decisions included: 1)  
198 whether the paper included Indigenous authors or Elders; 2) identifying whether a data collection or  
199 evaluation tool is included or referenced; 3) specifying that ‘training modality’ refers to the format (e.g.  
200 in-person, online etc.) and ‘training components’ relate to the topics covered; 4) including only ‘yes’ or  
201 ‘no’ on four specific data points; 5) specify that ‘duration of time the training program has been running’  
202 is in relation to the study publication year; 6) adding ‘recommendations outlined in the article’; and 6)  
203 adding ‘stated limitations of the evaluation’.

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205 The data-charting process involved charting each article twice and this was undertaken between August  
206 2020 and June 2021. The first author (TM) independently completed one round of data-charting and the  
207 second round was completed by a team of six reviewers independently, with a large majority of the second  
208 extraction (102/134 articles) carried out by three of the six reviewers (LA, RQ and LH). The decision to  
209 involve six reviewers was made to expedite the extraction process, as the study results were needed to

210 inform the development of pilot Indigenous cultural safety training intervention for Faculty members,  
211 staff and students of the Faculties of Nursing, Medicine, Social Work and Public Health at the University  
212 of Toronto. Several questions arose among the reviewers throughout the charting process concerning the  
213 nature and amount of the data to be extracted and charted, and these issues were generally resolved  
214 through discussion as a team. Any disagreements between two reviewers on a given paper were resolved  
215 through discussion or further adjudication by a third reviewer/co-author where necessary.

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## 217 **2.7 Data Items**

218 The items included in the data-charting tool were developed deductively and addressed four main themes  
219 (see Table 5: Data Themes and Focus). The first theme includes *Article Characteristic* for Indigenous  
220 cultural safety training for the sources of evidence included in the review, namely: bibliographic details;  
221 country of study; whether author(s) identified as Indigenous; study aim/objective(s); target  
222 field(s)/discipline(s) (i.e. medicine/physicians; nursing/midwifery; allied health; health, general;  
223 education; and/or social work); and target population (students and/or professionals). The second theme  
224 concerns *Cultural Safety Concepts, Critiques and Rationale*, which includes cultural safety and related  
225 concepts either articulated or cited by study authors, along with critiques of the concepts, and the  
226 rationale given for why cultural safety is necessary in the fields of health, education, and social work.

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234 Table 5: Data Themes and Focus

Data Themes	Data Focus
<b>1. Article Characteristics</b>	Title Journal Publication Year Country of Study Authors Did author(s) self-identify as Indigenous: [yes OR no] Study aim/objective(s) Target Field(s)/Discipline(s): [Medicine; Nursing/Midwifery; Allied Health; Health, General; Education; Social Work] Target Population: [students; professionals]
<b>2. Cultural Safety Concepts, Critiques and Rationale</b>	Articulate/cite a cultural safety or related concept Critique a cultural safety or related concept Rationale for cultural safety
<b>3. Characteristics of Cultural Safety Training (if applicable)</b>	Did article describe a cultural safety training? [yes OR no] [If yes, continue below]:  Who sponsored the training? Who developed the training? Is there evidence of Indigenous scholar, practitioner, knowledge keeper or community members in the development of the training [yes OR no] Which Indigenous community partners were engaged? Who delivered the training? No. years training has run (r/t publication year) Who received the training [Profession; Setting (rural OR urban)]? Training objectives Modalities used to deliver the training Training duration/timeline Brief description of training components Number of people who completed the training Details of post training supports provided Stated limitations of the training
<b>4. Evaluation Details of Cultural Safety Training (if applicable)</b>	Did article present an evaluation of a cultural safety training? [yes OR no] [If yes, continue below]:  Evaluation objective(s) Evaluation data collection methods Type of data collected (qualitative; quantitative) Key evaluation results Stated limitations of evaluation Recommendations provided Was a data collection tool provided [yes OR no]

236 The third theme involves the *Characteristics of Cultural Safety Training* described in the sources of  
237 evidence. Data themes include who sponsored and developed the training program, whether Indigenous  
238 scholars, and practitioners or knowledge keepers were involved in the development process and the roles  
239 of community partners who were engaged. Other themes include who delivered and received the training  
240 program, along with details of the training program itself – such as the objectives, delivery modality,  
241 component descriptions, delivery duration and timeline, details of any post-program support, and the  
242 programs' stated limitations. The fourth and final theme addresses *Evaluation Details of Cultural Safety*  
243 *Training*. This data involves the evaluation objectives, data collection methods, type(s) of data collected  
244 (i.e. qual, quant and both), evaluation results, stated evaluation limitations, recommendations for future  
245 cultural safety training programs, and whether a data collection tool was provided.

246

## 247 **2.8 Synthesis of Results**

248 The process of extracting data from selected articles and charting it into the data extraction tool was  
249 undertaken in one of two ways. For most data themes, the data was copied verbatim from selected studies  
250 and pasted into the data charting tool. However, there were four exceptions to this process, namely the  
251 following data themes that required only a yes/no response: 1) whether the author(s) self-identified as  
252 Indigenous; 2) whether there was evidence that Indigenous scholars, practitioners, knowledge keepers or  
253 community members were involved in developing the training; 3) whether the article describes an  
254 Indigenous cultural safety training; and 4) whether the study presented an evaluation of a cultural safety  
255 training. While the first two of these data themes made for useful data in and of themselves, the last two  
256 data themes were signposts to direct the reviewer to whether they should proceed and search within a  
257 given article to extract any data relevant to those themes.

258

259 Once the data was charted, the data synthesis process was undertaken in three stages and carried out by  
260 four reviewers (TM, RQ, LH, ER). The first stage involved analyzing both extractions of data for each theme  
261 to identify and resolve any discrepancies. All inconsistencies that were discovered were resolved through  
262 discussion and/or revisiting the sources of data where needed. The second stage involved analyzing data  
263 on the general characteristics of Indigenous cultural safety within the studies selected for the review, a  
264 process which involved categorizing the data within each data theme and then counting the frequency of  
265 findings within each category. The third stage involved synthesizing data that described a cultural safety  
266 training and/or the evaluation of a cultural safety training. The last stage involved synthesizing the data  
267 within each theme to create an overview of the data characteristics of Indigenous cultural safety, then  
268 categorizing the data within each theme into distinct groups, and finally, counting the frequency of  
269 findings within each category. Finally, the process of data synthesis also involved excluding or refocusing  
270 some of the data themes that were introduced in the protocol paper and proposed as part of this study.  
271 The reasons for these changes are varied and are set out in *Section 3.3: Evaluations of Indigenous Cultural*  
272 *Safety Training Interventions*.

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274

### 275 **3. RESULTS**

#### 276 **3.1 Selection of Sources of Evidence**

277 Based on the database searches detailed above, a total of 3,600 sources were imported into Covidence  
278 online screening (see Image 1: Prisma Flow Diagram, in Appendix). After removing 1117 duplicates and  
279 2153 irrelevant studies, Covidence screened and assessed 320 full-text articles for eligibility. From these  
280 selected studies, and additional 178 were excluded during the analysis phase by our team for the following  
281 reasons: a) not related to cultural safety training and/or cultural safety conceptualization (n=126); b) not  
282 peer reviewed (n=36); c) conference summary (n=8); d) duplicate content (n=2); e) literature review (n=2);

283 d) not focused on our target professional groups (n=2); e) full text of article not found/available (n=1); and  
284 f) published before 1996. While 142 remaining studies were selected for inclusion, an additional eight  
285 articles were removed during the process of data charting, because either the authors and content of  
286 these articles overlapped significantly with other selected articles, or the paper involved Indigenous  
287 peoples' review of a cultural safety training but did not focus on the targeted professionals or students  
288 and their experiences with the training. Data from a total of 134 included full-text articles, including  
289 quantitative and/or qualitative research studies as well as expert opinion pieces, were extracted for this  
290 study.

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### 292 **3.2 General Characteristics of Sources of Evidence**

293 Table 6 presents general characteristics from the 134 sources of evidence selected for this review. Over  
294 two-thirds (68%) of the studies were published between 2011-2020 (29-119), while over one-quarter  
295 (28%) were published between 2001-2010 (26, 120-155), and just over than 1 in 20 (4%) were published  
296 between 1996 and 2000 (28, 156-160). Approximately half of these studies (49%) were undertaken in  
297 Australia (36-39, 46, 47, 49, 53, 56, 58-60, 64, 66-69, 71, 72, 75, 77, 78, 80, 82, 83, 85-87, 89-91, 94, 95,  
298 98, 99, 101-108, 110, 113, 115-119, 121-123, 126, 128, 130, 133, 136, 137, 140, 143, 144, 148, 151, 152,  
299 160), with just over a fifth (21%) carried out in Canada (31-33, 35, 42-45, 50, 52, 55, 62, 63, 70, 74, 81, 84,  
300 96, 100, 109, 111, 112, 114, 127, 132, 135, 145, 154). An estimated third of selected articles were either  
301 undertaken in the United States (16%) (30, 40, 41, 48, 61, 63, 65, 76, 79, 92, 93, 97, 120, 125, 134, 146,  
302 153, 155, 156, 158, 159) or New Zealand (15%) (26, 28, 29, 34, 51, 54, 57, 73, 88, 124, 129, 131, 138, 139,  
303 141, 142, 147, 149, 150, 157). One or more authors self-identified as Indigenous in only a fifth of the  
304 papers (20%) selected for this study (28, 30, 32, 34, 38, 41, 45, 47, 49, 55, 59, 62, 64, 66, 67, 71, 77, 79,  
305 80, 83, 93, 104, 112, 118, 126, 136).

306

307 Table 6. General Characteristics of Sources of Evidence

<b>General Characteristics</b>		<b>Number (n=134)</b>	<b>Percent (%)</b>
<b>Publication Year</b>			
	2011-2020	91	68%
	2001-2010	37	28%
	1996-2000	6	4%
<b>Country(ies) of Study*</b>			
	Australia	66	49%
	Canada	28	21%
	United States	21	16%
	New Zealand	20	15%
<b>Author(s) Self-identified as Indigenous</b>			
	Yes	26	20%
<b>Relevant Indigenous Group Specified in Article</b>			
	Aboriginal (Australia)	66	49%
	Torres Straight Islander Australia)	46	34%
	Māori/Tangata Whenua	20	15%
	First Nation (Canada)	18	13%
	American Indian (United States)	17	12%
	Métis (Canada)	12	9%
	Inuit (Canada)	11	8%
	Unspecified (Canada)	9	7%
	Alaska Native (United States)	6	4%
	Kānaka Maoli/ Native Hawai'ians (United States)	2	1%
	Unspecified (United States)	3	2%
<b>Target Discipline(s)/Field(s)</b>			
	Nursing/Midwifery	45	34%
	General Health <sup>±</sup>	31	23%
	Medicine/Physicians	25	19%
	Allied Health <sup>¥</sup>	18	13%
	Social Work	15	11%
	Education <sup>α</sup>	13	10%
<b>Target Population(s)</b>			
	Students only	64	48%
	Professionals <sup>^</sup> /Academics only	62	46%
	Professionals/Academics and students	8	6%
<b>Cultural Safety (or similar) Concepts and Critiques</b>			
	Described and/or cited a cultural safety (or related) concept	69	51%
	Described and/or cited a critique of a cultural safety (or related) concept	26	19%
<b>Cultural Safety Training Interventions and Evaluations of Interventions</b>			
	Described an Indigenous cultural safety training Intervention	69	51%
	Described an evaluation of an Indigenous cultural safety training intervention	61	46%

308 \*A study undertaken in both Canada and the United States was counted twice.



309 <sup>‡</sup> *General Health* referred to Public Health professionals, Psychologists, health researchers, and otherwise  
310 unspecified health professionals or practitioners.  
311 <sup>¥</sup> *Allied Health Professionals* referred to Dentists, Pharmacists, Occupational Therapists, Physiotherapists,  
312 Audiologists and Speech Language Therapists, and Radiologists.  
313 <sup>α</sup> *Education* refers both to those in the field of Education and to university students/staff in unspecified fields.  
314 <sup>^</sup> *Professionals* refers to individuals who are employed in the context of the study (as opposed to students).

315  
316

317 Among the Indigenous groups identified as relevant to selected articles, Aboriginal peoples from Australia  
318 comprised the greatest proportion (49%) (36-39, 46, 47, 49, 53, 56, 58-60, 64, 66-69, 71, 72, 75, 77, 78,  
319 80, 82, 83, 85-87, 89-91, 94, 95, 98, 99, 101-108, 110, 113, 115-119, 121-123, 126, 128, 130, 133, 136,  
320 137, 140, 143, 144, 148, 151, 152, 160), followed by Torres Straight Islanders also in Australia (34%) (36-  
321 39, 46, 47, 49, 53, 56, 60, 66-69, 71, 72, 80, 83, 85-87, 89, 98, 103-108, 110, 113, 115, 116, 118, 121-123,  
322 126, 128, 130, 133, 137, 140, 148, 151, 152). Thereafter included Māori/Tangata Whenua in New Zealand  
323 (15%) (26, 28, 29, 34, 51, 54, 57, 73, 88, 124, 129, 131, 138, 139, 141, 142, 147, 149, 150, 157), First Nations  
324 in Canada (13%) and American Indians in the United States (12%) (30, 41, 48, 63, 65, 79, 92, 93, 97, 120,  
325 134, 146, 153, 155, 156, 158, 159). Other Indigenous groups included Métis in Canada (9%) (31, 32, 44,  
326 50, 52, 62, 63, 109, 112, 114, 135, 154), Inuit (8%) (31, 32, 44, 50, 52, 62, 63, 84, 109, 112, 135) and  
327 unspecified Indigenous peoples in Canada (7%) (43, 45, 55, 81, 96, 111, 127, 132, 145), with each identified  
328 in less than a tenth of articles. For publications from the United States, Alaska Natives (4%) (30, 61, 63,  
329 93, 120, 159), Kānaka Maoli/Native Hawai'ians (1%) (76, 125), and unspecified Indigenous peoples (2%)  
330 (40, 74, 79) were mentioned in (or less than) one in twenty-five papers.

331

332 With respect to the target disciplines/fields within the articles, nursing/midwifery comprised the largest  
333 share at approximately one-third (34%) (26, 28, 39, 41, 42, 46-49, 51-55, 63, 72, 80, 85, 87-92, 106, 110,  
334 111, 113, 121, 123, 124, 126-128, 130-133, 135, 136, 147, 149, 157, 158, 160). General Health  
335 Professionals – a category including public health professionals, psychologists, health researchers, and  
336 unspecified health professionals or practitioners – were the target of nearly one-quarter (23%) of papers.

337 Medicine (or physicians) was the target of nearly one-fifth of papers (19%) (26, 41, 43, 45, 47, 56, 57, 60,  
338 62, 63, 76, 93, 94, 96, 108, 109, 111, 112, 114, 119, 121, 124, 125, 143, 150). Following the these three  
339 fields, allied health (13%), (26, 31, 32, 69-71, 73, 74, 81, 100, 101, 110, 121, 138, 140, 141, 144, 145), social  
340 work (11%) (58, 59, 64-68, 75, 76, 105, 111, 154-156, 159), and education (10%) (29, 33-35, 78, 82, 83,  
341 102, 103, 118, 142, 146, 152), were the target fields for between one-seventh and one-tenth of papers.  
342 Nearly half of the studies targeted students of these disciplines (48%) (26, 28, 29, 32, 34, 39, 42-44, 46,  
343 49, 52, 57, 59, 64-68, 70, 71, 73-78, 81, 83-87, 89, 91, 92, 95, 98, 99, 101-104, 106-109, 112-114, 118, 121,  
344 123, 124, 135, 137, 139, 140, 142, 144, 150, 152, 153, 160), while a slightly smaller proportion targeted  
345 professionals and/or academics (46%) (30, 31, 35-38, 40, 41, 45, 47, 50, 51, 53-56, 58, 60-63, 69, 72, 79,  
346 80, 82, 88, 94, 96, 97, 100, 105, 110, 111, 115-117, 120, 122, 126-133, 136, 138, 141, 143, 145-149, 154-  
347 159). Only one in twenty articles targeted both professionals/academics and students (6%) (33, 48, 90,  
348 93, 119, 125, 134, 151).

349  
350 In terms of the content within the articles selected for this review, just over half of the articles (51%) either  
351 articulated or cited a cultural safety (or similar) concept (e.g. cultural safety, cultural sensitivity, cultural  
352 awareness, cultural competence etc.) (28, 31-34, 38, 39, 44-47, 49-55, 59, 63, 64, 68, 71, 72, 79, 82, 84-  
353 86, 88-90, 92, 94, 96, 97, 100, 102, 106, 107, 109-111, 113, 114, 116, 121-123, 125, 126, 128-132, 136,  
354 138, 139, 141, 144, 145, 147, 149-151, 154, 157, 159). Additionally, an estimated one-fifth of papers (19%)  
355 either articulated or cited a *critique* of a cultural safety or similar concept (28, 31, 38, 44, 50, 53-55, 59,  
356 63, 79, 85, 97, 106, 107, 113, 122, 127, 128, 130-132, 147, 150, 151, 157). With respect to training  
357 interventions, approximately half of the selected articles (n=69; 51%) described a cultural safety training  
358 intervention (26, 32, 34-37, 39, 41-43, 47-49, 57, 58, 60, 62, 65, 66, 68-70, 72, 74-81, 83-86, 89, 91-93, 95,  
359 101-108, 110, 111, 113, 114, 117, 119, 121, 123, 124, 134, 135, 137, 140, 142-144, 146, 148, 153, 154,  
360 160). While somewhat less than half of the papers (n=61; 46%) described an evaluation of a cultural safety

361 training intervention (32, 34, 35, 39, 41, 43, 46, 47, 49, 51, 54, 56-58, 60-62, 64-66, 70, 72, 74, 76-78, 80,  
362 81, 84, 86, 89, 91-93, 95, 98, 99, 101-108, 110, 111, 113, 117, 123, 124, 133, 134, 137, 144, 146, 148, 153,  
363 154, 156, 158).

364

### 365 **3.3 Details of Indigenous Cultural Safety Training Interventions**

366 The details of training interventions for Indigenous cultural safety are presented in Table 7: Details of  
367 Indigenous Cultural Safety Training Interventions). Of these papers (n=69), more than two-thirds  
368 mentioned the involvement of Indigenous peoples in the training development process (n=48; 70%) (32,  
369 34, 37, 39, 41-43, 46, 48, 49, 57, 58, 60, 62, 65, 68, 70, 75-79, 81, 83, 85, 86, 92, 93, 95, 101-104, 106-108,  
370 110, 113, 114, 117, 123, 137, 140, 143, 144, 146, 148, 153). A wide variety of teaching approaches to  
371 delivering cultural safety content were illustrated as part of these interventions, with all having described  
372 more than one modality. Teaching/lectures was the most common training modality, described in almost  
373 a third of papers (n=21; 30%) (32, 34, 39, 41, 43, 46, 49, 57, 75, 76, 78, 83, 84, 86, 93, 95, 101, 113, 121,  
374 124, 137). Workshops (n=18; 26%) (47, 57, 60, 62, 69, 72, 77, 79, 80, 93, 102, 103, 110, 117, 134, 137, 140,  
375 148), discussions sessions (n=16; 23%) (32, 39, 41, 42, 47, 72, 76, 77, 85, 101, 102, 110, 111, 121, 135,  
376 140), and immersive experiences/community visits (n=13; 19%) (32, 41, 43, 57, 76, 78, 92, 102, 106, 108,  
377 140, 146, 153) were also common, detailed by estimated quarter to approximately a fifth of relevant  
378 articles.

379

380 Table 7: Details of Indigenous Cultural Safety Training Interventions

<b>Indigenous Cultural Safety Training Interventions</b>		<b>Number (n=69)</b>	<b>Percent (%)</b>
<b>Indigenous people(s) Involved in development process</b>		48	70%
<b>Training Modalities</b>			
	Teaching/lectures	21	30%
	Workshop	18	26%
	Discussion	16	23%
	Immersive experience/community visit	13	19%

	Storytelling/Yarning	8	12%
	Reflective exercise/Practice	8	12%
	Online content	8	12%
	Video/Videocast	8	12%
	Clinical placement	7	10%
	Case-study	7	10%
	Tutorial	7	10%
	Workbook/readings	7	10%
	Elder/mentor/community support	6	9%
	Course-based modules	5	7%
	Group work	4	6%
	Drama/Role-Playing Exercise	2	3%
	Visit to Gallery/Museum	2	3%
	Post-Intervention Support Provided	8	6%
<b>Training Timeline</b>			
	1-5 days/sessions	15	22%
	Partial course (8-25h), 1 semester	12	17%
	1 Lecture/workshop/cultural visit	10	15%
	1-5 week(s) of immersion	7	10%
	4 years of embedded content, Bachelor's Degree	6	9%
	6-10 days/sessions	6	9%
	3-12 months of immersion	2	6%
	Full course (42h), 1 semester	2	6%
	Partial course (50-52h), 2 semesters	2	6%
	Intensive course content (148h), 2 semesters	1	1%
	2 years of content, embedded in health service organization	1	1%
	Not mentioned	13	19%
<b>Who delivered the Training</b>			
	Professors/Administrators, University	25	36%
	Clinicians/Clinical Instructors, Health	20	30%
	Indigenous Elder/Mentor/Cultural Educator/Community/Community organization	19	28%
	Lecturers/educators, University/College	15	22%
	Researchers	5	7%
	Allied Health Professional	3	4%
	Consultants	3	4%
	Not mentioned	2	3%
	Non-Clinician Staff, Health	1	1%
	<b>Indigenous people(s) Involved in delivering intervention<sup>^</sup></b>	<b>35</b>	<b>51%</b>

381 ^ Indigenous peoples involved in delivering cultural safety training includes both those categorized as "Indigenous  
382 Elder/Mentor/Cultural Educator/Community/Community organization" as well as those in other relevant categories  
383 listed above.  
384  
385

386 Following these modalities, storytelling/yarning (58, 66, 72, 80, 85, 93, 101, 113), reflective  
387 exercised/practice (77, 85, 89, 93, 101, 102, 110, 121), online content (66, 75, 83, 85, 104, 119, 121, 160),  
388 and video/videocasts (32, 46, 68, 75, 77, 89, 93, 107) were each described by an eighth of chosen studies  
389 (n=8; 12%). Also common among training modalities were clinical placements (43, 70, 114, 140, 143, 144,  
390 153), case-studies (26, 43, 46, 47, 68, 110, 121), tutorials (39, 46, 89, 95, 104, 137, 140), and  
391 workbooks/readings (32, 34, 85, 102, 117, 135, 146), each of which were included as part of approximately  
392 a tenth of interventions (n=7; 10%). Finally, Indigenous Elder/mentors/community supports (n=6; 4%) (48,  
393 76, 78, 85, 117, 146), course-based modules (n=5; 4%) (81, 93, 119, 123, 160), and group work (n=4; 3%)  
394 (26, 42, 57, 76) were each described by a few papers. The least common activities mentioned were  
395 drama/role-play exercises (142, 148) and a visit to a gallery/museum (32, 101), each mentioned by a  
396 couple of articles (n=2; 3%). Notably, eight papers (12%) described the provision of follow up support for  
397 learners of cultural safety beyond the primary training period (32, 34, 48, 59, 60, 123, 134, 153).

398  
399 With respect to the training timeline, the largest proportion of articles detailing a cultural safety training  
400 intervention described the training as lasting 1-5 days/sessions (n=15; 22%) (26, 37, 42, 57, 60, 62, 77, 86,  
401 103, 105, 108, 110, 134, 142, 148). Following this, in approximately one-sixth of selected articles, the  
402 training involved part of a one-semester undergraduate course (8-25 hours) (n=12; 17%) (41, 46, 49, 72,  
403 74, 75, 80, 84, 89, 91, 104, 113). The shortest training involved a one-off lecture/workshop/cultural visit,  
404 which was mentioned in an estimated one-sixth of articles (n=10; 15%) (47, 69, 79, 81, 93, 101, 117, 124,  
405 134, 148), followed by a 1-5 week(s) immersive experience in one of ten articles (n=7; 10%) (92, 102, 106,  
406 114, 144, 153, 160). The longest training experience involved embedded content across a four-year  
407 bachelor's degree (unknown total hours) (42, 43, 121, 123, 140, 146), followed by training of 6-10  
408 days/sessions (51, 57, 77, 83, 95, 114), both occurring in one of ten articles (n=6; 9%). Three training  
409 durations, namely, 3-12 months of immersion (89, 143), a one-semester undergraduate course (42 hours)

410 (39, 137), and a partial undergraduate course over two semesters (50-52 hours), (32, 70), similarly  
411 occurred in an estimated one-fifth of papers. The least frequent training timelines were included in only  
412 one article each (n=1; 1%), namely an intensive course over two semesters (148 hours) (34), and two years  
413 of content embedded in a health service organization (111). Nearly one in five articles did not include  
414 details on the duration of cultural safety training (n=13; 19%) (35, 36, 48, 65, 66, 68, 76, 85, 107, 123, 126,  
415 135, 154).

416  
417 In terms of delivering cultural safety training interventions, university professors/administrators were  
418 mentioned in approximately twenty-five articles that described a cultural safety training (25; 36%) (26,  
419 32, 34, 43, 46, 57, 65, 66, 68, 72, 74, 77, 85, 86, 93, 104, 107, 108, 110, 113, 114, 117, 121, 153, 160).  
420 Clinicians/clinical instructors (health professions) (n=20; 30) (32, 37, 41, 43, 48, 57, 60, 62, 72, 77, 79, 90,  
421 102, 106, 108, 113, 123, 124, 143, 160), and Indigenous Elders/mentors/cultural educators/community/  
422 organizations (n=19; 28%) (48, 78, 86, 92, 93, 95, 102-104, 106, 108, 110, 113, 114, 117, 143, 144, 146,  
423 153) were each mentioned in approximately one-third of relevant articles. University/college  
424 lecturers/educators delivered the training in an estimated one-fifth of articles (n=15; 22%) (39, 47, 49, 75,  
425 76, 78, 81, 83, 85, 89, 104, 108, 134, 137, 142), followed by researchers in approximately one in twenty-  
426 five articles (n=5; 7%) (47, 62, 78, 93, 110). Allied health professionals (58, 140, 148) and consultants (37,  
427 60, 111) were each mentioned in the context of training delivery in only a few articles (n=3; 4%). Two  
428 articles provided no details on who delivered the training (42, 116), while one article described non-  
429 clinician health staff as responsible for training delivery (26). Finally, half of the articles that described a  
430 cultural safety training reported that Indigenous people(s) were involved in delivering the intervention  
431 (n=35; 51%) (37, 39, 46-49, 57, 58, 60, 62, 72, 77-79, 81, 85, 86, 89, 92, 95, 101, 103, 104, 106-108, 110,  
432 113, 117, 137, 143, 144, 146, 148, 153).

433

434 **3.3 Evaluations of Indigenous Cultural Safety Training Interventions**

435 Nearly one-third of papers selected for this review described an evaluation of a cultural safety training  
 436 intervention (n=61; 46%) (see Table 8). These particular studies involved a broad range of objectives, with  
 437 the largest proportion of papers (n=19; 31%) aimed broadly at understanding learners' experiences,  
 438 perceptions, needs and/or preferences related to a cultural safety training in which they participated (32,  
 439 35, 41, 51, 58, 62, 70, 72, 101-104, 107, 108, 114, 123, 134, 137, 144). Another paper similarly focused on  
 440 understanding perceptions of a given training intervention but from the perspective of Indigenous  
 441 community members rather than participants (n=1; 2%) (32).

442

443 Table 8: Details of Evaluations of Indigenous Cultural Safety Training Interventions

<b>Evaluations of a Cultural Safety Training Intervention</b>		<b>Number (n=61)</b>	<b>Percent (%)</b>
<b>Evaluation Focus/Objectives</b>			
<b>Learner experiences, perceptions, needs and/or preferences</b>			
	Participapnts' general perceptions, experiences, preferences, learning needs and satisfaction with intervention	19	31%
	Indigenous community members' perceptions of intervention	1	2%
<b>Intervention outcomes</b>			
	General learning experiences/outcomes/barriers	16	26%
	New skills/behaviours/practices	15	25%
	New knowledge/awareness/attitudes/confidence	11	18%
	Perceptions of Indigenous peoples/health issues	1	2%
	Learners' receptivity/resistance to intervention content	1	2%
<b>Intervention and/or behaviour change processes</b>			
	Intervention planning and implementation process	2	3%
	Behaviour change processes	2	3%
<b>Relationship between intervention exposure and outcomes</b>			
	Between learners' perceptions of Indigenous peoples and their intervention participation	1	2%
<b>Intervention context</b>			
	Enabling factors within organizational context	1	2%
	Impact on organization processes and priorities	1	2%
	New organizational policies, positions, capacity, and mandate	1	2%
<b>Methodological approaches adopted</b>			
	Qualitative and quantitative methods	32	52%
	Qualitative methods only	20	33%
	Quantitative methods only	9	15%

<b>Research methods utilized</b>			
<b>1. Pre-Intervention</b>			
	Pre-survey	13	21%
	Pre-survey, with open-ended questions	4	6%
	Pre-focus group	2	3%
	Pre-test	1	2%
<b>2. Mid-Intervention</b>			
	Mid-researcher observations/reflections	4	6%
<b>3. Post-Intervention</b>			
	Post-survey	24	39%
	Post-surveys, with open-ended questions	12	20%
	Participant Interview	11	18%
	Oral/written Learner feedback	6	10%
	Post-focus group	6	10%
	Learners' reflections/case scenarios	4	6%
	Learner journal entries/digital storytelling	3	5%
	Post-test	1	2%
	Talking Circles	1	2%
	Analysis of developed curriculum	1	2%
	Post-researcher observations/reflections	1	2%
<b>4. Delayed Post-Intervention</b>			
	Delayed post-survey (3-55 months)	2	3%
	Delayed learners' reflections (2-3 weeks)	1	2%
<b>Limitations stated for chosen methods</b>		33	54%

444

445

446 Other common evaluation approaches involved exploring participants' reports of learning  
 447 experiences/outcomes/barriers (n=16; 26%) (35, 41, 49, 76, 77, 91-93, 95, 105-108, 111, 123, 148), and  
 448 the new skills/behaviours/practices that learners acquired (n=15; 25%) (51, 57, 81, 86, 99, 106, 107, 111,  
 449 113, 115, 117, 124, 133, 144, 148). Similarly common, reported in nearly one-fifth of relevant papers,  
 450 involved understanding learners' new knowledge/awareness/attitudes/confidence since the intervention  
 451 (n=11; 18%) (47, 80, 81, 84, 91, 92, 105, 110, 111, 148, 153). Other evaluation approaches included  
 452 learners' perceptions about Indigenous peoples and/or their health issues (91), as well as learners'  
 453 receptivity/resistance to intervention content (89), as mentioned in one intervention evaluation each  
 454 (n=1; 2%). A less common approach to evaluating cultural safety training interventions among the selected



455 articles involved exploring processes, and specifically intervention planning and implementation  
456 processes (n=2; 3%) (34, 66), and learners' behaviour change processes (n=2; 3%) (113, 124).

457 In terms of the methodological approaches adopted to evaluate cultural safety training interventions, just  
458 over half of relevant articles describe utilizing both qualitative and quantitative methodologies (n=32;  
459 52%) (32, 35, 46, 47, 51, 57, 60, 62, 66, 70, 72, 74, 76, 77, 81, 86, 89, 91, 93, 99, 102, 106-108, 113, 117,  
460 123, 134, 137, 144, 148, 153). Another third of articles outlined the use of qualitative methods only (n=20;  
461 33%) (34, 41, 43, 49, 54, 56, 58, 64, 65, 78, 80, 92, 95, 98, 101, 104, 111, 124, 133, 154), while  
462 approximately one in six papers used quantitative methods only as part of their intervention evaluations  
463 (n=9; 15%) (39, 61, 84, 105, 110, 115, 146, 156, 158). A broad range of research methods were taken up  
464 to evaluate the influence and/or impact of cultural safety training interventions on participants. Data  
465 collection methods prior to the intervention involved pre-surveys (n=13; 21%) (66, 70, 72, 81, 86, 89, 91,  
466 93, 107, 111, 115, 123, 153), only four of which included open-ended, qualitative questions (n =4; 6%) 18,  
467 48, 70, 76). Less common were pre-focus groups (n=2; 3%) (123, 154), and a pre-test (n=1; 2%) (110). A  
468 small number of evaluation papers undertook observations/reflections half way through the interventions  
469 (n=4; 6%) (72, 89, 92, 111).

470

471 The greatest range of data collection methods occurred immediately following the intervention, with  
472 post-surveys the most common approach, mentioned by two-thirds of relevant articles. A large proportion  
473 of these post-surveys focused only on quantitative data (n=24; 39%) (32, 35, 39, 47, 49, 66, 70, 72, 76, 84,  
474 86, 89, 102, 103, 107, 108, 111, 114, 115, 123, 134, 137, 144, 153), while others also included open-ended  
475 qualitative questions (n=12; 20%) (49, 51, 57, 58, 62, 81, 91, 93, 95, 104, 108, 146). Participant interviews  
476 were also common following an intervention, mentioned in nearly a fifth of relevant articles (n=11; 18%)  
477 4, 12, 51, 60, 63, 78, 82, 91, 92, 109, 134). Oral or written learner feedback (n=6; 10%) (70, 76, 77, 86, 101,  
478 108), and post-focus groups (n=6; 10%) (32, 86, 92, 102, 123, 154) were each mentioned in a tenth of

479 papers describing an training evaluation, followed by learner reflections or case studies (n=4; 6%) (92,  
480 108, 124, 153) and learner journal entries or digital storytelling (n=3; 5%) (66, 72, 102), as described in a  
481 quarter of relevant papers. A Post-test (110), Talking Circles (108), Analysis of developed curriculum (34),  
482 and Post-researcher observations/reflections (107) were each mentioned in only one relevant study (n=1;  
483 2%). Finally, a small number of relevant papers undertook data collection after a period of delay following  
484 a cultural safety training intervention. These methods included a delayed post-survey undertaken at  
485 various stages between 3-55 months following the intervention (n=2; 3%) (47, 113). While a third paper  
486 described delayed learner reflections collected at 1-2 weeks following the intervention (n=1; 2%) (92).  
487 Finally, of the papers that described a cultural safety training intervention, only approximately half of  
488 these papers presented the limitations of the methods chosen for the intervention evaluations (n=33;  
489 54%) (34, 39, 46, 47, 49, 51, 54, 57, 65, 66, 72, 74, 77, 80, 81, 84, 91, 93, 95, 98, 99, 106, 107, 110, 111,  
490 115, 117, 123, 133, 134, 144, 148, 156).

491  
492 The review team chose to exclude or refocus some of the data themes that were introduced in the  
493 protocol paper and proposed as part of this review study. The reasons for these changes were varied.  
494 First, data related to some of the data themes were largely homogenous. These themes included, for  
495 example, the rationale for providing training on cultural safety (or related) concepts -- reasons which  
496 overwhelming involved reducing disparities between Indigenous people and relevant settler populations  
497 on health outcomes (for health-related papers) or education achievement (for education related papers).  
498 Data was also not presented in this paper on themes wherein the data was not described consistently  
499 across selected studies. This included themes such as description of training components, number of  
500 people who completed the training, and details of post-training supports provided. Similarly, data on who  
501 sponsored or developed the training intervention, as well as the duration of the training intervention and  
502 whether it was implemented in rural or urban settings were largely incomplete, with a relatively small

503 proportion of articles including fulsome descriptions for these themes. For its part, data on ‘the  
504 aim/objective’ of the evaluation tended to be very general, including reasons such ‘to evaluate a cultural  
505 safety training intervention’, and was therefore replaced with ‘evaluation focus’, which instead centred  
506 on the *nature* of data collected (i.e. participants perceptions, intervention processes or outcomes etc.).  
507 Finally, the evaluation objectives and recommendation were not analyzed and included in this review  
508 because this data was rich in description and synthesizing the findings would require undertaking content  
509 analysis, which the authors determined were beyond the scope of this review, particularly given the time  
510 frame that was required to complete this review.

511

512

## 513 **4. DISCUSSION**

### 514 **4.1 Summary of Evidence**

515 This study found a significant growth in research about Indigenous cultural safety training in the fields of  
516 health, education, and social work over the last few decades, and primarily within the last ten years. The  
517 increased attention to cultural safety and related concepts has been fuelled by national initiatives to  
518 address the historical injustices against Indigenous peoples. For example, Canada’s Truth and  
519 Reconciliation Commission’s Calls to Action (2015) set out the need for cultural safety training for  
520 healthcare professionals, and federal funding for post-secondary institutions and educators to establish  
521 national research programs in collaboration with Indigenous peoples to advance Reconciliation (24). A  
522 similar 2008 initiative in Australia, entitled Closing the Gap (25), called for mutli-sectoral action in  
523 collaboration with Aboriginal communities to improve Indigenous health, which was followed in 2019 by  
524 the development of a National Indigenous Agency in 2019 responsible for leading and coordinating the  
525 implementation of the strategy (161). Australia’s commitment to action was published almost a decade  
526 before Canada’s Truth and Reconciliation Commission’s Final Report and Calls to Action, which may

527 explain why an overwhelming majority of studies selected for this review were published in Australia –  
528 nearly 2.5 times the number of studies published in Canada, and more than three times the number  
529 published in the United States.

530

531 Only a fifth of papers selected for this review included a named Indigenous author, while an estimated  
532 one-tenth of papers failed to specify even the broad Indigenous population relevant to the study (e.g. First  
533 Nations, as in Canada). These findings suggest that greater commitment to meaningfully engage  
534 Indigenous communities on projects concerning them is urgently needed by researchers and educators  
535 working to advance cultural safety in the health, social work, and education fields (162, 163). The greatest  
536 share of articles describing a cultural safety training tended to target the field of nursing/midwifery  
537 followed by medicine/physicians. This finding is unsurprising considering that nurses/midwives tend to  
538 comprise the largest share of the health service workforce followed by physicians (164). The education  
539 field, for its part, comprised only a tenth of selected articles, suggesting that much more is needed to  
540 improve access to cultural safety training for educators. Across the four broad fields included in this study,  
541 approximately half of the population targeted by the articles were students while the other half were  
542 professionals. This is an important finding as it suggests that not only are students learning about cultural  
543 safety within their post-secondary education programs, but so are instructors, mentors and employers  
544 working in health, social work, and education fields. This suggests that professionals may have the  
545 capacity to contribute to enabling environments for new graduates to practise cultural safety when they  
546 begin their careers.

547

548 Only half of selected papers described and/or cited a cultural safety or similar concept. This is a somewhat  
549 surprising finding given that this review sought to understand the concept of cultural safety and how  
550 training interventions have attempted to facilitate its achievement. It is notable that many different

551 concepts and definitions related to cultural safety emerged from the selected studies and were often used  
552 interchangeably. These concepts, in part, include cultural competence, cultural sensitivity, cultural  
553 responsiveness, cultural knowledge, cultural awareness, and cultural humility. Confusion related to these  
554 cultural concepts in selected studies was made worse by several factors, including: 1) few attempts to  
555 justify why a given concept was chosen over another; 2) original sources for these concepts tended to not  
556 be clearly cited; and 3) little demonstrated understanding and contextualization of the literature wherein  
557 these concepts emerged. Similarly, and perhaps unsurprisingly given the current nascent state of this  
558 literature, less than a fifth of papers provided a critique of a cultural safety or similar concept.

559

560 There is evidence to suggest there is some convergence around the geopolitical origins of two concepts,  
561 namely, cultural safety and cultural competence. Cultural safety emerged in New Zealand by a Māori  
562 nurse working within the health system at a time when the country was primarily bi-racial, comprising  
563 Indigenous peoples and Western European settlers (28). Cultural competence, for its part, is a term  
564 developed in the United States within the transcultural nursing movement and in response to nurses' lack  
565 of understanding of the unique health needs of immigrants (128). In addition to the convergence of these  
566 two concepts, Lauren Baba, a Canadian researcher at the National Collaborating Centre for Indigenous  
567 Health in British Columbia, published a 2013 report that draws upon multiple sources to conceptualize  
568 and articulate the distinctions between cultural safety, cultural competence, and other similar concepts,  
569 including cultural awareness and cultural sensitivity (165). These four cultural related concepts and their  
570 definitions are outlined in Table 9 (Defining Cultural Safety, Cultural Competence and Similar Concepts).

571

572

573

574

575 **Table 9: Defining Cultural Safety, Cultural Competence and Similar Concepts** (as set out in Baba, 2013)

<b>Concept</b>	<b>Definition</b>
<b>Cultural Awareness</b>	The acknowledgement and understanding of cultural differences by focusing on the 'other' and the 'other culture'. Does not consider the political or social-economic influences on cultural difference and does not require an individual to reflect on his/her own cultural perspectives.
<b>Cultural Sensitivity</b>	Recognizes the need to respect cultural differences. Involves exhibiting behaviours that are considered polite and respectful by the persons of other cultures. Focuses on the 'other' and the 'other culture' and does not require an individual to reflect on his/her own cultural perspectives.
<b>Cultural Competence</b>	Skills and behaviours that help a practitioner provide quality care to diverse populations. While cultural competence can build upon self-awareness, it is limited by reducing culture to a set of skills for practitioners to master, and over-emphasizes cultural differences as the course of conflict between healthcare providers and diverse populations.
<b>Cultural Safety</b>	Cultural safety within an Indigenous context means that the educator, practitioner or professional, whether Indigenous or not, can communicate competently with a patient in that patient's social, political, linguistic, economic, and spiritual realm. Moves beyond cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to healthcare.

576

577

578 Both academic research involving these cultural related concepts and training programs that seek to  
 579 facilitate their development, would benefit from considering, comparing and contrasting the concepts set  
 580 out by Baba (165). Not only would consolidating these terms across the literature work to further develop  
 581 the scholarly work in this area, but also it would facilitate the advancement of the field more broadly by  
 582 furthering the understanding of which concepts are preferable in different contexts and how to ensure  
 583 their achievement through targeted training programs. This field of research would also benefit from  
 584 advancing understanding on how these different concepts relate to one another in practice, how they  
 585 should be applied, and the merits and drawbacks of each. Moreover, careful attention must be paid to  
 586 the contexts in which these concepts are applied given the unique socio-political and historical situations  
 587 in which some of them have emerged (28, 128).

588

589 Half of the papers selected for this review described a cultural safety training. While a substantial  
590 proportion of these training interventions involved Indigenous people(s) in the development processes,  
591 the specific roles they played were rarely clear. These findings highlight the need to ensure Indigenous  
592 voices are central to identifying and prioritizing the content to be included in Indigenous cultural safety  
593 trainings (162). A substantial variety of training modalities was apparent in the training interventions, with  
594 teaching or lectures, workshops, and immersive experiences or community visits among the most  
595 common. Similarly, there was a huge range in the timeline or duration of cultural safety trainings.  
596 Interventions varied from several individual sessions to one or more months of immersive experience, to  
597 fully embedded content within a post-secondary course or throughout an entire undergraduate degree  
598 program. Even the actors who delivered the training ranged significantly, from university professors and  
599 health service clinicians, to lecturers, researchers, and consultants. While approximately half of training  
600 interventions involved Indigenous Elders, experts, and other community members in the process of  
601 training delivery, the roles played by Indigenous peoples vis-à-vis other actors that were involved was not  
602 always clearly described.

603

604 There was little consistency in the objectives and methods to evaluate Indigenous cultural safety training  
605 interventions. Some evaluations focused on the experiences of learners and how they made sense of  
606 those experiences, while others looked at specific outcomes or processes (or the relationships between  
607 these two factors). There were also evaluations that considered the contexts within which the  
608 interventions were implemented and how these contexts influenced the interventions. Methodological  
609 approaches chosen for intervention evaluations also varied widely, including qualitative, quantitative, and  
610 mixed methods approaches. Most studies collected data after a cultural safety intervention, while fewer  
611 considered relevant data prior to, during, or following a delay after an intervention. Pre- and post-surveys  
612 were the most common method adopted (with some including open-ended questions), followed by

613 interviews, focus-groups, and methods involving written reflections, case studies, journal entries and/or  
614 storytelling. Notably, only half of the studies included in this review set out the limitations of the methods  
615 chosen for intervention evaluations.

616

#### 617 **4.2 Limitations**

618 There is a risk that some relevant studies may have been missed, due to selection of databases or the  
619 exclusion of grey literature. The language skills of the researchers on the team also limited the search to  
620 English publications, where French, Spanish or Indigenous languages may have been used within the  
621 selected geographic regions. Furthermore, search terms for populations did not include Indigenous  
622 nation-specific names (e.g. Mohawk, Cree), and thus publications that did not use overarching terms like  
623 Indigenous or First Nations, may have been missed.

624

#### 625 **4.3 Conclusions and Recommendations**

626 The variation across studies that described a cultural safety training and/or an evaluation of a cultural  
627 safety training intervention reflects the reality of an emerging field of practice and research. It is an  
628 imperative that future work on cultural safety trainings engage Indigenous peoples at the outset and  
629 ensures their inclusion at every stage of the process, including training development, implementation,  
630 and evaluation. Moreover, to advance the field of cultural safety training in the fields of health, social  
631 work and education, research publishing rich detail is required on all aspect of developing, implementing,  
632 and evaluating interventions.

633

634 Evaluation research on cultural safety training that adopts exploratory approaches to understanding  
635 experience can identify salient aspects of training to be tested more rigorously in follow up studies.  
636 However, studies evaluating the impact of training on learning and professional practice could benefit



637 from adopting best practices in implementation science to understand how implementation processes  
638 influence intervention outcomes. Moreover, incorporating social theory on learning (166) and behaviour  
639 change (167) into the development of cultural safety training interventions and their evaluations, can  
640 facilitate the understanding both of participants' experience with learning about cultural safety and of  
641 how learning is applied in practice, as well as the factors that facilitate or pose barriers to these processes.  
642

643 This scoping review presents the substantial work that has been undertaken over the last twenty-five  
644 years in Canada, Australia, New Zealand, and the United States to deliver Indigenous cultural safety  
645 training interventions for the purpose of addressing ongoing anti-Indigenous racism and its historical  
646 legacy in national, publicly funded health and education systems. While the research findings from this  
647 review set out the substantive progress toward achieving cultural safety through training interventions,  
648 this field of research remains in its infancy. Future research on cultural safety and related training  
649 interventions requires greater clarity in conceptualization of cultural safety and similar concepts, and  
650 more robust and context sensitive approaches considered in evaluating such interventions. Moreover,  
651 future work in this area is required to identify and how and when cultural safety and related concepts  
652 should be applied, and this is likely to vary across countries, regions, and relevant Indigenous groups.

653  
654 To advance future research and practice on Indigenous cultural safety, relevant Indigenous groups must  
655 be meaningfully engaged throughout the entire duration of research and practice. A 2021 report  
656 published by the Yellowhead Institute on Canada's progress toward Reconciliation concluded that  
657 symbolic actions were being prioritized by the Canadian Government over lasting permanent and  
658 structural changes necessary to transform the country's relationship with Indigenous peoples (168). It's  
659 imperative that current momentum to advance the field on Indigenous cultural safety training is

660 capitalized upon to address anti-Indigenous racism and the legacy that colonial governments continue to  
661 impose upon Indigenous peoples in countries such as Canada.

662

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665 one-year salaried Post Doctoral Fellowship from the Dean's Office, Dalla Lana School of Public Health,  
666 University of Toronto, and a two-year salaried Canadian Institutes of Health Research Health System  
667 Impact Post Doctoral Fellowship, which enabled this research under the leadership of Dr. Angela  
668 Mashford-Pringle. Cultural safety comprises a new field of research and professional practice that has yet  
669 to be established within any given discipline, a reality that poses significant challenges to securing funding  
670 to develop and evaluate training programs within the applied fields of health, social work, and education.

671

#### 672 **4.5 Researcher Contributions**

673 **TM:** Led data extraction and analysis processes, completed one full data extraction, analyzed a significant  
674 portion of data, and drafted and edited the manuscript.

675 **JQ:** Undertook a significant portion of data extraction and analysis

676 **LHe:** Undertook a significant portion of data extraction and some data analysis.

677 **AB:** Created data extraction tool, ran database searches, screened articles, contributed to methodology  
678 section, and undertook some data extraction.

679 **LHo:** Undertook screening of some articles and some data extraction.

680 **PV:** Undertook screening of some articles and some data extraction.

681 **BT:** Undertook screening of some articles and some data extraction.

682 **ER:** Undertook some data analysis.

683 **EDR:** Provided guidance on screening, data extraction and data analysis and reviewed draft paper.

684 **AMP:** Supervised project and reviewed draft paper.

685

686

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Appendix: Image

Image 1: Prisma Flow Diagram

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