DiverseCity
THE GREATER TORONTO LEADERSHIP PROJECT

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Bright Minds. Big Hearts. The Best Medicine.

A Snapshot of Diverse Leadership in the Health Care Sector

November 2013

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DiverseCity Counts 8

DiverseCity Counts features research that measures the GTA's progress to diversify its leadership

www.diversecitytoronto.ca/counts

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About DiverseCity: The Greater Toronto Leadership Project

The Greater Toronto Area (GTA) is the most ethnically and racially diverse region in Canada, yet there is a striking lack of diversity at the top of our corporate, public and nonprofit organizations.

This is a missed opportunity.

DiverseCity is building a more prosperous region by changing the face of leadership through measurable initiatives. DiverseCity Counts is a research initiative that highlights the GTA's progress toward building a more diverse leadership. This is the eighth report in this series.

DiverseCity: The Greater Toronto Leadership Project is a partnership between Maytree and the Greater Toronto CivicAction Alliance, funded in part by the government of Ontario. Learn more at www.diversecitytoronto.ca.

About Mount Sinai Hospital

Mount Sinai Hospital is an internationally recognized 446-bed acute care academic health sciences centre affiliated with the University of Toronto that is dedicated to delivering the best medicine and best patient experience. It is focused on excellence in patient and family-centred care, innovative education and leading-edge research.

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In this eighth report of the DiverseCity Counts series examining diversity in senior leadership positions in the Greater Toronto Area (GTA), we focus on health care institutions. Specifically, we look at local health integration networks (LHINs), hospitals, and community care access centres (CCACs).

Along with hospitals, LHINs and CCACs play critical roles in health care in Ontario. LHINs plan, coordinate and fund local health systems, with the aim of making it easier for patients to access health care. CCACs coordinate health care in patients' homes and in the community as well as access to long-term care homes.

While past reports have focused solely on visible minorities, this edition broadens the scope of diversity to include sex/gender identity, visible minorities, disability, and sexual orientation.

Diverse leadership is critical for the health care sector

Physical and mental health is a fundamental part of individual, family and community well-being. Good health enhances our ability to be productive and engaged participants in economic, social and political life.

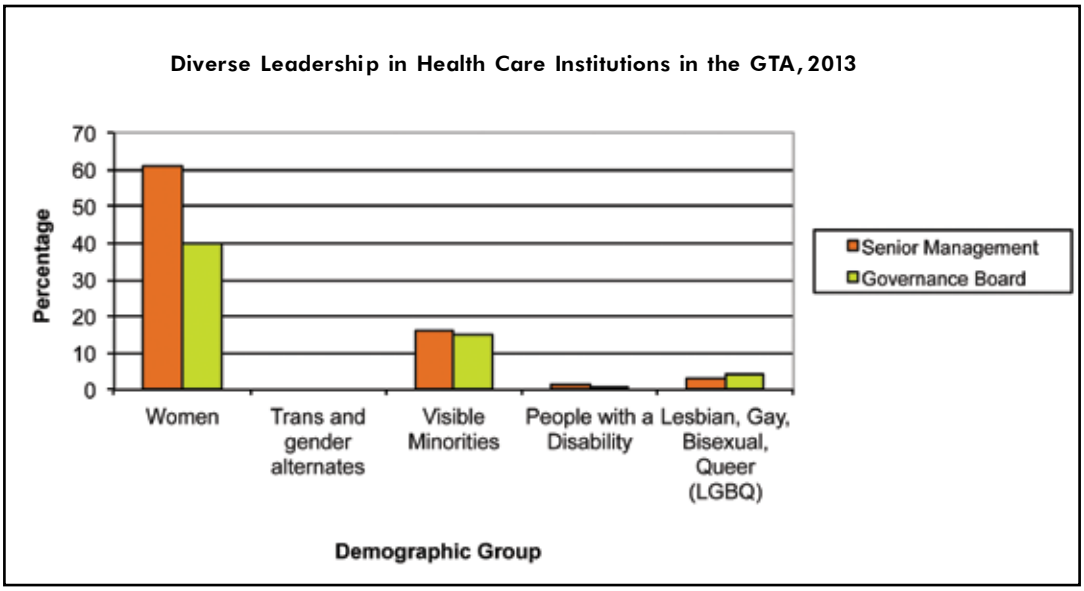
Furthermore, virtually all members of society come into contact with the health care system at some point in their lives. In fact, for most of us, health care services are one of a few public services that we use throughout our lives, from birth to death.

Senior management teams and governance boards in health care institutions play a critical role in setting mandates and priorities, and shaping services to help meet the needs of patients and providers alike. It is this leadership, for example, that has the influence and authority to recognize and acknowledge needs, approve systemic changes, and prioritize and commit the resources necessary to respond.

Health care leadership is diverse in some respects, but many groups are under-represented

We surveyed the five LHINs, 28 hospitals and five CCACs in the GTA, and found:

- Women are well represented in leadership positions – Women make up the majority (61%) of senior management positions, and 40% of governance board members. No gender alternates (transgender, transsexual, intersex) were reported in senior management teams or on boards of any of the institutions surveyed.
- Visible minorities are under-represented, but this varies widely between institutions – Only 16% of those in senior management positions and 14% of board members were reported to be visible minorities. Four in ten institutions reported *no* visible minorities in senior management positions, as did nearly one-fifth of boards.
- Few people with a disability are in leadership positions – Across the health care sector, in senior management and on boards, only 1% of leaders were reported to be people living with a disability.
- Few lesbian, gay, bisexual or queer (LGBQ) individuals are in leadership positions, with a few exceptions – About 3-4% of leaders were reported to be LGBQ individuals, though this includes a few institutions that reported many individuals, and a majority of institutions that reported none.



Ten tips to maximize the benefits of diversity

1. Articulate the business case for diversity
2. Make diversity a strategic priority across the organization
3. Make a public commitment to diversity in your leadership
4. Develop a practical plan to diversify your leadership
5. Set targets and report on your progress
6. Recognize the range of talents that diverse leaders bring to your organization
7. Measure the impact of diversity in your organization
8. Use promising and innovative human resources practices to develop pipelines for talent
9. Work with the broader community to help grow the pool of potential board members
10. Be a champion for diversity

LEADERSHIP IN THE HEALTH CARE SECTOR

This is the eighth report of the DiverseCity Counts series examining diversity in senior leadership positions in the Greater Toronto Area (GTA). It is the first to look at the GTA's health care institutions. Specifically, it looks at local health integration networks (LHINs), hospitals, and community care access centres (CCACs).

Along with hospitals, LHINs and CCACs play critical roles in health care in Ontario. LHINs plan, coordinate and fund local health systems, with the aim of making it easier for patients to access health care. CCACs coordinate health care in patients' homes and in the community as well as access to long-term care homes.

While past reports have focused solely on visible minorities, this edition broadens the scope of diversity to include sex/gender identity, visible minorities, disability, and sexual orientation.

Diversity is fast becoming the norm in the GTA. In 2011, 47% of the GTA's population were visible minorities and 46% were born outside of Canada (Statistics Canada, 2013). In some parts of the GTA, these numbers are even higher. For example, visible minorities make up 66% of Brampton's population, and 72% of Markham's.

In Ontario, 16% of the population has a disability (Statistics Canada, 2007). General estimates for the lesbian, gay, bisexual, or queer (LGBQ) population range from 5-10%. More than half (51%) of the GTA's population is female (Statistics Canada, 2013).

DiverseCity Counts has looked at visible minority representation in seven sectors in the GTA since 2009. It has focused on the municipalities with the highest proportions of visible minorities: Toronto, Mississauga, Brampton, Markham and Richmond Hill.

While some sectors have made progress over the years, as a whole, visible minorities remain under-represented in the leadership of the GTA (Cukier et al., 2011). In 2011, the proportions of leadership made up of visible minorities were:

Government agencies, boards and commissions	22%
Education sector	20%
Elected officials	19%
Voluntary sector	12%
Public sector	9%
Legal sector	7%
Corporate sector	4%

Similar research on women in leadership in the GTA shows that women are also under-represented (Cukier et al., 2012). In 2011, the proportions of leadership made up of women were:

Government agencies, boards and commissions	41%
Education sector	38%
Elected officials	38%
Voluntary sector	37%
Public sector	35%
Legal sector	27%
Corporate sector	17%

To our knowledge, no similar studies have examined the proportion of people with a disability, transgendered, transsexual or intersex individuals, or LGBQ individuals in leadership positions in the GTA.

Why does diversity in leadership matter?

Previous research demonstrates the benefits of diverse leadership. First, diverse leadership benefits the business and/or mission of organizations. It supports improved financial and organizational performance (Conference Board of Canada, 2008; Herring, 2009). In addition, diverse leadership supports innovation and creativity – in problem solving (Slater et al., 2008) and in product development and service delivery (Niebuhr, 2010). This innovation is particularly important when the market or population served is itself diverse.

Second, diverse leadership provides connections into diverse markets and client groups, which in turn can make organizations more responsive to client needs and trends.

Diverse leadership also provides connections to diverse talent, and previous research indicates that organizations with diverse leaders are more likely to attract and retain the most highly skilled workforce. Diversity on governance boards might signal an organization's commitment to its employees (Broome and Krawiec, 2008), and senior leadership commitment to diversity can also lead to reduced turnover intentions (McKay et al., 2007). An organization's efforts to support diversity can also moderate the effects of perceived discrimination (Triana et al., 2010).

In addition, diverse leadership can connect organizations to diverse supply chains, partners, and sources of revenue or donors.

The benefits of diverse leadership extend to the future as well, by providing role models and shaping the hopes and aspirations of young people (Aguirre, 2008).

Why is diverse leadership in the health care sector important?

Physical and mental health is a fundamental part of individual, family and community well-being. Good health enhances our ability to be productive and engaged participants in economic, social and political life.

Furthermore, virtually all members of society come into contact with the health care system at some point in their lives. For most of us, health care services are one of a few public services that we use throughout our lives, from birth to death.

Perhaps for these reasons, Canadians are fiercely proud of our public health care system. Access to high quality public health care has become a fundamental Canadian value. It is therefore incumbent on our health care institutions to reflect the public in their services, in their decision-making, and throughout their organizations. In fact, leading health care institutions are doing just that.

These leading institutions recognize the importance of understanding and responding to the diversity of their patients. They have innovated and adapted their services to meet the needs of patients in various demographic groups – for example, by providing multilingual and/or culturally appropriate services. Similarly, many recognize the benefits of diversity among their staff, and have made great progress in hiring and integrating diverse employees into their institutions.

Increasingly, health institutions are turning their attention to diversity in their leadership – that is, in senior management and on the governing boards of these organizations. Leadership in health care institutions plays a critical role in setting mandates and priorities, and shaping services to help meet the needs of patients and providers alike. It is the leadership, for example, that has the influence and authority to recognize and acknowledge needs, approve systemic changes, and prioritize and commit the resources necessary to respond.

In 2010, nearly 80% of Ontario hospital boards reported board recruitment practices that aimed to reflect the diversity of the communities they serve (Governance Centre of Excellence, 2012). In this report, we will look at the current state of diversity in leadership in health care institutions in the GTA.

How did we count leaders in the health care sector in the Greater Toronto Area (GTA)?

The research team distributed surveys to the Chief Executive Officers (CEOs) of:

- Twenty-eight hospitals and multi-hospital organizations;
- Five local health integration networks (LHINs); and
- Five community care access centres (CCACs)

The institutions represent five health regions serving the GTA. Please see Appendix 1 for a map of the five health regions.

The instructions asked the CEOs (or a designate) to identify, to the best of their knowledge, the number of people on their senior management teams and governance boards that are:

- Women
- Men
- Transgender, transsexual or other gender alternates
- Visible minorities
- People with a disability
- Lesbian, gay, bisexual, queer (LGBQ)

Please see Appendix 3 for a copy of the survey instrument.

In this report, we will refer to institutions by type (LHINs, hospitals and CCACs) and as a whole (the health care sector). Similarly, we refer to groups by function (senior management and governance boards), and as a whole (leadership).

This survey method has several limitations. First, diversity in each category is observed by a third party (the CEO or designate) rather than reported by the individuals themselves. The choice to use third-party observation rather than self-reporting was intended to increase the feasibility and response rate of the study. It was not intended to imply that these are visible characteristics that can be easily discerned by a third party. Of course many of the characteristics in question are not visible, and it is possible – even likely – that a CEO does not know how individuals identify themselves in each category. For example, a CEO might not know a senior staff or board member's sexual orientation or gender identity, or whether that person has a disability (as many disabilities are invisible). As a result, the numbers reported by CEOs or their designates might be inaccurate and/or underestimates of the diversity levels being examined.

Second, while this survey does use a broader definition of diversity than earlier works in this series, it did not ask about a number of groups, such as Aboriginal peoples, recent immigrants, francophones, members of religions/faiths, and younger or older workers. Each of these groups comprise significant portions of the GTA's population and might be under-represented in senior leadership. Future research should examine the proportion of these groups in the leadership of the health care and other sectors.

In addition, this study looks at a few, albeit critical, sectors of the health care system – LHINs, hospitals and CCACs. Future research should expand this view to look at other key components of the health care system, such as mental health services, long-term care homes, community health centres, community support services, family health teams and other primary care models.

Third, the survey instrument allows an individual to be counted under different categories. For example, a man who is a visible minority might be counted once under "male" and once under "visible minority." However, the survey cannot tell us that this individual is counted under two categories. In other words, we cannot determine or examine intersections of identity.

Fourth, the survey asked respondents to use their own definition of "senior leadership/management group." As a result, respondents are likely using varying criteria to define their own senior management teams.

Finally, this survey provides data for the state of diversity in senior management and governance boards as it was in July 2013. It cannot provide information on trends, future directions, or on efforts made by each institution to recruit, promote or appoint diverse senior staff and board members. However, it can provide a baseline for future research.

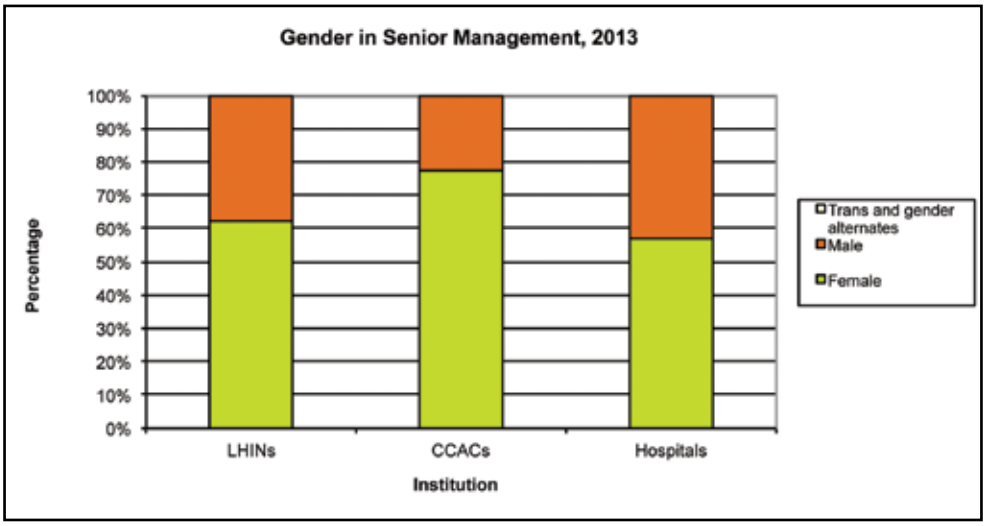
Fortunately, in this inaugural survey of the health care sector, all of the CEOs we approached responded to the survey, giving a response rate of 100%. As a result, the findings represent every LHIN, CCAC and hospital in the GTA, comprising 445 members of senior management and 622 board members. Please see Appendix 2 for a list of institutions that participated in this study.

How diverse are leaders in the health care sector in the GTA?

Women are well represented in leadership

The gender balance in the senior management of LHINs, CCACs and hospitals favours women. In the health care sector overall (that is, LHINs, CCACs, and hospitals combined), 61% of senior management positions are held by women.

In hospitals, 57% of senior management positions overall are held by women. The proportion of women in senior management positions varied widely between hospitals, from 29% to 89%. In LHINs, 62% of senior managers are women, while in CCACs, 77% are women.

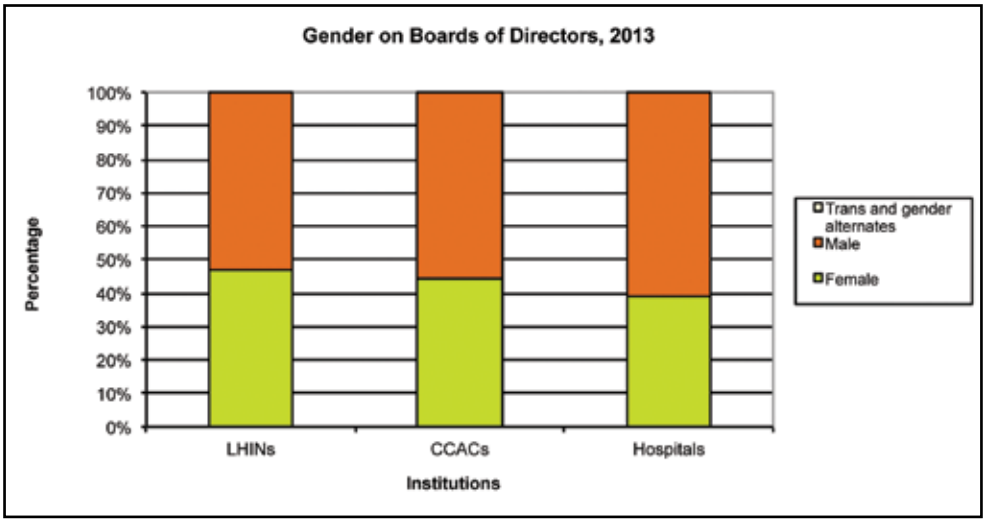


Fewer women serve on the governance boards of these institutions. In the health care sector overall, 40% of board members are women.

In hospitals, 39% of board members are women, though, as with senior management, this figure varied widely from hospital to hospital – from 23% to 96%.

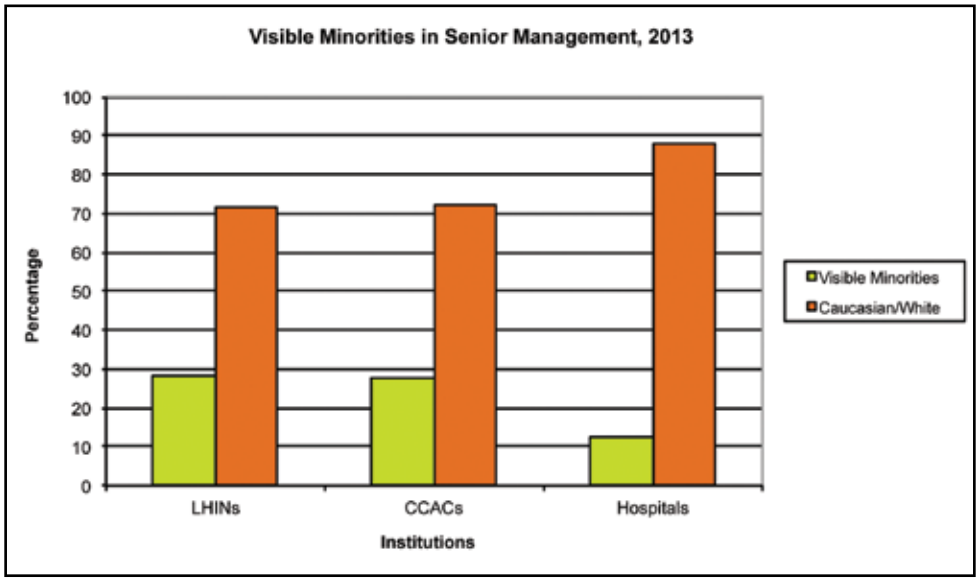
In LHINs, 47% of board members are women, and for CCACs the figure is 44%.

No gender alternates (transgender, transsexual, intersex) were reported in senior management or on boards of any of the institutions surveyed.

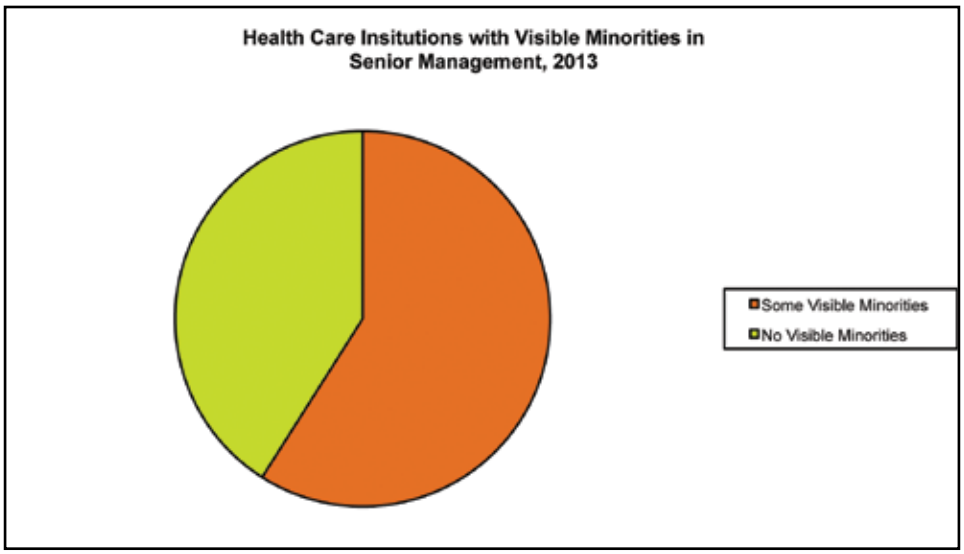


Visible minorities are under-represented, but this varies widely among institutions

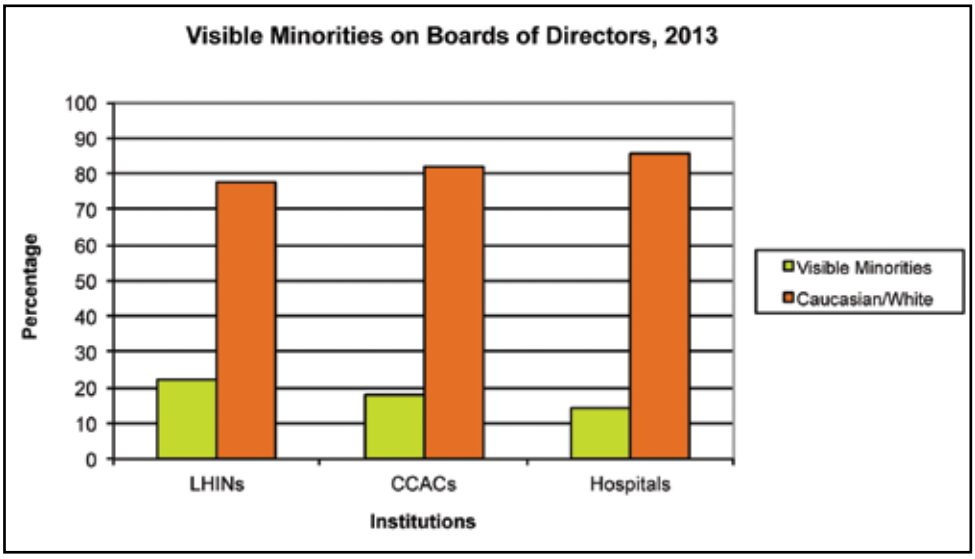
Only 16% of senior management positions in the health care sector are held by visible minorities. In hospitals, only 12% of senior management positions are held by visible minorities, though this number ranges from 0% to 40% between hospitals. The LHINs and CCACs overall have senior management teams made up of about 28% visible minorities.



However, 43% of hospitals, 40% of LHINs and CCACs had no visible minorities in senior management positions, including some that are located in areas with high visible minority populations.

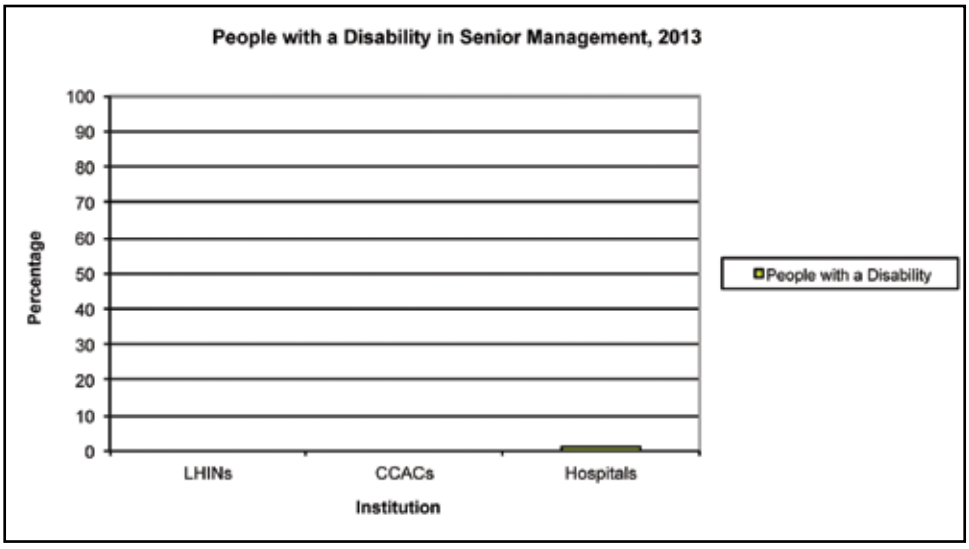


Visible minorities are similarly under-represented on governance boards. In hospitals, 14% of board members are visible minorities, with individual hospitals ranging from 0% to 33%. In LHINs, 22% of board members and in CCACs, 18% of board members are visible minorities. Nearly one-fifth of boards had no visible minority board members (18%).

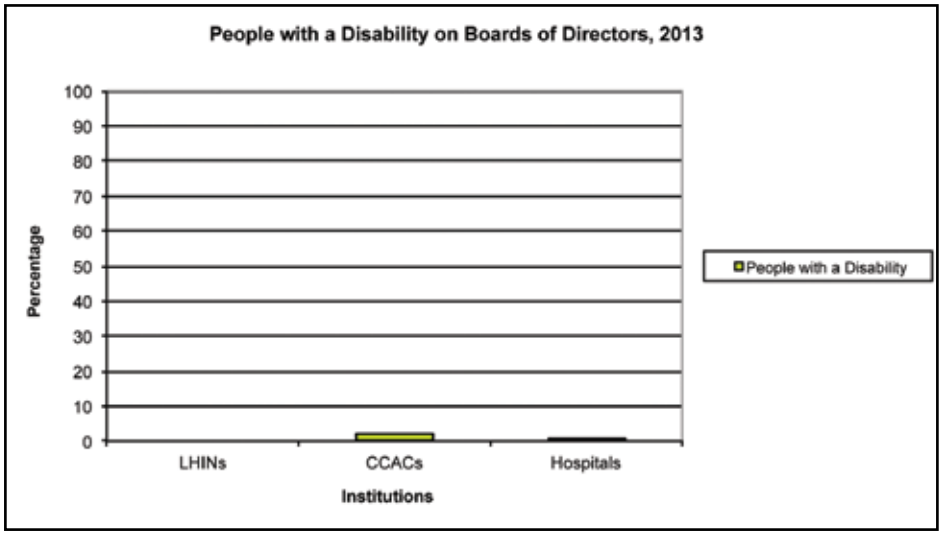


Few people with a disability are in leadership

The number of people with a disability counted in this survey is very low – approximately 1% across the health care sector, in senior management positions and on boards. The vast majority (87%) of institutions reported no people with a disability in their leadership. Every institution that reported people with a disability in their senior management team reported one individual; due to the varying size of senior management teams, this represents 8% to 17% of senior management teams.

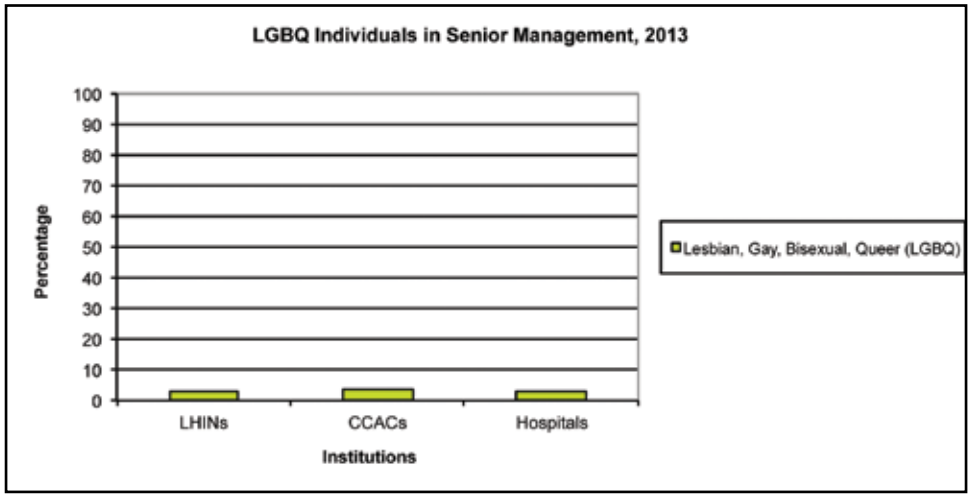


On boards, similarly, those institutions that reported people with a disability reported either one or two individuals, representing 3% to 10% of their board members.



Few LGBQ individuals are in leadership, with a few exceptions

Across the health care sector, about 3% of senior management positions were reported as being held by LGBQ individuals. However, this average figure includes a majority of institutions (74%) that reported none, and a small number of institutions that reported some LGBQ individuals in senior management positions. In the latter group, institutions reported senior management teams made up of 3% to 15%, and one institution with 29% and one with 50% LGBQ individuals.



Factors that might impact these results

This study did not ask participants to explain or to provide any information that might explain the composition of their senior management teams or governance boards. However, we suggest a few factors that might shed some light on these results.

Some of the results reflect the historical or current focus of the institutions. For example, some institutions were founded with a focus on specific populations and communities – such as women, people living with HIV/AIDS, and religious communities. Today, the leadership of these institutions might reflect efforts to attract and engage members of these specific populations and communities.

The relatively high proportion of women in leadership might reflect the tendency of health care institutions to draw from the ranks of nurses and allied health professionals, which remains a predominantly female pool of employees. Conversely, fewer doctors (a pool that remains dominated by men, although increasingly less so than in the past) tend to take up administrative positions.

Some of these results are striking, in particular where the composition of leadership varies greatly from the population in the area. For example, nearly half of the population (47%) of the GTA is made up of visible minorities, and in some regions of the GTA, this number is as high as 72% (Statistics Canada, 2013). And yet, four out of ten health care institutions studied had no visible minorities in their senior management teams.

Leading the way: William Osler Health System

Serving some of the most diverse communities in the Greater Toronto Area (GTA), William Osler Health System (Osler) has taken a unique approach to care delivery across its three hospital sites. The organization is committed to enhancing the patient experience in a manner that values diversity, inclusiveness and respect.

Osler's board began its diversity journey in 2007 after the opening of the Brampton Civic Hospital led to some community discontent over unfulfilled expectations. The provincial government subsequently took over operations and disbanded the board.

Since then, the community hospital corporation has embraced diversity as a foundation for inclusion and equity – and key to board renewal. Recruitment focuses on a skills-based model that has led to 54% of board members representing various ethno-cultural communities while 40% are women. Each hospital site has a Community Advisory Council, chaired by a board member, to provide local feedback. The result is a significant increase in applicants for board and council positions, greater engagement of board members and the development of more volunteer opportunities on other committees.

The highest levels of the organization make sure all decision-making, strategic planning and governance activities have adopted this focus. In 2012, Osler began work on a Strategic Plan to create a new vision and mission for the entire organization. The outcome was a commitment to patient-inspired and culturally-sensitive care.

This past year, Osler received national recognition of its diversity initiatives. This included a leading practice in "Embracing Diverse Practices in Palliative Care" as part of its Exemplary Accreditation designation. Osler was also named one of Canada's Best Diversity Employers and a Maytree Diversity in Governance Award winner in 2013.

Similarly, in Ontario, approximately 16% of the population reports living with a disability (Statistics Canada, 2007). And yet, only 1% of the leadership of these health care institutions are reported to have a disability. Even if we assume that the actual number is much higher than reported – for example, double or triple the reported number – this still represents a significant gap between the population being served by health care institutions and those who lead them.

These results raise a number of questions, including, how do recruiting, promotion, appointment practices and board governance structures influence these numbers? How do they affect the institution's ability to keep pace with the changing demographics of the community it serves? What practices or policies can be used to enhance the diversity of leadership in these institutions?

This study does not examine the efforts or progress made by these institutions to diversify their leadership. In fact, we know that leading health care institutions are committed to diversity in leadership and are taking action to make it happen.

However, in the health care sector overall, it is safe to say that more work remains to be done.

Leading the way: Women's College Hospital

Women's College Hospital's commitment to diversity runs deep. Perhaps this stems from the institution's connections with the suffragist movement. The hospital was founded in 1883 to provide medically trained women the rare opportunity to practice.

While today's organization is committed to women's health, as early as 2001, the board took the lead on building a more diverse organization with a two-pronged approach: change ourselves; and enact policy to change the organization.

The Hospital undertook a targeted recruitment strategy resulting in new diverse faces and voices at the boardroom table. This was coupled with ongoing education efforts to build a new board culture that would recognize the intrinsic value of diversity, thereby cultivating a rich and sustained contribution of expertise and insight.

In 2008 the board created an Equity Vision for the Hospital, extending the principles and benefits of diversity embraced by the board, down through the entire hospital organization. The operation's Diversity Committee was replaced by a new Board Equity Committee and the role of Equity Champion was established as a governance accountability strategy.

Today, 32% of the board is composed of visible minorities. The diverse board recognizes that delivering on a health equity agenda is good public policy. Their leadership has been instrumental in both promoting and facilitating increased access to underserved communities thereby promoting early intervention, and working to ensure equitable access to health care for all.

Women's College Hospital was a winner of a Maytree Diversity in Governance Award in 2010.

Leading the way: Toronto Central CCAC

Toronto Central Community Care Access Centre (TC-CCAC) is the lynchpin in a regional health care system to connect people to quality community-based health care and resources as well as help them find their way through the health care system and understand their options. By working with hospitals, community agencies and service providers, the TC-CCAC helps 23,000 clients a day.

Located in the most diverse urban region in the province, ensuring diversity in leadership has been a founding TC-CCAC principle since it was established in 1997. Today, 83% of senior leaders are women and 31% are visible minorities.

"Diversity is in our DNA. It is not a list in a strategic plan but part of the long-term development in our culture," says Stacey Daub, Chief Executive Officer. "It is a lived and breathed experience."

The TC-CCAC has a similar diversity philosophy when recruiting board members: Develop as wide a pool of candidates as possible, then hire the best person. Today, the board has an impressive level of diversity, with 50% female and 30% visible minority board members. It also includes members with a disability and representation from the LGBQ community.

"If you don't have diversity in the candidate pool, you will never have diversity at any level," says Dennis Fong, Senior Director, Human Resources & Organizational Development.

These values have permeated throughout the entire organization. In a 2013 Employee Engagement Survey conducted across all Ontario CCACs, its diversity and inclusivity measures significantly outscored all others.

"We think it makes for a richer and better workplace," says Daub. "It makes us who we are and it makes us strong."

What can health care institutions do to maximize the benefits of diversity?

Institutions can take practical steps to benefit from diversity:

Articulate the business case for diversity

Understand how diverse leadership will enhance innovation, patient care and the overall performance of your organization. Communicate the case for diversity to your stakeholders and throughout your organization to increase buy-in.

Make diversity a strategic priority across the organization

This should extend to all areas of activity – patient care, employment, procurement and leadership. The support of senior leadership might be the most important factor in influencing organizational commitment and effective practices.

Make a public commitment to diversity in your leadership

In addition to raising awareness of the issue, a public commitment paired with a plan of action will enhance your reputation and public trust in your institution.

Develop a practical plan to diversify your leadership

Include realistic actions that your organization can take to reach achievable goals. Initially, aim for some "quick wins" that will help you build support and momentum.

Set targets and report on your progress

What gets measured gets done. Targets will help you focus on your goals, and regular reporting will tell you how well you are doing at achieving them.

Recognize the range of talents that diverse leaders bring to your organization

Diversity in leadership does not mean compromising on knowledge or skill. Avoid tokenism by tapping into highly qualified, diverse talent pools and ensuring that diverse leaders work in their areas of expertise – not just on the diversity portfolio.

Measure the impact of diversity in your organization

Understanding the outcomes of your practices will help you to prioritize your efforts, and adapt or change them to maximize their impact.

Use promising and innovative human resources practices to develop pipelines for talent

Learn from other organizations that are using new or proven methods for hiring and promoting diverse talent. Adapt or try new practices that suit the needs of your organization.

Work with the broader community to help grow the pool of potential board members

Tools like DiverseCity onBoard can help you find diverse leaders who are ready to serve, now. Consider what your organization can do to mentor, train and develop future leaders.

Be a champion for diversity

Use your positions as leaders in our society to raise awareness of the organizational and social benefits of diversity. Share promising practices, how you deal with challenges, and what you do to make the most of diverse leaders in your organization.

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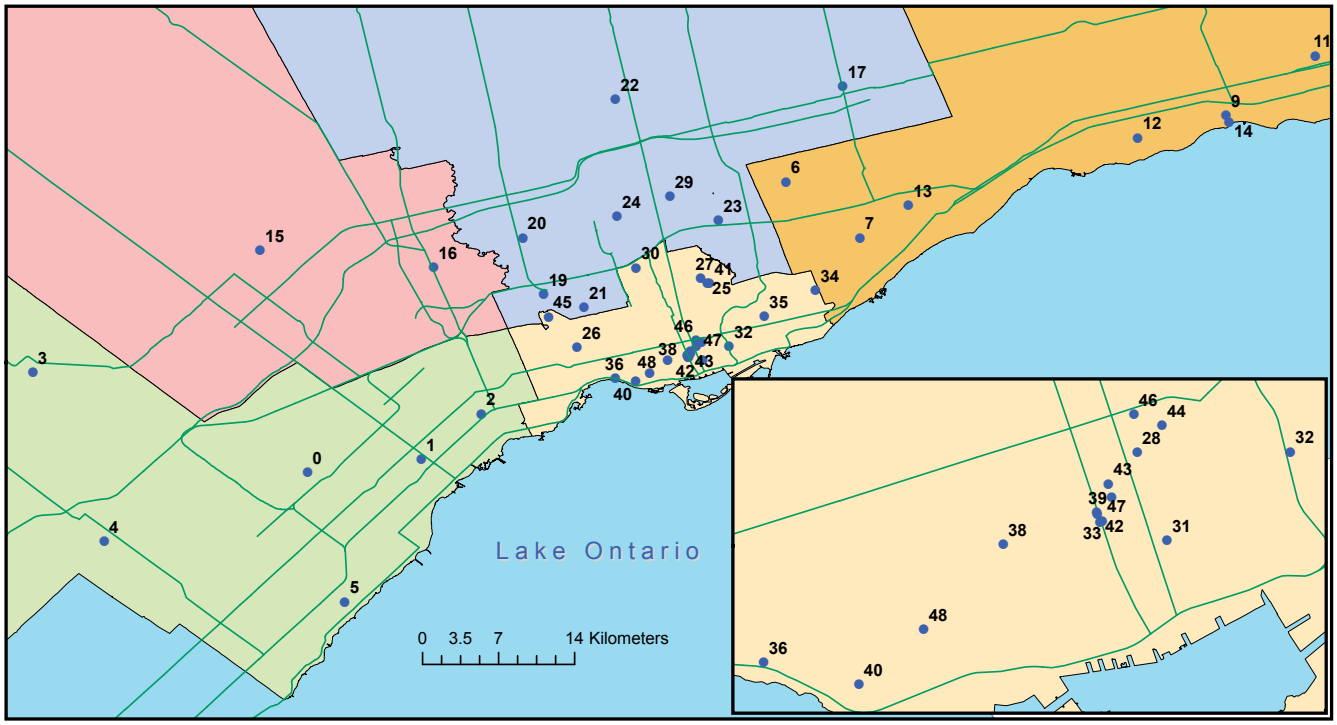
APPENDIX 1

Map of Local Health Integration Network/Community Care Access Centre Boundaries, and Hospitals Serving the Greater Toronto Area



Note: This map displays multiple locations of some institutions. For a full list of the institutions that participated in this study, please see Appendix 2.

APPENDIX 2

List of Survey Participants

Local Health Integration Networks

1. Central
2. Central East
3. Central West
4. Mississauga Halton
5. Toronto Central

Community Care Access Centres

1. Central
2. Central East
3. Central West
4. Mississauga Halton
5. Toronto Central

Hospitals

1. Baycrest
2. Bridgepoint Active Healthcare
3. Casey House
4. Centre for Addiction and Mental Health
5. Halton Healthcare Services
6. Holland Bloorview Kids Rehabilitation Hospital
7. Hospital for Sick Children
8. Humber River Hospital
9. Lakeridge Health
10. Mackenzie Health
11. Markham Stouffville Hospital
12. Mount Sinai Hospital
13. North York General Hospital
14. Ontario Shores Centre for Mental Health Sciences
15. Providence Healthcare
16. Rouge Valley Health System
17. Runnymede Healthcare Centre
18. Scarborough Hospital, The
19. St. Joseph's Health Centre
20. St. Michael's Hospital
21. Sunnybrook Health Sciences Centre
22. Toronto East General Hospital
23. Toronto Grace Health Centre
24. Trillium Health Partners
25. University Health Network (includes: Princess Margaret Cancer Centre, Toronto General Hospital, Toronto Rehabilitation Institute, Toronto Western Hospital)
26. West Park Healthcare Centre
27. William Osler Health System
28. Women's College Hospital

APPENDIX 3

Survey Instrument

GTA Health Care Leadership Diversity Survey

Organization: _____

Date of Submission (mmm/dd/yyyy): _____

Name of individual completing this Survey: _____

Role: _____

Phone #: _____ Mailing Address:_____

City: _____Province: _____Country: _____

Sample	Total	Gender: Female	Gender: Male	Gender: Trans and Other	Visible Minorities	People with a Disability	LGBQ
Senior Leadership / Management Team							
Board of Directors / Governors							

Explanatory Notes

Please identify the total numbers of individuals in each of these categories across the two sample groups.

Sample: This survey is designed to identify levels of diversity among leaders or decision-makers. The top tier management team refers to the highest level of leadership reporting to (and including) the CEO. Please note - we invite you to define the size of your Senior Leadership / Management Team as every organization differs in organizational structure.

Gender: To the best of your knowledge, count those individuals who identify themselves as a member of a gender group that can include the following Male, Female, or Others defined as:

- Trans is an abbreviation, which includes but is not limited to, transgender, transsexual, gender non-conforming, and gender questioning persons.

- Intersex refers to people whose bodies, reproductive systems, chromosomes and/or hormones are not easily characterized as male or female. Most intersex people identify as either male or female, but not all intersex people identify with the sex they were assigned at birth, and some choose to identify themselves as intersex.

Visible Minorities: To the best of your knowledge, count those individuals who identify themselves as a member of a visible minority group.

- The DiverseCity Project uses this term, as defined by the federal Employment Equity Act and by Statistics Canada, to refer to any person who is non-Caucasian in race or non-white in colour: Chinese, South Asian, Black, Arab/West Asian, South East Asian, Latin American, Japanese, and Korean.

People with a Disability: Count those individuals who self-identify as having a disability.

LGBQ: Count those individuals who self-identify as being lesbian, gay, bisexual, or queer.

DiverseCity
THE GREATER TORONTO
LEADERSHIP PROJECT

DiverseCity Counts is an initiative of
DiverseCity: The Greater Toronto Leadership Project.

www.diversecitytoronto.ca/counts

DiverseCity: The Greater Toronto Leadership Project is a partnership of Maytree and the Greater Toronto CivicAction Alliance

MAYTREE
For Leaders. For Change.

Maytree promotes equity and prosperity through leadership building.

CivicAction
Greater Toronto CivicAction Alliance
BECAUSE THIS IS WHERE WE LIVE

Transforming the Greater Toronto region through collective leadership.