Listening and Learning from Indigenous Health Leaders: Creating Culturally Safer Spaces to Strengthen Retention and Recruitment

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Background and Problem

Indigenous health leaders remain significantly underrepresented in executive and senior leadership roles across Canadian health systems despite longstanding commitments to reconciliation, equity, and culturally safe care. This gap stands in direct tension with the Truth and Reconciliation Commission of Canada Calls to Action, particularly Calls 23 and 24, which call for increased Indigenous representation in health professions and measurable institutional change (Truth and Reconciliation Commission of Canada, 2015).

National and provincial reviews consistently show that barriers to Indigenous leadership advancement are structural rather than individual. The *In Plain Sight* report documented systemic racism, tokenism, limited decision-making authority, and weak accountability mechanisms within health governance (Turpel-Lafond, 2020). Cultural safety frameworks similarly emphasize that meaningful change requires governance reform, workforce policy change, and leadership accountability rather than training alone (First Nations Health Authority, 2016).

Although federal policy recognizes the governance authority of First Nations, Inuit, and Métis Peoples in health matters, many health organizations continue to position Indigenous leaders primarily in advisory roles without formal authority over policy, budgets, or strategic decision-making. Reconciliation commitments often appear at the strategic level but remain insufficiently operationalized within human resources systems, recruitment practices, mentorship structures, and governance accountability mechanisms.

Through literature review and key informant interviews conducted during this project, ten recurring barriers to recruitment and retention were identified. These included culturally unsafe recruitment processes, absence of distinctions-based hiring frameworks, limited authority once hired, lack of mentorship pathways, unrecognized cultural workload, and minimal measurement of reconciliation outcomes.

These findings suggest that Indigenous leadership retention is primarily a systems design issue rather than an individual workforce issue. The continued underrepresentation and turnover of Indigenous leaders represent a measurable workforce stability and governance performance gap within Canadian health systems.

Problem Statement

What leadership practices can address Indigenous-specific racism and create organizational environments that attract and retain Indigenous health leaders?

Project Aim

By March 2026, develop an Indigenous Health Leadership Toolkit and secure commitment from at least one non-Indigenous health organization to pilot implementation of selected reconciliation-aligned leadership practices

This aim focused on design and organizational readiness rather than full implementation. Success was defined as executive endorsement and documented pilot commitment demonstrating movement from advisory engagement toward operational governance change.

Intervention and Strategic Alignment

The intervention involved the development of an Indigenous Health Leadership Toolkit using the Model for Improvement. A Driver Diagram was developed to articulate the theory of change and identify system drivers required to support Indigenous leadership retention.

Three primary drivers were identified:

1. Policy and structural reform, including distinctions-based recruitment practices, governance accountability mechanisms, and leadership performance measurement.
2. Authentic partnership with Indigenous governments and communities, supported by formal agreements and sustained resource commitments.
3. Peer mentorship and leadership support infrastructure to strengthen retention and leadership resilience.

Secondary drivers were translated into operational tools, including recruitment frameworks, cultural workload recognition mechanisms, leadership mentorship pathways, governance accountability templates, and reconciliation impact dashboards.

Following completion of the literature review and key informant interviews, identified themes were intentionally overlaid with existing healthcare human resources best practices to adapt and redefine those practices in ways that support Indigenous leadership authority, retention, and culturally safe governance outcomes.

The toolkit is organized across seven interconnected areas of action: organizational readiness, culturally grounded recruitment, relational onboarding, leadership retention, measurement and accountability, policy alignment, and long-term renewal.

The toolkit was developed through iterative feedback cycles with Indigenous advisors, human resource leaders, and executive partners, functioning as conceptual Plan-Do-Study-Act learning cycles.

This project aligns with organizational priorities related to reconciliation commitments, workforce sustainability, leadership development, and culturally safe care. Strengthening Indigenous leadership authority contributes to improved workforce experience, stronger governance, and safer policy development within health systems.

Context and Team Composition

The project was undertaken through Healthcare Excellence Canada's EXTRA program by a pan-Canadian team representing Indigenous government (Otipemisiwak Métis Government), a regional health authority (Island Health), and two non-Indigenous health organizations including CHLNet and the Good Samaritan Society. The team was unique within the cohort in that it did not originate from a single organization or province.

Rather than beginning with a predefined operational problem, the team identified a shared systems-level challenge through collective dialogue and literature review. Although reconciliation commitments were widespread across participating organizations, formal structures supporting Indigenous leadership authority and retention were inconsistent or absent.

The team composition intentionally reflected diverse expertise and perspectives, including Indigenous governance leadership, executive leadership, human resources expertise, and an advisory group of Indigenous health leaders. Because members did not share organizational hierarchy, collaboration required explicit relational agreements and shared accountability structures.

Engagement and Mapping

Engagement occurred at multiple levels throughout the project. Indigenous advisory members provided guidance on cultural safety and leadership experiences. Executive leaders at the pilot site reviewed governance implications and organizational readiness. Human resources consultations supported the feasibility of distinctions-based recruitment practices.

Leadership experience mapping replaced traditional patient journey mapping. This process traced the recruitment, onboarding, mentorship, and retention journey of Indigenous leaders within mainstream health organizations. The exercise identified structural friction points such as culturally unsafe hiring processes, unclear authority boundaries, and absence of mentorship structures.

Partner mapping was also conducted to clarify influence and engagement levels across participating organizations. This helped identify decision makers, implementers, and network partners necessary to support pilot implementation and spread.

A relational teamwork agreement was established at project initiation to clarify roles, communication expectations, and shared accountability. Attention was given to psychological safety and recognition of cultural labour within the team.

Measures and Data Collection

Because the project focused on design and organizational readiness, measurement emphasized structural outputs rather than workforce outcomes.

Process measures included completion of literature review, validation of leadership themes, development of toolkit components, and advisory feedback cycles.

Outcome measures focused on executive endorsement and formal commitment from a pilot organization to implement toolkit practices.

Balancing measures monitored risks including team workload strain, over-standardization across diverse contexts, and emotional labour impact on Indigenous team members.

Data collection included documentation of advisory feedback, iterative tool revisions, executive endorsement records, and pilot readiness discussions. Qualitative insights from interviews and team debriefs were synthesized to inform toolkit design.

Results

Quantitative Outputs

The design phase produced measurable structural outputs:

- Ten leadership recruitment and retention themes validated
- Seven toolkit sections developed
- Twenty-five operational tools and templates collected or created
- One formal pilot commitment secured
- Executive engagement established at the pilot organization

Validated themes included community accountability and Indigenous preference language; relational, distinctions-based hiring; culturally safe storytelling-centred interviews; relational onboarding; values alignment; cultural leave and wellness supports; mentorship and leadership pathways; authority and autonomy versus tokenism; measurement and accountability for cultural safety; and integrated reconciliation frameworks.

Because implementation had not yet begun, statistical process control charts were not applicable. Instead, project progression was tracked through development milestones and endorsement markers.

Qualitative Findings

Interviews with Indigenous health leaders across Canada consistently identified structural barriers to recruitment and retention within mainstream healthcare organizations. Participants emphasized that sustainability depends less on hiring efforts and more on organizational readiness, including relational accountability, distinctions-based recognition, and visible leadership commitment.

Recruitment processes were described as critical trust-building moments. Culturally grounded interview approaches that recognized lived experience and community accountability increased willingness to apply for leadership roles. Conversely, opaque hiring processes and generic equity language reinforced mistrust.

A dominant theme was unrecognized cultural workload. Indigenous leaders often carried expectations to represent community perspectives without corresponding authority, resources, or compensation. Retention was strongly associated with clear leadership authority, mentorship pathways, and visible executive sponsorship.

These findings position Indigenous leadership retention as a systems design challenge requiring structural reform across recruitment, onboarding, governance, and performance measurement.

Quadruple Aim Alignment

Although long-term outcomes remain prospective, early results demonstrate alignment with the Quadruple Aim. Workforce experience: Discussions within participating organizations reframed cultural contributions as organizational work rather than volunteerism, improving psychological

safety and retention potential. Organizational outcomes: Executive leaders gained clearer understanding of structural barriers affecting Indigenous leadership environments. Patient and community impact: Strengthening Indigenous leadership governance capacity has long-term implications for culturally safer policy development and care environments. Cost and sustainability: Improving leadership retention reduces recruitment turnover costs and organizational instability.

Organizational Learning and Early Signs of Readiness

Because the project remained within a design and readiness phase, cultural change was not yet implemented at the organizational level. However, engagement with executive partners and human resource leaders generated early signals of learning and increased awareness regarding structural barriers affecting Indigenous leadership environments.

Three areas of knowledge development emerged through these discussions.

First, human resources leaders began examining distinctions-based hiring language and recruitment practices. Conversations moved beyond generic equity language toward exploring how recruitment frameworks might explicitly recognize Indigenous governance authority and representation needs.

Second, participating leaders reflected on the concept of cultural labour. Discussions highlighted how Indigenous leaders often carry relational and cultural responsibilities that are not formally recognized within workload structures. This created new awareness among organizational partners regarding the need to consider cultural labour within leadership roles and expectations.

Third, dialogue at the pilot site shifted from consultation-based language toward discussions of Indigenous leadership authority within governance structures. While no formal governance changes have yet been implemented, this shift in framing represented an important step in recognizing that reconciliation within leadership environments requires structural accountability rather than advisory engagement alone.

These discussions represent early indicators of organizational readiness and learning rather than implemented change. They informed refinement of the toolkit and will guide the forthcoming pilot phase, where the proposed practices will be formally tested and evaluated.

Discussion and Conclusion

This project achieved its stated aim within the defined design phase by producing a validated Indigenous Health Leadership Toolkit (see Appendix A) and securing pilot commitment for structured implementation. While workforce retention outcomes remain prospective, the project translated reconciliation commitments into operational tools for governance and human resources reform.

The findings reinforce that Indigenous leadership retention is primarily a systems design challenge. Structural barriers such as limited authority, cultural workload inequities, and weak governance accountability require organizational change rather than individual resilience.

The integration of Indigenous governance principles with improvement science methodology strengthened the credibility and scalability of the intervention. The cross-provincial team composition also enhanced transferability by ensuring tools were not tailored to a single institutional context.

However, capacity constraints and the difficulty of measuring relational change remain ongoing challenges. These limitations highlight the importance of phased implementation and longitudinal evaluation.

Structural reconciliation within health systems requires more than strategic commitments. It requires operational tools, governance accountability, and measurable workforce reform.

This project demonstrates how Indigenous governance principles and improvement science methodologies can be combined to develop scalable leadership frameworks. Executive endorsement, pilot commitment, and pan Canadian network support provide a foundation for future implementation and spread.

Strengthening Indigenous leadership authority is essential to improving workforce experience, strengthening governance, and advancing culturally safe health systems across Canada.