

Advancing Health Equity Through Indigenous Health Education: Gaps in Implementation and Accountability in Canada

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ABSTRACT

Indigenous peoples in Canada experience persistent health inequities driven by colonial legacies and systemic barriers. The Truth and Reconciliation Commission's Call to Action #24 calls on medical schools to integrate Indigenous health, cultural safety, and anti-racism into curricula. We conducted a scoping review to examine how Canadian undergraduate medical education has responded since 2015. MEDLINE, Scopus, and Informat were searched from inception to March 2026. Data were extracted and analyzed using qualitative thematic synthesis, guided by cultural safety and decolonizing frameworks. Nine peer-reviewed studies met inclusion criteria, with gray literature used for contextualization. Three key themes emerged: (1) structural integration supported by institutional commitment and longitudinal curriculum design; (2) a shift from cultural competence toward cultural safety, emphasizing reflexivity, power awareness, and anti-racism; and (3) community-engaged experiential learning grounded in relational and decolonizing approaches. Canadian undergraduate medical education has made progress in integrating Indigenous health, but efforts remain uneven. The primary challenge is not the absence of Indigenous health content, but gaps between implementation and institutional accountability. These findings have implications beyond medical education, as gaps in training may contribute to persistent inequities in healthcare delivery and outcomes for Indigenous populations, with relevance to other settler-colonial and global health contexts.

Keywords: Indigenous Health, Medical Education, Reconciliation, Decolonization, Cultural Competence

Background

The term "Indigenous" refers to the original inhabitants of present-day Canada, including First Nations, Inuit and Métis Peoples. The terms "First Nations," "Inuit," and "Métis" will be used when referring to specific Indigenous groups whenever relevant. Indigenous groups in Canada (First Nations, Inuit, and Métis) comprise about 5% of the nation's population and embody a variety of histories, languages, and transitions [1].

Unfortunately, Indigenous cultures have been fragmented because of colonial legacies, which are rooted in systemic inequalities and continually reinforced. Policies like the residential school

system, which aimed to assimilate Indigenous children by erasing their cultural identities, have created intergenerational trauma and mistrust that continues to disproportionately impact Indigenous peoples today. The interplay between historical injustices, accessibility barriers in Indigenous communities, and deep-seated mistrust have led to a widespread misunderstanding of Indigenous health and the perpetuation of negative stereotypes in society [2].

This impact continues to reverberate in the healthcare system, where Indigenous peoples face significant barriers to accessing quality and culturally competent care. This is exemplified by the disproportionately high rates of chronic disease, cancer, and heart attacks/strokes among Indigenous peoples, driven by social determinants of health. These disparities are largely due to

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a limited understanding of their unique health needs, feelings of mistrust, and Indigenous peoples receiving culturally insensitive treatments [2,3].

Many past and current medical students have identified significant gaps in their training, including a lack of culturally sensitive curricula, implicit racial biases toward Indigenous peoples, and insufficient undergraduate medical education centered on Indigenous health. These shortcomings have often left medical students feeling unprepared to effectively address Indigenous health concerns. In response to this gap, medical institutions have begun to respond to the Truth and Reconciliation Commission of Canada's (TRC) Calls to Action (2015), which has been aimed at redressing the historical and ongoing impacts of residential schools on Indigenous peoples. Notably, Canadian institutions are responding to Call to Action #24, which says: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism [4-6].

With the release of the TRC's Calls to Action in 2015, many Canadian medical educational institutions made public commitments to address the lack of Indigenous education focus. As part of its commitment to social accountability, the Association of Faculties of Medicine of Canada (AFMC) released a report in 2020 which aimed to enhance these commitments by ensuring Canadian medical schools address reconciliation for the health and well-being of Indigenous peoples. Consequently, starting in 2019, the AFMC has developed the Joint Commitment to Action on Indigenous Health (JCAIH) reports by outlining the current faculty responses from 17 medical institutes across Canada. The JCAIH highlights the collective efforts to integrate Indigenous health issues into undergraduate and postgraduate medical programs through its recommendations for reconciliation practices [7,8].

This scoping review will examine how Canadian medical education has evolved in response to the TRC's Call to Action #24 (2015) with a particular focus on Indigenous competency and awareness. This review will identify trends in curricular changes, anti-racism training, and community-based learning experiences, highlighting how institutions have adapted to integrate Indigenous knowledge systems, appropriate healthcare practices, and accurate historical narratives into their programs. By examining the progress made in integrating Indigenous education, the review will also identify the gaps in current approaches, offering a critical lens on what still needs to be achieved for meaningful Indigenous reconciliation. This review contributes to a growing body of literature examining Indigenous health education and broader efforts to redress historical inequities.

Conceptual Framework

This review is informed by a conceptual framework grounded in cultural safety, anti-racism, and decolonizing approaches to medical education. Moving beyond earlier models of cultural

“competence,” which emphasize the acquisition of knowledge about Indigenous peoples, cultural safety reframes healthcare as a relational and power-conscious practice in which the quality of care is determined by those receiving it. This perspective emphasizes the role of structural inequities, colonial histories, and institutional power in shaping health outcomes, requiring learners and institutions to engage in ongoing critical self-reflection and systems-level change. In parallel, decolonizing approaches to education emphasize the importance of Indigenous knowledge systems, community authority, and relational accountability, challenging dominant Western epistemologies that have historically marginalized Indigenous perspectives. This framework guides both the synthesis and interpretation of findings, enabling a shift from descriptive mapping toward a more critical analysis of how Indigenous health is conceptualized and operationalized within Canadian medical education.

Methods

We conducted a comprehensive scoping review to map how Canadian medical schools have integrated Indigenous health content in response to the TRC's 2015 Calls to Action. We enhanced the original protocol with rigorous methodology and PRISMA-ScR reporting. The research question was framed to identify curriculum changes since 2015 aimed at promoting Indigenous health and cultural safety. Our analysis was guided by Indigenous frameworks: Two-Eyed Seeing to value both Indigenous and Western knowledges, the concept of cultural safety, and decolonizing principles [9-12].

Literature Search

A comprehensive literature search was conducted using COVID MEDLINE, Scopus and Informit, and gray literature. Databases were searched from their inceptions to March 2026. The search strategy aimed to identify relevant literature on the integration of Indigenous health in Canadian undergraduate medical education. The search strategy included terms ('Indigenous health' OR 'Aboriginal health' OR 'First Nations') AND ('medical education' OR 'undergraduate medical education') AND ('Canada'). This review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-ScR) guidelines [9].

Eligibility criteria

Studies were selected based on their relevance to the integration of Indigenous health education in Canadian medical curricula. Eligible studies were peer-reviewed, published in English, and focused on undergraduate medical education. The review considered a range of publication types, including qualitative studies, mixed-methods research, commentary pieces, and narrative reviews that addressed institutional strategies or programmatic initiatives. Titles/abstracts and full texts were screened independently by two reviewers. Discrepancies were resolved through discussion. From the selected articles, data was extracted into a structured data table documenting information on article publication date, medical school examined, curriculum changes, cultural competency, and training programs in Canadian medical schools. Data extraction included: year, institution, study design, curricular intervention, learning modality, and reported outcomes.

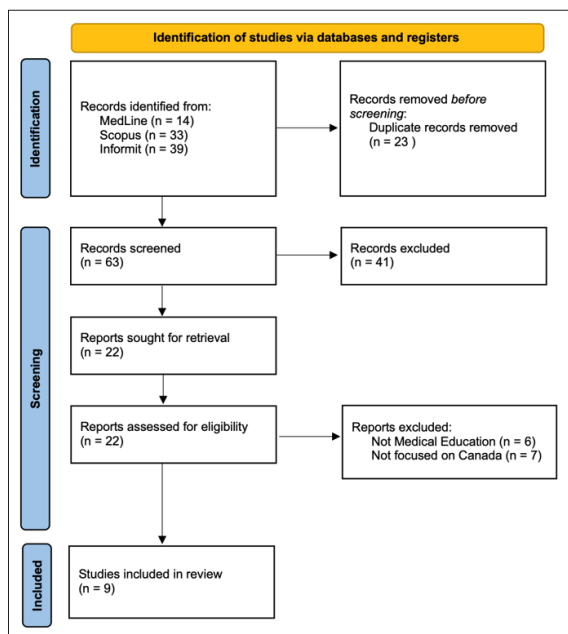


Figure 1: PRISMA Diagram

Data analysis

We conducted a qualitative thematic synthesis using Braun & Clarke's method. Two researchers immersed themselves in the data, coding excerpts iteratively. Initially, we generated open codes (e.g. "integrated Indigenous courses", "brief workshop", "student reflexivity", "community engagement", "cultural competence", "evaluation absent"). We then organized codes into categories and refined a codebook with definitions. We identified major themes by grouping related codes and contrasting patterns across studies [13].

Reflexivity

The review team included both Indigenous and non-Indigenous scholars and educators with experience in medical education, Indigenous health, and qualitative research. We recognize that our social locations, training, and relationships to the topic shape how evidence is interpreted and synthesized. Reflexivity was practiced throughout the review process. During study selection and data analysis, team members engaged in ongoing dialogue to critically examine how assumptions, prior knowledge, and disciplinary training influenced coding decisions and theme development. Differences in interpretation were discussed iteratively to ensure that themes did not reproduce deficit-based or overly descriptive narratives, and instead reflected structural and relational dimensions of Indigenous health education.

Results

A total of 86 articles were identified through the initial database search (MedLine: 14, Scopus: 33, Informat: 39). Following a detailed review, nine articles met the inclusion criteria and were selected for analysis. The PRISMA-ScR diagram (Figure 1) shows the literature selection process, including identification, screening, eligibility, and inclusion stages. Nine peer-reviewed studies formed the core analytic dataset; gray literature was used to contextualize findings. Three main themes emerged: 1) curriculum integration, 2) cultural safety and sensitivity, and 3) community-based experiential learning. Of the nine articles, five discussed recent changes to the curriculum at various institutions. Four articles focused on anti-racism initiatives, and three articles

highlighted community-based learning experiences. Findings were interpreted through a cultural safety and decolonizing lens, allowing us to move beyond descriptive mapping to examine how power, relationality, and institutional accountability were reflected in curricular approaches.

Theme 1: Structural Integration and Institutional Commitment

From a cultural safety and decolonizing perspective, integration extends beyond the inclusion of discrete content toward structurally embedding Indigenous health within institutional curricula and governance. Across the included studies, meaningful integration was described as a broader institutional commitment involving longitudinal curriculum design, leadership support, and alignment with accountability frameworks such as the Truth and Reconciliation Commission's Calls to Action and the AFMC Joint Commitment to Action on Indigenous Health. This shift reflects a growing recognition that Indigenous health education must be positioned as a core component of medical training, requiring sustained resourcing, faculty engagement, and mechanisms for ongoing evaluation and renewal.

In total, five articles had integration of Indigenous health/knowledge as a theme. These curricular reforms aim to promote culturally safe care by incorporating Indigenous perspectives into medical education and increasing learners' awareness of the social, historical, and structural determinants that shape Indigenous health outcomes. One notable example comes from the Northern Ontario School of Medicine (NOSM), whose approach allows 1st and 2nd year medical students to live and engage with rural and remote Indigenous communities, like Ojibway/Oji-Cree communities among others, before their clinical placements [14,15].

Shadowing local healthcare practitioners and interacting with community members offers students meaningful early exposure to the lived realities of Indigenous populations, including healthcare access challenges, geographic isolation, and the ongoing impacts of colonialism. For instance, this curriculum builds on experiential learning by incorporating traditional medicine and culturally specific healthcare practices, fostering empathy and enhancing the preparedness of medical students. The placements, which students can choose to complete in Indigenous communities, are designed to foster a deeper understanding of the systemic barriers faced by Indigenous peoples while building the foundational skills necessary for delivering culturally responsive care [16,14].

Similarly, the University of Alberta introduced a longitudinal Indigenous health curriculum in 2017, designed to integrate Indigenous perspectives across all four years of medical training. The curriculum combines lectures and small-group discussions during the preclinical years with reflective activities during clinical placements. This longitudinal approach ensures that students continually engage with Indigenous health issues throughout their training, reinforcing key concepts over time, supporting deeper retention and application of culturally safe practices. At the University of Manitoba, the Ongomiizwin Indigenous Institute of Health and Healing has implemented a comprehensive Indigenous health curriculum that centers

Indigenous cultures and integrates traditional knowledge into core medical training. This program includes interdisciplinary collaboration and emphasizes critical self-reflection to help students deconstruct systemic racism and biases within healthcare. The curriculum is further strengthened by its close partnerships with Indigenous communities, who host experiential learning opportunities for various professional programs and ensure that course content remains relevant, community-driven, and rooted in lived experience. For example, an undergraduate medical course on Indigenous health was developed by scholars at Ongomiizwin Indigenous Institute of Health and Healing alongside an Indigenous advisory group to improve students' understanding of Indigenous peoples. These efforts demonstrate the growing recognition that Indigenous health education should be embedded in the core curriculum rather than treated as optional content [17-19].

Theme 2: Advancing Cultural Safety through Reflexivity and Anti-Racism

The literature reflects a clear conceptual shift from cultural "competence" toward cultural safety, emphasizing reflexivity, power awareness, and anti-racist practice rather than the acquisition of static knowledge about Indigenous peoples. Within this framing, cultural safety is understood as being determined by those receiving care and requires learners to critically examine how historical and ongoing structures of colonialism shape health experiences and clinical interactions. The included studies highlight educational approaches, such as facilitated dialogue, immersive simulations, and reflective exercises, that aim to disrupt assumptions, foster humility, and develop learners' capacity to engage in equity-oriented care. However, they also point to the limitations of one-time or superficial interventions that fail to address deeper institutional and structural dynamics.

Four articles had cultural competency as a theme. Experiential learning activities, particularly those involving role-playing simulations, have demonstrated significant potential in advancing cultural safety and equity-focused education within medical training. For example, initiatives such as the KAIROS Blanket Exercise at UofT can be used to promote critical consciousness among students. This interactive exercise uses role-playing to simulate the historical and contemporary impacts of colonialism on Indigenous communities in Canada. Participants take on roles representing Indigenous peoples and move through a timeline marked by key events such as land dispossession, the implementation of residential schools, and the ongoing effects of systemic discrimination. Facilitated by trained Indigenous educators, the exercise creates a powerful emotional and intellectual experience that fosters empathy, disrupts assumptions, and deepens understanding of how colonial legacies continue to shape Indigenous health outcomes today [20].

Theme 3: Community-Engaged Learning as Relational and Decolonizing Practice

Community-based and experiential learning emerged as key approaches for translating classroom-based knowledge into relational and contextually grounded understanding. From a decolonizing perspective, however, these initiatives must be understood not simply as experiential opportunities, but as

relational processes shaped by reciprocity, community leadership, and accountability. The included studies describe placements, service-learning programs, and immersive activities that expose learners to Indigenous communities and health systems, offering insights into lived experiences and structural barriers. At the same time, the literature emphasizes that without careful design, such experiences risk reinforcing extractive or learner-centered approaches, underscoring the need for sustained partnerships and community-defined priorities in educational programming. Three articles had community-based and experiential learning as a theme. Community-based learning opportunities have emerged as a cornerstone of Indigenous health education. These initiatives provide students with the chance to engage directly with Indigenous communities, offering invaluable insights into the lived experiences of these populations. Programs such as NOSM's Community Engagement Through Research (CETR) allow students to collaborate with Indigenous communities on healthcare research projects, emphasizing the importance of mutual respect and understanding. These placements also enhance students' understanding of Indigenous perspectives and the social determinants of health. Educational and training opportunities underscore the profound value of experiential learning, like when a 4th year medical student from McGill University provided ophthalmic care in a rural Inuit community. By engaging directly with communities facing unique health challenges, students gain crucial insights into the realities of healthcare delivery in remote and underserved areas [16,21,22].

Discussion

Building on the identified themes, the literature reflects a gradual shift away from isolated teaching toward required, program-wide learning aligned with reconciliation priorities such as the AFMC Joint Commitment to Action on Indigenous Health (JCAIH) (The Association of Faculties of Medicine of Canada, 2020a, 2020b; Truth and Reconciliation Commission of Canada, 2015). By integrating Indigenous health into medical education, emphasizing the importance of cultural competency and awareness of Indigenous peoples, and using community-based learning opportunities, future healthcare providers will be better equipped to serve Indigenous peoples in a culturally safe and competent manner. Beyond mapping curricular initiatives, this review highlights a critical tension between symbolic inclusion and structural change. While many programs report Indigenous health content, fewer demonstrate sustained, accountable integration aligned with cultural safety principles. This review suggests that the central challenge is not the absence of Indigenous health content, but the gap between implementation and accountability.

Integration as Structural Commitment and Institutional Accountability

Across studies, meaningful integration was consistently framed as an institutional change process rather than an isolated, secondary module. Higher-intensity initiatives embedded Indigenous health objectives longitudinally across pre-clerkship and clerkship, aligned teaching with formal competencies, and paired curricular reform with governance structures and dedicated resourcing (The Association of Faculties of Medicine of Canada, 2020a, 2020b). This theme highlights that Indigenous health content is more effectively integrated into

medical education when positioned as necessary for professional identity formation, supported by leadership, and protected by accountable institutional mechanisms Commonwealth of Australia, Department of Health, 2014 [23].

In practice, this approach included co-developing learning objectives with Indigenous partners; integrating historical, contemporary policy, and social determinants content within clinical teaching; and establishing mechanisms for ongoing curriculum renewal and quality assurance. Internationally, similar principles are reflected in professional frameworks that define Indigenous health as a core competency area, emphasizing longitudinal integration, explicit learning outcomes, and shared institutional responsibility to improve patient health and safety [22-24]. Collectively, these findings suggest that Canadian medical schools can strengthen implementation by shifting from content “coverage” toward accountable integration by clarifying governance responsibility, resourcing pathways, and measuring progress for reconciliation commitments like the JCAIH reports The Association of Faculties of Medicine of Canada, 2020a, 2020b).

From Cultural Competence to Cultural Safety: Reflexivity, Power, and Anti-Racism

Consistent with the shift from cultural competence to cultural safety, the literature emphasizes reflexivity, power-awareness, and anti-racist practice rather than the acquisition of static cultural knowledge. The second theme reflects an important conceptual shift from cultural “competence” toward cultural safety and anti-racism [26-28].

Contemporary definitions emphasize that cultural safety is determined by those receiving care and depends on reflective practice and institutional conditions, not solely on acquiring knowledge about the “other” culture. Within the included studies, interventions such as facilitated dialogue, reflective exercises, and structured learning about stereotyping and systemic inequities were described as vehicles to disrupt harmful narratives and build humility in clinical encounters [26-28,29].

However, several papers also implied a risk of superficial implementation if learning is limited to one-time workshops or if institutions do not address the hidden curriculum (e.g., discriminatory norms in clinical environments) that can undermine formal teaching. This theme also connects to broader policy and regulatory shifts internationally. For example, the Medical Council of New Zealand articulated cultural safety as an expected professional standard, explicitly linking reflective practice and equity. For Canadian undergraduate medical education, the implication is that cultural safety education should be treated as both pedagogy and systems work, supported by faculty development, safe learning environments, and assessment strategies that evaluate reflective capacity and equity-oriented clinical reasoning, not only factual recall [30].

Relational and Community-Engaged Learning: Toward Decolonizing Practice

From a decolonizing perspective, community-based learning must be understood as relational and accountable, rather than solely experiential, raising important considerations around

reciprocity, power, and community benefit. Community-based experiential learning featured prominently as a mechanism for translating classroom concepts into relational, practice-relevant learning. Programs described rural/remote placements, service-learning electives, and experiential activities (e.g., the KAIROS Blanket Exercise) that can deepen understanding of Indigenous histories, community priorities, and the realities of delivering care amid geographic, jurisdictional, and resource constraints [31-33].

The Northern Ontario context illustrates how place-based learning can support learners to recognize community strengths alongside barriers, and to see how health systems and colonial policy histories shape access to care. At the same time, the literature cautions that experiential learning is not inherently equitable; without careful design, it can reproduce extractive relationships, place burdens on host communities, or privilege learner needs over community priorities. Across studies, stronger practice-based learning tended to emphasize reciprocity, appropriate preparation and supervision, and Indigenous governance over the learning agenda. Similar principles are echoed in international curriculum development work that centres community partnership and decolonizing approaches. These findings suggest that scaling experiential learning in Canada will require explicit partnership agreements, resourcing for community participation and teaching, and evaluation that includes community-defined indicators of respectful engagement and benefit [34].

Although the included studies were Canadian, their implications mirror international approaches that position Indigenous health curricula as essential to equity-oriented medical education. In Australia, the CDAMS Indigenous Health Curriculum Framework emphasizes integrating Indigenous health across training rather than isolating it in single modules [25]. In New Zealand, cultural safety is a professional expectation, underscoring reflective practice and attention to power as central to equity. In the United States, Indigenous curriculum initiatives similarly emphasize decolonizing approaches, shared governance, and relationship-based teaching with Indigenous communities. Across these contexts, the message is consistent: content alone is not enough. Meaningful change requires institutional accountability, sustained resourcing, and Indigenous authority in curriculum design, delivery, and evaluation. For Canada, these parallels support the direction of the JCAIH and point to the need for measurable implementation strategies, including longitudinal curriculum mapping, faculty development, and shared evaluation frameworks developed in partnership with Indigenous communities [35].

Gaps and Future Considerations

Despite these significant strides, considerable gaps persist, notably the inconsistent application of anti-racism education, limited standardization and availability of experiential learning opportunities, and inadequate preparation and training of faculty in Indigenous health education.

Canadian medical programs must take a comprehensive and collaborative approach to integrating Indigenous health into undergraduate medical education. Key priorities include standardizing anti-racism and cultural safety training, embedding

histories of colonialism and Indigenous rights in curricula, and building sustained partnerships with Indigenous communities to ensure content is culturally relevant and community-informed. Medical schools should also strengthen efforts to recruit, retain, and support Indigenous faculty, ensuring Indigenous voices shape academic environments and model culturally informed practice for learners. In addition, assessment should move beyond knowledge testing to evaluate cultural humility, empathy, and the ability to navigate systemic inequities. While current initiatives appear to improve student preparedness and sensitivity, further research is needed to determine whether these gains lead to better patient outcomes for Indigenous communities.

This review incorporated both peer-reviewed literature and key examples from gray literature to provide a holistic understanding of how Canadian medical institutions are responding to the TRC's Call to Action #24 (2015). However, given the evolving nature of this field, it is likely that additional promising practices are underway within schools but remain undocumented or unpublished. These internal, often grassroots efforts represent critical knowledge that should be surfaced, validated, and shared across institutions.

Future research should address these limitations by exploring longitudinal studies that evaluate the sustained impact of Indigenous health education on clinical practices and patient health outcomes. Further investigation is needed to determine effective strategies for the consistent implementation and standardization of anti-racism and cultural safety training across medical institutions. By proactively addressing these critical areas, Canadian medical schools can develop a healthcare workforce uniquely equipped not only to deliver culturally safe, equitable healthcare but also to meaningfully contribute to broader societal reconciliation efforts. These shifts are essential to moving beyond symbolic commitments toward accountable, equity-oriented transformation in Canadian medical education [38,39].

Positionality Statements

Srishti Sharma is non-Indigenous of South Asian descent. She has completed her undergraduate and graduate studies at McMaster University, which is located on the traditional territories of the Mississauga and Haudenosaunee nations.

Kaden Hill is Kanien'kehá:ka from Six Nations of the Grand River and is currently completing his undergraduate education at the University of Toronto.

Meelad Saber is non-Indigenous of Asian descent. He is completing his undergraduate medical education at McMaster University, which is located on the traditional territories of the Mississauga and Haudenosaunee nations.

Dr. Sawayra Owais is a non-Indigenous Pakistani-Canadian who worked with community members from Six Nations of the Grand River for her doctoral research on Indigenous perinatal mental health.

Dr. Patricia Farrugia is an Anishinaabe Scholar from Chippewas of Nawash Unceded First Nation in Saugeen-Ojibway territory in Ontario, Canada.

Statements and declarations

Ethical considerations

This article does not contain any studies with human or animal participants.

Consent to participate

Not applicable

Consent for publication

Not applicable

Declaration of conflicting interest

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