BRAIDING ACCOUNTABILITY:

A TEN YEAR REVIEW OF THE TRC'S HEALTHCARE CALLS TO ACTION

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ABSTRACT

Ten years after the Truth and Reconciliation Commission issued its Calls to Action, what has been achieved? Calls to Action 18–24 challenge governments and health authorities to acknowledge colonial harms, close health gaps, recognize Indigenous approaches to healing, and transform healthcare systems. This report assesses public health authority responses to Calls 18–24 through an environmental scan of provincial, territorial, and federal actions from April 2024 to April 2025.

Applying the Braiding Framework for Health Accountability, developed from the Cultural Responsiveness Framework, we assessed progress along three interrelated strands: restoring Indigenous wellness systems, establishing ethical space for engagement, and transforming mainstream service delivery. Grounded in relational accountability, this approach offers a culturally responsive lens to evaluate whether actions reflect meaningful structural change.

Unfortunately, our findings show limited progress across all three strands. Health authorities often rely on land acknowledgments, cultural safety training, or project-based initiatives while avoiding commitments that transfer power or resources to Indigenous Peoples. Reporting tends to focus on descriptive activities rather than Indigenous-defined outcomes, and rarely acknowledges institutional complicity in colonial harm.

Indigenous-led healing centres remain underfunded, jurisdictional disputes continue, and Indigenous health education is inconsistently embedded in medical and nursing curricula. Although promising initiatives exist, system-wide transformation is lacking. Reconciliation in health will require Indigenous-led accountability frameworks, co-governance, sustainable and flexible funding, transparent reporting based on Indigenous-defined indicators, and full implementation of UNDRIPA obligations. Without these shifts, reconciliation risks remaining rhetorical rather than transformative. In fact, we find Canada's health systems have perfected performative reconciliation.

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This analysis reaffirms what Indigenous Peoples have articulated for generations and what the TRC formalized nearly a decade ago: symbolic gestures divorced from structural accountability do not constitute reconciliation.

Genuine transformation requires
the redistribution of power, resources,
and decision-making authority.

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INTRODUCTION

Ten years after the Truth and Reconciliation Commission (TRC) issued its Calls to Action, Canada's health systems have perfected performative reconciliation.

WE SEE THIS TURN to performance in the health-related Calls to Action 18–24, which challenge governments and health authorities to acknowledge colonial harms, close health gaps, recognize Indigenous approaches to healing, and transform healthcare systems. And Call 57, which expands this responsibility to all levels of government, requiring public servants to be educated on Indigenous history, law, and Treaties to prevent the ongoing reproduction of colonial systems.

Over the past decade, instead of meaningfully engaging with the Calls, governments and health authorities have increasingly turned to what we call reconciliation theatre: symbolic gestures and highly visible activities that create the appearance of progress while leaving the structures of colonial power intact.

These are not accidental oversights or stalled reforms — they are deliberate choices to preserve control while projecting the image of reconciliation. Land acknowledgments, cultural safety workshops, and glossy reconciliation reports are showcased as progress, even as Indigenous peoples continue to experience chronic underfunding, systemic racism, and preventable deaths.

As Yellowhead Institute has documented (2021; 2023), settler institutions consistently prefer symbolic inclusion over structural transformation. This report extends that analysis into the health sector. Using the Braiding Framework for Health Accountability (Sasakamoose, forthcoming 2026), we evaluate how health authorities and governments respond to TRC Calls 18–24 and 57.

By braiding together three pathways — restoring Indigenous wellness, creating ethical middle ground, and transforming service delivery — the framework reveals where institutions remain stalled and what true transformation requires. Our findings demonstrate that most systems remain trapped in the earliest stages of symbolic engagement, while almost none advance toward Indigenous governance, law, or authority in health.

The result is stark: nearly a decade after the TRC, there has been little measurable improvement in Indigenous health outcomes. Institutions continue to substitute activity for accountability, performance for transformation.

METHODS & FRAMEWORK

We make this conclusion based on an systemic environmental scan, conducted by Miranda Field (April 2024–April 2025), and examining how provincial, territorial, and national health authorities publicly respond to TRC Calls 18–24 and 57.

THAT SCAN WAS BASED on publicly available information from provincial, territorial, and national health authorities, including organizational websites, published reports, strategic plans, press releases, policy documents, and web pages explicitly referencing the TRC or reconciliation. Search terms included variations of "Truth and Reconciliation," "Calls to Action," "TRC," "Indigenous Health," and "Reconciliation in Health," combined with jurisdiction-specific identifiers. Searches were conducted within health authority websites and through Google, limiting results to the first five pages.

DATA COLLECTION: Publicly available documents were gathered, including reports, strategic plans, press releases, and web pages referencing the TRC or reconciliation. If no explicit TRC references were found, secondary searches used "Indigenous Health" and related terms.

INCLUSION CRITERIA: Initiatives were included if they (1) were reported as TRC responses, (2) explicitly referenced Calls 18–24, or (3) aligned with their intent (e.g., cultural safety training, patient navigation). Community-led initiatives not acknowledged by institutions, unpublished documents, and research projects outside institutional reporting were excluded.

FOCUS: We evaluated *what institutions claim as reconciliation*, not what they deliver. Accountability begins with the gap between promise and practice.

LIMITATIONS: Reliance on public-facing data may underrepresent Indigenous-led initiatives. Search algorithms may have limited visibility. Initiatives reframed post hoc as reconciliation responses may distort the analysis.

This approach aligns with the Braiding Framework's principle of relational accountability: institutional self-reporting reveals how reconciliation theatre operates.

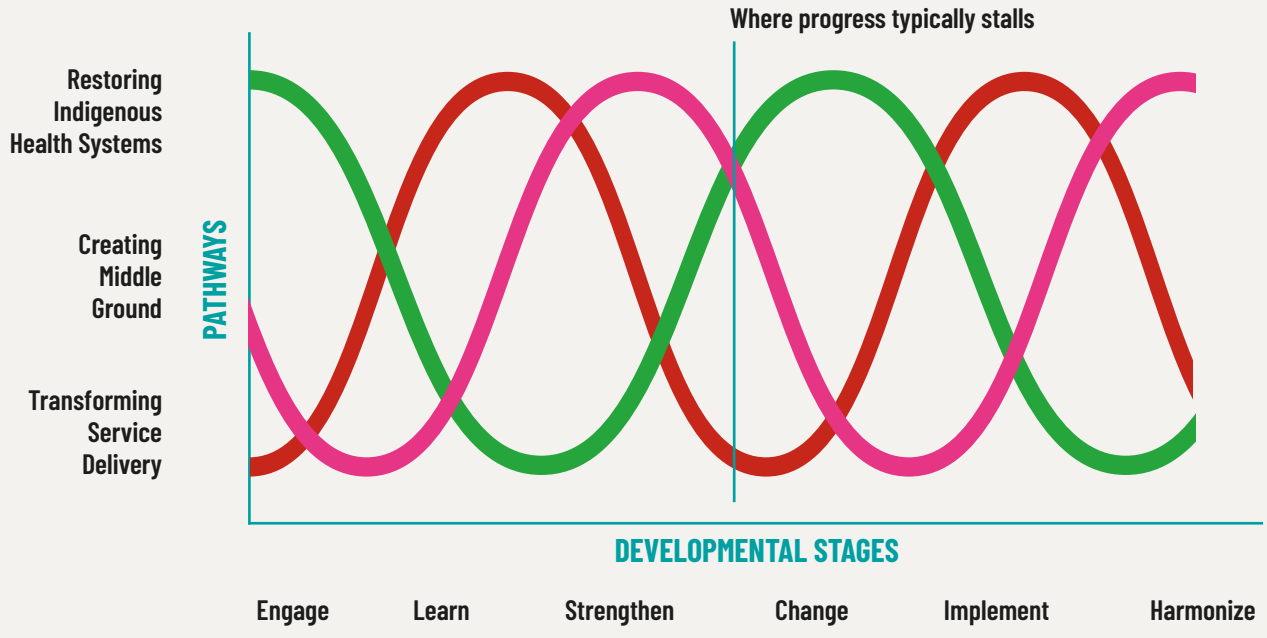
THE BRAIDING FRAMEWORK FOR HEALTH ACCOUNTABILITY

The Braiding Framework (Sasakamoose, forthcoming 2026) builds on the Cultural Responsiveness Framework (FSIN, 2013; Sasakamoose et al., 2017) and Ermine's (2007) concept of ethical space. It offers a way to evaluate reconciliation in health that is relational, grounded in Indigenous knowledge systems, and resistant to the tendency of institutions to substitute performance for transformation.

THE BRAID METAPHOR highlights three **interwoven pathways** that must be advanced together in health transformation:

1. **Restoring Indigenous Wellness:** revitalizing Indigenous-led health systems rooted in ceremony, land, language, and law.
2. **Creating Middle Ground:** establishing ethical space where Indigenous and Western systems engage as equals, guided by principles of relational accountability.
3. **Transforming Service Delivery:** embedding Indigenous governance, protocols, and values into mainstream health systems so that Indigenous law and practice are not "add-ons" but core.

The Braiding Framework



Our scan of TRC responses shows that most jurisdictions remain stuck at the first three stages (Engage, Learn, Strengthen). Land acknowlegements, cultural safety workshops, and Indigenous navigation services dominate, while very few systems advance to Change, Implement, or Harmonize.

Each pathway moves through developmental stages that reflect the depth of institutional change:

1. **Engage:** Institutions initiate symbolic gestures: statements of acknowledgment, consultation meetings, cultural programming.
2. **Learn:** Cultural competency or anti-racism training begins; Indigenous knowledge is introduced as supplementary "content."
3. **Strengthen:** Institutions hire Indigenous staff or create advisory councils; Indigenous health initiatives appear, but without decision-making authority.
4. **Change:** Indigenous Nations co-develop priorities, indicators, and accountability measures; resources begin to shift but authority is still negotiated.
5. **Implement:** Shared governance structures emerge; Indigenous-defined measures become standard; institutions are accountable to Indigenous governments.
6. **Harmonize:** Indigenous-led health systems operate as equal and authoritative; Indigenous governance, law, and knowledge are embedded into the foundation of healthcare delivery.

Our scan of TRC responses shows that most jurisdictions remain stuck at the first three stages (Engage, Learn, Strengthen). Land acknowledgments, cultural safety workshops, and Indigenous navigation services dominate, while very few systems advance to Change, Implement, or Harmonize. When institutions remain at the early stages of Engage, Learn, and Strengthen, it is not because they are "trapped." Rather, they actively choose to stop there. This is what we describe as *reconciliation theatre*: the calculated performance of reconciliation through acknowledgments, training, or program branding, without moving toward power-sharing, Indigenous-defined accountability, or Indigenous governance. Institutions rehearse and repeat these performances because they maintain colonial authority while deflecting criticism.

For example:

- **Engage:** Saskatchewan's 2021 TRC report acknowledges Calls to Action but avoids naming institutional racism or setting measurable outcomes.
- **Learn:** Manitoba's cultural safety modules educate health professionals but remain unlinked to Indigenous-defined equity indicators.
- **Strengthen:** Ontario's hospital Indigenous liaison programs provide individual support but leave governance structures untouched.

The later stages — **Change, Implement, Harmonize** — remain aspirational. No jurisdiction has legislated Indigenous data sovereignty, dismantled jurisdictional barriers, or transferred authority over health system governance to Indigenous Nations.

Defining the stages reveals reconciliation theatre for what it is: institutions celebrate activity in the early phases while avoiding the redistribution of power required in later phases. The braid metaphor insists that progress along one strand (for example, cultural competency training) must be matched by movement along the others (restoring Indigenous wellness, transforming service delivery). Without braiding, efforts unravel into fragmented gestures that leave colonial structures intact.

When institutions remain at the early stages of Engage, Learn, and Strengthen, it is not because they are “trapped.” Rather, they actively choose to stop there. This is what we describe as reconciliation theatre: the calculated performance of reconciliation through acknowledgments, training, or program branding, without moving toward power-sharing, Indigenous-defined accountability, or Indigenous governance.

ASSESSING PROGRESS ON THE HEALTH CALLS TO ACTION

Our analysis through the Braiding Framework reveals a consistent pattern across jurisdictions: Few jurisdictions fund or formally recognize Indigenous-led health systems. Instead, cultural safety training substitutes for co-governance or power-sharing; Indigenous knowledge integration is limited to cultural programming; Indigenous leadership in health governance remains scarce; reporting focuses on activities, not outcomes; and health systems remain trapped in early developmental stages, failing to progress toward shared governance or Indigenous control. Building on this framework, the following sections review each TRC Health Call to Action (18–24), demonstrating how institutional responses consistently prioritize reconciliation performance over structural transformation.

ANALYZING JURISDICTION responses to the Health Calls through the Braiding Framework reveals a number of specific patterns. They include:

Symbolic Inclusion Over Structural Change:
Across all Calls, institutions have mastered the language of reconciliation while avoiding the redistribution of power, resources, or authority required for transformation.

Consultation Without Decision-Making Power:
Indigenous peoples are consulted but not granted authority over the systems, funding, or governance structures that affect their health.

Add-On Approach:
Indigenous health initiatives are consistently framed as supplementary to "real" healthcare rather than integrated as legitimate, funded components of health systems.

Accountability Avoidance:
Institutions report activities and inputs while systematically avoiding outcome measurement or Indigenous-defined success indicators.

We have captured these general patterns in Figure 1, which applies the Braiding Framework to each of the health Calls to Action. Included as a description of the type of change observed from the environmental scan and our analysis. Below Figure 1, we move from general to specific and examine jurisdictional responses to each of the Calls to Action and highlight the tangible reconciliation efforts (or lack thereof).

FIGURE 1

TRC CALL	RESTORING INDIGENOUS WELLNESS	CREATING MIDDLE GROUND	TRANSFORMING SERVICE DELIVERY	COMMENTARY
18. **Acknowledge colonial harms and affirm health rights**	Policy acknowledgments without explicit recognition of institutional culpability	Statements of commitment without governance shifts or reparative measures	Symbolic references to reconciliation; service delivery unchanged	Health authorities perform acknowledgment while avoiding accountability. Generic reconciliation language substitutes for naming specific harms and institutional responsibility
19. **Establish measurable goals to close health gaps**	No Indigenous-defined indicators; communities excluded from measurement design	Limited integration of Indigenous knowledge in reporting frameworks	Descriptive activity reporting; no outcome accountability	The absence of Indigenous data sovereignty renders this Call meaningless. Institutions report on activities, not results, using settler-defined metrics that obscure ongoing inequities
20. **Address jurisdictional disputes (Métis, Inuit, off-reserve First Nations)**	Minimal jurisdictional coordination; disputes remain unresolved	Navigation services and pilots; no systemic restructuring	Gaps in equitable access persist; no national strategy implemented	Jurisdictional disputes continue to trap Indigenous peoples in bureaucratic limbo while governments pass responsibility between levels. Navigation services treat symptoms, not causes
21. **Sustainable funding for Indigenous healing centres**	Scattered, short-term funding; healing centres remain underfunded	Healing centres framed as "complementary" rather than essential health infrastructure	Healing centres operate as add-ons, not integrated care options	Chronic underfunding reveals that governments view Indigenous healing as supplementary, not legitimate healthcare. Integration remains rhetorical while funding structures maintain marginalization

TRC CALL	RESTORING INDIGENOUS WELLNESS	CREATING MIDDLE GROUND	TRANSFORMING SERVICE DELIVERY	COMMENTARY
22. **Recognition and integration of Indigenous healing practices**	Healing practices acknowledged rhetorically but not funded as core care	Cultural programming without clinical authority or recognition	Indigenous healing excluded from standard care pathways and insurance coverage	Institutions acknowledge Indigenous healing to appear culturally responsive while systematically excluding it from legitimate healthcare delivery. Recognition without integration equals tokenism
23. **Increase Indigenous professionals and support retention**	Recruitment initiatives without addressing systemic barriers or workplace racism	Academic partnerships focused on recruitment, not retention or advancement	Persistent underrepresentation; minimal reporting on retention or leadership progression	Recruitment without retention perpetuates a revolving door. Institutions recruit Indigenous professionals into hostile environments then blame "cultural factors" when they leave
24. **Require Indigenous health curriculum in medical/nursing schools**	Accreditation language references Indigenous content without enforcement mechanisms	Courses offered as optional or supplementary rather than mandatory core curriculum	Uneven curricular implementation; no accountability for content quality or uptake	Without mandatory, standardized, and accountable curriculum requirements, Indigenous health education remains an elective add-on, ensuring continued marginalization in clinical practice

CALL 18: ACKNOWLEDGMENT WITHOUT ACCOUNTABILITY

CALL TO ACTION 18

We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

CALL 18 URGES federal, provincial, territorial, and Indigenous governments to acknowledge that the current state of Indigenous health in Canada is a direct result of colonial policies, including residential schools, and to recognize and implement the health-care rights of Indigenous Peoples as affirmed in international, constitutional, and Treaty law (Treaty No. 6, 1876; Yellowhead Institute, 2023).

Nearly a decade later, health authorities have mastered the performance of acknowledgment while systematically avoiding accountability — generic statements about reconciliation substitute for institutional self-examination. Land acknowledgments replace concrete commitments. Cultural safety training becomes a substitute for transferring decision-making power to Indigenous communities (SHA, 2021; FNHA, 2015–present).

The pattern is clear: institutions acknowledge colonial harm in abstract terms while refusing to name their own complicity or commit to measurable change. This allows them to appear responsive while maintaining colonial control over Indigenous health systems (Palmater, 2011).

THE COST OF SYMBOLIC ACKNOWLEDGMENT

Acknowledgment without accountability perpetuates the same colonial relationships it claims to address. When health authorities issue generic reconciliation statements without examining their own discriminatory practices, they perform reconciliation while avoiding transformation.

When they recognize Indigenous rights in principle but refuse to operationalize them in practice, they maintain settler supremacy while claiming moral progress (Yellowhead Institute, 2023).

Indigenous peoples continue to die from preventable causes while health authorities celebrate their land acknowledgments and cultural safety certificates. Joyce Echaquan's death in 2020 revealed that institutional racism persists despite years of reconciliation rhetoric (Coroner's Report on Joyce Echaquan, 2021). Brian Sinclair's death in 2008 at Winnipeg's Health Sciences Centre demonstrated how acknowledgment without systemic change allows discriminatory practices to continue unchecked (Manitoba Ombudsman, 2014).

INSTITUTIONAL RESPONSES

Despite nearly a decade since Call 18, institutional responses have demonstrated consultation without power transfer, acknowledgment without accountability, and statements without structural change.

Alberta: Alberta Health Services shared a public TRC acknowledgment video and published the article Applying Truth and Reconciliation in Alberta Health Services (AHS, 2020).

British Columbia: The First Nations Health Authority has developed a Timeline of Declarations (2015–present) that documents its reconciliation commitments (FNHA, 2015–present).

Saskatchewan: The Saskatchewan Health Authority affirmed its commitment to the TRC in 2019 (and again in 2021), acknowledged the FSIN's Cultural Responsiveness Framework developed by the Federation of Sovereign Indigenous Nations, and released a 2021 report summarizing its interpretation of health-related Calls to Action (SHA, 2021).

Manitoba: The College of Physicians & Surgeons of Manitoba issued a formal Statement and Apology on Truth and Reconciliation, acknowledging the medical profession's

role in providing racist and substandard care to Indigenous peoples, recognizing CPSM's failure to regulate against such practices effectively, and committing to specific actions, including mandatory Indigenous cultural training for all registrants (CPSM, 2021).

New Brunswick: Horizon Health Network appointed Indigenous Patient Navigators in 2021, and in 2023, expanded their roles to include culturally safe doula services (Horizon Health, 2023).

Ontario: The Centre for Addiction and Mental Health (CAMH) has released a three-year Truth and Reconciliation Action Plan, which includes midpoint progress reporting (CAMH, 2022).

Prince Edward Island: The Department of Health and Wellness launched a public education site with a section on Indigenous health and the impact of historical policies: (Journey Towards Reconciliation 2023 Status Report) (PEI Department of Health and Wellness, 2023).

Through the Braiding Framework lens, these acknowledgment initiatives remain stuck in early developmental stages, demonstrating recognition without redistribution and consultation without power transfer.

- **Restoring Indigenous Wellness:** Policy acknowledgments without explicit recognition of institutional culpability; symbolic gestures substitute for material change.
- **Creating Middle Ground:** Statements of commitment without governance shifts or reparative measures; Indigenous frameworks acknowledged but not implemented with authority.
- **Transforming Service Delivery:** Symbolic references to reconciliation; service delivery structures remain unchanged despite acknowledgment rhetoric.

Even B.C.'s FNHA partnerships, the most advanced example, operate within frameworks that acknowledge Indigenous rights while maintaining settler institutional control over health system governance and resource allocation (FNHA, 2015–present).

THE PATTERN OF PERFORMANCE

Health authorities across Canada have learned to perform acknowledgment while avoiding accountability. They recognize colonial harm in general terms but refuse to examine their own discriminatory policies. They affirm Indigenous rights in principle but resist operationalizing them in practice. They commit to reconciliation in statements but maintain colonial structures in operations (Yellowhead Institute, 2023).

Saskatchewan's 2021 TRC report exemplifies this pattern: it acknowledges relevant Calls to Action but stops short of naming institutional complicity or committing to measurable outcomes defined by Indigenous communities (SHA, 2021). Manitoba's brief online statement indicates support without concrete commitments or timelines for change (CPSM, 2021).

This maintains colonial relationships under the guise of reconciliation. Indigenous peoples remain subjects of institutional benevolence rather than partners in governance. Acknowledgment substitutes for accountability, allowing institutions to appear responsive while avoiding transformation (Yellowhead Institute, 2023).

As Yellowhead Institute (2023) identifies, acknowledgment without accountability is a hallmark of performative reconciliation. The National Inquiry into Missing and Murdered Indigenous Women and Girls (2019) documented how institutional acknowledgments of discrimination coexist with ongoing discriminatory practices.

IMPLICATIONS

Indigenous health advocates consistently point out that land acknowledgments and cultural safety training do not address structural racism, underfunding, or the denial of Indigenous governance over health systems. Recognition without redistribution perpetuates the same power imbalances that created health inequities (AFN, 2023).

The human cost of symbolic acknowledgment cannot be overstated. Every day, Indigenous people experience discrimination in health systems that have officially committed to reconciliation. Every preventable death occurs in institutions that acknowledge colonial harm while perpetuating colonial practices.

Without legislation that mandates binding accountability mechanisms, transfers decision-making authority to Indigenous Nations, and establishes consequences for institutions that fail to operationalize Indigenous rights, Call 18 remains a hollow performance.

Call 18 will remain unfulfilled until acknowledgment is followed by accountability. Until institutional statements translate into structural change, recognition rhetoric will continue to coexist with discriminatory realities. Indigenous peoples cannot heal in systems that perform reconciliation while maintaining colonial control.

CALL 19: DARKNESS IN HEALTH DATA

CALL TO ACTION 19

We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

CALL 19 REQUIRES the federal government, in consultation with Indigenous Peoples, to establish measurable goals, identify and close health outcome gaps, and publish annual progress reports. Nearly a decade later, these obligations remain unfulfilled (Yellowhead Institute, 2023).

This isn't just about accountability, it is about life-and-death decisions. Indigenous communities cannot make informed healthcare decisions when the data they need is controlled by others, collected through colonial frameworks, and filtered through non-Indigenous interpretations. Without Indigenous control over health data, communities are forced to make critical healthcare decisions in the dark (FNIGC, 2014).

DEFINING DATA COLONIZATION

We define data colonization in the Indigenous health context as the systematic appropriation and control of Indigenous health information by settler institutions, denying Indigenous communities sovereignty over data about their own wellness, healing practices, and health outcomes (Sasakamoose, 2025). This process perpetuates colonial relationships by maintaining Indigenous peoples as subjects of research rather than authorities over their own information, preventing communities from defining success on their own terms and making informed healthcare decisions using Indigenous-defined metrics of wellness.

Data colonization operates through several mechanisms: settler institutions determine what gets measured and how; Indigenous communities are consulted about but not granted authority over data systems; research findings are published in venues Indigenous communities cannot access; and Western medical frameworks dominate the interpretation of Indigenous health data FNIGC, 2014; Yellowhead Institute, 2023). The result is that communities desperately need information to make critical healthcare decisions, but cannot access or control the data about their own people.

> **Consider the absurdity: in Saskatchewan, Indigenous communities face the highest rates of HIV, hepatitis C, and syphilis in the country, yet cannot access accurate provincial-level data because individual physicians control it.**

Data-sharing agreements between the Ministry of Health and medical practitioners do not exist (Saskatchewan Ministry of Health, 2022). Communities are often forced to address a health crisis without the necessary information to develop effective interventions.

More broadly, non-Indigenous researchers study Indigenous health using Western medical models, publish findings in academic journals that Indigenous communities cannot access, and present recommendations that ignore Indigenous knowledge systems (FNIGC, 2014). Meanwhile, settler-controlled systems rarely collect or validate data that Indigenous communities actually need for healthcare planning and resource allocation.

Band councils cannot effectively allocate limited health budgets. Tribal organizations often struggle to design culturally relevant programming. Indigenous healthcare providers cannot advocate for resources using evidence that resonates with their communities' understanding of wellness.

INSTITUTIONAL RESPONSES

Despite nearly a decade since Call 19, institutional responses demonstrate the same pattern: consultation without decision-making power, measurement without Indigenous authority, and reporting without Indigenous-defined success indicators.

Assembly of First Nations: Published national progress reports on the Calls to Action, including a comprehensive 2024 TRC

Report Card that reveals only one Call to Action was completed in the past year (AFN, 2024).

British Columbia: The First Nations Health Authority developed wellness indicators aligned with First Nations priorities. In partnership with the Office of the Provincial Health Officer, it launched the First Nations Population Health and Wellness Agenda, a 10-year monitoring initiative that utilizes 22 First Nations-specific indicators (FNHA, 2019).

National (Canada): The federal government continues to advance measurement through the Health Inequalities Reporting Initiative and the Health Inequalities Data Tool, which was updated in 2022 with 81 new indicators disaggregated by First Nations (off-reserve), Inuit, and Métis identity (Public Health Agency of Canada, 2022).

Manitoba: The Manitoba Centre for Health Policy published Health Status of and Access to Healthcare by Registered First Nation Peoples in Manitoba (MCHP, 2019). Shared Health has also begun developing an REI data framework for equity-focused reporting (Shared Health Manitoba, 2023).

Prince Edward Island: The Chief Public Health Office released a First Nations Health Status Report and is collaborating with the PEI Cancer Registry on a project to collect race, ethnicity, and Indigenous (REI) identity data with Indigenous-led governance (Government of PEI, 2023).

Yukon: The 2023 Yukon Health Status Report includes population-level indicators relevant to social determinants and Indigenous health (Government of Yukon, 2023).

Saskatchewan: The Office of the Treaty Commissioner developed a Growth Model to evaluate reconciliation, but its indicators remain internal and unpublished (OTC, 2022).

Through the Braiding Framework lens, these data initiatives remain stuck in early developmental stages, demonstrating consultation without power transfer and measurement without Indigenous authority.

- **Restoring Indigenous Wellness:** Few Indigenous-defined indicators exist; communities are excluded from determining what constitutes success or wellness in their own terms.
- **Creating Middle Ground:** Limited integration of Indigenous knowledge in reporting frameworks; Western medical models dominate indicator selection and interpretation.
- **Transforming Service Delivery:** Descriptive activity reporting continues; no jurisdiction has transferred authority over data governance to Indigenous Nations.

In all cases, settler control over data governance, methodology, and interpretation is maintained. Indigenous peoples are consulted about indicators but not granted authority over data systems, funding allocation for Indigenous-controlled research, or the fundamental frameworks that define health and wellness.

The absence of Indigenous data sovereignty renders Call 19 meaningless. Institutions report on activities, not results, using settler-defined metrics that obscure ongoing inequities (Yellowhead Institute, 2023).

The First Nations Information Governance Centre has long advocated for the application of OCAP principles — Ownership, Control, Access, and Possession — to all data about First Nations (FNIGC, 2014). Yet governments continue to collect and manage Indigenous data without transferring ownership or authority to Indigenous communities.

IMPLICATIONS

Data about Indigenous health continues to be collected on Indigenous communities rather than by them. Governments fund non-Indigenous researchers to study Indigenous health, then use these findings to justify program decisions without involving Indigenous communities in interpretation or governance (MCHP, 2019; FNIGC, 2014).

> **This maintains the same colonial relationship that created health inequities in the first place: Indigenous peoples as subjects of study rather than authorities over their own information. Recognition without integration equals tokenism. Consultation without decision-making power perpetuates colonial control.**

The human cost cannot be overstated. Indigenous communities are forced to make healthcare decisions without the data they need to save lives, improve outcomes, and build wellness in ways that align with their knowledge systems (AFN, 2024). Every prevention program designed without Indigenous-controlled data is less effective; every resource allocation decision made without community-defined metrics misses the mark.

Without legislation that mandates Indigenous data sovereignty, transfers authority over health data to Indigenous Nations, and establishes binding accountability frameworks using Indigenous-defined indicators, Call 19 remains hollow.

Call 19 will remain unfulfilled until Indigenous peoples control the data about their own health. Until then, reconciliation in healthcare is impossible — because you cannot heal what you cannot measure in ways that matter to those seeking healing.

CALL 20: JURISDICTIONAL GAPS PERSIST

CALL TO ACTION 20

In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

CALL TO ACTION 20 URGES the federal government to resolve jurisdictional disputes and ensure that Métis, Inuit, and off-reserve First Nations peoples receive equitable access to health services. Nearly a decade later, no province or territory has developed a comprehensive strategy to dismantle these jurisdictional barriers. What persists is not confusion — it is the deliberate maintenance of fragmentation, used to delay care, deny services, and deflect responsibility (Yellowhead Institute, 2023).

In 2020, Joyce Echaquan died in a Quebec hospital while livestreaming the racist abuse she faced. Her death exemplified how jurisdictional confusion enables systemic neglect — federal and provincial authorities debate responsibility while Indigenous people die waiting for care (Coroner's Report on Joyce Echaquan, 2021). The same jurisdictional disputes that killed Jordan River Anderson in 2005 continue to trap Indigenous families in bureaucratic limbo (House of Commons, 2007), forcing them to navigate between systems designed to exclude rather than serve.

THE ECONOMIC COST OF DYSFUNCTION

Jurisdictional disputes are not administrative gaps. They are a continuation of colonial governance, mirroring and perpetuating Indian Act divisions between status/non-status and on-reserve/off-reserve categories (Palmater, 2011). These deliberately maintained colonial classifications enable governments to debate responsibilities rather than fulfill them. The consequences are lived: chronic illness, untreated conditions, preventable deaths, and systematic exclusion that undermines Indigenous rights to health. These failures violate Treaty obligations — particularly the Medicine Chest Clause of Treaty 6, which affirms federal responsibility to provide comprehensive healthcare to First Nations (Treaty No. 6, 1876). Rather than uphold this commitment, federal and provincial governments engage in cost-shifting and blame-shifting, maintaining a system that costs more than integration would while delivering worse outcomes (Manitoba Centre for Health Policy [MCHP], 2019).

Canada spends billions maintaining jurisdictional dysfunction rather than creating integrated systems.

Navigation services, duplicate assessments, delayed care, and crisis interventions cost significantly more than coordinated care would. The MCHP (2019) documented that health gaps between Indigenous and non-Indigenous Manitobans have widened over 20 years, despite increased spending on fragmented services. Every dollar spent on jurisdictional band-aids could fund actual healthcare if systems were integrated under Indigenous authority.

INSTITUTIONAL RESPONSES

Some jurisdictions have introduced targeted initiatives, but these consistently demonstrate the same pattern: consultation without power transfer, navigation without governance change, cultural programming without system transformation.

Alberta: Implemented Indigenous Hospital Navigation Services with staff present during medical appointments and case conferences, and created the Continuing Care in Indigenous Communities Guidebook (Alberta Health Services, 2020). Policies support ceremonial access and spiritual care.

British Columbia: Developed the Urban and Away from Home initiative aimed at creating pathways to bring support closer to home for First Nations people (FNHA, 2022), including a framework for strategic direction and planning. Fraser Health's Indigenous Health Liaison program assists patients in navigating the healthcare system, supporting transitions, and connecting them with cultural advisors or Elders (Fraser Health, 2021).

Saskatchewan: Released a harm reduction policy explicitly including culturally safe services for First Nations and Métis people (SHA, 2021). The Saskatchewan Cancer Agency partnered with Métis Nation–Saskatchewan to co-create culturally specific cancer care tools (Saskatchewan Cancer Agency, 2022).

Manitoba: The Winnipeg Regional Health Authority developed Indigenous Health Patient Services (WRHA, 2020) and Indigenous Discharge Planning Coordinators. CancerCare Manitoba collaborated with Indigenous partners to launch an Indigenous Community Profile website supporting culturally relevant cancer care planning (CancerCare Manitoba, 2021).

Northwest Territories: Established an Indigenous Health and Community Wellness Division, allowing communities greater control over prevention and wellness funding allocation. (Government of Northwest Territories, 2021).

Ontario: London Health Sciences Centre provides Indigenous healing services to all Indigenous, Métis and Inuit persons regardless of whether they live on or off reserve, with partnerships including N'Amerind Friendship Centre (providing 24/7 Elder and ceremonial support since 2008) and Southwestern Ontario Aboriginal Health Access Centre (LHSC, 2022) (providing patient navigation services since 2011).

Quebec: Health care for Nunavik Inuit and James Bay Cree operates under the James Bay and Northern Quebec Agreement (1975), with services co-funded by federal and provincial governments and managed by Indigenous authorities (Grand Council of the Crees, 2021). Provincial funding supported establishment of Indigenous health clinics, including the Minowé clinic in Val-d'Or and Montreal's new Indigenous family clinic, with eight health clinics now operating through Quebec's Native Friendship Centres (2023).

Federal Level: Indigenous Services Canada continues co-developing distinctions-based Indigenous Health Legislation, though the Assembly of First Nations voted in December 2023 to reconsider the proposed process (AFN, 2023).

Through the Braiding Framework lens, these initiatives remain trapped in early developmental stages (Engage, Learn, Strengthen). Every provincial response demonstrates the same pattern: Indigenous peoples are consulted but not granted authority over systems, funding, or governance structures that affect their health.

- **Restoring Indigenous Wellness:** Minimal jurisdictional coordination; disputes remain unresolved while communities cannot determine their own health priorities.
- **Creating Middle Ground:** Navigation services and pilots treat symptoms rather than causes, maintaining settler control over system design.
- **Transforming Service Delivery:** Gaps in equitable access persist; no jurisdiction has implemented systemic restructuring or shared governance.

Navigation services exemplify this dysfunction. Rather than eliminating barriers, health authorities hire Indigenous staff to help people navigate barriers that should not exist. Cultural programming addresses individual patient experiences while leaving structural exclusion intact. These initiatives operate within existing jurisdictional frameworks rather than dismantling them.

As Assembly of First Nations National Chief Cindy Woodhouse Nepinak stated regarding the federal legislation process: "What has been achieved so far is by no means sufficient" (AFN, 2023). The AFN's December 2023 resolution to reconsider the federal approach reflects Indigenous leaders' recognition that current processes perpetuate rather than resolve jurisdictional barriers.

IMPLICATIONS

These scattered initiatives remain fragmented, temporary, and localized. None constitutes systems-level change or structural resolution of jurisdictional gaps. Jurisdictional disputes continue to trap Indigenous peoples in bureaucratic limbo while governments pass responsibility between levels. Navigation services treat symptoms, not causes. Cultural programming acknowledges Indigenous identity while systematically excluding Indigenous authority.

As Yellowhead Institute (2023) identifies, jurisdictional ambiguity serves as a recurring tactic to justify inaction. Governments have perfected the art of appearing responsive while avoiding transformation. They fund Indigenous staff to navigate colonial systems rather than transferring authority to Indigenous governments.

The pattern is clear across jurisdictions: symbolic inclusion substitutes for structural change. Indigenous peoples are included as service recipients and cultural consultants but excluded from governance, resource allocation, and system design. This maintains colonial control while creating the appearance of reconciliation.

Governments have perfected the art of appearing responsive while avoiding transformation. They fund Indigenous staff to navigate colonial systems rather than transferring authority to Indigenous governments.

Without legislation that mandates shared governance, transfers decision-making authority to Indigenous Nations, and establishes binding accountability frameworks co-developed with Indigenous partners, Call 20 remains unfulfilled. Current approaches perpetuate the same jurisdictional scaffolding that enables denial of care, systemic racism, and preventable deaths.

Reconciliation in health requires dismantling the jurisdictional architecture of colonialism, not managing its effects.

Until Indigenous Nations control the systems that serve their people, jurisdictional disputes will continue to function as designed — delaying care, deflecting responsibility, and maintaining settler supremacy in healthcare.

CALL 21, 22: FUNDING WITHOUT TRANSFORMATION

CALL TO ACTION 21

We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

CALL TO ACTION 22

We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

CALL 21 URGES the federal government to provide sustainable funding for existing and new Indigenous healing centers to address the physical, mental, emotional, and spiritual harms caused by residential schools, ensuring that funding of healing centers in Nunavut and the Northwest Territories is a priority.

CALL 22 CALLS upon those who can effect change within the Canadian health-care system to recognize the value of Indigenous healing practices and use them in the treatment of Indigenous patients in collaboration with Indigenous healers and Elders, where requested.

THE LIMITS OF FUNDING WITHOUT GOVERNANCE

Nearly a decade later, governments have responded with funding announcements and program expansions while maintaining colonial control over Indigenous healing and wellness. Infrastructure investments substitute for Indigenous governance. Integration initiatives replace genuine self-determination.

The pattern is clear: institutions provide funding for healing centers while retaining authority over their operation and evaluation. They acknowledge traditional healing practices while subordinating them to Western medical frameworks. This allows them to claim progress while preserving settler institutional control over Indigenous wellness.

Funding without governance transfer perpetuates the same colonial relationships that created the need for healing in the first place. When governments announce investments in healing centers while retaining oversight, they maintain paternalistic control while claiming to support Indigenous wellness.

Indigenous communities continue to wait years for culturally appropriate services while governments celebrate funding announcements. Healing centers operate under settler institutional oversight, limiting their ability to provide truly decolonized care.

INSTITUTIONAL RESPONSES

Despite nearly a decade since Calls 21 and 22, institutional responses have demonstrated funding without power transfer, integration without recognition of Indigenous health sovereignty, and program expansion without structural transformation.

Alberta: Health Services introduced the Indigenous Continuum of Addiction and Mental Wellness Grant and formed the Wisdom Council, an advisory board for Indigenous people to share their experiences and provide guidance for care.

The Honouring Life Program, the Four Winds Project, and the Indigenous Health Innovation Grant Program are other initiatives that support Indigenous health. The Edmonton Indigenous Wellness Clinic offers primary care, chronic disease management, and diabetes programming.

Additional programs include the Elbow River Healing Lodge, Indigenous Mental Health Program, and Traditional Wellness Counsellor Services. AHS also leads the Indigenous Health

Innovation and Cancer Prevention (HICP) Grant Program, which establishes community-led programs to prevent and reduce cancer through partnerships guided by Indigenous Ways of Doing — funding and advisory mechanisms that maintain provincial authority over resource allocation and program evaluation.

British Columbia: Mental Health and Substance Services published a therapeutic facility design and model of care for the Red Fish Healing Centre. The First Nations Health Authority supports numerous treatment centers. It operates an Indigenous Foods and Nutrition information and webinar series, as well as the "Increase the Support. Reduce the Harm" campaign, which addresses the toxic drug crisis through advocacy, harm reduction support programs, and training.

Additionally, the FNHA focuses on substance use and land-based healing. Northern Health has established Indigenous Health Action Tables, and Mental Health and Substance Services has created a staff position for an Indigenous Patient Experience Lead — representing the most advanced partnership model while still operating within provincial health system frameworks that limit genuine self-governance.

Manitoba: The Manitoba Keewatinowi Okimakanak (MKO) and the Southern Chiefs' Organization signed Memoranda of Understanding with Canada for healthcare transformation, with the MKO establishing Keewatinohk Inniniw Minoayawin.

The Winnipeg Regional Health Authority (WRHA) operates the Traditional Wellness Clinic, which offers opportunities for both Indigenous and non-Indigenous people to explore traditional healing approaches, although it is only open on two days per month.

Other programs and clinics include the Aboriginal Health and Wellness Centre of Winnipeg, the Ma Mawi Wi Chi Itata Centre, the Wa-Say Healing Centre, and the Ka Ni Kanichihk. WRHA also provides Prenatal Connections Public Health Nurses for individuals temporarily in Winnipeg from Nunavut awaiting childbirth — agreements that promise self-determination while maintaining federal oversight and funding dependency.

New Brunswick: Horizon Health Network has introduced sacred medicines in nine facilities, contracted an Indigenous psychologist for First Nations youth telepsychiatry, and developed policies supporting Indigenous birth practices — symbolic inclusion within systems that retain settler institutional authority over Indigenous healing practices.

Northwest Territories: Health and Social Services has allocated nearly $1 million from the federal Health Services Integration Fund to establish an Indigenous Advisory Body and develop an action plan. Additionally, the expansion of midwifery services has been community-driven and aligns with the TRC, MMIWG, UNDRIP, and WHO Sustainable Development Goals — consultation mechanisms and service expansions that advise settler institutions rather than exercise decision-making authority.

Nunavut: The federal government announced $83.7 million to build Aqqusariaq (formerly the Nunavut Recovery Centre) in Iqaluit — a significant investment that nonetheless operates within the territorial health system's oversight rather than under Inuit-controlled governance.

Prince Edward Island: The Primary Care Renewal Team engages Indigenous partners in recognizing the value of Aboriginal healing practices and includes them in discussions on patient-centred care. The Department of Health and Wellness launched a public education site with a section on Indigenous health and the impact of historical policies (Journey Towards Reconciliation 2023 Status Report).

Saskatchewan: The Health Authority has implemented a Medication Reconciliation Policy and Procedure that integrates traditional medicines, alongside initiatives such as the Chronic Pain Clinic in partnership with Grey Wolf Lodge.

Additionally, their Wellness Wheel clinics, operated by physicians and nurses, provide holistic care, complemented by the Indigenous Birth Support Worker program at Jim Pattison Children's Hospital, enhancing culturally safe healthcare services.

They also provide funding to support the Aboriginal Friendship Center initiative and established the Knowledge Keepers Advisory within the First Nations and Métis Health department — integration initiatives that incorporate Indigenous practices within settler institutional control rather than recognizing Indigenous health sovereignty.

The scale of provincial responses documented above obscures rather than addresses the fundamental issue: none transfers real decision-making power to Indigenous communities. Health authorities across Canada have learned to perform cultural inclusion while maintaining institutional control through three key mechanisms.

Integration Without Authority: Saskatchewan's Medication Reconciliation Policy exemplifies how traditional medicines become subordinated to provincial protocols rather than recognized as sovereign knowledge systems. Traditional healers must operate within Western medical frameworks that position Indigenous knowledge as supplementary rather than authoritative.

Advisory Without Power: From Alberta's Wisdom Council to the Northwest Territories' Indigenous Advisory Body, provinces establish consultation mechanisms that allow Indigenous voices to advise settler institutions rather than exercise governance authority. These bodies can recommend but cannot compel, creating the appearance of partnership while preserving colonial decision-making structures.

Programming Without Sovereignty: The dozens of programs documented across provinces — from B.C.'s numerous treatment centers to Alberta's multiple grant programs — represent significant investments that nonetheless maintain settler control over resource allocation, program evaluation, and service delivery models. Indigenous communities receive services designed according to settler priorities rather than controlling healing according to their own protocols.

This creates what can be termed "managed inclusion" — Indigenous peoples are included as clients, advisors, and service recipients while being excluded from positions of institutional authority. Manitoba's Memorandums of Understanding promise transformation but maintain federal control over funding and oversight, ensuring that even the most advanced partnership models preserve colonial power relations.

IMPLICATIONS

The documented provincial responses reveal a sophisticated system of colonial management disguised as reconciliation. Governments have learned to respond to TRC Calls with impressive programming portfolios while avoiding the fundamental transfer of authority that true reconciliation requires.

What's Missing: An actual implementation of Calls 21 and 22 would require Indigenous Nations to control healing center budgets, determine evaluation criteria, design service delivery models, and have the authority to reject or modify programs that fail to meet community-defined standards. None of the documented responses approaches this level of sovereignty transfer.

The Scale Deception: The sheer volume of documented programs — encompassing dozens of treatment centers, grants, clinics, and advisory bodies — creates an illusion of a comprehensive response while obscuring the fundamental issue: quantity substitutes for quality of relationship; programming substitutes for power transfer.

Systemic Colonial Control: This pattern mirrors broader colonial governance, providing resources while retaining authority, including voices while excluding decision-making power, and acknowledging cultures while maintaining settler supremacy. The health system's response to TRC Calls demonstrates how colonial institutions adapt to criticism without transforming their fundamental power relationships.

> **The human cost cannot be overstated. Indigenous people seeking culturally appropriate care navigate systems designed around settler institutional priorities rather than Indigenous healing protocols. Healing centers operate under constraints that prevent them from providing truly decolonized services, while traditional healers work within frameworks that subordinate Indigenous knowledge to Western medical authority.**

Without legislation that establishes Indigenous health sovereignty, mandates governance transfer to Indigenous Nations, and creates binding accountability mechanisms, Calls 21 and 22 will remain elaborate performances of support that maintain colonial control over Indigenous wellness.

CALLS 23, 24, 57: TRAINING WITHOUT TRANSFORMATION

CALL TO ACTION 23

We call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.

ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

iii. Provide cultural competency training for all healthcare professionals.

CALL TO ACTION 24

We call 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.

CALL TO ACTION 57

We call upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

CALL 23 urges all levels of government to: (i) increase the number of Aboriginal professionals working in the healthcare field, (ii) ensure the retention of Aboriginal healthcare providers in Aboriginal communities, and (iii) provide cultural competency training for all healthcare professionals.

CALL 24 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.

CALL 57 calls upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations.

THE LIMITS OF TRAINING WITHOUT POWER TRANSFER

Nearly a decade later, governments have responded with training programs, recruitment campaigns, and educational initiatives while maintaining colonial control over Indigenous health workforce development and cultural education. Professional development substitutes for structural change. Cultural competency training replaces systemic transformation. Educational requirements mask continued settler control over Indigenous health knowledge.

The pattern is clear: institutions create programs to train Indigenous professionals and educate settlers about Indigenous issues while retaining authority over curriculum

design, evaluation standards, and career pathways. This allows them to claim progress in "cultural safety" while preserving settler institutional control over Indigenous health systems.

Training without governance transfer perpetuates the colonial relationships that created the need for Indigenous health professionals in the first place. When institutions develop recruitment programs while maintaining settler control over hiring, promotion, and retention policies, they perform inclusion while avoiding structural change. When they require cultural competency training without transferring decision-making authority to Indigenous communities, they educate settlers about Indigenous peoples rather than empowering Indigenous peoples to control their own health systems.

Indigenous health professionals continue to work within systems designed around settler institutional priorities rather than Indigenous healing protocols. Cultural competency training teaches settlers to be more sensitive while delivering services, but does not transfer authority to Indigenous communities to design and control those services according to their own values and knowledge systems.

INSTITUTIONAL RESPONSES

Despite nearly a decade since Calls 23, 24, and 57 were made, institutional responses have continuously demonstrated training without power transfer, education without governance change, and recruitment without structural transformation.

Alberta: Health Services created an Indigenous Talent website landing page for recruitment, while the University of Alberta monitors Indigenous initiatives and developed the Indigenous Health in Canada course for health science students.

The University of Calgary offers an Indigenous Community Route for their nursing program, and Alberta Health Services developed Medical Response Training for Métis settlements and Indigenous Cultural Competency education — recruitment and training mechanisms that maintain institutional authority over career pathways and educational standards.

British Columbia: The First Nations Health Authority developed a recruitment poster campaign, "Many Backgrounds, One Journey," and created the B.C. First Nations-led Cultural Safety and Humility Technical Committee.

Northern Health has developed the Cultural Safety and System Change: An Assessment Tool and offers webinars on "Cultural Safety for Indigenous Peoples." They launched the "It Starts with Me" campaign and Cultural Safety and Humility Action Webinar Series — representing the most advanced cultural safety programming while still operating within provincial health system frameworks that limit Indigenous control over service delivery.

Manitoba: The Winnipeg Regional Health Authority established an Indigenous Health-Workforce Development program and Indigenous Health-Education and Training initiatives.

The University of Manitoba operates the Mahkwa omushki kiim: Pathway to Indigenous Nursing Education (PINE) program, which is designed to support Indigenous students entering nursing, along with grand rounds in Indigenous health and customizable education sessions — aimed at workforce development within systems that maintain settler institutional control.

New Brunswick: Vitalité Health Network developed cultural competency training, including the "Braiding First Nations' Culture" program and a "Dreamcatcher" model for First Nations clients with Fetal Alcohol Spectrum Disorder — training initiatives that educate providers while retaining institutional authority over program design and implementation.

Newfoundland and Labrador: Memorial University's Faculty of Medicine developed a program on culturally safe healthcare for Indigenous patients, and the Indigenous Health Research Exchange Group facilitates discussions on Indigenous health policy — educational programming that maintains academic institutional control over Indigenous health knowledge.

Northwest Territories: Reports that consolidation of health services has improved coordination, recruitment, and retention of healthcare professionals in remote communities — administrative changes that maintain territorial authority over workforce development.

Ontario: Health developed an Equity, Inclusion, Diversity, and Anti-Racism Framework, while the Centre for Addictions and Mental Health introduced a Health Equity and Inclusion Framework, and the Child-Bright Network established commitments to equity, diversity, inclusion, decolonization, and Indigenization — framework development that maintains provincial institutional control over implementation and evaluation.

Saskatchewan: The Health Authority collaborated with the Gabriel Dumont Institute to support Métis healthcare program graduates and develop the Indigenous Birth Support

Worker training program, combining Western medical practices with traditional Indigenous care approaches. This partnership initiative maintains provincial oversight over certification and program standards.

Health authorities and educational institutions across Canada have learned to perform cultural inclusion through training while maintaining institutional control over the Indigenous health workforce and knowledge systems. They develop recruitment programs while retaining authority over hiring and promotion standards. They require cultural competency training while maintaining settler control over curriculum design and evaluation criteria.

Saskatchewan's Indigenous Birth Support Worker program exemplifies this pattern, combining Western medical practices with traditional Indigenous care approaches. Still, it operates under provincial certification and oversight rather than Indigenous governance of conventional knowledge. Manitoba's PINE program provides pathways for Indigenous nursing students, but within educational frameworks designed according to settler institutional priorities rather than Indigenous knowledge systems.

This creates what can be termed "managed diversity." Indigenous peoples are recruited as professionals and educators while being excluded from positions of institutional authority over the systems that train and employ them. Cultural competency training educates settlers about Indigenous peoples while avoiding the transfer of decision-making power to Indigenous communities over their own health systems.

IMPLICATIONS

The documented responses reveal a sophisticated system of cultural inclusion that maintains colonial control over Indigenous health workforce development and knowledge transmission. Institutions have learned to respond to the TRC Calls with impressive training portfolios and recruitment campaigns while avoiding the fundamental transfer of authority that true reconciliation requires.

What's Missing: The actual implementation of Calls 23, 24, and 57 would require Indigenous Nations to control professional certification standards, design cultural competency curricula, determine recruitment priorities, and have the authority to evaluate and modify training programs according to community-defined standards. None of the documented responses approaches this level of sovereignty transfer over the Indigenous health workforce and knowledge systems.

The Training Deception: The extensive training programs and educational initiatives documented above create an illusion of cultural transformation while preserving settler institutional control over Indigenous health knowledge and professional pathways. Cultural competency substitutes for governance transfer; recruitment programs substitute for Indigenous control over health systems.

Systemic Colonial Control: This pattern illustrates how colonial institutions respond to criticism by expanding their cultural programming while maintaining fundamental power relationships. Training settlers to be more culturally sensitive maintains the colonial dynamic where settlers deliver services to Indigenous peoples rather than Indigenous peoples controlling their own health systems.

> **The human cost cannot be overstated. Indigenous health professionals work within systems that require them to adapt to settler institutional cultures rather than systems designed according to Indigenous values and protocols. Cultural competency training teaches settlers about Indigenous peoples while Indigenous communities remain excluded from positions of authority over their own health systems.**

Without legislation that establishes Indigenous control over health professional certification, mandates Indigenous governance over cultural competency curricula, and transfers authority to Indigenous Nations to design workforce development according to their own protocols, Calls 23, 24, and 57 will remain elaborate performances of inclusion that maintain colonial control over the Indigenous health workforce and knowledge systems.

Calls 23, 24, and 57 will remain unfulfilled until training is accompanied by governance transfer. Until Indigenous Nations control professional certification standards and cultural competency curricula according to their own knowledge systems, the extensive programming documented above will continue to perpetuate colonial control over Indigenous health workforce development under the performance of cultural safety.

The documented responses reveal a sophisticated system of cultural inclusion that maintains colonial control over Indigenous health workforce development and knowledge transmission. Institutions have learned to respond to the TRC Calls with impressive training portfolios and recruitment campaigns while avoiding the fundamental transfer of authority that true reconciliation requires.

DISCUSSION

The findings presented in this report substantiate longstanding arguments from Indigenous scholars, leaders, and communities: Canada's health systems continue to resist fundamental structural transformation. Despite nearly a decade since the Truth and Reconciliation Commission's Health Calls to Action (18–24), health authorities systematically favour symbolic compliance over substantive change — implementing measures that superficially align with reconciliation while preserving existing power structures and denying Indigenous Peoples meaningful control over resources and decision-making (Truth and Reconciliation Commission of Canada [TRC], 2015; Yellowhead Institute, 2021, 2023).

THE PATTERN OF INSTITUTIONAL RETRENCHMENT

A discernible pattern of institutional backtracking has crystallized across jurisdictions. Initial commitments to reconciliation, decolonization, and Indigenization are routinely diluted through implementation gaps, indefinite delays, or outright abandonment. Land acknowledgments, cultural safety workshops, and reconciliation rhetoric increasingly function as substitutes for genuine structural reform. Governance structures remain settler-dominated, Indigenous-led health systems continue operating under chronic underfunding, and accountability frameworks remain designed and controlled by settler institutions.

Cultural safety training exemplifies this dynamic of substitution. While potentially meaningful when properly implemented, it has devolved into a metric of institutional activity rather than a measure of health equity outcomes. Institutions quantify staff training but rarely evaluate whether such training produces demonstrable changes in policy frameworks, clinical practices, or health outcomes for Indigenous populations (Curtis et al., 2019). This approach transforms reconciliation from a process of structural transformation into a performance of institutional compliance.

THE MARGINALIZATION OF INDIGENOUS KNOWLEDGE SYSTEMS

Indigenous knowledge systems continue to be relegated to supplementary status rather than recognized as authoritative foundations for health and healing (Greenwood et al., 2015; Sasakamoose, forthcoming 2026). This marginalization reflects deeper colonial assumptions about the legitimacy of medicine and the validity of science. As Elder Mary Deleary emphasized to the TRC:

> **"We have always been a healing people. Our medicines, our ceremonies, our ways of being — these are not alternative, they are original. They come from the land, and from our ancestors, and they are meant to be part of every health system that touches our people" (TRC, 2015).**

The persistent framing of Indigenous healing practices as "alternative" or "complementary" maintains hierarchical relationships that position Western biomedical approaches as normative while Indigenous approaches remain exceptional. This epistemological colonialism undermines the integration of Indigenous healing systems as equal partners in healthcare delivery.

DATA SOVEREIGNTY AND ACCOUNTABILITY DEFICITS

The absence of Indigenous-defined health indicators represents a critical accountability failure. Call to Action 19 explicitly demands measurable goals to close health gaps, yet most jurisdictions fail to publicly report outcomes using Indigenous-determined metrics (Allan & Smylie, 2015). The denial of Indigenous data sovereignty compounds this absence. Despite OCAP® principles and Canada's legal obligations under the United Nations Declaration on the Rights of Indigenous Peoples Act (UNDRIPA), no coherent national framework exists for Indigenous control over health data.

Provincial governments, federal agencies, and professional regulatory bodies continue asserting ownership or custodial authority over Indigenous health information, often denying Indigenous communities access to data essential for their own health planning and governance.

In Saskatchewan, provincial legislation grants physicians legal ownership of patient records, effectively excluding Indigenous communities from guaranteed access to information about their own members.

These practices perpetuate colonial authority through information control, fundamentally undermining accountability mechanisms.

JURISDICTIONAL WEAPONIZATION

The jurisdictional disputes referenced in Call to Action 20 remain deliberately unresolved and are increasingly weaponized to avoid responsibility. Federal, provincial, and territorial governments routinely deflect accountability for Métis, Inuit, and off-reserve First Nations populations, relegating Indigenous Peoples to bureaucratic limbo. These jurisdictional gaps violate Treaty rights to health and contravene Canada's obligations under UNDRIPA (Government of Canada, 2021), rather than representing administrative complexity, jurisdictional ambiguity functions as a mechanism for denying Indigenous rights and avoiding institutional accountability.

BILL C-5 AND THE FEDERAL RETREAT FROM RECONCILIATION

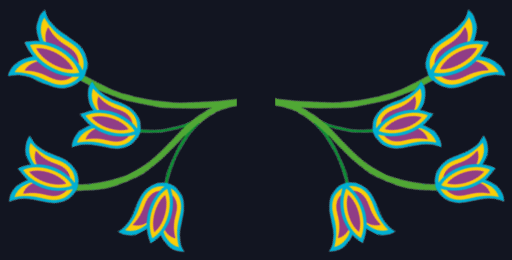
These jurisdictional challenges have persisted for generations. But they continue to influence policy, not just social policy but the natural resource regime as well. Recent federal legislation has further confused who is responsible for permitting and consultation, further exemplifying Canada's systematic retreat from reconciliation commitments. Bill C-5 (Building Canada Act) centralizes executive authority by enabling the cabinet to designate "national interest projects," thereby circumventing regulatory processes and superseding Indigenous governance structures.

Indigenous organizations, including the Assembly of First Nations, the Indigenous Bar Association, and the Canadian Bar Association, have identified Bill C-5 as fundamentally incompatible with Treaty rights and Canada's obligations under UNDRIPA. While federal officials frame this initiative as "economic reconciliation," Indigenous leaders characterize it as economic assimilation: forced integration into settler-defined economic systems. In contrast, Indigenous governance, Treaty rights, and Indigenous legal orders are systematically marginalized.

Prime Minister Mark Carney has positioned economic participation and resource project involvement as pathways to equity, emphasizing growth-based approaches to reconciliation (APTN News, 2025; Follett Hosgood, 2025). This framing fundamentally contradicts the TRC's understanding of reconciliation as centred on land, power, and law, reducing it instead to Indigenous participation in Canadian economic systems on state-determined terms.

Bill C-5 demonstrates how reconciliation rhetoric can mask policies that further entrench colonial authority while creating the appearance of Indigenous inclusion.

The persistent framing of Indigenous healing practices as “alternative” or “complementary” maintains hierarchical relationships that position Western biomedical approaches as normative while Indigenous approaches remain exceptional. This epistemological colonialism undermines the integration of Indigenous healing systems as equal partners in healthcare delivery.



BEYOND SYMBOLIC RECONCILIATION: THE BRAIDING APPROACH

The Braiding Framework for Health Accountability offers a relationally grounded alternative to existing accountability mechanisms (Sasakamoose, forthcoming 2026). This framework emphasizes accountability to Indigenous communities rather than to settler institutions, Indigenous-defined measures of success rather than colonial metrics, and governance structures rooted in Indigenous law and knowledge systems rather than imposed administrative frameworks.

HOWEVER, most health systems remain stalled at the preliminary consultation and cultural education phases, rather than advancing toward shared governance models, sustainable funding commitments, and the systematic integration of Indigenous knowledge. Without a structural transformation that redistributes power and resources, reconciliation remains confined to rhetoric rather than producing material change.

This analysis reaffirms what Indigenous Peoples have articulated for generations and what the TRC formalized nearly a decade ago: symbolic gestures divorced from structural accountability do not constitute reconciliation. Genuine transformation requires the redistribution of power, resources, and decision-making authority.

Current approaches that emphasize cultural awareness while preserving institutional control represent a form of reconciliation theatre that obscures rather than addresses fundamental inequities.

Genuine accountability, as Indigenous Elders and knowledge keepers consistently emphasize, requires restoring balance — between peoples, with the land, and among all relations. When Indigenous and Western systems are genuinely braided together through good faith collaboration guided by spirit and community governance, healing becomes possible not only for Indigenous Peoples but for all inhabitants of these territories.

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