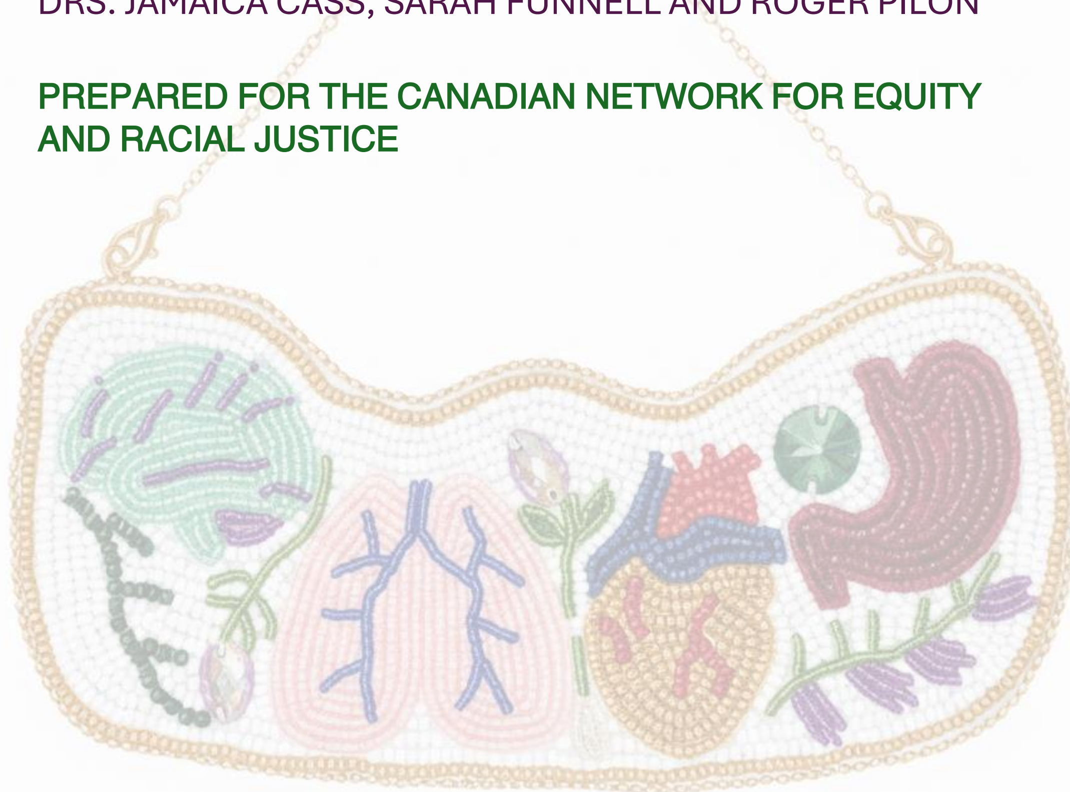
2026

Policy Paper: Advancing Indigenous Health and Wellness in Canada

DRS. JAMAICA CASS, SARAH FUNNELL AND ROGER PILON

PREPARED FOR THE CANADIAN NETWORK FOR EQUITY AND RACIAL JUSTICE



Acknowledgement of Territory

The authors live, work and play on the land once known as *Katarokwi*, now known as Kingston, Ontario. Kingston is situated on traditional Anishinaabe and Haudenosaunee Territory.

Authorship and Community Contributions

The authors contributed equally to the conception, execution, and writing of this report.

Dr. Jamaica Cass is a member of the Mohawks of the Bay of Quinte and is a primary care physician on Tyendinaga Mohawk Territory. She leads education transformation as the Director of the Queen's-Weeneebayko Health Education Program and the Director of Indigenous Health in the Department of Family Medicine at Queen's University.

Dr. Sarah Funnell (she/her) is a First Nations family physician, public health specialist, and clinician scientist of mixed Algonquin and Tuscarora ancestry. She grew up among the Mississaugas of Alderville First Nation and is a band member of Kitigan Zibi Anishinabeg First Nation. Her work focuses on advancing Indigenous health and integrating Indigenous perspectives within health education, research, and clinical practice. Dr. Funnell serves as Associate Dean and Chair of Indigenous Health at Queen's Health Sciences and Assistant Professor in the Department of Family Medicine at Queen's University.

Dr. Roger Pilon is a white male settler of mixed European ancestry, who acknowledges his privilege and commits to being an active ally. He is currently the Vice Dean of Health Sciences and Director of the Queen's University School of Nursing. He is honoured to collaborate with Indigenous colleagues and contribute respectfully to advancing Indigenous Peoples' health in Canada.

Advancing Indigenous Health and Wellness in Canada
February 2026

The authors thank Krystal Kehoe Macleod, PhD and Elaine Johnston, Director of Services, *Nogdawindamin* Family and Community Services for their thoughtful peer review and to Haley Kombargi, research assistant, for support with formatting and referencing.

The cover art was created by Dr. Jamaica Cass, and is a 2-D representation of an award-winning installation titled 'Mind, Body and Spirit' on permanent display at the School of Medicine at Queen's University in Kingston, Ontario.

Acronyms and Abbreviations

2SLGBTQ+-Two Spirit Lesbian Gay Bisexual Transgender Queer
ACE-Adverse childhood experience
CHA-Canada Health Act
FN-First Nation
FNHA- First Nations Health Authority
ISC-Indigenous Services Canada
MMIWG-Missing and Murdered Indigenous Woman and Girls
NAN- Nishnawbe Aski Nation
NCCIH- National Collaborating Centre for Indigenous Health
NIHB-National Indigenous Health Branch
NOSMU-Northern Ontario School of Medicine University
OCAP- Ownership, Control, Access, and Possession
PHAC-Public Health Agency of Canada
RCAP-Royal Commission on Aboriginal Peoples
SDH-Social Determinants of Health
TMU-Toronto Metropolitan University
TRC-Truth and Reconciliation Commission
UNDRIP-United Nations Declaration on the Rights of Indigenous Peoples

Table of Contents

Acknowledgement of Territory 1
Authorship and Community Contributions 1
Acronyms and Abbreviations 2
RCAP-Royal Commission on Aboriginal Peoples 2
Table of Contents 2
.... 5

1. Executive Summary 5
2. Introduction and Context 7
3. Conceptual and Methodological Framework 12
3.1 Guiding Principles and Ethical Foundations 13
3.1.1 Two-Eyed Seeing 13
3.1.2 OCAP® and Indigenous data sovereignty 13
3.1.3 Self-determination 14
3.1.4 Eschewing White Saviourism and Deficit Framing 14
3.2 Frameworks 14
3.2.1Determinants-based framing 14
3.2.2 Core frameworks informing the analysis 15
3.3 Framework commitments 15
3.4 Methodological Approach 16
4. Urgent and Systemic Issues in Indigenous Health 17
4.1 Barriers to Accessing Health Care 17
4.1.1 Jurisdictional confusion 17
4.1.2 Geography and service availability 19
4.1.3 Summary: Barriers to Access 20
4.2 Disproportionate Health Burden 20
4.3 Data Gaps 21
4.4 Systemic Racism 22
4.4.1 Systemic Racism and Institutional Barriers 23
5. Determinants of Health and Wellness 24
5.1 Poverty: Indigenous Peoples' experience with poverty and effects on health and wellness 25
5.1.1 Poverty as a gendered experience 26
5.1.2 Links between Indigenous Poverty and Health 26
5.1.3 Income support and effects on health 27
5.2 Employment: Indigenous Employment and Working Conditions as Determinants of Indigenous Peoples' Health and Wellness 27
5.2.1. Employment Rates, barriers and working conditions 27
5.2.2. Impacts of Employment on Health and Well-being 28
5.3 Homelessness: Housing as Determinants of Indigenous Peoples' Health and Wellness 28
5.3.1 Twelve Dimensions of Indigenous Homelessness 29
5.3.2 Impacts of Homelessness and overcrowding on Health and Well-being 30
5.4 Food Security: Food sovereignty as a determinant of Indigenous health and well-being 31
5.4.1. Barriers to Accessing Adequate, Culturally Relevant Foods 31
5.4.2. Indigenous-Led Community Food Programs 32
5.4.3. Food sovereignty as a positive determinant of health 32
5.5 Indigenous Languages: Language as a Determinant of Indigenous Peoples' Health and Wellness 33
5.5.1 Language as a Barrier to the Highest Attainable Health 34
5.5.2 Indigenous Language as a Right in UNDRIP and Canadian Law 34
5.5.3 Language Revitalization and positive impacts on Indigenous health and well-being 34
5.6 Education: Education as a determinant of Indigenous Peoples' health 35
.... 37

6. PROMISING FRAMEWORKS AND SOLUTIONS 37
6.1 Indigenous Rights Based Framework: Self-determination & Indigenous Jurisdiction Over Health *37*
6.2 Alignment with UNDRIP and Truth and Reconciliation Commission (TRC) Calls to Action 38
6.3 Culturally Safe and Anti Racist Health Care *40*
6.3.1 Mandatory Anti Racism and Cultural Safety Training 40
6.3.2 Respect for Traditional Healing and Knowledge Systems 41
6.4 Data Sovereignty & Shared Accountability *42*
6.4.1Indigenous Data Sovereignty 42
6.4.2 Shared Accountability *43*
7. CROSS-CUTTING DETERMINANTS AND EMERGING ISSUES 44
7.1. Root Causes of Indigenous Peoples' Health Inequities *44*
7.2. Racism as a Powerful Determinant of Indigenous Health *45*
7.3 Intersectionality, race and gender and impacts on health *46*
7.3.1 Healthy Indigenous Women, health families and communities 47
7.4 Emerging issues *47*
7.4.1 Climate change, environmental racism and solastalgia 47
7.4.2 Changing demographics 49
8. POLICY SYNTHESIS AND RECOMMENDATIONS 51
8.1 Policy Synthesis *51*
8.2 Policy gaps and structural issues *53*
8.3 General Recommendations *54*
8.4 Systems-Level Recommendations: From Commitment to Action *58*
8.5 Mechanisms for Implementation and Monitoring *58*
8.6 Co-Development and Shared Accountability Frameworks *59*
9. PATHWAYS FOR POLICY CHANGE 59
9.1 Embedding Indigenous Health Priorities in National and Provincial Strategies *60*
9.2 Legislative and Funding Reforms to Enable Indigenous Governance *61*
9.3 Novel Partnership Models: Academia, Health Institutions, and Indigenous Leadership *61*
9.4 Roadmap for Phased Implementation *62*
9.5 Toward Health Justice and Reconciliation in Practice *63*
10. CONCLUSION 63
11. REFERENCES 65
12. APPENDICES 83
Appendix A: Data tables by determinant *83*
Appendix B: Indigenous-led program exemplars *85*
Appendix C: Policy scan by jurisdiction *87*
Appendix D: TRC and UNDRIP alignment matrix *89*

1. Executive Summary

This paper examines the state of Indigenous health and wellness in Canada through a rights-based and Indigenous-led lens. It argues that persistent health inequities experienced by First Nations, Inuit, and Métis Peoples are not the result of individual or cultural deficits, but the foreseeable consequences of colonial governance structures that have failed to uphold treaty obligations, constitutional rights, and international human rights commitments.

Drawing on Indigenous scholarship, policy analysis, and community-grounded knowledge systems, the report situates health as relational and wholistic, shaped by spirituality, land, language, governance, culture, and social conditions. Indigenous self-determination is identified as a foundational determinant of health, consistent with frameworks such as the Royal Commission on Aboriginal Peoples, the Truth and Reconciliation Commission Calls to Action, and the United Nations Declaration on the Rights of Indigenous Peoples.

The analysis identifies four interrelated structural drivers of inequity:

- Fragmented governance and jurisdictional ambiguity that produce delays, denials of care, and inconsistent accountability across federal, provincial, and territorial systems.
- Systemic racism and culturally unsafe care, which undermine trust, discourage care-seeking, and contribute to preventable harm.
- Inequitable social determinants of health including housing, income, language access, and geographic isolation rooted in colonial policy.
- Data inequities and lack of Indigenous data sovereignty, limiting effective planning and accountability.

The paper highlights that Indigenous-led health systems already demonstrate improved access, trust, and outcomes. Models such as Indigenous health authorities, community-controlled care, and land-based wellness programs show that when governance authority aligns with Indigenous rights, health systems become more effective and equitable.

Based on this evidence, the report proposes a shift from consultation to shared authority. Key policy directions include:

- Recognizing Indigenous jurisdiction in health governance and legislation
- Embedding Indigenous priorities in national and provincial health strategies
- Implementing mandatory cultural safety and anti-racism standards in legislation and regulation
- Supporting Indigenous workforce development and traditional healing systems
- Establishing Indigenous-governed data and accountability frameworks
- Providing predictable, long-term funding aligned with rights obligations
- Implementing phased governance transfer and capacity building

The report concludes that advancing Indigenous health equity is not primarily a technical challenge but a governance one. Canada possesses sufficient evidence and guidance to make meaningful change; the central barrier is the sustained political will to shift decision-making power, resources, and accountability structures in ways consistent with Indigenous rights.

2. Introduction and Context

The current state of Indigenous health in Canada reflects both enduring colonial harms and powerful examples of Indigenous strength, leadership, and resurgence. Persistent inequities in life expectancy, chronic disease burden, mental health outcomes, and access to culturally safer care are well documented; however, these inequities are neither inevitable nor attributable to individual or community deficits. Rather, they are the foreseeable outcomes of historical and ongoing failures to uphold Indigenous rights, treaties, and constitutional obligations related to health, land, and self-determination.

Indigenous peoples in Canada, First Nations, Inuit, and Métis, experience profound health inequities compared to non-Indigenous populations (Greenwood et al., 2018). These disparities are deeply rooted in the country's colonial history, including the legacy of the *Indian Act*, residential schools, and ongoing systemic discrimination. The resulting intergenerational trauma and loss of cultural continuity have shaped the social, economic, and political disadvantages that persist today, manifesting in higher rates of chronic illness, mental health crises, and reduced life expectancy among Indigenous communities (Kim, 2019a).

National reconciliation frameworks have repeatedly affirmed that Indigenous health inequities are rooted in colonial policies and require structural, rights-based responses. The Royal Commission on Aboriginal Peoples (RCAP) identified health as inseparable from self-government, land, culture, and economic security, concluding that meaningful improvements in Indigenous health depend on restoring Indigenous control over the institutions that affect daily life. RCAP emphasized that federal approaches focused on service delivery without governance reform would be insufficient to close health gaps, a finding that remains highly salient decades later (Royal Commission on Aboriginal Peoples, 1996).

Colonial policies aimed at assimilating Indigenous Peoples have had lasting impacts on health and well-being (Matheson et al., 2022a). The residential school system and the *Indian Act* disrupted family structures, eroded cultural practices, and imposed intergenerational trauma, all of which continue to influence health outcomes. The Truth and Reconciliation Commission of Canada (TRC) has documented these harms and called for systemic change, emphasizing the need for culturally safe and equitable health care (The Truth and Reconciliation Commission of Canada, 2015a).

Building on RCAP, the TRC explicitly framed Indigenous health inequities as a legacy of residential schools and broader systems of colonial dispossession. The TRC Calls to Action (particularly Calls 18–24) affirm that the state has a responsibility to recognize, respect, and address the distinct health needs of Indigenous Peoples as a matter of reconciliation and justice. These Calls situate health not merely as a programmatic concern, but as a core indicator of whether reconciliation is being meaningfully advanced (The Truth and Reconciliation Commission of Canada, 2015b).

Internationally, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) reinforces this rights-based framing by affirming Indigenous Peoples' rights to the highest attainable standard of physical and mental health (Articles 23 and 24), as well as the right to self-determination and to design and deliver health programs according to Indigenous priorities (United Nations General Assembly, 2007). Canada's commitment to UNDRIP implementation signals a shift toward alignment between domestic health policy and international human rights standards, though significant gaps remain between commitment and realization.

The *Indian Act has* profoundly shaped the legal and policy context of Indigenous health in Canada, despite containing no substantive recognition of a right to health or health care (Government of Canada, 1985). Enacted in 1876 as a colonial governance statute, the Act regulates aspects of life for First Nations people and reserve lands but addresses health only indirectly, through limited administrative powers related to sanitation, quarantine, and the management of communicable disease. These provisions were historically used to enable surveillance and coercive public health interventions rather than to support community-led systems of care or Indigenous wellbeing.

Because the *Indian Act* does not establish enforceable health entitlements, federal involvement in Indigenous health has evolved through policy discretion rather than law. This has resulted in a fragmented system characterized by program-based funding, unclear accountability, and chronic underinvestment. This legal architecture has entrenched jurisdictional ambiguity between federal, provincial, and territorial governments, producing gaps in care and contributing to preventable harms, including delayed or denied access to essential services. The health inequities experienced by Indigenous Peoples are therefore not accidental but structurally produced through a legislative framework that prioritizes administrative control over rights, relationships, and responsibilities.

The *Indian Act* also obscures the true sources of Indigenous health rights. Treaty commitments related to health and wellbeing arise from nation-to-nation agreements, and Indigenous and treaty rights are constitutionally affirmed under section 35 of the *Constitution Act, 1982*, independently of the Act itself (The Constitution Act, 1982). From an Indigenous health and legal perspective, the *Indian Act* functions not as a foundation for equitable health systems, but as a colonial constraint that continues to limit Indigenous self-determination in health governance. Contemporary policy reform must therefore move beyond the *Indian Act* to ground Indigenous health systems in inherent and treaty rights, Indigenous law, and self-determined models of care aligned with the United Nations Declaration on the Rights of Indigenous Peoples(Lavoie, 2013a).Indigenous Peoples' health and wellbeing are rooted in enduring systems of knowledge, kinship, spirituality, land-based relationships, and collective responsibility that have sustained communities since time immemorial. Indigenous communities continue to demonstrate resilience, adaptability, and innovation in the face of structural conditions shaped by colonial policies that have constrained access to income, education, employment, housing, and health services (Kolahdooz et al., 2015a). Across rural, remote, and urban settings, communities are actively advancing self-determined approaches to housing, economic development, education, and culturally grounded health care that build on Indigenous worldviews and priorities. Where inequities in physical and mental health persist, they reflect ongoing systemic barriers rather than community deficit. At the same time, Indigenous-led models of care, community-driven maternal and child health programs, chronic disease prevention initiatives, and land- and culture-based mental wellness strategies continue to

strengthen health outcomes, reaffirming that Indigenous Peoples' health is best understood through a lens of strength, sovereignty, and relational wellbeing (C. A. M. Richmond & Cook, 2016a).

Treaty and constitutional obligations further ground Indigenous health within a legal framework that predates and supersedes contemporary policy. Historic and modern treaties contain commitments related to health, relief in times of need, and the protection of livelihoods, reflecting holisticreflect wholistic Indigenous conceptions of wellbeing. These treaty relationships are constitutionally affirmed under section 35 of the *Constitution Act, 1982*, establishing Indigenous health not as a matter of discretionary benevolence, but as a legal and moral obligation arising from nation-to-nation agreements.

Despite these strong normative and legal foundations, Indigenous health systems in Canada continue to be shaped by fragmented governance, jurisdictional ambiguity, and inequitable funding. At the same time, Indigenous-led health authorities, community-controlled primary care models, and Indigenous health workforce initiatives demonstrate what is possible when Indigenous governance, knowledge, and accountability are centered. These models consistently show improvements in access, cultural safety, continuity of care, and community trust affirming that self-determination is not only a rights imperative, but a practical pathway to improved health outcomes for Indigenous Peoples.

Taken together, RCAP, the TRC Calls to Action, UNDRIP, and treaty and constitutional obligations provide a coherent framework for understanding the current state of Indigenous health in Canada. They collectively call for a shift away from deficit-based narratives and toward justice-oriented, strengths-based approaches that recognize Indigenous Peoples as rights-holders, system designers, and leaders in health transformation. Advancing Indigenous health equity therefore does not require new evidence of disparity, but sustained political will to implement the rights and responsibilities that have already been clearly articulated.

Across Canada, Indigenous Nations and organizations are leading health and wellness strategies that demonstrate both the feasibility and the effectiveness of self-determined, rights-based approaches to care. These initiatives offer compelling evidence that when Indigenous governance, knowledge systems, and accountability structures are centered, health systems become more responsive, equitable, and effective. Rather than isolated successes, these examples reflect a broader pattern: Indigenous leadership in health is a proven pathway to improved outcomes, cultural safety, and reconciliation in practice.

A nationally significant example is the First Nations Health Authority (FNHA), the first province-wide Indigenous health authority in Canada. Established through tripartite agreements among First Nations, British Columbia, and Canada, the FNHA assumed responsibility for health programs and services previously delivered by the federal government. Grounded in First Nations governance, cultural safety, and community engagement, the FNHA has strengthened continuity of care, improved coordination with provincial systems, and embedded wellness-oriented and culturally grounded approaches across service delivery. Evaluations consistently identify enhanced trust, improved relationships with health providers, and system-level efficiencies, positioning the FNHA as a leading example of reconciliation through structural reform rather than symbolic action(First Nations Health Authority, 2026).

Similarly, Nishnawbe Aski Nation (NAN), representing 49 First Nations across Northern Ontario, has advanced Indigenous-led approaches to health and mental wellness that respond directly to the realities of remote and fly-in communities. NAN-affiliated communities have implemented land-based healing programs, Indigenous mental wellness teams, and community-driven crisis response strategies grounded in Indigenous knowledge systems. These approaches have demonstrated improved community engagement, greater cultural safety, and increased trust in health services, particularly in mental health and addictions care. Importantly, NAN's work reframes wellness as inseparable from land, language, governance, and youth leadership (Nishnawbe Aski Nation, n.d.).

Finally, the Tui'kn Partnership is a collaboration among five Mi'kmaq First Nations in Nova Scotia that transformed primary care delivery through shared governance, data sovereignty, and culturally grounded population health planning. By reclaiming control over health data and using it to inform prevention, screening, and chronic disease management, Tui'kn achieved measurable improvements in diabetes care, cancer screening rates, and primary care access (Canadian Health Human Resources Network, 2009). Tui'kn is frequently cited as a best-practice example of how Indigenous governance, evidence-informed planning, and regional collaboration can dramatically improve health outcomes while strengthening self-determination.

Collectively, these success stories illustrate that Indigenous-led health systems are not experimental alternatives, but evidence-informed and scalable approaches aligned with Indigenous rights, treaty relationships, and international standards such as the United Nations Declaration on the Rights of Indigenous Peoples. They centre Indigenous Peoples as health system designers and leaders whose governance produces tangible improvements in individual, community and population health and wellbeing. For policymakers, the implication is clear: advancing Indigenous health equity requires sustained investment in Indigenous authority, stable funding, and jurisdictional arrangements that enable Indigenous Nations to lead. These examples show that when reconciliation is operationalized through governance and trust, healthier communities follow.

3. Conceptual and Methodological Framework

This report is guided by ethical principles and grounded in an Indigenous-led conceptual framework that recognizes health inequities among Indigenous Peoples as the result of historical and ongoing discrimination, rather than individual or cultural deficits. The framework integrates multiple forms of evidence and knowledge systems to support a rigorous, respectful, and policy-relevant assessment of the state of Indigenous Peoples' health in Canada.

3.1 Guiding Principles and Ethical Foundations

3.1.1 Two-Eyed Seeing

Two-Eyed Seeing (Etuaptmumk), as articulated by Mi'kmaw Elder Albert Marshall, was adopted as a guiding principle to bring together Indigenous and Western ways of knowing while respecting their distinct origins and strengths (Bartlett et al., 2012). In this report, Two-Eyed Seeing is treated not as a symbolic gesture, but as an ethical commitment to:

- Avoid epistemic dominance
- Respect Indigenous knowledge as complete and valid systems, and
- Engage critically with Western evidence rather than assuming neutrality.

Figure 1: Two-Eyed Seeing- graphical depiction of a conceptual framework

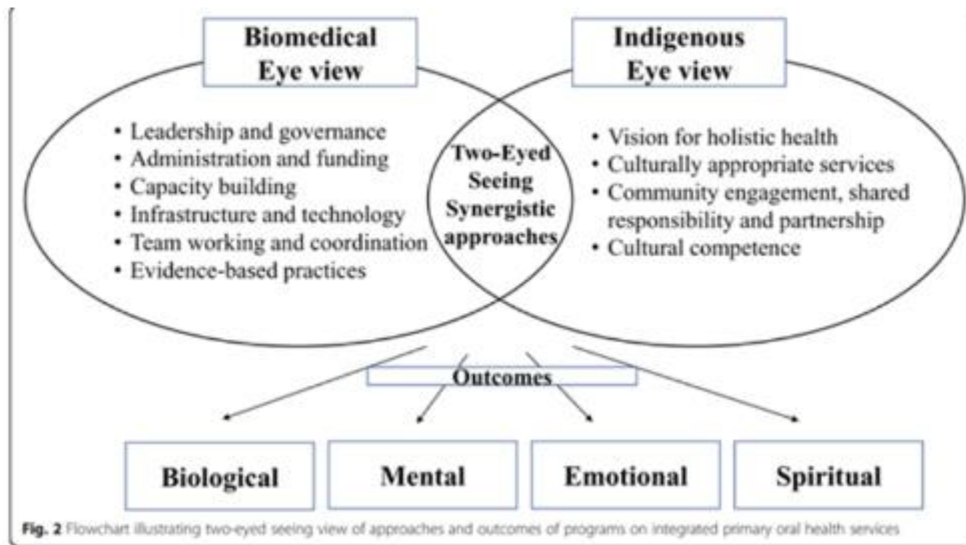


Fig. 2 Flowchart illustrating two-eyed seeing view of approaches and outcomes of programs on integrated primary oral health services

Bartlett, C., Marshall, M. & Marshall, A. Two-Eyed Seeing and other lessons learned within a co-learning journey of bringing together indigenous and mainstream knowledges and ways of knowing. J Environ Stud Sci 2, 331–340 (2012). https://doi.org/10.1007/s13412-012-0086-8

3.1.2 OCAP® and Indigenous data sovereignty

The principles of Ownership, Control, Access, and Possession (OCAP®) informed our decisions about data use, interpretation, and reporting, particularly in relation to First Nations data (First Nations Information Governance Centre, 2014).

More broadly, the report aligns with Indigenous data sovereignty principles that affirm Indigenous Peoples' rights to govern how their data are collected,

used, and interpreted (First Nations Information Governance Centre, 2014). Limitations related to data availability and quality are understood as consequences of historical exclusion and underinvestment, rather than methodological shortcomings.

3.1.3 Self-determination

Self-determination is treated as a core determinant of health, consistent with Indigenous scholarship and international human rights frameworks (C. Reading & Wein, 2009) (United Nations, 2007b). This principle informed an explicit shift away from deficit-based narratives toward recognition of Indigenous authority in defining health priorities, success, and solutions.

3.1.4 Eschewing White Saviourism and Deficit Framing

Indigenous health research and policy in Canada have historically privileged non-Indigenous expertise, framed Indigenous communities as problems to be solved, and obscured Indigenous leadership and innovation(Allan & Smylie, 2015; Kenny et al., 2004; Ortiz et al., 2025a). Such approaches have undermined trust, perpetuated power imbalances, and contributed to ineffective or harmful interventions. Unlike previous reports, this one deliberately acknowledges and challenges existing harmful power imbalances rather than reinforcing them. Explicitly addressing white saviourism strengthens the credibility, ethical integrity, and policy relevance of the report, and aligns with reconciliation and rights-based commitments across Canadian health systems (Truth and Reconciliation Commission of Canada (TRC), 2015).

3.2 Frameworks

3.2.1Determinants-based framing

The analysis was also guided by a Social Determinants of Indigenous Health lens, which extends beyond conventional social determinants frameworks by explicitly identifying colonization, self-determination, and Indigenous worldviews as foundational determinants of health (National Collaborating Centre for Indigenous Health (NCCIH), 2013). This framing provided a lens and recognizes that inequities in health outcomes are structurally produced and avoidable, rather than natural or inevitable as is so often represented in the literature (C. Loppie & Wien, 2022).

3.2.2 Core frameworks informing the analysis

Several Indigenous frameworks were used to guide and inform the analysis. Together, these frameworks guided the selection of evidence and indicators; the interpretation of disparities as structurally produced; and focused the attention on resilience, protective factors, and Indigenous-led solutions alongside inequities.

First Nations Health Authority (First Nations Health Authority, 2026)

The FNHA's wellness and determinants framework emphasizes:

- The interconnectedness of physical, mental, emotional, and spiritual health.
- The central role of land, language, culture, and governance
- Community-defined understandings of wellness and balance

This framework shifts our analysis away from illness-based indicators toward wholistic conceptions of health and wellbeing.

National Collaborating Centre for Indigenous Health (NCCIH)

The NCCIH framework identifies colonization as a distal determinant shaping intermediate and proximal determinants such as income, education, housing, access to care, and experiences of racism (National Collaborating Centre for Indigenous Health (NCCIH), 2013). In addition, the NCCIH explicitly identifies healthcare access, jurisdictional fragmentation, and systemic racism as determinants of health.

Medicine Wheel and wholistic wellness models

Grounded in Medicine Wheel teachings, our analysis treats health as relational and wholistic, resisting reductionist interpretations and privileging strengths-based understandings. (C. Reading & Wien, 2009a)

3.3 Framework commitments

- Privileging Indigenous expertise

Indigenous scholars, leaders, clinicians, and organizations are positioned as authoritative knowledge holders. Indigenous-authored sources were prioritized wherever possible.

- Relational accountability

The report emphasizes accountability to relationships, communities, organizations, and future policy implications rather than claims of value-neutral objectivity.

- Strengths-based, systems-focused analysis

Health inequities are located within systems, structures, and policies rather than individuals or cultures. Examples of Indigenous governance, innovation, and care models are highlighted alongside challenges.

- Acknowledging difference/uniqueness:

It is important to note that Indigenous Peoples are distinct and unique and represented by First Nation, Inuit and Métis Peoples. Although each of these groups tend to frame health and well-being wholistically through the integration of cultural, spiritual, social, environmental and economic indicators, their priorities may differ because of their unique backgrounds, identities, and the contexts in which they operate today. Understanding these points of overlap and distinction is fundamental to shaping health and well-being strategies that respect and respond to each group's cultural context (Nightingale et al., 2016).

3.4 Methodological Approach

The report used a multi-method approach combining a targeted literature synthesis, a policy and systems scan, and engagement with Indigenous-led knowledge systems to capture the complexity of Indigenous health realities beyond a single methodological lens or solely biomedical evidence (Allan & Smylie, 2015; National Collaborating Centre for Indigenous Health (NCCIH), 2013). The literature synthesis prioritized Indigenous-authored and led scholarship, community-based participatory research, and critical analyses of Indigenous health, equity, and colonial systems. A thematic synthesis integrated qualitative, conceptual, and policy-relevant evidence while recognizing data gaps as reflections of systemic inequities in data collection and governance (First Nations Information Governance Centre, 2020; Inuit Tapiriit Kanatami, n.d.; National Collaborating Centre for Indigenous Health (NCCIH), 2013)

The policy and systems scan examined federal, provincial, territorial, and Indigenous health policies, commission reports, and reconciliation commitments, assessing intent, feasibility, and governance while recognizing that implementation challenges often stem from systemic complexity, not lack of evidence (Lavoie, 2013b; Truth and Reconciliation

Commission of Canada, 2015a). Indigenous-led knowledge systems were treated as foundational evidence, shaping problem definition and interpretation through approaches that view knowledge as living, relational, and grounded in community authority and responsibility (Kovach, 2010; L. Tuhiwai. Smith, 2024). This ensured Indigenous voices and epistemologies guided the review and analysis throughout.

In the following section, the results of these three analysis methods have been consolidated to provide a wholistic view of the very complex issue of Indigenous health in Canada.

4. Urgent and Systemic Issues in Indigenous Health

This section explores key challenges affecting Indigenous Peoples' access to health care and overall health outcomes in Canada. It begins by examining barriers to care, including jurisdictional confusion between federal and provincial responsibilities, geographic isolation and limited-service availability, and the resulting financial, systemic, and cultural obstacles Indigenous communities face.

Following this, the disproportionate health burden borne by Indigenous Peoples is discussed, highlighting the deep-rooted social, economic, and colonial determinants that contribute to persistent health inequities. The section then addresses critical data gaps that hinder effective policymaking and health system planning, emphasizing the need for Indigenous-driven and culturally relevant data governance.

Finally, it considers systemic racism and institutional barriers within health care, outlining how discrimination and lack of culturally safe care exacerbate health disparities and undermine trust in the health system. Together, these topics provide a comprehensive overview of the structural factors shaping Indigenous health and the urgent need for equitable, culturally grounded reforms.

4.1 Barriers to Accessing Health Care

4.1.1 Jurisdictional confusion

The *Canada Health Act*, in its current form, has contributed to persistent barriers to health care access for Indigenous Peoples by failing to clearly articulate jurisdictional responsibility for service delivery (Lavoie, 2013). This lack of clarity has entrenched inequities by enabling ongoing disputes

between federal and provincial governments regarding fiduciary responsibility for Indigenous health care (Shirazi, 2025; Wylie et al., 2020).

As a result, Indigenous Peoples are frequently denied services or required to assume costs when provincial or territorial agencies refuse to provide care, citing federal responsibility. This jurisdictional ambiguity leads to service delays, interruptions in care, and avoidable harms (Shirazi, 2025). While the federal government maintains primary responsibility for Indigenous Peoples health services, provincial systems often remain the primary point of access for Indigenous Peoples, particularly for hospital-based and specialist care. These fragmented governance arrangements interact with broader socioeconomic, environmental, and political determinants to perpetuate inequitable access to health services (Greenwood & de Leeuw, 2012).

Under current federal policy in Canada, the Non-Insured Health Benefits (NIHB) program provides a defined set of health-related benefits including prescription drugs, dental and vision care, medical supplies, and medical transportation only to individuals who are registered as Status First Nations ("Status Indians") under the *Indian Act* and to recognized Inuit beneficiaries (Indigenous Services Canada, 2025). This eligibility framework creates a significant disparity with Métis peoples and First Nations individuals who are non-status (despite being constitutionally recognized as part of Canada's Aboriginal peoples alongside First Nations and Inuit under Section 35 of *the Constitution Act, 1982)* excluded from accessing these federally administered supplementary health benefits. Section 35(2) of *the Constitution Act, 1982* explicitly identifies three distinct groups as "Aboriginal peoples of Canada" - First Nations (Indian), Inuit, and Métis, affirming their collective existence and rights as original peoples of this land (The Constitution Act, Schedule B 1982). Yet the disparity between constitutional recognition and NIHB program eligibility is clear a gap in policy design. Over the past decade, multiple Canadian Human Rights Tribunal rulings have reinforced and expanded the scope of Jordan's Principle requiring jurisdictional or funding disputes to be resolved after First Nations children receive care without delay, underscoring its role in addressing ongoing systemic inequities in access to essential services (Canadian Human Rights Tribunal, 2017).

4.1.2 Geography and service availability

Many Indigenous communities are located in rural, remote, or northern regions where health services are limited or unavailable. Individuals often must travel long distances to access specialist care, cancer treatment, dialysis, and other essential services (Davy et al., 2016; Statistics Canada, 2024b). Poor or seasonal road conditions, reliance on air transportation, and weather-related delays can pose serious and at times life-threatening risks. The associated costs of travel, accommodation, and food are frequently prohibitive and place a disproportionate burden on patients and families. Evidence consistently demonstrates that Indigenous Peoples face disproportionate financial barriers to health care, including indirect costs related to travel, inadequate insurance coverage, and systemic underfunding of services. These factors intersect with higher rates of poverty in Indigenous communities, further compounding inequitable access to care.

In addition to geographic barriers, Indigenous Peoples often encounter complex bureaucratic systems characterized by excessive paperwork, referral bottlenecks, long wait times, and limited patient navigation supports. When accessing the healthcare system, many are faced with racism and discrimination. Recent Canadian studies have highlighted the effectiveness of Indigenous Patient Navigators and similar roles in supporting Indigenous Peoples to access and move through fragmented health systems, yet such supports remain unevenly available across jurisdictions (Canzani et al., 2025; Rankin et al., 2025).

Collectively, geographic isolation, limited-service availability, and systemic barriers render Canada’s universal health care system effectively inaccessible to many Indigenous Peoples. Addressing these challenges requires expanding local, mobile, and virtual services; reducing travel-related burdens; and ensuring care is culturally safe and Indigenous-led (Davy et al., 2016; National Collaborating Centre for Indigenous Health, 2019b; Statistics Canada, 2024b). Elevated rates of chronic and some infectious diseases, shaped by structural determinants of health and poor access to prevention and early treatment, remain a persistent consequence of these barriers to access.

4.1.3 Summary: Barriers to Access

Across Canadian studies, consistent evidence demonstrates that Indigenous Peoples experience:

- Disproportionate financial barriers, including travel costs and inadequate insurance coverage(Davy et al., 2016; Shirazi, 2025)
- Chronic underfunding and under-resourcing of Indigenous health services (Statistics Canada, 2024b)
- Jurisdictional gaps between federal and provincial responsibility (Indigenous Services Canada 2026)
- Geographic isolation requiring long-distance travel for primary, specialist, dialysis, dental and cancer care (Canadian Partnership Against Cancer, n.d.).
- Discrimination, racism, and culturally unsafe care within health systems (McCallum & Perry, 2018; Turpel-Lafond, 2020)
- Enduring colonial policy legacies that fragment service delivery and access (National Collaborating Centre for Indigenous Health, 2019b)

These factors interact with poverty and social exclusion, reinforcing inequitable access to health care and contributing to poorer health outcomes for Indigenous Peoples.

4.2 Disproportionate Health Burden

Health inequities must be understood within the broader historical, political, social, and economic contexts that have shaped and continue to shape Indigenous Peoples' health (Key Health Inequalities in Canada : A National Portrait*,* 2018). Colonial policies, including forced displacement to remote communities and the erosion of land-based livelihoods, have limited economic opportunity and disrupted the relationships of Indigenous communities to land, culture, and traditional healing practices. Ongoing social and economic marginalization, forced assimilation, and systemic discrimination continue to adversely affect health outcomes (Matheson et al., 2022b).

As a direct result of the historic and ongoing colonial policies and structural inequities describe above, Indigenous Peoples in Canada experience a disproportionately high burden of illness, reflected in poorer self-reported physical and mental health, higher prevalence of chronic conditions such as asthma and diabetes, increased substance use, and higher rates of disability compared with non-Indigenous populations(Gall et al., 2021; C. Loppie &

Wien, 2022; Statistics Canada, 2022b). These disparities are further exacerbated by poverty, inadequate housing, food insecurity, and climate-related impacts (Intergovernmental Panel on Climate Change (IPCC), 2023; Mikkonen & Raphael, 2010). Intergenerational trauma, over-representation in the child welfare and criminal justice systems, violence, and inequitable access to culturally grounded mental health supports further contribute to disproportionate health impacts (Allan & Smylie, 2015; Matheson et al., 2022b).

Life expectancy for First Nations, Inuit, and Métis Peoples remains consistently and significantly lower than that of the non-Indigenous population (Tjepkema et al., 2019). Reduced access to preventive care, delayed diagnosis, and inequitable treatment are key contributors (Davy et al., 2016). These patterns or determinants of health reflect structural, systemic, and cultural barriers that undermine health and well-being across the life course.

4.3 Data Gaps

The absence of reliable, comprehensive Indigenous health data remains a significant barrier to equitable policy development and effective health system planning in Canada that can work for the benefit of Indigenous Peoples. Inconsistent Indigenous identity data and uneven reporting obscure population need, contribute to under-resourcing, and weaken accountability particularly for Inuit and Métis populations relative to First Nations (C. Loppie & Wien, 2022; National Collaborating Centre for Indigenous Health, 2019b).

A substantial proportion of Indigenous Peoples live off reserve, yet data on First Nations individuals residing in urban and non-reserve settings is not routinely collected (Paul, 2023). Off reserve populations represent a significant proportion of the Indigenous Peoples accessing and navigating health systems outside their home communities, yet their needs are often rendered invisible within existing data frameworks.

Persistent inaccuracies in population counts represent one of the most significant structural barriers to understanding Indigenous health inequities, particularly in urban settings. Research demonstrates that Indigenous Peoples living in cities are routinely undercounted in national census data often by factors of two to four resulting in distorted estimates of population size and service need (Anderson et al., 2016; Smylie & Firestone, 2015).

These distortions directly affect funding allocation, service planning, and the ability to accurately assess health disparities(Paul, 2023; Walter & Suina, 2019). During the COVID-19 pandemic, these limitations became particularly evident when federal surveillance systems were unable to generate reliable, disaggregated national-level data for Indigenous Peoples, undermining equity-focused responses (Carroll et al., 2021a; Mashford-Pringle et al., 2021; Smylie & Firestone, 2015).

Beyond population counts, Indigenous scholars and leaders have long identified gaps in culturally relevant, Indigenous-governed data. Much of Canada's health surveillance relies on Western epistemologies and indicators that do not align with Indigenous knowledge systems or governance priorities(Kukutai & Taylor, 2016; Stelkia et al., 2023). National initiatives such as the First Nations and Inuit Health and Wellness Indicators acknowledge that inconsistent data sources and methodologies limit comparability and policy utility (Indigenous Services Canada, 2023a). Mainstream health information systems frequently fail to respect Indigenous data sovereignty principles most notably OCAP® contributing to mistrust and constraining meaningful, community-led data use (First Nations Information Governance Centre, 2020; Paul, 2023; Walter & Suina, 2019).

4.4 Systemic Racism

Compounding these challenges are persistent gaps in longitudinal, community-level, and health system performance data. Many Indigenous communities lack sustained datasets capable of tracking trends in chronic disease, mental health, or service utilization over time, with existing surveys providing episodic snapshots rather than actionable insight (Greenwood et al., 2018). Data on access and system performance including primary care attachment, wait times, and unmet need remain fragmented despite evidence of significant disparities, particularly in northern and remote regions (Statistics Canada, 2024a). These gaps reflect deeper jurisdictional fragmentation across federal, provincial, territorial, and Indigenous governance systems, resulting in inconsistent standards, variable data quality, and barriers to an integrated Indigenous health data infrastructure (Carroll et al., 2021b; National Collaborating Centre for Indigenous Health (NCCIH), 2019).

4.4.1 Systemic Racism and Institutional Barriers

Racism is deeply embedded within Canadian health systems and produces measurable harm. Experiences of racism and discrimination discourage Indigenous Peoples from seeking care, disrupt continuity of care, and contribute to delayed presentation of illness and poorer health outcomes (Allan & Smylie, 2015; Wilson et al., 2015). Racism is perpetuated through persistent stereotypes such as assumptions of substance use or non-compliance which influence things such as triage decisions, diagnostic assessment, pain management, and discharge planning (Wilson et al., 2015). These dynamics contribute to delayed or inappropriate treatment and poorer patient experiences, increasing morbidity and mortality among Indigenous Peoples (Canadian Institute for Health Information, 2021, 2025).

Indigenous Peoples continue to report widespread experiences of racism and discrimination when accessing health care, contributing to mistrust and perceptions of health providers, policies and systems as unsafe (C. Loppie & Wien, 2022). Language barriers, stereotyping, and dismissive interactions further reinforce avoidance of care and inadequate follow-up (Nelson & Wilson, 2018).

A recent Canadian study linked culturally unsafe care and racism to concrete harms, including adverse events and preventable deaths among First Nations, Inuit, and Métis Peoples (Pilarinos et al., 2023). The deaths of Brian Sinclair and Joyce Echaquan, two of many, illustrate the lethal consequences of systemic racism within health systems and underscore the urgency of structural reform.

The Truth and Reconciliation Commission's Calls to Action 23 and 24 identify critical workforce and training gaps related to Indigenous health professionals and cultural safety education (Truth and Reconciliation Commission of Canada, 2015a). Indigenous clinicians remain underrepresented across health systems, due in part to barriers to admission into health sciences programs, limited geographic and financial accessibility, and insufficient culturally safe and anti-racist curricula (National Collaborating Centre for Indigenous Health, 2019b; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; Truth and Reconciliation Commission of Canada, 2015a). Additional barriers include limited Indigenous governance and leadership within health systems

and weak accountability mechanisms, with complaint processes often perceived as unsafe or ineffective (Nightingale et al., 2016).

A further systemic gap lies in the absence of comprehensive mechanisms to measure Indigenous-specific racism and cultural safety. Until recently, Canada lacked standardized national indicators capable of capturing how racism shapes health care experiences and outcomes (Canadian Institute for Health Information, 2021, 2025). Emerging Indigenous-led partnerships with the Canadian Institute for Health Information have begun to address this gap; however, as of the publication of this paper, Canada still does not yet have a national Quality Standard for Indigenous Health or Cultural Safety.

Mainstream health datasets also fail to adequately capture broader Indigenous determinants of health, including land-based relationships, cultural continuity, environmental conditions, climate-related impacts, and access to natural environments. Despite growing recognition of their importance, data related to these determinants remain incomplete, inconsistent, and fragmented (C. Loppie & Wien, 2022).

5. Determinants of Health and Wellness

Systemic racism, jurisdictional confusion, and barriers to accessing health care all significantly impact the health of Indigenous Peoples. In addition, compared to the non-Indigenous population, major socio-economic disparities further hinder their ability to achieve the highest possible level of health. These disparities are evident in income levels, employment opportunities, housing conditions, food security and ultimately health outcomes (C. Reading & Wein, 2009; Truth and Reconciliation Commission of Canada, 2015a). A complex interplay of historical and ongoing colonialism, systemic racism, and social exclusion has resulted in poorer health outcomes for many Indigenous communities both on and off reserves (Allan & Smylie, 2015; Browne, Smye, et al., 2016; Browne, Varcoe, et al., 2016).

Indigenous wellness is deeply rooted in a wholistic understanding of health that embraces physical, emotional, mental, and spiritual balance, with culture serving as a vital source of healing and strength. From a strengths-

based perspective, key determinants of Indigenous wellness include strong connections to land, community, and traditional practices that foster resilience and empower individuals and collectives (Chandler & Lalonde, 1998; Kirmayer et al., 2011). Resiliency factors such as cultural continuity, language preservation, and intergenerational knowledge transmission reinforce identity and well-being, enabling Indigenous Peoples to navigate and overcome historical and ongoing challenges (Duran & Duran, 1995; King et al., 2009). Recognizing culture as a foundation for healing shifts the focus from deficits to the inherent strengths and capacities that sustain Indigenous health and vitality (Gone, 2013; Wexler, 2014).

Understanding how these well-known determinants of health are experienced by Indigenous communities is crucial to addressing these inequities and promoting reconciliation, social justice and highest attainable health.

5.1 Poverty: Indigenous Peoples' experience with poverty and effects on health and wellness

Based on 2021 data, approximately 25% of Indigenous peoples in Canada lived in poverty, compared to about 9% of the non-Indigenous population. This indicates that Indigenous peoples experienced poverty at nearly three times the rate of non-Indigenous Canadians. Experiences of poverty are clearly linked to adequate stable employment. According to the Indigenous Services Canada report based on statistics from 2021, the employment rate for Indigenous peoples was around 56%, compared to approximately 75% for non-Indigenous people, highlighting a significant employment gap between the two groups (Indigenous Services Canada, 2023b). Indigenous Peoples consistently face higher rates of unemployment and underemployment, limited access to quality housing, and greater health inequities than the general population (Greenwood et al., 2018).

The persistent poverty experienced by Indigenous Peoples arises from legacies of social exclusion tied to colonization. Stereotypes unjustly place blame on individuals while obscuring structural inequalities (Turpel-Lafond, 2020). Structural barriers on reserves such as limited employment opportunities, underfunded infrastructure, and inadequate social services contribute to economic marginalization (Greenwood et al., 2018). Indigenous people who move off reserves often face systemic challenges, including racism, unemployment, unstable housing, and poorer health outcomes due

to discrimination, negative stereotypes, inadequate housing investments, and barriers to accessing equitable healthcare services (Cooke & Bélanger, 2006; Samantha. Loppie et al., 2020).

5.1.1 Poverty as a gendered experience

Indigenous women experience intersecting oppressions linked to both their gender and Indigenous identity. Indigenous women experience poverty at higher rates compared to both Indigenous men and non-Indigenous women (Indigenous Services Canada, 2023). Indigenous women also disproportionately face poverty-related outcomes such as housing insecurity, unemployment, and the impacts of systemic discrimination in labour markets (Bourassa et al., 2016).

5.1.2 Links between Indigenous Poverty and Health

Poverty significantly impacts the health of Indigenous peoples in Canada, contributing to a range of adverse health outcomes that are often more severe compared to the non-Indigenous population. Indigenous communities frequently experience higher rates of poverty, which exacerbates existing health disparities, influenced by a complex interplay of social determinants of health including inadequate housing, limited access to nutritious food, and reduced access to healthcare services.

One of the primary health effects related to poverty among Indigenous peoples is an increased prevalence of chronic diseases such as diabetes, cardiovascular disease, and respiratory illnesses. Studies have shown that poverty limits access to healthy food, leading to nutritional deficiencies and higher rates of obesity and diabetes (C. Reading & Wein, 2009). Mental health outcomes are also adversely affected by poverty in Indigenous communities. Elevated levels of stress, depression, and anxiety are often reported, linked to the experiences of economic marginalization and social exclusion (Mikkonen & Raphael, 2010). The legacy of colonization, intergenerational trauma, and systemic discrimination compound these factors, resulting in disproportionately high suicide rates among Indigenous youth (Kirmayer et al., 2011).

Access to healthcare services is often limited for Indigenous populations living in poverty, particularly those in remote or rural areas. Compounding geographic isolation, culturally inappropriate healthcare provision, with additional financial barriers, reduces the ability to receive timely and

effective medical treatment (Lavoie et al., 2015). This lack of access leads to delays in diagnosis and treatment, worsening health outcomes.

Overall, poverty serves as a critical social determinant that profoundly impacts the physical, mental, and social health of Indigenous peoples in Canada, necessitating targeted policies and interventions that address both economic conditions and culturally safe healthcare delivery.

5.1.3 Income support and effects on health

Guaranteed minimum income (GMI) has the potential to significantly alleviate poverty among Indigenous communities by providing a stable and unconditional financial foundation that addresses the systemic economic disadvantages they face. By ensuring a baseline income, GMI programs can improve financial security, reduce stress related to economic instability, and promote greater participation in education and community activities (Forget, 2011). GMI can empower Indigenous individuals to make choices aligned with cultural values and self-determined goals, fostering social inclusion and wellbeing (Cornell & Kalt, 2007). Studies from pilot GMI projects have demonstrated improvements in health, mental wellbeing, and educational outcomes, which are crucial factors in breaking the cycle of poverty in Indigenous contexts (Forget, 2011; Standing, 2017).

Addressing poverty among Indigenous peoples requires recognizing its complex roots in systemic racism, gender oppression, inadequacies in housing and employment, and ongoing colonial legacies. Effective policy and social change must center Indigenous self-determination, respect diverse identities, and ensure equitable access to resources and decision-making power for all Indigenous peoples.

5.2 Employment: Indigenous Employment and Working Conditions as Determinants of Indigenous Peoples' Health and Wellness

5.2.1. Employment Rates, barriers and working conditions

Indigenous Peoples consistently face higher rates of unemployment and underemployment, limited access to quality housing, and greater health inequities than the general population (Greenwood et al., 2018). According to the Indigenous Services Canada report based on statistics from 2021, the employment rate for Indigenous peoples was around 56%, compared to approximately 75% for non-Indigenous people, highlighting a significant employment gap between the two groups (Indigenous Services Canada, 2023b). Indigenous workers earn consistently lower wages, with an average

hourly wage gap of $2.50 CAD compared to non-Indigenous workers. Indigenous people are underrepresented in knowledge-based industries and occupations and overrepresented in lower-skilled sectors like construction and retail. Key barriers include lower educational attainment, socio-economic challenges, lack of access to culturally sensitive services, and disproportionate levels of incarceration (OECD, 2018).

Indigenous youth experience employment rates that are considerably lower than those of both Indigenous adults and non-Indigenous youth likely because of lower educational attainment, fewer job opportunities in their communities, and systemic barriers (Indigenous Services Canada, 2023b).

5.2.2. Impacts of Employment on Health and Well-being

There is a clear link between lack of employment, income and their subsequent effects on physical health and mental well-being. Conversely, employment correlates with improved socioeconomic and health outcomes for Indigenous Peoples. Stable employment has been shown to significantly improve the physical and mental health outcomes of Indigenous peoples in Canada by providing income security, access to healthcare, and a sense of purpose and community belonging (C. Reading & Wein, 2009).

5.3 Homelessness: Housing as Determinants of Indigenous Peoples' Health and Wellness

The United Nations defines homelessness as "a condition where a person or household lacks habitable space with security of tenure, rights and ability to enjoy social relations, including safety. Homelessness is a manifestation of extreme poverty and a failure of multiple systems and human rights" (OECD, 2025). Indigenous housing has been conceptualized as housing that is deeply connected to the cultural, historical, and social realities of Indigenous peoples, emphasizing the importance of incorporating Indigenous worldviews, traditions, and relationships to the land rather than applying standardized Western housing models (Thistle, 2017).

Indigenous Peoples are dramatically overrepresented in the homeless and underhoused population across Canada. Data from urban areas in Western and Northern regions show that Indigenous People often constitute 35–60% of people experiencing homelessness in major western cities and up to 90–95% of visibly homeless people in parts of the Northwest Territories, despite representing a much smaller share of the general population (Agrawal & Zoe, 2024).

Point-in-Time (PiT) counts offer a snapshot of homelessness in major Canadian cities by tallying individuals experiencing homelessness on a single night. For example, Toronto's 2021 PiT count found over 9,200 people homeless, with 20-30% identifying as Indigenous, despite Indigenous people comprising only 2-3% of the population (City of Toronto, 2021). Similarly, Vancouver's 2020 count recorded about 2,095 homeless individuals, approximately 33% of whom were Indigenous (Vancouver Homeless Count, 2020). In Calgary and Winnipeg, Indigenous peoples also represented a disproportionately large share of the homeless population, roughly 25-30% and over 50% respectively, compared to their smaller percentages in the general populations (Calgary Homeless Foundation, 2021; Winnipeg Homelessness Partnering Strategy, 2020).

Indigenous homelessness is likely more prevalent than census data and one-night counts suggest. In Toronto, Indigenous-specific enumeration using respondent-driven sampling estimated that there are roughly 55,000 Indigenous people in the city (two to four times the census count) and found very high levels of poverty and housing precarity, indicating that standard data sources substantially undercount both the Indigenous population and its housing needs (Rotondi et al., 2017). A more recent analysis found that 27.3% of First Nations, Inuit, and Métis adults in Toronto were living in conditions that met a definition of physical homelessness (McConkey et al., 2024).

These findings align with broader work on social determinants of Indigenous health, which identifies housing and homelessness as central drivers of inequities, but also notes major gaps in understanding the pathways into current housing status and its health impacts (Kolahdooz et al., 2015b).

5.3.1 Twelve Dimensions of Indigenous Homelessness

Indigenous homelessness is a complex and multifaceted experience that goes beyond the conventional notion of lacking shelter. It has been described by twelve dimensions of Indigenous homelessness that capture the unique social, cultural, and spiritual aspects affecting Indigenous peoples. These dimensions include: (1) structural homelessness, referring to inadequate physical housing; (2) spiritual homelessness, which involves disconnection from Indigenous identity and spiritual practices; (3) mental homelessness, describing feelings of alienation and loss of self; (4) emotional homelessness, related to trauma and emotional dislocation; (5)

cultural homelessness, indicating loss of cultural continuity and traditions; (6) geographical homelessness, which is physical displacement from traditional lands; (7) historical homelessness, acknowledging the impacts of colonization and residential schools; (8) social homelessness, manifesting in loss of family and community ties; (9) political homelessness, relating to marginalization and exclusion from decision-making; (10) economic homelessness, meaning lack of access to economic resources; (11) legal homelessness, involving systemic discrimination and lack of recognition; and (12) compounded homelessness, where multiple dimensions overlap and exacerbate experiences of homelessness. This framework highlights the need for wholistic and culturally appropriate responses to Indigenous homelessness that address these interrelated dimensions rather than focusing solely on physical shelter (Thistle, 2017).

5.3.2 Impacts of Homelessness and overcrowding on Health and Well-being
Overall, homelessness contributes to excess morbidity and mortality, including injuries, respiratory and infectious disease, and reduced life expectancy (Fazel et al., 2014; Mitchell et al., 2023). Indigenous homelessness is strongly associated with mental illness, trauma, substance use, and physical illness. Compared with non-Indigenous people, Indigenous people who are homeless while also experiencing a mentally illness become homeless younger, remain homeless longer, and have higher rates of PTSD, alcohol dependence, severe recent substance use, and infectious disease. Indigenous women have especially high odds of PTSD, multiple mental disorders, suicidality, and physical and sexual violence (Bingham et al., 2019).

Indigenous housing conditions in Canada are frequently marked by overcrowding and poor ventilation, which contribute to a range of negative health outcomes. Overcrowded homes facilitate the spread of infectious diseases such as tuberculosis and respiratory infections, while inadequate ventilation leads to increased exposure to indoor air pollutants that exacerbate chronic respiratory conditions like asthma (Kolahdooz et al., 2017). Studies have documented that Indigenous populations living in these housing conditions experience higher rates of preventable illnesses, including acute lower respiratory infections and other chronic diseases (National Collaborating Centre for Indigenous Health, 2019a). Additionally, the stress and social impacts associated with inadequate and unsafe housing contribute to mental health challenges within these communities

(C. L. Reading & Wien, 2009). Therefore, improving housing quality for Indigenous peoples in Canada is essential to addressing health disparities and promoting well-being.

5.4 Food Security: Food sovereignty as a determinant of Indigenous health and well-being

Food security is fundamental to the physical, emotional, mental, and spiritual health and wellbeing of Indigenous Peoples. Traditional diets comprising protein-rich meats, fish, and locally gathered fruits and vegetables form an integral part of Indigenous food sovereignty - the right of Indigenous communities to control access to their traditional foods and food practices (Willows et al., 2012). Colonization severely disrupted Indigenous food systems through forced assimilation policies that banned cultural food practices, undermining food sovereignty and health outcomes (Power, 2008). In Canada, Indigenous food sovereignty is recognized as a justice movement and enshrined under Section 35 of the *Constitution Act* (The Constitution Act, 1982).

Food insecurity remains disproportionately high among Indigenous populations due to systemic inequities including poverty, geographic isolation, lack of access to traditional and culturally appropriate foods, and institutional racism (Li et al., 2022). The consequences of food insecurity include poor nutritional status, chronic disease risk, and reduced quality of life (Willows et al., 2012).

The necessity of culturally safe, nutritious foods is increasingly recognized as central to wholistic Indigenous health and wellbeing. Indigenous dietitians and community leaders emphasize the role of traditional foods within “Food as Medicine” frameworks that promote reconciliation and healing in health systems (Batal et al., 2021; Blanchet et al., 2020). Ensuring consistent access to culturally relevant foods is paramount to supporting food security and health equity among Indigenous Peoples.

5.4.1. Barriers to Accessing Adequate, Culturally Relevant Foods

Indigenous Peoples face numerous systemic barriers to accessing adequate, culturally relevant foods. Canadian food regulations often impose constraints on the use of traditional foods due to concerns about safety and traceability, which limits incorporation of these foods into institutional and community food programs (Bartlett et al., 2012). These restrictions hinder

Indigenous communities' ability to exercise food sovereignty and maintain cultural food practices.

Historical mistrust of institutions, rooted in colonial harms, further complicates access to food services (Browne et al., 2021). While food banks and other emergency food programs provide some relief, they are often not culturally appropriate nor are preferred solutions to food insecurity among Indigenous Peoples (Gentle et al., 2015). Institutionalized food systems also tend to rely heavily on processed foods, which diverge from traditional diets that emphasize fresh, locally sourced, and minimally processed foods known for their health benefits (Power, 2008). This disconnect exacerbates nutrition-related health disparities.

5.4.2. Indigenous-Led Community Food Programs

Indigenous-led community food programs across Canada have successfully addressed food insecurity through approaches that respect and revitalize traditional food knowledge and practices. These programs prioritize Indigenous governance, Elders' involvement, and incorporation of traditional knowledge in food sourcing, preparation, and sharing (Gutierrez et al., 2023). They create culturally safe spaces and foster food sovereignty as a means to improve physical, mental and spiritual health.

Research guided by Walker et al.'s Traditional Healing, Medicines, Foods, and Supports framework highlights the value of programs that center Indigenous leadership, support language accessibility, promote traditional healing practices, and include traditional medicines and foods in community-based nutrition initiatives (Walker et al., 2013). These programs serve as important models for culturally grounded food security initiatives.

5.4.3. Food sovereignty as a positive determinant of health

Indigenous food sovereignty and security are critical determinants of health for Indigenous peoples in Canada, as they foster access to traditional, culturally significant foods that are nutrient-dense and contribute to both physical and mental well-being. Reclaiming control over food systems allows Indigenous communities to strengthen cultural identity, promote sustainable land stewardship, and counteract the adverse effects of colonization and industrial food systems, which have historically led to food insecurity and diet-related chronic diseases (Power, 2008; Truth and Reconciliation Commission of Canada, 2015a). Studies have shown that participation in traditional food practices improves diet quality, increases

physical activity, and supports social cohesion, all of which contribute to improved health outcomes including lower rates of diabetes and heart disease among Indigenous populations (Chan et al., 2019; Willows et al., 2012).

Indigenous food sovereignty supports mental health by reinforcing cultural connection and self-determination, which are factors deeply linked to overall wellness in Indigenous worldviews. The ability to harvest, prepare, and share traditional foods fosters intergenerational knowledge transfer and resilience, enhancing community well-being (Power, 2008). Canadian health policy frameworks increasingly recognize the importance of Indigenous food sovereignty in addressing health disparities, advocating for collaborative approaches that empower Indigenous governance over food systems (National Collaborating Centre for Indigenous Health, 2020). Ensuring Indigenous Peoples' access to their traditional food sources is thus not only a matter of food security but a pathway to healing and health equity rooted in Indigenous rights and cultural continuity.

5.5 Indigenous Languages: Language as a Determinant of Indigenous Peoples' Health and Wellness

Indigenous Peoples face systemic barriers rooted in jurisdictional fragmentation, racism, and cultural and linguistic exclusion (Greenwood et al., 2018; C. A. M. Richmond & Cook, 2016b; Sehgal et al., 2025). Historical colonial instruments such as the *Indian Act* and residential schools deliberately suppressed Indigenous languages, undermining identity and health across generations (Khawaja, 2021; Kim, 2019b).

Indigenous language proficiency is intrinsically linked to health and well-being among Indigenous Peoples in Canada. Knowledge and use of Indigenous languages support spiritual balance, cultural continuity, and overall wellness (Catherine et al., 2025; Harding et al., 2024). Language vitality correlates positively with improved mental health, stronger community cohesion, and greater self-determination over health (Harding et al., 2024; Khawaja, 2021; Whalen et al., 2022). Conversely, language loss is associated with poor health outcomes and perpetuates intergenerational trauma caused by colonial policies (Khawaja, 2021; Kim, 2019b; C. A. M. Richmond & Cook, 2016b). Indigenous languages are foundational determinants of health, intertwined with broader social determinants including education, employment, and social inclusion.

5.5.1 Language as a Barrier to the Highest Attainable Health

Language discordance between patients and healthcare providers remains a significant barrier to health, contributing to poorer health outcomes such as higher hospital readmission rates and decreased patient satisfaction. Language proficiency alone does not guarantee culturally safe care, as patients with limited English skills often still face discrimination and bias within healthcare settings (Williams et al., 2019). Language barriers intersect with experiences of racism and discrimination, compounding health inequities for minority populations despite their language abilities (Ron Hays et al., 2006; Williams et al., 2019).

This underscores the need for healthcare systems to integrate both language access and broader cultural competence initiatives to reduce disparities effectively (Truong et al., 2014). Recognizing language as a key social determinant of health, major health organizations advocate for integrated approaches that combine language services with broader cultural competence to advance health equity (Marmot, 2020).

5.5.2 Indigenous Language as a Right in UNDRIP and Canadian Law

Indigenous language rights are affirmed in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and recognized as essential to reconciliation and Indigenous self-determination in Canadian law (Qechai, 2022; C. A. M. Richmond & Cook, 2016b; United Nations, 2007b). The *Canadian Indigenous Languages Act* (Government of Canada, 2019)(ILA, 2019) is the first federal statute to declare Indigenous languages as fundamental to Canadian society and commit to their revitalization, maintenance, and strengthening (Qechai, 2022; Selinger, 2022). The Act grounds language rights within broader Indigenous rights frameworks, moving toward enforceable obligations for Indigenous-language access in health and social services.

5.5.3 Language Revitalization and positive impacts on Indigenous health and well-being

Indigenous language revitalization is increasingly recognized as a positive determinant of health for Indigenous peoples in Canada. Language serves as a core component of cultural identity, linking individuals to ancestral knowledge, traditions, and community. The revitalization and maintenance of Indigenous languages have been associated with improvements in

mental, emotional, social, and spiritual well-being, which are essential dimensions of health within Indigenous worldviews.

Reclaiming and using Indigenous languages helps strengthen cultural identity and self-esteem. Language embodies unique worldviews, values, and practices; thus, reconnecting with one's language fosters cultural pride and a sense of belonging. These factors act as protective mechanisms against psychological difficulties such as depression and substance abuse(Chandler & Lalonde, 1998). Language revitalization promotes social cohesion and community resilience since the transmission of language often involves intergenerational interaction between elders and youth. These connections fortify family ties and community bonds, reduce social isolation, and contribute to collective resilience (McIvor et al., 2009).

Beyond social benefits, Indigenous language is integral to wholistic health concepts, encompassing physical, mental, emotional, and spiritual dimensions. Language is the means through which traditional ceremonies, healing practices, and knowledge are expressed and preserved, which supports overall well-being (First Nations Health Authority, 2026). The protective role of language is further underscored by evidence suggesting that communities with higher levels of Indigenous language speakers experience lower youth suicide rates, illustrating how language maintenance can help address health inequities faced by Indigenous populations (Chandler & Lalonde, 1998). By reinforcing cultural identity, enhancing community connections, and sustaining wholistic understandings of well-being, language revitalization serves as a culturally grounded and effective health determinant.

5.6 Education: Education as a determinant of Indigenous Peoples' health

Education plays a critical role in shaping the health and well-being of Indigenous Peoples in Canada. Systemic barriers rooted in colonial histories, ongoing racism, underfunded schooling, and limited access to culturally relevant curricula contribute to lower educational attainment compared to non-Indigenous populations (Allan & Smylie, 2015; Truth and Reconciliation Commission of Canada, 2015a). This educational gap adversely affects employment opportunities, income security, and access to health resources, perpetuating cycles of poverty and health inequities such

as higher rates of chronic disease and mental health challenges (Indigenous Services Canada, 2023b; Kirmayer et al., 2011; C. Reading & Wein, 2009).

Indigenous-led health education is increasingly recognized as a crucial strategy for addressing these disparities and advancing reconciliation in health systems. Indigenous communities directing the training of health professionals to ensure curricula reflect Indigenous worldviews, languages, and cultural practices is important (Cass, 2025). Education programs with this in mind have the potential to not only increase Indigenous representation within the health workforce but also foster culturally safe care that builds trust and improves service access in Indigenous communities.

Despite longstanding calls to action from the TRC Calls to Action 23 and 24, which call for increased Indigenous health professionals and mandatory Indigenous health education, progress remains uneven and insufficient (Cass, 2025; Truth and Reconciliation Commission of Canada, 2015b).

Indigenous learners face multi-layered challenges including financial constraints, inadequate preparation from under-resourced primary and secondary schools, and experiences of racism and isolation within post-secondary professional programs. Evidence indicates that health professionals trained in rural or remote Indigenous settings are more likely to serve those communities, highlighting the value of localized, community-driven educational pathways (Cass, 2025; Indigenous Services Canada, 2023b).

To achieve genuine reconciliation and health equity, policies must prioritize sustainable investments in Indigenous-led education initiatives that are fully resourced and embedded within Indigenous governance frameworks. Such commitment supports Indigenous self-determination, enhances cultural safety in health care delivery, and strengthens the Indigenous health workforce to meet the unique needs of Indigenous populations across Canada.

6. Promising Frameworks and Solutions

This section highlights promising frameworks and solutions that are reshaping approaches to Indigenous health in Canada. These models emphasize self-determination, the importance of restoring community-led governance in health systems, culturally grounded care, and the need for improved data, education and accountability. Together, they offer pathways for more equitable, responsive, and sustainable improvements in health and wellbeing for First Nations, Inuit, and Métis communities. determination, the importance of restoring community-led governance in health systems,

6.1 Indigenous Rights Based Framework: Self-determination & Indigenous Jurisdiction Over Health

Centering Indigenous self-governance and authority is fundamental to a rights-based approach to transforming health systems and supporting wellness. There needs to be a shift away from health systems that prioritize consultation with Indigenous Peoples to health systems that ensure Indigenous-led decision making and governance are well established. This can be accomplished by supporting and encouraging more Indigenous-controlled health authorities such as the First Nations Health Authority model. This model demonstrates how authority and resources can be successfully transferred to an Indigenous governed system while maintaining coordination across jurisdictions.

In addition to Indigenous-led decision making and governance, there must be a transition from colonial control in the areas of primary care, public health and health sciences training and education. Under Canadian law and international commitments including negotiated education jurisdiction agreements and the United Nations Declaration on the Rights of Indigenous Peoples Act, Indigenous Peoples have the legal right to define and govern their own education systems in accordance with their cultures, languages, and priorities. However, the absence of a nationwide, sustainable funding framework aligned with this right continues to constrain its full and effective realization. This shift will require co-developed legislation supporting Indigenous governments to set their own standards and deliver more comprehensive and culturally safe services (Smith et al., 2008)(Smith et al.,

2008). For example, federal legislation such as the Indian Act respecting First Nations, Inuit and Métis children, youth and families, though focused on child and family services, offers a legislative model for recognizing Indigenous jurisdiction that could inform future health policy.

Collectively, these frameworks highlight that self-determination is a key determinant of the health of Indigenous Peoples and that jurisdictional reform is essential to close equity gaps (Truth and Reconciliation Commission of Canada, 2015a; United Nations General Assembly, 2007b).

6.2 Alignment with UNDRIP and Truth and Reconciliation Commission (TRC) Calls to Action

Greater self-determination also aligns with the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP),* particularly Articles 3, 18, 21, 23, and 24, which address matters of health, education, culture, and jurisdiction. These articles affirm Indigenous Peoples' rights to self-governance, participation in decision-making, socioeconomic development, and equitable access to traditional medicines and health services without discrimination (United Nations, 2007b).

It has been over a decade since the TRC's Calls to Action were released, including Calls 18–24, which set out clear responsibilities for governments and institutions to eliminate health disparities, integrate Indigenous healing practices, strengthen Indigenous representation in health professions, and implement antiracism education across the health system (Truth and Reconciliation Commission of Canada, 2015b). These Calls were created for immediate implementation, and to provide a concrete roadmap for reforming curricula, regulation, and accountability structures in support of reconciliation. Complementing this, the National Inquiry into Missing and Murdered Indigenous Women and Girls calls for decolonized, culturally safe service systems that address gendered and racialized violence, further underscoring the need for Indigenous-led approaches across health and social sectors (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a).

TRC Calls to Action 23 & 24 emphasize:

- Increasing and retaining Indigenous healthcare professionals;

- Providing cultural competency training for all providers, and

- Requiring mandatory education on Indigenous health, the history and legacy of residential schools, Treaties, UNDRIP, and Indigenous healing practices, including skills-based training in antiracism, intercultural competency, conflict resolution, and human rights. based training in antiracism, intercultural competency, conflict resolution, and human rights.

Despite clear directives and over a decade of opportunity since the release of the TRC's Calls to Action (18–24) and the recommendations of the National Inquiry into Missing and Murdered Indigenous Women and Girls, progress on implementation has been unacceptably slow and insufficient. The health disparities, systemic racism, and lack of Indigenous representation these Calls seek to address largely persist, reflecting a failure to fully commit to the transformative reforms necessary for reconciliation. Immediate and sustained action remains essential to embed Indigenous healing, culturally safe care, and antiracist education throughout health systems, aligned with Indigenous leadership and accountability. Without urgent acceleration and genuine commitment, the promises of these landmark reports risk remaining unmet, perpetuating harm rather than fostering meaningful change.
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6.3 Culturally Safe and Anti Racist Health Care

6.3.1 Mandatory Anti Racism and Cultural Safety Training

Improving health outcomes for Indigenous Peoples requires a systemwide commitment to cultural safety and antiracism as core competencies for all health professionals and institutions (Canadian Indigenous Nurses Association, 2025; Canadian Institute for Health Information, 2021; Royal College of Physicians and Surgeons of Canada, 2021; The Association of Faculties of Medicine of Canada, 2020; Wilson et al., 2015). This must begin in health education programs and continue throughout professional practice, supported by mechanisms to ensure that these expectations are upheld for all licensed providers.

Findings from the *In Plain Sight* investigation in British Columbia demonstrated widespread Indigenous-specific racism and its impact on access, quality, safety, and health outcomes (Turpel-Lafond, 2020). This investigation affirmed the need for mandatory, competency-based training codesigned with Indigenous communities and linked to licensure and continuing professional development. Nationally, the MMIWG Calls for Justice reinforced the requirement for trauma informed, culturally safe services and equitable access to care, particularly for Indigenous women, girls, and 2SLGBTQQIA+ people (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a).

Curricular reform is central to addressing these gaps. Codeveloping health curricula with Indigenous Elders and Knowledge Holders ensures that learners receive meaningful education grounded in Indigenous worldviews and histories (McFadden et al., 2023; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; Truth and Reconciliation Commission of Canada, 2015a; United Nations, 2007a). For example, NOSM University and Toronto Metropolitan University have integrated longitudinal, community engaged, culturally safe learning across all four years of their undergraduate medical programs. This approach sets a critical precedent, suggesting that all schools of medicine and other health disciplines should adopt similar comprehensive and sustained curricula to effectively prepare health professionals to provide equitable, culturally safe care to Indigenous Peoples. Consistent with TRC Calls to Action 23 and 24, expanding and supporting Indigenous medical and nursing professionals is essential to

transforming health systems (Truth and Reconciliation Commission of Canada, 2015b).

System level change depends on Indigenous leadership in governance including representation on boards, executive teams, and regulatory bodies supported by strong pathways for Indigenous learners and leaders across medicine, nursing, public health, and allied health professions (Royal College of Physicians and Surgeons of Canada, 2021; The Association of Faculties of Medicine of Canada, 2020). Sustained progress requires comprehensive reform in health education. National standards now call for Indigenous health curricula that address the history and ongoing effects of colonization, treaty relationships, structural determinants of health, clinical antiracism, and community engaged learning across training programs (Canadian Indigenous Nurses Association, 2025; Royal College of Physicians and Surgeons of Canada, 2021; The Association of Faculties of Medicine of Canada, 2020). Strengthening recruitment, mentorship, and retention of Indigenous students within health professions is both an equity imperative and a strategy to improve care quality, and must be supported by safe, culturally grounded learning environments (The Association of Faculties of Medicine of Canada, 2020; Truth and Reconciliation Commission of Canada, 2015a).

6.3.2 Respect for Traditional Healing and Knowledge Systems

Strengthening Indigenous health also requires meaningful recognition of traditional practitioners, Elders, and Knowledge Keepers as integral to health service delivery. TRC Call to Action 22 states: "Healthcare systems must recognize the value of Indigenous healing practices and collaborate with Indigenous healers and Elders when requested by Indigenous patients"(Truth and Reconciliation Commission of Canada, 2015b).

Co-locating Indigenous midwives, healers, and counsellors within mainstream health centres is one effective approach (Canadian Institute for Health Information, 2025). Broader integration of land-based practices, ceremony, and Indigenous medicines supported by respectful protocols, Elder involvement, and community governance is consistent with TRC guidance and supported by a growing body of Indigenous health scholarship (Bartlett et al., 2012; Montour, 2000; National Collaborating Centre for Indigenous Health, 2019b; Reynolds Turton, 1997; Shrivastava et al., 2020; Truth and Reconciliation Commission of Canada, 2015a).

The burden of mental health challenges and intergenerational trauma on Indigenous individuals, families, and communities remains substantial. Growing evidence highlights the effectiveness of land-based healing, cultural approaches to wellness, and Indigenous-led mental health frameworks such as those advanced by the Thunderbird Partnership Foundation and the First Nations Health Authority as essential components of a comprehensive system (First Nations Health Authority, 2026; National Collaborating Centre for Indigenous Health, 2019b)(NCCIH, 2019; First Nations Health Authority, 2019). Ensuring meaningful progress across these areas requires aligning policies with UNDRIP, the TRC Calls to Action, OCAP®, Inuit and Métis ethical data principles, and co-governance models, creating a coherent, rights-based foundation for measurable improvements in Indigenous mental wellness.

Integration of traditional practitioners, Elders, and Knowledge Keepers into health systems must be deliberate, respectful, and non-tokenistic. Effective codesign requires Indigenous leadership from the earliest concept stages through implementation and evaluation, including shared decision making, clear benefit sharing agreements, and local hiring practices that embed Indigenous healers, midwives, and counsellors within interprofessional teams (National Collaborating Centre for Indigenous Health, 2019b; Ortiz et al., 2025b; Turpel-Lafond, 2020)(Turpel Lafond, 2020; NCCIH, 2019; Ortiz et al., 2025).

6.4 Data Sovereignty & Shared Accountability

6.4.1Indigenous Data Sovereignty

Indigenous data sovereignty is foundational to meaningful, evidence-informed, and community-led health system transformation (Paul, 2023)(Paul, 2023). The OCAP® principles: *Ownership, Control, Access, and Possession* establish the ethical and governance framework through which First Nations assert authority over all phases of data stewardship, including collection, linkage, analysis, interpretation, and dissemination (First Nations Information Governance Centre, 2014) (OCAP, 2014). Integrating OCAP® into health system planning ensures that data use aligns with Indigenous priorities and supports rights-based, transparent, and accountable decision-making (Konczi & Bill, 2024)(Konczi & Bill, 2024). Inuit and Métis Peoples have nuanced data sovereignty principles that should also be respected and applied when appropriate.

Policy frameworks should consist of co-governed data systems in which Indigenous Peoples or groups determine the indicators used to reflect wholistic and Indigenous understandings of wellness and to assess progress in areas such as anti-racism, reconciliation, and system performance (First Nations Information Governance Centre, 2014; National Collaborating Centre for Indigenous Health, 2019b; Paul, 2023; Stelkia et al., 2023)(FNIGC, 2014; NCCIH, 2019; Paul, 2023; Stelkia et al., 2023). This approach moves health measurement beyond traditionally narrow biomedical indicators and aligns surveillance and reporting processes with Indigenous-defined goals and values (Smylie & Firestone, 2015)(Smylie & Firestone, 2015).

As digital health systems continue to expand, robust data governance becomes increasingly critical (Konczi & Bill, 2024; Kukutai & Taylor, 2016)(Kukutai & Taylor, 2016; Konczi & Bill, 2024). While digital technologies offer opportunities to enhance access and coordination of care, failure to align these systems with OCAP® and individual community-specific protocols risks reinforcing surveillance, privacy violations, and inappropriate use of Indigenous data (First Nations Information Governance Centre, 2014; National Collaborating Centre for Indigenous Health, 2019b)(FNIGC, 2014; NCCIH, 2019). Clear and enforceable policy direction is required to ensure that digital health innovations strengthen rather than compromise Indigenous rights and data sovereignty.

6.4.2 Shared Accountability

Sustainable health system improvement depends on shared accountability mechanisms that formally embed Indigenous governance and Indigenous-defined measures of success (Canadian Institute for Health Information, 2025)(CIHI, 2025). Structures such as joint decision-making tables between Indigenous governments and health authorities, public reporting on equity and anti-racism outcomes, and performance metrics grounded in Indigenous worldviews provide concrete mechanisms for tracking progress and ensuring commitments translate into measurable change (National Collaborating Centre for Indigenous Health, 2019b; Truth and Reconciliation Commission of Canada, 2015a)(TRC, 2015; NCCIH, 2019).

Funding policies must actively support and reinforce these accountability structures. Financial models should incentivize culturally safe, community-led service innovations and address longstanding jurisdictional inequities identified through Jordan's Principle and related human rights decisions (Canadian Human Rights Tribunal, 2016; National Collaborating Centre for Indigenous Health, 2019b)(Canadian Human Rights Tribunal, 2016; NCCIH, 2019). Aligning funding with Indigenous-determined priorities and rights-based standards is essential to achieving rights-based and equity-focused system reform and advancing both equity and quality across the health system.

7. Cross-Cutting Determinants and Emerging Issues

Root causes of Indigenous health inequities in Canada are inexplicably tied to anti-Indigenous racism. By examining how racism operates as a powerful determinant of health in its interpersonal, systemic, and internalized forms reveals individual, structural and healing-centred programs and services that required to address the health inequities experience by Indigenous Peoples. Solutions to improve health outcomes must embrace Indigenous self-determination, cultural revitalization, and institutional reforms grounded in reconciliation. Key recommendations from the Truth and Reconciliation Commission of Canada (TRC) Calls to Action along with strategies from seminal documents and frameworks can guide policymakers to advance Indigenous Peoples' health(Truth and Reconciliation Commission of Canada, 2015b).

7.1. Root Causes of Indigenous Peoples' Health Inequities

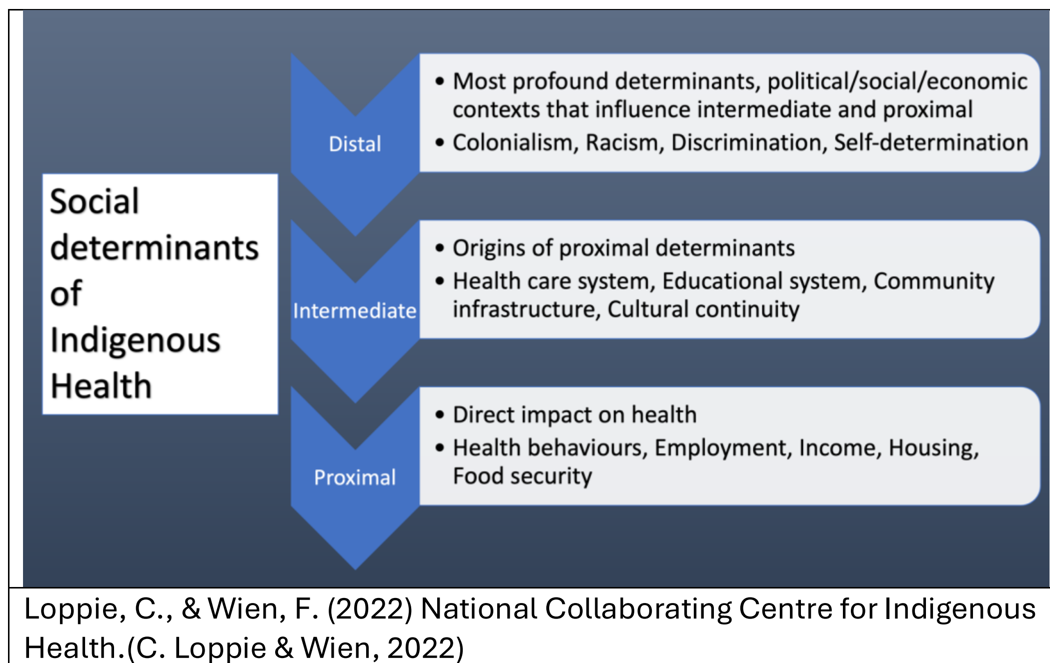
Indigenous health disparities as has been described earlier in this report, including higher rates of diabetes, suicide, infant mortality, and reduced life expectance, are often linked to social determinants such as food insecurity, poor housing, and limited access to bias-free healthcare. However, these proximal determinants reflect deeper, systemic colonial and racist structures impacting health (Czyzewski, 2011; C. Reading & Wein, 2009)(Reading & Wien, 2009; Czyzewski, 2011).

Colonialism established a Eurocentric worldview that has marginalized Indigenous epistemologies and imposed power over Indigenous Peoples and

their lands. The ongoing impacts of these colonial processes uniquely shape the Canadian context of Indigenous health inequity (Manuel & Derrickson, 2015)(Manuel & Derrickson, 2015).

Engaging openly with Canada's colonial history, while recognizing contradictory narratives and confronting discomfort, is essential for meaningful reconciliation and improved health outcomes (Truth and Reconciliation Commission of Canada, 2015a)(Truth and Reconciliation Commission of Canada [TRC], 2015).

Figure 2. Understanding Indigenous health inequalities through a social determinants model.



Loppie, C., & Wien, F. (2022) National Collaborating Centre for Indigenous Health.(C. Loppie & Wien, 2022)

7.2. Racism as a Powerful Determinant of Indigenous Health

Racism affects Indigenous health through multiple levels: interpersonal, systemic and internalized.

Interpersonal racism includes acts of discrimination or violence against Indigenous individuals. Systemic racism is embedded in institutions and policies across health, education, justice, and social services, restricting access and opportunities (Williams et al., 2019)(Williams, Lawrence, & Davis, 2019). Internalized racism results from colonization-induced assimilation, eroding cultural identity and contributing to adverse health

effects (Goodwill, 2016; Walters et al., 2011)(Goodwill, 2016; Walters, Mohammed, & Evans-Campbell, 2011).

Racist, sexist discourses foster internalized oppression and stigma, harming mental health and agency among Indigenous women, reinforced by cumulative adversity (Catherine et al., 2025; Johnson, 2020)(Johnson, 2020; Catherine et al., 2025). These intersecting forms perpetuate trauma and multigenerational health inequities. Nevertheless, Indigenous cultures provide resilience and healing through language, traditions, and identity critical protective determinants mitigating colonial harms (Chandler & Lalonde, 2008; Gone, 2013).

7.3 Intersectionality, race and gender and impacts on health

Indigenous women in Canada face profound health inequities fueled by violence, poverty, and systemic discrimination. Once regarded as influential leaders before colonization, they now face systemic marginalization that profoundly undermines their wellbeing (Olmstead, 2025; Weckman & Farrugia, 2025). The National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) reveals persistent gendered colonial violence and government failures to protect Indigenous women, girls, and Two-Spirit people (Johnson, 2020; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; Pabla, 2021; Rousseau, 2025). Indigenous women’s overrepresentation in prisons reflects intersecting criminalization and colonial control (McGuire & Murdoch, 2022).

Violence against Indigenous women is multifaceted, including sexual, psychological, spousal, and financial abuses exacerbated by racist stereotypes portraying them as “willing victims” (Johnson, 2020; Olmstead, 2025). Survivors seeking help from justice systems often face revictimization (Kaye & Glecia, 2025). Rooted in colonial dispossession and ongoing structural racism, poverty, food insecurity, and social exclusion contribute to chronic diseases and poor perceived health (Bacciaglia et al., 2023; Neufeld & Richmond, 2020).

Gender inequity compounds colonial harms. The MMIWG Final Report frames violence as gendered colonial violence perpetuated by institutions that individualize harm (Johnson, 2020; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a; Pabla, 2021). Within colonial systems, Indigenous women are racialized as less than human and criminalized, increasing vulnerability to violence and incarceration (McGuire & Murdoch, 2022; Olmstead, 2025).

Common present-day approaches to reproductive health vividly illustrates colonial gendered control. For example, coercive sterilizations and pressure toward contraceptive use or pregnancy termination have been documented (McKenzie et al., 2022). Indigenous pregnant women face more violence, food insecurity, inadequate prenatal care, and adverse birth outcomes, affecting intergenerational health (Bacciaglia et al., 2023; Catherine et al., 2025; Weckman & Farrugia, 2025), demonstrating how gender, colonialism, and Indigeneity intersect to shape health risks.

7.3.1 Healthy Indigenous Women, health families and communities

If Indigenous women in Canada were treated fairly and without discrimination, the overall health of Indigenous communities would greatly improve, as these women are vital to the social, cultural, and economic well-being of their nations. According to the Native Women's Association of Canada (NWAC, 2019), systemic discrimination and violence against Indigenous women contribute to poor health outcomes, including higher rates of chronic illness, mental health challenges, and limited access to quality healthcare(Native Women's Association of Canada). Fair treatment would empower Indigenous women to access equitable healthcare, education, and economic opportunities, thereby improving both their individual health and that of their families (NWAC, 2019). Moreover, Indigenous women are often knowledge keepers and caregivers within their communities, and when supported, they play a crucial role in strengthening cultural continuity and raising healthy future generations (Nelson & Wilson, 2018). Addressing discrimination against Indigenous women is therefore integral to breaking cycles of marginalization and improving social determinants of health, which in turn fosters greater community resilience and well-being overall(Assembly of First Nations, 2024). As such, advancing gender equity and eliminating discrimination against Indigenous women is essential for the health and vitality of Indigenous peoples across Canada.

7.4 Emerging issues

7.4.1 Climate change, environmental racism and solastalgia

The intersection of climate change, food sovereignty, and social and structural determinants are compounded to significantly and increasingly impact Indigenous health. Solastalgia describes the profound emotional or existential distress experienced when one's home environment is progressively degraded or altered (Albrecht et al., 2007). For Indigenous Peoples, whose cultural identity, health, and livelihoods are intimately tied to land and traditional food systems, solastalgia manifests deeply. The ongoing climate-related changes to land, water, and food resources

challenge Indigenous ways of knowing, connection to territory, and cultural continuity, amplifying mental health burdens alongside physical health inequities (Albrecht et al., 2007; Comtesse et al., 2021)

Environmental racism refers to the disproportionate exposure of Indigenous peoples and other marginalized communities to environmental hazards and pollutants due to systemic discrimination in environmental policy, regulation, and enforcement (Bullard, 2005; United Nations, 2020). This often results from the placement of toxic waste sites, polluting industries, and resource extraction projects on or near Indigenous lands, coupled with limited political power to oppose these decisions (Mohai et al., 2009).

Climate-Related Food Insecurity (CRFI) arises as climate change disrupts the availability, safety, and accessibility of traditional Indigenous food sources. This can occur through changing weather patterns leading to, for example, shorter ice cover on lakes, environmental degradation such polluted waters, or reduced wildlife populations and changing migration patterns. These stressors undermine Indigenous food sovereignty, defined as the right to access, control, and nurture traditional foodways, which are vital to community health and cultural survival (Kukutai & Taylor, 2016; Power, 2008).

Climate change compounds historic and ongoing colonial impacts that have restricted Indigenous access to traditional territories and imposed regulations on subsistence practices. This increases reliance on costly, often less nutritious market foods, fostering significant health inequities (Willows et al., 2012). Indigenous households, especially in the North, experience food insecurity at disproportionately high rates (up to 28% compared to 13% in non-Indigenous households) with associated chronic disease prevalence, mental health burdens, and increased healthcare costs (Power, 2008; Willows et al., 2012).

Contaminated environments have clear impacts on Indigenous Peoples' health through increased rates of respiratory diseases, cancers, waterborne illnesses, and other chronic health conditions linked to exposure to contaminated air, water, and soil (C. Reading & Wein, 2009; United Nations General Assembly, 2019). Environmental degradation also affects traditional food sources and cultural practices tied to the land, leading to physical, mental, and social health challenges and contributing to ongoing health disparities in Indigenous communities (C. Reading & Wien, 2009b).

Integration of climate, environment, and food policies is crucial to addressing these intersecting determinants of health. Supporting Indigenous leadership by providing stable funding and resources empowers community-based solutions (Power, 2008).

7.4.2 Changing demographics

Indigenous Peoples in Canada are experiencing significant demographic changes, including population growth, urbanization, shifts in age distribution, and evolving gender dynamics. These demographic transformations necessitate responsive adaptations in health policy and healthcare planning to meet emerging needs effectively and equitably.

According to the 2021 Canadian Census, the Indigenous population has grown substantially, outpacing the growth rate of the non-Indigenous population (Statistics Canada, 2022a). The population is also considerably younger; approximately 50% of Indigenous peoples are under the age of 25, compared to 27% of the non-Indigenous population (C. Reading & Wien, 2009b). Urbanization is increasing as more Indigenous peoples live in cities than on reserves (Anderson et al., 2016), complicating access to culturally safe health services traditionally geared toward rural or reserve communities.

Gender-specific care needs

Indigenous family and community structures are also evolving, with a growing emphasis on Métis and Inuit identities, whose health needs and service access differ from First Nations populations (Greenwood & de Leeuw, 2012). There are increasing recognition of Two-Spirit and non-binary identities requiring gender-affirming, safer care, which influences healthcare needs and service provision (Browne, Smye, et al., 2016).

As described earlier, gender plays a crucial role in shaping health outcomes among Indigenous peoples. Indigenous women face disproportionately higher rates of violence, chronic diseases, and mental health challenges compared to Indigenous men and non-Indigenous counterparts (Smylie et al., 2011). Indigenous gender-diverse individuals, including Two-Spirit people, often encounter compounded barriers related to stigma, discrimination, and limited culturally appropriate services (Ross et al., 2018). These intersecting identities must be considered in health policies to ensure inclusive, equitable healthcare access.

Gender influences health seeking behavior, with Indigenous women more likely to engage with healthcare services but also more vulnerable to systemic barriers including cultural insensitivity and racism within healthcare settings (Browne, Varcoe, et al., 2016). Health policies must explicitly address these gendered disparities, ensuring trauma-informed care and services that recognize and respect diverse gender identities.

These demographic and gender-related changes significantly impact health policy. The younger Indigenous population calls for enhanced youth-focused and preventive care, including mental health services tailored to address gender-specific risks and experiences (Kirmayer et al., 2021). Urbanization intensifies the need for accessible, culturally safe healthcare in cities, accounting for gender-specific barriers Indigenous peoples might face in urban environments (C. A. Richmond & Ross, 2009).

The dual burden of communicable and chronic diseases in an aging but still relatively young population requires integrated health services that consider gendered patterns of illness and differing health priorities. Indigenous self-determination and data sovereignty remain vital as they enable collection and use of disaggregated data to identify and respond to gender-specific health needs effectively (Smylie et al., 2019).

Healthcare planning must prioritize culturally safe and trauma-informed approaches that integrate Indigenous worldviews and respect diverse gender identities. Investments in Indigenous-led urban health centers are crucial for delivering tailored services that address urban Indigenous peoples' complex health needs, including supports specific to women, Two-Spirit, and gender-diverse individuals.

Youth engagement strategies must include frameworks that recognize the diversity of gender identities and experiences, promoting mental health resilience and leadership opportunities in health decision-making. Integrated, community-driven approaches that blend traditional Indigenous healing with Western medicine should also incorporate a gender lens, ensuring that health interventions are equitable and responsive.

The increasing number of Indigenous youth places education at the forefront of health and social policy considerations. Education is a key social determinant of health that influences employment opportunities, income, and health literacy, all of which are critical for long-term health outcomes (C.

Reading & Wien, 2009b). Improving access to culturally relevant, high-quality education that supports Indigenous languages, histories, and perspectives is essential. Strengthening education systems can empower Indigenous youth, improve mental and physical health outcomes, and address intergenerational health disparities (Greenwood & de Leeuw, 2012).

Enhancing Indigenous data infrastructure with a focus on disaggregated gender data will aid in identifying disparities and targeting interventions more effectively. Policies must also address systemic racism and gender-based violence as fundamental determinants influencing health outcomes.

The evolving demographics and gender dynamics of Indigenous peoples in Canada require health policies that are flexible, culturally grounded, and gender-responsive. Addressing the unique intersectional needs of Indigenous women, Two-Spirit, and gender-diverse peoples alongside broader population trends is essential for advancing health equity and Indigenous self-determination in healthcare planning and delivery.

8. Policy Synthesis and Recommendations

8.1 Policy Synthesis

Canada's obligations affecting Indigenous health arise first from treaty relationships and constitutional recognition and affirmation of 'Aboriginal' and treaty rights (s.35), which together establish a nation-to-nation framework for responsibilities tied to wellbeing, lands, livelihoods, and mutual aid. In practice, however, the translation of these constitutional and treaty commitments into health governance and funding remains inconsistent across jurisdictions and populations, producing uneven access and accountability.

Internationally, UNDRIP affirms Indigenous Peoples' rights to the highest attainable standard of physical and mental health and to maintain traditional medicines and health practices (including access to health services without discrimination). Canada's United Nations Declaration on the Rights of Indigenous Peoples Act (UNDA) requires federal measures to advance consistency of Canadian law with UNDRIP and to develop/implement an

action plan, establishing a legislated platform for rights-implementation work that directly implicates health policy (United Nations Declaration on the Rights of Indigenous Peoples Act, 2021).

RCAP and the TRC provide the most widely accepted national reconciliation frameworks shaping Indigenous health policy discourse and expectations. The TRC Calls to Action explicitly call for systemic change in health systems (including recognition of Indigenous healing practices and measurable closing of health gaps). These frameworks are reflected in many federal/provincial strategies, but implementation is frequently partial, time-limited, and not consistently tied to enforceable governance transfer.

Canada Health Act (CHA): The CHA sets the conditions for provinces/territories to receive full federal cash contributions for insured health services, reinforcing the provincial/territorial role in “insured” care (physician/hospital). The CHA does not, however, resolve the jurisdictional complexities that often arise for First Nations and Inuit services (including on-reserve and remote delivery), nor does it establish Indigenous-specific governance or accountability mechanisms (Canada Health Act, 1985).

Indigenous Services Canada (ISC) health programming: ISC funds or directly provides health programs for First Nations and Inuit that supplement provincial/territorial insured services (e.g., primary care, health promotion, and other supports). This includes the Non-Insured Health Benefits (NIHB) program, which provides coverage for certain benefits not otherwise covered (e.g., drugs, dental/vision, medical supplies and equipment, mental health counselling, and medical transportation) for registered First Nations and recognized Inuit.

While NIHB is an essential access mechanism, it is policy-based, administratively complex, and shaped by eligibility categories that do not reflect the full scope of Indigenous rights-holders (Indigenous Services Canada, 2025).

Jordan's Principle functions as a critical rights-remedy mechanism aimed at ensuring substantively equal access to services for First Nations children and reducing harms caused by jurisdictional disputes and inequitable funding. The ongoing evolution of this area (including settlements and implementation milestones) illustrates both the magnitude of historic discrimination and the continuing need for enforceable, child-first approaches in health and social services. Notably, there is ongoing ligation as of the publication of this paper, with Indigenous rights-holders challenging the government's gross delays in addressing thousands of Jordan's Principle claims (Sis-moqon, 2025).

Indigenous-led governance innovations provide proof-of-concept that structural change improves systems. The BC First Nations health governance arrangement formalized through the Tripartite Framework Agreement is a leading example of shifting planning, design, and delivery toward First Nations governance and partnership accountability (First Nations Health Authority, 2026).

8.2 Policy gaps and structural issues

Rights–implementation gap: Canada has strong normative frameworks (RCAP, TRC, UNDRIP) and constitutional recognition, but health policy is still frequently executed through discretionary programs rather than enforceable rights and reciprocal obligations.

Jurisdictional fragmentation and accountability diffusion: The division of powers and multi-order governance can produce "no-wrong-door" rhetoric without "no-denial" reality, particularly for remote communities and for services that sit between health, social, and educational domains (where Jordan's Principle has become necessary as a corrective).

Eligibility and inequity-by-design: Many federal programs are tied to specific legal/administrative categories (e.g., NIHB eligibility), which can exclude or complicate access for Métis, non-status, and urban Indigenous populations, despite rights frameworks that recognize Indigenous peoples more broadly.

Cultural safety and racism not consistently treated as a quality-and-safety issue: While cultural safety is widely referenced, it is not uniformly embedded as a regulated quality standard with clear accountability, resourcing, workforce supports, and measurement. It should be noted, however, that both Ontario Health and the Standards Council of Canada are currently drafting Cultural Safety Quality Standards (Standards Council of Canada, 2024)

Data sovereignty and meaningful measurement: Indigenous governance over health data, performance measurement, and evaluation remains uneven; without Indigenous-defined indicators and OCAP®, Métis and Inuit data collection ethics-aligned approaches, reporting can reproduce deficit narratives and weaken community control of solutions.

Short-term funding and projectization: Many promising initiatives rely on proposal-based, time-limited funding that undermines continuity, workforce stability, and long-term planning.

8.3 General Recommendations

1. Implement recommendations from landmark reports previously released

Extensive inquiry and Indigenous community leadership have already produced a clear path forward. Foundational frameworks including the Truth and Reconciliation Commission's *Calls to Action*, the First Nations' Health Authority's *In Plain Sight* report, and the National Inquiry into Missing and Murdered Indigenous Women and Girls' *Calls to Justice* set out concrete obligations grounded in rights, safety, and self-determination (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019b; The Truth and Reconciliation Commission of Canada, 2015a; Turpel-Lafond, 2020)

The policy gap is not a lack of recommendations, but in the lack of implementation of the existing recommendations. Governments must act in partnership with Indigenous Peoples, supported by distinctions-based sustainable funding, transparent accountability, and regular public reporting on progress, and implement the recommendations already made.

2. Move from "program-based" to "rights-implemented" health policy

Use the UNDRIP Act as a practical lever to align federal health laws/policies with UNDRIP's health-related rights (including traditional medicines and non-discriminatory access to care), with transparent targets and timelines for reform, and consequences of Indigenous-defined targets are not met.

3. Co-develop distinctions-based Indigenous health legislation with enforceable commitments

Prioritize legislation (or binding intergovernmental accords) that clarifies roles of Indigenous leadership and government partners, secures stable funding, and recognizes Indigenous jurisdiction in health, consistent with section 35 of the Constitution Act and UNDRIP.

4. Scale up Indigenous governance transfer and Indigenous-led health authorities

Treat Indigenous-led governance models (e.g., BC tripartite health governance and other models) as evidence-informed system reforms, not pilot projects. Support regional Indigenous governance capacity through accountability agreements and stable financing.

5. Embed cultural safety and anti-racism as core patient-safety standards

Require health systems to implement Indigenous-led cultural safety standards, complaint pathways, and workforce supports. Link compliance to accreditation, funding, and executive accountability.

6. Make "no denial of services" operational across the lifespan

Strengthen and broaden the practical effect of Jordan's Principle by ensuring timely access to medically necessary and wellness-supporting services without jurisdictional delays, while simultaneously reducing reliance on case-by-case remedies by fixing upstream structural funding inequities including differences in access for Métis and non-status First Nations children.

7. Modernize NIHB through equity, access, and administrative justice

Simplify processes, strengthen appeal and navigation supports, and ensure coverage aligns with contemporary standards of care (including mental wellness supports and medical transportation realities), while co-developing governance reforms to reflect Indigenous authority and lived access barriers.

8. Advance Indigenous data sovereignty and Indigenous-defined measures of wellness

Invest in Indigenous-led data infrastructure, community-defined indicators, and governance that supports OCAP®-aligned, Inuit and Métis-led data governance principles. Ensure evaluation frameworks elevate protective factors (language, land, kinship, cultural continuity) alongside clinical measures.

9. Shift investment toward prevention, land-based and cultural continuity interventions, and community capacity

Scale up what Indigenous communities have already demonstrated works: culturally grounded maternal-child health, chronic disease prevention, and land- and culture-based mental wellness strategies funded sustainably, not as short-term projects.

Table 1: Priority actions, supporting evidence, responsible parties, indicators of progress, and indicative timelines

Recommendation (from 8.3)	Evidence Base	Primary Responsible Parties	Key Indicators	Timeline
Implement UNDRIP-aligned, rights-based health policy	UNDRIP Articles 23–24; TRC Calls 18–24; RCAP	Federal government; Indigenous governments; PT governments	UNDRIP action plan health targets met; legislation/policies amended for consistency	Short–medium (1–3 yrs)
Co-develop distinctions-based Indigenous health legislation	Section 35 jurisprudence; FNHA tripartite agreements	Indigenous governments; Canada; PT governments	Legislation enacted; stable funding agreements; governance transfer milestones	Medium (3–5 yrs)
Scale Indigenous-led health authorities and governance models	FNHA evaluations; Tui'kn Partnership; international Indigenous governance literature	Indigenous governments; Canada; PT governments	Number of Indigenous-led authorities; service integration measures; patient-reported trust	Medium (3–5 yrs)
Embed cultural safety as a regulated quality and safety standard	TRC Calls 19–24; anti-Indigenous racism literature	PT health ministries; regulators; accreditation bodies	Cultural safety standards adopted; complaints resolved; workforce training completion	Short–medium (1–3 yrs)
Operationalize "no denial of services" across the lifespan	Jordan's Principle; CHRT decisions	Canada; PT governments; Indigenous governments	Reduction in service delays; decline in JP claims over time	Short (1–2 yrs)
Modernize NIHB for equity and access	Auditor General reports; access-to-care studies	Indigenous Services Canada; Indigenous partners	Approval times; appeals outcomes; client satisfaction	Short–medium (1–3 yrs)
Advance Indigenous data sovereignty	OCAP®; Inuit and Métis data governance frameworks	Indigenous governments; data stewards; health systems	Indigenous-governed data agreements; Indigenous-defined indicators	Medium (3–5 yrs)
Sustain prevention, land-based, and cultural continuity investments	Determinants-of-health literature; land-based healing evidence	Indigenous governments; funders	Stable multi-year funding; wellness indicators; youth engagement	Medium–long (5+ yrs)

8.4 Systems-Level Recommendations: From Commitment to Action

Translating rights-based commitments into improved health outcomes requires deliberate system-level implementation strategies, shared accountability, and transparent monitoring. Building directly on the recommendations outlined in Section 8.3, Table 1 identifies priority actions, supporting evidence, responsible parties, indicators of progress, and indicative timelines. The table is intended as a practical policy tool to support coordinated action across jurisdictions while respecting Indigenous governance and distinctions-based approaches.

8.5 Mechanisms for Implementation and Monitoring

Effective implementation requires moving beyond aspirational commitments toward enforceable, transparent, and Indigenous-defined accountability mechanisms. A core strength of Indigenous-led systems is their emphasis on relational accountability—answering not only to institutions, but to communities, future generations, and the land.

Key mechanisms for implementation and monitoring should include:

1.Indigenous-defined indicators of success

Monitoring frameworks must prioritize Indigenous conceptions of wellness, including cultural continuity, language revitalization, land-based relationships, community safety, and trust in services, alongside conventional clinical indicators. This shift counters deficit-based reporting and aligns evaluation with Indigenous values and priorities.

2. Public reporting tied to rights commitments

Federal, provincial, and territorial governments should report publicly and regularly on progress toward TRC, UNDRIP, and treaty-related health obligations, using Indigenous-defined metrics. Reporting should be transparent, accessible, and co-interpreted with Indigenous partners.

3.Independent Indigenous-led oversight

Indigenous-led oversight bodies—at national and regional levels—can play a critical role in monitoring implementation, identifying barriers, and recommending corrective action. Such bodies strengthen accountability while respecting Indigenous governance and legal orders. The authors recognize that this has been proposed before- notably, the National Council

for Reconciliation- however this Council, struck a decade after the TRC were published, has yet to produce any reporting (Government of Canada, 2025). We therefore recommend a structured reporting timeline be embedded in the terms of reference for such oversight bodies.

4. Long-term funding and policy stability

Short-term pilot funding undermines implementation and monitoring. Multi-year, predictable funding agreements are essential to support workforce stability, infrastructure development, and longitudinal evaluation.

8.6 Co-Development and Shared Accountability Frameworks

Co-development is not consultation; it is the shared exercise of authority. From an Indigenous policy perspective, meaningful co-development requires early, sustained, and resourced participation of Indigenous governments and organizations in agenda-setting, design, implementation, and evaluation.
Shared accountability frameworks should be grounded in the following principles:
1. Recognition of Indigenous jurisdiction and law, consistent with section 35 and UNDRIP
2. Distinctions-based approaches that reflect the unique rights, histories, and priorities of First Nations, Inuit, and Métis peoples
3. Reciprocal accountability, where governments are accountable to Indigenous partners for outcomes, not merely expenditures
4. Capacity resourcing, ensuring Indigenous governments have the infrastructure, data, and workforce needed to exercise authority effectively

Examples such as the FNHA and the Tui'kn Partnership demonstrate that when co-development is embedded in governance structures—rather than appended to programs—health systems become more equitable, responsive, and trusted. Scaling such approaches nationally represents one of the most promising pathways for advancing reconciliation in health.

9. Pathways for Policy Change

Advancing Indigenous health equity in Canada requires more than articulating principles or documenting disparities; it requires clear,

resourced, and enforceable pathways for policy change that are Indigenous-led and rights-anchored. Building on the systems-level recommendations outlined in Section 8, this section identifies practical pathways to embed Indigenous health priorities within national and provincial strategies, reform legislative and funding frameworks to enable Indigenous governance, foster novel partnership models, and support phased, sustainable implementation. Taken together, these pathways emphasize that reconciliation in health must be operationalized through governance, accountability, and long-term investment, rather than symbolic commitments or short-term programming.

9.1 Embedding Indigenous Health Priorities in National and Provincial Strategies

A foundational pathway for change lies in embedding Indigenous health priorities explicitly and consistently within national and provincial/territorial health strategies. Despite repeated commitments under the Truth and Reconciliation Commission of Canada, the United Nations Declaration on the Rights of Indigenous Peoples, and the Royal Commission on Aboriginal Peoples, Indigenous health considerations remain unevenly integrated across health system planning, often treated as parallel or supplemental rather than core system responsibilities.

A strengths-based approach reframes Indigenous health not as a “special population” issue, but as a central indicator of health system performance, equity, and legitimacy. Embedding Indigenous priorities requires that national and provincial strategies explicitly articulate Indigenous-defined goals related to cultural safety, access, continuity of care, workforce development, and community wellness, with clear accountability for outcomes. This includes aligning population health targets with Indigenous conceptions of wellbeing, recognizing protective factors such as language, land, kinship, and cultural continuity alongside conventional clinical measures.

Importantly, embedding Indigenous priorities must be distinctions-based, recognizing the unique rights, governance structures, and priorities of First Nations, Inuit, and Métis peoples. A one-size-fits-all approach risks reproducing the very inequities these strategies seek to address. National frameworks should therefore establish enabling conditions such as rights recognition, funding commitments, and accountability mechanisms while

supporting Indigenous governments and organizations to define and operationalize priorities in their own contexts.

9.2 Legislative and Funding Reforms to Enable Indigenous Governance

Meaningful policy change in Indigenous health cannot occur without legislative and funding reforms that enable Indigenous governance. As outlined in Section 8, Canada's current approach remains heavily reliant on discretionary programs and contribution agreements, which constrain Indigenous authority, undermine long-term planning, and diffuse accountability. Moving toward rights-implemented health systems requires a shift from program-based funding to legislative and intergovernmental arrangements that recognize Indigenous jurisdiction and secure stable, predictable resources.

Legislative reform pathways may include distinctions-based Indigenous health legislation or binding intergovernmental accords that clarify roles and responsibilities across Indigenous, federal, and provincial/territorial governments. Such instruments should be grounded in section 35 of the Constitution Act, 1982 and aligned with Canada's obligations under UNDRIP, particularly the rights to self-determination and to design and deliver health programs according to Indigenous priorities. Importantly, legislative reform should be co-developed with Indigenous governments from the outset, with adequate resourcing to support participation, legal analysis, and implementation capacity.

Funding reform is equally critical. Multi-year, flexible funding arrangements that support Indigenous-led planning, workforce development, infrastructure, and evaluation are essential to moving beyond short-term pilots and projectization. Evidence from Indigenous-led governance models demonstrates that when funding aligns with Indigenous authority and accountability structures, health systems become more responsive, culturally safe, and effective. Reforming funding mechanisms is therefore not only a matter of equity, but of system efficiency and sustainability.

9.3 Novel Partnership Models: Academia, Health Institutions, and Indigenous Leadership

While Indigenous governance must remain central, partnerships with academia and health institutions can play an important supportive role when they are grounded in respect, reciprocity, and Indigenous leadership. Novel partnership models offer opportunities to strengthen policy implementation, workforce development, research, and evaluation provided they do not reproduce extractive or colonial dynamics.

Academic institutions, in particular, can contribute by aligning education, research, and service missions with Indigenous health priorities. This includes co-developing Indigenous-led research agendas, supporting Indigenous data sovereignty, and reforming health professions education to centre cultural safety, anti-racism, and Indigenous knowledges. Partnerships that embed Indigenous leadership within governance structures rather than relegating Indigenous partners to advisory roles are more likely to produce meaningful and lasting impact.

Similarly, partnerships with health institutions can support shared accountability for culturally safe care, quality improvement, and system transformation. Indigenous-led agreements with hospitals, health authorities, and regulatory bodies can establish expectations related to workforce training, complaint resolution, and service redesign. When aligned with Indigenous governance and oversight, such partnerships can accelerate change while reinforcing Indigenous authority rather than undermining it.

9.4 Roadmap for Phased Implementation

Given the scale and complexity of health system transformation, a phased approach to implementation is both pragmatic and necessary. A strengths-based roadmap recognizes that Indigenous communities and governments are already leading transformative work, and that policy change should build on existing successes while addressing structural barriers.

Phase 1: Foundation and Alignment (1–2 years)

This phase focuses on aligning policy commitments with rights frameworks and establishing enabling conditions. Key actions include embedding Indigenous health priorities in national and provincial strategies, initiating co-development processes for legislative and funding reform, and strengthening mechanisms for cultural safety and anti-racism as quality and safety standards.

Phase 2: Governance Transfer and Capacity Building (3–5 years)

The second phase emphasizes scaling Indigenous governance and building long-term capacity. This includes expanding Indigenous-led health authorities and governance arrangements, implementing reformed funding models, investing in Indigenous workforce development, and advancing Indigenous data governance and performance measurement systems.

Phase 3: Consolidation, Evaluation, and Renewal (5+ years)

The final phase focuses on consolidation and continuous improvement. Ongoing evaluation using Indigenous-defined indicators, transparent public reporting, and Indigenous-led oversight will support accountability and learning. This phase also creates space for renewal, ensuring that health systems continue to evolve in response to community priorities, demographic change, and emerging challenges such as climate impacts on health.

9.5 Toward Health Justice and Reconciliation in Practice

Taken together, these pathways for policy change affirm that advancing Indigenous health equity is both a justice imperative and a practical opportunity to strengthen health systems for all. Indigenous-led, rights-based approaches are not aspirational ideals; they are evidence-informed, operational, and already demonstrating impact across Canada. The challenge before policymakers is not a lack of guidance, but the need for sustained political will, shared accountability, and the courage to shift power, resources, and decision-making authority in ways that honour Indigenous rights and leadership.

10. Conclusion

Improving Indigenous health in Canada requires moving beyond program reform toward structural transformation grounded in rights, relationships, and responsibility. The evidence reviewed in this report demonstrates that inequities persist not because solutions are unknown, but because health systems remain organized around administrative control rather than Indigenous jurisdiction and partnership.

Reconciliation in health must therefore be operationalized through governance. Embedding Indigenous authority within legislation, funding arrangements, service design, and accountability mechanisms is essential to align health systems with treaty obligations, section 35 constitutional rights, and international human rights standards. This shift entails transferring decision-making authority, supporting Indigenous-governed institutions, and establishing reciprocal accountability between governments and Indigenous Nations.

Effective implementation requires sustainable funding pathways, transparent monitoring tied to rights commitments, Indigenous-defined indicators of wellness, and independent Indigenous-led oversight. These mechanisms ensure accountability not only to institutions but to communities, future generations, and the land.

The pathway forward is practical and achievable. Indigenous-led governance models, culturally grounded care, and community-controlled data systems are already improving outcomes across Canada. Scaling these approaches through sustained funding, legislative reform, and co-development can transform health systems for Indigenous Peoples and strengthen care for all.

Ultimately, advancing Indigenous health equity is both a legal obligation and a collective opportunity. When Indigenous rights guide policy, health systems become more humane, trusted, and effective. The task before governments and institutions is therefore not to design new solutions, but to honour existing commitments by aligning power, resources, and accountability with Indigenous leadership.

Only through this shift can Canada move from acknowledging inequity to achieving health justice.

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12. Appendices

Appendix A: Data tables by determinant

Table 1. Distal Determinants			
Determinant of Health	Description	Context / Notes from Document	System level of responsibility
Indigenous Self-Determination	The ability of Indigenous peoples to control their own governance, cultural expression, and health systems.	Emphasized as critical for health and wellness; linked to better health outcomes through empowerment.	Federal / Indigenous Governments
Legal and Policy Environment	Laws, policies, and jurisdiction related to Indigenous health and rights.	Calls for respecting treaties, implementing UNDRIP, and Indigenous participation in policy development.	Federal / Provincial / Territorial
Historical and Ongoing Trauma	Experiences of colonization, residential schools, systemic discrimination, and racism.	Trauma is a root cause of many health issues; healing and trauma-informed care are essential components.	Federal / Indigenous Governments
Environment and Land	Access to traditional lands, clean water, and a healthy environment.	Environmental stewardship linked to physical and spiritual wellbeing; land rights impact social determinants.	Federal / Indigenous Governments / Regional

Table 2. Intermediate Determinants			
Determinant of Health	Description	Context / Notes from Document	System level of responsibility
Access to Healthcare	Availability of culturally safe, accessible, and adequate health services in Indigenous communities.	Document highlights gaps and calls for improved Indigenous-led healthcare options.	Federal / Provincial / Territorial / Regional / Local
Socioeconomic Status	Income, employment, education levels, and housing conditions.	Poverty and poor housing are major contributors to health disparities in Indigenous communities.	Federal / Provincial / Territorial / Regional

Education	Quality and availability of educational opportunities that incorporate Indigenous knowledge.	Education disparities contribute to socioeconomic inequalities and impact health literacy.	Provincial/ Territorial/Local/ Indigenous Governments
Social Support and Community Networks	Family ties, community cohesion, and social networks.	Strong social support improves resilience and health outcomes; policies support strengthening these networks.	Local / Indigenous Governments

Table 3. Proximal Determinants			
Determinant of Health	Description	Context / Notes from Document	System level of responsibility
Mental Health and Wellness	Psychological well-being and access to mental health services.	Indigenous models of holistic health are stressed; integration of mental health into wellness approaches needed.	Provincial / Territorial / Regional / Local
Health Behaviors	Lifestyle choices influenced by social determinants including substance use and physical activity.	Addressed as outcomes rather than causes; supports needs culturally relevant prevention programs.	Local / Regional
Cultural Continuity and Identity	Maintaining Indigenous languages, traditions, and cultural practices.	Supports mental and emotional well-being; loss of culture linked to poor health outcomes.	Indigenous Governments / Local
Nutrition and Food Security	Access to traditional and nutritious food sources.	Food insecurity disproportionately affects Indigenous peoples; promoting traditional food systems recommended.	Federal / Local / Indigenous Governments
Housing Conditions	Adequate, safe, and culturally appropriate housing.	Overcrowding and poor housing quality in Indigenous communities contribute to infectious diseases and stress.	Federal / Provincial / Territorial / Regional

Appendix B: Indigenous-led program exemplars

Program / Initiative	Location / Population	Type of Intervention	Core Features	Documented Impact / Policy Relevance
First Nations Health Authority (FNHA)	British Columbia – First Nations communities	Indigenous-governed health authority	Transfer of federal health programs to First Nations governance; culturally grounded service delivery; community engagement	Improved trust, continuity of care, and coordination; demonstrates structural reconciliation through governance reform
Nishnawbe Aski Nation (NAN) Mental Wellness & Land-Based Programs	Northern Ontario remote communities	Community-led mental health & crisis response	Land-based healing, Indigenous mental wellness teams, youth-engaged approaches	Increased engagement and cultural safety; reframes wellness as land- and relationship-based
Tui'kn Partnership	Mi'kmaq communities, Nova Scotia	Indigenous population health governance & data sovereignty	Community-controlled data; prevention planning; regional collaboration	Improved diabetes care, screening rates, and primary care access
Indigenous Patient Navigator roles	Multiple jurisdictions	Health system navigation support	Guides patients through fragmented systems; reduces bureaucratic barriers	Improves access and continuity but uneven availability highlights policy gap
Indigenous Midwifery & Maternal Health Models	Community-based programs across Canada	Holistic perinatal care	Integrates family support, ceremony, and cultural practice	Builds trust and improves maternal-child outcomes
Land-based Healing Programs	Multiple First Nations and urban programs	Mental health and trauma recovery	Culture-based wellness, connection to land and identity	Effective for intergenerational trauma and engagement

Thunderbird Partnership Foundation Mental Wellness Frameworks	National Indigenous mental wellness initiatives	Community-driven mental health frameworks	Culture-centred treatment, ceremony, community authority	Supports comprehensive Indigenous mental wellness systems
Indigenous-Governed Housing & Supportive Housing Models	Urban and northern Indigenous communities	Housing as health intervention	Cultural programming, trauma-informed supports, community governance	Addresses homelessness as multidimensional disconnection

Appendix C: Policy scan by jurisdiction

Jurisdiction	Policy/Initiative	Key Date (Year)
Federal (Canada)	Indigenous Services Canada Act	2019
Federal (Canada)	Indigenous Health Legislation Bill (proposed)	2023
Federal (Canada)	Jordan's Principle Implementation	2007
Federal (Canada)	First Nations Health Authority (collaboration)	2011
British Columbia (BC)	Establishment of First Nations Health Authority	2013
British Columbia (BC)	BC Tripartite Framework Agreement	2011
Alberta	Alberta Indigenous Health and Wellness Strategy	2015
Alberta	Métis Nation of Alberta Health Services Agreement	2014
Saskatchewan	First Nations and Métis Health Governance Agreements	2016
Saskatchewan	Treaty 6, 7, 8 Health Initiatives	2010
Manitoba	Manitoba Indigenous Health Strategy	2017
Manitoba	Manitoba Keewatinowi Okimakanak Health Authority	2018
Ontario	Ontario Indigenous Health Access Fund	2014
Ontario	Ontario Indigenous Healing and Wellness Strategy	2018
Quebec	Quebec Indigenous Health Action Plan	2015
Quebec	Collaboration with Cree and Inuit Health Boards	2013
New Brunswick	Indigenous Health and Wellness Strategy	2016
New Brunswick	Mi'kmaq Health and Wellness Agreements	2012
Nova Scotia	Indigenous Health Strategy	2017
Nova Scotia	Nova Scotia Mi'kmaq Health Framework	2013
Prince Edward Island	Indigenous Wellness Initiative	2014
Newfoundland and Labrador	Inuit Health Advisory Committee Initiatives	2015
Northwest Territories	Devolution of Health Services to Indigenous Governments	2014
Northwest Territories	Indigenous Wellness Strategy	2016
Yukon	Yukon First Nations Health Partnership Agreement	2015
Yukon	Yukon Indigenous Health Framework	2017

Nunavut	Nunavut Inuit Health Strategy	2012

Appendix D: TRC and UNDRIP alignment matrix

TRC Calls to Action Number & Summary	Corresponding UNDRIP Article Number & Summary	Alignment / Notes
18. Governments must formally acknowledge that Indigenous health inequities stem from colonial policies, including residential schools, and uphold Indigenous health-care rights as protected in international law, the Constitution, and Treaties.	**Article 24** – Affirms Indigenous peoples' right to traditional medicines and to the highest attainable standard of physical and mental health and obligates states to take necessary steps to achieve this right.	Both emphasize respecting Indigenous health traditions and reinforcing state responsibility and Indigenous authority in health systems.
19. The federal government, in partnership with Indigenous peoples, must set measurable targets to close health outcome gaps and publicly report annually on progress across key health indicators.	**Article 21:** Indigenous peoples have the right to improvement of their economic and social conditions, including clean water and sanitation.	Both align on delivering equitable health care that is sensitive to cultural needs and addresses disparities.
20. The federal government must resolve jurisdictional gaps by recognizing and addressing the distinct health needs of Métis, Inuit, and off-reserve Indigenous peoples.	**Article 21:** Indigenous peoples have the right to improvement of their economic and social conditions, including clean water and sanitation.	Both stress the importance of fundamental resources like clean water as a determinant of health.
21. The federal government must ensure sustained funding for Indigenous healing centres prioritizing Nunavut and the Northwest Territories to address the multi-dimensional harms of residential schools.	**Article 24:** Ensures Indigenous peoples' right to health services without discrimination, including culturally appropriate services.	Both align on delivering equitable health care that is sensitive to cultural needs and addresses disparities.
22. Integrate Aboriginal healing practices into healthcare with collaboration from Aboriginal healers and Elders upon patient request	**Article 24:** Recognizes Indigenous peoples' right to access traditional medicines and maintain health practices.	Both stress the incorporation of Indigenous healing practices in healthcare systems in partnership with Indigenous knowledge holders.
23. Governments should increase and retain Aboriginal healthcare professionals and provide cultural competency training for all healthcare workers	**Article 24**: The article affirms Indigenous peoples' rights to traditional medicines, equal access to non-discriminatory health and social services, and the highest attainable standard of physical and mental	Both affirm Indigenous self-determination and align on delivering equitable health care that is sensitive to cultural needs and addresses disparities.

	health, with states responsible for ensuring these rights.	
24. This call aims to ensure that healthcare professionals are educated about Indigenous Peoples' history, rights, and health needs to provide culturally safe care.	**Article 24:** The article affirms Indigenous peoples' rights to traditional medicines, equal access to non-discriminatory health and social services, and the highest attainable standard of physical and mental health, with states responsible for ensuring these rights.	Both affirm Indigenous self-determination and participation in all health-related research and programs.