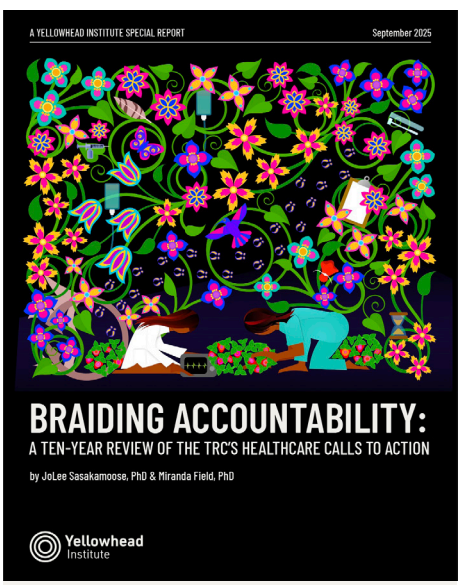
PART 2

Applying the Braiding Framework to the TRC Health Calls to Action (18–24): Symbolic Progress Without Structural Change

Yellowhead Institute

INTRODUCTION

This factsheet, Part 2 of a two-part resource, applies the Braiding Framework to determine whether government actions and policies represent meaningful progress or are merely symbolic gestures of reconciliation. It provides a summary evaluation of how federal, provincial, and territorial governments have responded to health-specific Calls to Action over the past decade.



Visit yellowheadinstitute.org for Part 1 of this resource, which introduces the Braiding Framework and for the full Yellowhead Institute Special Report, *Braiding Accountability: A Ten-Year Review of The TRC's Healthcare Calls to Action*.

OUR ANALYSIS

Our scan of TRC responses shows that most jurisdictions remain stuck at the first three stages (Engage, Learn, Strengthen). Gestures such as 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.

The table below applies the Braiding Framework to each of the seven TRC Health Calls to Action. It summarizes government responses under three dimensions – Restoring Indigenous Wellness, Creating Middle Ground, and Transforming Service Delivery. Together, these findings show how institutional responses often prioritize the appearance of reconciliation over the structural transformation required for genuine change.

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

The later stages of the Braiding Framework— Change, Implement, Harmonize — remain aspirational. For example, no jurisdiction has legislated Indigenous data sovereignty, dismantled jurisdictional barriers, or transferred authority over health system governance to Indigenous Nations. Health authorities must name their complicity and commit to measurable structural change. This commitment looks like handing power and ownership to Indigenous communities to control budgets, measurement criteria, data, program design and implementation. Indigenous-led health systems must be able to operate as equal and authoritative with Indigenous governance, law, and knowledge embedded into the foundation of healthcare structures.

See Part 1 for an Overview of the Braiding Framework