Cultural Safety and Anti-Racism Training in Master of Public Health Curricula in “British Columbia”: Determinants of Uptake and Implementation

by

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Declaration of Committee

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Abstract

Racism and colonialism, among other intersecting forms of oppression, operate as social determinants of health and contribute to inequities among Indigenous, racialized, and equity-deserving groups. To counteract these injustices, over the last three decades, there have been a series of nation-wide and world-wide calls to action that put forward clear recommendations for cultural safety and anti-racism praxis (and related concepts) across all sectors, but in particular within healthcare. Across all sectors and disciplines, higher education plays a crucial role in establishing teaching and learning standards, recruiting a representative workforce, and shaping professional culture. Embedding cultural safety and anti-racism training into the learning pathways of the future public health workforce will help advance health equity for the entire population.

This research examines the barriers and facilitators shaping the uptake and implementation of these training interventions in Master of Public Health (MPH) programs. As a qualitative research study, a case study design was applied to MPH programs across three universities within a common provincial context. Conceptual frameworks offered by implementation science were coupled with a theoretical lens grounded in anti-colonialism and intersectionality. Data was collected through key informant interviews and focus groups among departmental leadership, faculty, staff, and students; and triangulated with document analysis of academic/ strategic plans, syllabi, and public communications. Framework analysis categorized determinants of uptake and implementation across five core domains: intervention characteristics; characteristics of individuals involved; inner setting; outer setting; and process.

Results highlight similarities and variations in cultural safety and anti-racism training across MPH programs, as well as how their respective approaches have evolved and continue to evolve within unique contexts. Recommendations offer a starting point for discussions around revising core competencies for cultural safety and anti-racism practice, as well as promoting standardized interventions and best practices that can be spread, scaled, and adapted to other settings. The significance and impact of this research lies in the potential to inform pedagogy, practice standards, and organizational policies within higher education, health systems, as well as professional accreditation, certification, or regulatory bodies.

Keywords: cultural safety; anti-racism; training interventions; implementation; Master of Public Health; curriculum

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I respectfully honour the history, customs and cultures of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Səl̓ílwətaɬ (Tsleil-Waututh) and kʷikʷəƛ̓əm (Kwikwetlem) peoples, on whose unceded lands SFU is located. I acknowledge their enduring relationship with and ongoing stewardship of the land, waterways and natural resources. As an uninvited guest on these territories, I embrace my responsibility to listen, learn and follow the leadership of its original inhabitants, past, present and future. I stand alongside Indigenous Nations in their assertion of their inherent rights and fight for self-determination and justice, and am committed to disrupting ongoing oppression and colonialism/ colonial complicity for our collective liberation.

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List of Acronyms

2SLGBTQQIA	Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual
APHA	American Public Health Association
ASPH	Association of Schools of Public Health
ASPHER	Association of Schools of Public Health in the European Region
BC	British Columbia
BC NEIHR	BC Network Environment for Indigenous Health Research
BIPOC	Black, Indigenous, and People of Colour
CEPH	Council on Education for Public Health
CFIR	Consolidated Framework for Implementation Research
CIHR	Canadian Institutes of Health Research
CPHA	Canadian Public Health Association
EDI	Equity, Diversity, and Inclusion
FNHA	First Nations Health Authority
MMIWG	Missing and Murdered Indigenous Women and Girls
MPH	Master of Public Health
NAHO	National Aboriginal Health Organization
NCCIH	National Collaborating Centre for Indigenous Health
NCCDH	National Collaborating Centre for Determinants of Health
NHS	National Health Services
PHAC	Public Health Agency of Canada
PHSA	Provincial Health Services Authority
RCAP	Royal Commission on Aboriginal Peoples
SFU	Simon Fraser University
TRC	Truth and Reconciliation Commission of Canada
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
US	United States

About the Cover Art

Okanagan captikʷɬ: How Names Were Given (write-up by Taylor Baptiste)

captikʷɬ are a collection of teachings about Syilx Okanagan laws, customs, values, governance structures and principles that, together, define and inform *Syilx Okanagan* rights and responsibilities to the land and to our culture (syilx.org).

In the world before this world, there were no humans yet and only Plant and Animal People. They lived on this earth just like us, laughing, playing, and learning just like we do. One day, Creator gathered all of the plant and animal people to let them know that the People-to-Be would be coming soon, referring to us humans. But before the humans would arrive, each Plant and Animal person would be given a name, and with their name came an important job to do.

Creator told the Plant and Animal people that they would all gather again the following morning to be given their names and important jobs. This perked Coyote's interests greatly, as he wanted to get the most important name and the most important job. The other Animal people didn't like Coyote very much, they said he bragged too much and pretended to know everything. Coyote wanted to be the first one to arrive at the name giving so that he could receive the most important name. He wanted to be named " Grizzly Bear" and be Chief of the four leggeds, or "Salmon" and be Chief of all in the water, or "Eagle" and be Chief of everything in the sky.

Coyote's brother Fox told him that he may not get to choose which name he receives, and that he should be thankful for what name and job Creator gifts him with. Coyote scoffed at Fox and created a plan to stay up all night, by putting sticks in his eyelids to keep them open so that he wouldn't fall asleep. However, as the night went on, Creator saw what Coyote was doing and decided to cause him to go to sleep anyway, with his eyes wide open.

In the morning, all of the Plant and Animal people made their way to the gathering, walking past Coyote sleeping with his eyes open. When Coyote finally woke up, he went running to Creator and shouted, "I want to be named Chief of all the animals!" Creator shook their head: "All of the Chiefs have already been named, in fact, everyone has

already received their names except you, Coyote. Only your name is left, nobody wanted to take it from you."

Coyote became very sad and hung his head low. Creator couldn't bear to see Coyote so sad and told Coyote, "I made you go to sleep on purpose, I have a very important job with lots of work for you to do to prepare for the People-to-Be. They will not have fur to keep themselves warm, or know what food to eat, or how to keep themselves safe from hardships and monsters. I need to give you the important and special power to shapeshift and destroy these monsters. Use this power wisely, for it is to help the People-to-Be."

Coyote became so excited he began running in circles.

"However, Coyote, I know you well and know that you can be foolish and not always careful, I am also giving your brother Fox the power to revive you if you are ever harmed or killed. Fox will be able to bring you back to life by jumping over your bones, or anything that's left of you, even a hair. If Fox steps over you, you will be brought back to life."

Coyote left the name-giving proud to have a very important role in his community. Creator watched Coyote leave. He knew Coyote would not do a perfect job. He knew Coyote would make mistakes, and that there would still be some hardships for the People-to-Be. However, it was very important that everything on this land be given a purpose.

About the Artist

Taylor Baptiste is a Syilx Okanagan artist from the Osoyoos Indian Band. Taylor was raised in Nk’mip; a field of sagebrush and wild roses between the mountains and Osoyoos Lake. She gives thanks to and draws inspiration from the land that nurtured her while growing up, and from her cultural teachings and Okanagan epistemologies. Taylor is currently beginning her fourth year of study at Emily Carr University of Art & Design in Vancouver, BC. To follow more of her journey, you can follow her on Instagram @taylorbaptiste.art

Chapter 1. Introduction

Indigenous peoples have long understood and drawn attention to the profound impacts of colonial oppression and racism on individual and community wellbeing. Only recently has mainstream scholarship caught up, theorizing and documenting systemic, structural, and interpersonal oppression as critical barriers to health care access and equitable health outcomes for Indigenous peoples in colonized parts of the world (Allan & Smylie, 2015; Browne, 2017; Cameron et al., 2014; Hayman, 2010; Hayman, White & Spurling, 2009; Loppie, Reading & de Leeuw, 2014; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Over the last three decades, there have been a series of nation-wide as well as world-wide calls to action that put forward clear recommendations for cultural safety and anti-racism praxis, and related concepts, across all sectors, but in particular within healthcare (Aboriginal Affairs and Northern Development Canada, 1996; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020; United Nations, 2008). In response, there has been growing uptake and implementation of cultural safety and anti-racism interventions among health organizations, education institutions, and government bodies in Canada and other settler-colonial countries (Baba, 2013; Diffey & Mignone, 2017; Downing, Kowal, & Paradies, 2011; Durey, 2010; Greenwood, 2019; Guerra & Kurtz, 2017; Hassen et al., 2021; MacLean et al., 2023). Guerra and Kurtz explain a period of transition in the past decade, “from arguing the importance of… delivery of equitable healthcare and closing the gap between Indigenous and non-Indigenous peoples in Canada to… educat[ing] and train[ing] HCPs [Healthcare Professionals] to embody the notion of cultural safety” (2017, p. 140).

Public health is an important yet largely overlooked discipline for cultural safety and anti-racism training interventions, given the field’s emphasis on promoting social justice and health equity through action on the determinants of health. Many graduates in public health training programs, including Master of Public Health (MPH) programs, go on to be practitioners within public health and related settings, where they contribute to patients’ and clients’ experiences of culturally safe healthcare encounters. Some go on to shape healthy public policy, health authority mandates and strategic directions, health service delivery, health research, health program evaluation, health promotion and education,

and more. As such, they are a key lever of change in the healthcare system and society at large. Implementing cultural safety and anti-racism training in MPH curricula supports efforts to “hardwire” these principles and praxes into all levels of the healthcare system through educating the hearts and minds of the future public healthcare workforce (de Leeuw et al., 2021; Nickerson, 2019).

There has been significant uptake and rapid evolution of cultural safety and anti-racism training in the field of public health. This is coupled with growing research that establishes a body of evidence for developing, implementing, and evaluating training interventions. Yet, there are still notable gaps in understandings around their development and delivery. Specifically, there is a need for research that details the challenges, strategies, and best practices associated with implementing cultural safety and anti-racism training within MPH and other public health training curricula. This study contributes to advancing awareness and knowledge in this area through an in-depth case study analysis of relevant training interventions in three MPH programs within a unified provincial context.

1.1. Purpose

The purpose of this study is to explore the determinants (i.e. barriers and facilitators) shaping the uptake and implementation of cultural safety and anti-racism training in MPH curricula in so-called “British Columbia” (BC). This research question is explored within core domains of implementation, informed by the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009) (see **Consolidated Framework for Implementation Research**). Specifically, the study is guided by five primary objectives under the following domains:

1. **Intervention Characteristics:** Characterize the core components and adaptable features of cultural safety and anti-racism training interventions in MPH curricula within each institution;
2. **Characteristics of Individuals:** Identify the key individuals and groups influencing uptake and implementation and/ or directly involved in implementing cultural safety and anti-racism training in MPH curricula within each institution;

3. **Process:** Describe the stage of implementation from planning through sustainment, and how approaches or strategies have evolved or been adapted over time to capture the temporal context;
4. **Inner Setting:** Document the institutional conditions in which implementation of cultural safety and anti-racism training takes place within each institution;
5. **Outer Setting:** Examine the broader social, cultural, political and historical contexts that shape uptake and implementation.

Findings highlight similarities and variations in cultural safety and anti-racism training across universities and their respective approaches to implementing these interventions. Furthermore, findings demonstrate how MPH programs have evolved and continue to evolve within unique contexts, which shape uptake and implementation. This study is *not* intended to evaluate the effectiveness of training interventions by measuring changes in beliefs and attitudes or testing learning objectives and outcomes among students. Nor does it provide longitudinal monitoring on the effects of cultural safety and anti-racism training on students' professional practice and the experiences of Indigenous patients and clients receiving care and public health interventions. These lines of inquiry warrant their own dedicated studies, and the intent is for results from this study to leverage further research in this area.

1.2. Navigating this Dissertation

This dissertation is divided into several chapters, each of which builds upon the other to provide a comprehensive picture of this study's examination of the implementation of cultural safety and anti-racism training in MPH curricula. Chapters and sections of the dissertation can be navigated using the navigation pane in the left margin. Additionally, throughout the document, readers are directed to sections using hyperlinks that can be used to jump from one section to the next. **Chapter 1: Introduction** provides an overview of the research topic, how I am approaching the topic as a researcher, as well as the topic's significance to public health practice and scholarship. **Chapter 2: Literature Review** synthesizes the existing literature on cultural safety and anti-racism training and MPH education, including a review of relevant calls to action and an assessment of gaps in evidence. **Chapter 3: Methodology** describes the research question, epistemological and theoretical orientation, research design, data collection

methods, and data analysis techniques used in the study. It also provides background information on implementation research, and relevant considerations for the application of qualitative approaches. **Chapter 4: Findings and Interpretation** presents the study's findings, with themes and relationships in the data interpreted and organized within the guiding theoretical framework in relation to the research question. Unlike research write-ups that separate interpretation into a discussion section, the intent with combining it with the findings is to provide a cohesive and coherent summary of insights gleaned from the study; furthermore, this helps keep the dissertation concise by reducing repetition of content and redundancy. **Chapter 5: Recommendations** draws from the findings and integrates existing literature to share recommendations relevant to public health practice, policy, research, and theory. The final chapter, **Chapter 6: Conclusion** summarizes the research, discusses strengths and limitations, and suggests potential implications and applications for future action.

1.3. Locating Myself

I position myself in this area of research as a fifth-generation settler of Dutch, British, and Irish ancestry. By virtue of settler colonization and as a beneficiary of the dispossession of Indigenous peoples, I have spent most of my life residing on unceded Indigenous lands in so-called Canada— at present, on the territories of the Syilx Okanagan Nation (colonially known as Kelowna). I am bestowed power and privilege in society as a white, English-speaking, university-educated, middle-class, able-bodied, cis-woman. Moreover, my upward mobility was propelled by the pre-existing racial privilege and social status of my parents, grandparents, and those before them. I locate myself in this way to explicitly acknowledge that I am speaking from a place of privilege— and as an extension, a place of blindness that is enabled by my privilege. My socio-cultural affiliations have encultured me with a biased worldview and lens through which I experience and engage with the world, and thus shape how I approach and interpret this research.

Historically and contemporarily, mainstream research has resembled colonial oppression, taking the form of research on instead of by, with, and for Indigenous peoples. Indigenous peoples have spoken of research as "a dirty word" and have described their communities as "researched to death" (Kowal & Paradies, 2005). Allied researchers Dr. Annette Browne, Dr. Victoria Smye and Dr. Colleen Varcoe (2005)

advise that “Given the long history of exploitation in academic research and the expropriation of knowledge from Aboriginal communities, [non-Indigenous] researchers must reflect carefully on the responsibilities and implications of conducting research in today’s postcolonial context” (2005, p. 31). In wrestling with the question of whether non-Indigenous researchers can or should engage in research about Indigenous issues, these authors take the stance that settlers have a parallel responsibility to engage in decolonization and must support the efforts of Indigenous peoples to transform society. While I share similar convictions about my duty to refuse complicity in ongoing injustices and do my part in responding to calls to action (see **Calls to Action**), I challenge their idea that current inequities are “Indigenous issues.” Indigenous peoples bear the burden of health and social inequities, but these are firmly rooted colonial and racial oppression, which are precisely non-Indigenous— mostly white— problems. As such, non-Indigenous people have a responsibility to unlearn and undo sources of injustice, with appropriate guidance from Indigenous peoples.

As a white settler and as a student of health sciences, I am embedded in the communities that I am invested in critiquing and exposing. Without doubt, it is more appropriate to have Indigenous peoples leading research involving or of relevance to Indigenous peoples as insiders to the communities, cultures, and/ or shared experience of colonization (Kovach, 2009; Smith, 2012; Wilson, 2008). Inversely, it could theoretically be argued that settlers may also be positioned to embrace the responsibility of insider research within colonized institutions and systems, with the aim of disrupting and dismantling systems of oppression. On the one hand, my insider status grants me privileged access to knowledge, resources, and people that will leverage my aims (Came & Griffith, 2018); on the other hand, I need to take caution to not let my position as an insider blind me to the influence of Euro-colonial norms that I take for granted or that serve to protect my unearned privilege (Mercer, 2007). As a non-Indigenous researcher socialized in the norms of the dominant culture and steeped in the Eurocentric academy, I need to resist and reject my inclination to default to these tendencies. Practicing reflexivity can help to examine my own self location, subconscious beliefs, and biases (Krusz, Davey, Wigginton, & Hall, 2020), but I humbly acknowledge that I will always have an incomplete field of vision. It requires lifelong learning, and throughout my journey I welcome correction and being held accountable by my Indigenous friends, colleagues, and mentors.

By engaging in this area of research, I aim to work in solidarity with Indigenous peoples in order to disrupt and dismantle colonial oppression to advance our collective liberation. I refuse complicity in ongoing injustices, and I take ownership of my role in decolonizing at the individual and societal levels, which includes decolonizing research and academia. As Michi Saagiig Nishnaabeg scholar Leanne Simpson (2004) states:

> Academics who are to be true allies to Indigenous Peoples in the protection of our knowledge must be willing to step outside of their privileged position and challenge research that conforms to the guidelines outlined by the colonial power structure and root their work in the politics of decolonization and anticolonialism (as cited in Carlson, 2017, p. 6).

My intent is to challenge the pathologizing norms of public health research and shift the focus of investigation upstream towards colonial systems and structures, particularly health and education systems. In addition to the important work that is being done to understand the effects of oppression and the lived experiences of equity-deserving groups, we need to look at the sources of hegemonic power that create, reproduce, and perpetuate inequities (Moradi & Grzanka, 2017).

1.4. Key Terms

1.4.1. Indigenous

I use the term ‘Indigenous peoples’ to refer to the political and cultural entities who have continuity with the original inhabitants of a current or historic land/ water base, predating disruptive colonizing and settler populations (Allan & Smylie, 2015; Brown, Smye & Varcoe, 2005; Claxton et al., 2021). There is no universally recognized formal definition of Indigenous peoples, as each community, nation, or collectivity has the right to define and identify itself. In most instances, I am referring specifically to Indigenous peoples of so-called ‘Canada,’ including First Nations, Métis, and Inuit peoples; at times, I use the term ‘global Indigenous peoples’ to encompass Indigenous peoples from other land bases with a shared history of colonization, while respecting the diversity across and within countries/ regions. Exceptions to the use of the term Indigenous will be made

when quoting sources that use antiquated terminology that remain as a by-product of the Indian Act (e.g. ‘Aboriginal’, ‘Indian’), and/ or to respect instances in which an Indigenous person uses an alternative term in self-identifying.

1.4.2. Race/ Racialized

I do not use definitions of Indigenous based on theories of ‘race’ or blood-quantum (i.e. threshold based on percentage of bloodline). The concept of race is arbitrary and biologically inaccurate. It is socially constructed through processes of assigning meaning and imposing categories to skin colour and other phenotypic variation such as hair texture, stature, or facial characteristics (American Association of Physical Anthropologists, 2019; Clark et al., 2022; Claxton et al., 2021; Ford & Airhihenbuwa, 2010; Ford et al., 2019; Kendi, 2019; Singh, 2019; St. Denis, 2007; Turpel-Lafond, 2020). The hierarchical system of racial classification was first used by French physician Francois Bernier then widely propagated through Carolus Linnaeus’s Natural History in 1735 (Ford & Airhihenbuwa, 2010; Menakem, 2017). Systems of racial classification are intimately tied to imperialism, colonialism, slavery, oppression, and discrimination. Therefore, although I reject the normalization of the term ‘race’ as a marker of identity or proxy signaling risk, I acknowledge the very real effects of racism and racialization as a critical determinant of health. I use the term ‘racialized’ to describe members of populations affected by racism because of their perceived or assigned skin colour. Unless otherwise stated, it does not include individuals who are white— another socially constructed category with no basis in biology (Clark et al., 2022; National Collaborating Centre for Determinants of Health, 2020).

1.4.3. BIPOC

Additionally, throughout this dissertation, I use the acronym BIPOC to stand for Black, Indigenous, and People of Colour, with Black encompassing African, African-American, African-Canadian, and Afro-Caribbean peoples. Variations of the acronym such as IBPOC or POC may appear in direct quotes from the literature or data. I acknowledge that in some spaces IBPOC is preferred as a way to recognize the unique history and context of settler colonization, and symbolically position “First Peoples first” (data source: [Case 200] President’s Task Force on Anti-Racism and Inclusive Excellence Report, 2022). However, I made the intentional choice to consistently use BIPOC to

honour the origins of the acronym and the efforts of the Black community in response to anti-Black racism in the United States (US) (data source: [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022).

1.4.4. Cultural Safety and Anti-Racism

While there is a broad spectrum of conceptual models of health professional training that aim to "undo, eliminate or ameliorate the effects of racism" (Came & Griffith, 2018, p. 182), the concepts of cultural safety and anti-racism are used throughout this dissertation for consistency. These terms were selected as representing popular discourses of the time in which the research was conceived and conducted (2017-2023). However, just as other conceptual models have evolved into or been replaced by more relevant and/ or appropriate ones over the years, the relevance and appropriateness of these terms is likely time bound and contextual. For now, widespread agreement on the use of cultural safety and anti-racism fills a need for a shared language and standardization to support the establishment of an evidence base. Cultural safety can be understood as an outcome of an effective care encounter that is respectful of individuals' cultural identities, and is deemed physically, socially, emotionally, and spiritually safe by a service recipient and/ or their family (Nursing Council of New Zealand, 2011; Turpel-Lafond, 2020). Anti-racism has boundless applications, but in the context of this dissertation can be understood as a model for education and health service delivery that seeks to confront systems of power and oppression in order to eradicate racism in all its forms (Association of Faculties of Medicine of Canada, 2019; Came & Griffith, 2018). Detailed explanations of these concepts, their origins, their merits and limitations, as well as a comparison to co-aligned concepts can be found in **Health Professional Training**.

1.4.5. Training Interventions

In this study, cultural safety and anti-racism training interventions serve as the evidence-based intervention being examined. Evidence-based interventions, also referred to as evidence-informed practices, can be understood as "programs, practices, principles, procedures, products, pills, and policies that have been found to be effective at improving health behaviors, health outcomes, or health-related environments" (Leeman, Birken, Powell, Rohweder & Shea, 2017, p. 3). For the purposes of this study, 'evidence-based' includes interventions that are supported by community-driven calls to action,

scientific research, seminal reports, guidelines, and/ or lived experience. Training is used as a general term to encompass a broad range of teaching and learning strategies, including both formal curricula (e.g. classroom instruction, workshops, modules, skills-based practical exercises, experiential learning, practicums) and informal education (e.g. mentorships, modelling, hidden curriculum). This may involve— but is not necessarily tied to— formal training programs, which are structured, organized programs designed to impart specific skills and knowledge to learners within a prescribed curriculum. The term is used in this way to provide flexibility in capturing the wide spectrum of cultural safety and anti-racism training interventions that vary between and within institutions.

1.5. Background

> **Content Warning:** this section includes mention of colonization, genocide, residential schools, Indian hospitals, the Sixties Scoop, child abuse, gender-based violence, racism, etc., which may be triggering for some readers. To skip this section, jump to **Literature Review**.
>
> Indigenous people who may require emotional support can contact the 24-Hour **KUU-US Crisis Line** at 1-800-588-8717.

Indigenous peoples experience avoidable and unjust social, economic and environmental marginalization, including but not limited to: disproportionate rates of poverty, under-/ unemployment, homelessness and substandard housing, unsafe water/ plumbing/ sewage, food insecurity, child welfare apprehension, incarceration, barriers to education, and piecemeal health services that are often inadequate or culturally unsafe (Allan & Smylie, 2015; Claxton et al., 2021; National Collaborating Centre for Indigenous Health, 2021; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Woodward et al., 2021). These inequities give rise to alarming “gaps” in health status between Indigenous and non-Indigenous populations. It is stated that “Indigenous peoples experience the worst health outcomes of any population group in Canada” (Royal College of Physicians and Surgeons of Canada, 2013, as cited in Allan & Smylie, 2015, p. 1).

A range of survey data, such as the Statistics Canada Aboriginal Peoples Survey, the First Nations Regional Health Survey and the Our Health Counts study of urban Aboriginal health, document poorer health outcomes than the general population across virtually all indicators. Indigenous peoples experience higher rates of communicable

diseases, chronic and degenerative diseases, co-morbid conditions, infant mortality, neonatal mortality, preventable injury, violence, self-destructive behaviour, opioid-related overdose, and mental health conditions (Aboriginal Affairs and Northern Development Canada, 1996; Allan & Smylie, 2015; Baba, 2013; Baba & Reading, 2012; Butler-Jones, 2008; Loppie, de Leeuw et al., 2021; Reading & de Leeuw, 2014; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020). According to the most recent data available from Statistics Canada in 2017, the projected life expectancy for Indigenous peoples is approximately five years shorter than their non-Indigenous counterparts and the age-standardized rate of potential years of life lost has been calculated to be two and a half times higher (Statistics Canada, 2017).

Both health inequities and social inequities were magnified and exacerbated during the COVID-19 pandemic (Tam, 2021; Turpel-Lafond, 2020). As explained by the National Collaborating Centre for Indigenous Health, “Often referred to as the ‘great revealer,’ COVID-19 exposed gross inequities lying just below the surface of everyday life for many Indigenous peoples and which exacerbate efforts to address the pandemic” (2021, p. 26). Compounding with the global pandemic, Indigenous peoples are also disproportionately impacted by a second interlocking public health emergency in the form of unprecedented rates of overdose due to a toxic drug supply (Turpel-Lafond, 2020).

It is necessary to apply an intersectionality lens to fully understand the injustice of persisting inequities experienced by Indigenous peoples. Intersectionality helps analyze how co-occurring social identities (e.g. racialized identity, age, sex, gender, sexuality, socio-economic status, and geographic location) interact with their associated layered sources of oppression (e.g. colonialism, racism, xenophobia, ageism, sexism, transphobia, homophobia, classism) (Ford & Airhihenbuwa, 2010; National Collaborating Centre for Determinants of Health, 2022). Black American civil rights advocate Kimberlé Crenshaw is widely credited with coining the term intersectionality in the late 1980s to expose the reality of racism and sexism experienced by women of colour (Crenshaw, 1989) (see **Intersectionality**). It also offers a valuable discourse for unpacking the differential impact of inequities within and between Indigenous subgroups, such as women, Elders, children, as well as Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual (2SLGBTQQIA) people. For example, not only

do Indigenous women carry a disproportionate burden of ill-health and disease in comparison to non-Indigenous women, but also in comparison to Indigenous men (Statistics Canada, 2015; Turpel-Lafond, 2020). Perhaps the most disturbing example of intersectional oppression is the higher rates of violence as well as more severe forms of violence among Indigenous women, girls and 2SLGBTQQIA people (Allan & Smylie, 2015; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). The gross injustice manifested in mass numbers of missing and murdered Indigenous women and girls compounded with societal silence and inaction has been extensively documented in the recent final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019).

1.5.1. Determinants of Indigenous Health

When drawing on epidemiological statistics, it is important to emphasize that these disparities are not indications of genetic predispositions or “vulnerability,” as these discourses can perpetuate pathologizing and reductionist stereotypes and distract from the root cause of inequities. Instead, these discussions must be accompanied by critical analyses of social determinants of health that trace health inequities to social, environmental, political, and historical forces. Indigenous peoples have expanded upon traditional determinants of health frameworks that identify determinants (e.g. employment, housing, education, health behaviours), presenting additional determinants that are salient for Indigenous peoples, including colonization, racism, self-determination, culture, language, land and water, among others (Josewski, de Leeuw, & Greenwood, 2023; Loppie Reading & Wien, 2009; Reading, 2015). Although there is great diversity across cultural understandings of health, many Indigenous models of determinants of health, such as the First Nations Perspective on Health and Wellness (First Nations Health Authority, 2012) and Measuring Wellness: An Indicator Development Guide for First Nations (Geddes, 2015), draw from Indigenous ways of knowing to situate individual and community health within a broader context. Common elements include holistic dimensions of wellness (e.g. physical, mental, emotional, spiritual), lifecycle approaches (e.g. from preconception through afterlife), and sacred connection with all living beings and the natural world (Allan & Smylie, 2015; Claxton et al., 2021; Greenwood, 2019; Josewski, de Leeuw, & Greenwood, 2023; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). From a determinants of

health perspective, it would be impossible to provide a truly “comprehensive” overview of the multitude of conditions and forces that shape Indigenous health and wellbeing. Instead, in the following pages, I will highlight the determinants of health that are most relevant to my topic of cultural safety training and anti-racism education in schools of public health. This decision is not to undermine the significance or interconnected nature of other important determinants, such as ecological determinants (Durkalec, Furgal, Skinner & Sheldon, 2015; Ford, 2012).

1.5.2. Historical Determinants

Discussions around Indigenous determinants of health must include recognition of historical determinants and how they shape present-day experiences because “We look to the past, and to these intersectional systems of oppression as they were developed, as a way to look toward how to transform the present and the future” (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 90). In particular, consideration of present-day inequities must be grounded in an understanding of the legacy of the colonial past as well as the ongoing manifestations of colonial oppression, which some term “neocolonialism” (Browne, Smye, & Varcoe, 2005).

Colonization

European imperial expansion across the globe was initially led by Spain and Portugal, but was followed shortly after by the Netherlands, France, and Britain. These colonial forces relied on myths of European superiority, terra nullius (“empty land”) and the Doctrine of Discovery (Europeans could claim ownership of “discovered” lands) as the rationale for their imposed sovereignty over Indigenous peoples and lands (Truth and Reconciliation Commission of Canada, 2015). Canada has a long history of colonization, setting motion with the voyages of maritime explorers in the fifteenth century, and gradually expanding west (Truth and Reconciliation Commission of Canada, 2015). Beginning in the sixteenth century, both Britain and France used mass migration of settlers as a tool of colonization to displace Indigenous peoples and assert power through numbers (Aboriginal Affairs and Northern Development Canada, 1996).

Genocide

Since first contact, colonizing powers and elected Canadian governments have used deliberate tactics of mass settlement and mass genocide to enforce their illegitimate sovereignty. The Royal Commission on Aboriginal Peoples (RCAP) (1996), the Truth and Reconciliation Commission (TRC) of Canada (2015), and the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) (2019) all take a firm stance that colonization in Canada constitutes genocide. Consistent with the definition of genocide put forth by the Convention on the Prevention and Punishment of the Crime of Genocide of 1948, this includes both physical genocide and cultural genocide. Indigenous peoples have endured colonial warfare that sought to eliminate their nationhood and existence, biological attacks in the form of infectious diseases (e.g. influenza, tuberculosis, small pox) that were introduced to decimate entire populations, unlivable conditions that were imposed to marginalize families and communities, and forced or coerced sterilization intended to impede their reproductive capacity (Aboriginal Affairs and Northern Development Canada, 1996; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Truth and Reconciliation Commission of Canada, 2015). Cultural genocide was enacted through legislating assimilation, criminalizing Indigenous cultures and languages, persecuting cultural and spiritual leaders, destroying cultural artefacts, and disrupting transmission of cultural identity (Truth and Reconciliation Commission of Canada, 2015). This history of physical and cultural genocide compound with other determinants of health to contribute to distrust in government, healthcare, and education institutions, as well as individuals representing them,

Residential schools and Indian hospitals

One of the primary tools of physical and cultural genocide was the establishment and operation of residential schools, day schools, industrial schools, and Indian hospitals. Together, this network of institutionalized “education” and “care,” run by the government and the churches, functioned to forcibly remove children from their families and communities (Truth and Reconciliation Commission of Canada, 2015). Under the guise of an “education” system, residential schools operated more like a prison, with inadequate diets, poor sanitation, and overcrowded conditions (Truth and Reconciliation Commission of Canada, 2015). Moreover, severe discipline and abuse were rampant in the residential school system, with appalling levels of physical, sexual, psychological,

emotional, and cultural abuse of students (Aboriginal Affairs and Northern Development Canada, 1996; Truth and Reconciliation Commission of Canada, 2015). Indigenous peoples' experiences of residential schools are well-documented, with thousands of Survivor testimonies collected by the Truth and Reconciliation Commission (TRC) of Canada (2015). The residential school system lasted well over 100 years in Canada, with the first school opening its doors in 1849 and the last school closing its doors in 1998 (Truth and Reconciliation Commission of Canada, 2015). The TRC (2015) estimates that at least 150,000 First Nations, Métis and Inuit children passed through the system, starting from the age of six. In recent years, the remains of thousands of Indigenous children who attended residential schools have been unearthed, starting with the recovery of 215 unmarked graves at the site of the former Kamloops Indian Residential School in Tk'emlúps te Secwepemc territory in May 2021 (data: [Case 100] Reconciliation Report, 2022; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). The total number of students who did not survive the horrors of these schools may never be known due to the lack of reporting and efforts to cover up the truth (Truth and Reconciliation Commission of Canada, 2015). The residential school system caused unimaginable pain and suffering for those families and communities whose children never returned.

In the mid-1900s, Canada also developed a segregated system of Indian hospitals that worked hand in hand with the residential schools, supporting efforts to cover up injuries and deaths. "Patients" of these institutions suffered physical and psychological harm through emotional, physical, and sexual abuse; forced sterilization; malpractice and negligent care; and non-consensual medical experimentation (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Turpel-Lafond, 2020). This devastating history of residential schools, day schools, and Indian hospitals has eroded trust in western institutions, including education and health systems, making many Indigenous people apprehensive to access healthcare (Johnson & Sutherland, 2022).

Sixties Scoop

As reports of abuse across the residential school system began to be exposed in the late 1940s, a new tactic of cultural genocide emerged. Again, children were being forcibly removed from their families and communities at a mass scale and being taken into the care of child welfare agencies to be adopted into non-Indigenous families far away from

their homes. Through a systematic series of mass child apprehensions between 1950 and 1980, an era collectively known as the Sixties Scoop, approximately 20,000 Indigenous children were taken from their families and placed in the foster and adoptive homes of primarily white families (Allan & Smylie, 2015; Truth and reconciliation Commission of Canada, 2015). At the peak of these efforts in the 1960s, nearly one in three Indigenous children were taken (Truth and Reconciliation Commission of Canada, 2015).Cultural genocide and mass apprehension of Indigenous children is not a vestige of the past. Indigenous children continue to be overrepresented in the child welfare system across Canada. According to the latest, albeit outdated, National Household Survey from 2011, Indigenous children represented 48% of children in care, despite accounting for only 7% of all children in Canada (Statistics Canada, 2016). Practices of birth alerts and child apprehension in clinical settings once again contributes to healthcare settings being seen as unsafe environments for Indigenous families.

Intergenerational trauma

Residential schools, Indian hospitals, and the Sixties Scoop left a legacy of intergenerational trauma for Survivors, their children, grandchildren, and great-grandchildren, as well as rippling effects on their partners, extended families, and communities. In testimonies shared with the TRC and the National Inquiry into MMIWG, many Survivors and their family members used the term “trauma” to describe “the deep emotional, spiritual, and psychological pain or ‘soul wounds’ they and their loved ones endure” (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 112). The National Inquiry into MMIWG (2019) explains that unlike western medical and psychological conceptions of trauma, Indigenous understandings of traumatic experience is not confined to individualized pain but also includes shared experiences of collective, historical, and intergenerational trauma. These terms are commonly used to explain how in some cases, Survivors perpetuate the abuse and unhealthy relationships they experienced in residential schools, leading to a cycle of violence that has far-reaching outcomes such as disproportionate rates of school attrition, unemployment, child welfare apprehensions, domestic violence, incarceration, alcoholism and addictions, mental health conditions and suicide [in some, but not all communities] (Aboriginal Affairs and Northern Development Canada, 1996; Menakem, 2017; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019).

In most cases, mainstream health and social services are inadequately prepared to offer support for intergenerational trauma, limiting their ability to provide culturally safe care.

1.5.3. Resilience as a Protective Determinant

Just as trauma can be passed from one generation to the next, so too can resilience: “Like trauma, resilience can ripple outward, changing the lives of people, families, neighborhoods, and communities in positive ways. Also like trauma, resilience can be passed down from generation to generation” (Menakem, 2017, p. 77). Resilience is closely linked to resistance. Whereas resilience indicates an individual’s or community’s capacity to adapt, recover, and heal; resistance can be understood as overcoming difficult circumstances or opposing negative forces. Despite relentless attempts by colonial forces to perpetrate genocide against Indigenous peoples, from the early days of contact, Indigenous peoples have demonstrated resilience and resistance in the face of colonial violence (Claxton et al., 2021; Turpel-Lafond, 2020). During the residential school era, this was demonstrated through parents refusing to allow their children to be taken away and demanding the establishment of schools within their communities (Truth and Reconciliation Commission of Canada, 2015). The children who attended residential schools drew on their agency to exemplify resilience, many of whom engaged in active resistance by using their Indigenous languages, defending their peers/ family members, running away and/ or simply surviving the horrors that they endured (Truth and Reconciliation Commission of Canada, 2015). The TRC commemorates the lived experiences of Survivors and commends their strength, stating:

> Survivors are more than just victims of violence… They are women and men who have resilience, courage, and vision. Many have become Elders, community leaders, educators, lawyers, and political activists who are dedicated to revitalizing their cultures, languages, Treaties, laws, and governance systems. Through lived experience, they have gained deep insights into what victims of violence require to heal (2015, p. 260).

Through what is known as cultural continuity, Indigenous peoples have preserved their cultural identities, their languages, their own health and wellness systems, their

ceremonies and traditions, their oral histories and their inherent right to self-determination (Aboriginal Affairs and Northern Development Canada, 1996; Turpel-Lafond, 2020). One of the most valuable sources of cultural continuity is Elders [also referred to as the Old Ones, the Wise Ones, Grandmothers/ Grandfathers], who are "living embodiments of Aboriginal traditions and cultures… Elders are keepers of spiritual knowledge that has sustained people through thousands of years" (Aboriginal Affairs and Northern Development Canada, 1996, n.p.). Additionally, Indigenous peoples derive their strength from their family and extended kinship networks, which function as the central unit of Indigenous societies (Aboriginal Affairs and Northern Development Canada, 1996). Indigenous peoples' strength is reinforced by their nationhood and their self-determination over their own governing institutions and laws, which stems from their stewardship of the land and waterways since time immemorial and was never ceded at any point throughout history (Aboriginal Affairs and Northern Development Canada, 1996; National Collaborating Centre for Indigenous Health, 2021; Tam, 2021; Turpel-Lafond, 2020). Collectively, these sources of strength serve as protective determinants that counter the destructive historical determinants outlined above and support healing towards a thriving future for generations to come. These understandings of resiliency, resistance, collective strength, and respect for agency also inform culturally safe care.

1.5.4. Health System Determinants

Healthcare systems have a mandate to provide public services that have a primary purpose of promoting, restoring, or maintaining the health of the population. However, as a colonial system, it also has the potential to reproduce and perpetuate inequities, particularly in relation to presenting barriers to accessing health care for Indigenous clients and patients. Despite the praise Canada often receives for its "universal" healthcare, Indigenous peoples' experiences of accessing health services demonstrates egregious shortcomings.

Jurisdictional divisions

Some of the fundamental flaws of Canada's health system include structural and systemic barriers for Indigenous peoples such as fragmented governance, jurisdictional complexity, gaps in service coverage, and lack of government accountability (Kelly, 2011; Tam, 2021; Turpel-Lafond, 2020). Canada's health system has been

characterized as a ‘bureaucratic maze’ (Adelson, 2005, p. 5) and ‘a complex patchwork of policies, legislation and relationships’ (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011, p. 1). The divisions not only exist across tiers of government, but also translate to divisions across ancestry, place of residence and land claim agreements. In particular, the division of jurisdiction produces “uneven distribution of health funding, resources and services according to state-constructed Indigenous identities” (Allan & Smylie, 2015, p. 26), with the federal government accepting responsibility for administering health services to status First Nations and Inuit peoples, while excluding Métis, non-status, and urban Indigenous people (Aboriginal Affairs and Northern Development Canada, 1996; Truth and Reconciliation Commission of Canada, 2015).

As a result of the jurisdictional divisions, there are often disputes over which level of government or department is responsible for paying costs. These disputes have had devastating consequences for Indigenous peoples, as represented by the story of Jordan River Anderson from Norway House Cree Nation:

> Born with complex medical needs, Jordan spent more than two years unnecessarily in hospital while the Province of Manitoba and the federal government argued over who should pay for his at home care. Jordan died in the hospital at the age of five years old, never having spent a day in his family home (First Nations Child & Family Caring Society, 2019).

In response to the injustice of the unnecessary and avoidable death of Jordan, Gitxsan scholar and children’s rights advocate Dr. Cindy Blackstock led the development of Jordan’s Principle, a “child first” approach to ensuring Indigenous children access necessary care without experiencing service denials, delays, or disruptions due to jurisdictional disputes. According to Jordan’s Principle, it is the responsibility of the government of first contact to pay for the service then pursue reimbursement later if necessary (First Nations Child & Family Caring Society, 2019). In 2007, Jordan’s Principle was unanimously supported by Parliament, issuing a statement of principle, yet did not ratify it with legislation; since then, the Government of Canada has failed to fully implement Jordan’s Principle, perpetuating inter-governmental disputes (Truth and Reconciliation Commission of Canada, 2015).

Accessibility

In addition to the jurisdictional divisions that complicate and delay health coverage, accessibility of health services is often a major barrier to equitable healthcare for Indigenous peoples. Barriers to accessibility include far distance, long wait times, complexity of navigating the system, lack of Indigenous staff, lack of available services, and poor quality of service (National Collaborating Centre for Indigenous Health, 2019; Turpel-Lafond, 2020). As a key example of inequitable access, many Inuit, northern, and remote Indigenous communities lack essential services that most Canadians have easy access to. As a result, many Indigenous people must travel to urban centres for their care needs, which often involves travelling alone and being placed in culturally and physically unsafe environments. This is particularly difficult for women who are relocated or evacuated from their communities and their families to give birth, which has been found to have long-term negative impacts on both the mother and the child (National Collaborating Centre for Indigenous Health, 2019; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Turpel-Lafond, 2020). Another barrier to accessibility that is more pronounced in northern and remote communities is a transient healthcare workforce, which diminishes the quality and effectiveness of healthcare interactions and relationships with care providers. Moreover, because of the limited options for education and training in these communities and the need to relocate to the south/ urban centres to pursue advanced education, Indigenous peoples are underrepresented in the healthcare workforce and their cultures are not represented in the design or delivery of health services (National Collaborating Centre for Indigenous Health, 2019; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Turpel-Lafond, 2020).

Institutional and interpersonal racism

Indigenous peoples have long understood and drawn attention to the profound impacts of racism in healthcare settings as a critical barrier to accessible healthcare and equitable health outcomes for Indigenous populations. Only recently has mainstream scholarship caught up, with several landmark studies exposing widespread experiences of racism in Canada’s health system, which are well documented in qualitative and survey data (Allan & Smylie, 2015; Browne, 2017; Harding, 2018; Loppie, Reading & de Leeuw, 2014; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Turpel-Lafond, 2020). Furthermore, it is understood that countless personal

accounts of racism go unreported. Racism in healthcare settings is manifested in both institutional racism and interpersonal racism. Institutional racism operates through organizations' internal culture, policies and procedures. Racism and hegemonic colonial culture permeate health systems and institutions through physical environments in which Indigenous patients do not feel safe, health professional workforces that do not represent Indigenous peoples, as well as service and program designs that do not incorporate Indigenous cultures and ways of knowing (Came & Griffith, 2018; Clark et al., 2022; de Leeuw et al., 2021; Diffey & Mignone, 2017; Ford et al., 2018; National Collaborating Centre for Determinants of Health, 2020; National Collaborating Centre for Indigenous Health, 2021; Nickerson, 2019; Turpel-Lafond, 2020).

Institutional racism is directly related to interpersonal racism, as internal culture, policies, and procedures are enacted and perpetuated by individuals who make up the organizations and who embody institutional culture in their attitudes, beliefs, and behaviours (Ly & Crowshoe, 2015). Interpersonal racism is experienced by Indigenous patients and families through everyday interactions with care providers that are disrespectful, demeaning, diminishing, or disempowering towards their cultural identities (Brown, 2009, as cited in Loppie, Reading & de Leeuw, 2014). The landmark 'In Plain Sight Report' authored by Mary Ellen Turpel-Lafond that was released at the end of 2020, provides an in-depth inquiry into anti-Indigenous racism in BC's health system. The report concluded that 84 percent of Indigenous respondents reported some form of discrimination, and provided detailed patient accounts of racism, including: being the target of stereotypes or bigotry, being mocked or belittled, being turned away from the hospital, being denied treatment/ pain relief, not receiving appropriate assessments, receiving inappropriate referrals, and being discharged early or without enough planning and support.

Institutional and interpersonal racism contribute to feelings of distrust, fear, and hostility towards the health system, which in turn influence Indigenous peoples' utilization of health services and their feeling of safety within the system. Leading scholars in the area of Indigenous determinants of health, Samantha Loppie, Dr. Charlotte Loppie [Dr. Charlotte Reading at the time of publication] and Dr. Sarah de Leeuw, offer an explanation of how racism contributes to inequitable access and health outcomes to elucidate its significance as a determinant of health:

> The consequence of racism within health care settings is first and foremost emotional and social harm to Aboriginal peoples. A more long-term and insidious outcome, however, is that Aboriginal people lose trust in a system that claims to care for them. Experiences of harm and lack of trust can translate into [delayed or] diminished utilization of services critical to Aboriginal peoples' health, including screening for infectious or chronic disease as well as access to essential medical treatment or pharmaceutical interventions (2014, p. 8).

Extreme cases of institutional and interpersonal racism in Canada's health system have even resulted in fatal outcomes, as in the case of Jordan River Anderson (2005), Brian Sinclair (2008), and Joyce Echaquan (2020) (National Collaborating Centre for Indigenous Health, 2021; Turpel-Lafond, 2020).

1.5.5. Education System as a Determinant

A commonly overlooked problem related to Indigenous peoples' negative experiences accessing health care is the failure of the education system to adequately train a workforce for cultural safety and anti-racism praxis. Additionally, many of the barriers to accessible and culturally appropriate health services could be mitigated through training, hiring, and retaining Indigenous health professionals; yet these efforts have been hindered by systemic barriers within the education system.

Barriers to education

There are shortages of Indigenous people in the healthcare workforce as well as other important professions, including teachers, social workers, and legal professionals, in part because of the additional hurdles Indigenous peoples face to complete not only advanced professional degrees but also grade school (Aboriginal Affairs and Northern Development Canada, 1996; Claxton et al., 2021; Truth and Reconciliation Commission of Canada, 2015). These hurdles include the need to relocate to attend education institutions in urban centers; lack of representation of Indigenous teachers as role models; education curricula that do not reflect Indigenous cultures, worldviews and ways of knowing; institutional and peer-mediated racism within the education system… all of

which compound with other social, cultural and economic inequities that Indigenous peoples face on a daily basis (Allan & Smylie, 2015; Ford et al., 2019; Gaudry & Lorenz, 2018; Ly & Crowshoe, 2015).

Colonized setting

Systems of oppression, such as colonialism, racism, ageism, classism, heterosexism, patriarchy, and ableism, are present at all levels of the education system— much like the healthcare system (Djulus et al., 2021; Gaudry & Lorenz, 2018). Education institutions, particularly universities, are steeped in the academy's colonial foundations and ongoing colonial culture. They are often unwelcome and even hostile places for Indigenous students, teachers, staff, and community members. The names of universities alone tend to evoke colonial ties, for instance: Simon Fraser University being named after a European explorer, University of Victoria's name originating from the Crown, and University of British Columbia or University of Northern British Columbia normalizing the province's unchallenged colonial origin. Universities are built on top of Indigenous lands, and in some cases on top of historical village sites of cultural significance (Leonard & Mercier, 2016). Although institutions are increasingly embracing the practice of territorial acknowledgements, these often amount to lip service, without seeking permission of its hosts, without following local protocols, without surrendering decision-making capacity, and without committing to repatriation of land (Gaudry & Lorenz, 2018). Furthermore, throughout history, education institutions have contributed to the assimilation agenda by expecting Indigenous people to conform to Eurocentric worldviews and ways of knowing with the aim of integration into mainstream society (Gaudry & Lorenz, 2018).

Interpersonal Racism

Indigenous students, faculty, staff, and community members often experience racism in university settings. This can include overt forms of racism, such as derogatory remarks or harassment, as well as more subtle forms of microaggressions, like ignorance of their cultural backgrounds or assumptions about their abilities (Allan & Smylie, 2015; Ford et al., 2019; Singh, 2019; Ward, 2018). These experiences of racism can lead to feelings of isolation, anxiety, and decreased confidence. Furthermore, education institutions offer inadequate and unsupportive systems for reporting racist incidents:

> Indigenous students overcome much greater systemic racism, including socio-economic disparities, to reach admission to health professional education, only to be faced with learning and collegial environments reported to be chilling and racked with fear of reprisal for raising issues of racism and discrimination. The racism experienced by Indigenous health care students and workers has a negative impact on their health and well-being. It is career-limiting to voice concern about racism and can bring negative professional impacts, and can lead to decisions to leave their profession. Those who do raise concerns are often traumatized by the experience (Turpel-Lafond, 2020, p. 91).

Epistemic racism

Despite the underlying mission of the academy to "expand the bounds of the human imagination and explore truth in all its forms" (Kuokkanen, 2008, as cited in Gaudry & Lorenz, 2018, p. 221), academic institutions are complicit in sanctioning the legitimation and universalization of hegemonic Eurocentric knowledge systems. The education system reinforces and perpetuates epistemic racism, which can be understood as positioning one knowledge system as superior over those of racialized groups or using one knowledge system to marginalize others (Association of Faculties of Medicine of Canada, 2019; Turpel-Lafond, 2020). In medical and health sciences, this is especially evident in the dominance of western biomedicine, which centers curriculum around physiological illness and allopathic treatment (Diffey & Mignone, 2017; Tam, 2021). While privileging western science, education institutions simultaneously suppress Indigenous knowledge systems and ways of knowing, contributing to the erasure of Indigenous knowledge (Gaudry & Lorenz, 2018; Rodriguez, 2012). Epistemic racism is also woven throughout an unwritten "hidden curriculum" that influences what is taught and learned in such a way that reinforces and reproduces worldviews, values, and perspectives that serve a colonial assimilationist agenda (Association of Faculties of Medicine of Canada, 2019; Leonard & Mercier, 2016; Ly & Crowshoe, 2015).

The education system has played a significant role socializing and enculturing Canadians so that colonialism and racism permeate society. The Truth and Reconciliation Commission of Canada argues that "Much of the current state of troubled

relations between Aboriginal and non-Aboriginal Canadians is attributable to educational institutions and what they have taught, or failed to teach, over many generations" (2015, p. 285). At all levels of education and throughout all subject areas, curricula omit Indigenous peoples, cultures, worldviews, and histories (Johnson & Sutherland, 2022; Ly & Crowshoe, 2015; National Aboriginal Health Organization, 2008; Turpel-Lafond, 2020). Furthermore, when Indigenous peoples are included in curricula, there is a tendency to essentialize them as a single 'pan-Indigenous' identity, which fails to represent the diversity across and within cultures (Downing & Kowal, 2011). In this way, the education system enables and perpetuates ignorance. It also enables prejudice and bigotry by 'othering' and objectifying Indigenous peoples (Downing & Kowal, 2011), relegating Indigenous Nations to a 'mythic past' (Lawrence & Dua, 2005), and reinforcing negative stereotypes (Browne, Smye, & Varcoe, 2005). In medical and health sciences, negative stereotypes surface in deficit-based discourses that associate poor health with poverty, alcohol and substance use, bad parenting, laziness, and ineptitude (Association of Faculties of Medicine of Canada, 2019; Browne, Smye, & Varcoe, 2005). These dangerous stereotypes directly feed into institutional and interpersonal racism in the healthcare system.

Education systems steeped in colonial culture, interpersonal racism, and epistemic racism feed into healthcare systems that are fraught with racism and not culturally safe environments for Indigenous clients and patients. Education plays a pivotal role in shaping individuals' beliefs, attitudes, and values. When education systems are built upon the foundations of racism and colonialism, these harmful ideologies permeate the healthcare workforce and extend into the care of Indigenous patients and clients. However, as illustrated in the following section, the education system can also positively influence healthcare by equipping the workforce with knowledge and skills for cultural safety and anti-racism praxis.

Chapter 2. Literature Review

The previous section illustrates that persisting gaps in health outcomes and inequitable determinants of health faced by Indigenous peoples are well-established, as evidenced by a multitude of research studies, landmark reports, and personal testimonies from Indigenous peoples. The literature review transitions from arguing for recognition of the presence of inequities to providing an overview of current evidence and best practices for developing, implementing, and evaluating interventions that address systemic racism and promote wellness for Indigenous peoples. The calls to action and best practices presented below are the culmination of generations of Indigenous activism and leadership. This section further provides context to understand and appreciate the challenges and opportunities for public health programs to implement these interventions.

2.1. Calls to Action

2.1.1. Royal Commission on Aboriginal Peoples (RCAP)

In 1991, the Canadian government appointed four Indigenous and three non-Indigenous commissioners to the RCAP, charging them with the monumental task of advising the government on how to "...restore justice to the relationship between Aboriginal and non-Aboriginal people in Canada and to propose practical solutions to stubborn problems" (Aboriginal Affairs and Northern Development Canada, 1996, p. 2). The RCAP released its final report in 1996, which includes 440 recommendations, intended to be embraced as a comprehensive and holistic agenda for a new nation-to-nation relationship. The RCAP proposed that the foundation of this renewed relationship would be a new Royal Proclamation, co-created through treaty relationships, which would outline commitments of a respectful and equal relationship. This overarching goal was also supported by a comprehensive set of recommendations to be taken up and implemented by the government, systems, institutions, and individuals across Canada. Recommendations specific to the health system include: establishing a system of health centres and healing lodges under Indigenous control; educating and training Indigenous people in all health-related professions; correcting problems in the mainstream health system to better serve the needs of Indigenous patients; and developing action plans and service standards to

implement these recommendations within government agencies, professional organizations, academic institutions and accrediting bodies. The RCAP set out an ambitious 20-year timeframe for implementation of the recommendations, or at the very least momentum to move steadily forward. However, 20 years has come and gone, and a majority of the RCAP's recommendations have yet to be implemented (Allan & Smylie, 2015; Greenwood, 2019).

2.1.2. Truth and Reconciliation Commission of Canada (TRC)

Despite minimal follow through on the recommendations put forward by the RCAP, a decade later in 2008, the federal government appointed another commission with similar aims. The TRC was established to conduct a thorough investigation of the experiences of Indigenous peoples in residential schools and set forward a path for reconciliation. As part of this process, the TRC held a series of national and regional public forums in all corners of the country to a) listen to, gather, and document testimonies from Survivors and their families as well as those who worked in the residential schools; and b) to raise awareness of the truth of this chapter of history as well as its ongoing legacy (Truth and Reconciliation Commission of Canada, 2015). Over six years of the TRC's operation, more than 150,000 people attended these events and more than 6,750 statements were shared. In June 2015, the TRC released a final report to commemorate the stories that were shared and to issue 94 Calls to Action to guide governments, religious groups, systems, institutions, and individuals in doing their part to contribute to reconciliation. The Calls to Action span the domains of child welfare, education, language and culture, health, justice, and reconciliation. Calls to Action 18 through 24 are specific to health, and include recommendations for recognizing and implementing healthcare rights; addressing health inequities; fixing jurisdictional gaps; providing sustainable funding for Indigenous healing centres; incorporating Indigenous healing practices into care practices; increasing the number of Indigenous health professionals; and training health professionals. The implementation of the 94 Calls to Action are now being overseen by the National Centre for Truth and Reconciliation, which was created as part of the mandate of the TRC. Progress is also being monitored by independent bodies such as the Yellowhead Institute, which publishes annual status updates on the Calls to Action (Jewell & Mosby, 2022); and Beyond94, an initiative led by CBC- Radio Canada (2019). As of March 2023, Beyond94's website indicates that of the 94 Calls to Action, 19 have

not been started, 31 are at a proposal stage; 31 are in progress, and 13 are complete. Similarly, the Yellowhead Institute's 2022 Status Update on Reconciliation indicates, "… As of December 2022, zero out of the seven Calls to Action in the area of health have been completed" (Jewell & Mosby, 2022).

2.1.3. United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

In their final report, the TRC recommended use of UNDRIP as a framework for reconciliation in Canada, calling on all levels of government to fully adopt and implement the Declaration (Calls to Action #43 and #44). The Declaration affirms the rights of Indigenous peoples on an international level, with 46 Articles that are intended to be interpreted as the "minimum standards for the survival, dignity and well-being of the Indigenous peoples of the world" (2008, p. 14), and do not detract from existing rights as outlined in treaties or other nation-to-nation agreements. Perhaps the most significant element of UNDRIP is its explicit acknowledgement of Indigenous peoples' collective right to self-determination. Furthermore, it also asserts that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health" (2008, p. 9). UNDRIP was adopted by the United Nations and its member states in 2007, after twenty-five years in the making. Initially, Canada, the United States, Australia, and New Zealand refused to adopt the Declaration. Canada objected to provisions related to Indigenous peoples' free, prior, and informed consent in issues related to development on their lands, arguing that it could be interpreted as a "veto" (Truth and Reconciliation Commission of Canada, 2015). This concern is unfounded, but more importantly, it demonstrates the government's incessant refusal to acknowledge Indigenous sovereignty. In 2010, Canada partially endorsed the Declaration as a "non-legally binding document" that does not change Canadian laws; then following the release of the TRC Calls to Action— nearly ten years after the UN adopted UNDRIP— the Canadian Government finally followed suit with full endorsement of the Declaration (Greenwood, 2019). The Province of BC is the first government in Canada and among Common Law states to pass legislation implementing UNDRIP (Bill 41, 2019).

2.1.4. National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG)

The Government of Canada appointed the MMIWG Commission in 2016 to conduct a similar process as the RCAP and the TRC, with an aim of uncovering the truth of violence against Indigenous women, girls, and 2SLGBTQQIA people, and further identifying steps that must be taken to end this violence (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). The Commission sought to set itself apart from the previous two, explaining “solutions that up to now have been imposed by outsiders, or by the state, must in fact rest with Indigenous women, as defined by themselves” (2019, p.91). The process and the resulting report centered the voices and experiences of Indigenous families, survivors, Knowledge Keepers, and Elders, who shared their wisdom and guidance. From May 2017 through December 2018, the Commission led a truth gathering process across Canada, consisting of Community, Institutional, and Expert and Knowledge Keeper hearings. In total, 2,386 people participated, offering courageous testimonies and sharing through artistic expressions. In the final report, the Commission put forward 231 Calls for Justice, noting that they “… are legal imperatives – they are not optional” (2019, p. 168). Among these Calls for Justice are demands for proper investigation of missing and murdered Indigenous women and girls; laws and policies to punish acts of violence; compensation for survivors and their families; as well as training and public education to raise awareness and prevent violence.

2.1.5. In Plain Sight Report

Most recently, increased public awareness around anti-Indigenous racism in the healthcare system prompted a special inquiry in BC. In 2020, Mary Ellen Turpel-Lafond was appointed by BC’s Minister of Health, the Hon. Adrian Dix, to conduct an independent review of Indigenous-specific racism in the provincial healthcare system, with a focus on emergency departments. The resulting "In Plain Sight" report is a comprehensive examination of the systemic, institutional, and interpersonal racism faced by Indigenous patients and their families when accessing healthcare services. The report captures the contributions of nearly 9,000 voices detailing widespread experiences of racism across the province through survey results, email, and phone testimony submissions, health care data, policy documents, and interview data (Turpel-

Lafond, 2020). The report also highlights the urgent need for immediate action, putting forward 24 recommendations that offer a comprehensive approach to achieving systemic change. The report states:

> One cannot 'pick and choose' from amongst the Recommendations. They are not an interchangeable 'laundry list' – they rely and depend on each other and must be read as part of one action plan for moving forward. They need to be implemented through strategies and efforts that pursue all of them in a co-ordinated and systematic way (Turpel-Lafond, 2020, p. 184).

It further advises the Provincial Government to accept and implement all 24 recommendations, and to ensure implementation is coordinated in alignment with UNDRIP.

2.2. Health Professional Training

Across the RCAP's 440 recommendations for a new relationship, the TRC's 94 Calls to Action for reconciliation, UNDRIP's 46 Articles for Indigenous rights, the MMIWG Inquiry's 231 Calls for Justice for MMIWG, and the In Plain Sight Report's 24 recommendations for systemic change, there is a strong message that we all have a role to play. These imperatives apply to all levels of government, all sectors, all systems, all institutions, and all individuals from all backgrounds across all regions of Canada. In particular, the health system and the institutions, leadership, health professionals, and other staff within it have an important role in advancing these agendas. The Inquiry into MMIWG explains that rather than contributing to perpetuation of inequities among Indigenous peoples, the health system has an opportunity to contribute to wellness and health equity. Specifically, Call to Justice 7.6 calls upon all persons involved in the provision of health care to receive "ongoing training, education, and awareness in areas including, but not limited to: the history of colonialism in the oppression and genocide of Inuit, Métis, and First Nations Peoples; anti-bias and anti-racism; local language and culture; and local health and healing practices" (2019, p.189). Similarly, the TRC's Calls to Action call for "cultural competency training for all health-care professionals" (Call to Action #23, 2015, p. 211), and for medical and nursing schools to "require all students to

take a course dealing with Aboriginal health issues… [and] skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism" (Call to Action #24, 2015, p. 211). The In Plain Sight Report makes multiple recommendations to implement and support the advancement of anti-racism, cultural safety, and trauma-informed training for healthcare professionals. In addition to calling for a "refreshed approach" to training for all health workers in Recommendation 20, Recommendation 21 calls for mandatory training in university and college programs for health practitioners "to ensure all students receive accurate and detailed knowledge of Indigenous-specific racism, colonialism, trauma-informed practice, Indigenous health and wellness" (2020, p. 200).

Over the last few decades, more and more training programs for health professionals have been introduced and implemented across Canada and other settler-colonial countries with the aim of improving the quality, accessibility, and acceptability of health services for Indigenous peoples. These training programs range in their format and rigour (e.g. online modules, in-person workshops, multi-session training programs); the concepts and principles they promote (e.g. cultural awareness, cultural sensitivity, cultural responsiveness, cultural appropriateness, cultural competency, cultural humility, cultural safety, anti-racism); as well as their emphasis and scope of influence (e.g. focusing on health professional behaviour, changing health services, transforming medical culture) (Baba, 2013; Downing & Kowal, 2011; Guerra & Kurtz, 2017). Not to mention, the increasing number of parallel initiatives promoting co-aligned concepts with overlapping principles (e.g. equity-oriented, patient-centered, trauma-informed care). There is a spectrum of conceptual models of training that need to be considered, as presented below.

2.2.1. Cultural Awareness and Cultural Sensitivity

Cultural awareness is one of the early models of health professional training that was introduced to improve quality of care for Indigenous peoples and other racialized groups. Cultural awareness teaches health professionals to observe and acknowledge cultural differences (e.g., understandings of wellness) as a factor influencing patient experience (Baba, 2012; Baba, 2013; Downing & Kowal, 2011; Johnson & Sutherland, 2022; Nickerson, 2019). Whereas cultural awareness merely encourages health professionals to 'tolerate' differences, cultural sensitivity promotes respect for different cultural

worldviews, values, and beliefs (Baba, 2012; Baba, 2013). In the late 1990s and early 2000s, cultural awareness and cultural sensitivity were the predominant models endorsed by health institutions and medical schools (Aboriginal Nurses Association of Canada, 2009; Downing & Kowal, 2011; National Aboriginal Health Organization, 2008; St. Denis, 2007). They have since been critiqued for reinforcing stereotypes that essentialize Indigenous peoples as a single homogenous culture and othering them as 'different from the norm' (Baba, 2013; Downing & Kowal, 2011). These approaches also run the risk of pathologizing Indigeneity by attributing inequities to cultural difference, which has oftentimes been used as synonymous with racial difference (Gustafson & Reitmanova, 2010). By focusing on what makes Indigenous people different, both cultural awareness and cultural sensitivity place the onus on Indigenous peoples to "fit in, or do a better job of explaining themselves, healing themselves, or abandoning their culture." (Truth and Reconciliation Commission of Canada, 2015, as cited in Provincial Health Services Authority Indigenous Health, 2019, p. 9). Furthermore, they fail to hold health professionals and health institutions responsible for changing their practices and/ or the underlying systems of oppression (Downing & Kowal, 2011).

2.2.2. Cultural Appropriateness and Cultural Responsiveness

Health professionals and health institutions began to recognize the need to go beyond acknowledging and respecting diversity to responding to patients' unique needs and preferences with culturally and linguistically appropriate care (Downing & Kowal, 2011; Ogbolu & Fitzpatrick, 2015). The terms culturally appropriate and culturally responsive have been used interchangeably to describe "effective, understandable, and respectful care that is provided in a manner compatible with [patients'] cultural health beliefs and practices and preferred language" (Baba, 2012, p. 33). This approach to health service delivery has been recommended by the RCAP, the TRC, and the MMIWG Inquiry. In order for health professionals to be able to respond to patients' cultural needs, they require training to become familiar with appropriate care practices and protocols. Therefore, public health education and accreditation bodies in North America, such as the Public Health Agency of Canada (PHAC), the American Public Health Association (APHA), the Association of Schools of Public Health (ASPH), and the Council on Education for Public Health (CEPH), have each endorsed cultural appropriateness and cultural responsiveness as competencies that students should learn, as outlined in

Lauren Baba's (2013) environmental scan of cultural competency and safety in education, training, and health services. However, training health professionals to be knowledgeable about appropriate care practices and protocols for Indigenous peoples is a difficult— if not impossible— endeavour without resorting to pan-Indigenous stereotypes or requiring an encyclopedic knowledge base. It is important to emphasize the vast diversity across and within Indigenous cultures; for example, understandings of wellness (e.g. teachings of the Medicine Wheel) and ceremonies (e.g. Smudging, Sweat Lodge) will not only vary from one Nation to the next, but are also highly personal and not followed by all members of a cultural group. For this reason, it may be more appropriate to prepare health professionals to "recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal leaders and Elders, where requested by Aboriginal patients," as recommended by the TRC in Call to Action #22 (2015, p. 210).

2.2.3. Cultural Competency

Closely related to the concepts of cultural appropriateness and cultural responsiveness, the term cultural competence has been widely used in training and practice settings, partly in response to TRC's endorsement of the concept in Calls to Action #23 and #24 (Aboriginal Nurses Association of Canada, 2009; de Leeuw et al., 2021; Gustafson & Reitmanova, 2010; Truth and Reconciliation Commission of Canada, 2015). Cultural competence captures a set of skills, knowledge, and attitudes to equip health professionals to adapt their practice to interact effectively with patients in the context of their cultural worldviews, practices, and needs (Baba, 2013; Horvat, Horey, Romios & Kis-Rigo, 2014; Nickerson, 2019; Utley-Smith, 2017). This includes, for instance, using correct pronunciation and preferred titles, adapting to language needs, adjusting non-verbal expressions, incorporating healing practices and protocols into care plans, among other practices that convey consideration for patients' cultures (Baba, 2012). Like cultural appropriateness and cultural responsiveness, cultural competency has some inherent limitations, not least of which being the assumption that non-Indigenous health professionals can "master" a set of skills that would make them "competent" in cultural context outside of their own (Krusz, Davey, Wigginton, & Hall, 2020). For this reason, it has been critiqued, with valid arguments that "…you learn culture your whole life. You're born into it, you're raised in it, you're learning it probably until the day you die…this

notion of competency in someone else's culture is ridiculous" (participant cited in Beavis et al., 2015, p. 6). These critiques have led some organizations to shift away from their use of cultural competency frameworks. For example, BC's Provincial Health Services Authority (PHSA) developed one of Canada's first and most widely recognized training programs in cultural competency, the Indigenous Cultural Competency (ICC) Training Program, with visionary leadership from the program's founder and creator, Kwakwaka'wakw scholar Dr. Cheryl Ward (Provincial Health Services Authority, n.d.; Ward, 2018). In recent years, PHSA has rebranded their training as San'yas: Indigenous Cultural Safety Training Program. San'yas is broadly considered the primary source of training in the area of Indigenous health for health professionals in BC, and is endorsed by many health authorities, health regulators, and other organizations across BC and Canada (Turpel-Lafond, 2020).

2.2.4. Cultural Safety

The concepts outlined above provide a starting point for improving healthcare interactions for Indigenous peoples. Yet, as the Aboriginal Nurses Association of Canada explains, cultural safety encompasses all of these concepts and extends beyond them:

> Cultural safety takes us beyond cultural awareness and the acknowledgement of difference. It surpasses cultural sensitivity, which recognizes the importance of respecting difference. Cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of practitioners (2009, p. 2).

Cultural safety shifts the focus away from cultural differences and teaching about 'Indigenous culture' towards critically analyzing and transforming the culture of healthcare to counter its tendencies to deny, diminish, devalue, disrespect, demean or disempower Indigenous peoples' cultural identities (Baba, 2012; Browne, Smye, & Varcoe, 2005, National Aboriginal Health Organization, 2008; Oxford Bibliography, 2019; Shah & Reeves, 2015; PHSA Indigenous Health, 2019). Cultural safety encourages health professionals to engage in self-reflection to examine how their socio-cultural locations, beliefs and attitudes shape their professional practice and interactions with

Indigenous peoples (Allan & Smylie, 2015; Baba, 2012; Baba, 2013; Downing & Kowal, 2011; Shah & Reeves, 2015). In addition to getting health professionals to think about power dynamics in their relationships with patients, cultural safety prompts critical interrogation of unjust social processes and colonial structures within health systems (Baba, 2012; Baba, 2013; Canadian Public Health Association, 2019; Shah & Reeves, 2015).

An important distinction between cultural safety and other models is that it is both a process and an outcome; specifically, it is up to the recipient of care to determine whether or not their encounter with the health professional and health institution was culturally safe in order to shift power from provider to client (Allan & Smylie, 2015; Baba, 2013; Beavis et al., 2015; Downing & Kowal, 2011; Johnson & Sutherland, 2022; Nickerson, 2019; Oxford Bibliography, 2019; Shah & Reeves, 2015; Turpel-Lafond, 2020). Ideally, a culturally safe encounter or culturally safe environment is one that is "spiritually, socially and emotionally safe, as well physically safe for people… where there is no assault, challenge or denial of their identity, of who they are or what they need. It is about shared respect, shared meaning, shared knowledge, and experience of learning together" (Williams, 1999, p. 213, as cited in National Collaborating Centre for Indigenous Health, 2021, p. 26). However, it is important to note that although cultural safety can be understood as an outcome, it is more of a journey than an endpoint, as the "assessment of whether care has been culturally safe should be revisited over time and across multiple visits [and] is an active and ongoing process" (Shah & Reeves, 2015, p. 119). Because cultural safety does not focus on the 'cultural other', it has broad applications beyond challenging racism towards Indigenous patients; it is also a useful framework for engaging with power and oppression across other areas of diversity (e.g. gender, sexual orientation, language, (dis)abilities, etc.).

Cultural safety was originally introduced as a postcolonial theoretical framework for nursing practice to address inequities experienced by Maori people in Aotearoa (New Zealand); the concept was developed by Maori nurse Dr. Irihapeti Ramsden in the 1980s (Ramsden, 1990) and was subsequently adopted and expanded upon by the Nursing Council of New Zealand (Nursing Council of New Zealand, 2011). Since then, there has been broad uptake across health disciplines and in other settler-colonial countries such as Australia, Canada, and the United States (Allan & Smylie, 2015; Johnson & Sutherland, 2022; Oxford Bibliography, 2019). It has been increasingly adopted into

healthcare practice, policy, and research by professional organizations and regulatory bodies (Allan & Smylie, 2015; Baba, 2013; Halseth, Stout & Atkinson, 2019; Guerra & Kurtz, 2017; British Columbia Network Environment for Indigenous Health Research, 2022; Carlson, 2017). Environmental scans and syntheses demonstrate that there are a myriad of cultural safety training programs currently offered, including Anishnawbe Health Toronto's Aboriginal Cultural Safety Initiative and PHSA's San'yas Cultural Safety Training mentioned above; furthermore, demand for this training continues to increase (Anishnawbe Health Toronto, 2011; Baba, 2013; Downing, Kowal, & Paradies, 2011; Durey, 2010; Greenwood, 2019; Guerra & Kurtz, 2017; Provincial Health Services Authority, n.d.). With its international proliferation, cultural safety has been extensively theorized, adapted, and refined for specific contexts. However, some scholars caution that it is a "uniquely New Zealand concept" (Gray & McPherson, 2005, as cited in Downing & Kowal, 2011, p. 13); therefore, its origins as a postcolonial framework for Maori people must be acknowledged and coupled with careful consideration for its translation to different settings.

2.2.5. Cultural Humility

The concept of cultural safety is often paired with the related concept of cultural humility. For example, in 2015, the First Nations Health Authority (FNHA), Ministry of Health, and all Health Authorities across BC signed the Declaration of Commitment to Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal People in BC (Declaration of Commitment) (Nickerson, 2019). The Declaration commits signatories to undertaking development and implementation of action plans to advance cultural safety and humility in their respective organizations. Cultural humility complements cultural safety's underlying principle that health professionals must "first acknowledge the assumptions and beliefs that are embedded in their own understanding, rather than delving into patient's belief system" (Chang, Simon & Dong, 2012, p. 273). It engages health professionals in a lifelong process of learning about their own socio-cultural positions of power and privilege, as well as critically self-reflecting on systemically conditioned biases and racist attitudes (Beavis et al., 2015; First Nations Health Authority, n.d., First Nations Health Authority, 2016; Johnson & Sutherland, 2022; Turpel-Lafond, 2020; Ward, 2018). Cultural humility requires health professionals to humbly acknowledge the limitations of their knowledge and perspectives

when it comes to understanding another's experiences (Aboriginal Nurses Association of Canada, 2009; First Nations Health Authority, 2016). In recognizing these limits, health professionals can redress power imbalances by listening to Indigenous patients and clients, and involving them in decisions as partners in care (Canadian Public Health Association, 2019; First Nations Health Authority, 2016; Greenwood, 2019; Nickerson, 2019; Turpel-Lafond, 2020).

2.2.6. Anti-Racism

Like cultural safety and cultural humility, anti-racism praxis moves beyond a narrow focus on the culture of patients to emphasize oppressive structures, relationship dynamics, and processes (Downing & Kowal, 2011; Ford et al., 2019; Harding, 2018; Hollinsworth, 1992; Ly & Crowshoe, 2015). Anti-racism goes one step further by removing the term culture and explicitly naming racism, arguing that re-packaging issues of racism, power and privilege as "culture" evades the real issues (Allan & Smylie, 2015; Diffey & Mignone, 2017; St. Denis, 2007; Ward, 2018). Anti-racism is a model for education and health service delivery that seeks to confront intersectional systems of power and oppression to eradicate racism in all its forms (Association of Faculties of Medicine of Canada, 2019; Came & Griffith, 2018; Ford et al., 2019; Kendi, 2019). Proponents of anti-racism argue that educators and health professionals— among other service providers— need to develop a fundamental understandings of how racism is manifested in interpersonal, systemic, and epistemic forms, as well as the impacts of racism on racialized groups (Association of Faculties of Medicine of Canada, 2019; Ly & Crowshoe, 2015; McDermott, 2012). In addition to examining how racism oppresses racialized groups, it is important for individuals to unpack how it privileges others, particularly through white supremacy and its legitimization in society (de Leeuw et al., 2021; Ford et al., 2019; Ly & Crowshoe, 2015; Menakem, 2017; Singh, 2019; St. Denis, 2007). Health professionals should understand how they are complicit in oppressive structures and practices as well as what role they can play in systems transformation. Anti-racism offers guidance and a set of tools to deconstruct or dismantle these systems, as well as the values, norms, policies, and practices that hold oppressive systems in place. As Ibram X. Kendi, a leading scholar of anti-racism, explains, "The opposite of 'racist' isn't 'not racist'. It is 'antiracist'" (2019, p. 9).

Anti-racism emerged during the early 1980s in the field of education and has only recently been gaining traction within health-related fields (Association of Faculties of Medicine of Canada, 2019). Uptake of anti-racist approaches in education systems and health systems has been slow, but is gaining momentum (Diffey & Mignone, 2017). The TRC Final Report, the MMIWG Inquiry, and the In Plain Sight Report advocate for anti-racism training for health professionals. Furthermore, the Canadian Public Health Association (CPHA) recently released an official position statement calling on "all agencies and organizations involved in education, research and the provision of health and social services in Canada to… Provide mandatory, rigorous and system-wide anti-racism and anti-oppression training for all staff and volunteers within their organizations" (2018, p. 1), which is reaffirmed in their latest Policy Statement on Indigenous Relations and Reconciliation (2019).

Nevertheless, there is significant resistance to the concept of anti-racism because unlike the "feel good" approaches of 'culture-based' concepts, anti-racism is provocative, uncomfortable, and unpalatable for people in positions of power and privilege (Downing & Kowal, 2011; Gustafson & Reitmanova, 2010; McDermott, 2012; Nickerson, 2019; St. Denis, 2007). While these reservations need to be challenged, anti-racism models should not be adopted into training programs without due consideration. Along the same lines as cautions about cultural safety being developed for a uniquely Maori context, anti-racism was not designed specifically for anti-Indigenous racism (Association of Faculties of Medicine of Canada, 2019; Downing & Kowal, 2011). Therefore, any efforts to implement anti-racism training should be supplemented with focused analyses of how racism intersects with colonial oppression as well as gendered oppression. There are also some proponents of a more encompassing framework of anti-oppression that accounts for multiple layered forms of oppression, power, and privilege (Aqil et al., 2021; Djulus et al., 2021). Aqil and colleagues (2021), in particular, argue that an anti-oppressive framework is most appropriate for public health because it can be employed alongside other social justice frameworks to catalyze systems change on a range of complex, multi-dimensional social issues, such as poverty.

2.3. Role of the Education System in Health Professional Training

Eliminating anti-Indigenous racism in healthcare requires the combined efforts of both the health system and the education system. Just as the education system has a role in perpetuating colonial oppression and racism, it also has the potential to counteract and prevent harm caused by ignorance, normalized stereotypes, reinforced western hegemony, and racist attitudes. To support the health system's efforts to train health professionals in cultural safety and anti-racism, the education system can incorporate relevant learning objectives and standards into the curriculum of health-related disciplines (Baba, 2012; Beavis et al., 2015; Came & Griffith, 2018; de Leeuw et al., 2021; Djulus et al., 2021; Guerra & Kurtz, 2017; Muntinga et al., 2016; National Aboriginal Health Organization, 2008; Nickerson, 2019; Turpel-Lafond, 2020; Verdonk et al., 2009). The important role of the education system in preparing culturally safe health professionals is acknowledged in the In Plain Sight Report's Recommendation #21:

> That all B.C. university and college degree and diploma programs for health practitioners include mandatory components to ensure all students receive accurate and detailed knowledge of Indigenous-specific racism, colonialism, trauma-informed practice, Indigenous health and wellness, and the requirement of providing service to meet the minimum standards in the UN Declaration (Turpel-Lafond, 2020, p. 200).

This is reaffirmed in TRC's Call to Action #24, which calls upon medical and nursing schools in Canada to:

> … require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency,

> conflict resolution, human rights, and anti-racism (2015, p. 211).

According to Beyond94's ongoing monitoring of implementation of the TRC's Calls to Action, Call to Action #24 is currently "In Progress-Projects Proposed," with several medical schools across Canada offering courses in Indigenous health, but they are not mandatory (last updated June, 2022).

2.3.1. Master of Public Health (MPH) Programs

Although the TRC's Call to Action #24 specifically identifies medical and nursing schools as the intended audience for training efforts, cultural safety and anti-racism training have value across all health disciplines as well as other systems and sectors. In comparison to medicine and nursing, the field of public health has not received as much attention in the literature concerning health professional training; yet, it is important to move interventions upstream to support culturally safe anti-racism praxis beyond the clinical domain (Steinberg, 2023, personal correspondence). Public health has an emphasis on promoting, protecting, improving, and restoring the health of the population through health promotion and prevention of illness at the community level. Public health practice is therefore a key site for promoting health equity and social justice, given the field's efforts to address the social determinants and structural factors driving the inequitable health outcomes presenting in the clinical setting (Canadian Public Health Association, 2019; Ford et al., 2019; Kent, Loppie, Carriere, MacDonald & Pauly, 2017; McSorley, Manalo-Pedro, & Bacong, 2021; Perez, Leonard, Bishop, & Neubauer, 2021; Tam, 2021). Public health is a highly interdisciplinary field, with public health practitioners coming from a range of professional and educational backgrounds; furthermore, "each university has a unique interpretation of how to categorize public health, resulting in programs placed in a variety of faculties, divisions or departments" (Baba, 2013, p. 14). Lauren Baba's work in the area of core competencies for Indigenous public health (2012; 2013) supports the need for closer attention to cultural safety training in MPH programs and provides a strong foundation for further investigation. Baba (2012) explains that MPH degrees are a logical focal point for curricular development in cultural safety and anti-racism because it is the most widely accepted professional degree for public health practice, and graduates have the ability to shape health policy, health service mandates, service delivery, research, and program evaluation.

In Canada, MPH programs are built around core competencies, which are the essential knowledge, skills, and attitudes that all graduates are expected to possess with a standard level of proficiency (Public Health Agency of Canada, 2007). These competencies were developed by the Joint Task Group on Public Health Human Resources in 2005 and published by the Public Health Agency of Canada (PHAC) in 2007 as the 'Core Competencies for Public Health in Canada'. In total, there are 36 core competencies that are organized into seven categories: public health sciences; assessment and analysis; policy and program planning, implementation and evaluation; partnerships, collaboration and advocacy; diversity and inclusiveness; communication; and leadership. Under the diversity and inclusiveness category, there is a competency related to applying "culturally-relevant and appropriate approaches" (p. 5); however, the report fails to include discussion around Indigenous health/ Indigenous determinants of health, colonization or racism (Baba, 2012; Baba & Reading, 2012). Furthermore, the report has not been revised since its release in 2007, yet continues to be upheld as the guideline for MPH curricula. There has been discussions around developing a revised list of core competencies or a parallel list of competencies for Indigenous public health, including a strategy to develop and implement Core Competencies for Indigenous Public Health, Evaluation and Research (CIPHER) (Baba, 2012; Baba & Reading, 2012), but these were never fully realized or adopted into practice. In the Chief Public Health Officer of Canada's Report on the State of Public Health in Canada 2021, Dr. Theresa Tam, highlights the calls to clarify and expand public health competencies, noting that "… Additional or enhanced competencies could include those related to working in complex government systems, collaboration for intersectoral action, healthy public policymaking, social and racial equity, ecological determinants linked to climate change, community engagement, and Indigenous health" (p. 66).

For accredited Schools of Public Health (currently there are five in Canada), there is a requirement to align MPH curricula with competencies and knowledge areas developed by accreditation bodies, including the US-based Council on Education for Public Health (CEPH) and the European counterpart Association of Schools of Public Health in the European Region (ASPHER) (Apatu et al., 2021; ASPHER, 2018; Cambourieu & Snelling, 2023, CEPH, 2016). In 2016, CEPH updated its competencies, adding one that reads, "Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational,

community, and societal levels" (CEPH, 2016, p. 17). ASPHER Core Competencies do not include competencies that explicitly or implicitly address cultural safety and anti-racism praxis (ASPHER, 2018).

2.3.2. MPH Curriculum

Equipping MPH graduates with a foundational knowledge base to understand the current state of Indigenous health is a necessary precondition to addressing anti-Indigenous racism in the health system and improving accessibility of health services. Students need to learn about the determinants of inequities, including colonization, residential schools, intergenerational trauma, barriers in the health system, etc. Moreover, this should be balanced with strengths-based discussions around protective determinants such as resilience, cultural continuity, self-determination, and community control of health services (Baba, 2012; Baba & Reading, 2012; Carlson, 2017; National Collaborating Centre for Indigenous Health, 2021; Mahara et al., 2011; PHSA Indigenous Health, 2019; Shah & Reeves, 2015; Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020; Virdun et al., 2013). Several authors argue that this content needs to be mandatory for all future health professionals, if not all students in all areas of study (Baba, 2013; Baba, 2012; Gaudry & Lorenz, 2018; Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020). Additionally, many authors advocate for introducing this content early in curricula, ideally embedded in core courses in the MPH program; more importantly, it should be woven throughout subsequent coursework to reinforce, scaffold, and strengthen learning (Beavis et al., 2015; Coombe, Lee & Robinson, 2017; Ly & Crowshoe, 2015; Mahara et al., 2011; Virdun et al., 2013). In their article, "Integration models for Indigenous public health curricula," Coombe, Lee and Robinson (2017) recommend that integration should be both horizontal (e.g. linkages between related concepts across concurrent courses) as well as vertical (e.g. progressive advancement of learning over the course of the program). However, in a 2023 scoping review that synthesizes the state of knowledge on Indigenous cultural safety training and available evaluation evidence, a key finding reported, "Notably, eight papers (12%) described the provision of follow up support for learners of cultural safety beyond the primary training period" (MacLean et al., 2023, p. 6).

When presented with information related to inequities in Indigenous health, students should be able to critically analyze the underlying determinants of health, and further interrogate public health culture and norms in terms of how health issues are defined and who defines them (Came & Griffith, 2018; de Leeuw et al., 2021; Diffey & Mignone, 2017; Ford & Airhihenbuwa, 2010; Muntinga et al., 2016). Critical analysis can be supported by the discourses of cultural safety and anti-racism; these can also be complemented by theoretical orientations such as postcolonialism (Beavis et al., 2015), Critical Race Theory (Aqil et al., 2021; Shelton, Adsul & Oh, 2021), and/ or anti-oppression (Aqil et al., 2021). Students may also engage in deliberative unlearning and re-learning. MPH students need to unlearn conditioned assumptions they uphold as truth (e.g. race and genetic predisposition), deconstruct unquestioned notions of what constitutes legitimate knowledge (e.g. western science and biomedicine) and rethink how they understand health (e.g. wellness vs. illness) (Beavis et al., 2015; Came & Griffith, 2018; Coombe, Lee & Robinson, 2017; de Leeuw et al., 2021; Djulus et al., 2021; Ford et al., 2019; PHSA Indigenous Health, 2019).

Public health promotes reflexive praxis to encourage practitioners to examine their own subconscious beliefs and explore any ‘blind spots’ to better understand how these shape thoughts and behaviours (Beavis et al., 2015; Guerra & Kurtz, 2017; Gustafson & Reitmanova, 2010). Reflexive praxis and critical consciousness work hand in hand with cultural humility, cultural safety, and anti-racism to help guide health professionals and students in introspection about their own socio-cultural location, particularly their positions of power and privilege, and how these are manifested in relation to others in their professional practice (Aqil et al., 2021; de Leeuw et al, 2021; Ford et al., 2019; Krusz, Davey, Wigginton, & Hall, 2020; McSorley, Manalo-Pedro, & Bacong, 2021; Muntinga et al., 2016). While reflexivity is an important intrapersonal skill for culturally safe public health practice, students must also develop interpersonal skills to ensure Indigenous patients’ healthcare encounters are experienced as culturally safe. MPH students require skills-based training that builds off the skills and competencies promoted by cultural appropriateness, cultural responsiveness, cultural competency, as well as the PHAC’s Core Competencies related to diversity and inclusiveness. MPH curricula should include training in interdisciplinary collaboration, active listening, effective communication, and conflict resolution, among other interpersonal skills, to prepare students to engage with Indigenous patients, clients, colleagues, and

stakeholders (Aboriginal Nurses Association of Canada, 2009; Djulus et al., 2021; Ford et al., 2019; Muntinga et al., 2016; Truth and Reconciliation Commission of Canada, 2015).

2.3.3. Curriculum Delivery

Engaging in critical analysis of Indigenous health and reflexive praxis is both intellectually and emotionally challenging for students and instructors alike. Instructors have an important responsibility to model cultural humility, demonstrate respect for Indigenous knowledge and ways of knowing, and create culturally safe learning environments. Students should feel comfortable participating in self-reflection and respectful dialogue around sensitive topics (Aboriginal Nurses Association of Canada, 2009; Ly & Crowshoe, 2015; National Aboriginal Health Organization, 2008; Utley-Smith, 2017). It is especially important to give thoughtful consideration to the experiences of Indigenous students in the classroom when facilitating discussions that could be deeply personal, triggering, or create potentially unsafe situations; instructors therefore need to be prepared to co-create community guidelines, effectively mediate offensive comments by other students, and ensure counselling resources are available, without singling out Indigenous or racialized students in the process (Aqil et al., 2021; Diffey & Mignone, 2017; Djulus et al., 2021; National Aboriginal Health Organization, 2008; Shah & Reeves, 2015; Virdun et al., 2013).

When training students in cultural safety and anti-racism, learning can be enriched through experiential activities and/ or cultural immersion. These approaches to active learning support development of necessary skills for respectful engagement, and help “transform hearts and minds” (de Leeuw et al., 2021, p. 89). Examples include attending local Indigenous events and ceremonies (if available/ appropriate), site visits to Indigenous health organizations, field-based training programs, and/ or practicum placements in Indigenous communities or organizations (Baba, 2013; Beavis et al., 2015; de Leeuw et al., 2021; MacLean et al., 2023; Tam, 2021). Several scholars advocate for moving sites of learning out of the classroom and decentring the academy through place-based, community-based, and community-engaged education (de Leeuw et al., 2021; Diffey & Mignone, 2017; Gaudry & Lorenz, 2018; Guerra & Kurtz, 2017; Gustafson & Reitmanova, 2010). At the same time, these recommendations come with cautions that these efforts must be rooted in relationships, partnerships and reciprocity

with Indigenous peoples and communities (Baba, 2012; Giroux, 2017; Mahara et al., 2011). Experiential activities should not be invasive or put Indigenous peoples and communities at risk of harm for the sake of students' exposure; careful planning needs to go into preparing students in advance and coordinating activities that are mutually beneficial for the hosts of community-based engagement (Beavis et al., 2015; Mahara et al., 2011).

Building on recommendations for community-engagement in education, in recent years, universities across Canada have been deliberating the concepts of decolonization and Indigenization in response to demands from Indigenous scholars, community partners and nation-wide calls to action. These terms are often used interchangeably (see **Discourses** for further discussion). Both call upon education institutions to create space for Indigenous knowledge and ways of knowing alongside representation of Indigenous peoples and cultures throughout the academy (Gaudry & Lorenz, 2018; Giroux, 2017). While decolonization and Indigenization of post-secondary education is promoted by many Indigenous scholars, as highlighted in Gaudry and Lorenz's (2018) survey of Indigenous faculty, these concepts and their application have been problematized by both their proponents and opponents (Gaudry & Lorenz, 2018; Giroux, 2017, Hill, 2012). The primary argument being that education institutions— as they stand— are not ready for transformative Indigenization, which would fundamentally require a critical mass of Indigenous faculty, staff, and leadership with necessary supportive infrastructure. Indigenization cannot be reduced to a process of "settler self-Indigenization" (Giroux, 2017) or an "intellectual free-for-all" (Gaudry & Lorenz, 2018). Although there are strong arguments that training students in cultural safety and anti-racism is everyone's responsibility, particularly in support of cross-curriculum integration (Coombe, Lee & Robinson, 2017; Krusz, Davey, Wigginton, & Hall, 2020; Virdun et al., 2013), it cannot be overstated that Indigenous peoples must be actively involved in curriculum development, delivery and evaluation (Association of Faculties of Medicine of Canada, 2019; Beavis et al., 2015; Jewell & Mosby, 2020; Johnson & Sutherland, 2022; MacLean et al., 2023; PHSA Indigenous Health, 2019; Virdun et al., 2013). Indigenous peoples can shape MPH curricula as curriculum advisors, Elders in Residence, community/ organizational partners, guest lecturers, sessional instructors, faculty members and/ or in positions of leadership (Downing & Kowal, 2011; MacLean et al., 2023; Mahara et al., 2011; Shah & Reeves, 2015; Virdun et al., 2013).

2.4. Challenges for Implementation

2.4.1. Underrepresentation of Indigenous Peoples

One of the biggest challenges facing MPH programs interested in incorporating cultural safety, anti-racism and related training into curricula is the lack of Indigenous faculty available to facilitate the training. Across all Canadian universities, there is marked underrepresentation of Indigenous peoples in staff, faculty, and leadership positions (Gaudry & Lorenz, 2018; Giroux, 2017; Leonard & Mercier, 2016; Shah & Reeves, 2015). The underrepresentation of Indigenous scholars contributes to misrepresentation of Indigenous peoples, cultures, histories, knowledge systems, and contributions to the field of public health (see Epistemic Racism). Indigenous scholars play a crucial role in challenging dominant narratives, providing authentic perspectives, and fostering a more nuanced understanding of Indigenous peoples' health (Gaudry & Lorenz, 2018; Leonard & Mercier, 2016; Virdun et al., 2013). The handful of Indigenous faculty members at academic institutions bear heavy workloads and countless demands for representation on committees, student supervision, collaboration on research studies, guest lectures, curriculum consultation, etc. (Carlson, 2017; Coombe, Lee & Robinson, 2017; Mahara et al., 2011; Virdun et al., 2013). These pressures compound with the day-to-day challenges Indigenous peoples face within the isolating, unsupportive, and hostile Eurocentric academy. While many universities are implementing initiatives to recruit more Indigenous scholars, these efforts are not matched with structural change to remove obstacles that impede their success (Ford et al., 2019; Gaudry & Lorenz, 2018; British Columbia Network Environment for Indigenous Health Research, 2022).

2.4.2. Resistance

Despite repeated calls to action and a growing body of literature advocating for cultural safety, anti-racism, and related training, uptake has been slow, partial, or misguided in MPH programs and other health disciplines in Canada (Baba, 2013; Diffey & Mignone, 2017). The status quo is maintained by lack of will among institutions, where these are deemed as "optional topic[s], left to the discretion and good will of the leadership of each school" (Association of Faculties of Medicine of Canada, 2019, p. 3). In some cases, institutions give lip service or make aspirational commitments to reconciliatory and/ or Indigenizing initiatives, but the rhetoric is not followed through with substantive action

(Gaudry & Lorenz, 2018; Jewell & Mosby, 2020; Ogbolu & Fitzpatrick, 2015). In other cases, curriculum transformation is met with active resistance from students, faculty, and administrators. The literature indicates that a minority of students resent the 'imposition' of cultural safety and anti-racism training, reacting with indifference, wariness, and/ or contempt (Beavis et al., 2015; Coombe, Lee & Robinson, 2017; Diffey & Mignone, 2017; Ly & Crowshoe, 2015). A more significant hurdle, however, is the resistance among faculty and administrators, who may question the relevance, credibility, and/ or appropriateness of this training— or alternatively question their responsibility, ability, or preparedness to contribute to its delivery. These opinions may lead to omitting content from syllabi, avoiding or dismissing discussions in class, withholding resources, and even sabotaging or dismantling initiatives (Aqil et al., 2021; Beavis et al., 2015; Diffey & Mignone, 2017; Jewell & Mosby, 2020; McSorley, Manalo-Pedro, & Bacong, 2021; Guerra & Kurtz, 2017; Perez, Leonard, Bishop, & Neubauer, 2021). However, it is worth noting that, "… This resistance is more emblematic of the system than it is of the individual in that faculty often have many competing demands and with a culture not prioritizing teaching, spending time revising teaching habits may not seem worth the effort" (Aqil et al., 2021, p. 351).

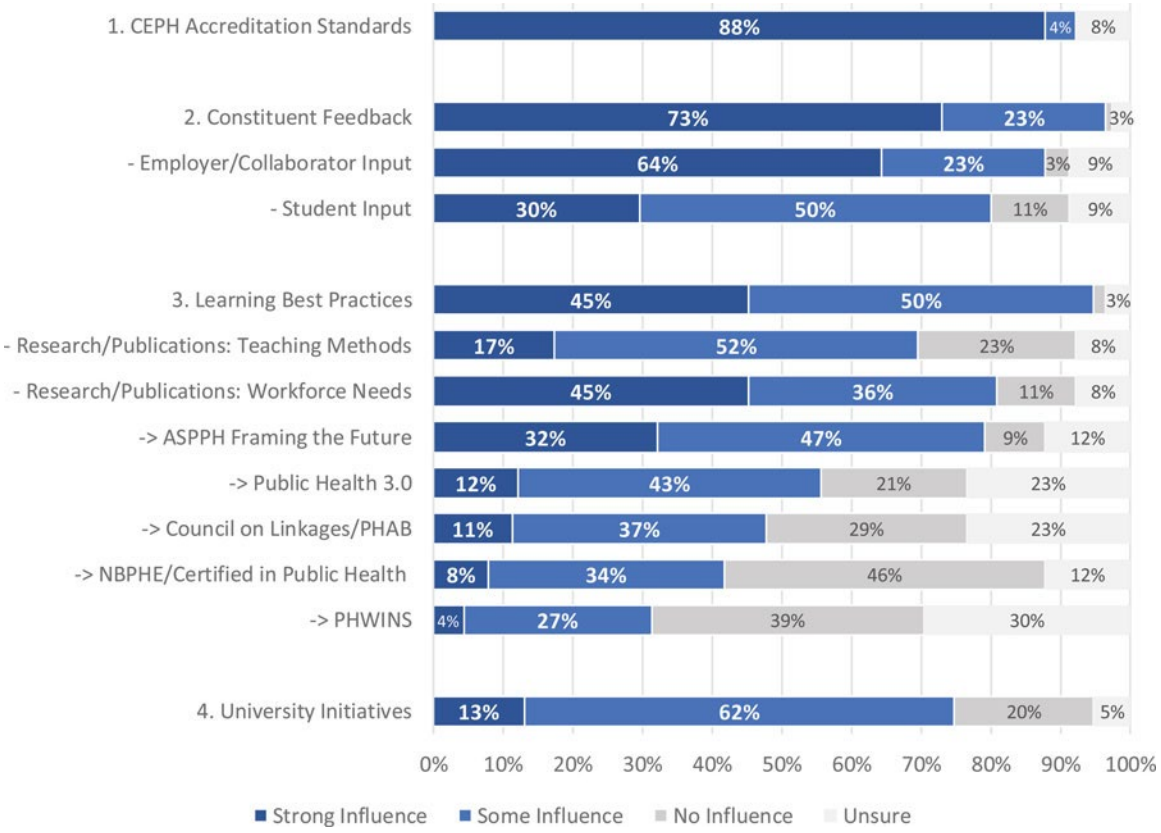
2.4.3. Standardization and Accreditation

For academic units that have embraced cultural safety and anti-racism training in their MPH programs, for the most part, implementation is not guided by standardized guidelines or enforced by accreditation standards. Across Canada, there is significant variation in how this training is incorporated into MPH curricula with regards to the conceptual model of training (e.g. cultural awareness vs. anti-racism), the degree of enforcement (e.g. mandatory vs. elective), where the training appears in the program (e.g. core course vs. integrated), the depth of engagement (e.g. single lecture vs. series of modules); the pedagogical approaches (e.g. didactic vs. experiential), etc. (Aqil et al., 2021; Baba, 2012; Gustafson & Reitmanova, 2010; Horvat, Horey, Romios & Kis-Rigo, 2014; MacLean et al., 2023; Nickerson, 2019). One of the barriers to standardization is the lack of consensus on best practices and the corresponding lack of national core competencies to promote a foundational set of skills, knowledge, and attitudes for MPH graduates (Baba, 2012; Baba & Reading, 2012; MacLean et al., 2023). The FNHA and the Health Standards Organization released the British Columbia Cultural Safety and

Humility Standard in 2022, which now provides direction for both the practice environment and the training environment. This resource is designed to establish standards for culturally safe care for First Nations, Métis, and Inuit peoples in health and social services in BC. It is intended for use by organizational leaders, governance structures, teams, and individuals working in health and social service organizations in the province. The standard consists of an overarching thematic statement on cultural safety and humility with assessment criteria, evidence-based requirements, statements of intent, actions for implementation, and accountability mechanisms. The resource also includes accompanying guidelines to support implementation.

Unlike the fields of medicine and nursing, MPH programs in Canada do not have a formal accreditation body to regulate core competencies or their implementation. Five of the 23 MPH programs in Canadian universities have voluntarily sought accreditation from the CEPH, the official accreditation agency for public health education in the United States (Cambourieu & Snelling, 2023; CEPH, 2021). A recent study by Meredith and colleagues (2023) reported that in the US, the CEPH accreditation standards are the most influential factor catalyzing changes, updates, and adaptations made by MPH programs (see Figure 1), which in turn shapes the public health workforce by establishing teaching and learning standards.

Figure 1. Reported Degree of Influence of Various Factors on MPH Program Changes (Meredith et al., 2023, p. 92)



% of Survey Respondents (N = 115) Reporting Degree of Influence
Abbreviations: ASPPH, Association of Schools and Programs of Public Health; CEPH, Council on Education for Public Health; MPH, Master of Public Health; NBPHE, National Board of Public Health Examiner; PHAB, Public Health Accreditation Board; PH WINS, Public Health Workforce Interests and Needs Survey.

However, in Canada, the voluntary nature of accreditation warrants further investigation on the impact of accreditation on public health practice. As noted above, in 2016, the CEPH's accreditation standards were updated to include a competency for "Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community, and societal levels" (CEPH, 2016, p. 17). However, in their 2021 article, "Engaging in Anti-Oppressive Public Health Teaching: Challenges and Recommendations," Aqil and colleagues note that while this addition is an important development for setting standards for MPH programs, there is limited guidance for implementing these new competencies into curricula.

2.4.4. Evidence Base

The considerable heterogeneity and variation across MPH programs' incorporation of cultural safety and anti-racism training indicate there is uncertainty around best practices, and further makes it difficult to evaluate through cross-comparison. The available literature demonstrates that there is a lack of evidence about which conceptual models are most appropriate, what teaching techniques are most effective, and how these can be operationalized and implemented in curricula (Diffey & Mignone, 2017; Guerra & Kurtz, 2017; Gustafson & Reitmanova, 2010; Housman, Meaney, Wilcox & Cavazos, 2012; MacLean, 2023). Furthermore, even though various training initiatives have been implemented over the past three decades, there is a paucity of evaluative evidence linking these interventions to transformative change in reducing racism in the health system, enhancing the cultural safety of healthcare encounters, and/ or improving inequitable health outcomes (Chang, Simon & Dong, 2012; Guerra & Kurtz, 2017; Gustafson & Reitmanova, 2010; Horvat, Horey, Romios & Kis-Rigo, 2014; MacLean, 2023; Nickerson, 2019; Turpel-Lafond, 2020). Several studies and systematic reviews have demonstrated positive immediate impacts on student knowledge, skills, and attitudes (Downing & Kowal, 2011; Horvat, Horey, Romios & Kis-Rigo, 2014; MacLean, 2023; McElfish et al., 2018; Rowan et al., 2013; Shah & Reeves, 2015); however, it is noted that the quality of evidence and methodological rigour is weak, primarily comprised of self-reporting and anecdotal reports (Beavis et al., 2015; Downing & Kowal, 2011; Horvat, Horey, Romios & Kis-Rigo, 2014; McElfish et al., 2018). Although it was commonly reported that there was no evidence of effect, very few studies concluded that training initiatives were ineffective or counterproductive, and those that did tended to represent cultural awareness models (Came & Griffith, 2018; Downing & Kowal, 2011). The challenge of insufficient evidence is exacerbated by the absence of appropriate tools for evaluation:

> There is a lack of evidence-based standard assessment criteria and indicators, particularly as related to outcomes of anti-racism efforts. This may be due to the newness of the field, the lack of integration of cultural safety into legislated standards, and the inherent complexity of translating an individual-based practice underpinned by personal

> reflection and learning into quantitative or statistical measures (Turpel-Lafond, 2020, p. 144).

There is broad consensus on the need for further investigation of how this training is being implemented as well as longitudinal impact assessment with respect to sustained change in practice and long-term patient health outcomes (Allan & Smylie, 2015; Clark et al., 2022; Downing & Kowal, 2011; Gustafson & Reitmanova, 2010; Horvat, Horey, Romios & Kis-Rigo, 2014; Johnson & Sutherland, 2022; Lin, Guo & Chang, 2017; National Aboriginal Health Organization, 2008; Shah & Reeves, 2015).

2.4.5. Multi-level Transformation

Another challenge to the implementation of cultural safety and anti-racism training interventions is the need for multi-level action to support sustained change and societal transformation. “Hardwiring” cultural safety into health and education systems requires coordinated action across the individual/ interpersonal, institutional, and system levels (Greenwood, 2019; NAHO, 2008; Nickerson, 2019; Tam, 2021; Turpel-Lafond, 2020). In a 2021 scoping review of anti-racism interventions in outpatient healthcare settings, 62% of articles included multi-level interventions, with most interventions targeting the individual (54%), interpersonal (51%) and organizational (57%) levels; the authors noted that “Only 21% of the peer-reviewed articles included an anti-racism intervention at the community-level and 24% included an intervention at the policy-level” (Hassen et al., 2021, p. 7). The same scoping review highlights pitfalls of interventions that focus exclusively on individual-level training as a standalone or one-time intervention, noting sustainability as a key issue when not supported by a multi-level approach. Public health approaches are well-suited to promoting comprehensive multi-level interventions that address determinants at both the individual and structural levels. From this lens, cultural safety and anti-racism interventions should focus on modifying the knowledge, behaviours, and attitudes of health professionals, while simultaneously overhauling and reimagining policies, practices, decision-making processes, resource allocation, and organizational/ professional culture.

2.5. Gaps in the Literature

There has been substantive uptake and rapid evolution of cultural safety and anti-racism training in the field of public health. This is coupled with a growing body of research including seminal reports, case studies, evaluations, and metasyntheses. Nonetheless, there are still several gaps in the published literature on the subject. A 2023 scoping review that synthesizes the state of knowledge on Indigenous cultural safety training and available evaluation evidence concludes that “this field of research remains in its infancy;” suggesting, “Future research on cultural safety and related training interventions requires greater clarity in conceptualization of cultural related concepts” (MacLean et al., 2023, p. 12). As noted throughout the literature review, cultural safety and anti-racism tend to be conflated with other related concepts (e.g. cultural competence) and adjacent training areas (e.g. equity, diversity, and inclusion), which can make it challenging to distinguish this as a distinct area of study. Another area for further development is research and practice guidelines specific to public health. There has been a greater emphasis on cultural safety and anti-racism training, and correspondingly more published literature, in the fields of nursing and medicine. This assessment of the body of literature is consistent across four published evidence syntheses on topics related to cultural safety and anti-racism training interventions: Diffey and Mignone (2017), Guerra and Kurtz (2017), Hassen and colleagues (2021), and MacLean and colleagues (2023). Additionally, it is worth noting that the focus of research on cultural safety and anti-racism training interventions has tended to be on descriptions of the intervention itself or on evaluation of its outcomes, rather than on detailing the implementation processes or the barriers and facilitators shaping implementation (Aqil et al., 2021; Beavis et al., 2015; Came & Griffith, 2018; Diffey & Mignone, 2017; MacLean et al., 2023). As such, there is a need for more research that provides insights and practical guidance on effective strategies for implementing cultural safety and anti-racism training into health professional education programs, particularly within MPH programs.

Chapter 3. Methodology

3.1. Research Question

This doctoral research examines the barriers and facilitators shaping the uptake and implementation of cultural safety and anti-racism training interventions in MPH programs in BC. Specifically, the study is guided by five primary objectives under the following domains:

1. **Intervention Characteristics:** Characterize the core components and adaptable features of cultural safety and anti-racism training interventions in MPH curricula within each institution;
2. **Characteristics of Individuals:** Identify the key individuals and groups influencing uptake and implementation, and/ or directly involved in implementing cultural safety and anti-racism training in MPH curricula within each institution;
3. **Process:** Describe the stage of implementation from planning through sustainment, and how approaches or strategies have evolved or been adapted over time;
4. **Inner Setting:** Document the institutional conditions in which implementation of cultural safety and anti-racism training takes place within each institution;
5. **Outer Setting:** Examine the broader social, cultural, political, and historical contexts that shape uptake and implementation.

As a qualitative research study, a case study design was applied to MPH programs across three universities within a common provincial context. Conceptual frameworks offered by implementation research were coupled with a theoretical lens grounded in anti-colonialism and intersectionality. Anti-colonialism, intersectionality, and implementation research share a common commitment to action for social change (Browne, Smye & Varcoe, 2005; Carlson, 2017; Ford & Airhihenbuwa, 2010; Johnson & Sutherland, 2022; Knowledge Translation Program, 2019; Yousefi Nooraie et al., 2020). Together, alongside qualitative methods and tools, they are ideally suited to unpack the complexity of phenomena and the social, cultural, and political context in which they are embedded.

3.2. Epistemology

I engage with this research with a pre-existing theoretical orientation and critical perspective, which inevitably shape data collection, coding, analysis, and interpretation. To guard against implicit bias and imposed preconceptions that reflect Eurocentric norms, reflexivity is necessary to uncover my own hidden assumptions. This includes assumptions and beliefs about knowledge and how it is generated. While I do not have an unquestioned allegiance to a predefined epistemology, my understanding of knowledge is most consistent with social constructivism. Social constructivism is based on the idea that knowledge is produced by humans and is constructed through social interaction (Padgett, 2012; Sullivan, 2009). This is relevant to cultural safety and anti-racism because it emphasizes that norms (e.g. Eurocentrism), concepts (e.g. race), cultures (e.g. Indigenous Nations), subcultures (e.g. public health) and conventions (e.g. training practices) are inherently subjective and shaped by sociopolitical forces. As such, they can be used to reinforce colonial agendas, but they also have the potential to be redefined in order to advance decolonization (Ford & Airhihenbuwa, 2010). Social constructivism also informs how I understand the knowledge that I hold and where I stand in relation to the existing body of knowledge. As I have learned through the teachings from Elders in my life, I do not own knowledge and my ideas are not solely my own; my thoughts and the words that I share are inspired by a lifetime of social interactions and influences, in particular the wisdom of my teachers and mentors.

3.3. Theoretical Lens

In addition to not claiming ownership of knowledge in general, I do not claim a special ability to understand or use Indigenous knowledge, much less apply a complex Indigenous methodology. In recent decades, prominent Indigenous methodologists such as Dr. Shawn Wilson (Opaskwayak Cree from northern Manitoba) (2008), Dr. Margaret Kovach (Plains Cree and Saulteaux ancestry and a member of Pasqua First Nation) (2009), and Dr. Linda Tuhiwai Smith (Ngāti Awa and Ngāti Porou, Māori) (2012) have established a strong body of literature sharing Indigenous methodologies with the world. Indigenous methodologies are grounded in Indigenous ontologies, epistemologies, cultural teachings, languages, knowledge systems, and ways of knowing. They are locally- and culturally- informed, reflecting the distinctive cultures of Indigenous Nations;

but many of these methodologies share common traits such as: respecting self-determination; honouring cultural protocols; being land-based; promoting balance, holism, and connection; understanding knowledge as collective and relational; and upholding principles of ownership, control, access, and possession (Carlson, 2017). These approaches have tremendous value in decolonizing and Indigenizing research, and are increasingly recognized among academic institutions and funding bodies as the gold standard for community-driven research in Indigenous health. However, it cannot be an "intellectual free-for-all" (Gaudry & Lorenz, 2018), whereby non-Indigenous researchers appropriate Indigenous methodologies without proper guidance or permission. I agree with settler colonial studies scholar Elizabeth Carlson, who clarifies that employing an Indigenous research methodology would not be an ethical fit for settlers, who "[lack] early socialization by Indigenous families and communities, decades of cultural immersion and learning, and the impacts of identifying as and being identified as 'Indigenous'" (2017, p. 3). This is not to say that we do not have responsibilities to respect Indigenous knowledges and cultural protocols in our research; rather, we must engage in a parallel process of critically examining and decolonizing the extractive, exploitative, and Eurocentric research practices that have remained unquestioned and unchallenged (Carlson, 2017; Harding, 2018; Krusz, Davey, Wigginton, & Hall, 2020; Mahoney, Grain, Fraser & Wong, 2021).

3.3.1. Anticolonialism

Emerging in parallel to Indigenous methodologies, postcolonialism has been proposed by Indigenous scholars, such as Cree-Métis scholar Dr. Emma LaRocque, as a tool to support non-Indigenous scholars to "re-evaluate their colonial frameworks of interpretation, their conclusions and portrayals, not to mention their tendencies of excluding from their footnotes scholars who are Native" (LaRocque, 1996, p. 13). With its theoretical underpinnings in poststructuralism, critical theory, feminism, and anti-oppression, postcolonialism shares a common focus on power dynamics, social hierarchies, and justice; but specifically guides researchers in situating issues within the context of the colonial past and its ongoing manifestations (Browne, Smye, & Varcoe, 2005; Carlson, 2017; Ford & Airhihenbuwa, 2010). Postcolonialism is a transdisciplinary theoretical lens that offers a common discourse connecting multiple research disciplines (e.g. sociology, political science, gender studies, education, nursing) with a common

goal of dissecting colonial structures, systems and relationships. Due to its contentious name, some scholars have opted to use the more fitting term ‘anti-colonialism’ (Association of Faculties of Medicine of Canada, 2019; Carlson, 2017), which I will use hereafter. Although the use of “post” in postcolonialism implies that we have moved past our colonial history, it is used to draw attention to the new and evolving forms of colonial oppression that tend to be more indirect and insidious. Some refer to this continuation of the exercise of colonial power as ‘neocolonialism’(Beavis et al., 2015; Browne, Smye, & Varcoe, 2005).

Some of the key strengths of an anti-colonial theoretical lens are that it brings colonization to the foreground, decenters the dominant culture to the periphery, and makes space for Indigenous voices and leadership. Anti-colonial theory not only draws attention to the influence of colonization, but also calls on researchers to actively subvert colonialism as part of the research process (Carlson, 2017). Resisting and rejecting colonization requires that researchers push back against the dominant culture’s norms, paradigms, research traditions, and standards of legitimate evidence, while simultaneously honouring and respecting Indigenous knowledges and ways of knowing (Beavis et al., 2015; Carlson, 2017; Ford et al., 2019; Gaudry & Lorenz, 2018; Krusz, Davey, Wigginton, & Hall, 2020; Mahoney, Grain, Fraser & Wong, 2021). Black Critical Race Theorists Dr. Chandra Ford and Dr. Collins Airhihenbuwa frame this act of privileging the voices of oppressed groups as “centering in the margins” (2010). In addition to privileging Indigenous voices, a core tenet of anti-colonial theory is relational accountability, which must occur through relationship and ongoing dialogue with Indigenous peoples (British Columbia Network Environment for Indigenous Health Research, 2022; Carlson, 2017). Relational accountability can be enacted through guidance from Indigenous literature, early consultation with Indigenous peoples, mentorship from Indigenous scholars, oversight by Indigenous Knowledge Holders, as well as meaningful engagement with Indigenous community members and stakeholders. Relational accountability should also be demonstrated through commitment to applying research findings for social change to redress inequities and injustices (Browne, Smye & Varcoe, 2005; Carlson, 2017; Ford & Airhihenbuwa, 2010). In the context of health research, anti-colonialism helps situate persisting health and social inequities within social, historical, and political contexts to better understand colonization and racial oppression as root determinants of health (Browne, Smye, & Varcoe, 2005; Kent,

Loppie, Carriere, MacDonald & Pauly, 2017). For this research study, it offers direction for examining how academic institutions perpetuate Eurocentrism, epistemic hegemony, and cognitive imperialism, “especially the ideas taught, what is held to constitute valid knowledge, and how that knowledge is disseminated and assessed” (Stavrou & Miller, 2017, p. 98). Anti-colonialism has been applied in previous studies as an analytic framework to explore healthcare experiences of Indigenous patients (Browne, Smye & Varcoe, 2005); guide critical analysis of the limitations of cultural awareness models (Downing & Kowal, 2011); and recommend areas for improvement in health professional training programs (Beavis et al., 2015).

An anti-colonial theoretical lens holds promise for examining cultural safety training, considering the concept of cultural safety originally stemmed from postcolonial discourses (Ramsden, 1990). However, it also poses some inherent limitations, most notably its origins in western theories and paradigms (Browne, Smye, & Varcoe, 2005). This critique speaks to Audre Lorde’s well-known quote that “the master’s tools will never dismantle the master’s house.” I am critically aware of the risks of perpetuating western dominance in academia; nevertheless, as I’ve articulated above, it is not my intention to forge Indigenous knowledge and ways of knowing— which arguably carries a greater risk of reproducing extractive and expropriative research practices.

Anti-colonialism has also been critiqued for its preoccupation with colonization, which can overshadow other layered forms of oppression (e.g. racism, sexism), oversimplify complex dimensions of identity and social relations (e.g. colonized-colonizer binary), and overlook the agency of those experiencing oppression (Anderson et al., 2003; Browne, Smye & Varcoe, 2005; Harding, 2018; Moradi & Grzanka, 2017; Muntinga, Krajenbrink, Peerdeman, Croiset & Verdonk, 2016). This can inadvertently render invisible some individuals’ lived experiences of colonial oppression (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Depending on the context of the research, it may be appropriate to combine anti-colonial theory with other critical lenses, such as feminist scholarship (Anderson et al., 2003; Kendi, 2019), Critical Race Theory (Ford & Airhihenbuwa, 2010; Lawrence & Dua, 2005), Queer Theory (Kendi, 2019), and/or intersectionality (Clark, 2016; Crenshaw, 1989; Moradi & Grzanka, 2017).

3.3.2. Intersectionality

In conjunction with anti-colonial theory, this study incorporates an intersectionality lens to surface overlapping and intersecting axes of power and oppression. Advocates of intersectionality-informed pantheoretical frameworks explain that “Critical theoretical integration that promotes fruitful exchanges between [single-axis] research pipelines can advance a fuller understanding of how multiples axes of power operate simultaneously” (Moradi & Grzanka, 2017, p.19). Black American civil rights advocate Kimberlé Crenshaw is widely credited with coining the term intersectionality in the late 1980s to challenge one-dimensional single-identity politics and expose the mutually-reinforcing reality of racism and sexism experienced by women of colour. The concept’s development is also credited to the contributions of BIPOC feminist scholars and activists that provided the foundations of Crenshaw’s work (Moradi & Grzanka, 2017; National Collaborating Centre for Determinants of Health, 2022; Singh, 2019). Theoretically, intersectionality conceptualizes individuals and groups as occupying multiple and coexisting social identities that they identify with and/ or have been ascribed in society; it further recognizes that one’s social location can shift over time and in different contexts (Crenshaw, 1989; Moradi & Grzanka, 2017). Intersectionality helps us analyze how co-occurring social identities (e.g. Indigeneity, race, age, sex, gender, sexuality, (dis)ability, socio-economic status) at the micro-level interact with their associated axes of oppression at the macro-level (e.g. colonialism, racism, ageism, sexism, cis-heteropatriarchy/ transphobia, homophobia, ableism, classism—respectively), and/ or manifestations of privilege stratified along these dimensions (Ford & Airhihenbuwa, 2010; Ford et al., 2019; Moradi & Grzanka, 2017; Muntinga, Krajenbrink, Peerdeman, Croiset & Verdonk, 2016; National Collaborating Centre for Determinants of Health, 2022; Singh, 2019).

In this study, the theoretical lens combines both intersectionality and anti-colonialism to explicitly interrogate the ways in which power, privilege, and oppression operate across interlocking social dynamics, systems, and structures to produce inequity in academic environments and society at large. Together, they prompt reflective engagement with considerations such as how does the researcher relate to the role of power in knowledge production; whose voices and experiences are centered; how are the influences of various oppressive forces woven together in the analysis; where is focus directed for the site of intervention (e.g. individual, institution, system, society); and how might this

research feed into the trap of pitting one anti-oppression agenda against another to compete for resources?

3.4. Qualitative Inquiry

Qualitative approaches are often a more suitable fit for research questions for which the complexity of context is instrumental to understanding the phenomena of interest, as in the case of research guided by anti-colonialism and intersectionality. Anti-racism scholars Dr. Heather Came and Dr. Derek Griffith make the case that qualitative tools are especially valuable when “capturing the effects of anti-racism efforts as the implications are not always anticipated or easily measured (2018, p. 186). Qualitative data can offer deeper, richer, and more nuanced insights around socially constructed meanings, definitions and descriptions that would otherwise be unobtainable through numerical data (Benzer et al., 2013; Ford & Airhihenbuwa, 2010; Tam, 2021). Unlike quantitative research, the goal of qualitative research is not to produce results that are generalizable, but rather to create a thorough understanding of a defined phenomenon embedded within its specific historical/ geographic/ cultural/ socio-political context to generate new knowledge and theories that are transferable to other settings (Beavis et al., 2015; British Columbia Network Environment for Indigenous Health Research, 2022; Shelton, Adsul, & Oh, 2021). Qualitative inquiry is predominantly characterized by highly inductive reasoning that resists predefined hypotheses or imposed conclusions, and draws upon emergent data to support development of new theories or hypotheses (MacFarlane & O’Reilly-de Brun, 2012; Southam-Gerow & Dorsey, 2014). In this way, qualitative approaches allow space for knowledge to be socially constructed, for dominant paradigms to be decentered, and for marginalized voices to be privileged.

3.5. Implementation Research

The terms integrated knowledge translation, dissemination, implementation research, and implementation science are increasingly used to describe approaches to research that focus on translating research into meaningful application and impact. These overlapping and interrelated areas of research emerged out of recognition of the chasm between scientific evidence and real world practice, particularly in healthcare, with the oft-cited 17-year lag reported by the Institute of Medicine in 2001 (Aarons, Hurlburt &

Horwitz, 2011; Damschroder, 2019; Southam-Gerow & Dorsey, 2014; Tam, 2021). The science of implementation can be distinguished from the practice of implementation, dissemination, and knowledge translation with the common definition of implementation research as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and hence, to improve the quality and effectiveness of health services and care” (Lane-Fall, Curran & Beidas, 2019, p. 1). Implementation research is a relatively young field, but is rapidly spreading across health disciplines, including medicine, public health, health promotion, mental health, and health services research (Aarons, Hurlburt & Horwitz, 2011; Damschroder, 2019; Lane-Fall, Curran & Beidas, 2019; Norton, Lungeanu, Chambers, & Contractor, 2017; Wandersman et al., 2008). It encompasses a spectrum of research methods and tools, spanning both qualitative and quantitative traditions. Implementation research studies aim to improve the implementation of evidence-based interventions—or alternatively, facilitate the de-implementation of ineffective or dangerous interventions (Eslava-Schmalbach, Garzón-Orjuela, Elias, Reveiz, Tran & Langlois, 2019; Pinnock et al., 2017; Shelton, Adsul & Oh, 2021; Wolfenden et al., 2021). Studies can consider any aspect of implementation, including any or all of the following: suitability of interventions (e.g. randomized controlled trials, efficacy studies), organizational readiness (e.g. needs assessments), barriers and facilitators affecting implementation (e.g. context analysis), strategies and processes for executing implementation (e.g. process evaluation), as well as outcomes of implementation (e.g. impact evaluation, effectiveness-implementation hybrid designs) (Benzer et al., 2013; Damschroder et al., 2009; Lane-Fall, Curran & Beidas, 2019; Peters et al., 2013; Pinnock et al., 2017). Implementation research therefore helps build the evidence base to inform decisions regarding adopting evidence-based interventions; assist in adapting them to specific contexts and needs; support their implementation and ongoing sustainment; as well as facilitate their spread and scale-up to other settings.

..2. Evidence-based interventions

At the core of all implementation research studies are evidence-based interventions. Evidence-based interventions, also referred to as evidence-informed practices and other similar terms, can be understood as “programs, practices, principles, procedures, products, pills, and policies that have been found to be effective at improving health

behaviors, health outcomes, or health-related environments" (Leeman, Birken, Powell, Rohweder & Shea, 2017, p. 3). Conventional definitions specify that interventions are evidence-based insofar as they are supported by rigorous scientific research that establishes a causal relationship between the intervention and its intended outcome(s) to show efficacy and effectiveness (Brown et al., 2017; Lane-Fall, Curran & Beidas, 2019; Leeman, Birken, Powell, Rohweder & Shea, 2017; Pinnock et al., 2017). Broader understandings of evidence include additional sources such as guidelines, results from pilot projects, anecdotal stories from colleagues, and patient experiences (Damschroder et al., 2009). Implementation scientists are increasingly challenging narrow conceptions of evidence, arguing that the evidence base should be cumulative, self-correcting, and translatable into real-world settings (Snell-Rood et al., 2019). However, Indigenous knowledges and ways of knowing are just beginning to be incorporated into implementation research and have not yet been widely recognized.

3.5.1. Implementation Theories and Frameworks

While qualitative research is generally highly inductive, there can be value in applying deductive reasoning positing established theory to guide the methodological focus and elucidate complex relationships in the data (MacFarlane & O'Reilly-de Brun, 2012; Tolley, 2016; Public Health Training for Equitable Systems Change, 2020). Still, researchers must take caution not to let theories blind us to concepts or relationships that do not fit into predefined explanations or hinder us from seeing problems in new ways (Nilsen, 2015). In implementation research, theory advances our knowledge about which evidence-based interventions work, under which circumstances, and why to guide successful implementation (Birken et al., 2017b; Damschroder, 2019; Nilsen, 2015; Public Health Training for Equitable Systems Change, 2020). Implementation theories range in their level of abstraction (e.g. low-level, mid-level, high-level) as well as their focus (e.g. theorizing behaviour change, explaining the influence of organizational context, predicting outcomes, charting causal pathways) (Damschroder, 2019; Nilsen, 2015).

Implementation research has been critiqued for being under-theorized or for superficially or haphazardly applying theory, with some critics suggesting that it amounts to "an expensive version of trial-and-error" (Eccles et al., 2005, p. 108 as cited in Nilsen, 2015). A scoping review of implementation research studies on dissemination strategies for

physician guidelines covering 2006 to 2016 showed that, although theory use had increased over time, fewer than half (47%) of included studies reported using a theory (Liang et al., 2017). Prominent implementation scientist Dr. Laura Damschroder rebuts that “The science of implementation is relatively young, without the benefit of the long decades of research necessary to establish widely accepted, more highly specified models of change nor broadly established generalized theories” (2019, p. 2). Others argue that there is, in fact, a myriad of theories available within implementation research and across complementary disciplines, but that they lack scientific consensus and practical guidance to facilitate their widescale adoption and application (Birken et al., 2017a; 2017b).

In response to these critiques, there has been a growing recognition for the need to establish a strong theoretical foundation for implementation research; this has led researchers to borrow from disciplines such as psychology, sociology, health services research, management science, and complexity science as well as adapt and develop new theories specific to implementation research (Birken et al., 2017b; Nilsen, 2015; Snell-Rood et al., 2021; Wolfenden et al., 2021). Notably, scholars are drawing from theoretical foundations offered by other disciplines to complement and extend existing implementation theory to better capture power, equity, intersectionality, and racism (Allen et al., 2021; Eslava-Schmalbach, Garzón-Orjuela, Elias, Reveiz, Tran & Langlois, 2019; Shelton, Adsul & Oh, 2021; Snell-Rood et al., 2021; Woodward et al., 2021). They are also drawing from theories concerning organizational culture, organizational learning, and complex systems change to inform understandings of how context shapes implementation. Despite increased interest in structural- and systems-level theories, their use is not as prevalent in implementation research as individual-level behaviour-change theories (Nilsen, 2015).

Unlike critiques about the lack of implementation theory, the range of implementation frameworks that have been developed over the last two decades is overwhelming. Frameworks provide shared terminology and semantic scaffolding for cross-synthesis, thereby contributing to an integrated body of knowledge (Birken et al., 2017b; Damschroder, 2019; Hill et al., 2018; Nilsen, 2015). However, the proliferation of frameworks also results in fragmented knowledge due to inconsistent and inadequate descriptions of how frameworks are employed within implementation research studies (Birken et al., 2017a; Damschroder, 2019). Systematic reviews continue to find dozens

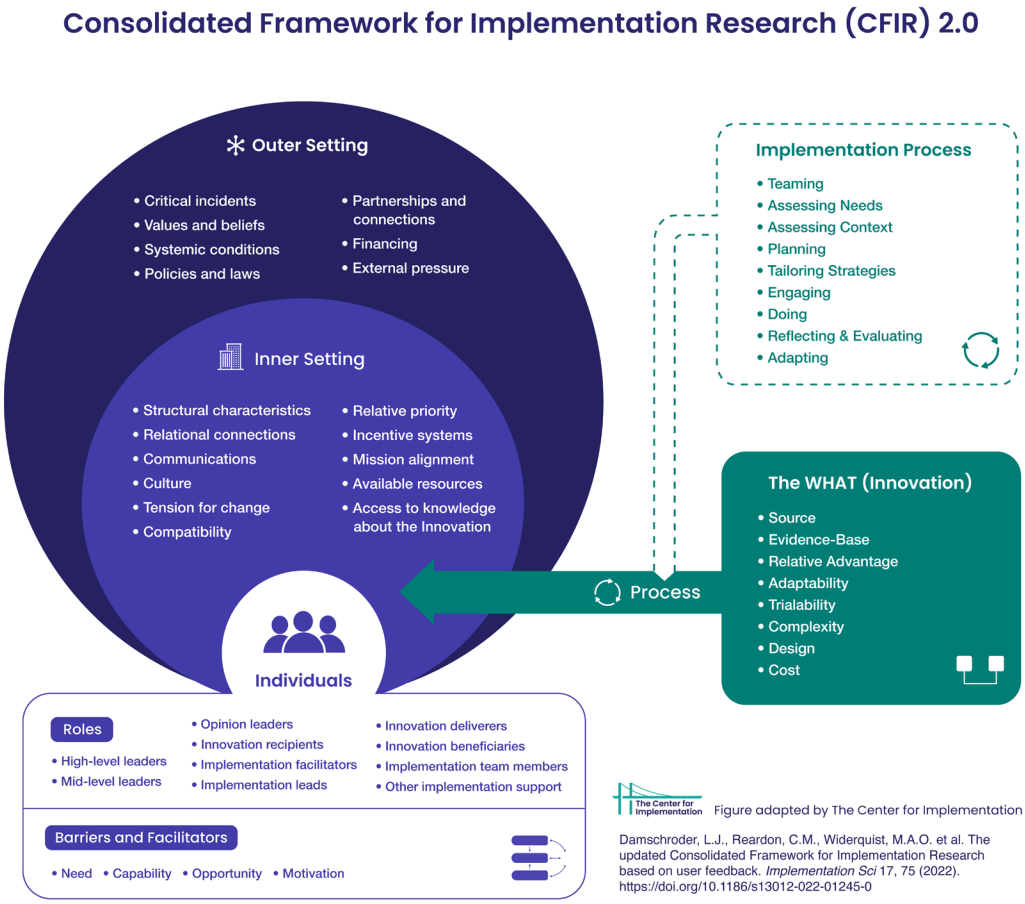
of frameworks, with over 60 frameworks identified in Birken and colleagues' international survey (2017b); and 114 theories, models, and frameworks listed in the Dissemination & Implementation Models in Health Webtool (2023). Moreover, trends in the literature show that frameworks continue to be developed or adapted for new purposes (Damschroder, 2019). Implementation frameworks differ from one another in a number of ways, including the degree of theoretical integration (e.g. theory-driven, adapted, emergent); the purposes they serve (e.g. describing the implementation process, evaluating implementation outcomes, identifying determinants of implementation); the conceptual level of focus (e.g. individual level, organizational level, systems level); the degree of specificity (e.g. meta-frameworks, frameworks specific to certain interventions); as well as the ease of operationalizing (e.g. abstract conceptual frameworks, practical guidelines and templates) (Birken et al., 2017a; Damschroder, 2019; Nilsen, 2015; Woodward et al., 2021). Implementation frameworks can be used to inform all phases of research. For instance, they can be used to plan intervention implementation, select implementation strategies, identify key constructs for investigation, specify outcomes of interest, stimulate hypotheses and frame research questions, describe the process of implementation, explain what influences implementation outcomes, evaluate implementation, contextualize results and/ or develop recommendations (Birken et al., 2017b).

Consolidated Framework for Implementation Research

To understand the barriers and facilitators shaping uptake and implementation of cultural safety and anti-racism training interventions in MPH programs, determinant frameworks offer the most value. The most well-known and frequently cited determinants framework is the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009)— updated in 2022 to the CFIR 2.0 (Damschroder, Reardon, Widerquist, & Lowery, 2022) (see Figure 2). The authors of the CFIR consolidated 19 previously-published sources relevant to implementation theory, including a synthesis of nearly 500 published sources across 13 fields of research (Greenhalgh, Robert, MacFarlane, Bate & Kyriakidou, 2004); they then compiled the terminology and definitions into one meta-theoretical framework. The resulting framework includes 39 conceptually-distinct constructs organized across five unifying domains: intervention characteristics, characteristics of individuals involved, process, inner setting and outer setting. A

diagram of the CFIR is illustrated in Figure 2 below and a complete list of constructs and their definitions can be found in **Appendix B: CFIR Codebook**.

Figure 2. The Consolidated Framework for Implementation Research (CFIR) 2.0



Adapted from "The updated Consolidated Framework for Implementation Research based on user feedback," by Damschroder, L.J., Reardon, C.M., Widerquist, M.A.O. et al., 2022, Implementation Sci 17, 75. Image copyright 2022 by The Center for Implementation. https://thecenterforimplementation.com/toolbox/cfir

Damschroder and colleagues note that all the constructs and domains interact in complex ways. The relationship between inner setting and outer setting is conceptualized as follows:

> Generally, the outer setting includes the economic, political, and social context within which an organization resides, and the inner setting includes features of structural, political, and cultural contexts through which the implementation process will proceed. However, the line between inner and outer

> setting is not always clear and the interface is dynamic and sometimes precarious. The specific factors considered 'in' or 'out' will depend on the context of the implementation effort (Damschroder et al., 2009, p. 5).

The domain ‘Process’ is also complex and dynamic. A conventional implementation model or process framework may be designed to unfold in an orderly, linear fashion. Conceptualizing implementation this way may help assess incremental progress, understand mechanisms of change, and predict causal pathways, as in the case of efficacy trials, process evaluations, or effectiveness-implementation hybrid designs (Aarons, Hurlburt & Horwitz, 2011; Wolfenden et al., 2021). However, in practice, interventions rarely conform to a rigid model. The implementation process may be formally planned or spontaneous; it may be a series of sequential, overlapping, or disjointed sub-processes; it may be linear or recursive; and it may have a start and end point or be cyclical (Damschroder et al., 2009; Hill et al., 2018; Knight et al., 2015; Nilsen, 2015). For the purposes of examining implementation determinants within the ‘Process’ domain of the CFIR, the primary aim is to understand the current state of efforts underway, the historical context, and general trajectory of implementation/ de-implementation. This may necessitate a departure from conventional western understandings of linear paths towards progress, instead inviting appreciation for alternative and concurrent routes that embrace fluidity, non-linear growth, setbacks, correction, and complexity.

One of the major strengths of the CFIR is its comprehensive nature, but it is not intended to be applied in its entirety to all implementation research studies. Researchers can select constructs from the CFIR that are most relevant for their research question and study setting, adapt the definitions as appropriate, determine how to measure and evaluate each construct, and apply theory and/ or inductive analysis to explore relationships between them. The CFIR does not predefine relationships between constructs, predict hypotheses about how implementation happens, or propose explanations of causality (Damschroder et al., 2009; Hill et al., 2018; Nilsen, 2015). It is therefore compatible to combine with implementation theories or other theoretical lenses appropriate to the study purpose and context.

3.5.2. Advancing Implementation Research

While implementation research is an emerging field with an expanding body of literature, there are significant gaps in how its tools and discourses have been applied to date. For instance, there are few published studies that investigate the implementation of cultural safety, anti-racism, or related health professional training interventions. One noteworthy study applied the CFIR to examine the predictors of intervention success in addressing health inequities and understand the influence of structural racism in implementation efforts (Allen et al., 2021). Additionally, though not considered an implementation research study, Rowan and colleagues (2013) drew from the field of quality improvement to develop a conceptual model of integration of cultural competence and/ or cultural safety into Schools of Nursing, which they applied in a survey of 38 Canadian Schools of Nursing. They concluded that three main elements are required in order to successfully integrate cultural competency and cultural safety programs into healthcare education and training: contextual, process, and structural (Rowan et al., 2013). These constructs align closely with the CFIR, suggesting that a determinants framework may be useful for expanding our understanding of the factors shaping implementation of cultural safety and anti-racism training.

A second area in which there is potential to advance implementation research is within education settings, such as post-secondary institutions. Systematic reviews confirm that almost all implementation research studies are conducted within healthcare organizations, such as hospitals, primary care, and community health agencies (Birken et al., 2017a; Damschroder, 2019). Some studies discuss education institutions as “support systems” in relation to healthcare delivery systems (Wandersman et al., 2008); however, in the literature identified, no studies have framed an education institution as the service delivery setting where implementation of an intervention is being examined. Nonetheless, the work by Wandersman and colleagues (2008) that presents the education system as a support system within an “Interactive Systems Framework for Dissemination and Implementation” is important because it emphasizes the important role of education in capacity building for the healthcare system as well as for implementation practice. As this study demonstrates, many of the constructs used in implementation research are applicable in education settings and can be used to understand training interventions and their implementation. Moreover, expanding

implementation research to education settings will uncover new insights to advance implementation theory and frameworks.

This research is one step towards advancing implementation research to fill these gaps and demonstrate a broader potential not previously explored. It represents a novel application of an implementation research framework combined with a critical theoretical lens to examine the implementation determinants shaping cultural safety and anti-racism training interventions in MPH programs. The CFIR, anti-colonialism, and intersectionality offer theoretical guidance that is woven throughout all components of the study, including but not limited to: identifying the research question, anchoring background literature, informing recruitment, shaping data collection tools, defining key constructs, guiding framework analysis, sensitizing interpretation of findings, contextualizing results, generating appropriate recommendations, and ensuring knowledge translation is intentionally designed for user uptake.

3.6. Research Design

3.6.1. Stakeholder Engagement

As a commitment to relational accountability as a core tenet of anti-colonial theory (Carlson, 2017), this study was conducted with early and ongoing consultation with key stakeholders in the health system and education system; mentorship and oversight from Indigenous scholars and Knowledge Holders; as well as authentic relationships and accountability with Indigenous colleagues, friends, and family. Early in the study (May 2021), knowledge users were invited to participate in a virtual forum to learn about the study and provide feedback to ensure the research questions, design, sample, intended outputs, and knowledge translation strategies were relevant to their information needs and priorities. Invitees included key informants from BC universities offering MPH programs (e.g. those most closely involved with implementing cultural safety and anti-racism training) as well as knowledge users from BC's public health practice environment (e.g. the First Nations Health Authority, the Provincial Health Services Authority, regional health authorities and their respective Indigenous health departments, and selected community based and non-governmental organizations), and national public health organizations and groups (e.g. the Network of Schools and Programs of Population and Public Health, Public Health Agency of Canada and the National

Collaborating Centre for Indigenous Health). Fifteen individuals were invited to participate in the virtual forum, and six attended. Knowledge users contributed to the research in an advisory capacity and did not participate in data collection. They offered guidance as leaders in the field of public health/ Indigenous health and were not asked to speak on behalf of their organizations. The group offered valuable insights that shaped the research design, and they made an informal commitment to supporting dissemination and implementation of findings in practice.

To support reporting of findings and knowledge translation, an Indigenous artist collaborated to interpret the findings and visualize key themes. Taylor Baptiste, a Syilx Okanagan artist from the Osoyoos Indian Band, created **cover art** and **back cover art** telling the Okanagan captikʷɬ (teachings about laws, customs, values, and governance) about 'How Names Were Given'. The art portrays the important message that everyone has a purpose, and it is ok that we will make mistakes along our journeys (see full description of cover art and artist biography at the beginning of the dissertation). At various stages of the research, progress and results were disseminated to academic and public health practice audiences through conference presentations, including the Canadian Public Health Association's annual conference (2019, 2022), the International Union for Health Promotion and Education World Conference on Health Promotion (2022), the Canadian Society for the Study of Higher Education Annual Conference (2023), the KT Canada Scientific Meeting (2023), and the Qualitatives (2023). Results will also be published in peer-reviewed, open-access journals (e.g. Implementation Science, Frontiers in Public Health). Each participating MPH program will receive a case report highlighting key findings specific to their program and synthesized across programs; they will also have the option of organizing a presentation of findings that can be tailored to their needs and preferences.

3.6.2. Case Study Design

Employing a case study design, this study explored the uptake and implementation of cultural safety and anti-racism training within BC universities with academic faculties or departments that offer MPH programs. In this study, each of the three MPH programs is considered a case or "bounded systems of action" (Snow & Anderson, 1991, p. 152, as cited in Padgett, 2014, p. 5). The names of the universities are anonymized throughout the Findings to protect the privacy of participants; however, limitations were noted with

regards to anonymizing data within a defined regional sample and small professional community involved in Indigenous public health. The decision to focus on these three cases is motivated by the need to balance quality, depth, and feasibility, as it will generate contextually-rich and nuanced data for each institution within a unified provincial and national context. The province of BC is regarded nationally and globally as a leader in innovation in culturally safe care for Indigenous peoples (Greenwood, 2019; Nickerson, 2019). First Nations communities in BC were the first in Canada to collectively control their healthcare services through an historical transition to "community-driven, nation-based" health governance with leadership from the First Nations Health Authority (FNHA) (Nickerson, 2019). The Province of BC is also the first government in Canada and among Common Law states to pass legislation implementing UNDRIP (Bill 41, 2019). Additionally, BC's Provincial Health Services Authority (PHSA) developed one of Canada's first and most widely recognized Indigenous cultural safety training programs, San'yas: (Provincial Health Services Authority, n.d.; Turpel-Lafond, 2020). Most recently, BC has also been the site for a recent inquiry on anti-Indigenous racism in the health system (Turpel-Lafond, 2020).

Including all MPH programs across BC ensures findings are sensitive to the provincial context, and helps generate recommendations that are relevant to the public health practice environment that the programs' curricula are responsive to. At the same time, it offers the benefit of transferability of findings to other settings because of the diversity across the three institutions, in terms of the academic unit in which the MPH program is situated, the disciplinary influences, the organizational size and structure, etc. The sample was narrowed to MPH programs because they are professional, course-based degrees that provide the basic competencies for students to complete before (re-) entering their professional careers in public health. Public health's emphasis on promoting, protecting, improving, and restoring the health of the population makes it an important site for studying the implementation of cultural safety and anti-racism training (Canadian Public Health Association, 2019; Ford et al., 2019; Kent, Loppie, Carriere, MacDonald & Pauly, 2017; Tam, 2021). To date, the majority of the research in the area of cultural safety and anti-racism has been conducted within medical and nursing programs (Baba, 2012; Baba, 2013). In order to have a relatively homogenous sample with standardized core competencies, accreditation standards, and professional regulatory bodies, programs outside of MPH programs were excluded. In particular,

medicine and nursing programs; other health professional training programs (e.g. physiotherapy, occupational therapy, dentistry, alternative medicine, etc.); other public health degrees (e.g. Bachelor or Doctor of Public Health); as well as research-based degrees in the health disciplines (e.g. Master of Science) were excluded from the study.

3.6.3. Sampling and Recruitment

Recruitment began with inviting two to three key informants from each of the three MPH programs to participate. Key informants are strategically positioned to influence the development, instruction and evaluation of cultural safety and anti-racism training within MPH curricula. Key informants supported identification of additional participants, including Deans of the faculties in which public health is situated, Program Directors of MPH programs, Indigenous faculty members, professors who instruct core public health courses or Indigenous health electives, staff involved in supporting implementation, as well as current MPH students to capture their experiences of cultural safety and anti-racism training. Purposive sampling was supplemented by snowball sampling to ensure these various perspectives were represented. Professional networks, key informants, and publicly-available contact information through university websites assisted with identifying and recruiting potential participants. With the permission of the three MPH programs, email listservs were utilized to recruit current faculty, staff, and students. Recruitment of students was driven by convenience sampling, open to any student who was (at the time of recruitment) actively enrolled in MPH training at one of the three institutions. In order to honour the ways in which intersectional identity shapes lived experiences, participants were given the option to share a brief positionality statement where they could share demographic details or identifiers that they deemed relevant (e.g. professional title, Indigeneity, Nationhood, pronouns, international, immigrant or settler identity). Because this was optional and out of respect for individuals' preferences for anonymized data, demographics are not reported.

3.6.4. Data Collection

Data was collected from multiple sources to get a complete picture of the process and context of implementing cultural safety and anti-racism training in MPH curricula. An iterative process of concurrent and successive data collection and analysis, each serving to inform and advance the other (Charmaz & Belgrave, 2012), enabled refinement of

recruitment and data collection based on new insights that emerged (Benzer et al., 2013). Data collection began with key informant interviews to help build relationships, and get oriented to key contacts and important data sources. At the outset and throughout the course of data collection, key informants were asked to share relevant institutional and departmental academic plans that provide institutional context shaping MPH curricula, and/ or outline commitments or intentions to incorporate cultural safety and anti-racism training. Additionally, key informants were asked about the availability, relevance, and appropriateness of other sources of data, such as syllabi, teaching materials, and/or training manuals, which were included in data analysis.

Following key informant interviews, interviews and focus groups were conducted with faculty, staff, administrators, and students. Interviews and focus groups were semi-structured, guided by key questions informed by the CFIR (see **Appendix A: Interview & Focus Group Guide**). Participants were invited to comment on relevant training interventions, individuals involved, implementation processes, inner setting and outer setting that are relevant to cultural safety and anti-racism training within their respective academic units. Focus groups were facilitated with care to create a safe space for dialogue and encourage collective construction of shared meaning through social interaction. When necessary, multiple smaller focus groups or individual interviews were arranged to mitigate power differentials within groups. Case 200 helped organize a faculty forum to support recruitment of faculty across the MPH program, which helped generate insights from individuals with varying levels of engagement with cultural safety and anti-racism training. Data sources and numbers of respondents are summarized in Table 1 below.

Table 1. Data Sources

	Case 100	Case 200	Case 300	Total
Administrators	4	1	1	6
Faculty/ Instructors/ Sessionals	3	15	1	19
Staff	0	1	1	2
Students	4	3	8	15
Institutional Reports	3	2	1	6
Faculty/ Departmental Reports	2	1	2	5
Public Communications	8	8	2	18
Total	24	31	16	71

Due to institutional restrictions on in-person data collection in light of the COVID-19 pandemic during the time of data collection, interviews and focus groups were conducted virtually using Zoom webconference software. Interacting in person offers advantages for relationship building and establishing rapport as well as making observations and responding to non-verbal and visual cues during focus groups. However, a comparative analysis of data quality of in-person versus online focus group discussions by Woodyatt, Finneran and Stephenson (2016) concluded that online methods do not compromise the quality of data generated. In fact, online webconference platforms offer advantages by creating a safe space for participants to be more open with others and express their disagreements more freely than in face-to-face communication (Woodyatt, Finneran and Stephenson, 2016).

3.6.5. Coding & Analysis

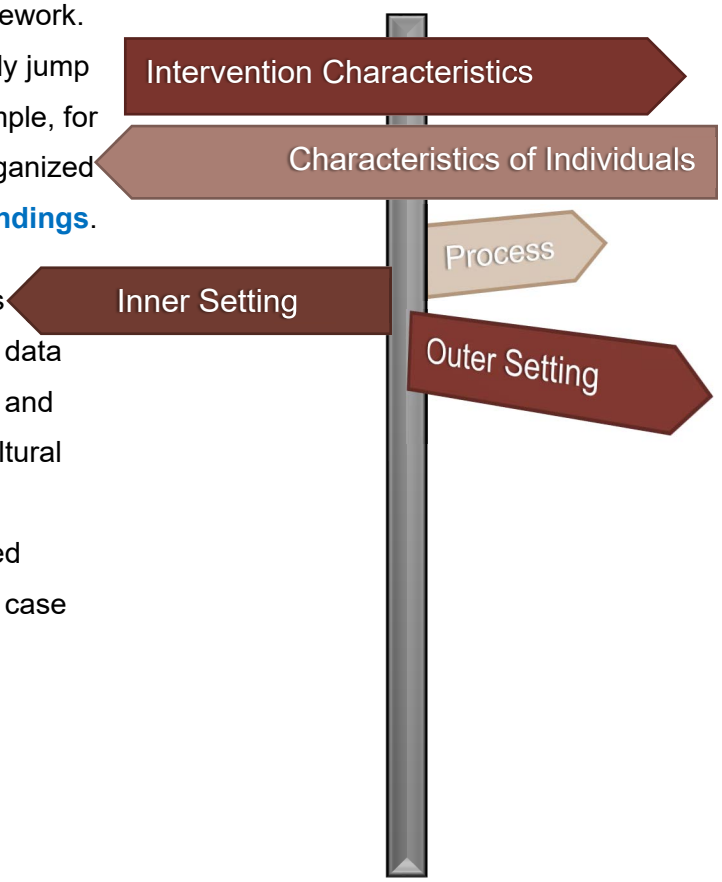
Framework analysis was used to index and interpret the data with domains and constructs from the CFIR (Damschroder et al., 2009; Ritchie & Lewis, 2003; Ritchie et al., 2010). Qualitative research generally employs inductive approaches that build emergent themes from the ground up, and occasionally theories— as in the case of Grounded Theory approaches (Glaser & Strauss, 1994). However, there can be value in applying established theory to guide the methodological focus and elucidate complex relationships in the data (MacFarlane & O'Reilly-de Brun, 2012; Tolley, 2016). Hill and colleagues (2018) make the case that "… The comprehensive nature of the [CFIR] framework lends itself to use as an initial coding structure because the dynamic and numerous constructs offer coverage for wide-ranging themes and ensures the capture of those factors important to implementation" (p. 4); furthermore, they argue that it "provides a means to expedite the analysis of large amounts of qualitative data and facilitates the rapid turnaround of recommendations…" (p. 3).

All sources of data (interview and focus group transcripts, documents, and any other sources) were transcribed, cleaned, and imported into NVivo software to facilitate data organization. Qualitative analysis followed a systematic process of line-by-line coding, thematic analysis, and constant comparison. A pre-existing codebook and NVivo coding shell developed by the CFIR Research Team-Center for Clinical Management Research (2020) was used, which eliminated the need to construct a thematic framework (see **Appendix B: CFIR Codebook**). The CFIR coding framework guided initial deductive

line-by-line coding. While coding, in vivo codes were added so as not to allow the thematic framework to restrict the development of themes or relationships that do not fit into predefined CFIR constructs (Nilsen, 2015). Both a priori codes from the CFIR and in vivo codes that emerged from open coding the data are reported in **Appendix C: Number of Files and References Coded**. Once all sources were coded, thematic analysis was used to inductively develop sub-themes within each CFIR construct. Thematic analysis was informed by sensitizing concepts derived from anti-colonialism and intersectionality theory, which further supported continuous questioning of what was missing from the data. Simultaneously, constant comparative analysis was used to identify patterns and discordance within each case (i.e. consistencies and inconsistencies with the responses of informants) as well as across cases (i.e. convergences and divergences across MPH programs) (Benzer et al., 2013). Reflexive memo writing also helped record observations about relationships among codes and specify the conditions under which codes or relationships developed (Charmaz & Belgrave, 2012). Analysis highlights the determinants shaping uptake and implementation of cultural safety and anti-racism training in MPH curricula, and illuminates the interrelationships between constructs both within and across the constructs and domains of the CFIR.

Chapter 4. Findings and Interpretation

Initial coding and subsequent thematic analysis were compatible with the analytic framework offered by the CFIR (see **Appendix C** for coding breakdown). Findings and interpretations are organized under headings that correspond to each domain and construct of the framework, with definitions highlighted in text boxes below each heading. Themes are generally presented in the order that they originally appear in the CFIR, with some constructs combined or rearranged to show relationships and natural progressions in the data. However, readers are encouraged to disrupt linearity by choosing their own journey and reading the Findings in whichever sequence is intuitive for them and/ or selecting specific constructs to focus on. This can easily be achieved by using the navigation pane in the left margin or clicking on one of the hyperlinked arrows that appears on the directional sign post graphic at the end of each section. Additionally, throughout the document, readers are directed to sections that expand upon or illuminate findings with insights related to other themes, illustrating the interconnected and cross-fertilizing nature of the framework. Hyperlinks are provided to conveniently jump from one section to the next. For example, for a concise overview of key findings, organized by CFIR domain, see **Summary of Findings**.



Under Summary of Findings, a table is presented that provides a snapshot of data highlighting themes related to barriers and facilitators to the implementation of cultural safety and anti-racism training in MPH programs. This is followed by a detailed description of each theme within each case and across cases.

4.1. Summary of Findings

Table 2. Determinants of Uptake and Implementation Across the Three Cases

CFIR Domain	Barriers	Facilitators
Intervention Characteristics	• No predefined or standardized intervention • Rapidly changing discourses • Lack of evidence, inconclusive evidence, or lack of awareness of evidence • Potentially triggering content • Facilitator burnout • Need for ongoing and sustained learning • Communication in online or hybrid modalities is challenging	• Flexibility for instructor to adapt intervention • Adaptability across settings and contexts • Asynchronous learning options • Resistance to Eurocentrism • Student leadership in catalyzing change • Guest speakers supporting facilitation
Characteristics of Individuals	• Denial of presence and severity of racism • Unfamiliarity, apprehension, low self-efficacy • Limited training opportunities for instructors • Feelings of disconnect among BIPOC students/ instructors • Feelings of detachment from institution among sessionals • Increased demands on Indigenous faculty and students • Underrepresentation of BIPOC faculty	• Perceived importance and widespread support • Subject matter expertise among faculty • Faculty experienced in facilitating cultural safety training • Self-guided learning among staff, faculty, and administrators • Indigenous leadership in implementing calls to action • Leadership of Indigenous students • Leadership of BIPOC faculty in championing anti-racism • Allies working in solidarity to do this work
Process	• Slow pace of change • Power and privilege detracting from engagement practices • Challenge of measuring or quantifying transformation • Time demands of purposeful engagement • Time required to implement changes to curricula • Complexity of expanding or scaling existing interventions • Limited resources for critical evaluation activities	• Formally appointed leaders in MPH program • Senior leadership positions supporting these issues in the institution • Champions at all levels: students, staff, faculty, administrators • Student engagement in leadership and decision-making • Networks of relationships with Indigenous communities • Established cultural safety training programs to partner with • Institutional grants and special initiatives to support evaluation
Inner Setting	• Colonial spaces and lack of Indigenous representation • Organizational culture of colonialism and Eurocentrism • Organizational culture of racism and white supremacy • Micro-aggressions in the classroom • Academic freedom as a barrier to mandating activities	• Interdisciplinary academic unit structure • New generations to demand and lead culture change • Compatibility with public health discipline's ethos • Supportive learning climate of universities • Institutional commitments affirmed in strategic and academic plans

	• Minimal accountability mechanisms for senior leaders • Underrepresentation of BIPOC leaders in universities • Limited time and faculty working at full capacity • Perceived lack of/ unfair distribution of financial resources • Lack of awareness of knowledge resources or where to start • Relationship building hindered by geographic distance	• Tenure and promotion as an incentive system • Support and active engagement among program directors and deans • Senior leadership (e.g. presidents) passionate about EDI • Institutional funds and grants for decolonization and anti-racism • Institutional and provincial guidelines for preferential/ limited hires • Extensive resources on campuses or in practice environment • Internal and external communication channels to relay information
Outer Setting	• Partnerships not seen as connected to academic unit • No public health accreditation standards in Canada • Slow uptake and implementation of calls to action • Pandemic shifting education to online learning • Students have varying levels of knowledge and experience • Systemic barriers to Indigenous access to higher education • Scholarship programs' limited applicability or discontinued	• Robust partnership network cultivated by faculty • Leadership from public health practice environment • Profiling of events that raised public awareness of systemic racism • Societal movements to redress racism and colonialism • Series of recommendations put forward over several decades • Institutional commitments to reconciliation and anti-racism • Tools and guidelines for implementing institutional commitments • Students bring professional experience and lived experience

4.2. Intervention Characteristics

Research Objective: Characterize the core components and adaptable features of cultural safety and anti-racism training interventions in MPH curricula within each institution.

4.2.1. About the Interventions

One of the inherent challenges with studying cultural safety and anti-racism training interventions is that the intervention is not predefined or standardized. Because this is not common for implementation studies, this subsection is added to complement the CFIR constructs and contextualize subsequent findings by briefly introducing the range of interventions captured within the data. Data illustrates that interventions vary between institution, course, instructor, year, or semester of delivery, and further varies across individual students' learning experiences and how they engage with or perceive the training intervention. Differences between interventions are evident in the location in the curriculum, format, delivery, learning materials, key concepts, discourses, and definitions used. The lack of standardization is noted as a tension that warrants further discussion:

> It comes down to the individual professor… I mean they have their own approaches. And, you know, that's part of the thing, but I don't know the tension between maybe there should be some kind of core competencies, and then some sort of freedom for professors to teach what they want, and students to inform the process. In other words, I think it's more of a process thing than a than a recipe book. (Participant 103)

Participants noted that their understandings of cultural safety, anti-racism, and related concepts have evolved over the years in recognition of how discourses have adapted over time (Participants 101, 102, 201, 204, 301, 302, 303). Largely due to the leadership of the Provincial Health Services Authority's (PHSA) San'yas Indigenous cultural safety training and the FNHA-led movement of declarations of commitment to cultural safety and humility (see **Peer Pressure**), over the past two decades, the provincial health system has witnessed a "trajectory of different models" (Participant 102) in preferred terminology and the respective approaches these terms encapsulate. This trajectory has

generally evolved from cultural awareness and cultural sensitivity, to cultural competency, to cultural safety and cultural humility, and more recently there are movements towards anti-racism and interrogating white supremacy. Participants commented on the rapid pace at which discourses are shifting. For instance, Participant 303 explained “There’s a myriad of terminology, and I feel like it’s changing with every workshop I attend, or seminar, or sit with somebody;” with Participant 204 similarly noting, “There’s all these different terms, and they seem to be like one comes up, and then people figure out why it’s problematic, and then another one comes along.”

Definitions

Despite a lack of agreement on ever-changing terminology, several of the documents included in the analysis included glossaries with definitions of cultural safety and anti-racism consistent with the literature (see **Cultural Safety** and **Anti-racism**). Most participants explained their current understanding of cultural safety as encompassing a range of core tenets that are promoted across various concepts (see **Key Concepts**). In defining cultural safety, participants commonly framed it as an outcome or environment that can only be defined as ‘culturally safe’ by the recipient of care (Participants 101, 102, 201, 301). One participant explained the concept as follows:

> … a person should be able to come into an institutional environment, whether it's the university or the healthcare system or any other institutional environment, and not feel threatened or shamed, or scared, that they're who they are, how they express themself, you know the language they use, the values they have are not going to be… that their cultural being will be respected and will be treated with the same kind of respect as anybody else coming into the system... (Participant 102).

Across interviews and focus groups, most participants gravitated towards and demonstrated more comfort with defining and applying the concept of cultural safety over anti-racism, but often noted that the two are intertwined and interdependent (Participants 102, 103, 301, 302). One participant simplified the definition of anti-racism as, “There’s a difference between saying I’m not racist versus I’m anti-racist, right?

Where it's like being anti-racist is actually taking action… Like if you're not doing anything, you're part of the problem" (Participant 206).

Key Concepts

In expanding upon understandings of cultural safety and anti-racism, data highlights several core tenets and key concepts that are consistently associated with the training interventions. Across the three case sites, participants involved in the delivery of cultural safety and anti-racism training expressed the importance of incorporating seminal documents and policies (e.g., Indian Act, UNDRIP, MMIWG Calls for Justice, TRC Calls to Action) into the curriculum to support students in developing a foundational understanding of the calls to action that are relevant to public health professional practice. Interestingly, students noted that the In Plain Sight Report was not covered in the curriculum, but came up in discussion posts (Participants 305, 309). Yet both participants and strategic plans articulated a strong commitment to the TRC's Calls to Action: "I think we have a unique obligation at this moment to be pushing on TRC" (Participant 202).

The responsibility to teach students about the historical and ongoing legacy of colonization has been taken up across all three case sites and tailored to MPH curricula by framing it as a determinant of health for Indigenous peoples with implications for population health outcomes and health equity. To complement discussions around Indigenous health, some of the instructors also made efforts to showcase Indigenous perspectives on health, such as the FNHA Model of Wellness and the Tree Framework of determinants of health (Participants 101, 301). Moreover, instructors facilitated critical interrogation of dominant Eurocentric ideas:

> … Supporting students to learn how to question, both other learnings and what they're getting within the university setting, but also within their careers. And I actually hadn't thought of this when developing the syllabus, but students talked about what they unlearned, and we often think in the university setting, we're developing curriculum, so what are students going to learn? And some of it was about unlearning as well. So what are they unlearning in regards to the colonial setting that we're in? (Participant 217).

Beyond cultural safety and anti-racism, complementary models such as cultural humility and allyship were frequently discussed as key elements of training interventions. Cultural humility was emphasized as particularly compatible with reflexivity in public health praxis, encouraging students to situate their social location or positionality within their work, and to engage in self-reflection to identify and deconstruct preconceived biases (Participants 101, 202). Allyship is understood by some as the next step once one "works to recognize their privilege (based on race, gender, sexuality, class, etc.) and works in solidarity to end a form of discrimination for a particular oppressed individual or designated group" (Canadian Race Relations Foundation, Glossary of terms, as cited in [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022).

Discourses

Cultural safety and anti-racism are interwoven with a range of discourses that use different terminology and communication practices to convey socially-constructed meaning. Consistently across the three case sites, administrators, faculty, staff, students, and authors of institutional reports commented on the relationship between these concepts and decolonization or Indigenization, noting that the concepts are "very hard to disentangle [from one another]" (Participant 302). Institutional reports from each of the case sites provide complementary definitions of decolonization and Indigenization that illustrate how the two concepts are distinct but work hand-in-hand to contribute to creating culturally safe learning environments that are free from racism and promote respect. Case 100 has a university-wide report that outlines recommendations and strategies for the university community to collectively respond to and be held accountable to the TRC Calls to Action; the report explains their use of the concepts as follows:

> We also use the terms "decolonizing" and "Indigenizing." [The authors] respectfully acknowledge tensions around the use of both terms, noting again that no single term is acceptable to or preferred by all. This Report uses the term 'decolonizing' to represent a socio-political agenda that seeks to redress historical and current practices that have had deleterious effects on Aboriginal peoples. The term

> ‘Indigenizing’ indicates incorporating Indigenous knowledge and ways of knowing into the practices (such as the curriculum) of the institution.

In complement to these definitions, one of Case 200’s institutional reports notes that “In the Canadian context, decolonization is viewed through Indigenous frameworks and centres Indigenous land, Indigenous sovereignty and Indigenous ways of thinking.” This is largely enacted through land acknowledgements, which are modelled by administrators and faculty, embedded in reports and webpages, formalized in syllabus templates, and taught as a cultural protocol to be observed in practice.

The focus on Indigenous peoples, cultures, languages, and lands that is observed within Indigenization and decolonization discourses at the three case sites also extends to cultural safety and anti-racism. There was a common conflation of cultural safety and anti-racism with topics such as “Indigenous health issues” or “Indigenous issues” in general. Moreover, the discourse paired with these topics is described by participants as “negative” or “deficit-based” (Participants 205, 207, 302), “problematic” or “stigmatizing” (Participants 301, 206), “medicalized” or “pathologizing” (Participants 301, 302), “decontextualized” (Participants 205, 206, 305), and “outdated” (Participant 308). A common example cited was referring to Indigenous peoples as “a burden,” “high risk,” “vulnerable,” or “needing help/ not capable on their own” (Participants 103, 203, 211). It is worth noting that more often than not, the above descriptions of discourses were linked to epidemiology and biostatistics courses. Participant 307 offered a particularly provocative description of one of the discourses used in conjunction with the topic of Indigenous health:

> [It’s] like trauma porn… Like look at these really intense examples of injustices and let’s react to them. And it’s geared towards usually White people, which are the people who need to do the most learning… It’s tricky because we need to know those histories and we need to study those histories to be able to do better in the future, but at the same time, it’s a very dangerous construction of certain groups…

Several participants agreed that the discourse needs to be reframed to highlight strength, resilience, and resurgence within Indigenous communities (Participants 103,

302), and showcase examples of successful initiatives that promote cultural safety and anti-racism (Participants 101, 307, 309).

At each case site, faculty members who teach relevant subject areas reflected on how their current approach to teaching largely centers First Nations groups that are local to the geographic area in which their respective universities are situated. On the one hand, they justify that this has been a deliberate decision to honour the relationships and protocols that the university is accountable to; on the other hand, they critically reflect that this results in some exclusion of other BIPOC communities that experience discrimination in the healthcare system, such as black, Asian, and global Indigenous peoples (Participants 101, 102, 104, 301, 302). Similarly, students at all three case sites were vocal about what they perceived to be a gap in the curriculum with regards to applying cultural safety and anti-racism to additional cultural groups and expanding beyond local contexts (Participants 108, 109, 110, 205, 206, 207, 306, 311). Two representative quotes are highlighted below:

> I think there is definitely a heavier emphasis on Indigenous populations. And I would like to see more learning opportunities for anti-racism for other marginalized groups and how to incorporate that as a public health professional. So far, I think I've been like pretty satisfied with the training. But I do wish it was just a bit more broad and kind of like I mentioned before, like a bit more applicable to various settings versus just BC and to various groups as well. I think that'd be really beneficial (Participant 108).

> When we were talking about antiracism, we would often pair it up with white settler. And it's really hard as a non-white person… to put myself in the conversation… When we think about antiracism, cultural safety, everyone plays a role. It's not just about white settlers (Participant 109).

In addition to recommendations for a broader application of cultural safety and anti-racism, several participants (202, 206, 302, 307, 308) advocated for an intersectional

approach to “disrupting power dynamics” (Participant 202) across “all of the systems of oppression and the -isms… rather than just the sexy ones” (Participant 308).

Another dominant discourse or association with adjacent discussions that frequently came up in discussions around cultural safety and anti-racism is Equity, Diversity and Inclusion (EDI). EDI seemed to be used as a proxy or nondescript catch-all in interviews and focus groups. The interview guide intentionally invited participants to interpret cultural safety and anti-racism through their own lens and share their own definitions at the outset to ground the conversation. However, the invitation to participate, the consent form, the initial preamble and subsequent questions repeatedly located the focus of the research on cultural safety and anti-racism training within MPH curricula. Nevertheless, participants steered the conversation towards matters such as EDI themes in the curriculum; recruitment/ hiring standards to increase representation of students and faculty from equity-deserving groups; EDI orientation and professional development training for faculty and staff; EDI considerations in tenure and promotion; research portfolios that foreground EDI; institutional policies against discrimination; forming departmental EDI committees; establishing leadership roles such as Vice President Equity, Diversity, Inclusion; etc. While principles of EDI are interconnected with cultural safety and anti-racism, so too with Indigenization and decolonization, there are also cautions against subsuming one within the other or mistaking them as synonymous. With regards to EDI initiatives within Case 200— though consistent with activities at Case 100 and 300— Participant 204 critically reflected:

> … There's a lot of tokenism. There's a lot of like using the word “diverse” to mean people who aren't white, which then sends the message that white is normal and everybody else is “other.” And there's a lot of like equity is about counting the people of color or people who have disabilities or LGBTQ people in the room, and if we have enough people in the room, whether we’re listening to them or not… we're just ticking boxes.

Case 200 is also leading a path forward with their Task Force on Anti-Racism and Inclusive Excellence Report, which both celebrates and problematizes the university’s efforts around EDI:

> The predominance of the Equity, Diversity and Inclusion (EDI) framework has engendered many positive developments at [Case 200] over the last decade, yet it has equally been criticized… for working against the establishment and implementation of anti-racist and decolonized institutional practices (Tamtik & Guenter, 2019). It has also been criticized for working within extremely limiting and ineffective frameworks of equality, multiculturalism, and tolerance concepts that have in fact contributed to and resulted in the expansion and normalizing of structural and systemic barriers to IBPOC students, faculty, and staff. Although EDI undisputedly has its place within the conversation on race and justice matters, there is a need for a sharp distinction between matters of diversity and inclusion on the one hand and anti-racism and decoloniality on the other.

4.2.2. Design Quality and Packaging

CFIR Definition: Perceived excellence in how the innovation is bundled, presented, and assembled (CFIR Research Team-Center for Clinical Management Research, 2023).

Location in the Curriculum

In recent years (2021/2022), both Case 100 and Case 200 have revised their MPH curricula to require students to take a mandatory course in Indigenous public health, which is where many participants identified the location of cultural safety and anti-racism training. This development was highlighted by both MPH program directors as a significant improvement:

> I think that the most hopeful step that I witnessed recently is… the recognition that we cannot allow any student to come through [Case 100 Faculty] that's undergraduate and graduate, without exposing them to significant learning in this area (Case 100 MPH Program Director).

> In the past until this year you could have gone through the [Case 200] MPH and never taken a course on the social determinants of health, and so not been exposed to the way in which you know power dynamics related to racism, sexism, etc. might be influencing the conditions under which people are born, grow, live, work, and age. You didn't have to take a course on the harmful history of colonization and why that's a reality, you know for shaping public health outcomes right now… So that's one way in which we've transformed the pedagogy to make sure that no one's leaving our degree program without those things (Case 200 MPH Program Director).

In the case of Case 200, the program has two mandatory courses— maintaining a more advanced 500-level Indigenous public health course that was previously an elective, and reserving seats for MPH students in a more introductory 400-level Indigenous public health course that was re-introduced into course offerings. These two courses were established to meet the institution's Indigenous Strategic Plan (2020) in response to calls to action put forward by the TRC and other seminal reports (Participant 201). Moreover, informed by feedback from students, having two courses provides a culturally safe space for [primarily] Indigenous students to explore topics related to Indigenous health in depth, while also ensuring that students with limited background are provided an opportunity to gain a foundational knowledge (Participants 202, 203, 207; [Case 200] Truth and Reconciliation webpage). This structure is anticipated to mitigate concerns around exposing students to potentially culturally unsafe learning environments, which could result from requiring students to take a course that they may not perceive as relevant to their learning needs for their career (Participants 103, 104, 105, 202, 206, 207). However, based on Case 100's first year of mandating the course, these concerns have not materialized (Participant 103) (See **Compatibility**). To supplement the mandatory course in Indigenous health, Case 200 also requires students to participate in mandatory professional development sessions that take place outside of class, and starting in 2021-2022 included a session that focuses exclusively on reconciliation (Participant 202).

Case 300 is moving in a similar direction with taking initial steps to eventually require students to complete an introductory course in Indigenous peoples' health (see **Planning and Executing**). For now, the program is unique in that they offer two areas of focus, Social Policy and Indigenous People's Health, of which MPH students must select one that determines their learning pathway. Within the Indigenous People's Health stream, cultural safety and anti-racism training is woven throughout the three required courses ([Case 300] Graduate Program Handbook). Within one of these three courses, there is a two-week unit with a specific focus on cultural safety. These courses are required for students enrolled in the Indigenous People's Health area of focus, but also available as an elective for other MPH students=](Participants 301, 302). Although some MPH students may complete the program without registering in one of the three Indigenous Health courses, all students are required to participate in a 90-minute session on cultural safety that is part of the orientation (Participants 301, 305, 306, 308, 309, 310, 311). Both Case 300 and Case 100 also bring in a local Indigenous Knowledge Holder or Elder to offer a welcoming and grounding teachings during their MPH orientations.

To varying degrees, cultural safety and anti-racism training is scaffolded throughout core courses and elective courses in MPH curricula:

> You know it's not as if we're saying we have one whole course on cultural safety, that's not the case. I think what we're doing is… weaving it through a range of our curriculum and multiple spaces… that's where the whole is larger than the sum of the individual parts. And over time… do more cross fertilization… (Participant 202).

Currently, participants and departmental reports show evidence of integration in MPH courses such as core courses in public health practice (Cases 100, 300), social determinants of health (Cases 100, 200, 300), health promotion (Cases 100, 300), public health interventions (Case 300), program planning and evaluation (Cases 100, 200), knowledge translation (Case 200), health ethics (Case 200), and Canadian healthcare policy (Case 200). However, data is somewhat skewed because, although all faculty across the three case sites were invited to participate in an interview or focus group, there is a significant representation of faculty from Case 200 because they co-organized

a faculty forum that brought together 16 faculty members and administrators who teach in the MPH program. To corroborate interview data, Case 300 conducted a syllabus review (2019-2020) that reported that 50% of MPH courses (excluding Indigenous Peoples' Health courses) included Indigenous-focused content, and further reported "inclusion of cultural safety in some courses" ([Case 300] Celebrating Indigenous Ways Syllabus Review). As noted above, across the three cases there were mixed reviews of whether Biostatistics and Epidemiology are effectively integrating themes related to cultural safety and anti-racism. For Case 100, students and faculty alike commended the efforts of one instructor to incorporate Indigenous ways of knowing and anti-racist practices, but noted that "The course on epidemiology is a sort of shifting domain in a sense for inclusion of these concepts and depends on the instructor" (Participant 101). For Case 200, on the other hand, multiple students, who will remain anonymized, expressed concerns that any Indigenous or race-based examples provided in these courses were "problematic," "stigmatizing," "decontextualized," and "unsettling." Finally, for Case 300, students commented that they would "love to see a little bit more innovation in how that content [epidemiology and biostatistics] is delivered… I wouldn't say that it was absent entirely, but really kind of reframing, approaches to teaching… kind of humanizing it a bit and taking more of a relational approach" (Participant 304).

Students across the three cases also pointed out that there is room for improvement in fully integrating cultural safety and anti-racism training to achieve horizontal and vertical scaffolding. For Case 100, the training was perceived among students as largely front-loaded in the first semester, with the exception of the Indigenous health course, which they take towards the end of their studies (Participant 109). In contrast to what faculty reported in the Case 200 faculty forum, students commented that cultural safety and anti-racism training is siloed and only found in Indigenous health courses.

> I'm in one of the classes we're administering right now on Indigenous health, and I took the other one that was offered. And I have really enjoyed them and found a lot of value in them, but it feels like it's in a vacuum. It's like that's the only place in the context of like anti-racism, cultural safety, colonialism is talked about… It feels a little disingenuous. Like, okay, like we did our job and like these are the only

> things offered rather than incorporating that into the broader curriculum (Participant 205).

Similarly, students from Case 300 reflected on their initial impressions that the brief or "blitzed" (Participants 305, 307, 309) introduction during the orientation was a "snippet of what's to come… throughout the entirety of the program" (Participant 308); however, for those who elected for the Social Policy area of focus, it fell short of their expectations in that regard. Some students in the Social Policy stream mentioned that cultural safety and anti-racism are not embedded in the core curriculum and there has been minimal discussion of the concepts since the orientation. As such, in retrospect, they felt like the introduction during the orientation came across as a "tick box… an add-on or an extra or an afterthought" (Participant 309). Other students, however, had different experiences within the same stream: "I feel like it's kind of woven into every single thing that we do. So, it wasn't just like that one-off… It's been a consistent theme" (Participant 310).

Beyond the perception that cultural safety and anti-racism training are siloed in the curriculum, students at all three of the case sites thought that elements of the training are absent altogether. There was general consensus among students that there was an emphasis on Indigenous cultural safety and that anti-racism is missing from the curriculum, unless initiated by students (Participants 206, 207, 305, 306, 310, 311). The realization of this void generated reactions of surprise, disbelief and even laughter:

> Participant 310: … I actually haven't even realized until this conversation that we never talked about anti-racism just because in my head, it's a space where we would, and I feel like there's many common themes, but like, yeah. Like that's never, never…
>
> Participant 311: No. Not even – not even those words, like I don't think I've ever [Laughter]
>
> Participant 306: [Laughter] Yeah. So, sorry I shouldn't laugh. It's just like… The separation is kind of silly.

A similar reaction was shared by a student in another case site, evidencing a common shortcoming in curricula: "Nothing. Literally, when I tell you nothing, I literally mean

nothing [Laughter]" (Participant 206). For this same student, however, the glaring omission evoked frustration and anger: "I've never seen it. Like honestly. And that's why I don't feel comfortable in these spaces… Like I felt like I was being gaslighted my whole degree."

Delivery

Cultural safety and anti-racism training is delivered in a variety of formats, including in-person seminars, online lectures, recordings of presentations, online modules, discussion forums, experiential learning, applied learning through practicums, as well as modelling and mentorship. Consistent with most graduate programs in western universities, lectures were the standard delivery format, ranging from 1 to 3 hours in duration. However, between 2020 and 2022, COVID-19 shifted lectures from in-person to online, relying on Zoom for synchronous sessions or pre-recorded lectures for asynchronous learning. Challenges with lecture-based delivery were noted by faculty and students, not least of which being the limitation of time, since a one-hour presentation could barely scratch the surface of these complex topics (see **Complexity**).

With the temporary transition to online learning, Case 300 had a head start, as the MPH program has always been primarily online, with the exception of three required on-campus components: orientation, a one-week intensive course, and a culminating conference. Participant 103 remarked, "It turned out to be really serendipitous because when the whole world went online, [Case 300] was obviously at a very distinct advantage, having done it for five years before the pandemic." Case 300 uses online modules and discussion forums as the core structure for teaching and learning. As one of the primary spaces for engagement and sources of student assessment, discussion forums bring their own advantages and disadvantages (see **Relative Advantage**).

Case 100 has taken an experiential approach to cultural safety and anti-racism training, which is intentionally built into both the mandatory Indigenous health course and the core public health practice course. For instance, in the Indigenous health course, students participate in field trips to local organizations, such as FNHA, where they have an opportunity to engage with policy analysts, medical doctors, nurses, epidemiologists, etc. (Participant 103). Similarly, in students' first semester of the MPH program, they are required to attend a full-day immersive workshop that takes place outside of the classroom in settings such as a Friendship Centre, a dedicated Indigenous healthcare

center, a First Nations community or simply on the land on campus. The value of experiential learning and its appropriateness for cultural safety and anti-racism training is articulated by Participant 101:

> I think the fundamental challenge for this kind of work within our curriculum, is that it's done within a classroom, and one can try and make it more real for students by bringing people into the classroom who can share their lived experiences... Finding ways of integrating those kinds of experiences into teaching, I think, are exciting, they make things real for students, but they're difficult to organize and plan because it's so different to what one normally does in class.

Students who participated in the experiential learning similarly shared that they valued the opportunity and that it was impactful in their learning; however, they also mentioned drawbacks associated with designing training interventions to take place outside the classroom setting. In particular, the full-day immersive workshop took place on a weekend and attendance was mandatory, which was inconvenient for students with jobs or family commitments (Participants 108, 109).

Closely linked to experiential learning is applied learning through practicum placements, which is a defining characteristic of MPH training and a requirement of accredited MPH programs, such as Case 100. As described in Case 100's 2015 Council on Education for Public Health (CEPH) Accreditation Final Report:

> The one-semester practicum is designed as an opportunity for graduate students to apply public health concepts, methods and theory to real-world settings in Canada and globally, bridging theory and practice. It is a planned, supervised and evaluated experience in which students are mentored and supported by prescreened public health supervisors and faculty. There are a variety of practicum sites, local and far away, and site visitors learned that sites have served as an excellent bridge to employment.

All three MPH program directors highlighted the practicum as an important milestone by which students should already complete cultural safety and anti-racism training to prepare them to enter the public health practice environment; they also framed the practicum as an important learning opportunity for students to continue to reflect on and apply the knowledge and skills they cultivate through their coursework. Some of the students also mentioned that their practicum placements provided valuable opportunities to enrich their learning (Participants 111, 304).

A final mechanism by which cultural safety and anti-racism training is imparted is through modelling and mentoring. In particular, one student completing Case 300's Indigenous Peoples' Health area of focus emphasized the impact that professors had on her learning journey through modelling and mentoring:

> I remember the instructor, and I was like just blown away by her ability to facilitate and create an environment of like cohesion and relationship building in a virtual space… There is so much emotion and personal sharing and just opportunities for connection. I actually… I don't remember what the curriculum was [Laughter] like the material that we were learning, but it was more the connection piece that stood out. And then I ended up approaching her to be my thesis supervisor, and we really fostered like a mentor relationship afterwards. So, that's what I took away from this (Participant 304).

Most mentorship relationships are informal and outside of the MPH curriculum; however, Case 200 has established a peer mentorship program, and introduced special programming and dedicated resources for Indigenous peer mentoring in 2021-2022 (Participant 202).

4.2.3. Innovation Source

CFIR Definition: Perception of key stakeholders about whether the innovation is externally or internally developed (CFIR Research Team-Center for Clinical Management Research, 2023).

Because cultural safety and anti-racism training interventions are not standardized within or across MPH programs, the innovation source is a variable that determines a range of factors in uptake and implementation. As mentioned above, individual instructors and sometimes collectives of faculty and administrators have a great deal of influence over the content in the curriculum and mode of delivery (Participants 101, 102, 103, 105, 107, 108, 111). Generally speaking, faculty members are given freedom to design their course syllabi as they see fit. Administrators (e.g. program directors, deans) also play an instrumental role in leading change in their respective departments and faculties (see **Champions**). Participants commented on the role administrators play in mandating cultural safety and anti-racism training, designing and updating curricula, teaching courses that embed this training, encouraging and inviting faculty to participate in implementation, coordinating curricular scaffolding across courses, allocating resources to prioritize this work, evaluating efforts, etc. (Participants 101, 102, 105, 202, 302).

Instructors and administrators are also receiving substantial input from students and teaching assistants (see **Engaging** and **Other Personal Attributes**), who in themselves are an innovation source through a variety of means. For example, students initiate conversations in discussion forums or in-class discussions; they share insights across professional settings and jurisdictional contexts; students support efforts to facilitate peer mentorship; instructors defer to students with lived experience or professional experience to answer questions in class; TAs and students provide feedback that has catalyzed priority setting and curricular reform; and senior students or alumni advise on curriculum refinement and deliver guest lectures (Participants 101, 106, 202, 204, 207, 214, 215, 218, 301, 303, 305, 306, 310, 311). Case 200's program director admired the leadership of students: "Our students are such savvy thinkers at this moment in time culturally and politically, where they're like, 'Is that enough? Is that good enough? Are you sure you're taking full responsibility?'" Participant 301 similarly commended, "I've seen this real growth in students' expectations and their willingness to call instructors out, call programs out, like really be vocal and resistant to racist comments in the classroom." At Case 100, participants were inspired by the initiative of the Graduate Student Caucus, who circulated an open letter calling for anti-racism action in response to the murder of George Floyd.

In some cases, the innovation source of cultural safety and anti-racism training is external to the academic unit hosting the MPH program. Guest lecturers have been

brought in to support curriculum development and delivery, including subject matter experts, community members with lived experience, Indigenous scholars, Indigenous Elders and Knowledge Holders, and professional Indigenous cultural safety training facilitators (Participants 101, 102, 104, 108, 109, 213, 218, 307, 309). Students appreciated the value added through learning from individuals with lived experience or professional experience, but also commented that they would like to see more diverse voices amplified, including community-level practitioners doing activism or advocacy work and/ or members of marginalized communities that are often silenced (Participants 108, 306, 307, 310, 311). Training is also sourced from outside expertise through experiential learning activities that bring students outside the classroom to learn from professionals in the field and/ or Indigenous communities or organizations (Participants 101, 108). However, for resource reasons (see **Available Resources**), they are moving towards "bring[ing] this in house to have the capacity within the program to do this work" (Participant 101). Case 200 is working to partner with a Unit on campus that has an established program for delivering Indigenous cultural safety training to students, staff, and faculty (see **Pre-Implementation & Planning**) (Participants 201, 202). The Unit is closely involved in the development and delivery of the introductory-level Indigenous health course that Case 200 has recently made a requirement in their MPH curriculum (Participant 207).

4.2.4. Evidence Strength & Quality

> CFIR Definition: Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the innovation will have desired outcomes (CFIR Research Team-Center for Clinical Management Research, 2023).

Across the data, there were very few references to the quality of evidence supporting the effectiveness of cultural safety and anti-racism training interventions. Participant 104 reflected on the challenge of measuring or quantifying "transformation" resulting from any kind of training, but especially Indigenous cultural safety. Similarly, Case 200's President's Task Force on Anti-Racism and Inclusive Excellence Report provided a critical reflection of the evidence supporting anti-racism within EDI training interventions:

> [Case 200 institution] … the overall effectiveness of these initiatives is questionable. The delivery of EDI training remains fragmented and inconsistent. There is no way of

> knowing whether the training participants embrace the materials and apply their learning to their interactions with Indigenous, Black and People of Colour (IBPOC) or their decisions affecting the lives of IBPOC. Learners often see these experiences as abstract and irrelevant. Finally, the depth and adequacy of specifically anti-racism coverage in these EDI initiatives remain a mystery.

One student participant surmised that in western academia, "quantitative data is king… and qualitative data, lived experience just isn't as important— that's not 'real evidence'…" and as a result, uptake of these interventions is slow because "other types of learning and incorporating stuff like anti-racism and cultural safety… it's just not as evidence-based. Like, very much not what they [mostly faculty] consider valuable evidence" (Participant 205). Faculty, administrators, and institutional reports supported the claim that academic institutions— as Eurocentric/ colonial settings (see **Culture**)— favour certain types of data, contributing to the underrepresentation, misrepresentation, misinterpretation, and dismissal of some forms of evidence, including knowledge systems stemming from Indigenous, Black, African, South American, and Asian cultures. As an example, "In classroom environments, Indigenous worldviews are diminished, often portrayed overtly or passively as inferior 'myths' in comparison to Eurocentric models of knowledge origin stories" ([Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022).

To counteract the dominance of Eurocentric conceptions of valid or rigorous evidence, faculty, administrators, and students are holding space for Indigenous worldviews/ knowledge systems/ ways of knowing, stories/ storytelling, and lived/ living experience to be incorporated into teaching and learning (103, 104, 105, 301; [Case 300] Celebrating Indigenous Ways Syllabus Review Report; [Case 300] 2020 Syllabus Template). One of the promising practices is a Two Eyed Seeing[1] approach that blends rigorous evidence as found in academic literature and research with community voices, perspectives and stories. This approach is modelled by the aforementioned Indigenous cultural safety

[1] Two-Eyed Seeing, or Etuaptmumk, is a widely-accepted guiding principle developed by Mi'kmaq Elder Albert Marshall, who explained it as "Learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing… and learning to use both these eyes together, for the benefit of all" (Iwama, Marshall, Marshall, & Bartlette, 2009).

training program offered by a Unit associated with Case 200; one participant explained the evidence behind Two Eyed Seeing as follows:

> In the evaluation data, overwhelmingly, those stories, and the kind of heart centered human type approaches that we really value, have the biggest impact in the data; but I think, well I know it's also made stronger by being backed up by research and data, being in an academic institution. But the stories are what students— and the facilitator too— what we all come back for (Participant 201).

4.2.5. Relative Advantage

CFIR Definition: Stakeholders' perception of the advantage of implementing the innovation versus an alternative solution (CFIR Research Team-Center for Clinical Management Research, 2023).

Conversations around relative advantage gravitated towards the pros and cons of online compared to in-person learning, with attention to the compatibility or incompatibility of online delivery for cultural safety and anti-racism training. The focus on modality is likely influenced by both the inclusion of one online MPH program as well as the data collection taking place during the COVID-19 pandemic, which caused in-person programs to transition online.

Multiple students from Case 300 shared their reasoning behind selecting an online program and why it suited their learning needs, including but not limited to the flexibility it offers to accommodate professional commitments, geographic location, financial constraints associated with relocating, family or community commitments, etc. (Participants 304, 309, 310). Online modalities also come with advantages for engaging with topics related to cultural safety and anti-racism, such as creating space for students to initiate in-depth conversations about topics that may not otherwise get covered in the formal curriculum (e.g. anti-racism); and also allowing time for students to process content, reflect, and prepare thoughtful responses (Participants 305, 306, 310, 311). It further has the unique advantage of facilitating co-learning among peers, who may be participating from across the country or across the globe, and/ or may be bringing professional experience from practice settings that provide real-life examples to help

contextualize the learning material (Participants 306, 310). However, for both students who electively enroll in an online program as well as students who did not have another choice due to the pandemic, online learning also comes with disadvantages. Drawbacks include learning curves with optimizing technology (Participant 309); fatigue from extended periods of engaging in virtual spaces (Participant 111); feelings of loneliness, disconnection, and isolation (Participants 109, 304, 306); and various communication barriers expanded upon below. With regards to communication, participants shared challenges they experienced with being misunderstood or fearing being misunderstood, in part due to the limited ability to convey or decipher tone through written discussions (Participants 309, 310, 311). They also expressed hesitation with having a written record or permanent record of an idea that is not fully formed or may be counter to popular opinion (Participants 305, 306, 309). Participant 306 reflected, “You are a bit censored when you’re typing something on the computer. And like you lose that sense of comfort, I think.” Furthermore, Participant 307 offered, “I know for me, I’m quite comfortable discussing things face to face, asking harder questions, having more productive conflict per se than in a forum.”

The challenges with communication in online learning mirror the perceived advantages of in-person learning. Advantages include quality of engagement and in-class discussions enriching the learning (Participants 109, 207, 302, 303, 306); and also the opportunity to build relationships, which fosters trust and accountability (Participants 304, 310). One sessional instructor that teaches in-person and online at both Case 100 and Case 200 commented that it is more difficult to facilitate dialogue in online courses and that conversation is more free-flowing in a classroom setting (Participant 204).

Nevertheless, there are disadvantages that are common for both online and in-person modalities. In particular, a significant theme across all three case sites is the complexity of cultivating a culturally safe environment (Participants 103, 104, 105, 201, 202, 206, 207, 301, 304, 305, 306, 310, 311). This concern is present throughout the findings, illustrating the interconnected and layered nature of its impact as an implementation determinant (see **Design Quality & Packaging** and **Culture**). Conversations about sensitive topics can result in tension or expose students to micro-aggressions, harm, and/ or lateral violence (Participants 301, 304, 306, 310, 311). With direct relevance to the relative advantage of online or classroom-based interventions, one faculty member has taken measures to adapt the curriculum in light of this consideration:

> … Racist comments in the classroom to culturally unsafe [interactions]— and in my classes I've seen the same thing. To the point where I don't do, like, because it's all online I don't do discussion, like, allow any kind of online discussion between students anymore because it can be very unsafe… The more I heard about you know unsafe stuff and then I thought, this is because you can't monitor it, right. Once it's out there, once it's been written down by a student, you can't take it back it's not like in a classroom where you can manage students, and in a much more direct way and in a very timely way. You know, if someone starts to say something inappropriate, you can take them out of the room and you can address it there and you can even address the harm, trying to mitigate the harm; but not online you can't do that. So I've been quite vocal about that in my School about, like, making sure that you know Indigenous and other BIPOC students are not harmed in these online environments (Participant 301).

4.2.6. Adaptability and Trialability

CFIR Definitions (CFIR Research Team-Center for Clinical Management Research, 2023):
Adaptability: The degree to which an innovation can be adapted, tailored, refined, or reinvented to meet local needs.
Trialability: The ability to test the innovation on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted.

All three case sites were forced to adapt their MPH curriculum to online learning between 2020 and 2022 as a result of the COVID-19 pandemic. This includes Case 300's online MPH program, which had to adapt their on-campus orientation, one-week intensive courses, and culminating conference (Participants 301, 302, 304, 307, 308, 309). Once again, the onus was largely on instructors to adapt their courses, with some departmental or institutional supports (Participant 204). Because of the rapid transition and the unpredictable duration of the policies, the process of adapting to online

modalities was initially guided by trial and error. The pandemic also affected Case 100's approach to experiential learning. Their curriculum has undergone several iterations of full-day immersive workshops and guest lectures that included bringing students to a Friendship Centre, a dedicated Indigenous healthcare center, and learning about Indigenous plants and medicines on the land (Participant 101). Between 2020 and 2022, while courses were being delivered online, this component of the curriculum was replaced by guest lectures from experts in the field of cultural safety and anti-racism.

Cultural safety and anti-racism training interventions were described as adaptable across disciplines, such as nursing, medicine, and social work, and can be tailored to public health curriculum (Participants 103, 201). A key informant from the academic unit with an Indigenous cultural safety training program affiliated with Case 200 commented, "right now, we have a mandate for health at [Case 200], but the sky's the limit" (Participant 201). However, she also mentioned limitations with scaling up, spreading, and adapting, which has contributed to delays in extending the programming to the MPH program (see **Planning and Executing**). One of the key challenges with expanding the program is related to the demands on training facilitators, as the emotional labour involved can lead to burnout (Participant 201) (see **Complexity**). Burnout for instructors and sustainability of models that require the same person to teach this content every year was also expressed as a concern in Case 100. In response, Case 100 is piloting a model of co-teaching that pairs a senior non-Indigenous faculty member with a more junior Indigenous faculty member to deliver a course on Indigenous health. The intention is to alleviate burnout and mitigate negative interactions and micro-aggressions in the classroom (Participants 104, 105). The course is currently being piloted as an elective outside the MPH curriculum, with the intent of trialing the approach, then revising and replicating as appropriate. Interestingly, the strategy of pairing an Indigenous instructor with a non-Indigenous instructor resembles the co-facilitation model embraced by the Indigenous cultural safety training program, which has been noted as very successful and well-received (Participant 201) (see **Other Personal Attributes**).

Participants also shared insightful reflections regarding humility and transparency around recalibrating direction, correcting course, or reversing course. This surfaced disagreement around the pace of innovation. Some participants made the observation that academic institutions should, in theory, encourage experimentation and trialability, and yet the pace of change within these settings is "glacial" (Participants 102, 203):

> It's the strangest irony of I think of universities, they pride themselves on innovation and new ideas and experimentation. But absolutely elephants when it comes to actually making any change within their own institutions (Participant 102).

> There's a kind of school culture of not wanting to make a mistake doing it. It's really interesting to see institutions with power being nervous about making mistakes; but they're not recognizing that if we just continue what we're doing, we're using that power to reinforce the status quo. And so a fear of making mistakes to disrupt the status quo causes us to do little or, you know, less than we might wish. And so that is a really interesting tension. And that fear or nervousness or anxiety it's well intentioned, and it is maybe even well founded, and yet it's this double-edged sword (Participant 202).

There was agreement that the culture of academia puts pressure on individuals to produce rapid results, yet some participants supported a slower and more intentional approach:

> … Let's hold to good processes let's continue to walk gently down this path rather than trying to push ahead (Participant 302).

> … When you're in a results-oriented capitalist institution, like there is pressure to always produce and perform… Like good things take time. I would actually more respect them saying like, 'Let's just pause this for a second and just like really do a deep dive, and we'll come back when we got our shit together,' rather than being like, 'We are pressured and now let's just put something up,' because you actually cause more harm that way (Participant 206).

This tension around the demand for timely action and the pursuit of perfection presumably made it challenging for participants to openly reflect on initiatives that were not successful or that needed to be adapted or de-implemented.

4.2.7. Complexity

> CFIR Definition: Perceived difficulty of the innovation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement (CFIR Research Team-Center for Clinical Management Research, 2023).

The nature of cultural safety and anti-racism training interventions is inherently complex, "messy" (Participant 102; [Case 100] 2022 Reconciliation Report, 2022), and "fraught with tension" (Participant 301); yet at the same time, it is built on fundamentally simple principles (Participants 302, 306, 311). One of the elements that make these interventions so complex is that it encourages and in fact requires participants to step outside their comfort zones and work through their discomfort by confronting their own preconceived biases, unearned privileges, ignorance, denial, complicity, and ways in which they perpetrate or perpetuate harm (Participants 103, 105, 206, 310, 311). The content can also be triggering for BIPOC students, when discussing content of a sensitive nature such as residential schools, colonization, genocide, racism, among others. These interventions can similarly take a toll on the individuals delivering the training because of the emotional labour that is demanded of them, particularly when the instructor, facilitator or guest speaker is teaching from a position of lived experience and/ or sharing stories of trauma or tragedy (Participants 101, 103, 104, 201, 202, 301).

Another complexity associated with cultural safety and anti-racism training interventions is that it embodies counterculture in the sense that it challenges dominant cultural norms that permeate academia and wider society (see **Culture**). [Case 200]'s President's Task Force on Anti-Racism and Inclusive Excellence Report explicitly labels this challenge in implementing changes related to anti-racism "… we appreciate the many potential hurdles to implementation. The requisite changes could potentially threaten the long-established, White-dominated power structure…" Because the aim is transformative change, it takes a great deal of time. Moreover, it requires lifelong learning, engagement and practice that surpasses the boundaries of a single lecture, module, course, practicum placement or degree (Participants 102, 103, 104, 206, 210, 302, 305, 309).

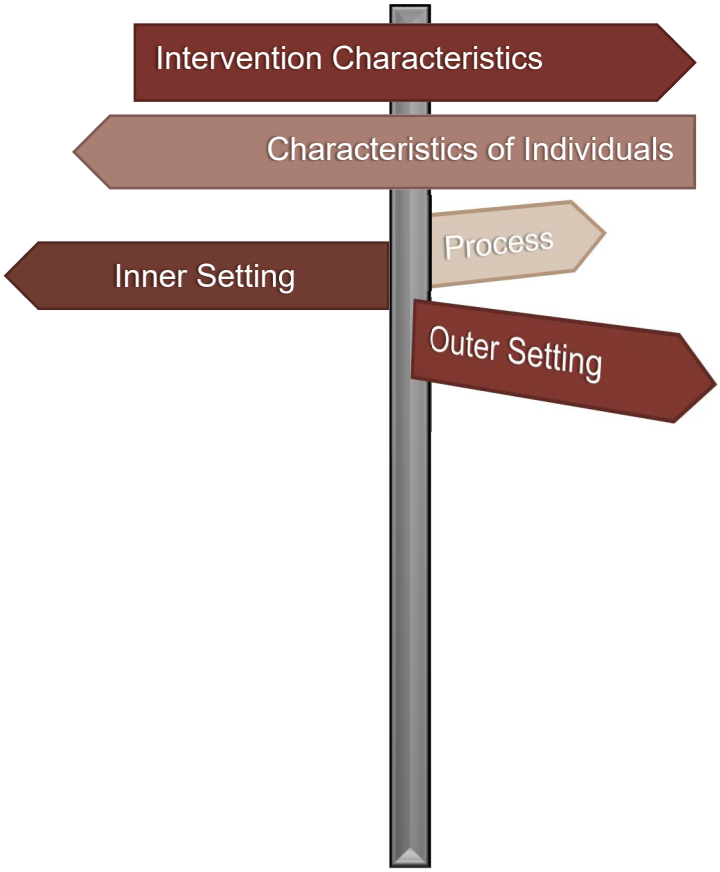
4.2.8. Cost

> CFIR Definition: Costs of the innovation and costs associated with implementing the innovation including investment, supply, and opportunity costs (CFIR Research Team-Center for Clinical Management Research, 2023).

See also **Available Resources**

The primary cost associated with cultural safety and anti-racism interventions within MPH programs is remuneration for instructors. Some of the most prominent barriers noted were time and capacity of existing faculty; as a result, MPH programs are allocating funds to pay honouraria for guest speakers and sessional instructors (Participants 101, 203) (see **Available Resources**). During the Case 200 faculty forum, an idea was proposed to appoint a curriculum lead for anti-racism to facilitate the expansion of this topic area in the MPH curriculum; this was presented as a "relatively modest cost" (Participants 202, 203) compared to longer-term solutions such as recruiting and hiring more Indigenous instructors.

Another cost-related barrier came up around funding faculty-driven initiatives. Participants from Case 200 expressed disappointment and feelings of demoralization that within the department, funding had been cut for a reconciliation audit that was underway. As a result of the funding cut, the initiative came to a halt prior to completion (Participants 203, 207) (see **Reflecting and Evaluating**).



4.3. Characteristics of Individuals

Research Objective: Identify the key individuals and groups influencing uptake and implementation, and/ or directly involved in implementing cultural safety and anti-racism training in MPH curricula within each institution.

4.3.1. Knowledge & Beliefs About the Innovation and Self-Efficacy

CFIR Definitions (CFIR Research Team-Center for Clinical Management Research, 2023): **Knowledge and Beliefs About the Innovation:** Individuals' attitudes toward and value placed on the innovation, as well as familiarity with facts, truths, and principles related to the innovation. **Self-Efficacy:** Individual belief in their own capabilities to execute courses of action to achieve implementation goals.

Across all three case sites, faculty and administrators self-reported that they and their colleagues place value on cultural safety and anti-racism. This is embodied by institutional- or unit-level priority setting (see **Relative Priority**) as well as individual-level commitments to engage in self-learning and action (Participants 101, 102, 105, 107, 202, 301). While it is not surprising that participants who chose to contribute to this study deemed this topic important, they also noted that "… Everyone is trying; there isn't any sort of active resistance" (Participant 102), and that while individuals may not take a leadership role in its implementation, they are "very supportive of and very engaged in the process" (Participant 301) (see **Tension for Change**). Yet, Case 200's President's Task Force on Anti-Racism and Inclusive Excellence Report tells a different story of "widespread denialism" pertaining to the presence and severity of racism across the institution, suggesting there may be some ambivalence, dismissal, or opposition—whether internal or external to the MPH program (see **Culture** and **Compatibility**).

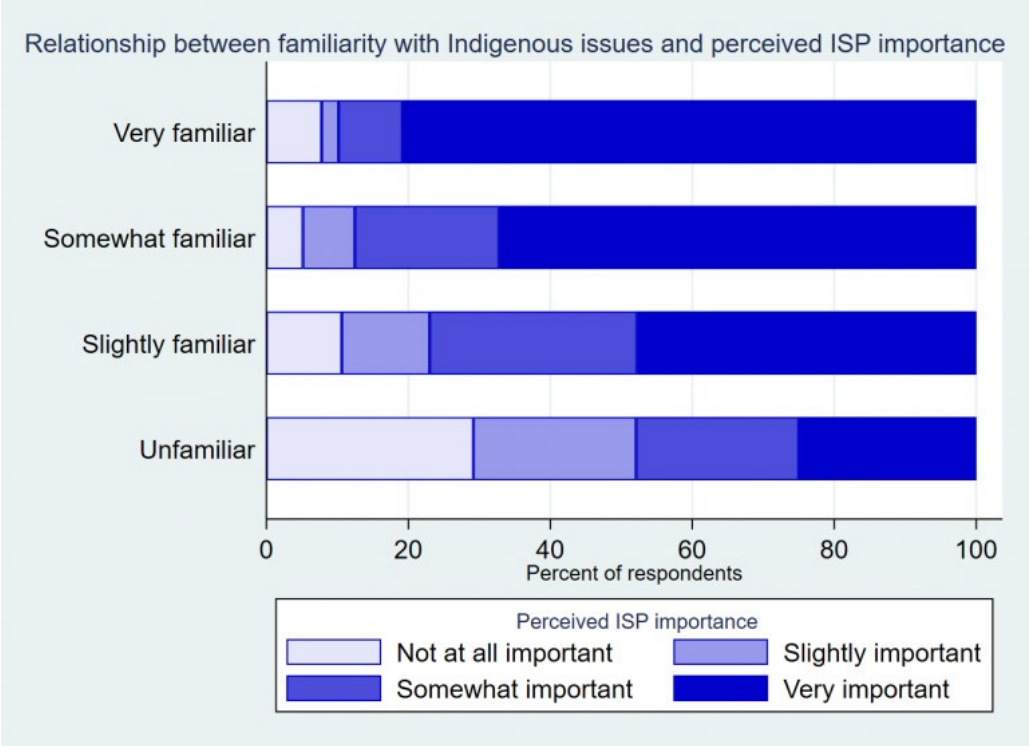
Some participants expressed that the level of understanding and uptake is inconsistent across the academic unit. In particular, Participant 101 clarified:

> I'm not using the royal we here, but I think I'm really referring to individual colleagues of mine who are more focused on integrating this content and these perspectives and issues into their own courses in their own curriculum… But I do

> think that it's not necessarily an understanding that is sufficiently understood across the whole faculty.

This inconsistency in familiarity with the topics is particularly pronounced among faculty from outside Canada. The correlation between perceived importance and familiarity is clearly illustrated by Case 200's Indigenous Strategic Plan (2020), which assessed this relationship in the context of advancing Indigenous rights and reconciliation across the institution. The following graphic depicts a positive correlation between self-reported familiarity with Indigenous issues and perceived importance of implementing the Indigenous Strategic Plan (2020) in their courses, faculty, school, or unit (N=1,273).

Figure 3. [Case 200] Indigenous Strategic Plan (2020)



One of the facilitators highlighted in the data is the relevant knowledge that faculty members bring, including subject matter expertise in cultural safety, health equity, Indigenous health, Indigenous rights and justice, decolonization and anti-colonialism, cultural determinants of health, social-structural drivers of health, among others. Faculty also bring skills related to scholarship of teaching and learning, Indigenizing curricula, and cultural safety education and facilitation (Participants 104, 107, 201, 217, 301; [Case 300] Graduate Program Handbook). However, many faculty also acknowledged that they and their colleagues lack requisite knowledge and/ or confidence to fully and

appropriately incorporate cultural safety and anti-racism content into their teaching (see **Individual Stage of Change**). This lack of knowledge among faculty was perceived as a barrier as noted by students (participant identifiers removed to preserve anonymity).

> If they're not already working on this topic, it's very difficult for them because a lot of them are kind of like fish out of water where they're like, "I feel now pressure to do this and I don't know what I'm doing."

> [There's] no one actually able to teach anything about cultural safety. Like even if they wanted to, all of a sudden implemented in all their classes, they couldn't… That's the biggest issue that I've seen is that there's no staff or faculty or researchers that are competent, or understand what to do… Like implementing the required Indigenous health course was hard enough because they're like, "Oh shoot, who's going to teach this?"

This lack of knowledge related to cultural safety and anti-racism training interventions is consistent with perceptions across institutions and other academic units, with faculty admitting that they are apprehensive to integrate Indigenous knowledge systems and ways of knowing into their teaching due to low self-efficacy ([Case 200] Indigenous Strategic Plan, 2020). Among participants, this hesitancy was most often expressed by faculty who identified as non-Indigenous/ racialized as white, but also came up in conversations with Indigenous faculty (see **Other Personal Attributes**).

In addition to varying levels of knowledge about cultural safety and anti-racism topics, faculty also have a range of skills and experience when it comes to facilitating these training interventions. Facilitation skills, in particular the ability to teach this material effectively and safely, were noted as both a barrier and a facilitator to implementation (Participants 104, 111, 201, 210). Some faculty bring extensive experience with developing and delivering Indigenous cultural safety training in academic settings as well as public health practice environments. Yet even those who have this experience recognize that there are limited opportunities to develop and hone one's skills in facilitating this type of training and staying up-to-date with pedagogical advancements:

> This kind of training is very difficult to do… And we don't provide them with any training themselves or support… But we throw people into full time jobs where they do nothing but cultural safety training with people who often don't want to be there, and some more overtly racist. And we ask those people to just do that all the time without training and without support (Participant 301).

> I'm very attentive to the need for that work to be taken up by people who have specific interest, expertise, and knowledge and that is especially current knowledge because I have not really been keeping up to date on, you know… what the best way of doing that training is (Participant 104).

Two opportunities for facilitation training were mentioned in the data. First, faculty within Case 200 who teach this content as part of their curriculum will soon have access to a faculty training program that is being developed by a Unit on campus that has a mandate to deliver Indigenous cultural safety training across health sciences within the institution (Participant 201). Second, one participant mentioned training they received as part of their education that provided professional development in facilitation and public engagement, grounded in evidence-based techniques (Participant 104).

4.3.2. Individual Stage of Change

CFIR Definition: Characterization of the phase an individual is in, as s/he progresses toward skilled, enthusiastic, and sustained use of the innovation (CFIR Research Team-Center for Clinical Management Research, 2023).

Across the three case sites, many participants acknowledged that they themselves or their colleagues are at an early stage of learning about cultural safety and anti-racism. This is a prominent theme that emerged in Case 200's faculty forum, where participants noted that it was a safe space to reflect on their role as learners and their desire to learn more. Participants also noted that it can be challenging to teach topics that as a professor you are learning (e.g. antiracism, intersectionality) because of the expectation that professors are the "expert" (Participant 204). Both faculty and students commented that they appreciated instructors' vulnerability and humility when it comes to openly

sharing their own learning journeys (Participants 204, 211, 304, 305, 307, 308). One student mentioned:

> [The instructors] are very receptive and I think like humble in their cultural safety learning journeys, and I hold my hands up to instructors that are really transparent about that. And so, I think I get the sense from most of the instructors that it is absolutely a focus of their work, but also their personal growth and development (Participant 304).

Faculty and administrators noted that as part of their learning journeys, they are engaging in self-guided learning by reading books and reports, participating in workshops offered through the university, completing PHSA's San'yas Cultural Safety Training, and following more BIPOC people on Twitter, for instance (Participants 101, 102, 105, 204, 208, 215). In Case 100 and Case 300, self-mobilized groups have formed to lead collective learning initiatives within their respective units (Participants 101, 105, 301, 302, 303) (see **Champions**). Whereas in Case 200, some participants commented that they feel like they have been left to their own devices to develop their knowledge base and grow their teaching practice (Participants 204, 208, 215) (see **Access to Knowledge & Information**).

While many participants described their stage of change as learning, participants also recognized that there has been significant growth in awareness, knowledge, skills, and enthusiasm among staff, faculty, and administrators in recent years (Participants 101, 104, 212) (see **Tension for Change**). There are also several subject matter experts who are in more advanced stages of change, whose focus is on advancing discourses; refining their pedagogical practice; supporting their colleagues; as well as spreading, scaling and sustaining cultural safety and anti-racism training interventions (Participants 101, 102, 104, 201, 210, 301) (see **Champions**).

4.3.3. Individual Identification with Organization

CFIR Definition: A broad construct related to how individuals perceive the organization, and their relationship and degree of commitment with that organization (CFIR Research Team-Center for Clinical Management Research, 2023).

Within the context of discussing cultural safety and anti-racism initiatives, participants had mixed feelings about the universities or academic units they are affiliated with. Administrators expressed pride in their respective departments/ faculties and the people within them: “I just think we're so lucky as a school to have so many amazing people… I am just constantly amazed by our people, staff, faculty, and students” (Participant 302). Another praising quote from an administrator (identifiers undisclosed) simultaneously highlights tensions around how BIPOC faculty relate to the institution:

> I think, only one colleague identifies as black... But we do have a culturally diverse group more generally beyond that. But I do know that my super talented, well regarded, award-winning scholar who would self-identify as black does feel a disproportionate responsibility to be representing that space.

The feeling of bearing a disproportionate responsibility to represent one’s cultural or ethno-racial group within a predominantly white space resonated with other faculty and students who self-identified as Indigenous or black (see **Other Personal Attributes**). These participants also shared feelings of tokenization, demoralization, embarrassment, and “tick-box fatigue” surrounding their affiliation with the institution (identifiers undisclosed). One participant divulged:

> … so not only are these pieces demoralizing for Indigenous people, they're demoralizing for faculty who are banging their heads against the wall around ‘guys we've got to do this’. And for me, I’m now at the space where I’m thinking like ‘is this really the institution that I want to be at?’… It's a great gig being a prof, it's hard, but it's a great gig. But I’m not necessarily that committed to [institution] anymore.

These sentiments are consistent with institution-wide reports that indicate that students, staff and faculty racialized as non-white feel disconnected or alienated, and lack a sense of belonging to the campus community ([Case 200] President’s Task Force on Anti-Racism and Inclusive Excellence Report, 2022). This indicates that one’s identification with an organization cannot be separated from one’s identity and socio-cultural location.

4.3.4. Other Personal Attributes

> CFIR Definition: A broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style (CFIR Research Team-Center for Clinical Management Research, 2023).

Indigenous Leaders

Undeniably, one of the most consistent and prominent themes across interview/ focus group data and documents is the important role of Indigenous leaders in the uptake and implementation of cultural safety and anti-racism training interventions. There is a clear justification for the need for leadership and direction of Indigenous peoples in this area of work, epitomized by the phrase “Nothing about us without us,” commonly used by FNHA but originating from the disability community ([Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 100] Reconciliation Report, 2022; [Case 200] Indigenous Strategic Plan, 2020; [Case 300] Indigenous Plan, 2017-2022). Participants emphasized that Indigenous health courses, which is where most cultural safety and anti-racism training is located within the curriculum (see **Design Quality and Packaging**), should be rightfully developed and delivered by Indigenous scholars— and where capacity exists, full-time faculty (Participants 101, 102, 203, 207). The representation of Indigenous peoples in these spaces is important to ensure authenticity of Indigenous knowledge being shared, enrich the learning through sharing from a position of lived/ living experience, help foster safe spaces, and enhance the educational experience for Indigenous students (Participants 105, 203, 213, 303, 304, 306, 311). Indigenous faculty, staff, and students are also recognized as essential leaders and resources in driving forward Indigenization and decolonization efforts to integrate relevant content throughout the MPH curricula (Participants 101, 104, 107, 108, 301, 302, 303).

Participants recognize that not all Indigenous scholars center their programs of research and teaching praxis around cultural safety and anti-racism— or related topics such as Indigenization, decolonization, EDI, etc. (Participants 101, 104, 301). Participant 101 explained, “We shouldn't just assume because a person is an Indigenous scholar, their main work is to do cultural safety training.” Nevertheless, due to the insufficient number of Indigenous faculty, Indigenous individuals are repeatedly asked or assigned to fill this gap in the curricula by teaching courses, training other faculty, or developing resources

for their colleagues. In addition to external pressure, Indigenous faculty expressed feelings of personal duty, as shared by two Indigenous women (identifiers undisclosed):

> It's an interesting time to be doing this kind of work as an Indigenous faculty member because you want to do the good work, you want to start to influence change and be on the front lines of that. But it can be really exhausting to take up a lot of time and energy.

> But we're being put in a position where that's an obligation we have, whether it's an obligation that is like forced on us by our directors, or we just feel an obligation to doing it right… so it's another burden on us, which again, we have a vested interest in doing it, so of course we do it.

The expectation that Indigenous faculty lead implementation of cultural safety and anti-racism training compounds with disproportionate demands for administrative tasks and service through committee work placed on BIPOC faculty (see **Organizational Incentives & Rewards**). Again, this finding directs us back to the unresolved concern around instructor burnout (see **Complexity**). As mentioned above, Case 100 is trialing various strategies to mitigate overburdening Indigenous faculty, including "buffering" the time commitments of newly-hired Indigenous faculty (Participants 101, 104, 105); establishing co-teaching arrangements (see **Adaptability and Trialability**); and hiring more Indigenous faculty (see **Available Resources**).

Indigenous students were also recognized as key leaders throughout the data. Expanding on the examples of student involvement noted in Innovation Source, Indigenous students make substantial contributions to the uptake and implementation of cultural safety and anti-racism training in a variety of ways, including but not limited to: bringing these topics into focus; sharing their own lived/ professional experiences; leading Indigenous peer mentorship programs; informing curriculum refinement; supporting facilitation as teaching assistants; teaching guest lectures on Indigenous health; consulting on priority setting; advising on cultural protocols; and/ or supporting efforts to decolonize and Indigenize (Participants 101, 105, 106, 202, 207, 301). While Indigenous students may feel impelled to help improve the quality and cultural safety of

education, this can also create a disproportionate burden. Several quotes from the data indicate a common experience within MPH programs and across the institutions whereby Indigenous students are inappropriately expected to be "experts":

> … They're kind of like looking to us but like, "Okay, well what do we do?" It's like, well why do I have to be the one to tell you?... [Laughter] Like it shouldn't be put on the students (Student Participant, identifiers undisclosed).

> … They basically like put the onus on the student to be the expert in Indigenous health, completely absolving themselves of any responsibility for it (Participant relaying the experience of a student, identifiers undisclosed).

> I don't want to be the "authority" on First Nations history. I don't want instructors or students turning to me to ask, "So, what was it like?" (Student quoted in [Case 100] Aboriginal Reconciliation Council Report, 2017).

BIPOC Leaders

Consistent with the finding that discussions largely centered Indigenous-specific cultural safety and that this overshadowed anti-racism and the experiences of other racialized groups, there were relatively few references to the role of BIPOC folks who are not Indigenous to so-called North America (see **Appendix C**). Of the references that did emerge, participants mentioned that faculty racialized as black or persons of colour are underrepresented and that recent recruitment efforts have been implemented to attract a more diverse and representative faculty complement (see **Available Resources**). Because these efforts are recent (relative to data collection), the data does not capture the ways in which BIPOC faculty are supporting or leading implementation of cultural safety and anti-racism training interventions. That being said, several participants highlighted the important role of BIPOC faculty and staff in advocating for and leading uptake of anti-racism initiatives (Participants 102, 302, 303). Particularly around the time of the heightened media awareness of police violence and the Black Lives Matter Movement (see **Tension for Change**), these voices championed uptake of anti-racism as a priority within their respective department/ faculty/ institution:

> … What's happened over the last year, I think there's a couple of people, it's not at all surprising women of color, who have recognized— who just are fed up, and basically said, you know, we cannot be complacent about these issues any longer. We have to have these conversations... We have got to have accountability among ourselves to each other… (Participant 102).

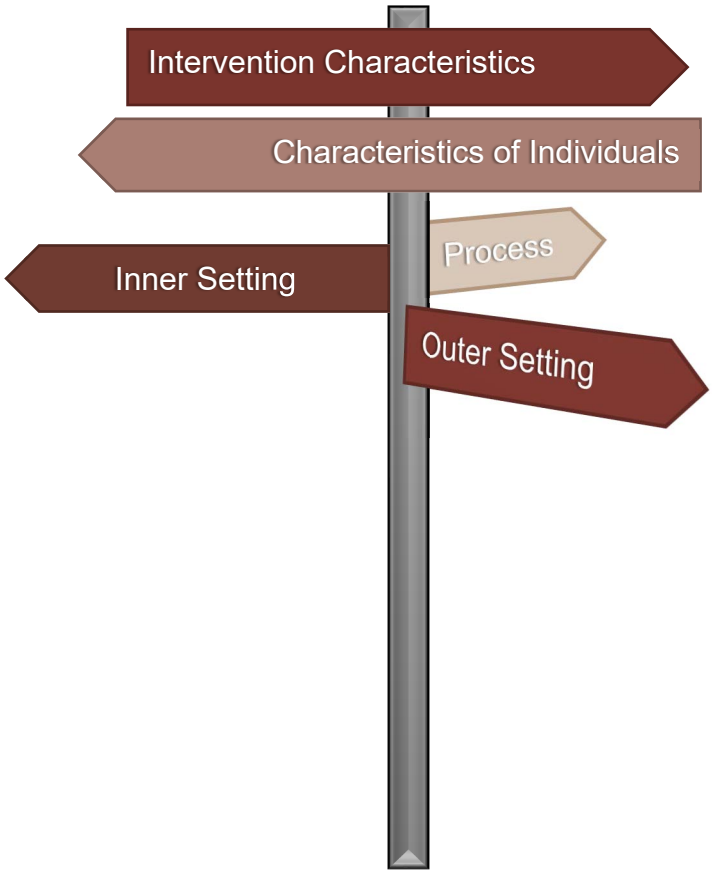
Allies

The role of allies (see **Key Concepts** for definition) in supporting the implementation of cultural safety and anti-racism training surfaced as a tension in the data, particularly around whether or not it is appropriate for them to be engaging in this work. Participants recognized the increasing number of allies in university settings who are willing and active in working in solidarity to disrupt colonialism and racism. Participants commented on their own or their colleagues' role as allies in facilitating or co-facilitating cultural safety and anti-racism training, supporting curricular reform to incorporate Indigenous perspectives, and/ or ceding space and creating opportunities for Indigenous peoples to lead this work (Participants 101, 104, 105, 201, 301, 302). However, they also expressed hesitancy or discomfort with engaging in these types of activities as a white ally, or shared stories of encountering others' reluctance that was not only associated with low self-efficacy (see **Knowledge & Beliefs about the Innovation and Self-Efficacy**) but also perceived inappropriateness around taking up space or need for permission (Participants 101, 102, 104). Indigenous leaders and recognized allied leaders in the area of cultural safety and anti-racism encouraged involvement of allies who have genuinely embraced the responsibilities of allyship in action and continuously demonstrate their commitment. These leaders shared the following sentiments:

> The responsibility needs to be placed across the faculty, and especially because cultural safety is not just about Indigenous— I mean, obviously it's about working with Indigenous people but it's a lot of work around doing that sort of reflective practice and understanding positionality and social location and all these kinds of things. So, you know, that's the work for allies and non-Indigenous faculty and others to do (Participant 104).

We [Indigenous Cultural Safety Training Program] very strongly acknowledge that this is both non-Indigenous people's and Indigenous people's work, and that we have different roles to play… It's just about knowing the boundaries, right, about what spaces you can and can't step into, and what you can and can't speak for (Participant 201).

I like to call her an ally, because I feel like she really takes on the responsibility, right, so doesn't try to sort of shift it over to Indigenous faculty or other Indigenous peoples to lead or to, you know, create the change… I really appreciate that, that she takes that responsibility on and that she actually does the work, so that the burden isn't always on Indigenous faculty members (Participant 301).



4.4. Process

Research Objective: Describe the stage of implementation from planning through sustainment, and how approaches or strategies have evolved or been adapted over time to capture the temporal context.

4.4.1. Engaging

Opinion Leaders, Formally Appointed Internal Implementation Leaders, and Champions

CFIR Definitions (CFIR Research Team-Center for Clinical Management Research, 2023): **Opinion Leaders:** Individuals in an organization that have formal or informal influence on the attitudes and beliefs of their colleagues with respect to implementing the innovation. **Internally Appointed Implementation Leaders:** Individuals from within the organization who have been formally appointed with responsibility for implementing an innovation as coordinator, project manager, team leader, or other similar role. **Champions:** "Individuals who dedicate themselves to supporting, marketing, and 'driving through' an [implementation]", overcoming indifference or resistance that the innovation may provoke in an organization

Indigenous faculty are well regarded as opinion leaders who influence the attitudes, knowledge, and behaviours of their colleagues in relation to implementing cultural safety and anti-racism training interventions. At each Case, there is at least one Indigenous person who is respected among participants for their expertise in Indigenous health and the reputation they have established in public health practice and/ or research. In Case 100, the Dean extolled, "we have senior mentorship from [name undisclosed], who… is a rain maker and a networker and a builder of connections and a mentor and a supporter." Yet, of these Indigenous leaders, only one of them is formally appointed in a role that is dedicated to cultural safety and anti-racism training or entails direct responsibility for its implementation. Since the program's early days, Case 300 has had an Indigenous scholar as part of their core faculty team; this individual is responsible for facilitating the cultural safety orientation session for all MPH students, and also leading the program's Indigenous Peoples' Health Area of Focus, which has always included cultural safety training in the curriculum. Additionally, this Indigenous scholar is deeply involved in

decolonizing the MPH curriculum and supports other faculty members to better understand cultural safety, cultural humility, land acknowledgements, how to incorporate Indigenous perspectives into their courses, etc.

Case 300 and 100 have both recently (2018-2023) hired Indigenous and/ or racialized faculty members, who have already begun— or are anticipated to begin— assuming roles that will lead or support implementation efforts (Participants 101, 104, 107, 303) (see **Available Resources**). Faculty members and administrators in Case 200 have had initial conversations about recruiting more Indigenous faculty and appointing a curriculum lead to help instructors usher cultural safety and anti-racism content into their courses (Participants 202, 203). These hiring initiatives mirror efforts across all three institutions to appoint leaders in Indigenization or anti-racism into senior leadership positions, which is a trend with growing uptake among academic institutions across the country (Participant 102). New positions have been created and filled within the past three years (2020-2022) to lead institutional action around Indigenous, anti-racism, and equity priorities, such as 'Director, Indigenous Initiatives and Reconciliation' (Case 100), 'Special Advisor to the President on Anti-Racism' (Case 100), 'Associate Vice-President, Equity and Inclusion' (Case 200), and 'Non-Academic Associate Vice-President Indigenous' (Case 300). Furthermore, Indigenous leaders are being hired into mainstream senior leadership positions, as in the case of Case 300, where "we now have an Associate Dean Research, who's Indigenous and an Associate Dean Academic in our faculty who are Indigenous. And that I think is going to shake things up a little bit, in a good way" (Participant 302).

Alongside faculty members, administrators and staff were identified as champions or agents of change in supporting the implementation of cultural safety and anti-racism training interventions. Staff were described as being committed to timely response and action with regards to calls to action, and have supported efforts to foster relationships with Indigenous groups on campus and decolonize curricula (Participants 202, 302). Program directors were identified as strong champions, especially in Case 100:

> We're fortunate to have [name undisclosed] as the director of the MPH program, who has a passion for these issues just, partly because of his own personal history and his own

> background and also partly because he believes in trying to embrace some of these values (Participant 102).

In Case 100, the program director incorporates cultural safety and anti-racism training into two core courses that he teaches in the MPH program, and does so by organizing experiential learning opportunities, inviting guest speakers, and delivering lectures that weave in reflections on his own learning journey (see **Design Quality and Packaging**). He has also championed a Decolonizing and Indigenizing Grant to evaluate and refresh the Indigenous Health Module within his core courses. In Case 300, a faculty member who is identified by Indigenous participants as an ally worked with a respected Indigenous scholar (mentioned above) and an Indigenous student to champion a grant that supported efforts to decolonize each of the courses in their program. In Case 200, a former student of the program who is Indigenous and has extensive experience as a leader in Indigenous health in BC's public health practice environment championed a Reconciliation Audit (Participants 203, 207) (see **Reflecting and Evaluating**). These champions were consistently referred to as key facilitators in the successful implementation of cultural safety and anti-racism interventions; however, participants also expressed concerns that over-reliance on individuals to lead change risks losing momentum or losing the intervention altogether in the event that the individual retires or is recruited elsewhere without a successor in place (Participant 203) (see **Culture**).

Innovation Participants

CFIR Definition: Individuals served by the organization that participate in the innovation, e.g., patients in a prevention program in a hospital (CFIR Research Team-Center for Clinical Management Research, 2023).

As highlighted throughout the findings, students are active participants in the implementation of cultural safety and anti-racism training, and a driving force behind its uptake (see **Innovation Source**, **Other Personal Attributes**). Students often provide feedback on their experience, including what content is or is not covered in the curriculum, how it is being taught and the quality of the teaching, as well as whether or not the learning environment is conducive to learning (Participants 202, 203, 206, 207). They are also presenting innovative solutions, such as advising Case 200 to divide the mandatory Indigenous health course into two offerings with an introductory and advanced level (see **Design Quality and Packaging**).

To harness the knowledge and guidance of students, MPH programs are engaging them through formal and informal consultation. Intake and exit surveys, course evaluation surveys, dialogue groups, and town hall meetings are used to better understand students' experiences (Participants 104, 203, 303; [Case 100] CEPH Accreditation Final Report). Additionally, faculty have hired students as research assistants, teaching assistants, or MPH practicum students to support efforts to teach, evaluate or incorporate a decolonizing or Indigenizing lens into training relevant to cultural safety and anti-racism (Participants 106, 203, 207, 301). Students are engaged in academic planning and strategic planning through providing input and feedback (Participants 101, 202, 203; [Case 100] Academic Plan). Furthermore, student voices are included in leadership and decision-making through elected or appointed membership on committees that inform curriculum in an advisory capacity (Participants 202, 203, 204, 302; [Case 100] Academic Plan; [Case 100] CEPH Accreditation Final Report).

On occasion, student engagement can have good intentions but undesirable or even harmful outcomes. As an example, Case 200 hires two to three active students to participate in the MPH Program's leadership team as student facilitators, and they "reserve one of these spots for an Indigenous student to ensure Indigenous leadership on our team, and to provide Indigenous students with opportunities to disrupt power dynamics in our School and profession" ([Case 200] webpage). Case 200's MPH Program Director humbly acknowledged that this initiative initially surfaced questions and tensions around how the representative was selected and the appropriateness of having one Indigenous student representing all Indigenous voices, but also BIPOC voices. This scenario resulted in inadvertent harm for the Indigenous student leader. Dynamics around power, privilege and representation were also raised by student participants, who commented that there are inadequate opportunities for students to express their concerns in a safe way, and that some voices are amplified over others.

Key Stakeholders and External Change Agents

CFIR Definitions (CFIR Research Team-Center for Clinical Management Research, 2023):

Key Stakeholders: Individuals from within the organization that are directly impacted by the innovation, e.g., staff responsible for making referrals to a new program or using a new work process.

External Change Agents: Individuals who are affiliated with an outside entity who formally influence or facilitate innovation decisions in a desirable direction.

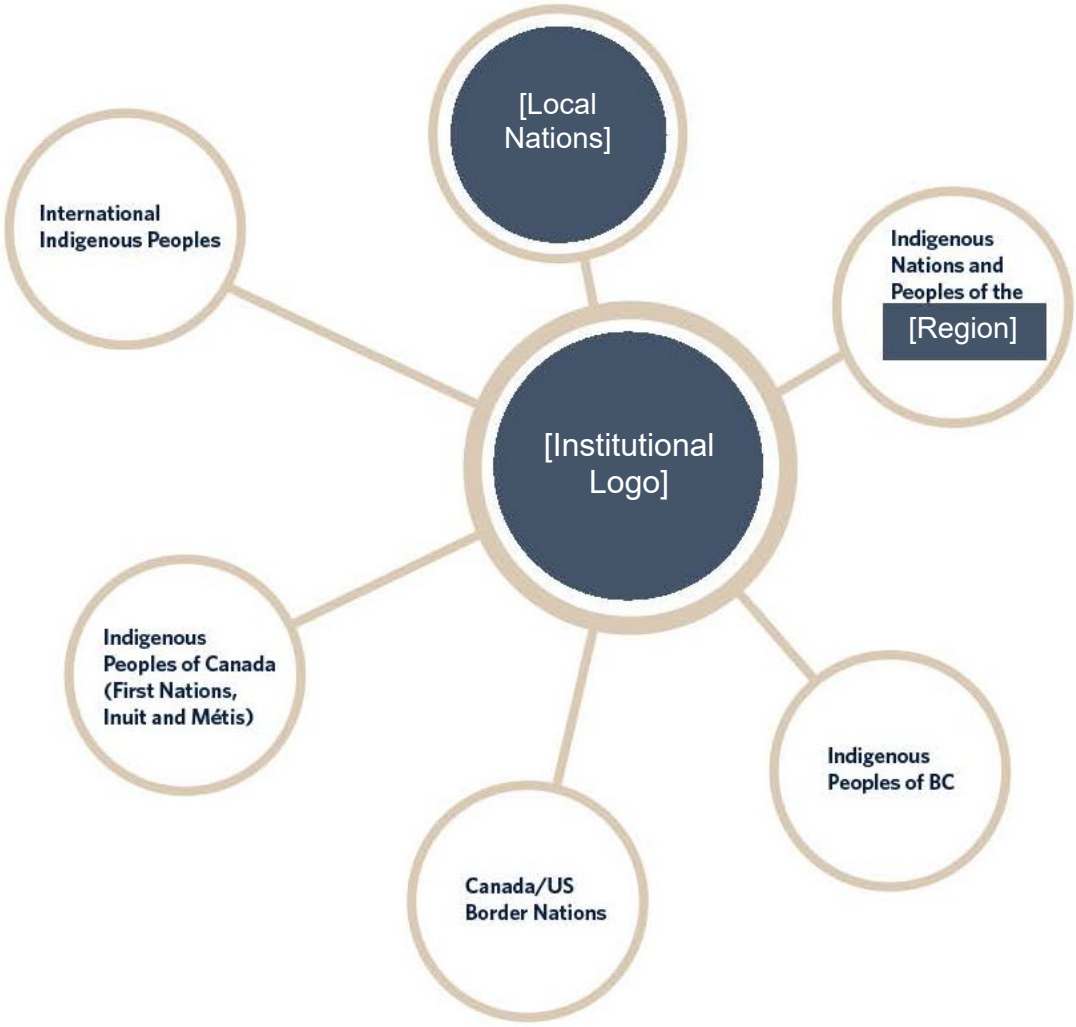
In this study, the case is defined as the academic unit (e.g. school, department, faculty) in which the MPH program is delivered, which are embedded within complex structures of academic institutions (see **Structural Characteristics**), therefore blurring the lines of 'internal' or 'external' stakeholders and change agents. Further obscuring this distinction is the increasing role of adjunct professors, endowed research chairs, and partnerships that bridge academic units with external organizations, such as health organizations (see **Cosmopolitanism**). Within the universities, there are a number of groups that function as both stakeholders and change agents linked to cultural safety and anti-racism programming, such as: the Aboriginal Reconciliation Council (Case 100), the Office for Aboriginal Peoples (Case 100), the Center for Excellence in Indigenous Health (Case 200), the Anti-Racism and Inclusive Excellence task force (Case 200), and the Office of Indigenous Academic and Community Engagement (Case 300). For Case 200, there is a Unit on campus that brings extensive expertise in Indigenous cultural safety training (see **Planning & Executing**), and has played a key role in developing and delivering the MPH program's mandatory Indigenous health courses (Participants 203, 207, 217).

Another key stakeholder that operates as both an internal and external change agent is FNHA, who are widely recognized as a leader in Indigenous-led and culturally-informed healthcare for First Nations communities in BC. To varying degrees, all three cases have connections with FNHA (see **Cosmopolitanism**). Participants from Case 100, emphasized this partnership as a crucial facilitator to cultural safety and anti-racism training that "is going to permeate our classroom teaching" (Participant 105), but noted that engagement needs to be more "systematized" and less "ad hoc" (Participant 102). PHSA and PHAC were also identified as external change agents that shape cultural safety and anti-racism training. PHSA is recognized as a provincial— and increasingly national— trailblazer in Indigenous cultural safety training for healthcare personnel. Case 100 has encouraged faculty and staff to participate in PHSA's San'yas Indigenous Cultural Safety Training, and the institution has offered to cover registration for all employees (Participant 107; [Case 100] website). Participants also mentioned engaging with San'yas facilitators as guest speakers, consultants, and/ or curriculum developers (Participants 102, 104). PHAC is a national body that informs practice standards and accreditation requirements through the 'Core Competencies for Public Health in Canada' (see **External Policy & Incentives**). Case 100 engages in national and regional forums

to review public health competencies to keep them relevant and current ([Case 100] CEPH Accreditation Final Report, 2015). Additionally, the Case 100 MPH Program Director is an active member in a national working group that is working to refresh the Core Competencies to include competencies such as Indigenous health and anti-racism.

Across the data, Indigenous communities are identified as a foremost stakeholder and change agent, in that they are both impacted by and influential over teaching, research, and administration at all levels of the university. The responsibility and commitment to engage with Indigenous communities "in purposeful and meaningful ways" is articulated by Case 200's Indigenous Strategic Plan (2020), which comprehensively outlines a "complex network of relationships" with Indigenous peoples locally and globally. The Plan presents the following diagram to help visualize this network:

Figure 4. Case 200 Indigenous Strategic Plan, 2020- "Our Relationships", redacted



Engagement with Indigenous communities takes many forms, including signing memorandums of affiliation, meeting with Indigenous governing bodies, seeking guidance from Elders and Knowledge Holders, assembling institutional steering committees, visiting local Nations for Indigenous-led/ land-based faculty retreats, and cultivating or nurturing reciprocal relationships between individual faculty members and Indigenous communities. Participants elaborated that increasingly there is an expectation that engagement with appropriate Indigenous representatives be embedded into all decision-making and that local protocols be respected; but they note that this presents challenges because of the amount of time required to go through multiple and often iterative stages of engagement (Participants 102, 202). Furthermore, participants contemplated whether the institution's standard of engaging with Indigenous communities for all decisions is an appropriate request of time and resources:

> You know there's a really critical statement 'nothing about us without us.' There's a risk though that that means that people with the honor and privilege don't exercise their responsibility to make change… And so that's the piece that I personally right now wrestle with, because I'm not sure my program should be saying to [local Nation], 'I want you to reprioritize what you're doing, so that you can lend more support to decolonizing our program' (Participant 202).

4.4.2. Planning and Executing

CFIR Definitions (CFIR Research Team-Center for Clinical Management Research, 2023):

Planning: The degree to which a scheme or method of behavior and tasks for implementing an innovation are developed in advance, and the quality of those schemes or methods.

Executing: Carrying out or accomplishing the implementation according to plan.

The majority of cultural safety and anti-racism training interventions referred to in the data can be characterized as in planning or early implementation stages. In particular, all three cases decided to introduce a mandatory Indigenous health course in recent years. Case 100 and Case 200 are in early stages of implementing this mandatory course, with

their first cohorts completing the courses in 2021/2022 (see **Design Quality and Packaging** and **Adaptability and Trialability**). Case 300's Program Director explained that a decision has been made to introduce a 200-level "Introduction to Indigenous Health in Canada" course. This course or an equivalent will become a pre-requisite for entry into the MPH program, similar to the current statistics course requirement; however, "It will be several years until the major program changes are implemented fully, but we are gearing up to make the changes now."

The Program Director of Case 200 similarly noted that changes to curricular requirements can take several years. As noted in **Key Stakeholders and External Change Agents**, there is a Unit that has an established Indigenous cultural safety training program that it delivers to health disciplines across the Case 200 institution. The MPH program is not currently accessing this training program, but a participant representing the Unit noted that plans are underway to expand access over the next one to two years. The MPH Program Director commented:

> … it has been a conversation for three years, but how do we partner, cooperate, collaborate, amplify the activities that are happening at [Unit]. You know, we want to be a user of them, and that has actually been way more challenging than you might have thought.

The complexities of expanding the training were further addressed by someone closely associated with the Unit that delivers an Indigenous cultural safety training program:

> … We have this incredible offering that could give a baseline for a lot of people and a lot of programs and units and universities. And so it's something we're wrestling with right now around expanding access. What could that look like, what do you give up when you expand access in terms of making sure that our community-based model of accountability is upheld. Because part of the reason we get the evaluations that we do and we're so successful is because we're very, very careful with what we do. And when you open access, you kind of are opening up opportunities

> for it to be used in a way where it might not be able to uphold or center our Indigenous values and priorities… So we really have to do checks and balances of like what are we giving up, what are we gaining, what can we do to contribute to our larger communities of learning. Those are active conversations right now. But yes, the intention is to expand… But what I would like to see is it done very methodically and strategically with an implementation model attached to it, and some kind of accountability process around if you're going to have access to this, this is how it needs to be rolled out and in partnership with whom.

In addition to cultural safety and anti-racism training interventions that are in early stages of planning and implementation, some interventions have also been fully embedded into regular practice and are undergoing iterative refinement. In Case 300, cultural safety training has been an integral component of the Indigenous Peoples' Health stream since the program's inception, and the training has been evolving with changing discourses and best practices (Participant 301). Furthermore, the introductory cultural safety workshop has been included in the week-long orientation at the beginning of the MPH program for seven or eight years, prompted by a change in director, according to Participant 301. The Indigenous health, cultural safety, cultural humility, and anti-racism modules in Case 100's core MPH courses have also been in place for several years and have undergone iterative refinement on an annual basis in consultation with opinion leaders, innovation participants, key stakeholders, and external change agents.

4.4.3. Reflecting & Evaluating

> CFIR Definition: Quantitative and qualitative feedback about the progress and quality of implementation accompanied with regular personal and team debriefing about progress and experience (CFIR Research Team-Center for Clinical Management Research, 2023).

Each of the three cases utilized resources from grants and special initiatives to support efforts to formally evaluate cultural safety and anti-racism training interventions. Case 100 received a Decolonizing and Indigenizing Curricula Grant from the university's Centre for Educational Excellence to assess the impact of MPH training in the areas of Indigenous Health, anti-racism, cultural safety, and allyship (Participant 101). Similarly,

Case 300 received a grant from the university's Learning and Teaching Support and Innovation to advance decolonizing curricula across each course in the academic unit. This grant resulted in a report, "Decolonization Within [Case 300] Through Celebration of Indigenous Ways of Knowing Report," which is shared with all faculty and sessional instructors, and findings were presented at both the regular monthly School Council meeting as well as a faculty retreat. This initiative led to direct changes including incorporating recommendations into the syllabus template, updating the academic unit's value statement, and committing to further Indigenize all courses at the undergraduate and graduate levels (Participants 301, 302). Case 200 also applied for funds from the university's Strategic Investment Fund to complete a reconciliation audit that they initiated, involving questionnaires and interviews with Indigenous students past and present to understand their experiences within the academic unit. However, the team was forced to put the project on hold due to insufficient budget or backing from those who allocate resources (Participants 203, 207).

The interruption of Case 200's reconciliation audit is one of several "starts and stops" that leaders within the program have spent time reflecting on. The Program Director was candid in sharing honest reflections about the "growing pains of trying to move proactively to address the various calls to action…," noting, "…in my view as a program director, that's a key piece of just being authentic about efforts to try and do the work, be honest about when we do it well but also cause harm other moments." These reflections were also published publicly on the program's website (see Figure 5).

Figure 5. Case 200 Indigenous Strategic Plan, 2020- "Our Relationships"

Reflecting and evaluating is also formalized in processes required by institutions or accreditation bodies. Across academic institutions, academic units regularly undergo external review every five to ten years for continuous monitoring, quality assurance, and accountability. In addition to this institutional review process, Case 100 is unique as an accredited MPH program in that it completes accreditation reviews with the Council on Education for Public Health (CEPH). Their 2015 CEPH Accreditation Final Report expands on Case 100's mechanisms for evaluation:

> The MPH program utilizes a series of internal surveys and feedback strategies for assessing the extent to which core competencies and program curriculum provide students with clear acquisition of public health knowledge. Intake, exit and alumni surveys are administered annually, and the MPH Committee conducts curriculum review and revision on a bi-annual basis.

Beyond the evaluation activities conducted within academic units, various cultural safety and anti-racism interventions are monitored across the institutions. For instance, following the publication of Case 100's Aboriginal Reconciliation Council's 2017 report, annual and bi-annual reports were shared to report on progress on the implementation of the calls to action and maintain momentum for long-term sustainment ([Case 100] Reconciliation Report, 2022). However, Participant 101 noted that, as an academic unit, Case 100 needs to re-examine the specific deliverables they are responsible for. At Case 200, an Associate Vice-President, Equity and Inclusion was appointed to lead the implementation of equity and anti-racism commitments as identified in the Anti-Racism and Inclusive Excellence task force report. They also established a 'Strategic Equity and Anti-Racism Framework and Roadmap for Change' to help guide implementation and evaluation. Similarly, Case 300 appointed an Indigenous Plan Steering Group to oversee implementation of the Indigenous Plan, monitor progress against baseline metrics and timelines, and provide annual reports ([Case 300] Indigenous Plan, 2017-2022). These university-wide initiatives also support the efforts of academic units to evaluate progress on institutional goals. Case 200, in particular, has provided an Indigenous Strategic Plan Implementation Toolkit, which includes resources such as a self-assessment tool, an intent to action tool, and a performance measurement framework to provide structure for

academic units to systematically implement and evaluate goals related to the Indigenous Strategic Plan (2020) (see Figure 6 for sample excerpt).

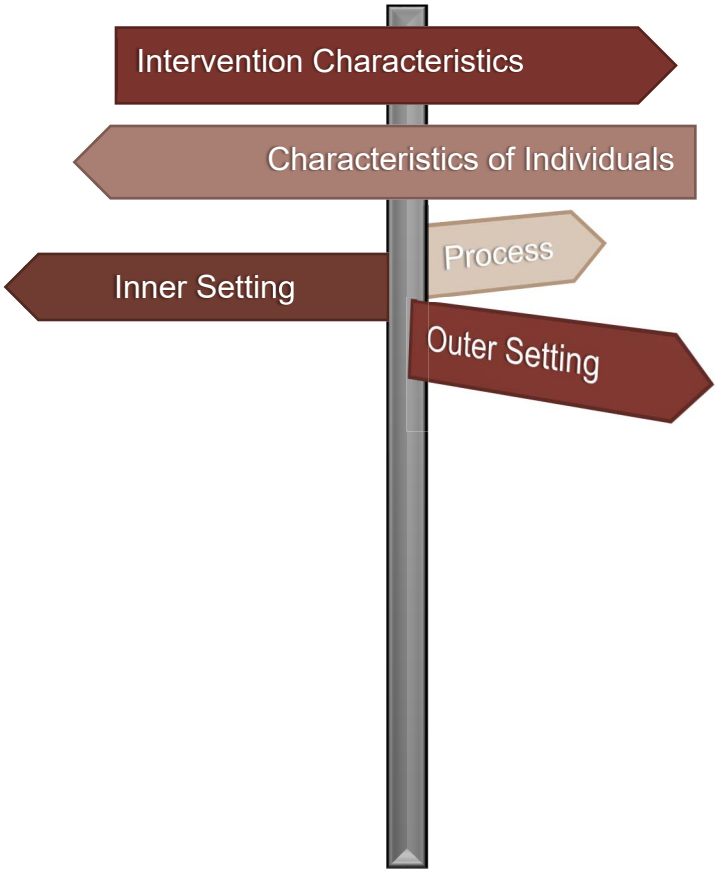
Figure 6. Excerpt from Case 200 Indigenous Strategic Plan Self-Assessment Tool, 2020

2. We actively promote Indigenous curricula for all students through responsive programming, orientations, and instruction.

Related ISP actions: 15 16 17 18

Not at all/Don't know	Working on it	Integrated into our plans/ priorities	Yes, we are there	Not applicable
○	○	○	○	○

Reflections on what our unit is doing in this area: *What are you thinking of when giving this rating? Why do you feel that this score reflects work that has been done? Is this item something your unit can work on? Are there disagreements in scores?*



4.5. Inner Setting

Research Objective: Document the institutional conditions in which implementation of cultural safety and anti-racism training takes place within each institution.

4.5.1. Structural Characteristics

CFIR Definition: The social architecture, age, maturity, and size of an organization (CFIR Research Team-Center for Clinical Management Research, 2023).

Each case has defining structural characteristics that influence determinants of implementation within the inner setting. Case 100 is situated within a uniquely non-departmentalized faculty to promote an interdisciplinary approach to teaching and research in population and public health. Case 100's Academic Plan (2018-2023) promotes, "In its 'cell to society' design, [Case 100] interests are broader than other Schools of Public Health, integrating natural sciences, social sciences and humanities with population health, policy and societal applications." Case 200 is a school of public health located within a Faculty of Medicine: "… We're a tiny little school and a much larger faculty— so big, it's bigger than all of [Case 100 institution]" (Participant 202). Case 300 is a school of public health that is based in a faculty that hosts a diverse range of degree programs and specializations, including Nursing, Social Work, Child and Youth Care, Health Information Science, Public Administration, and Indigenous Governance.

Case 300's offers degree programs through both in-person and online offerings; however, the MPH program is primarily online and has been intentionally designed this way from the beginning. One key informant shared the history of Case 300's inception, recalling that the School's leadership reached out to the Program Directors at Case 100 and Case 200, who advised them to "carve out a niche that's different… and not to be in competition with the other programs" (Participant 103). The online delivery has unique advantage and disadvantages that shape implementation of cultural safety and anti-racism training interventions, as detailed above in **Design Quality and Packaging** and **Relative Advantage**. It is worth noting that "Online doesn't always mean distance" (Participant 303), considering there are a number of students who choose to enroll in the online program but participate in the university community in-person.

Another relevant structural characteristic emphasized throughout the data is whether or not the physical surroundings and social environments embody cultural safety. The colonial legacies of academic institutions (see **Culture**) are visible in the names of universities, buildings, or varsity teams that bear names of colonizers, as well as offensive art installations on campuses ([Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 100] Reconciliation Report, 2022). Moreover, the presence of Indigenous peoples and cultures is sometimes invisible, with the lack of place name signs in local Indigenous languages, visible expressions of land acknowledgements, Indigenous artwork, or ceremonial spaces (Participants 101, 102, 203). Participant 203 commented, "… People walk into the School and they don't have any sense of Indigenous space, you know, we're absent of anything Indigenous to help people feel at least safe…" Academic units are taking steps to display more Indigenous artwork, with some commissioning local Indigenous artists to create custom works; as explained by Participant 303: "we wanted to have some art in our space that reflected the land on which we're sitting, and the ethos of the people who have been caretaking that land for thousands of years" (see Figure 7).

Figure 7. Moon Mandala by Sarah Jim, on display at Case 300

Each institution has designated— or is in the process of constructing— culturally safe and welcoming learning spaces, such as an Indigenous student lounge, an Indigenous Student Support Centre, a First Peoples' Gathering House, an outdoor classroom, and a TRC Memorial Garden. However, they have also ran into challenges when setting up these spaces, including considerations around Indigenizing colonial settings, engaging in proper consultation, ensuring meaningful representation, avoiding appropriation, and allocating limited resources (Participant 101; [Case 100] Reconciliation Report, 2022).

4.5.2. Culture

CFIR Definition: Norms, values, and basic assumptions of a given organization (CFIR Research Team-Center for Clinical Management Research, 2023).

> There is a belief — and criticism — that post-secondary institutions are liberal and progressive. Not true… They are simply "a microcosm of the larger society." "Universities, like any institution, are relatively conservative insofar as we have established practices and policies to maintain the status quo…" ([Case 100 independent newspaper], 2021).

Cultural safety and anti-racism training interventions and their implementation are contextualized within organizational cultures, academic cultures, and disciplinary subcultures. Universities mirror the norms, values, and unwritten rules of their societal contexts, including regionally-specific social, cultural, and political climates. Participants with experiences across multiple universities in different regional contexts (e.g. Alberta, Ontario) shared their opinion that universities in BC are comparatively more attuned to matters related to advancing cultural safety, reconciliation, and Indigenous rights (Participants 108, 111, 302). As evidenced across institutional reports, the universities pride themselves on being multicultural and promoting principles of EDI. However, they are also critiqued for being performative, tokenistic, and resistant to challenging the status quo through transformational change (Participant 204; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022).

Consistent with the literature, institutional reports and participants point to the presence of colonialism, Eurocentrism, racism, and white supremacy in academic culture. Universities are colonial institutions, deriving from their origination from and governance

under colonially-imposed provincial legislation (Participant 105; [Case 200] Indigenous Strategic Plan, 2020). Some institutions are beginning to reckon with their colonial legacies, but largely frame it in an historical context without acknowledging or redressing ongoing occupation of stolen land or colonial naming practices (see **Structural Characteristics**) (Participants 102, 203, 301; [Case 300] Indigenous Plan, 2017-2022). In 2018, Case 200's President apologized for the university's role in supporting the operation of residential schools and "tacitly accepting the silence surrounding it" ([Case 200] Indigenous Strategic Plan, 2020). Following this lead, in 2021, Case 200's Faculty of Medicine issued a formal apology for the faculty's contributions to training policy makers, administrators, and researchers who were involved in establishing and enforcing colonial policies, and for excluding Indigenous peoples from higher education through admissions and hiring processes. As an extension of colonial culture, universities are also sites of Eurocentrism. Dominant Eurocentric and North-American-centric approaches to teaching and research are valued as superior, while knowledge systems and ways of knowing rooted in Indigenous or global South perspectives are invalidated and suppressed ([Case 200] Indigenous Strategic Plan, 2020; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). Eurocentrism surfaces in what is taught (including in the "hidden curriculum"), how it is taught, who it is taught by, who holds power, and who controls resources (see **Evidence Strength & Quality** and **Other Personal Attributes**).

Coinciding with colonial and Eurocentric culture, racism and white supremacy also infiltrate cultural norms across academic institutions. Independent reviews and institutional reports at each of the cases concluded that within the university community there are widespread experiences of racism, as well as sexism, ageism, and ableism ([Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 100] Diversity Meter Final Report; [Case 100 Independent Newspaper], 2021; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022; [Case 300 Independent Newspaper]). Prompted by a racist event on Case 100's campus involving police violence against a black man, an independent newspaper spent 23 months investigating incidents of racism at the university and how they were handled (2021). Examples of interpersonal and systemic racism documented in this article and other reports include: racist stereotypes, micro-aggressions, and bigotry being exhibited among faculty, staff, and students; racist ideas and misconceptions being reinforced by curricula and course

materials; and BIPOC faculty, staff and students facing discrimination in hiring and advancement opportunities. Compounding with racism against members of the BIPOC community, white supremacy and white privilege are unquestioned, normalized, and even strengthened in academic institutions (Participants 202, 203, 301; [Case 100] Diversity Meter Report; [Case 100 Independent Newspaper], 2021; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). In 2019, Case 100's EDI Office launched a Diversity Meter survey, and one respondent commented, "Not only is the environment designed by white people, it is designed for white people to succeed." Examples of manifestations of white supremacy include a noticeable predominance of white persons in senior leadership or management positions, white scholars and white scholarship being valorized, and people "using the word 'diverse' to mean people who aren't white, which then sends the message that white is normal and everybody else is other" (Participant 204).

As much as universities entrench and perpetuate oppressive culture, they also have the potential to catalyze culture change. As highlighted by Case 200's Indigenous Strategic Plan (2020), "We [universities] are uniquely positioned to generate and mobilize knowledge that can produce systemic change. We are a place to develop and implement innovative and path-breaking research, teaching, and engagement with Indigenous communities." Participants wrestled with the tension of trying to destabilize and dismantle oppressive culture within the confines of a colonial institution, but also expressed optimism that change is on the horizon. Several individuals commented that culture change happens slowly over time and will require patience (Participants 102, 104, 105, 202, 212, 301, 302). Some noted that this change will naturally occur over generations as the population changes, and that this shift is already taking place (Participants 102, 105, 302). They further commented on the role of educational institutions in propelling this movement and accelerating change:

> … wherever we can instill these kinds of values in undergraduate students as they're coming through our courses, those undergraduate students will become strong advocates as graduate students. They'll push their professors in this direction. They'll, like you, push their own graduate work and hopefully eventually their faculty goals and ideas about what they want to accomplish. Then the

> system changes kind of incrementally. I think that's what we've seen over the last ten years (Participant 102).

Beyond training a new generation of leaders, administrators across all three cases emphasized the importance of creating academic job opportunities then attracting, recruiting, hiring, and retaining these change makers as a key strategy to shape the university culture (Participants 102, 105, 202, 302) (see **Other Personal Attributes** and **Available Resources**).

4.5.3. Implementation Climate

> CFIR Definition: The absorptive capacity for change, shared receptivity of involved individuals to an innovation, and the extent to which use of that innovation will be rewarded, supported, and expected within their organization. Includes constructs: Tension for Change; Compatibility; Learning Climate; Relative Priority; Goals & Feedback; and Organizational Incentives & Rewards (CFIR Research Team-Center for Clinical Management Research, 2023).

Tension for Change

> CFIR Definition: The degree to which stakeholders perceive the current situation as intolerable or needing change (CFIR Research Team-Center for Clinical Management Research, 2023).

In recent years, there has been greater awareness and renewed commitments to anti-racism across the globe, but particularly in North America, which undeniably incited an intensified tension for change within academic institutions. Amplified in 2020— but preceded by a long history of BIPOC-led activism— there was increased media attention, social media engagement, and social uprisings fueled by injustices such as the murder of George Floyd, Breonna Taylor, Ahmaud Arbery, and other unarmed black individuals. The Black Lives Matter movement was and continues to be a powerful catalyst for societal change (Participants 101, 102, 105, 109, 204, 206, 301; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). Though intentionally designed to shed light on systemic racism and police violence faced by Black Americans, this movement provided a platform to advance calls for justice to end racism against Indigenous, Asian, and other racialized groups (Participants 102, 301; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). Furthermore, the timing coincided with other pivotal moments in history that shed light on racism, including the surge of anti-Asian racism exacerbated by the COVID-19 pandemic ([Case 200] President's Task Force on Anti-Racism and Inclusive Excellence

Report, 2022). The year 2020 was also marked by the tragic death of Joyce Echaquan, an Indigenous woman from the Atikamekw Nation, who live-streamed her final moments on Facebook, capturing the racist and derogatory comments made by hospital staff towards her (Participants 103, 301). Not long after, in May 2021, the unearthing of 215 unmarked graves at the site of the former Kamloops Indian Residential School in Tk'emlúps te Secwepemc territory sent shockwaves throughout the country. This event prompted many Nations to conduct their own investigations and recovery efforts using ground penetrating radar, resulting in the identification of countless mass graves containing the remains of thousands of Indigenous children who attended residential schools (Participants 101, 217, 301; [Case 100] Reconciliation Report, 2022; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022).

Participants acknowledged that while it has been a painful and retraumatizing time for many communities and individuals, these events have "moved the conversation forward in a leap… People are paying attention, and are listening and learning" (Participant 217). In October 2021, the President of Case 100 issued a letter with the key message "Inclusion Benefits us All," which named racism as a societal problem that the university has a responsibility to address:

> Over the last 19 months, we have seen worldwide increases in racism, discrimination and hate. The oral histories of residential school survivors were confirmed in Kamloops and at former residential school sites across Canada. The effects of ongoing anti-Black racism continue to ripple out through our communities. There has been a sharp increase in anti-Asian and anti-Muslim hate in the lower mainland… This is unacceptable. We have much work to do as a community. But over these past months, we have also seen a surge of energy. From protests in the streets to calls for action on social media and in government offices, there has been a renewed societal effort to move towards creating a more inclusive and equitable world. We have the opportunity to join this movement and make [Case 100 university] a leader for change.

These societal movements helped create an appetite for action and opened doors for complex conversations to take place (Participants 101, 104, 203, 301, 302). It sparked or accelerated action within each of the cases, including: hosting dialogue sessions (Case 100) and national forums (Case 200) to discuss anti-racism; creating faculty positions for BIPOC scholars and/ or scholars with a teaching and research focus in anti-racism (Cases 100, 200, 300); creating scholarships for Indigenous and Black students (Cases 200, 300); launching an anti-racism initiatives fund (Case 200); participating in the Canadian Scholar Strike to draw attention to anti-Black and anti-Indigenous racism (Cases 100, 200); signing the Scarborough Charter as a commitment to redressing anti-Black racism in universities across Canada (Cases 100, 200, 300); appointing a Special Advisor to the President on Anti-Racism (Case 100); and establishing a President's Task Force on Anti-Racism and Inclusive Excellence (Case 200).

Participants emphasized that now more than ever there is zero tolerance for racism, and cultural safety and anti-racism are non-negotiable (Participants 103, 201). People are demanding that their universities take concrete steps to address racism, colonialism, Eurocentrism, white supremacy, and other forms of oppression within their institutions. Students, in particular, are driving the momentum by pushing for changes on and off campus (Participants 103, 105, 202, 204, 206, 207, 301). Deans at two of the cases underscored the tension for change driven by students as follows:

> I think a lot of the momentum is being driven by the students, you know they're holding us accountable and they're holding our feet to the fire. They want the change… They might think that— individually they might feel powerless, but collectively they have a very strong voice. I think that institutions are attempting to respond to that voice (Case 100 Dean).

> I actually sometimes think that our students are such savvy thinkers at this at this moment in time culturally and politically where they're like, "Is that enough? Is that good enough? Are you sure you're taking full responsibility?" (Case 200 Dean).

Compatibility

> CFIR Definition: The degree of tangible fit between meaning and values attached to the innovation by involved individuals, how those align with individuals' own norms, values, and perceived risks and needs, and how the innovation fits with existing workflows and systems (CFIR Research Team-Center for Clinical Management Research, 2023).

Cultural safety and anti-racism training interventions have a high degree of compatibility with the discipline of public health. MPH programs are practice-oriented graduate degrees designed to prepare future public health professionals to promote population health and well-being; prevent illnesses or diseases; and improve social, environmental, and structural determinants of health to reduce health inequities ([Case 100] CEPH Accreditation Final Report, 2015; [Case 100] Academic Plan 2018-2023; [Case 300] Graduate Program Handbook). In recognition that many MPH graduates will go on to work closely with Indigenous peoples/ communities, racialized, or marginalized groups, the MPH programs have embraced a commitment to ensure that students are equipped with the requisite knowledge and skills to engage in culturally safe and anti-racist praxis. The programs' visions, missions, and values reflect core principles that are congruent with cultural safety and anti-racism; these then inform all teaching, research, and service activities, and further attract students, staff, faculty, and administrators who share a compatible ethos (Participants 102, 105, 301, 302; [Case 100] Academic Plan 2018-2023; [Case 300] Syllabus Template). Each case has an explicit focus on health equity and social justice. Case 100 was "founded around a vision of developing a faculty that would be all about social justice and equity… and we intentionally designed positions and hired people who had as their intellectual focus issues of racism, inequity, and justice" (Participant 102). Case 300 also made the importance of these values prominent in a 2022 faculty posting: "The School values commitment to social justice, health equity, diversity and inclusion, and seeks candidates with demonstrated social justice action(s) and anti-oppressive and antiracist approaches to teaching and research."

Learning Climate

> CFIR Definition: A climate in which: 1. Leaders express their own fallibility and need for team members' assistance and input; 2. Team members feel that they are essential, valued, and knowledgeable partners in the change process; 3. Individuals feel psychologically safe to try new methods; and 4. There is sufficient time and space for reflective thinking and evaluation (CFIR Research Team-Center for Clinical Management Research, 2023).

Universities are generally recognized as supportive learning climates that foster personal and academic growth, and inspire intellectual creativity, experimentation, and critical thinking. Case 100's Academic Plan (2018-2023) and Case 300's Strategic Plan (2021) both encourage innovation in curricular design and pedagogical approaches to meet the evolving needs of students. Lifelong learning is also promoted among faculty, staff, and administrators through opportunities for professional development (e.g. faculty retreats, workshops, learning circles, mentorship) (Participants 101, 102, 105, 204, 301, 303). Case 100 offers subsidized registration for staff and faculty to complete PHSA's San'yas Indigenous Cultural Safety Training (Participant 101). Case 300's Office of Indigenous Academic and Community Engagement has their own in-house Indigenous cultural acumen training, which is part of orientation for new faculty and staff (Participants 301, 303). In the coming years, a Unit will also be offering Indigenous cultural safety training to faculty across health sciences in Case 200's institution (Participant 201).

Throughout the data, there was a strong theme of humility associated with learning cultural safety and anti-racism. Embracing the role of learner, and accepting imperfection and correction has been a learning journey among many faculty and administrators, who are positioned in their institutions/ their fields as experts and leaders (Participants 105, 107, 204, 217). A dean from Case 100 reflected, "I have needed to learn— it's been a very steep learning curve— to take three deep breaths and several steps backwards, and to do an awful lot of listening." Participants highlighted the importance of listening to and learning from Indigenous communities, Elders, and Knowledge Holders (Participants 105, 302, 303; [Case 100] Reconciliation Report, 2022]. They also commented that it is inevitable that people will make mistakes and that it is possible to learn from those instances (Participants 111, 201, 202, 204, 217). Participant 203 shared a lesson from a colleague: "… We're never going to be perfect at this, but let's fail forward together." Moreover, students expressed that they appreciated transparency and vulnerability among instructors in sharing about their personal learning journeys and areas where they are still growing (Participants 305, 308) (see **Individual Stage of Change**).

Relative Priority

CFIR Definition: Individuals' shared perception of the importance of the implementation within the organization (CFIR Research Team-Center for Clinical Management Research, 2023).

Increasingly, universities are making efforts to prioritize cultural safety and anti-racism in response to a growing recognition of the need to respond to calls to action within their institutions, as well as a broader societal recognition of the need to redress historical and ongoing injustices (see **Knowledge and Beliefs About the Innovation** and **Tension for Change**). Institutional reports highlight reconciliation, Indigenous rights, and anti-racism as high priorities within their institutions, positioning them as a moral and ethical responsibility ([Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 200] Indigenous Strategic Plan, 2020; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022; [Case 300] Indigenous Plan, 2017-2022). Across all three cases, academic units are reflecting commitments to these priorities in curricular planning by creating a mandatory course in Indigenous health (see **Planning and Executing**). Case 100 is undergoing curricular reforms or "curricular pruning" (Participant 105), yet the Dean of Education explained that "even at the same time that we are constraining the programs and trying to find what's sort of fundamentally important, we're actually… mak[ing] way for Indigenization, which is just an indicator of the priority of the importance that it's given." Additionally, both institutions and academic units are making commitments to important initiatives that are adjacent to the implementation of cultural safety and anti-racism training in MPH curricula, including but not limited to: developing a cultural safety training module for faculty, teaching assistants, and sessional instructors; decolonizing and Indigenizing courses; creating culturally safe learning environments; creating safe and welcoming Indigenous spaces; hiring Indigenous health scholars; hiring anti-racism scholars; among other strategies ([Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 100] Academic Plan, 2018-2023; [Case 200] Indigenous Strategic Plan, 2020; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022; [Case 300] Celebrating Indigenous Ways Syllabus Review Report; [Case 300] Indigenous Plan, 2017-2022).

While universities are positioning reconciliation, Indigenous rights, and anti-racism as key priorities, they also face competing priorities that result in certain initiatives being prioritized over others. Universities are also regularly responding to rapidly changing external factors, such as shifts in government funding priorities or emerging issues (e.g. COVID), which influence relative priority. For instance, EDI is currently a priority that is being foregrounded across many institutions, and some argue that it is eroding the focus on Indigenous-specific calls to action (Participants 101, 102, 204; [Case 200] President's

Task Force on Anti-Racism and Inclusive Excellence Report, 2022) (see **Discourses**). Participants also commented on competing pressures as they relate to limited resources in terms of both budget allocation and time constraints, which present barriers to the ongoing curriculum refinement that is needed for sustained cultural safety and anti-racism training (Participants 202, 301, 302) (see **Available Resources**). With "time and energy in short supply" (Participant 302), some faculty "see it as a massive amount of work in an already overtaxed schedule" (Participant 301), competing against teaching schedules, research activities, grant writing, publication, peer review, service work, etc.

Institutional commitments to cultural safety and anti-racism can sometimes be seen as lip service if they are not backed up by concrete action or allocated sufficient resources to sustain change over the long term. Some participants were disheartened by the lack of action or extremely slow action corresponding to commitments made in institutional reports or academic plans (Participants 101, 102, 203). Data also surfaced concerns that some of the efforts to operationalize commitments are performative or disingenuous in nature, serving as a public-facing gesture to 'tick off a checkbox'— a phrase used by several participants (Participants 203, 204, 205, 207, 302, 307; [Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 100] Diversity Meter Final Report; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022).

Goals & Feedback

> CFIR Definition: The degree to which goals are clearly communicated, acted upon, and fed back to staff, and alignment of that feedback with goals (CFIR Research Team-Center for Clinical Management Research, 2023).

The primary mechanism by which universities communicate their priorities is through strategic plans and reports that articulate institutions' or academic units' mission, vision, and values, and further outline specific goals and objectives that will help to achieve these aims. These plans may also identify key performance indicators and metrics to track progress towards these goals. Each of the cases have relevant plans that outline institutional commitments to Indigenous reconciliation and/ or anti-racism, including Case 100's Aboriginal Reconciliation Council's Final Report (2017), Case 200's President's Task Force on Anti-Racism and Inclusive Excellence Report (2022), Case 200's Indigenous Strategic Plan (2020), and Case 300's Indigenous Plan (2017-2022). Academic Units have also reinforced these institutional commitments through their academic plans. Case 100 symbolically located goals related to advancing Indigenous

reconciliation at the top of each section of their 5-year academic plan (Participant 101; [Case 100] Academic Plan, 2018-2023) (see Figure 8).

Figure 8. Excerpt from Case 100 Academic Plan, 2018-2023, Redacted

I. Student Life, Learning and Success....8

1. Create a culturally safe learning environment for Indigenous students....8
2. Create an [redacted] Student Commons....8
3. Review and Improve Student Support Services and Programs....9
4. Review and Improve Student Communications:....9
5. Develop and Implement an Alumni Relations Strategy....9

II. Academic Quality/Curriculum....10

1. Create a culturally safe curriculum and research environment for Indigenous students....10
2. Complete and Implement Undergraduate Curricular Reforms....10
3. Improve Flexibility in Course Delivery to Support Timely Degree Completion....11
4. Strengthen Student Participation in [redacted] Research....11
5. Complete and Monitor the Implementation of the [redacted] MPH Curriculum....11
6. Complete and Implement MSc/PhD Curricular Reforms....12
7. Improve Training for Graduate Student TAs, TMs and Sessional Lecturers....12
8. Improve Evaluation Methods for Teaching....12

III. Engagement....13

1. Strengthen Collaborations with Indigenous communities....13
2. Enhance Capacity for Experiential and Work-Integrated Learning Opportunities....13
3. Enhance Capacity for Engagement with Global, Federal and Provincial Governance Groups and Government Ministries as well as Health Authorities, Municipalities and Indigenous Governments/Nations..14
4. Enhance [redacted] Communications and Its Capacity to Engage with its Prospective and Current Students, Alumni and External Partners....14
5. Implement an Advancement strategy that supports areas of research excellence and supports faculty and student development....14

In contrast, Case 200 was critiqued by participants for originally omitting commitments to Indigenous reconciliation from their most recent Strategic Plan (2021-2025), despite discussions taking place in the Plan's development (Participants 202, 203, 207). One participant recalled, "When they came out with it, there were zero things about reconciliation. There were zero things about Indigenous people. I was appalled. I was so angry… I was like, this is embarrassing. I'm embarrassed to be part of this program" (anonymized). This omission was subsequently and quickly corrected to include a land acknowledgement and a commitment to addressing the TRC Calls to Action after an Indigenous student flagged it as a concern with the MPH Program Director. The MPH Director brought the concern to the next faculty meeting where it was well-received by leadership and faculty colleagues. As reflected by the MPH Program Director:

> … Instantly, my colleagues and I agreed the omission is harmful and embarrassing, out of step with the strategic

> conversations that informed the plan, and a problem we needed to fix right away. So this example reflects both good and bad. The initial omission caused harm to many, and still does. The rapidity with which the omission was addressed reflects there really is momentum in our School to advance decolonizing and anti-racism objectives. But how could we allow the omission in the first place?

Organizational Incentives & Rewards

CFIR Definition: Extrinsic incentives such as goal-sharing, awards, performance reviews, promotions, and raises in salary, and less tangible incentives such as increased stature or respect (CFIR Research Team-Center for Clinical Management Research, 2023).

Universities commonly use tenure and promotion as an incentive system to recognize and reward faculty members who demonstrate exceptional teaching, research, and service in alignment with academic units' vision, mission, and values. Faculty may be rewarded with academic ranking, which is often accompanied by salary increases, additional benefits, and job security. Participants proposed revising tenure and promotion guidelines as a promising strategy for incentivizing and holding faculty accountable to the implementation of cultural safety and anti-racism training. Specifically, they recommended incorporating recognition of diverse forms of scholarship, and encouragement of professional development activities to refine their syllabi and advance their pedagogical practice (Participants 104, 105, 301). The academic units are in early stages of updating their processes. For instance, Case 200 has implemented a required equity statement as part of their activity report to encourage faculty to report on contributions to equity, diversity, and inclusion in teaching, research, and service (Participant 211). Case 100 held a faculty workshop on applying an anti-colonial and anti-racism lens to tenure and promotion guidelines (Participant 104). Case 100 is also engaging in conversations about the need to recognize and address the disproportionate burden of service work faced by BIPOC faculty and junior faculty, which includes the additional workload associated with developing curriculum and teaching cultural safety and anti-racism (Participants 102, 105) (see **Other Personal Attributes**).

Participants also cautioned that incentive systems have limited effectiveness within academic settings due to academic freedom. Academic freedom is an essential principle

in higher education that ensures faculty members can engage with controversial or contentious topics in their research and teaching without fear of censorship or loss of employment. However, participants commented on how academic freedom makes it difficult to motivate or mandate faculty to take on additional work associated with learning new ideas, refining their syllabi, and updating their teaching materials (Participants 102, 103, 203, 301). Participant 102 explained the tension as follows:

> You know the old saying of you can lead a horse to water, but you can't make it drink?… You can sort of set out principles— you want to be a university that embraces diversity and inclusion, recognizes reconciliation… But you can't tell people how to do it.

4.5.4. Readiness for Implementation

> CFIR Definition: Tangible and immediate indicators of organizational commitment to its decision to implement an innovation. Includes constructs: Leadership Engagement; Available Resources; Access to Knowledge & Information (CFIR Research Team-Center for Clinical Management Research, 2023).

Leadership Engagement

> CFIR Definition: Commitment, involvement, and accountability of leaders and managers with the implementation of the innovation (CFIR Research Team-Center for Clinical Management Research, 2023).

Formally appointed leaders such as program directors, deans, and senior leadership play a crucial role in shaping the vision and direction of academic institutions, and inspiring others to take action. Across the three academic units, participants emphasized that program directors and/ or deans are supportive of cultural safety and anti-racism training interventions (Participants 101, 102, 105, 202, 203, 301, 302). Program directors and deans have been actively involved in implementation in a variety of ways, including: engaging with key stakeholders to align the academic plan with institutional commitments to reconciliation (Case 100); embedding EDI considerations into decision-making and admissions (Cases 100, 200, 300); allocating resources towards curriculum development (Cases 100, 200, 300); making Indigenous health a required course (Cases 100, 200, 300); integrating cultural safety and anti-racism into their personal teaching practice (Case 100); creating space for decolonization and Indigenization

(Cases 100, 300); assigning teaching and service work to mitigate overburdening BIPOC faculty (Case 100); and publicly sharing progress on the academic unit's path to reconciliation (Case 200). Participants also commented on the impact of having senior leadership who are invested in advancing cultural safety and anti-racism:

> … We have a president who really lives and breathes these values, and puts it in every tweet, in every communication and, you know, getting the robes changed for convocation to have them sewn by elders. She is doing everything she can to communicate to the wider community she takes this very seriously and people should also take it seriously. You know, the institutional changes, about creating other leadership at the university level and at the faculty level, where people have dedicated time and commitment to addressing these issues (Participant 102).

While leadership engagement was generally viewed as a facilitator to implementation within academic units, the data also surfaced concerns associated with leadership in the wider institutional context. Concerns include turnover in leadership resulting in priorities being dropped, underrepresentation of BIPOC leaders throughout the university but especially at higher levels of the institutional hierarchy, and lack of accountability mechanisms for leaders (Participants 203, 301; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022).

Available Resources

CFIR Definition: The level of resources organizational dedicated for implementation and on-going operations including physical space and time (CFIR Research Team-Center for Clinical Management Research, 2023).

'Available Resources' is a recurring and prominent theme in the data, with the highest coding frequency at 204 references across 44 sources (see **Appendix C**). The foregrounding of this theme suggests a common perception shared by participants and reaffirmed in documents that resources are a significant determining factor in the uptake and implementation of cultural safety and anti-racism training. Financial resources, human resources, and time were presented as key considerations. First, financial

resources are a key enabler of successful implementation and ongoing sustainment of interventions. Participant 217 explains:

> … when there's funding to support different things like positions for curriculum development or things like the audit or instructors, that's where we really see movement. When things are sort of done off the side of the desk, it's harder to get some traction… Where there's money brought forward to something then there's also accountability and reporting.

Across participants and across the three cases there was disagreement about whether or not universities have financial resources. On the one hand, a senior faculty member at Case 100 stated, "… faculties have quite limited resources, although it may not appear that way." Similarly, a staff member at Case 300 commented, "There's really no extra money. There's no getting more money right now, it's just how are we going to use what we have differently." Whereas one anonymized participant shared, "… universities have money, like they tell you that they don't have money, but they do have money."

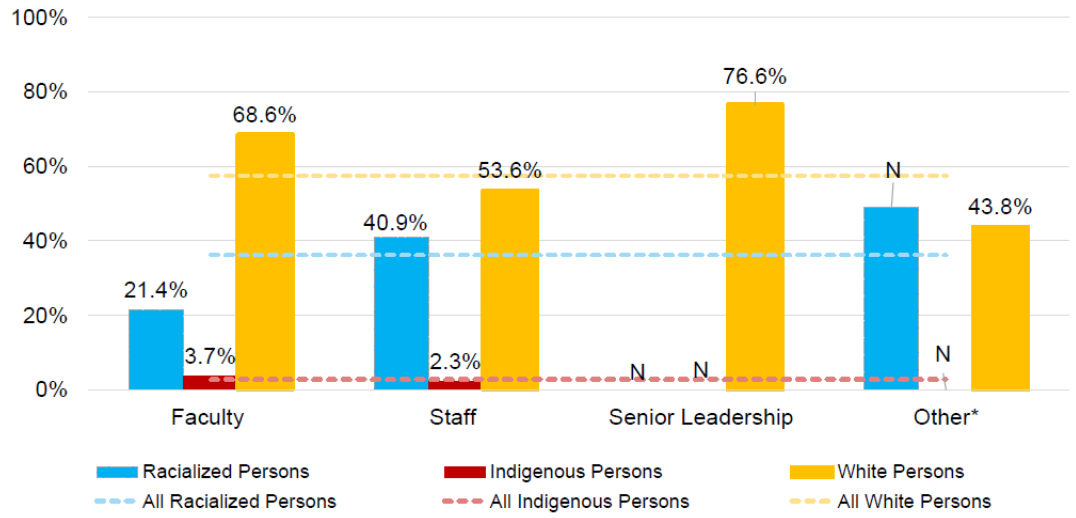
Participants noted that progress has been made in making financial resources available to provide honoraria or culturally appropriate gifts to Elders or guest speakers, which is a practice across all three cases. Institutions are also making pockets of funding available for special initiatives related to reconciliation, decolonization, Indigenization, and anti-racism. For instance, Case 100's university invested $9 million to advance Aboriginal Strategic Initiatives; a portion of this funding goes towards a Decolonizing and Indigenizing Grant program that faculty can apply to, and has been successfully used to advance the MPH curriculum in Case 100 ([Case 100] Aboriginal Reconciliation Council Report, 2017). Case 200 launched an Anti-Racism Initiatives Fund, that provides $200,000 to support faculty and staff to undertake anti-racism focused activities (email correspondence). Case 300 also provides grants through the Learning and Teaching Support and Innovation Centre that supports decolonizing and Indigenizing curricula (Participant 301). Despite these initiatives, some participants expressed that funding is inadequate or grants are unfairly adjudicated, resulting in key interventions being underfunded (Participant 203) (see **Cost** and **Reflecting & Evaluating**).

The availability of human resources is a key factor in shaping academic units' ability to implement cultural safety and anti-racism training interventions. These interventions

require skilled individuals to plan, execute, evaluate, and sustain implementation. Especially considering the rapidly evolving pace of change surrounding these interventions, the availability of human resources determines academic units' ability to respond to the practice environment, needs of students, and/ or societal context, and adapt their strategies as needed. A common barrier experienced across the three cases is limited faculty capacity, resulting in gaps in teaching areas and "over-reliance on sessional instructors, especially in core courses, which should be taught by continuing faculty wherever possible" ([Case 100] Academic Plan 2018-2023). Part of this issue is that a number of existing faculty have reduced teaching loads either because they are newly hired or hold Scholar Awards or endowed chairs (Participants 105, 302; [Case 100] Academic Plan 2018-2023). For those who are teaching, participants consistently expressed time as a debilitating barrier (Participants 104, 204, 214, 301), noting that "Everybody's bandwidth is maxed out" (Participant 303). For BIPOC faculty, there are increased demands of their time, with disproportionate service commitments and expectations of supporting other faculty with guest lectures or professional development (Participants 104, 105, 303; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). Participants mentioned that their academic units would benefit from having a designated position, such as a curriculum lead that would have a dedicated focus on cultural safety and anti-racism (Participants 202, 203) (see **Formally Appointed Internal Implementation Leaders**).

With regards to human resources, there is a significant theme in the data that Indigenous and black scholars are underrepresented in academia due to structural and systemic barriers to employment, advancement, and wage equity ([Case 100] Diversity Meter, 2020; [Case 100] Reconciliation Report, 2022; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). As highlighted in **Other Personal Attributes** and **Engaging**, Indigenous peoples are respected as leaders, champions, and change makers in the area of cultural safety and anti-racism training; their underrepresentation not only affects academic units' capacity to deliver this training, but compounds on the overstretched workloads of few Indigenous faculty, leading to burnout (Participants 101, 102, 104, 105, 301). The following figures illustrate the underrepresentation of Indigenous, Black, and other racialized groups, particularly in faculty and senior leadership positions, across the three academic institutions.

Figure 9. Racial Representation Among Various Roles at [Case 100], taken from [Case 100] Diversity Meter Report, 2020



'N' represents more than one but less than ten respondents.
*Other category includes respondents who did not select "Faculty", "Senior Leadership" or "Staff" as best describing their primary role.

Figure 10. Employment Equity Data, taken from [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022

	Employee Rank	Arab	Asian	Black	Indigenous	Latin American	White
Faculty and Related Academic Staff	Executives and Other Academic Leaders	0.0%	sup.	0.0%	0.0%	0.0%	84.1%
	Tenure Stream (Professional ranks and Educational Leadership)	0.7%	18.2%	0.8%	1.6%	3.1%	74.4%
	Term, Part-time and Other Faculty Appointment	1.2%	25.5%	sup.	2.0%	2.8%	65.2%
	Emeriti & Other Faculty and Staff Positions	sup.	25.9%	sup.	sup.	sup.	66.7%
Staff	Senior or Professional Leader	sup.	27.7%	1.4%	sup.	2.5%	69.3%
	All other roles*	0.7%	45.5%	1.4%	1.6%	3.4%	49.8%
	TOTAL	0.7%	37.9%	1.2%	1.5%	3.2%	56.7%

sup.: percentages based on numbers between 0-5 were supressed. Totals do not add to 100 due to suppressed data, and those with multiple racial/ethnic identifies checked off more than one.

*All other roles include: Mid-Level Professionals, Junior Professionals, Staff-Academic support and other staff (see tab employee Rank and description)

Figure 11. Employment Equity Data, taken from [Case 300] Employment Equity Plan, 2022

Designated group	N=820	Weighted representation	Availability
Women	397	48.4%	44.9%
Indigenous Peoples	41	5.0%	1.4%
Persons with Disabilities	32	3.9%	8.9%
Visible Minorities	120	14.6%	20.8%

Consistent with trends seen across Canada and globally, the three cases are taking steps to address the underrepresentation of Indigenous and Black scholars through deliberate recruitment, hiring, retention, advancement, and wage equity strategies. In recent years, each of the three academic units have successfully recruited and hired one or more Indigenous scholars as instructors or full-time professors, and highlighted this as a key development in their capacity to implement cultural safety and anti-racism training (Participants 101, 102, 104, 105, 202, 302, 303). For both Case 100 and Case 300, there has been concerted efforts to hire multiple Indigenous scholars, and supporting these new hires through campus resources and mentorship to avoid overburdening one individual (Participants 102, 104, 105, 302, 303; [Case 100] Academic Plan 2018-2023). The Dean of Case 100 explained the rationale behind this decision as follows:

> It's very clear that you can't have a commitment to Indigenous scholarship and to changing the culture and bringing in or instantiating notions of cultural safety without a core of faculty and staff. You can't just have one and then expect them to be all things to all people… And so we've been focusing on doing some cluster hiring so increasing the complement of Indigenous faculty members…

There are also initiatives— either within academic units or at the institutional level— to increase representation of Black faculty and leaders. Case 200's President's Task Force on Anti-Racism and Inclusive Excellence made a strong recommendation to hire more Black scholars, particularly "in roles that require special expertise and lived experience

of Black individuals combined with relevant professional experience.” In response to the Scarborough Charter, Case 100’s university senate approved a motion to hire at least 15 Black tenure-track faculty members, which is supported centrally out of the Office of the Vice President Academic (Participant 105).

Preferential and limited hiring practices are being used in recruitment initiatives to build capacity for cultural safety and anti-racism within academic units. Participant 303 emphasized why these practices have been embraced: “The work we are doing to diversify our faculty is not to check boxes, but rather to enrich our school with diverse experience, perspectives, and to create opportunity for people who are being held back with experienced barriers… I strongly believe in that.” At the time of data collection, Case 300 had hired four individuals belonging to "designated groups" (Indigenous Peoples, visible minorities, persons with disabilities, or women) and was in the process of hiring another member of such groups, in compliance with the University's Equity Plan and the BC Human Rights Code (Participants 301, 302, 303; [Case 300] Faculty Posting). Using Case 300's latest faculty posting from 2022 as an illustration, the hire was limited to Indigenous applicants, and the posting linked the position to cultural safety and anti-racism, stating, “The School values commitment to social justice, health equity, diversity and inclusion, and seeks candidates with demonstrated social justice action(s) and anti-oppressive and antiracist approaches to teaching and research.” Similarly, at the time of data collection, both Case 100 and Case 200 had active faculty searches for scholars who specialize in anti-racism, and were restricted to applicants self-identifying as members of designated equity groups. Case 100 was advertising a tenure track faculty position in Quantitative Research in Racism and Health, and Case 200 was advertising a tenure-track Assistant Professor/ Tier 2 Canada Research Chair in Anti-Racism in Population and Public Health. Case 200’s faculty posting outlined the expectations of the position as follows:

> The successful candidate will undertake research that aims to improve the health status of Black, racialized and Indigenous communities in British Columbia, Canada, and globally; and will lead training in anti-racist research and practice in population and public health. The successful candidate will also be expected to participate in the teaching activities of the School, as well as provide mentorship and

training to undergraduate, graduate, and postgraduate learners.

Academic institutions are taking significant strides towards building capacity for implementing cultural safety and anti-racism training by prioritizing applicants who identify as Indigenous, Black, or as members of other equity-deserving groups, as well as recruiting scholars who have demonstrated a commitment to anti-racism scholarship.

Access to Knowledge & Information

> CFIR Definition: Ease of access to digestible information and knowledge about the innovation and how to incorporate it into work tasks (CFIR Research Team-Center for Clinical Management Research, 2023).

Closely associated with the theme of 'Available Resources,' human resources, in particular Indigenous faculty and staff, play a critical role in facilitating access to knowledge and information related to cultural safety and anti-racism. Indigenous faculty can serve as important mentors and role models for students and colleagues alike by providing guidance on decolonizing and Indigenizing curricula; sharing their expertise and lived experiences (when appropriate) through guest lectures or pre-developed modules; as well as directing people to learning materials, current literature, and other media (Participants 104, 105). With increasing recognition of the workload demands and burnout experienced by Indigenous faculty who are doing this work off the sides of their desks (see **Other Personal Attributes** and **Available Resources**), academic units are exploring solutions to have dedicated personnel to assist with facilitating access to relevant information and resources. For instance, Case 200 initiated discussions around appointing a curriculum lead in anti-racism (Participant 202, 203). Case 300 has access to a recently-appointed Faculty Lead who is working with each of the Schools in the Faculty to support implementation of the Indigenous Plan, and serve as an advisor on decolonization and Indigenization (Participant 302). Additionally, there are a number of institutional resources available at universities that offer professional development programming (e.g. workshops and training programs), resources (e.g. curriculum guides and catalogues), and expert advice (e.g. Elders in Residence, one-on-one mentorship, and referral programs) for faculty who are interested in incorporating Indigenous knowledges and ways of knowing and/ or anti-racist pedagogies into their courses. Examples referenced in the data [not an exhaustive list] include:

Case 100:

- Employee Indigenous Cultural Awareness R.E.S.P.E.C.T. program
- Indigenous Curriculum Resource Centre
- Transforming Inquiry into Learning and Teaching
- Centre for Educational Excellence
- Office for Aboriginal Peoples

Case 200:

- Centre for Excellence in Indigenous Health
- [Case 200] Learning Circle
- Centre for Teaching, Learning and Technology

Case 300:

- Indigenous Cultural Acumen Training
- Office of Indigenous Academic and Community Engagement
- Learning and Teaching Support and Innovation
- Indigenous Academic Advisory Council

Additionally, faculty have access to a variety of external resources that can enhance their comprehension and competencies in cultural safety and anti-racism, and provide tools to support their delivery of training interventions. The most frequently-cited example in the data is PHSA's San'yas Indigenous Cultural Safety Training (Participants 101, 102, 105, 208, 301; [Case 100] Reconciliation Report, 2022). Participants also referenced seminal reports such as the TRC's Calls to Action and the In Plain Sight Report, as well as organizations such as FNHA, the British Columbia Centre for Disease Control, and the British Columbia Teachers' Association (Participants 101, 102, 103, 202, 211, 301; [Case 100] Aboriginal Reconciliation Council Report, 2017).

Perceptions of the availability and accessibility of knowledge and information varied among participants. On the one hand, some participants acknowledged that there is an abundance of learning materials that can inform cultural safety and anti-racism training interventions (Participants 101, 104, 105, 204). Participant 101 commented, "… There's an enormous richness that is quite accessible." Participant 104 expanded, "There's

always new programs, there's always new initiatives, there's always new films and podcasts, and reflections that are coming out. It doesn't stop in terms of Indigenous outputs, you know, we're prolific people." In fact, it was suggested that the overwhelming amount of knowledge resources available could be a deterrent to those who are unsure where to begin or how to assess credibility (Participant 104). Data sources indicated that there are many faculty who are interested in incorporating cultural safety and anti-racism into their teaching, but do not know how to start their learning journey or where to access resources to help them (Participants 202, 204, 215; [Case 100] Aboriginal Reconciliation Council Report, 2017). The Program Director of Case 200 commented on the lack of awareness of resources as a shortcoming of curricular innovation:

> … There are resources on our campus, and there are resources in our intellectual community… And it's very possible that many program directors, myself included, don't even know half of them. And so don't think about— or make the time to figure out— how to take advantage of a broader range of resources as we're trying to do this work, which is a potential shortcoming.

Offering a different perception on the availability of knowledge resources, some faculty drew attention to the lack of written resources or textbooks specific to their area of teaching, and that the ones that do exist are inadequate. Participants 212 and 213 attributed the lack of relevant teaching resources to systemic barriers, noting that it will take time to change how literature is published, but that faculty have a responsibility to transform the system through their own publications and peer review.

4.5.5. Networks & Communications

CFIR Definition: The nature and quality of webs of social networks, and the nature and quality of formal and informal communications within an organization (CFIR Research Team-Center for Clinical Management Research, 2023).

Universities use internal communications networks to facilitate information sharing with members of the academic community and to ensure that all members are informed of and engaged in the institution's activities. Standard communication pathways include faculty meetings or committee meetings, email listservs, intranet portals, and online

learning management systems. Participants commented that faculty have become more engaged in communicating about topics related to cultural safety and anti-racism in response to the profiling of events that raised public awareness of systemic oppression, such as the Black Lives Matter Movement, the publication of the In Plain Sight Report, and the unearthing of Residential School burial grounds (Participants 101, 102, 302) (see **Tension for Change**). For instance, faculty councils allocated time or added a standing agenda item during monthly meetings for dialogue around these topics (Cases 100, 300). Furthermore, academic units, senior leadership offices, and student associations issued position statements, and circulated learning resources and supports (Cases 100, 200, 300).

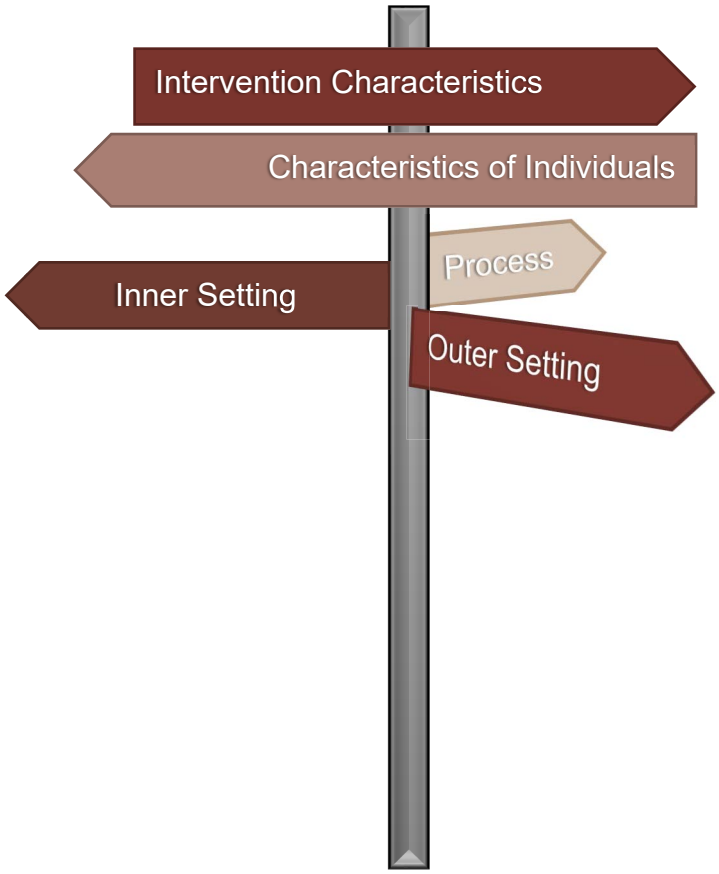
Universities also use communications channels such as annual reports, emails, newsletters, websites, and town hall meetings as an accountability mechanism to ensure that the wider campus community and external stakeholders are informed about the institution's activities, and have opportunities to provide feedback on their implementation. For example, Case 200's Office of the President hosted a virtual forum at the beginning of 2023 to share progress and plans on the implementation of the Anti-Racism and Inclusive Excellence Report, and to introduce the task force leadership team charged with putting recommendations into institutional action. Similarly, Case 100's Office for Aboriginal Peoples publishes bi-annual reports on progress on the recommendations put forward in their 2017 Aboriginal Reconciliation Council Report to "highlight the story of reconciliation at [Case 100], where we are today, and where we want to go in our journey together."

Some participants commented that the goal of implementing cultural safety and anti-racism training is not clearly communicated to students, suggesting that communication strategies could be better tailored to that audience (Participant 308). One Dean commented, "I think we're walking the walk but we're not talking the talk yet, and that's something that we've talked about as [Case 300] that's kind of our next layer of work to do… is to be a little more explicit about that anti racist perspective."

There were only a handful of coded references to interpersonal relationships and social networks in the data, which may indicate a potential area for improvement in the inner setting. Of the references that did emerge, Participant 102 posited a potential challenge to authentic relationship building among colleagues at Case 100:

> … Faculty don't live proximate to each other and so, you know, away from work there aren't that many friendships, there aren't that many sort of clusters of people who are close friends. And that makes this kind of engagement [around sensitive topics] where you don't really know someone very well… I think people are just a little bit reluctant to fully engage.

Despite challenges of forming friendships in certain academic environments, a key informant from a Unit on campus delivering Indigenous cultural safety training emphasized that relationship building through informal check-ins and coffees with colleagues is crucial for operating a successful cultural safety training program.



4.6. Outer Setting

Research Objective: Examine the broader social, cultural, political, and historical contexts that shape uptake and implementation.

4.6.1. Cosmopolitanism

CFIR Definition: The degree to which an organization is networked with other external organizations (CFIR Research Team-Center for Clinical Management Research, 2023).

Universities, academic units, and/ or individual faculty or staff are connected to a regional, national, and global network of external organizations that support teaching, research, and community outreach activities. These organizations can include health authorities and hospitals, research centres and institutes, government agencies, Indigenous governing bodies, non-profit organizations, industry partners, and community-based organizations. The three cases are also affiliated with each other through research partnerships, adjunct professors, and joint initiatives such as the Public Health Association of BC's annual Summer School ([Case 100] CEPH Accreditation Final Report, 2015). Another key connection is the public health practice environment. As noted in **Key Stakeholders and External Change Agents**, all three cases have connections with FNHA. Connections take the form of formal partnerships, endowed research chairs, research collaborations, adjunct professors, sessional teaching contracts, guest speakers, practicum placements, and experiential learning activities. Case 100, in particular, has a unique partnership with FNHA; their 2018-2023 academic plan identifies a commitment to:

> … Strengthen[ing] partnership with the First Nations Health Authority (FNHA) and other Indigenous organizations to attract Indigenous students, and strengthen Indigenous health curricula, and expand research opportunities; and continue to work with FNHA to provide training opportunities for FNHA staff and opportunities for [Case 100] students to undertake work-integrated and research training.

The Program Director of Case 100 emphasized that he sees the next step in cultural safety and anti-racism training being strengthening partnerships with the health

authorities “to come on board as training partners.” Strengthening these partnerships would entail expanding opportunities for experiential learning (see **Design Quality and Packaging**) and practicum placements, as well as engaging health authorities to better understand their priorities for competencies that they are seeking from the workforce.

One tension that emerged in the data is the question of who holds the relationships with external organizations, whether it be the university, the academic unit, the school of public health, a research centre or institute, or individual faculty. Participants and documents highlighted the robust network of research and practice partnerships cultivated by faculty members as a strong asset (Participants 101, 103, 105, 202; [Case 100] CEPH Accreditation Final Report, 2015; [Case 100] Academic Plan 2018-2023). Yet the Program Director of Case 200 described this as a “double-edged sword:”

> I think that [Case 200] would have a difficult time right now mapping out what are the relationships the School has as opposed to what is the vast array of relationships that people who work in the School have. And I think that, as a result, the School might feel in certain ways that it doesn't have some of those formal relationships with actors.

4.6.2. Peer Pressure

CFIR Definition: Mimetic or competitive pressure to implement an innovation, typically because most or other key peer or competing organizations have already implemented or are in a bid for a competitive edge (CFIR Research Team-Center for Clinical Management Research, 2023).

Across the data, there were very few references to any perceived peer pressure or competition from other MPH programs or other academic programs offering cultural safety and anti-racism training (see **Appendix C: Number of Files and References Coded**). It is noteworthy that while the signing of the Scarborough Charter on Anti-Black Racism and Black Inclusion in Canadian Higher Education is mentioned in the findings (see **Tension for Change**), this data was retrieved by the researcher through web searches, and was not mentioned in interview/ focus group data or institutional reports—despite data collection taking place around the same time that the three cases became signatories (2021-2022). It can be assumed that peer pressure may be one factor in institutional commitments to anti-racism, with more than 40 Canadian post-secondary

institutions signing the Scarborough Charter as a united commitment to combat anti-Black racism and promote inclusion of Black scholars in universities across Canada.

Similarly, the data yielded no references to the Declaration of Commitment, signed by the BC Minister of Health, the FNHA, and all Health Authority CEOs in BC in 2015 (see Figure 12); nor FNHA's #itstartswithme campaign launched in 2016 (see Figure 13). These initiatives have been and continue to be a significant driving force in BC's healthcare system, effectively utilizing peer pressure to amplify the profile of cultural safety and cultural humility standards in professional practice. This gap in the data suggests a need to further strengthen relationships between MPH programs and the public health practice environment to better understand needs for workforce competencies (see **Cosmopolitanism**).

Figure 12. Declaration of Commitment

Figure 13. FNHA #itstartswithme Pledge Card

4.6.3. Needs & Resources of Those Served by the Organization

CFIR Definition: The extent to which the needs of those served by the organization (e.g., patients), as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization (CFIR Research Team-Center for Clinical Management Research, 2023).

MPH students come from a range of disciplinary backgrounds as well as diverse cultural, linguistic, socio-economic, and regional contexts. As such, they bring different levels of understanding and exposure to topics related to cultural safety and anti-racism. Student participants commented on the different levels of familiarity with the history of colonization (e.g. residential schools, Indian Hospitals), terminology used (e.g. status and non-status; First Nations, Métis, and Inuit), and protocols (e.g. land acknowledgements) (Participants 108, 109, 110, 111, 307, 309). Some participants suggested that it seemed like there was an expectation that students would enter the program with an existing knowledge base, and that those who had previously studied in BC had an advantage, whereas students from other provinces or other countries were at a disadvantage (Participants 108, 111). This was framed as a barrier to cultural safety and anti-racism training because while some students are seeking advanced skills-based training, others require more foundational learning. Furthermore, some students who were relatively new to these topics expressed hesitation or embarrassment to ask questions or participate in discussions. On the other hand, student diversity was also

presented as a facilitator; having students with professional experience, lived experience or from other regional contexts in the classroom or participating in online discussion forums was considered to bring the learning to life (Participants 302, 306, 310) (see **Relative Advantage** and **Other Personal Attributes**).

As noted in **Design Quality and Packaging**, Case 200 has addressed the need to tailor their cultural safety and anti-racism training to students' varying learning needs by dividing their required Indigenous health course into two offerings: an introductory-level and an advanced level (Participants 202, 203, 207). Similarly, Case 300 is introducing a new course titled "Introduction to Indigenous Health in Canada," which will become a pre-requisite for admission into the MPH program, either as the course itself or an equivalent (Participants 302, 303) (see **Planning and Executing**).

Participants also recognized that it is necessary to tailor the learning material to students' cultural and racialized identities, when possible and as appropriate. Currently, the majority of the cultural safety and anti-racism training interventions focus on settler colonialism in Canada and tend to cater to white settler learners (see **About the Interventions**). The content may therefore be less relevant to students who are international, immigrants, or of immigrant descent, and/ or it may overshadow their lived experience of racism and/ or colonialism (Participants 101, 109, 301). Moreover, for participants who are racialized and have lived experience of racism, being in a learning environment in which people are learning the basics of cultural safety and anti-racism can be triggering. In particular, revisiting past experiences of discrimination, systemic oppression, and/ or micro-aggressions can be traumatic and emotionally distressing. Some instructors are taking steps to foster safe learning environments by establishing ground rules at the beginning of courses, carefully moderating discussions, and/ or limiting interactions between students when engaging with sensitive subjects (Participants 103, 111, 301, 310, 311) (see **Relative Advantage**).

Data also highlighted the need for attention to the range of systemic barriers that students, particularly Indigenous students, face when accessing and advancing in higher education. These systemic barriers include but are not limited to distance from family and cultural support networks, economic barriers associated with studying away from one's home community, insufficient financial support, inadequate academic supports, microaggressions in learning environments, epistemic racism in curricula, and systemic

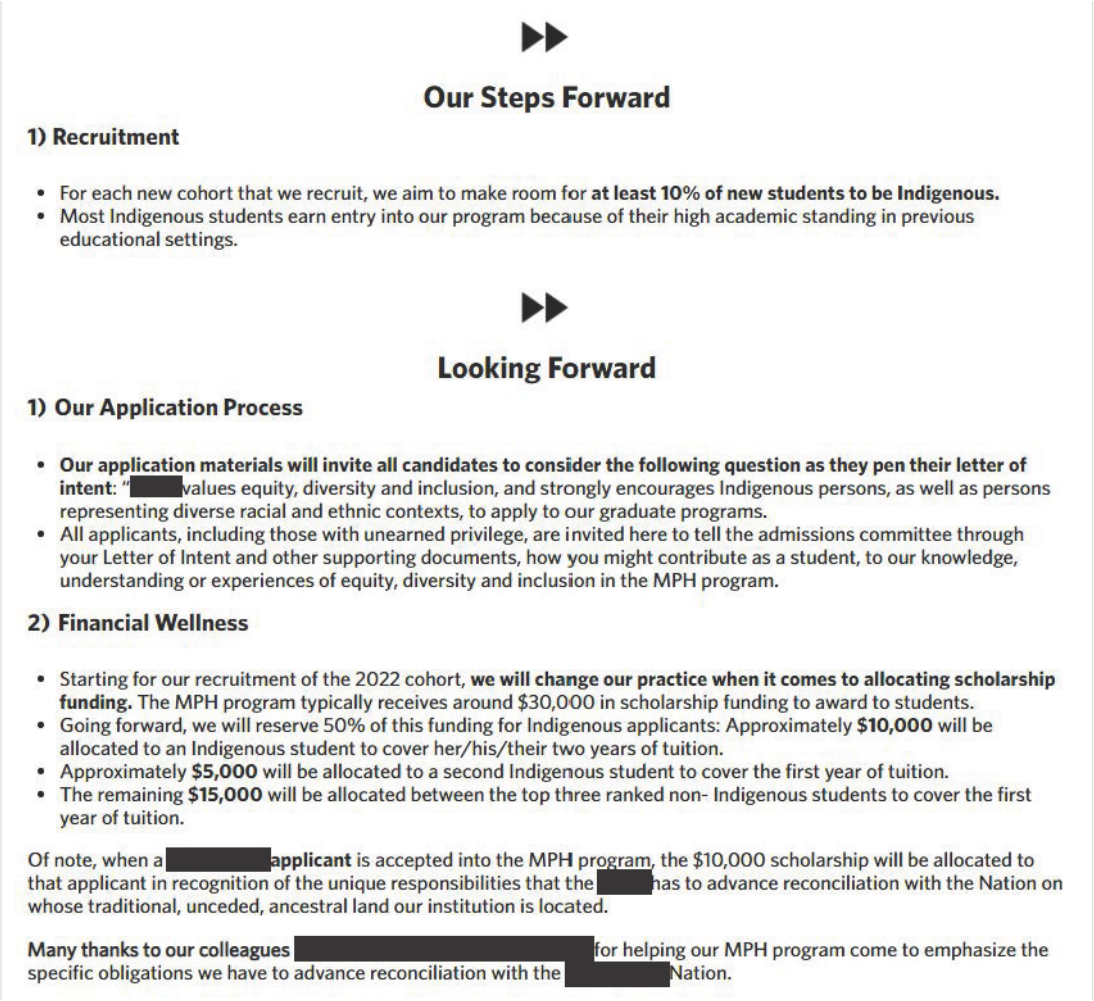
racism in the education system (Participants 103, 203, 302, 303; [Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022; [Case 300] Indigenous Plan, 2017-2022). A team within Case 200 was gathering stories of students' experiences of these types of barriers within their academic unit through surveys and interviews as part of the Reconciliation Audit; however, the audit was put on hold until further funding is secured (see **Reflecting and Evaluating**).

In recognition of the systemic barriers to higher education and the complicity of academic institutions in colonial injustices (see **Culture**), each of the three cases is undertaking initiatives to enhance the recruitment, enrolment, and retention of Indigenous students as part of their commitment to reconciliation and anti-racism. One strategy is to create admissions policies that prioritize Indigenous applicants and consider merit criteria such as community involvement, cultural knowledge, and lived experiences (Participants 202, 301, 302; [Case 100] CEPH Accreditation Final Report, 2015). Case 200 aims to reserve 10% of seats in each cohort for Indigenous applicants; furthermore, they have mechanisms to waive the requirement of having an undergraduate degree to enter a graduate program (Participants 202, 203; Case 200 webpage) (see Figure 14). Case 200's application process explicitly invites and considers applicants' contributions to EDI, with the intent of reflecting diversity across the cohort (Participants 202; Case 200 webpage). Case 300 similarly embeds equity considerations into their selection criteria. A senior faculty member explained, "We can look at those applications through the social justice and equity lens to say, is the student going to be a good fit for our program?"; the Program Director expanded, "It would be doing the student a disservice to bring them into our program if they weren't coming from that perspective because it would not be a good fit for them." Case 300 also has an unwritten policy that gives preference to Indigenous applicants by "fast-tracking" their applications to the director, who will admit them to the program as long as they meet the minimum criteria. The Program Director estimated that in recent years, Indigenous students make up 10-15% of each cohort; however, it should be noted that not all Indigenous applicants self-identify in their applications or after entering the program.

To supplement admissions policies, some of the cases and their academic institutions offer scholarships and bursaries that specifically provide financial support to Indigenous and Black students. Starting in 2022, Case 200 has committed to reserving half their

annual scholarship funds for the MPH program to be allocated to Indigenous applicants; moreover, if an applicant self-identifies as a member of the local Nation on whose territories the university is located, they will cover their full tuition for the two-year program (Case 200 Program Director, Case 200 webpage) (see Figure 14).

Figure 14. Case 200 Webpage for Recruiting Indigenous Students, redacted



Our Steps Forward

1) Recruitment

- For each new cohort that we recruit, we aim to make room for **at least 10% of new students to be Indigenous.**
- Most Indigenous students earn entry into our program because of their high academic standing in previous educational settings.

Looking Forward

1) Our Application Process

- **Our application materials will invite all candidates to consider the following question as they pen their letter of intent**: "[redacted]values equity, diversity and inclusion, and strongly encourages Indigenous persons, as well as persons representing diverse racial and ethnic contexts, to apply to our graduate programs.
- All applicants, including those with unearned privilege, are invited here to tell the admissions committee through your Letter of Intent and other supporting documents, how you might contribute as a student, to our knowledge, understanding or experiences of equity, diversity and inclusion in the MPH program.

2) Financial Wellness

- Starting for our recruitment of the 2022 cohort, **we will change our practice when it comes to allocating scholarship funding.** The MPH program typically receives around $30,000 in scholarship funding to award to students.
- Going forward, we will reserve 50% of this funding for Indigenous applicants: Approximately **$10,000** will be allocated to an Indigenous student to cover her/his/their two years of tuition.
- Approximately **$5,000** will be allocated to a second Indigenous student to cover the first year of tuition.
- The remaining **$15,000** will be allocated between the top three ranked non- Indigenous students to cover the first year of tuition.

Of note, when a [redacted]**applicant** is accepted into the MPH program, the $10,000 scholarship will be allocated to that applicant in recognition of the unique responsibilities that the [redacted]has to advance reconciliation with the Nation on whose traditional, unceded, ancestral land our institution is located.

Many thanks to our colleagues [redacted]for helping our MPH program come to emphasize the specific obligations we have to advance reconciliation with the [redacted]Nation.

Prior to the launch of Case 200's scholarship program, the Faculty of Graduate and Postdoctoral Studies "match[ed] funds provided by graduate programs (to a maximum of $8,000 per student and to a maximum of $50,000 for the program in total) to support master's Indigenous students" ([Case 200] President's Task Force on Anti-Racism and Inclusive Excellence Report, 2022). However, the institution's website confirms that this funding program was discontinued as of 2022. Similarly, Case 200's university partnered with MasterCard Foundation to provide scholarships to applicants from Sub-Saharan Africa; but once again, this opportunity was not renewed for 2022 (Case 200 Program

Director; university website). The university also has opportunities for financial support for Black students through the Beyond Tomorrow Scholars Program; however, this is only applicable to undergraduate programs (university website).

Case 100 is prioritizing retention and advancement of Indigenous students by creating supportive learning environments that promote a sense of belonging. Strategies include increasing Indigenous representation in student enrolment and faculty hires, supporting Indigenous peer-mentorship and tutoring programs, and investing in Indigenous student supports and physical space ([Case 100] Academic Plan, 2018-2023).

4.6.4. External Policy & Incentives

> CFIR Definition: A broad construct that includes external strategies to spread innovations including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting (CFIR Research Team-Center for Clinical Management Research, 2023).

Policies and guidelines set by academic institutions, accreditation bodies, public health agencies, and other external change agents influence how MPH students are trained by setting standards for the specific knowledge and skills they are expected to acquire. Across Canada, MPH programs generally develop their curricula in alignment with the PHAC's Core Competencies for Public Health in Canada, which establish professional standards for the essential knowledge and skills required for public health practice in Canada ([Case 100] CEPH Accreditation Final Report, 2015; [Case 100] Academic Plan 2018-2023). The Core Competencies were released in 2008 and outline 36 core competencies that are organized under seven categories: public health sciences; assessment and analysis; policy and program planning; implementation and evaluation; partnerships, collaboration and advocacy; diversity and inclusiveness; communication; leadership. Several participants critiqued the Core Competencies for inadequately reflecting knowledge and skills related to cultural safety and anti-racism (Participants 101, 103, 104, 307, 309). Participants suggested that the Core Competencies should be refreshed to include an expanded set of competencies or a cross-cutting lens that would specifically address Indigenous health (Participants 101, 103) (see **Discussion**). The PHAC Core Competencies are especially salient in Case 100, which is required to embed competencies in the curriculum as an accredited MPH program. Of the three cases, Case 100 is the only MPH program that is accredited by US-based Council on

Education for Public Health (CEPH); as such they are required to meet 27 CEPH competencies and five of their own, which draw from and expand upon the PHAC Core Competencies (Participant 101; [Case 100] CEPH Accreditation Final Report, 2015; [Case 100] Academic Plan 2018-2023). Among the five competencies that Case 100 has added, three are directly relevant to cultural safety and anti-racism training:

> 1. Describe the Indigenous social determinants of health, demonstrate understanding of and respect for Indigenous perspectives on health and wellbeing, and appreciate the practice of cultural safety and anti-racism practice for Indigenous peoples within health and welfare services and public health initiatives; 2. Identify theories and frameworks that explain constructions of gender and sex, race and ethnicity, social class, and other markers of social location with attention to their intersections, historical and contemporary contexts, and relationships to health equity;… and 5. Engage in self-reflection and self-reflexivity about one's own social position relative to others and discuss implications of one's positionality for research and practice addressing health inequities ([Case 100] MPH Core Competencies and Knowledge Areas).

While some MPH programs in Canada may adhere to US accreditation standards, the profession of public health in Canada is not currently subject to any standardized accreditation process (Participants 103, 301).

The uptake and implementation of cultural safety and anti-racism training interventions is strongly influenced by recommendations put forward in seminal documents, such as the RCAP recommendations, the TRC Calls to Action, the UNDRIP, and the In Plain Sight Report. Participants 102, 103, and 301, who are each renowned for their legacies in Indigenous health research and Indigenous health governance, credited RCAP as a watershed in mobilizing action to redress colonial oppression across Canada. They further acknowledged its profound influence on subsequent reports. The TRC Calls to Action were more widely referenced throughout the data as strong foundations for cultural safety and anti-racism training, especially Sections 62 to 65, which call upon all

educational institutions to educate for reconciliation, and Calls to Action 23 and 24, which call for skills-based training in intercultural competency and anti-racism for healthcare professionals. Commitments to the TRC Calls to Action are explicitly stated in Case 100's Aboriginal Reconciliation Council Report (2017), Case 200 School of Public Health's Strategic Plan (2021), and Case 300's Indigenous Plan (2017-2022). Commitments to the UNDRIP were also woven into institutional reports and course content (Participant 213; [Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 200] Indigenous Strategic Plan, 2020). Case 200's Indigenous Strategic Plan (2020) celebrated that the Province of BC is the first government in Canada and among Common Law states to pass legislation implementing the UN Declaration in 2019; moreover, that their institution is the first university in North America— and possibly the world—to endorse the UNDRIP and commit to its implementation. Provincial mandates now require academic institutions in BC to have UNDRIP response plans and report annually on their implementation progress. The recommendations put forward in the In Plain Sight report also came up as key context for cultural safety and anti-racism training in MPH programs in BC (Participants 101, 104, 204, 301). At the time of data collection, the Program Director of Case 100 noted that the MPH program had not yet incorporated the recommendations of the In Plain Sight report into the curriculum, as the report was still relatively new; furthermore, translating the clinical focus of the report into a public health context would require some attention. Other participants also commented on delays in uptake and implementation of these various calls to action, and expressed frustration with the lack of response. For Participant 102, the incremental change resulting from 30+ years of Commissions, reports, and calls to action has not yielded significant transformation. Participant 301 lamented, "we've been writing about this for decades, right, decades;" and Participant 204 sarcastically remarked, "If you ever talked to an Indigenous person, they have known this forever, but white people are now aware because somebody wrote a report on it."

External to the MPH programs' academic units but internal to the academic institutions they are situated within, each university has policies, guidelines, and strategic plans that shape the implementation of cultural safety and anti-racism training. As noted above and throughout the findings, all three cases have Indigenous Plans that help advance the institutions' commitments to reconciliation ([Case 100] Aboriginal Reconciliation Council Report, 2017; [Case 200] Indigenous Strategic Plan, 2020; [Case 300] Indigenous Plan,

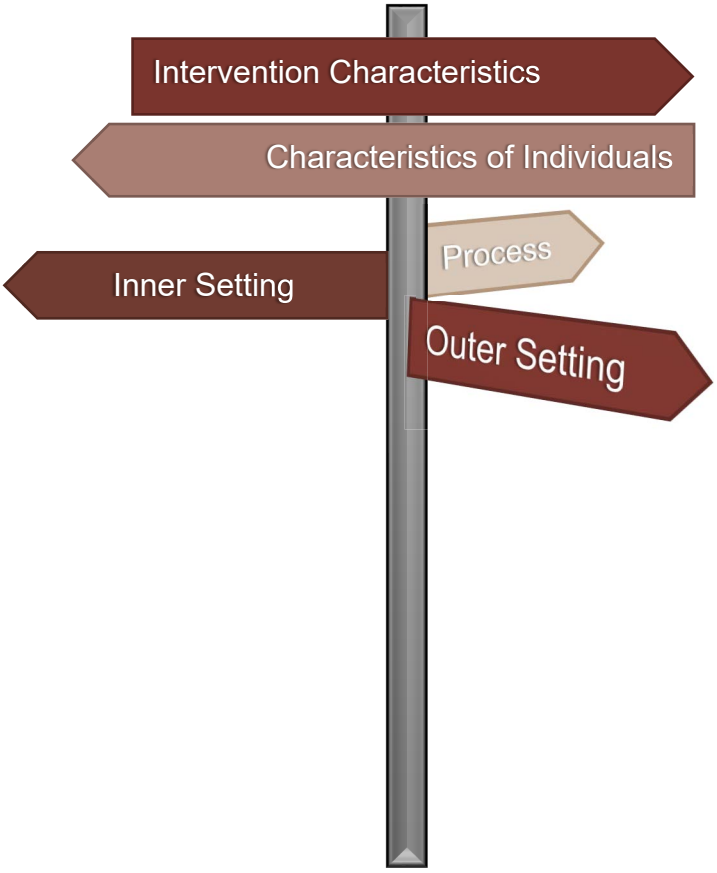
2017-2022). Moreover, each of these Plans include recommendations in support of cultural safety and anti-racism training. For example, Case 100's Aboriginal Reconciliation Council Report (2017) includes a call to action to "Develop mandatory intervention programs teaching cultural safety and anti-racism for all employees." The Aboriginal Reconciliation Council Report has been fully embraced by Case 100's academic unit, and a commitment to implementing its calls to action is written into multiple sections of their 2018-2023 Academic Plan. Case 200's Indigenous Strategic Plan (2020) includes a guide to help academic units develop their own plans for implementation, which supports comprehensive and cohesive integration of institutional commitments throughout the university.

Case 200 also released their Anti-Racism and Inclusive Excellence Task Force Report in 2022, which presents a series of recommendations aimed at addressing interpersonal and institutional racism against BIPOC students, faculty, and staff at the university. Similar to their Indigenous Strategic Plan, this report was coupled with a Strategic Equity and Anti-Racism (StEAR) Framework and Roadmap for Change to support implementation in academic units. Once again, the Report's recommendations placed strong emphasis on the need for sustained anti-racism training and education for all individuals at the university, positioning it as theme #1 in their summary of key findings and recommendations. One of several recommendations related to this theme draws attention to capacity building:

> … Recommendation 4: Increase educational opportunities on anti-racism for all faculty members and administrators" aims to require all faculty and leaders to raise anti-racist awareness so that they can enact anti-racism in teaching, research, service, personnel decisions, administering programs, developing initiatives and so on. It is important to recognize that this should be done through multiple channels in a sustained manner, since anti-racism and decolonization is a lifelong commitment of unlearning, relearning and enacting through critical reflection.

Due to the timing of the report's release, the interview and focus group data does not reflect participants' perceptions of or engagement with the Anti-Racism and Inclusive

Excellence Task Force Report (2022), or how it is being implemented within Case 200. Nor does it capture the influence of recent provincial developments, including FNHA's and the Health Standards Organization's (HSO) BC Cultural Safety and Humility Standard or the Province of BC's Bill 24: Anti-Racism Data Act, which were both released in June 2022.



Chapter 5. Recommendations

The recommendations shared in this section build upon the findings by highlighting promising practices and areas for improvement across the three cases. Additionally, they integrate direction offered by the literature and calls to action, thereby drawing from the extensive consultation that went into the various reports as well as decades of advocacy led by Indigenous peoples. Recommendations extend beyond the three academic institutions, spanning across practice, policy, research, and theory. They reinforce the need for a systematic, multi-sector, and multi-tiered approach to transformative change across Canada. Cultural safety and anti-racism interventions are needed across individual/ interpersonal (e.g. patient/ provider), institutional (e.g. health authority, university), and system (e.g. policy, accreditation) levels to create impactful and sustainable change. Some of this work is already underway, and it is more a matter of coming alongside, amplifying, and properly resourcing what is being done, rather than reinventing the wheel. The hope is that these recommendations will contribute to the ongoing conversation by highlighting key levers of change to enhance uptake, implementation, and sustainment of cultural safety and anti-racism in public health training and public health practice.

5.1. Practice

The data identified a variety of promising practices as well as areas for improvement to enhance practice and pedagogy for implementation of cultural safety and anti-racism training in MPH curricula. Below, recommendations are summarized in each domain of the CFIR, first presented in a summary table (see Table 3), followed by written descriptions that incorporate complementary insights from the literature. These recommendations provide suggestions to support MPH programs with navigating barriers and facilitators to implementation of relevant training interventions. They are intended to be practical and actionable, and are firmly grounded in the experiences of three MPH programs in BC. However, with acknowledgement that the implementation of cultural safety and anti-racism training interventions is context-specific, it would be futile to present a prescriptive checklist, definitive blueprint, or one-size-fits-all handbook. These recommendations are simply an invitation for reflection, and an offering for consideration and potential adaptation.

Table 3. Areas for Improvement and Promising Practices Across the Three Cases

CFIR Domain	Areas for Improvement	Promising Practices
Intervention Characteristics	• Embrace a more global approach • Avoid conflation of cultural safety and anti-racism with "Indigenous health issues" • Disrupt stigmatizing and deficit-based discourses • Include diverse experiences and theoretical lens informed by intersectionality and determinants of health • Extend duration of training • Scaffold learning throughout curriculum • Build in anti-racism training • Amplify diverse voices through speakers and materials	• Incorporate seminal documents and policies • Apply strengths-based approaches that showcase Indigenous knowledges, ways of knowing, and initiatives • Promote critical interrogation and unlearning • Teach cultural humility, positionality, reflexivity and allyship • Honour relationships with local First Nations groups • Embed cultural protocols and ceremonies into regular practice • Incorporate territorial acknowledgements and land-based learning • Require mandatory course on Indigenous health • Offer both introductory and advanced levels of training • Offer an Indigenous health area of focus or concentration • Introduce cultural safety and anti-racism during program orientation • Design opportunities for experiential learning • Promote mentorship from faculty and peers • Bring in guest speakers
Characteristics of Individuals	• Provide support and training for instructors • Mitigate demands that overburden BIPOC faculty • Avoid putting undue pressure on Indigenous students	• Utilize co-facilitation models • Appoint a curriculum lead in cultural safety & anti-racism • Recruit and retain more Indigenous faculty • Buffer the time of new Indigenous faculty hires
Process	• Improve opportunities for student input • Provide funding for evaluation activities and audits • Reflect on progress in implementing institutional goals • Accept imperfection and correction	• Elect or appoint students to internal committees • Formalize partnerships with stakeholders and change agents • Establish engagement mechanisms with Indigenous communities • Utilize tools and resources developed by university task forces
Inner Setting	• Address colonial legacies in the built environment • End micro-aggressions, bigotry, and systemic racism • Challenge normalization of white supremacy culture • Appropriately recognize and reward service work • Intentionally build commitments into strategic planning • Tailor strategies to communicate goals to students • Appoint more BIPOC leaders throughout the university • Adequately resource faculty-led interventions	• Cultivate welcoming and culturally safe learning environments • Highlight compatible values in faculty postings • Establish task forces or special advisor positions • Embed core principles in vision, mission, and values • Offer professional development opportunities for staff and faculty • Embrace discomfort and mistakes— "fail forward together" • Position priorities related to Indigenous reconciliation at top of plans • Revise tenure and promotion guidelines to reward implementation

	• Recruit and retain Indigenous and Black faculty • Familiarize faculty with available resources • Clearly communicate vision and goals to students	• Engage program directors and deans in implementation efforts • Use cluster hires to establish a “critical mass” of Indigenous faculty • Use preferential or limited hiring practices to recruit BIPOC faculty • Support new hires with campus resources and mentorship plans • Take advantage of institutional resources for curricular innovation • Allocate time for cultural safety and anti-racism during meetings
Outer Setting	• Strengthen training partnerships with health authorities • Sign or endorse the Declaration of Commitment • Refresh PHAC Core Competencies for Public Health • Tailor training to students’ learning needs and identities	• Collaborate with other Schools of Public Health • Expand experiential learning and practicums with health authorities • Follow the lead of the public health practice environment • Endorse UNDRIP and commit to implementing various calls to action • Implement admissions policies that privilege Indigenous applicants • Consider EDI contributions in application criteria • Provide scholarships and bursaries to Indigenous and Black students • Support retention & advancement of Indigenous and Black students • Establish ground rules and moderate classroom/ online interactions

5.1.1. Intervention Characteristics

To improve the effectiveness of cultural safety training, it is recommended to embrace a more inclusive approach that recognizes intersecting identities and incorporates perspectives from other settings across the globe. It is also important to challenge and critically deconstruct stigmatizing and deficit-based discourses that perpetuate negative stereotypes; in particular, conflating cultural safety and anti-racism with "Indigenous health issues" should be avoided. Instead, curricula should balance discussions around health inequities with strengths-based approaches that celebrate the contributions of Indigenous peoples and Indigenous knowledges to the field of public health, including Indigenous models of wellness and advanced understandings of determinants of health (Josewski, de Leeuw, & Greenwood, 2023). Furthermore, more attention should be given to thoughtfully incorporating skills-based anti-racism training, such as case scenarios and active bystander training.

An area for further improvement that did not surface as a significant theme in the data is the need to explicitly name systems of oppression, including colonization, racism, and white supremacy. Since the release of the TRC Calls to Action, Canadian society has gotten more comfortable with engaging in difficult conversations about colonization— though largely in a past tense— and reconciliation— though largely in a symbolic sense that conveniently overlooks land back. Similarly, with the influence of the Black Lives Matter Movement amplified in 2020, we are seeing more conversations about anti-Black racism as well as anti-Indigenous racism and anti-Asian racism. However, uptake of terminology associated with white supremacy is still lagging, presumably because it is an uncomfortable concept for many white folks to grapple with. When individuals are confronted with their own white identity as one piece of their positionality, it is common to experience emotions such as guilt, shame, anger, and discomfort (Participant 301; NCCDH, 2020). In the context of cultural safety and anti-racism training, it is important to frame white supremacy not as an individual act, but as a system of oppression that affects us all. Case 200’s President’s Task Force on Anti-Racism and Inclusive Excellence Report defines white supremacy as: “A historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and peoples of colour by White peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power and privilege” (2022, p. 295). The

National Collaborating Centre for Determinants of Health (NCCDH) is advancing these discussions in the field of public health, and made a clear statement about the need to disrupt racism and White supremacy in public health in their 2020 publication, 'Let's Talk Whiteness and Health Equity.' The resource outlines examples of actions to disrupt white supremacy through a critical whiteness approach; recommendations include but are not limited to:

- Be aware of one's own racial identity as well as be aware of how Whiteness manifests in society and how this contributes to racial inequities;
- Engage people in positions of power in conversations on Whiteness;
- Conduct organizational racial equity and White supremacy culture assessments, communicate the findings and implement meaningful changes;
- Meaningfully involve BIPOC communities in the development of public policy;
- Divest from oppressive institutions and systems that harm BIPOC communities.

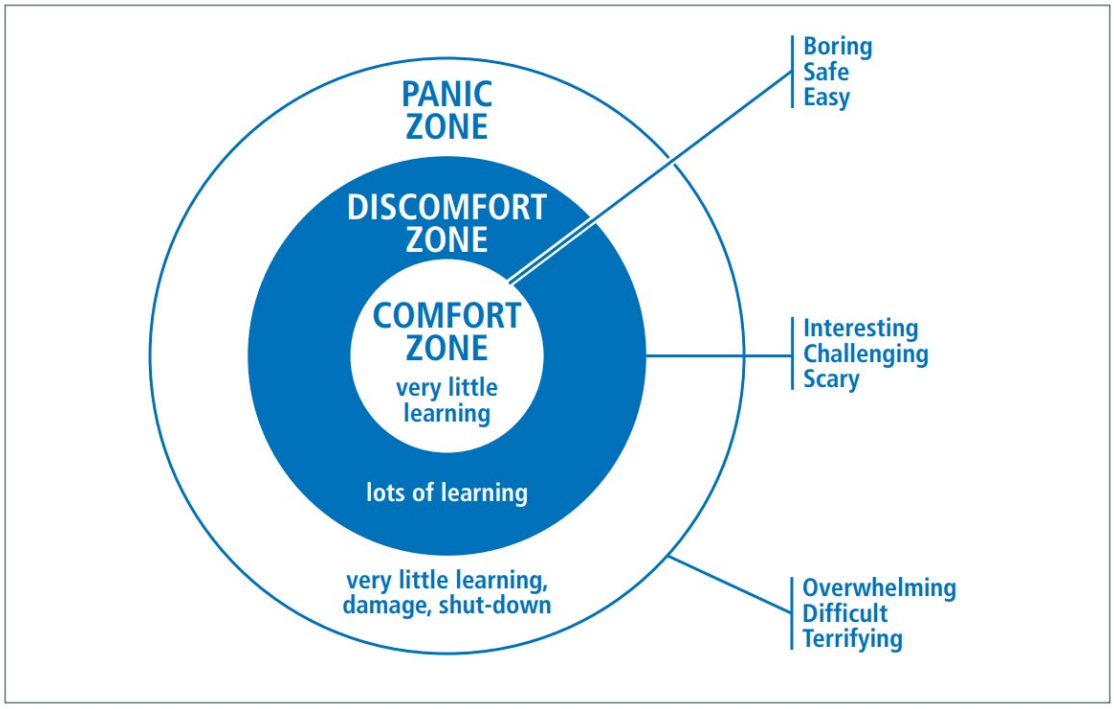
These practices could be promoted within cultural safety and anti-racism training interventions in MPH curricula. Moreover, to keep up with evolving discourses, white supremacy should be explicitly labelled and addressed as a determinant of health inequities alongside colonialism, racism, and other layered forms of oppression.

Other recommendations to improve cultural safety and anti-racism training interventions include scaffolding learning by providing gradual and structured support throughout the curriculum to build upon conceptual understanding and practice deeper skills. Additionally, the duration of the training should be extended to allow sufficient time for learners to gain a comprehensive understanding of cultural safety and anti-racism. As endorsed by all three cases, a mandatory course on Indigenous health should be required of all MPH students. Mandatory training in Indigenous health is also supported by the literature; for example, Coombe, Lee, and Robinson (2017) advocate for core-based integration as opposed to elective-based or parallel models so that all students receive foundational education. Nevertheless, both introductory and advanced levels of training can and should be offered to meet diverse learner needs. Advanced training could be offered in the form of an Indigenous health area of focus, which can help learners gain a deeper understanding and skillset for public health careers that have a specific focus on working with Indigenous patients, clients, communities, and/ or organizations.

Specific recommendations to enhance delivery of cultural safety and anti-racism training include teaching concepts such as cultural humility, positionality, reflexivity, and allyship. Furthermore, critical interrogation and unlearning should be promoted to challenge harmful attitudes and biases. Designing opportunities for experiential learning can provide learners with hands-on experience to practice relevant skills. This can be supplemented with mentorship from faculty and peers to provide guidance in professional practice. Delivery of training interventions should pay close attention to amplifying diverse voices through intentionally curated learning materials, as well as building in review of seminal documents and calls to action to provide historical and contextual understandings. Similarly, curricula should hold space for Indigenous knowledge holders and community members to bring lived experience and expertise to the curriculum. This requires building authentic relationships with local First Nations groups (see **Process**), and honouring cultural protocols, which should be embedded into regular practice to demonstrate respect for Indigenous cultures and traditions.

Complementing the finding that learners need to engage in unlearning and embrace uncomfortable concepts such as white supremacy, NHS England and NHS encourage ‘Learning in the Discomfort Zone’. This idea posits that “In the discomfort zone people are most likely to change and learn how to do things differently… The key to encouraging people into the discomfort zone is to make it safe enough for them to both express their anxieties and experiment doing new things” (2022, p. 2). In Figure 15 below, the discomfort zone is visualized alongside the comfort zone and panic zone in relation to their respective potential for transformative learning. Cultural safety and anti-racism training interventions should strategically build in opportunities for students to engage in learning in the discomfort zone. One approach to this could be introducing challenging concepts (e.g. genocide, systemic oppression, privilege, white supremacy) and facilitating a safe space for students to work through their discomfort to foster growth. This may involve personal reflection to confront their own preconceived biases, ignorance, complicity, and ways in which they perpetrate or perpetuate harm.

Figure 15. Zones of comfort (NHS England and NHS Improvement, 2022, p. 3)



5.1.2. Individuals Involved

The findings highlight that everyone has a role to play in implementing cultural safety and anti-racism training; however, Indigenous peoples are recognized as leaders in championing this work, and must be actively involved in curriculum development, delivery, and evaluation. The need for Indigenous leadership is explained by Johnson and Sutherland as follows:

> While the problem of Indigenous-specific racism and the required changes to enhance cultural safety lies with non-Indigenous individuals, communities, organizations and governments, those who experience racism in the health care system – Indigenous Peoples and, in particular, Indigenous women (Fridkin et al., 2019) – must be intimately involved in developing solutions and making decisions about health policy (Fridkin et al., 2019) as, ultimately, success in achieving cultural safety can only be determined by Indigenous Peoples themselves (2022, p. 28)

Indigenous peoples can shape MPH curricula as curriculum advisors, Elders in Residence, community/ organizational partners, guest lecturers, sessional instructors, faculty members, administrators in positions of leadership, and/ or students. The findings specifically call for hiring a curriculum lead in cultural safety and anti-racism that can be appointed within an academic unit or as a centralized resource for faculty clusters or across an institution. Yet, availability and time of Indigenous experts is recognized as a significant barrier. A key finding in the data that spanned across multiple CFIR domains was the need to recruit and retain more Indigenous people in faculty and leadership positions with decision-making authority. This is also emphasized in the literature to counteract underrepresentation of Indigenous peoples in academia and the healthcare workforce (Aboriginal Affairs and Northern Development Canada, 1996; Gaudry & Lorenz, 2018; Giroux, 2017, Leonard & Mercier, 2016; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Shah & Reeves, 2015; Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond, 2020). Furthermore, Indigenous faculty should have the option to be engaged in this work, and it should not be assumed that cultural safety and anti-racism are their areas of interest (National Collaborating Centre for Determinants of Health & Canadian Institutes of Health Research Institute of Population and Public Health, 2023). Individuals involved in implementing cultural safety and anti-racism training expressed a need and desire for ongoing support and training for instructors to build their capacity in delivering effective cultural safety education (see **Inner Setting**). Additionally, to mitigate demands that overburden BIPOC faculty, additional support should be provided. Examples include buffering the time of new faculty hires to help them adjust to their new roles and responsibilities; providing mentorship from more senior faculty or other BIPOC faculty in the institution; and/ or utilizing co-teaching models for safety, support, and mentorship in the teaching environment.

5.1.3. Process

The three MPH programs included in the sample are all in relatively early stages of implementing cultural safety and anti-racism training. This is consistent with evidence syntheses in the published literature as well as reports of progress on calls to action that indicate that across Canada and other countries, uptake of these types of training interventions in health professional education are in early stages of development and

implementation. Therefore, promising practices and areas for improvement highlighted in this section largely focus on engagement activities. For instance, to ensure that the training is responsive to the needs and realities of Indigenous peoples, it is recommended that MPH programs formalize partnerships with stakeholders and change agents, such as Indigenous communities and healthcare organizations. Specifically, establishing ongoing engagement mechanisms through community advisory committees and MOUs can help build trust and strengthen relationships with Nations on whose territories universities are located as well as Métis diasporas and urban Indigenous collectives. It is also recommended to provide more opportunities for students to provide input and/ or critical feedback in ways that they deem as safe to ensure that their perspectives and experiences are incorporated into their education. Electing or appointing students to internal committees can provide them with meaningful opportunities to contribute to the development, delivery, and iterative refinement of the training.

Under the CFIR construct of Reflection and Evaluation, it is recommended that MPH programs measure and report on progress in implementing institutional goals to be accountable to broader university mandates related to reconciliation, Indigenization, anti-racism, etc. MPH programs are encouraged to utilize tools and resources developed by university task forces, which can provide guidance for implementation and assessment of progress towards achieving strategic goals. Academic institutions are also recognized as a valuable source of funding to support evaluation efforts. However, evaluation activities and audits need to be adequately resourced over an appropriate amount of time. Though not discussed in the findings, an important area for further consideration is the ongoing sustainment and quality improvement of cultural safety and anti-racism training interventions. Ongoing cycles of monitoring, evaluation, and iterative refinement must be sustained long-term. Furthermore, longitudinal evaluative research of outcomes should be conducted to demonstrate effectiveness of the interventions, or otherwise advise on de-implementation of ineffective interventions (see recommendations under **Research**).

5.1.4. Inner Setting

Uptake and implementation of cultural safety and anti-racism training interventions needs to be accompanied by changes in the inner setting, including structural

characteristics, organizational culture, policies, and decision-making power within institutions and academic units. Within the inner setting and across multiple other constructs, a significant theme across all three case sites was the complexity of cultivating a culturally safe environment. Cultivating welcoming and culturally safe learning environments involves creating spaces that respect and value diverse cultures, histories, and perspectives. Indigenous students and partners should see themselves and their cultures reflected in their surroundings; this includes holding space for Indigenous knowledges and languages, displaying Indigenous artwork and designs, and hosting events that celebrate Indigenous cultures. It is also recommended to address colonial legacies in the built environment by removing artwork, artefacts, and building names that have colonial connotations. Promoting diversity and inclusiveness must also be coupled with displacing and eliminating oppressive culture. Ending micro-aggressions, bigotry, and systemic racism requires active efforts to confront these harmful attitudes and behaviors. This can be achieved through anti-racism training for faculty and staff; creating reporting mechanisms for incidents of discrimination; and addressing discrimination in hiring, tenure, and promotion— as just a few examples. At a more systemic level, challenging the normalization of white supremacy culture involves recognizing and challenging the ways in which Eurocentrism, English language, and whiteness are often prioritized and centered in academic institutions, while other cultures, languages, histories, and bodies are marginalized or silenced. Again, we can start to reckon with white supremacy in our institutions by implementing the recommendations offered by the NCCDH's 'Let's Talk Whiteness and Health Equity' resource (see **Intervention Characteristics**).

It is recommended that academic units intentionally embed commitments to cultural safety and anti-racism into strategic planning by clearly outlining goals and targets. Core principles can be embedded in the organization's vision, mission, and values, with priorities related to Indigenous reconciliation positioned at the top of plans to reflect their importance. Additionally, time should be allocated to revisit these commitments during regular meetings. Importantly, commitments must be followed through with deliberate action. It is noteworthy that while resistance among faculty and administrators (e.g. questioning the relevance, credibility and/ or appropriateness of training interventions) was identified as a critical barrier in the literature review (Aqil et al., 2021; Beavis et al., 2015; Diffey & Mignone, 2017; Jewell & Mosby, 2020; McSorley, Manalo-Pedro, &

Bacong, 2021; Guerra & Kurtz, 2017; Perez, Leonard, Bishop, & Neubauer, 2021) (see **Resistance**), this was not a factor noted within any of the three cases. Nevertheless, to encourage faculty to actively participate in implementing cultural safety and anti-racism training interventions, incentivization can be built into tenure and promotion guidelines to recognize and reward these contributions. Furthermore, faculty-led interventions for curricular innovation should be adequately resourced, which may include familiarizing faculty with institutional resources and supporting them to apply for grants.

Even in the absence of active resistance, faculty and administrators may question their ability or preparedness to contribute to the implementation of cultural safety and anti-racism training interventions. To build institutional and individual capacity, there are several recommendations to consider. Recommendations start with but extend well beyond offering professional development opportunities to support existing faculty with acquiring and maintaining the knowledge and skills needed to effectively implement cultural safety and anti-racism training. Beyond professional development, it is a top priority to recruit and retain Indigenous and Black faculty to enhance overall capacity and reflect diversity within the university community. This can be achieved by using preferential hiring, limited hiring practices, or cluster hires to recruit a "critical mass" of BIPOC faculty. It is also recommended to highlight compatible values in faculty postings to specifically attract individuals who are committed to cultural safety and anti-racism. Supporting new hires with campus resources and mentorship plans can help to ensure their retention, advancement, and success. Additionally, there is a pressing need to appoint more BIPOC leaders in administrator roles with decision-making/ resource allocating authority throughout the university. Establishing task forces or special advisor positions can help provide guidance to these leaders and inform institutional action plans.

5.1.5. Outer Setting

To address barriers and build on facilitators in the outer setting, recommendations include strengthening training partnerships with health authorities. Following the lead of the public health practice environment ensures students are learning relevant and practical skills, in alignment with core competencies for the public health workforce. Expanding experiential learning and practicums with health authorities can reinforce training by providing opportunities for a more hands-on approach to learning. MPH

programs can also align with and endorse formal and informal policies in the outer setting. For instance, academic units and/ or institutions can commit to implementing various calls to action (e.g. TRC, UNDRIP, In Plain Sight); signing the Declaration of Commitment to Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal People in BC; and/ or adopting the British Columbia Cultural Safety and Humility Standard (see **Policy**). MPH programs can also strengthen their networks by collaborating with other schools of public health, for instance by forming a community of practice to share experiences and promising practices, holding dialogue sessions with partners from the public health practice environment, co-hosting summer schools for MPH students, developing shared resources and learning materials, and/ or advocating for updated core competencies. MPH programs can also get involved in refreshing the PHAC Core Competencies for Public Health to ensure that practice and curricula standards are relevant to cultural safety and anti-racism (see **Policy**).

Recommendations in the outer setting also include a range of strategies to ensure cultural safety and anti-racism training interventions meet the needs of students. This may include offering scholarships and bursaries to Indigenous and Black students to support their recruitment, retention, and advancement. Furthermore, admissions policies can be implemented to prioritize Indigenous applicants and consider EDI contributions in application criteria. Additionally, training interventions should be tailored to students' learning needs and prior exposure, which may necessitate offering both introductory and advanced levels of training, as mentioned in **Intervention Characteristics**.

5.2. Policy

A key recommendation emerging from both the data and the literature is standardization of cultural safety and anti-racism training in MPH curricula through core competencies (see **Standardization and Accreditation** and **External Policy & Incentives**). Core competencies can help establish a baseline to promote a foundational set of skills, knowledge, and attitudes expected of the public health workforce in Canada. Specific recommendations were put forward that propose updating and refreshing the PHAC ‘Core Competencies for Public Health in Canada’ (2007) to better capture cultural safety and anti-racism (Baba, 2012; MacLean et al., 2023; Tam, 2021). This could take the form of adding an eighth category for an expanded set of competencies, incorporating a cross-cutting lens that applies to all competencies, and/ or creating a parallel set of

competencies specific to Indigenous health. As noted in the Literature Review, Canada can follow the leadership of New Zealand and Australia by establishing national core competencies specific to cultural safety (Baba, 2012; Baba, 2013; Baba & Reading, 2012). Both New Zealand and Australia have public health core competency models that include expectations around cultural competence and cultural safety; these competency models are incorporated as required content in health professional education (Baba, 2012). Similarly, in Canada, the fields of medicine, nursing, and community health have core competency models for Indigenous health and cultural safety, which can serve as reference points for developing similar standards for public health.

In the field of public health in Canada, the six National Collaborating Centres have recently been commissioned by PHAC to modernize and refresh the core competencies, which provides a timely opportunity for advancing this recommendation (National Collaborating Centre for Determinants of Health Webinar, March 29, 2023). As this process unfolds, it is pertinent that the forthcoming iteration of the core competencies is responsive to the British Columbia Cultural Safety and Humility Standard (FNHA & the Health Standards Organization, 2022), which offers assessment criteria, evidence-based requirements, statements of intent, actions for implementation, accountability mechanisms, and accompanying guidelines to support implementation (see **Standardization and Accreditation**). To support standardization of cultural safety and anti-racism as core competencies in public health, efforts to refresh the PHAC Core Competencies can follow BC's established leadership in this area by mirroring the terminology and expectations set forth by the BC Cultural Safety and Humility Standard. While the BC Cultural Safety and Humility Standard does not explicitly name post-secondary institutions as an intended audience, it stands to reason that standards for public health practice or any health professional practice should be embedded within the education and training of the workforce. Therefore, MPH programs should take steps to incorporate the Standard's assessment criteria, requirements, actions for implementation, and accountability mechanisms into curriculum development processes.

To further support standardization of cultural safety and anti-racism training, uptake and implementation of the PHAC Core Competencies could be regulated through more consistent accreditation of MPH programs in Canada. While some MPH programs in Canada may opt for accreditation through the US-based CEPH, there currently is no formal accreditation body to regulate public health core competencies in Canada. The In

Plain Sight Report put forward a recommendation that proposed pursuit of accreditation mechanisms to advance cultural safety and anti-racism in the healthcare system, as follows:

> Recommendation 8: That all health policy-makers, health authorities, health regulatory bodies, health organizations, health facilities, patient care quality review boards and health education programs in B.C. adopt an accreditation standard for achieving Indigenous cultural safety through cultural humility and eliminating Indigenous-specific racism that has been developed in collaboration and cooperation with Indigenous peoples (Turpel-Lafond, 2020, p. 191).

Once the PHAC Core Competencies are updated, their implementation should be upheld through accountability mechanisms, which could be enforced by a public health accreditation body. Having a Canadian-based public health accreditation body could help ensure that MPH programs and public health professionals meet established standards, and will support standardization of cultural safety and anti-racism in MPH curricula across jurisdictions and practice settings.

5.3. Research

The **Literature Review** highlights that even though numerous cultural safety and anti-racism training initiatives have been implemented over the past three decades, there is a paucity of evaluative evidence linking these interventions to real change in: reducing racism in the health system, enhancing the cultural safety of healthcare encounters, and/ or improving inequitable health outcomes (Baba, 2013; Chang, Simon & Dong, 2012; Guerra & Kurtz, 2017; Gustafson & Reitmanova, 2010; Horvat, Horey, Romios & Kis-Rigo, 2014; Johnson & Sutherland, 2022; Nickerson, 2019; Turpel-Lafond, 2020). Furthermore, the challenge of insufficient evidence is compounded by the absence of methodologically rigorous tools and standardized indicators for evaluation (Beavis et al., 2015; Downing & Kowal, 2011; Horvat, Horey, Romios & Kis-Rigo, 2014; Johnson & Sutherland, 2022; McElfish et al., 2018; Turpel-Lafond, 2020). These critiques of the available evidence and absence of systematic evaluation were echoed in the data, with

barriers noted around measuring or quantifying transformation resulting from training interventions (see **Evidence Strength & Quality** and **Reflecting and Evaluating**).

As stated at the outset of this dissertation (see **Purpose**), this study was not intended to evaluate the effectiveness of cultural safety and anti-racism training interventions by measuring outcomes. Again, this line of inquiry warrants closer and more long-term examination that is beyond the scope of this study. As such, a key recommendation is that further research be conducted to evaluate the impact of cultural safety and anti-racism training interventions in health professional education. Specifically, future studies could investigate immediate changes in beliefs and attitudes, as well as sustainment of acquired knowledge and skills over time. Arguably more importantly, studies should conduct longitudinal impact assessment to document the presence (if any) of transformations in healthcare (e.g. changes in professional practice, experiences of Indigenous patients receiving care), and situate this within the context of population health outcomes to assess contributions to health equity. Furthermore, research should be conducted with a specific focus on the impacts of cultural safety and anti-racism training in the field of public health; this would address a current knowledge gap and advance understandings of how these interventions contribute to public health's unique role in promoting health equity.

To support efforts to evaluate cultural safety and anti-racism training interventions, the NCCIH published a resource authored by Harmony Johnson (sɛƛakəs) and Julie Sutherland that presents a conceptual framework for Indigenous cultural safety measurement (2022). The purpose of the framework is to assess the impacts of colonialism and racism on Indigenous peoples' health and wellness, and monitor implementation of cultural safety in healthcare using standardized indicators (see Figure 16). Standardized indicators and measures offer "the ability to aggregate across settings, regions, and geographies for system-wide monitoring and knowledge development;" however, this framework is also designed to "support local settings to develop indicators that reflect their cultures, priorities, and practices" (p. 28). Use of this framework will promote consistency and comparability in data collection and reporting to generate a robust evidence base to support implementation of evidence-based interventions— or alternatively de-implementation of interventions that prove ineffective. In alignment with recommendations put forward in the NCCIH resource, future directions for research and evaluation should include using this conceptual framework to guide

cultural safety audits and assessments in the healthcare system at the organizational and provider level. The framework could also be adapted for application in the education system at the level of academic institutions (e.g. the Aboriginal Reconciliation Council's Report that spanned across Case 100's institution), academic units (e.g. the reconciliation audit initiated by participants within Case 200), or courses (e.g. the decolonizing curricula report that assessed Indigenous content in all courses in Case 300).

Figure 16. Cultural Safety Measurement Conceptual Framework (Johnson & Sutherland, 2022, p. 20)

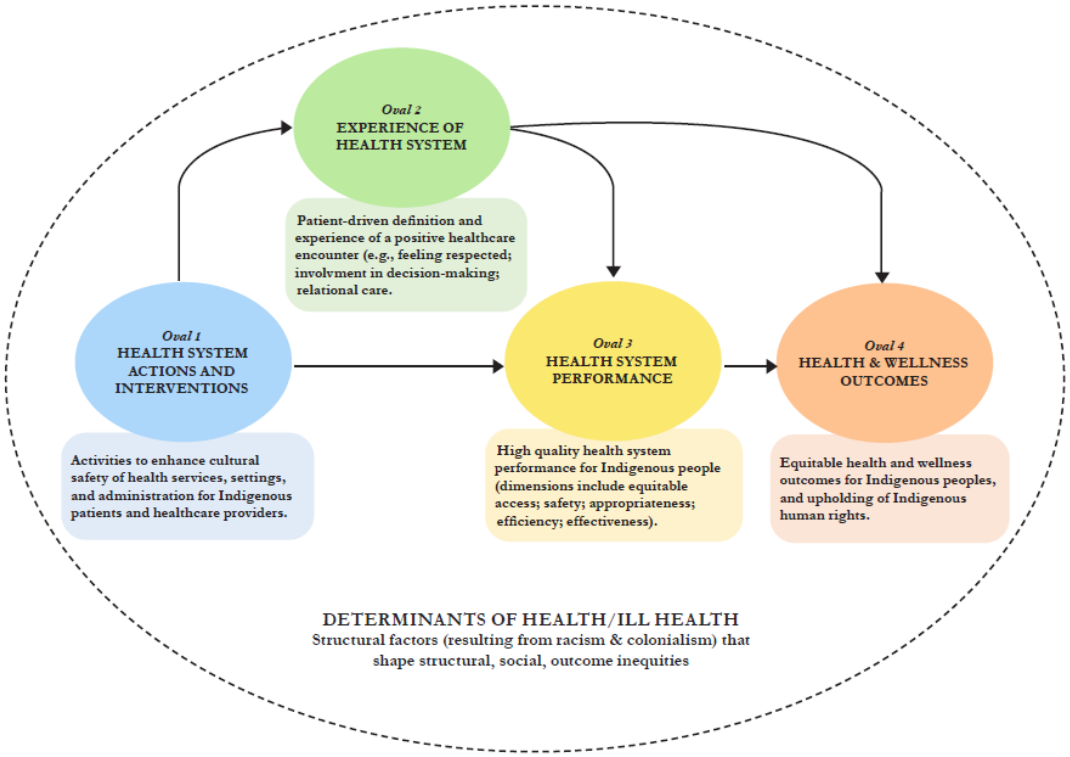


Figure 1: Cultural Safety Measurement Conceptual Framework

5.4. Theory

As noted in **Implementation Research**, the field of implementation research has been critiqued for being under-theorized or for superficially or haphazardly applying theory. Incorporating theoretical perspectives in implementation research can strengthen our understandings of the variables that drive successful implementation, as well as the complex interactions and relationships between these factors. There has been a growing

recognition for the need to strengthen theoretical foundations in implementation research; this has led researchers to draw from other disciplines and adapt or develop new theories specific to implementation research (Birken et al., 2017b; Nilsen, 2015). There is a particular need to complement and extend existing implementation theory to better capture power, equity, intersectionality, and racism (Allen et al., 2021; Eslava-Schmalbach, Garzón-Orjuela, Elias, Reveiz, Tran & Langlois, 2019; Shelton, Adsul & Oh, 2021; Snell-Rood et al., 2021; Woodward et al., 2021).

In this study, the CFIR, a widely used implementation determinants framework, was coupled with a theoretical lens grounded in anti-colonialism and intersectionality to guide framework analysis and support theoretical integration. The application of critically-oriented theories supported analysis of underlying power dynamics embedded within various constructs of the framework. For instance: the dominance of Eurocentric conceptions of valid or rigorous evidence was challenged under the construct of **Evidence Strength and Quality**; the open construct of **Other Personal Attributes** facilitated description of the roles of Indigenous, BIPOC, and allied individuals in implementation processes; the importance of engaging with Indigenous communities was foregrounded in **Key Stakeholders and External Change Agents**; colonialism, Eurocentrism, racism, and white supremacy were examined as permeating the **Culture** of the Inner Setting; and under **Peer Pressure**, gaps in the data were critically analyzed to recognize societal movements related to cultural safety and anti-racism. These findings demonstrate the value of integrating critical theoretical perspectives into implementation research to help surface significant hidden forces that are interwoven throughout implementation determinants and contexts.

As an extension of the recommendation to integrate critical theories such as anti-colonialism and intersectionality into implementation research, there is an opportunity to advance implementation research and theory through the guidance of Indigenous knowledge systems and ways of knowing. There is a significant gap in implementation research studies, frameworks, and theory led by Indigenous scholars, and incorporating Indigenous worldviews and perspectives. Snell-Rood and colleagues critique implementation research for its “ethnocentric nature [that] almost exclusively employs theories narrowly designed around Western governance to understand diverse implementation settings globally” (2021, p. 1). There is one example of an Indigenous implementation research study in the published literature: the He Pikinga Waiora

Implementation Framework (Oetzel et al., 2017). The Māori framework incorporates core concepts of self-determination, cultural-centeredness, community engagement, systems thinking and integrated knowledge translation, which are “are wrapped around a center grounded in indigenous critical theory (i.e., Kaupapa Māori) and each element is consistent with, and supportive of, indigenous knowledge creation and use” (Oetzel et al., 2017, p. 6). The framework has been applied in a systematic review to analyze diabetes prevention in Indigenous communities in Australia, Canada, New Zealand, and the United States. The Framework is an exemplar of Indigenous scholarship in implementation research; however, like cultural safety, it is firmly grounded in Māori culture and therefore may not reflect the cultural principles and priorities of other Indigenous Nations (Downing & Kowal, 2011). Implementation research and theory can be advanced over time through community-driven efforts to redefine, reinterpret, or reinvent understandings of quality evidence, relevant and appropriate interventions, principled processes, meaningful outcomes, and culturally-informed approaches to measurement and evaluation.

Chapter 6. Conclusion

This study examined the barriers and facilitators shaping the uptake and implementation of cultural safety and anti-racism training in three distinct MPH programs in BC, which each presented as unique case studies for investigation and comparison. The CFIR (Damschroder et al., 2009) provided a valuable framework for understanding determinants of implementation, while facilitating theoretical integration with an existing body of literature from implementation research. Predefined core domains and constructs helped structure and give greater meaning to themes that organically emerged in the data. Specifically, findings responded to the following objectives under the five core CFIR domains:

1. **Intervention Characteristics:** Characterize the core components and adaptable features of cultural safety and anti-racism training interventions in MPH curricula within each institution;

2. **Characteristics of Individuals:** Identify the key individuals and groups influencing uptake and implementation, and/ or directly involved in implementing cultural safety and anti-racism training in MPH curricula within each institution;

3. **Process:** Describe the stage of implementation from planning through sustainment, and how approaches or strategies have evolved or been adapted over time to capture the temporal context;

4. **Inner Setting:** Document the institutional conditions in which implementation of cultural safety and anti-racism training takes place within each institution;

5. Outer Setting: Examine the broader social, cultural, political, and historical contexts that shape uptake and implementation.

This dissertation provided a description of the variation and similarities in approaches to implementing cultural safety and anti-racism training interventions across the three cases. It further offered a set of recommendations to highlight promising practices and areas for improvement. Recommendations were integrated with the literature and presented for broad application across practice, policy, research, and theory.

6.1. Strengths

There are several elements of this study that contribute to its quality, rigor, credibility, and practical relevance to the field of public health. One of the primary strengths of this study is the multi-case design that explored the implementation of cultural safety and anti-racism training interventions across three distinct MPH programs. The multi-case design has the advantage of situating case-specific findings within their specific contexts, while also identifying common patterns for potential transferability to other settings (e.g. schools of public health in other regions). Additionally, the study's application of a widely used implementation framework supports theoretical integration, and presents opportunities for adapting the study design to public health practice settings (e.g. health authorities) or alternatively other professional fields (e.g. nursing). Internal validity was strengthened by member checking processes employed to seek feedback from participants to ensure their contributions were captured accurately and verify interpretations. Triangulating multiple sources of data provided a more rich and nuanced description of the interventions and their implementation, and further helped address potential biases or limitations of a single data source. Within each case, multiple forms of data were collected, including interviews, focus groups, documents, and public correspondence; moreover, the data included a diverse sample of participants, capturing the perspectives of students (N=15), faculty (N=19), staff (N=2), and administrators (N=6). In particular, the contributions of MPH students offered valuable forthright insights about their experiences and perceptions; additionally, reports prepared by university task forces or councils compiled anonymized stories from across their respective institutions (e.g. [Case 100] Aboriginal Reconciliation Council Report, 2017, [Case 200] President's Task Force on Anti-Racism and Inclusive Excellence, 2022). During data collection, multiple participants commented on the perceived value of participating. One participant noted, "… Not only is this powerful and useful, hopefully, for your research, but I think it has been very powerful and useful for me in terms of reflections" (Participant 303). Both students and faculty appreciated the opportunity to engage with peers or colleagues in focus groups to dive deeper into discussions around cultural safety and anti-racism, as well as share common challenges, strategies, and resources. Participants expressed interest in continuing these types of conversations within their academic units on a regular basis (Participants 202, 305), and potentially creating opportunities for sharing across institutions through symposia or small conferences (Participant 101).

6.2. Limitations

Limitations of this study include standard considerations for in-depth qualitative research around generalizability and transferability of findings. The sample was limited to three MPH programs and did not include other programs of study relevant to public health or from regions outside of BC. Because of this focus, findings and recommendations may be less relevant to other practice settings, disciplinary contexts, or geographic regions. Furthermore, it is important to situate the research within its temporal context, understanding that the data is collected over a defined period and does not capture a complete historical background. Moreover, any changes or developments that occur after the data collection period (2021-2023) may not be reflected in the data. External validity is another inherent limitation of qualitative research, as it is not possible to ascertain the extent to which the views and experiences of those included in the sample are representative of others who were not included. It should be noted that as a doctoral research study, data collection and analysis was conducted by a single investigator, and interpretations were informed by my social location, worldview, and previous experiences.

Beyond standard limitations of qualitative research, this study also has some topic-specific limitations. First, the study is limited by its focus on anti-Indigenous racism in Canada, resulting in the experiences of racism of other racialized groups and anti-racism training interventions to counteract this problem not being represented in the background, literature review, and recommendations. This omission is consistent with the findings, which reported that within MPH programs, discussions around cultural safety and anti-racism largely centered the experiences and needs of Indigenous peoples. The centering of Indigenous voices was also intentionally built into the sample frame, whereas the perspectives of Black Canadians and People of Colour were underrepresented. To uphold anonymity, demographic information (e.g. age, gender, racial identity/ Indigeneity, years affiliated with institution, etc.) were not collected. However, participants were invited to provide a personal statement with any identifying information that they deemed relevant, either in writing in their consent form or verbally during the interview/ focus group. Nevertheless, demographic information is not reported due to the small community of practice that comprises MPH programs in BC—particularly individuals involved in cultural safety and anti-racism training (study sample

size= 42). This limited the application of anticolonial theory and intersectionality theory in the presentation of findings because the positionality of participants was [generally] not foregrounded.

6.3. Potential Impact

The significance and impact of this research lies in its contributions to providing insights about the extent to which MPH programs in BC universities are preparing a public health workforce effectively trained in cultural safety and anti-racism praxis. Descriptions of the training interventions and the implementation processes being undertaken offer a starting point for discussions around defining and measuring core competencies, standardized interventions, and best practices that can be spread, scaled, and adapted to other settings. MPH programs can benefit greatly from sharing knowledge and learning from one another to better prepare students to address the most pressing public health issues of our time. Widespread uptake of cultural safety and anti-racism training interventions will help ensure that the public health system and the wider healthcare system is appropriately and effectively addressing the healthcare needs of Indigenous peoples throughout Canada. Moreover, because cultural safety and anti-racism target the underlying power dynamics that connect various forms of intersectional oppression, these interventions contribute to broader aims of enhancing health and education systems for other equity-deserving groups and all Canadians.

The knowledge generated from this research has potential to contribute to long-term outcomes, which could include: 1) cultural safety and anti-racism are embedded in core competencies and accreditation standards; 2) cultural safety and anti-racism training becomes a required component of MPH training; 3) cultural safety and anti-racism training interventions are regularly monitored and evaluated for ongoing quality improvement; 4) culturally safe anti-racism praxis is considered a practice standard across the public health system; and 5) instances of racism in public health practice settings are reduced, and Indigenous peoples— and all patients— experience culturally-safe care. However, the presence of cultural safety and anti-racism training in MPH curricula does not guarantee change in behaviour or the professional culture of public health practice. In addition to increasing capacity among the public health workforce, change requires sustained commitment among leadership and managerial level staff at all levels of the healthcare system, as well as educational institutions, professional

associations, accreditation and regulatory bodies, and provincial and federal governments (Baba, 2013; NAHO, 2008). Permanently “hardwiring” cultural safety into public health practice and the wider healthcare system in BC and beyond is a long-term investment (Nickerson, 2019). Amidst the current provincial, national, and global context of persisting anti-Indigenous racism, there is an urgent ethical, social, and economic imperative for governments, health systems, education systems, and society at large to take action. It is going to take time, money, and transformative change, but the cost and consequences of doing nothing or maintaining the status quo is far greater.

The captikʷɬ (teachings about laws, customs, values, and governance) shared by Syilx Okanagan artist Taylor Baptiste at the beginning of this dissertation (see Figure 17) offers a powerful and optimistic message to move forward in a good way. First, it serves as a reminder that we all bear the responsibility to respond to calls to action and recognize the significance of our distinct roles in weaving cultural safety and anti-racism into the fabric of society. Second, that we need to embrace discomfort and learn from our mistakes— as Participant 203 shared, “… We're never going to be perfect at this, but let's fail forward together.” Our shared journey towards cultural safety and anti-racism may be imperfect, but by embracing our individual responsibility and harnessing our collective strength, we can pave the way for a more equitable society for generations to come.

Figure 17. Okanagan captikʷɬ: 'How Names Were Given' by Taylor Baptiste

References

Aarons, G. A., Green, A. E., Trott, E., Willging, C. E., Torres, E. M., Ehrhart, M. G., & Roesch, S. C. (2016). The roles of system and organizational leadership in system-wide evidence-based intervention sustainment: A mixed-method study. *Administration and Policy in Mental Health, 43*(6), 991-1008. doi:10.1007/s10488-016-0751-4

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 4-23. doi:10.1007/s10488-010-0327-7

Aboriginal Affairs and Northern Development Canada. (1996). Highlights from the report of the royal commission on Aboriginal people. Government of Canada. Available from http://www.aadnc-aandc.gc.ca/eng/1100100014597/1100100014637

Aboriginal Nurses Association of Canada. (2009). Cultural competence and cultural safety in nursing education a framework for First Nations, Inuit and Métis nursing. Retrieved from http://www.anac.on.ca/Documents/ Making%20It%20Happen%20Curriculum%20Project/ FINALFRAMEWORK.pdf.

Abrums, M. E., Resnick, J., & Irving, L. L. (2010). Journey or destination? Evaluating student learning about race, class, and privilege in health care. *Nursing Education Perspectives, 31*(3), 160.

Accomplices not allies: Abolishing the ally industrial complex: An Indigenous perspective & provocation. (2014). Indigenous Action Media. www.indigenousaction.org

Allan, B. & Smylie, J. (2015). First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto, ON: the Wellesley Institute.

Allen, M., Wilhelm, A., Ortega, L.E., Pergament, S., Bates, N. & Cunningham, B. (2021). Applying a race(ism)-conscious adaptation of the cfir framework to understand implementation of a school-based equity-oriented intervention. Ethn Dis., 31(1), 375-388. doi:10.18865/ed.31.S1.375

American Association of Physical Anthropologists. (2019). AAPA Statement on Race and Racism. Available from http://www.physanth.org/about/position-statements/aapa-statement-race-and-racism-2019/

Anderson, M. (2017, December 15). Reconciliation in public health. Webinar. National Collaborating Centre for Aboriginal Health. Retrieved from https://www.nccah-ccnsa.ca/docs/context/WEBINAR-Reconciliation-Public-Health-Anderson-EN.pdf

Adelson, N. (2005) The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 96(S2), S45-S61.

Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K. B., . . . Smye, V. (2003). “Rewriting” cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science, 26*(3), 196-214. doi:10.1097/00012272-200307000-00005

Anishnawbe Health Toronto. (2011). Aboriginal cultural safety initiative. Retrieved from https://www.aht.ca/component/content/article/91-acsi/104-aboriginal-cultural-safety-initiative

Apatu, E., Sinnott, W., Piggott, T., Butler-Jones, D., Anderson, L. N., Alvarez, E., Dobbins, M., Harrison, L. & Neil-Sztramko, S. E. (2021). Where are we now? A content analysis of Canadian master of public health course descriptions and the Public Health Agency of Canada’s core competencies. *Journal of Public Health*

Management and Practice, 27(2), 201-207. https://doi.org/10.1097/PHH.0000000000001173
Aqil, A. R., Malik, M., Jacques, K. A., Lee, K., Parker, L. J., Kennedy, C. E., Mooney, G., & German, D. (2021). Engaging in anti-oppressive public health teaching: challenges and recommendations. *Pedagogy in Health Promotion, 7*(4), 344–353. https://doi.org/10.1177/23733799211045407
Association of Schools of Public Health in the European Region. (2018). ASPHER's European List of Core Competences for the Public Health Professional. *Scandinavian Journal of Public Health, 46*(23_suppl):1-52. doi:10.1177/1403494818797072
Association of Faculties of Medicine of Canada. (2019). Joint commitment to action on Indigenous health. Retrieved from https://afmc.ca/sites/default/files/AFMC%20Position%20Paper%20JCAIH_EN.pdf
Association of Schools of Public Health. (2019). MPH core competency model. Retrieved from https://www.aspph.org/teach-research/models/mph-competency-model/
Baba, L. & Reading, J. (2012). Core competencies for Indigenous public health, evaluation and research (CIPHER): A health inequity mitigation strategy. *The Canadian Journal of Nursing Research, 44*(2), 123.
Baba, L. (2012). Indigenous public health curriculum and health disparities mitigation: How the CIPHER Project Can Impact Public Health Education and Practice. Centre for Aboriginal Health Research.
Baba, L. (2013). Cultural safety in First Nations, Inuit and Métis public health: Environmental scan of cultural competency and safety in education, training and health services. Prince George, BC: National Collaborating Centre for Aboriginal Health.
Beavis, A. S. W., Hojjati, A., Kassam, A., Choudhury, D., Fraser, M., Masching, R., & Nixon, S. A. (2015). What all students in healthcare training programs should learn to increase health equity: Perspectives on post-colonialism and the health of Aboriginal peoples in Canada. *BMC Medical Education, 15*(1), 155. doi:10.1186/s12909-015-0442-y
Benzer, J. K., Beehler, S., Cramer, I. E., Mohr, D. C., Charns, M. P., & Burgess, J., James F. (2013). Between and within-site variation in qualitative implementation research. *Implementation Science, 8*(1), 4. doi:10.1186/1748-5908-8-4
Birken, S. A., Powell, B. J., Presseau, J., Kirk, M. A., Lorencatto, F., Gould, N. J., . . . Damschroder, L. J. (2017). Combined use of the consolidated framework for implementation research (CFIR) and the theoretical domains framework (TDF): A systematic review. *Implementation Science, 12*(1), 2. doi:10.1186/s13012-016-0534-z
Birken, S. A., Powell, B. J., Shea, C. M., Haines, E. R., Alexis Kirk, M., Leeman, J., . . . Presseau, J. (2017). Criteria for selecting implementation science theories and frameworks: Results from an international survey. *Implementation Science, 12*(1), 124-9. doi:10.1186/s13012-017-0656-y
Brown, C. H., Curran, G., Palinkas, L. A., Aarons, G. A., Wells, K. B., Jones, L., . . . Cruden, G. (2017). An overview of research and evaluation designs for dissemination and implementation. *Annual Review of Public Health, 38*(1), 1-22. doi:10.1146/annurev-publhealth-031816-044215
Browne, A. J., Smye, V. L., & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *Canadian Journal of Nursing Research, 37*(4), 16-37.

Brian Sinclair: Killed by racism. (n.d.). Retrieved from http://ignoredtodeathmanitoba.ca/
British Columbia Network Environment for Indigenous Health Research. (2022). *Indigenous cultural safety in research framework*. Retrieved from https://onlineacademiccommunity.uvic.ca/bcneihr/wp-content/uploads/sites/4766/2022/09/FINAL_ICSR_Framework1.8.pdf
Butler-Jones, D. (2008). Our population, our health and the distribution of our health. In *The state of public health in Canada: Report of the Chief Public Health Officer* (pp. 19-33). Ottawa, ON: Public Health Agency of Canada. Retrieved from http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/fr-rc/cphorsphc-respcacsp06b-eng.php
Cambourieu, C. & Snelling, S. (2023). Supporting Public Health Human Resource Planning: A Survey of Canadian Universities' Public Health Training Programs. National Collaborating Centre for Healthy Public Policy and National Collaborating Centre for Methods and Tools.
Came, H., & Griffith, D. (2018). Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis. *Social Science & Medicine,199*, 181.
Canadian Public Health Association. (2019). Policy statement: Indigenous relations and reconciliation. Retrieved from https://www.cpha.ca/policy-indigenous-relations-and-reconciliation
Canadian Public Health Association. (2018). Racism and public health. Policy and Position Statements. Retrieved from https://www.cpha.ca/racism-and-public-health
Carlson, E. (2017). Anti-colonial methodologies and practices for settler colonial studies. *Settler Colonial Studies, 7*(4), 496-517. doi:10.1080/2201473X.2016.1241213
CBC Radio-Canada. (2019). Beyond 94: Truth and reconciliation in Canada. Retrieved from https://newsinteractives.cbc.ca/longform-single/beyond-94?&cta=1
CFIR Research Team-Center for Clinical Management Research. (2023). The consolidated framework for implementation research. Retrieved from https://cfirguide.org/
Chang, E., Simon, M., & Dong, X. (2012;2010). Integrating cultural humility into health care professional education and training. *Advances in Health Sciences Education, 17*(2), 269-278. doi:10.1007/s10459-010-9264-1
Clark, E.C., Cranston, E., Polin, T., Ndumbe-Eyoh, S., MacDonald, D., Betker, C., & Dobbins, M. (2022). Structural interventions that affect racial inequities and their impact on population health outcomes: A systematic review. *BMC Public Health 22*, 2162. https://doi.org/10.1186/s12889-022-14603-w
Clark, N. (2016). Red intersectionality and violence-informed witnessing praxis with Indigenous girls. *Girlhood Studies, 9*(2), 46-64. https://doi.org/10.3167/ghs.2016.090205
Claxton, N. X., Fong, D., Morrison, F., O'Bonsawin, C., Omatsu, M., Price, J. & Sandhra,S. K. (2021). Challenging racist "British Columbia:" 150 years and counting. University of Victoria and The Canadian Center for Policy Alternatives (BC Office).
Coombe, L., Lee, V., & Robinson, P. (2017). Integration models for Indigenous public health curricula. *Higher Education Research & Development, 36*(4), 645-15. doi:10.1080/07294360.2016.1229269
Council on Education for Public Health. (2016). Accreditation criteria: Schools of public health and public health programs. Retrieved from https://media.ceph.org/documents/2016.Criteria.pdf
Council on Education for Public Health. (2021). List of accredited schools and programs. https://ceph.org/about/org-info/ who-we-accredit/accredited/

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine. *Feminist Theory and Antiracist Politics, 1*(8). Available from http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Damschroder, L. J. (2019). Clarity out of chaos: Use of theory in implementation research. *Psychiatry Research*. doi:10.1016/j.psychres.2019.06.036

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science, 4*(1), 50-50. doi:10.1186/1748-5908-4-50

Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated consolidated framework for implementation research based on user feedback. *Implementation Science, 17*(1), 1-75. https://doi.org/10.1186/s13012-022-01245-0

Dawson, J., Laccos-Barrett, K., Hammond, C., & Rumbold, A. (2022). Reflexive practice as an approach to improve healthcare delivery for indigenous peoples: A systematic critical synthesis and exploration of the cultural safety education literature. *International Journal of Environmental Research and Public Health, 19*(11), 6691. https://doi.org/10.3390/ijerph19116691

Declaration of Cultural Safety and Humility. (2017). Retrieved from https://www.fnha.ca/Documents/Declaration-of-Commitment-on-Cultural-Safety-and-Humility-in-Health-Services.pdf

de Leeuw, S., Larstone, R., Fell, B., Cross, N., Greenwood, M., Auerbach, K., & Sutherland, J. (2021). Educating Medical Students' "Hearts and Minds": A Humanities-Informed Cultural Immersion Program in Indigenous Experiential Community Learning. International Journal of Indigenous Health, 16, Issue 1, 87-107. DOI: 10.32799/ijih.v16i1.33078.

Diffey, L., & Mignone, J. (2017). Implementing anti-racist pedagogy in health professional education: A realist review. *Health Education and Care, 2*(1). doi:10.15761/hec.1000114

Dissemination & Implementation Models in Health Webtool (2023). Retrieved from https://dissemination-implementation.org/tool/

Djulus, G., Sheikhan, N. Y. & Nawaz, E. (2021). Advancing allyship through anti-oppression workshops for public health students: A mixed methods pilot evaluation. *Pedagogy in Health Promotion*, *7*(4), 304–312. https://doi.org/10.1177/2373379920962410

Downing, R., & Kowal, E. (2011). A postcolonial analysis of Indigenous cultural awareness training for health workers. *Health Sociology Review, 20*(1), 5-15. doi:10.5172/hesr.2011.20.1.5

Durkalec, A., Furgal, C., Skinner, M. W., & Sheldon, T. (2015). Climate change influences on environment as a determinant of Indigenous health: Relationships to place, sea ice, and health in an Inuit community. *Social Science & Medicine,* 136-137, 17-26. doi:10.1016/j.socscimed.2015.04.026

Eslava-Schmalbach, J., Garzón-Orjuela, N., Elias, V., Reveiz, L., Tran, N., & Langlois, E. (2019). Conceptual framework of equity-focused implementation research for health programs (EquIR). *International Journal for Equity in Health, 18*. 10.1186/s12939-019-0984-4.

Everyone calls themselves an ally until it's time to do some real ally shit. (2014). Xhopakelxhit- Ancestral Pride.

First Ministers of Canada. (2003). 2003 First Ministers' Accord on Health Care Renewal. Canada.

First Nations Child & Family Caring Society. (2019). Jordan's principle. Retrieved from https://fncaringsociety.com/jordans-principle

First Nations Health Authority. (n.d.).#Itstartswithme: Creating a climate for change. Retrieved from https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf

First Nations Health Authority. (2016). It starts with me: FNHA's policy statement on cultural safety and humility. Retrieved from https://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf

First Nations Health Authority. (2012). First Nations perspective on health and wellness Retrieved from: http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness

First Nations Health Authority & Health Standards Organization. (2022). *British Columbia Cultural Safety and Humility Standard*. British Columbia.

First Nations Information Governance Centre. (2018). National report of the First Nations regional health survey phase 3: Volume two. Ottawa, ON: author. Retrieved from https://fnigc.ca/sites/default/files/docs/fnigc_rhs_phase_3_volume_two_en_final_website_0.pdf

Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *Am. J. Public Health 100*(S1), S30eS35.

Ford, C. L., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine, 71*(8), 1390-1398. doi:10.1016/j.socscimed.2010.07.030

Ford, C. L., Griffith, D. M., Bruce, M. A., Gilbert, K. L., & Rittenhouse Book Distributors, I. (2019). *Racism: Science and tools for the public health professional* (1st ed.). American Public Health Association.

Ford, J. D. (2012). Indigenous health and climate change. *American Journal of Public Health, 102*(7), 1260-1266. doi:10.2105/AJPH.2012.300752

Frambach, R. T., & Schillewaert, N. (2002). Organizational innovation adoption: A multi-level framework of determinants and opportunities for future research. *Journal of Business Research, 55*(2), 163-176. doi:10.1016/S0148-2963(00)00152-1

Francis, J.J, O'Connor, D. & Curran, J. (2012). Theories of behaviour change synthesised into a set of theoretical groupings: Introducing a thematic series on the theoretical domains framework. Implement Sci, 7(1), 35. doi:10.1186/1748-5908-7-35

Gagliardi, A. R., Kothari, A., & Graham, I. D. (2017). Research agenda for integrated knowledge translation (IKT) in healthcare: What we know and do not yet know. *Journal of Epidemiology and Community Health, 71*(2), 105-106. doi:10.1136/jech-2016-207743

Gaudry, A. & Lorenz, D. (2018). Indigenization as inclusion, reconciliation, and decolonization. *AlterNative, 14*(3) 218-227. doi:10.1177/1177180118785382

Geddes, B. (2015). Measuring wellness: An indicator development guide for First Nations. First Nations of British Columbia, held in trust by Ktunaxa Nation Council. Retrieved from https://static1.squarespace.com/static/558c624de4b0574c94d62a61/t/558f15c6e4b0c84f9abe4c66/1435440582698/BCFNDGI-Measuring-Wellness-An-Indicator-Development-Guide-for-First-Nations.pdf

Gehl, L. (n.d.) Ally bill of responsibilities. Retrieved from http://www.lynngehl.com/uploads/5/0/0/4/5004954/ally_bill_of_responsibilities_poster.pdf

Giroux, M. (2017, November 19). If 'Indigenizing' education feels this good, we aren't doing it right. The Conversation. Retrieved from https://theconversation.com/if-indigenizing-education-feels-this-good-we-arent-doing-it-right-87166

Glaser, B. & Strauss, A. (1994). The discovery of grounded theory. Qualitative Data Analysis: An Expanded Sourcebook (2nd Ed.). London: Sage.

Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: The RE-AIM framework. *American Journal of Public Health, 89*, 1322–1327.

Green, L. W. (2008). Making research relevant: If it is an evidence-based practice, where's the practice-based evidence? *Family Practice, 25*(Supplement 1), i20-i24. https://doi.org/10.1093/fampra/cmn055

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly, 82*(4), 581-629. doi:10.1111/j.0887-378X.2004.00325.x

Greenwood, M. (2019). Modelling change and cultural safety: A case study in northern British Columbia health system transformation. *Healthcare Management Forum, 32*(1), 11-14. doi:10.1177/0840470418807948

Guerra, O., & Kurtz, D. (2017). Building collaboration: A scoping review of cultural competency and safety education and training for healthcare students and professionals in Canada. *Teaching & Learning in Medicine, 29*(2), 129-142. doi:10.1080/10401334.2016.1234960

Gustafson, D.L., & Reitmanova, S. (2010). How are we “doing” cultural diversity? A look across English Canadian undergraduate medical school programmes. *Medical Teacher, 32*, 816–23.

Halseth, R. Stout, R., & Atkinson, D. (2019). Cultural safety. In Oxford Bibliographies. Oxford University Press. Retrieved from https://www.oxfordbibliographies.com/view/document/obo-9780199756797/obo-9780199756797-0192.xml#obo-9780199756797-0192-div1-0002

Harding, L. (2018). *What’s the harm? Examining the stereotyping of Indigenous peoples in health systems.* [Doctoral dissertation, Simon Fraser University]. https://summit.sfu.ca/_flysystem/fedora/sfu_migrate/18715/etd19994.pdf

Harjo, L. (2019). *Spiral to the stars: Mvskoke tools of futurity*. The University of Arizona Press.

Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A.D. & Rackal, J. (2021). Implementing anti-racism interventions in healthcare settings: A scoping review. *Int. J. Environ. Res. Public Health, 18*, 2993. https://doi.org/10.3390/ijerph18062993

Henry, F., James, C., Li, P. S., Kobayashi, A., Smith, M. S., Ramos, H., & Enakshi, D. (2017). *The equity myth: Racialization and Indigeneity at Canadian universities*. UBC Press.

Hill, E. (2012). A critique of the call to "always Indigenize!". *Peninsula, 2*(1). Available from https://journals.uvic.ca/index.php/peninsula/article/view/11513

Hill, J. N., Locatelli, S. M., Bokhour, B. G., Fix, G. M., Solomon, J., Mueller, N., & LaVela, S. L. (2018). Evaluating broad-scale system change using the consolidated framework for implementation research: Challenges and strategies to overcome them. *BMC Research Notes, 11*(1), 560-14. doi:10.1186/s13104-018-3650-9

Hollinsworth, D. (1992). Cultural awareness training, racism awareness training or antiracism? Strategies for combating institutional racism. *Journal of Intercultural Studies 13*(2), 37–52.

Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural competence education for health professionals. *The Cochrane Database of Systematic Reviews,* (5). doi:10.1002/14651858.CD009405.pub2

Housman, J., Meaney, K. S., Wilcox, M., & Cavazos, A. (2012). The impact of service-learning on health education students' cultural competence. *American Journal of Health Education, 43*(5), 269-278. doi:10.1080/19325037.2012.10599245

Institute of Medicine. (2001). Crossing the quality chasm: A new health systemfor the 21st century. Washington, DC: National Academy Press.

Iwama, M., Marshall, M., Marshall, A., & Bartlette, C. (2009). Two-eyed seeing and the language of healing in community based research. *Canadian Journal of Native Education, 32*(3). Available from http://www.integrativescience.ca/

Jewell, E. & Mosby, I. (2022). Calls to action accountability: A 2022 status update on reconciliation. Yellowhead Institute. Available from https://yellowheadinstitute.org/trc/

Johnson, H., & Sutherland, J. (2022). A conceptual framework for Indigenous cultural safety measurement. Prince George, BC: National Collaborating Centre for Indigenous Health. Available from https://www.nccih.ca/495/A_conceptual_framework_for_Indigenous_cultural_safety_measurement.nccih?id=10375

Josewski, V., de Leeuw, S., & Greenwood, M. (2023). Grounding wellness: Coloniality, placeism, land, and a critique of “social” determinants of Indigenous mental health in the Canadian context. *International Journal of Environmental Research and Public Health, 20*(5), 4319. MDPI AG. Retrieved from http://dx.doi.org/10.3390/ijerph20054319

Kelly, M. D. (2011). Toward a new era of policy: Health care service delivery to First Nations. *International Indigenous Policy Journal, 2*(1), 1-12.

Kendi, I. X. (2019). *How to be an antiracist* (First ed.). New York: One World.

Kent, A., Loppie, C., Carriere, J., MacDonald, M., & Pauly, B. (2017). Xpey' relational environments: An analytic framework for conceptualizing Indigenous health equity. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice, 37*(12), 395-402. doi:10.24095/hpcdp.37.12.01

Knight, D., Belenko, S., Robertson, A., Wiley, T., Wasserman, G., Leukefeld, C., . . . Scott, C. (2015). Designing the optimal JJ-TRIALS study: EPIS as a theoretical framework for selection and timing of implementation interventions. *Addiction Science & Clinical Practice, 10*(S1), A29-A29. doi:10.1186/1940-0640-10-S1-A29

Knowledge Translation Program. (2019). Intersectionality and knowledge translation. Retrieved from https://knowledgetranslation.net/portfolios/intersectionality-and-kt/

Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations and contexts*. Toronto: University of Toronto Press.

Kowal, E., & Paradies, Y. (2005). Ambivalent helpers and unhealthy choices: Public health practitioners’ narratives of indigenous ill-health. *Social Science & Medicine, 60*(6), 1347-1357. doi:10.1016/j.socscimed.2004.07.009

Krusz, E., Davey, T., Wigginton, B., & Hall, N. (2020). What contributions, if any, can non-indigenous researchers offer toward decolonizing health research? *Qualitative Health Research, 30*(2), 205-216. https://doi.org/10.1177/1049732319861932

Kumaş-Tan, Z., Beagan, B., Loppie, C., Macleod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine, 82*(6), 548-557. doi:10.1097/ACM.0b013e3180555a2d

Lane-Fall, M. B., Curran, G. M., & Beidas, R. S. (2019). Scoping implementation science for the beginner: Locating yourself on the “subway line” of translational

research. *BMC Medical Research Methodology, 19*(1), 1-5. doi:10.1186/s12874-019-0783-z
LaRocque, E. D. (1996). The colonization of a Native woman scholar. In C. Miller & P. Chuchryk (Eds.), *Women of the First Nations: Power, wisdom, and strength* (pp. 11–17). Winnipeg: University of Manitoba Press.
Lavoie, J., Gervais, L., Toner, J., Bergeron, O., & Thomas, G. (2011). The Aboriginal health legislation and policy framework in Canada. Prince George, BC: National Collaborating Centre for Aboriginal Health.
Lawrence, B., & Dua, E. (2005). Decolonizing antiracism. *Social Justice, 32*(4), 120-143.
Leeman, J., Birken, S. A., Powell, B. J., Rohweder, C., & Shea, C. M. (2017). Beyond "implementation strategies": Classifying the full range of strategies used in implementation science and practice. *Implementation Science, 12*(1), 125. doi:10.1186/s13012-017-0657-x
Leonard, B. R., & Mercier, O. R. (2016). Indigenous struggles within the colonial project: Reclaiming Indigenous knowledges in the western academy. *Knowledge Cultures, 4*(3), 99-116.
Liang, L., Bernhardsson, S., Vernooij, R. W. M., Armstrong, M. J., Bussières, A., Brouwers, M. C.,… & Members of the Guidelines International Network Implementation Working Group. (2017). Use of theory to plan or evaluate guideline implementation among physicians: A scoping review. *Implementation Science, 12*(1), 26. doi:10.1186/s13012-017-0557-0
Lin, H., Guo, J. L., & Chang, L. (2017). Cultural competence education for health professionals from pre-graduation to licensure delivered using Facebook: Twelve-month follow-up on a randomized control trial. *Nurse Education Today, 59*, 94.
Loppie, S., Reading, C. & de Leeuw, S. (2014). Aboriginal experiences with racism and its impacts. National Collaborating Centre for Aboriginal Health.
Loppie Reading, C. & Wien, F. (2009). Health inequalities and social determinants of Aboriginal peoples' health. Prince George, BC: National Collaborating Centre for Aboriginal Health.
Ly, A., & Crowshoe, L. (2015). 'Stereotypes are reality': Addressing stereotyping in Canadian Aboriginal medical education. *Medical Education, 49*(6), 612-622. doi:10.1111/medu.12725
MacFarlane A., & O'Reilly-de Brun, M. (2012). Using a theory-driven conceptual framework in qualitative health research. *Qualitative Health Research*, *22*(5): 607-618.
MacLean, T.L., Qiang, J.R., Henderson, L., Bowra, A., Howard, L., Pringle, V., Butsang, T., Rice, E., Di Ruggiero, E., & Mashford-Pringle, A. (2023). Indigenous cultural safety training for applied health, social work, and education professionals: A PRISMA scoping review. *Int. J. Environ. Res. Public Health, 20*, 5217. https://10.3390/ijerph20065217
Mahara, M. S., Duncan, S. M., Whyte, N., & Brown, J. (2011). It takes a community to raise a nurse: Educating for culturally safe practice with aboriginal peoples. *International Journal of Nursing Education Scholarship, 8*(1) doi:10.2202/1548-923X.2208
Mahoney, T., Grain, K., Fraser, P., & Wong, J. (2021). Community Resource Handbook. Community-Engaged Research Initiative, Simon Fraser University.
Marker, M. (2004). Theories and disciplines as sites of struggle: The reproduction of colonial dominance through the controlling of knowledge in the academy. *Canadian Journal of Native Education, 28*(1/2), 102.

Martínez, A. G., & Lázaro, A. M. S. (2014). Proposed methodology of health education for cultural diversity. A working tool: Method apprêt. *Procedia - Social and Behavioral Sciences, 132*, 330-335. doi:10.1016/j.sbspro.2014.04.318
May, C., & Finch, T. (2009). Implementing, embedding, and integrating practices: An outline of normalization process theory. *Sociology, 43*(3), 535-554. doi:10.1177/0038038509103208
McDermott, D. R. (2012). Can we educate out of racism? *Medical Journal of Australia, 197*(1), 15. doi:10.5694/mja12.10936
McElfish, P. A., Moore, R., Buron, B., Hudson, J., Long, C. R., Purvis, R. S., . . . Warmack, T. S. (2018). Integrating interprofessional education and cultural competency training to address health disparities. *Teaching and Learning in Medicine, 30*(2), 213. doi:10.1080/10401334.2017.1365717
McSorley, A.-M. M., Manalo-Pedro, E., & Bacong, A. M. (2021). Doctoral students as agents for change: Shaping our public health training environment. *Pedagogy in Health Promotion*, *7*(4), 299–303. https://doi.org/10.1177/23733799211042642
Meredith, G., Welter, C., Risley, K., Seweryn, S., Altfeld, S. & Jarpe-Ratner, E. (2023). Levers of change: How to help build the public health workforce of the future. *Journal of Public Health Management and Practice, 29*(3), E90-E99. doi: 10.1097/PHH.0000000000001618.
Menakem, R. (2017). *My grandmother's hands: Racialized trauma and the pathway to mending our hearts and bodies*. Las Vegas, NV: Central Recovery Press.
Mercer, J. (2007). The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas. *Oxford Review of Education, 33*(1), 1-17. doi:10.1080/03054980601094651
Mignolo, W. & Walsh, C. E. (2018). *On decoloniality: Concepts, analytics, praxis*. Duke University Press. https://doi.org/10.1515/9780822371779
Moradi, B., & Grzanka, P. R. (2017). Using intersectionality responsibly: Toward critical epistemology, structural analysis, and social justice activism. *Journal of Counseling Psychology*. doi:10.1037/cou0000203
Muntinga, M. E., Krajenbrink, V. Q. E., Peerdeman, S., Croiset, G., & Verdonk, P. (2016). Toward diversity-responsive medical education: Taking an intersectionality-based approach to a curriculum evaluation. *Advances in Health Sciences Education, 21*(3), 541-559. doi:10.1007/s10459-015-9650-9
Murray, E., Treweek, S., Pope, C., MacFarlane, A., Ballini, L., Dowrick, C., . . . May, C. (2010). Normalisation process theory: A framework for developing, evaluating and implementing complex interventions. *BMC Medicine, 8*(1), 63-63. doi:10.1186/1741-7015-8-63
Murray-Garcia, J. L., & Garcia, J. A. (2008). The institutional context of multicultural education: What is your institutional curriculum? *Acad Med 87*(7):646–652.
National Aboriginal Health Organization. (2008). Cultural competency and safety: A guide for health administrators, providers, and educators. Ottawa, ON: author.
National Collaborating Centre for Determinants of Health. (2023). Webinar series on anti-Black racism and public health. Available from https://nccdh.ca/resources/entry/lets-talk-whiteness-and-health-equity
National Collaborating Centre for Determinants of Health. (2022). Let's Talk: Intersectionality. Antigonish, NS: NCCDH, St. Francis Xavier University.
National Collaborating Centre for Determinants of Health. (2020). Let's talk: Whiteness and health equity. Available from https://nccdh.ca/workshops-events/entry/webinar-series-on-anti-black-racism-and-public-health
National Collaborating Centre for Determinants of Health & Canadian Institutes of Health Research Institute of Population and Public Health. (2023). Future Search: Action

for Disrupting White Supremacy and Racism in Public Health Systems Workshop Report. Antigonish, NS: NCCDH, St. Francis Xavier University.
National Collaborating Centre for Indigenous Health. (2021). Visioning the future: First Nations, Inuit, & Métis population and public health. Prince George, BC: Author. Available from https://www.nccih.ca/495/Visioning_the_Future__First_Nations,_Inuit,___M%C3%A9tis_Population_and_Public_Health_.nccih?id=10351
National Collaborating Centre for Indigenous Health. (2019). *Access to health services as a social determinant of First Nations, Inuit and Métis health*. Prince George, BC: Author. Retrieved from https://www.nccih.ca/495/Access_to_health_services_as_a_social_determinant_of_First_Nations,_Inuit_and_M%C3%A9tis_health.nccih?id=279
National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). Reclaiming power and place: The final report of the national inquiry into missing and murdered Indigenous women and girls. Available from https://www.mmiwg-ffada.ca/final-report/
NHS England & NHS Improvement. (2022).Discomfort zone. Online library of Quality, Service Improvement and Redesign tools. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-discomfort-zone.pdf
Nickerson, M. (2019, December). Cultural Safety and Humility Case Study. First Nations Health Authority, Province of British Columbia & Indigenous Services Canada. Retrieved from https://www.fnha.ca/Documents/FNHA-BC-Tripartite-Agreement-Case-Study-Cultural-Safety-and-Humility.pdf
Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science, 10*(1), 53. doi:10.1186/s13012-015-0242-0
Norton, W. E., Lungeanu, A., Chambers, D. A., & Contractor, N. (2017). Mapping the growing discipline of dissemination and implementation science in health. *Scientometrics, 112*(3), 1367-1390. https://doi.org/10.1007/s11192-017-2455-2
Nursing Council of New Zealand. (2011). Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice. Wellington, NZ: Nursing Council of New Zealand. Retrieved from http://pro.healthmentoronline.com/assets/Uploads/refract/pdf/Nursing_Council_cultural-safety11.pdf
Oetzel, J., Scott, N., Hudson, M., Masters-Awatere, B., Rarere, M., Foote, J., . . . Ehau, T. (2017). Implementation framework for chronic disease intervention effectiveness in māori and other Indigenous communities. *Globalization and Health, 13*(1), 69-13. doi:10.1186/s12992-017-0295-8
Ogbolu, Y., & Fitzpatrick, G. A. (2015). Advancing organizational cultural competency with dissemination and implementation frameworks: Towards translating standards into clinical practice. *Advances in Nursing Science, 38*(3), 203-214. doi:10.1097/ANS.0000000000000078
O'Neil, J. D., Reading, J. R., & Leader, A. (1998). Changing the relations of surveillance: The development of a discourse of resistance in Aboriginal epidemiology: Negotiating with communities. *Human Organization, 57*(2), 230-237.
Padgett, D. (2012). Choosing the right qualitative approach(es). Chapter 2 in *Qualitative and Mixed Methods in Public Health*. SAGE. https://dx-doi-org.ezproxy.library.uvic.ca/10.4135/9781483384511.n2

Perez, J., Leonard, W. R., Bishop, V., & Neubauer, L. C. (2021). developing equity-focused education in academic public health: A multiple-step model. *Pedagogy in Health Promotion, 7*(4), 366–371. https://doi.org/10.1177/23733799211045986

Perreault, A. & Crey, K. (n.d.). What I learned in class today. University of British Columbia First Nations and Indigenous Studies. Retrieved from https://intheclass.arts.ubc.ca/

Peters, D. H., Adam, T., Alonge, O., Akua Agyepong, I., & Tran, N. (2013). Implementation research: What is it and how to do it. British Medical Journal, 347. doi:10.1136/bmj.f6753

PHSA Indigenous Health. (2019, March). Dismantling Anti-Indigenous Racism Within the Health Care System: Final Report of the 2019 Think Tank on Anti-Indigenous Racism. Vancouver, BC. Retrieved from https://umanitoba.ca/faculties/health_sciences/medicine/education/undergraduate/media/think_tank_on_anti_indigenous_racism_2019.pdf

Pinnock, H., Barwick, M., Carpenter, C. R., Eldridge, S., Grandes, G., Griffiths, C. J., . . . StaRI Group. (2017). Standards for reporting implementation studies (StaRI) statement. *BMJ, 356*. doi:10.1136/bmj.i6795

Powell, B. J., Waltz, T. J., Chinman, M. J., Damschroder, L. J., Smith, J. L., Matthieu, M. M., . . . Kirchner, J. E. (2015). A refined compilation of implementation strategies: Results from the expert recommendations for implementing change (ERIC) project. Implementation Science : IS, 10(1), 21-21. doi:10.1186/s13012-015-0209-1

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., . . . Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(2), 65-76. doi:10.1007/s10488-010-0319-7

Provincial Health Services Authority. (n.d.). San'yas Indigenous cultural safety training. Retrieved from http://www.sanyas.ca/

Public Health Agency of Canada (2007). Core competencies for public health in Canada: Release 1.0. Retrieved from http://www.phac-aspc.gc.ca/php-psp/ccph-cesp/pdfs/cc-manual-eng090407.pdf

Public Health Training for Equitable Systems Change. (2020). Implementation research in public health. Available from https://phesc.ca-central.catalog.canvaslms.com/browse/ephp/courses/implementation-research-in-public-health

Ramsden, I. (1990). Cultural safety. *The New Zealand Nursing Journal. Kai Tiaki., 83*(11), 18-19.

Reading, C. (2015). Part 1: Setting the context: Structural determinants of Aboriginal peoples' health. In M. Greenwood, L. De Leeuw, N. M. Lindsay, C. & Reading, (Eds),.*Determinants of Indigenous peoples' health in Canada: Beyond the social*. Toronto : Canadian Scholars' Press.

Reading, J., Loppie, C., & O'Neil, J. (2016). Indigenous health systems governance. *International Journal of Health Governance, 21*(4), 222-228. doi:10.1108/IJHG-08-2016-0044

Ritchie, J. & Lewis, J. (2003). Qualitative research practice: A guide for social science students and researchers. Sage, London.

Rodriguez, D. (2012). Racial/Colonial genocide and the "Neoliberal academy": In excess of a problematic. *American Quarterly, 64*(4), 809-813. doi:10.1353/aq.2012.0054

Rogers, E. (2003). *Diffusion of Innovations, 5th edition*. New York, NY: Free Press.

Rosario, C., Al Amin, S. & Parker, C. (2022). [Un]forgetting history: Preparing public health professionals to address structural racism. *Journal of Public Health Management and Practice, 28* (Supplement 1), S74-S81. doi: 10.1097/PHH.0000000000001432.

Rowan, M.S., Rukholm, E., Bourque-Bearskin, L., Baker, C., Voyageur, E., & Robitaille, A. (2013). Cultural competence and cultural safety in Canadian schools of nursing: A mixed methods study. *International Journal of Nursing Education Scholarship,10*(1).

Schick, M. R., Kirk-Provencher, K. T., Goldstein, S. C., Nalven, T., & Spillane, N. S. (2021). A framework for the adaptation of positive psychological interventions to North American Indigenous populations. Prev Sci. doi:10.1007/s11121-021-01282-z

Shah, C. P., & Reeves, A. (2015). The Aboriginal cultural safety initiative: An innovative health sciences curriculum in Ontario colleges and universities. *International Journal of Indigenous Health, 10*(2), 117. doi:10.18357/ijih.102201514388

Shelton, R.C., Adsul, P. & Oh, A. (2021). Recommendations for addressing structural racism in implementation science: A call to the field. Ethn Dis., 31(1), 357-364. doi:10.18865/ed.31.S1.357

Singh, A. (2019). *The racial healing handbook: Practical activities to help you challenge privilege, confront systemic racism and engage in collective healing*. Oakland, CA: New Harbinger Publications.

Smith, L. T. (2012). *Decolonizing methodologies: Research and Indigenous peoples*. London; New York: Zed Books.

Snell-Rood, C., Trott Jaramillo, E., Hamilton, A. B., Raskin, S. E., Nicosia, F. M., & Willging, C. (2021). Advancing health equity through a theoretically critical implementation science. *Translational Behavioral Medicine*, ibab008. https://doi.org/10.1093/tbm/ibab008

Southam-Gerow, M. A., & Dorsey, S. (2014). Qualitative and mixed methods research in dissemination and implementation science: Introduction to the special issue. *Journal of Clinical Child & Adolescent Psychology, 43*(6), 845-850. doi:10.1080/15374416.2014.930690

St. Denis, V. (2007). Aboriginal education and anti-racist education: Building alliance across cultural and racial identity. *Canadian Journal of Education, 30*(4), 1068-1092. Retrieved from journals.sfu.ca/cje/index.php/cje-rce/article/download/2987/2276

Statistics Canada. (2017). Aboriginal statistics at a glance: Life expectancy. Retrieved from https://www150.statcan.gc.ca/n1/pub/89-645-x/2010001/life-expectancy-esperance-vie-eng.htm

Statistics Canada. (2015). Health at a glance: Select health indicators of First Nations people living off reserve, Métis and Inuit. Retrieved from https://www150.statcan.gc.ca/n1/pub/82-624-x/2013001/article/11763-eng.htm

Stirman, S.W., Miller, C.J., Toder, K. & Calloway, A. (2013). Development of a framework and coding system for modifications and adaptations of evidence-based interventions. *Implementation Sci., 8(*65). doi:10.1186/1748-5908-8-65

Sullivan, L. E. (2009). Social constructivism. In The SAGE glossary of the social and behavioral sciences (pp. 476-477). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412972024.n2350

Tam, T. (2021). State of Public Health in Canada 2021, A Vision to Transform Canada's Public Health System. Public Health Agency of Canada. Available from https://www.canada.ca/en/public-health/corporate/publications/chief-public-

health-officer-reports-state-public-health-canada/state-public-health-canada-2021.html
Tolley, E. E. (2016). *Qualitative methods in public health: A field guide for applied research* (Second ed.). San Francisco, CA: Jossey-Bass, A Wiley Brand.
Truth and Reconciliation Commission of Canada. (2015). Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada. Winnipeg, MB: Truth and Reconciliation Commission of Canada.
Turpel-Lafond, M.E. (2020). *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care.* Retrieved from https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf
United Nations. (2008). United Nations Declaration on the Rights of Indigenous Peoples. United Nations. Retrieved from https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
Utley-Smith, Q. E. (2017). Meeting a growing need: An online approach to cultural competence education for health professionals. *Nursing Education Perspectives, 38*(3), 159. doi:10.1097/01.NEP.0000000000000120
Verdonk, P., Benschop, Y. W. M., De Haes, J. C. J. M, & Lagro-Janssen, A. L. M. (2008). Making a gender difference: Case studies of gender mainstreaming in medical education. Medical Teacher, 30(7), e194-e201. https://doi.org/10.1080/01421590802213206
Verdonk, P., Benschop, Y., de Haes, H., Mans, L., & Lagro-Janssen, T. (2009). 'Should you turn this into a complete gender matter?' Gender mainstreaming in medical education. *Gender and Education, 21*(6), 703-719. https://doi.org/10.1080/09540250902785905
Verdonk, P., Benschop, Y. W. M., de Haes, Hanneke C. J. M, & Lagro-Janssen, T. L. M. (2009). From gender bias to gender awareness in medical education. *Advances in Health Sciences Education : Theory and Practice, 14*(1), 135-152. https://doi.org/10.1007/s10459-008-9100-z
Verdonk, P., Mans, L. J. L., & Lagro-Janssen, T. L. M. (2006). How is gender integrated in the curricula of dutch medical schools? A quick-scan on gender issues as an instrument for change. *Gender and Education, 18*(4), 399-412. https://doi.org/10.1080/09540250600805070
Virdun, C., Gray, J., Sherwood, J., Power, T., Phillips, A., Parker, N., & Jackson, D. (2013). Working together to make Indigenous health care curricula everybody's business: A graduate attribute teaching innovation report. *Contemporary Nurse: A Journal for The Australian Nursing Profession, 46*(1), 97-104. doi:10.5172/conu.2013.46.1.97
Wandersman, A., Duffy, J., Flaspohler, P., Noonan, R., Lubell, K., Stillman, L., . . . Saul, J. (2008). Bridging the gap between prevention research and practice: The interactive systems framework for dissemination and implementation. *American Journal of Community Psychology, 41*(3), 171-181. doi:10.1007/s10464-008-9174-z
Ward, C. (2018). *Teaching about race and racism in the classroom: Managing the Indigenous elephant in the room.* [Doctoral dissertation, Simon Fraser University]. https://summit.sfu.ca/_flysystem/fedora/sfu_migrate/18705/etd19984.pdf
Weiner, B. J. (2009). A theory of organizational readiness for change. *Implementation Science, 4*(1), 67-67. doi:10.1186/1748-5908-4-67

Whitehead, M. (1990). The concepts & principles of equity & health. Copenhagen: WHO Europe Retrieved from http://whqlibdoc.who.int/euro/-1993/EUR_ICP_RPD_414.pdf

Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Black Point, N.S: Fernwood Pub.

Wiltsey Stirman, S., Baumann, A. A., & Miller, C. J. (2019). The FRAME: An expanded framework for reporting adaptations and modifications to evidence-based interventions. *Implementation Science, 14*(1), 58-58. doi:10.1186/s13012-019-0898-y

Wolfenden, L., Foy, R., Presseau, J., Grimshaw, J. M., Ivers, N. M., Powell, B. J. … Yoong, S.L. (2021). Designing and undertaking randomised implementation trials: Guide for researchers. *BMJ, 372*. doi:10.1136/bmj.m3721

Woodward, E.N., Singh, R.S., Ndebele-Ngwenya, P. et al. (2021). A more practical guide to incorporating health equity domains in implementation determinant frameworks. Implement Sci Commun, 2(61). https://doi.org/10.1186/s43058-021-00146-5

Woodyatt, C. R., Finneran, C. A., & Stephenson, R. (2016). In-person versus online focus group discussions: A comparative analysis of data quality. *Qualitative Health Research, 26*(6), 741-749. doi:10.1177/1049732316631510

Yousefi Nooraie, R., Kwan, B., Cohn, E., AuYoung, M., Clarke Roberts, M., Adsul, P., & Shelton, R. (2020). Advancing health equity through CTSA programs: Opportunities for interaction between health equity, dissemination and implementation, and translational science. *Journal of Clinical and Translational Science, 4*(3), 168-175. doi:10.1017/cts.2020.10

Appendix A. Interview & Focus Group Guide

Introduction & Territorial Acknowledgement

I have started the recording. My name is Alex Kent. I use she/ her pronouns, but invite you to address me by my first name. I am a PhD Candidate in Simon Fraser University's Faculty of Health Sciences, and I am conducting this research for my dissertation, which explores the barriers and facilitators shaping the uptake and implementation of cultural safety and anti-racism training in Master of Public Health curricula in British Columbia. I am a fifth-generation settler of white British and Dutch ancestry, and I acknowledge my location as an uninvited guest on the unceded lands and waterways stewarded by xʷməθkwəy̓əm, Skwxwú7mesh, Sə̓ílwətaɬ and kʷikʷəƛ̓əm peoples.

Preamble

I appreciate that you have agreed to make time to contribute your knowledge and experiences to this research. There will be a diverse range of responses to the following questions, and there are no expectations for how you will respond; please feel at ease to say whatever comes to mind. Also please bear in mind that this is a focus group; I hope we can all contribute to creating a safe space for dialogue and that we can address tensions and resolve disagreements in a respectful way. Further, as we are engaging in a virtual space, I ask that we collectively navigate any challenges with patience and allow the conversation to unfold as naturally as possible.

At any time, feel free to skip a question or come back to it at a later time. Additionally, you may leave the conversation at anytime without prior announcement and return if and when you choose. The conversation may unfold to uncover potentially sensitive or distressing subjects, such as racism and colonialism; should the need arise, I encourage you to refer to the list of support services and resources for which you can self-refer; this list is included with the consent form and is also posted in the chat.

About the Participants' Role(s)

1. We will begin with a round of introductions. I will use the names you have provided in Zoom to call upon you one at a time to introduce yourself by name and role within [SFU Faculty of Health Sciences/ UBC School of Population and Public Health/ UVic School of

Public Health and Social Policy]. You may also provide any other identifying information that you would like associated with your identity in any reports (e.g. Indigeneity/ Nationhood, titles, pronouns). Please note that I will respect your preferences indicated in the consent form, whether you choose to have your contributions associated with your identity or to have your data remain confidential. Either way, it is up to you whether you respond to this first question and subsequent questions.

2. Do you have a focus on cultural safety and anti-racism in your role?

Defining Cultural Safety and Anti-Racism

3. The terms cultural safety and anti-racism mean different things to different people. What do they mean to you?

- Starting with cultural safety?
- And anti-racism?

4. Do people talk about cultural safety and/ or anti-racism in your [department/ faculty]? If yes, what terms or discourses are used?

Relevant Interventions

5. Can you think of any examples of cultural safety and anti-racism training within the MPH curricula at [SFU Faculty of Health Sciences/ UBC School of Population and Public Health/ UVic School of Public Health and Social Policy]?

Potential Prompts:

- What was your involvement in this training (e.g. learner, facilitator, consultant, none)?

6. Have you been involved in any other cultural safety and anti-racism training, for instance outside of your department/ faculty? If so, please describe.

Potential Prompts:

- What was your involvement in this training (e.g. learner, facilitator, consultant)?

Intervention Characteristics

7. Thinking about the training offered within the MPH curricula [or if not applicable, any other training you have been involved in], could you describe some of the characteristics of this training, for instance what are the learning objectives or key themes, how is it delivered, etc.

Potential Prompts:

- How long does the session last?
- Is it a one-time event or recurring?
- At what point does it occur in the curricula?
- Is it mandatory or elective?
- Is it based on/ informed by a framework, set of guidelines or training model?

8. Is anything missing or anything that could be improved upon?

Potential Prompt:

- How does it compare to other training options that you are aware of?

Characteristics of Individuals

The next few questions will ask about individuals involved in the training interventions. As a reminder, you are asked to refrain from directly naming or sharing indirectly identifying information that may compromise the confidentiality and privacy of others. If and when referring to someone other than yourself, please limit descriptors to their professional roles. If relevant, you may forward the recruitment information to members of your network to connect them to this research study so they may choose to have their information included.

9. Who develops and/ or delivers this training?

Potential prompts:

- What is their role/ affiliation?
- How did they come into this role (e.g. appointed, volunteered, voluntold)?

- What qualifications or leadership qualities do they have to deliver this training?

10. Who influences uptake and implementation in your department/ faculty/ institution?

Potential prompts:

- What is their role/ affiliation/ authority?

11. Is there anyone who is not involved that should be?

Potential prompt:

- What's preventing their involvement?

Process

12. Are there any strategies being employed to enhance the uptake, implementation, adaptation and sustainment of cultural safety and anti-racism training in your department/ faculty/ institution?

Potential prompt:

- Are you aware of any monitoring, evaluation or quality improvement efforts?

13. How have strategies evolved or been adapted over time?

Potential prompt:

- Were there any events that prompted this/these change(s) (e.g. calls to action, COVID-19, BLM Movement)?
- Have any challenges or hurdles been encountered?

14. Are there any strategies that could be employed, but currently are not?

Potential prompt:

- What's preventing these strategies from being enacted?

Inner Setting

15. What conditions within your department/ faculty/ institution influence uptake, implementation, adaptation and sustainment of cultural safety and anti-racism training?

Potential prompts:

- Are there any barriers?
- Are there any facilitators?
- Are there any strategic plans that outline priorities or goals?

Outer Setting

16. Can you identify some of the broader social, cultural, political and historical contexts that shape uptake, implementation, adaptation and sustainment of cultural safety and anti-racism training?

Potential prompts:

- Are there any barriers?
- Are there any facilitators?
- Are you familiar with any calls to action for cultural safety and/ or anti-racism—regional, provincial, national, global?
- How has COVID-19 affected training initiatives?

Moving Forward

17. What do you envision as the future directions in cultural safety and anti-racism training in MPH curricula?

Potential prompts:

- Within your department/ faculty/ institution?
- Provincially/ nationally?

Closing Thoughts

18. Is there anything further you would like to add?

Closing Remarks

Thank you for your time and valuable contributions. I will now end the recording. If you would like to ask any questions or provide any comments off the record, you are welcome to stay in the meeting.

Appendix B. CFIR Codebook

Adapted from https://cfirguide.org/

I. Innovation Characteristics	
A. Innovation Source	Definition: Perception of key stakeholders about whether the innovation is externally or internally developed. Inclusion Criteria: Include statements about the source of the innovation and the extent to which interviewees view the change as internal to the organization, e.g., an internally developed program, or external to the organization, e.g., a program coming from the outside. Note: May code and rate as "I" for internal or "E" for external. Exclusion Criteria: Exclude or double code statements related to who participated in the decision process to implement the innovation to Engaging, as an indication of early (or late) engagement. Participation in decision-making is an effective engagement strategy to help people feel ownership of the innovation.
B. Evidence Strength & Quality	Definition: Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the innovation will have desired outcomes. Inclusion Criteria: Include statements regarding awareness of evidence and the strength and quality of evidence, as well as the absence of evidence or a desire for different types of evidence, such as pilot results instead of evidence from the literature. Exclusion Criteria: Exclude or double code statements regarding the receipt of evidence as an engagement strategy to Engaging: Key Stakeholders. Exclude or double code descriptions of use of results from local or regional pilots to Trialability.
C. Relative Advantage	Definition: Stakeholders' perception of the advantage of implementing the innovation versus an alternative solution. Inclusion Criteria: Include statements that demonstrate the innovation is better (or worse) than existing programs. Exclusion Criteria: Exclude statements that demonstrate a strong need for the innovation and/or that the current situation is untenable and code to Tension for Change.

D. Adaptability	Definition: The degree to which an innovation can be adapted, tailored, refined, or reinvented to meet local needs. Inclusion Criteria: Include statements regarding the (in)ability to adapt the innovation to their context, e.g., complaints about the rigidity of the protocol. Suggestions for improvement can be captured in this code but should not be included in the rating process, unless it is clear that the participant feels the change is needed but that the program cannot be adapted. However, it may be possible to infer that a large number of suggestions for improvement demonstrates lack of compatibility, see exclusion criteria below. Exclusion Criteria: Exclude or double code statements that the innovation did or did not need to be adapted to Compatibility.
E. Trialability	Definition: The ability to test the innovation on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted. Inclusion Criteria: Include statements related to whether the site piloted the innovation in the past or has plans to in the future, and comments about whether they believe it is (im)possible to conduct a pilot. Exclusion Criteria: Exclude or double code descriptions of use of results from local or regional pilots to Evidence Strength & Quality.
F. Complexity	Definition: Perceived difficulty of the innovation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement. Inclusion Criteria: Code statements regarding the complexity of the innovation itself. Exclusion Criteria: Exclude statements regarding the complexity of implementation and code to the appropriate CFIR code, e.g., difficulties related to space are coded to Available Resources and difficulties related to engaging participants in a new program are coded to Engaging: Innovation Participants.
G. Design Quality & Packaging	Definition: Perceived excellence in how the innovation is bundled, presented, and assembled. Inclusion Criteria: Include statements regarding the quality of the materials and packaging.

	Exclusion Criteria: Exclude statements regarding the presence or absence of materials and code to Available Resources. Exclude statements regarding the receipt of materials as an engagement strategy and code to Engaging.
H. Cost	Definition: Costs of the innovation and costs associated with implementing the innovation including investment, supply, and opportunity costs. Inclusion Criteria: Include statements related to the cost of the innovation and its implementation. Exclusion Criteria: Exclude statements related to physical space and time, and code to Available Resources. In a research study, exclude statements related to costs of conducting the research components (e.g., funding for research staff, participant incentives).
II. Outer Setting	
A. Needs & Resources of Those Served by the Organization	Definition: The extent to which the needs of those served by the organization (e.g., patients), as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization. Inclusion Criteria: Include statements demonstrating (lack of) awareness of the needs and resources of those served by the organization. Analysts may be able to infer the level of awareness based on statements about: 1. Perceived need for the innovation based on the needs of those served by the organization and if the innovation will meet those needs; 2. Barriers and facilitators of those served by the organization to participating in the innovation; 3. Participant feedback on the innovation, i.e., satisfaction and success in a program. In addition, include statements that capture whether or not awareness of the needs and resources of those served by the organization influenced the implementation or adaptation of the innovation. Exclusion Criteria: Exclude statements that demonstrate a strong need for the innovation and/or that the current situation is untenable and code to Tension for Change. Exclude statements related to engagement strategies and outcomes, e.g., how innovation participants became engaged with the innovation, and code to Engaging: Innovation Participants.

B. Cosmopolitanism	Definition: The degree to which an organization is networked with other external organizations. Inclusion Criteria: Include descriptions of outside group memberships and networking done outside the organization. Exclusion Criteria: Exclude statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning, and code to Networks & Communications.
C. Peer Pressure	Definition: Mimetic or competitive pressure to implement an innovation, typically because most or other key peer or competing organizations have already implemented or are in a bid for a competitive edge. Inclusion Criteria: Include statements about perceived pressure or motivation from other entities or organizations in the local geographic area or system to implement the innovation. Exclusion Criteria:
D. External Policy & Incentives	Definition: A broad construct that includes external strategies to spread innovations including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting. Inclusion Criteria: Include descriptions of external performance measures from the system. Exclusion Criteria:
III. Inner Setting	
A. Structural Characteristics	Definition: The social architecture, age, maturity, and size of an organization. Inclusion Criteria: Exclusion Criteria:
B. Networks & Communications	Definition: The nature and quality of webs of social networks, and the nature and quality of formal and informal communications within an organization.

	Inclusion Criteria: Include statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning. Exclusion Criteria: Exclude statements related to implementation leaders' and users' access to knowledge and information regarding using the program, i.e., training on the mechanics of the program and code to Access to Knowledge & Information. Exclude statements related to engagement strategies and outcomes, e.g., how key stakeholders became engaged with the innovation and what their role is in implementation, and code to Engaging: Key Stakeholders. Exclude descriptions of outside group memberships and networking done outside the organization and code to Cosmopolitanism.
C. Culture	Definition: Norms, values, and basic assumptions of a given organization. Inclusion Criteria: Inclusion criteria, and potential sub-codes, will depend on the framework or definition used for "culture." For example, if using the Competing Values Framework (CVF), you may include four sub-codes related to the four dimensions of the CVF and code statements regarding one or more of the four dimension in an organization. Exclusion Criteria:
D. Implementation Climate	Definition: The absorptive capacity for change, shared receptivity of involved individuals to an innovation, and the extent to which use of that innovation will be rewarded, supported, and expected within their organization. Inclusion Criteria: Include statements regarding the general level of receptivity to implementing the innovation. Exclusion Criteria: Exclude statements regarding the general level of receptivity that are captured in the sub-codes.
1. Tension for Change	Definition: The degree to which stakeholders perceive the current situation as intolerable or needing change. Inclusion Criteria: Include statements that (do not) demonstrate a strong need for the innovation and/or that the current situation is untenable, e.g., statements that the innovation is absolutely necessary or that the innovation is

		redundant with other programs. Note: If a participant states that the innovation is redundant with a preferred existing program, (double) code lack of Relative Advantage, see exclusion criteria below. Exclusion Criteria: Exclude statements regarding specific needs of individuals that demonstrate a need for the innovation, but do not necessarily represent a strong need or an untenable status quo, and code to Needs and Resources of Those Served by the Organization. Exclude statements that demonstrate the innovation is better (or worse) than existing programs and code to Relative Advantage.
2.	Compatibility	Definition: The degree of tangible fit between meaning and values attached to the innovation by involved individuals, how those align with individuals' own norms, values, and perceived risks and needs, and how the innovation fits with existing workflows and systems. Inclusion Criteria: Include statements that demonstrate the level of compatibility the innovation has with organizational values and work processes. Include statements that the innovation did or did not need to be adapted as evidence of compatibility or lack of compatibility. Exclusion Criteria: Exclude or double code statements regarding the priority of the innovation based on compatibility with organizational values to Relative Priority, e.g., if an innovation is not prioritized because it is not compatible with organizational values.
3.	Relative Priority	Definition: Individuals' shared perception of the importance of the implementation within the organization. Inclusion Criteria: Include statements that reflect the relative priority of the innovation, e.g., statements related to change fatigue in the organization due to implementation of many other programs. Exclusion Criteria: Exclude or double code statements regarding the priority of the innovation based on compatibility with organizational values to Compatibility, e.g., if an innovation is not prioritized because it is not compatible with organizational values.
4.	Organizational Incentives & Rewards	Definition: Extrinsic incentives such as goal-sharing, awards, performance reviews, promotions, and raises in salary, and less tangible incentives such as increased stature or respect.

	Inclusion Criteria: Include statements related to whether organizational incentive systems are in place to foster (or hinder) implementation, e.g., rewards or disincentives for staff engaging in the innovation. Exclusion Criteria:
5. Goals & Feedback	Definition: The degree to which goals are clearly communicated, acted upon, and fed back to staff, and alignment of that feedback with goals. Inclusion Criteria: Include statements related to the (lack of) alignment of implementation and innovation goals with larger organizational goals, as well as feedback to staff regarding those goals, e.g., regular audit and feedback showing any gaps between the current organizational status and the goal. Goals and Feedback include organizational processes and supporting structures independent of the implementation process. Evidence of the integration of evaluation components used as part of "Reflecting and Evaluating" into **on-going or sustained** organizational structures and processes may be (double) coded to Goals and Feedback. Exclusion Criteria: Exclude statements that refer to the implementation team's (lack of) assessment of the progress toward and impact of implementation, as well as the interpretation of outcomes related to implementation, and code to Reflecting & Evaluating. Reflecting and Evaluating is part of the implementation process; it likely ends when implementation activities end. It does not require goals be explicitly articulated; it can focus on descriptions of the current state with real-time judgment, though there may be an implied goal (e.g., we need to implement the innovation) when the implementation team discusses feedback in terms of adjustments needed to complete implementation.
6. Learning Climate	Definition: A climate in which: 1. Leaders express their own fallibility and need for team members' assistance and input; 2. Team members feel that they are essential, valued, and knowledgeable partners in the change process; 3. Individuals feel psychologically safe to try new methods; and 4. There is sufficient time and space for reflective thinking and evaluation. Inclusion Criteria: Include statements that support (or refute) the degree to which key components of an organization exhibit a "learning climate." Exclusion Criteria:
E. Readiness for Implementation	Definition: Tangible and immediate indicators of organizational commitment to its decision to implement an innovation.

		Inclusion Criteria: Include statements regarding the general level of readiness for implementation. Exclusion Criteria: Exclude statements regarding the general level of readiness for implementation that are captured in the sub-codes.
1.	Leadership Engagement	Definition: Commitment, involvement, and accountability of leaders and managers with the implementation of the innovation. Inclusion Criteria: Include statements regarding the level of engagement of organizational leadership. Exclusion Criteria: Exclude or double code statements regarding leadership engagement to Engaging: Formally Appointed Internal Implementation Leaders or Champions *if* an organizational leader is also an implementation leader, e.g., if a director of primary care takes the lead in implementing a new treatment guideline. Note that a key characteristic of this Implementation Leader/Champion is that s/he is also an Organizational Leader.
2.	Available Resources	Definition: The level of resources organizational dedicated for implementation and on-going operations including physical space and time. Inclusion Criteria: Include statements related to the presence or absence of resources specific to the innovation that is being implemented. Exclusion Criteria: Exclude statements related to training and education and code to Access to Knowledge & Information. Exclude statements related to the quality of materials and code to Design Quality & Packaging. In a research study, exclude statements related to resources needed for conducting the research components (e.g., time to complete research tasks, such as IRB applications, consenting patients).
3.	Access to Knowledge & Information	Definition: Ease of access to digestible information and knowledge about the innovation and how to incorporate it into work tasks. Inclusion Criteria: Include statements related to implementation leaders' and users' access to knowledge and

		information regarding use of the program, i.e., training on the mechanics of the program. Exclusion Criteria: Exclude statements related to engagement strategies and outcomes, e.g., how key stakeholders became engaged with the innovation and what their role is in implementation, and code to Engaging: Key Stakeholders. Exclude statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning, and code to Networks & Communications.
IV.	**Characteristics of Individuals**	
1.	Knowledge & Beliefs about the Innovation	Definition: Individuals' attitudes toward and value placed on the innovation, as well as familiarity with facts, truths, and principles related to the innovation. Inclusion Criteria: Exclusion Criteria: Exclude statements related to familiarity with evidence about the innovation and code to Evidence Strength & Quality.
2.	Self-efficacy	Definition: Individual belief in their own capabilities to execute courses of action to achieve implementation goals. Inclusion Criteria: Exclusion Criteria:
3.	Individual Stage of Change	Definition: Characterization of the phase an individual is in, as s/he progresses toward skilled, enthusiastic, and sustained use of the innovation. Inclusion Criteria: Exclusion Criteria:
4.	Individual Identification with Organization	Definition: A broad construct related to how individuals perceive the organization, and their relationship and degree of commitment with that organization. Inclusion Criteria: Exclusion Criteria:

5. Other Personal Attributes	Definition: A broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style. Inclusion Criteria: Exclusion Criteria:
V. Process	
A. Planning	Definition: The degree to which a scheme or method of behavior and tasks for implementing an innovation are developed in advance, and the quality of those schemes or methods. Inclusion Criteria: Include evidence of pre-implementation diagnostic assessments and planning, as well as refinements to the plan. Exclusion Criteria:
B. Engaging	Definition: Attracting and involving appropriate individuals in the implementation and use of the innovation through a combined strategy of social marketing, education, role modeling, training, and other similar activities. Inclusion Criteria: Include statements related to engagement strategies and outcomes, i.e., if and how staff and innovation participants became engaged with the innovation and what their role is in implementation. Note: Although both strategies and outcomes are coded here, the outcome of engagement efforts determines the rating, i.e., if there are repeated attempts to engage staff that are unsuccessful, or if a role is vacant, the construct receives a negative rating. In addition, you may also want to code the "quality" of staff - their capabilities, motivation, and skills, i.e., how good they are at their job, and this data affects the rating as well. Exclusion Criteria: Exclude statements related to specific sub constructs, e.g., Champions or Opinion Leaders. Exclude or double code statements related to who participated in the decision process to implement the innovation to Innovation Source, as an indicator of internal or external innovation source.

1.	Opinion Leaders	Definition: Individuals in an organization that have formal or informal influence on the attitudes and beliefs of their colleagues with respect to implementing the innovation. Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how the opinion leader became engaged with the innovation and what their role is in implementation. Note: Although both strategies and outcomes are coded here, the outcome of efforts to engage staff determines the rating, i.e., if there are repeated attempts to engage an opinion leader that are unsuccessful, or if the opinion leader leaves the organization and this role is vacant, the construct receives a negative rating. In addition, you may also want to code the "quality" of the opinion leader here - their capabilities, motivation, and skills, i.e., how good they are at their job, and this data affects the rating as well. Exclusion Criteria:
2.	Formally Appointed Internal Implementation Leaders	Definition: Individuals from within the organization who have been formally appointed with responsibility for implementing an innovation as coordinator, project manager, team leader, or other similar role. Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how the formally appointed internal implementation leader became engaged with the innovation and what their role is in implementation. Note: Although both strategies and outcomes are coded here, the outcome of efforts to engage staff determines the rating, i.e., if there are repeated attempts to engage an implementation leader that are unsuccessful, or if the implementation leader leaves the organization and this role is vacant, the construct receives a negative rating. In addition, you may also want to code the "quality" of the implementation leader here - their capabilities, motivation, and skills, i.e., how good they are at their job, and this data affects the rating as well. Exclusion Criteria: Exclude or double code statements regarding leadership engagement to Leadership Engagement *if* an implementation leader is also an organizational leader, e.g., if a director of primary care takes the lead in implementing a new treatment guideline.
3.	Champions	Definition: “Individuals who dedicate themselves to supporting, marketing, and ‘driving through’ an [implementation]”, overcoming indifference or resistance that the innovation may provoke in an organization.

		Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how the champion became engaged with the innovation and what their role is in implementation. Note: Although both strategies and outcomes are coded here, the outcome of efforts to engage staff determines the rating, i.e., if there are repeated attempts to engage a champion that are unsuccessful, or if the champion leaves the organization and this role is vacant, the construct receives a negative rating. In addition, you may also want to code the "quality" of the champion here - their capabilities, motivation, and skills, i.e., how good they are at their job, and this data affects the rating as well. Exclusion Criteria: Exclude or double code statements regarding leadership engagement to Leadership Engagement *if* a champion is also an organizational leader, e.g., if a director of primary care takes the lead in implementing a new treatment guideline.
4.	External Change Agents	Definition: Individuals who are affiliated with an outside entity who formally influence or facilitate innovation decisions in a desirable direction. Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how the external change agent (entities outside the organization that facilitate change) became engaged with the innovation and what their role is in implementation, e.g., how they supported implementation efforts. Note: Although both strategies and outcomes are coded here, the outcome of efforts to engage staff determines the rating, i.e., if there are repeated attempts to engage an external change agent that are unsuccessful, or if the external change agent leaves their organization and this role is vacant, the construct receives a negative rating. In addition, you may also want to code the "quality" of the external change agent here - their capabilities, motivation, and skills, i.e., how good they are at their job, and this data affects the rating as well. Exclusion Criteria: Note: It is important to clearly define what roles are external and internal to the organization. Exclude statements regarding facilitating activities, such as training in the mechanics of the program, and code to Access to Knowledge & Information *if* the change agent is considered internal to the study, e.g., a staff member at the national office. If the study considers this staff member internal to the organization, it should be coded to Access to Knowledge & Information, even though their support may overlap with what would be expected from an External Change Agent.

5. Key Stakeholders	Definition: Individuals from within the organization that are directly impacted by the innovation, e.g., staff responsible for making referrals to a new program or using a new work process. Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how key stakeholders became engaged with the innovation and what their role is in implementation. Note: Although both strategies and outcomes are coded here, the outcome of efforts to engage staff determines the rating, i.e., if there are repeated attempts to engage key stakeholders that are unsuccessful, the construct receives a negative rating. Exclusion Criteria: Exclude statements related to implementation leaders' and users' access to knowledge and information regarding using the program, i.e., training on the mechanics of the program, and code to Access to Knowledge & Information. Exclude statements about general networking, communication, and relationships in the organization, such as descriptions of meetings, email groups, or other methods of keeping people connected and informed, and statements related to team formation, quality, and functioning, and code to Networks & Communications.
6. Innovation Participants	Definition: Individuals served by the organization that participate in the innovation, e.g., patients in a prevention program in a hospital. Inclusion Criteria: Include statements related to engagement strategies and outcomes, e.g., how innovation participants became engaged with the innovation. Note: Although both strategies and outcomes are coded here, the outcome of efforts to engage participants determines the rating, i.e., if there are repeated attempts to engage participants that are unsuccessful, the construct receives a negative rating. Exclusion Criteria: Exclude statements demonstrating (lack of) awareness of the needs and resources of those served by the organization and whether or not that awareness influenced the implementation or adaptation of the innovation and code to Needs & Resources of Those Served by the Organization.
C. Executing	Definition: Carrying out or accomplishing the implementation according to plan. Inclusion Criteria: Include statements that demonstrate how implementation occurred with respect to the implementation plan. Note: Executing is coded very infrequently due to a lack

	of planning. However, some studies have used fidelity measures to assess executing, as an indication of the degree to which implementation was accomplished according to plan. Exclusion Criteria:
D. Reflecting & Evaluating	Definition: Quantitative and qualitative feedback about the progress and quality of implementation accompanied with regular personal and team debriefing about progress and experience. Inclusion Criteria: Include statements that refer to the implementation team's (lack of) assessment of the progress toward and impact of implementation, as well as the interpretation of outcomes related to implementation. Reflecting and Evaluating is part of the implementation process; it likely ends when implementation activities end. It does not require goals be explicitly articulated; it can focus on descriptions of the current state with real-time judgment, though there may be an implied goal (e.g., we need to implement the innovation) when the implementation team discusses feedback in terms of adjustments needed to complete implementation. Exclusion Criteria: Exclude statements related to the (lack of) alignment of implementation and innovation goals with larger organizational goals, as well as feedback to staff regarding those goals, e.g., regular audit and feedback showing any gaps between the current organizational status and the goal, and code to Goals & Feedback. Goals and Feedback include organizational processes and supporting structures independent of the implementation process. Evidence of the integration of evaluation components used as part of "Reflecting and Evaluating" into **on-going or sustained** organizational structures and processes may be (double) coded to Goals and Feedback. Exclude statements that capture reflecting and evaluating that participants may do during the interview, for example, related to the success of the implementation, and code to Knowledge & Beliefs about the Innovation.
VI. Additional Codes	
A. Code Name	Definition: Inclusion Criteria: Exclusion Criteria:

B. Code Name	Definition: Inclusion Criteria: Exclusion Criteria:

Appendix C. Number of Files and References Coded, Organized by CFIR Construct and # of References

CFIR Construct	Files Coded	References Coded
Intervention Characteristics		
Complexity	19	37
Design Quality & Packaging	10	33
Innovation Source	12	28
Relative Advantage	11	28
Evidence Strength & Quality	13	27
Adaptability	9	18
Trialability	3	3
Cost	2	3
Characteristics of Individuals		
Knowledge & Beliefs about the Innovation	21	79
Individual Stage of Change	11	40
Individual Identification with Organization	13	25
Self-efficacy	9	12
Other Personal Attributes		
Indigenous Leaders*	27	102
Allies*	15	37
BIPOC Leaders*	9	14
Process		
Reflecting & Evaluating	28	86
Planning	13	23
Executing	10	15
Engaging		
Innovation Participants	14	35
Key Stakeholders	17	34
External Change Agents	15	26
Champions	10	24
Formally Appointed Internal Implementation Leaders	10	20
Opinion Leaders	9	17
Inner Setting		
Culture	32	158
Structural Characteristics	24	90
Networks & Communications	17	44
Implementation Climate		

Relative Priority	31	95
Goals & Feedback	17	62
Learning Climate	20	56
Tension for Change	19	47
Compatibility	21	42
Organizational Incentives & Rewards	16	42
Readiness for Implementation		
Available Resources	44	204
Access to Knowledge & Information	15	51
Leadership Engagement	15	38
Outer Setting		
External Policy & Incentives	31	105
Needs & Resources of Those Served by the Organization	21	90
Cosmopolitanism	18	48
Peer Pressure	8	10

*Theme added to the CFIR coding framework by researcher