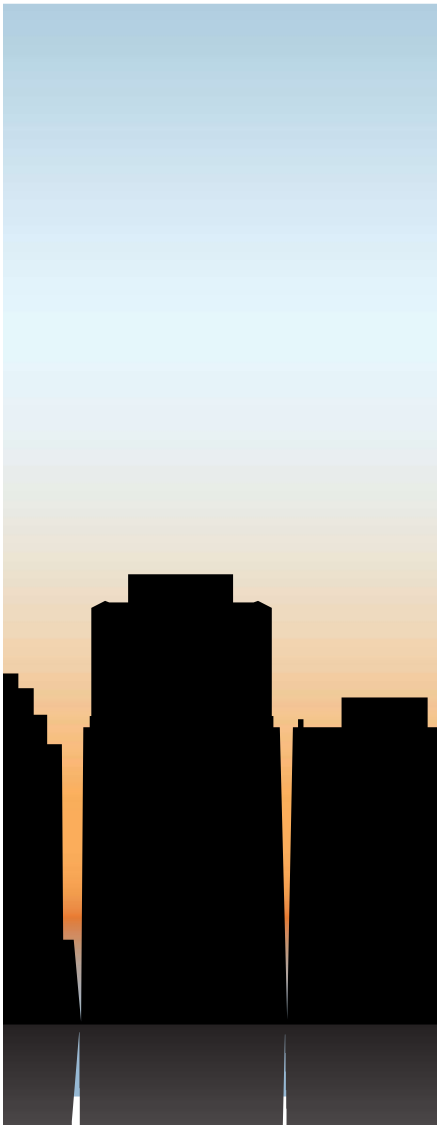

TURNER CONSULTING GROUP

July 2021

DIVERSITY & INCLUSION ASSESSMENT

PART 2 Workforce Census

MIDDLESEX-LONDON HEALTH UNIT

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EXECUTIVE SUMMARY

This is the first Workforce Census conducted by the Middlesex-London Health Unit (MLHU, the Health Unit). It was designed to help the Health Unit understand the diversity of its workforce and to answer the following key questions:

- What is the current demographic makeup of Health Unit employees?
- What is the representation of employees in various demographic groups, including disability, religion/faith, Indigenous identity, racial identity, gender identity, and sexual orientation?
- How does the diversity of the Health Unit workforce compare with that of residents living in Middlesex-London?

The survey consisted of 13 questions and took respondents less than 10 minutes to complete. Census Week was designated as April 23 to 30, 2021. Staff were also given time at the weekly townhall meeting on both April 23 and 30 to complete the census.

An overall response rate of 84% was achieved for permanent full-time and part-time staff.

THE DEMOGRAPHIC CONTEXT

Middlesex-London is a growing community, with more people, jobs, and services expected to come to the region in the coming years. Adding to this growth are housing prices in Toronto, leading many people to move farther away from the city in search of affordable housing. This growth will be further fuelled by the COVID-19 pandemic, with Toronto experiencing a record population loss during the pandemic as more people move away from the city in response to work-from-home options becoming increasingly available.

The Census of Canada data shows that the Indigenous and racialized communities within Middlesex-London are growing at a faster rate than the overall population and therefore will constitute an increasingly larger proportion of the Middlesex-London community. Between 2006 and 2016, the Indigenous population grew by 69%, from 6,580 to 11,145 individuals, increasing from 1.6% of the community to 2.4%. During that same period, the racialized population grew by 56%, from 48,915 to 76,460 individuals, growing from 12% of the population to 17%.

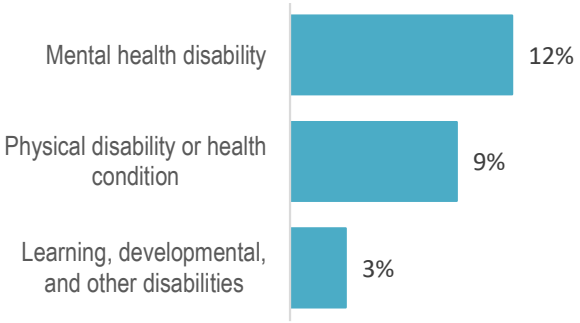
PERSONS WITH DISABILITIES

A person with a disability is defined as someone with a long-term or recurring physical, mental, sensory, psychiatric, or learning challenge.

20% of survey respondents reported having a disability similar to their representation in the external labour market.

12% reported a mental health disability, while 9% of survey respondents reported having a physical disability or health condition. In addition, about 3% of all survey respondents reported having a learning, developmental, or other type of disability.

Type of Disability, Permanent Full-Time and Part-Time Employees, Workforce Census.

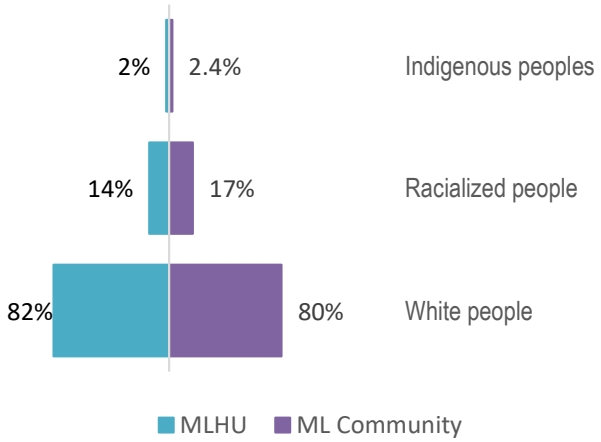


INDIGENOUS PEOPLES & RACIALIZED PEOPLE

Compared with their representation in the population of Middlesex-London, Indigenous peoples are slightly underrepresented in the MLHU workforce — fewer than 2% of employees who responded to the survey identify as Indigenous compared with 2.4% of the residents of Middlesex-London.

Similarly, racialized people are underrepresented in the MLHU workforce — 14% of survey respondents identified as racialized, compared with 17% of the residents of Middlesex-London.

Indigenous Peoples and Racialized People, Permanent Full-Time and Part-Time Employees, Workforce Census.



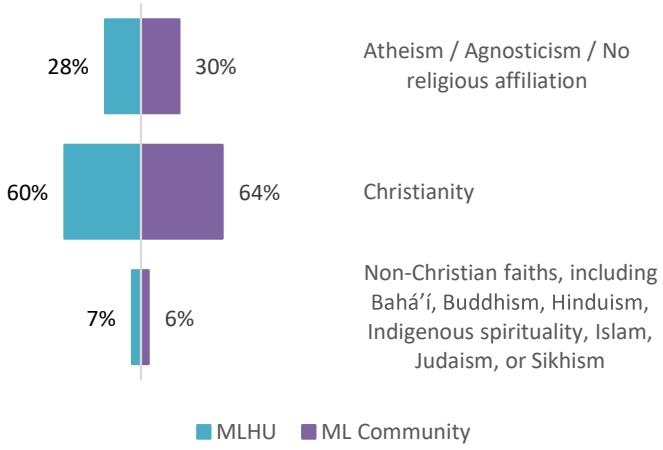
RELIGION/FAITH

Compared with the religious diversity of Middlesex-London, a similar proportion of MLHU employees reported being atheist, agnostic, or having no religious affiliation (28% of survey respondents versus 30%).

A slightly smaller proportion (60%) of MLHU employees reported being affiliated with Christianity compared with the proportion of Middlesex-London residents who identified that way (64%).

A similarly small proportion (7%) of MLHU employees identified with a non-Christian religion (e.g., Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism) compared with the proportion of the community served that identified that way (6%).

Religion/Faith, Permanent Full-Time and Part-Time Employees, Workforce Census.



GENDER/GENDER IDENTITY

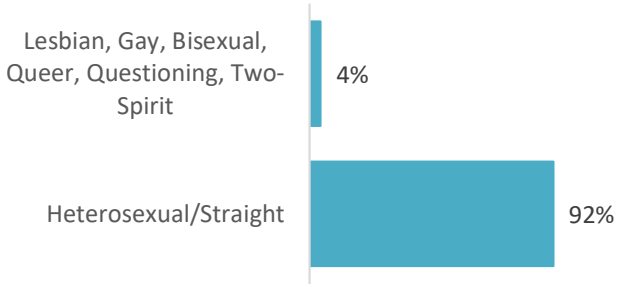
The vast majority of employees are women (82%), while 15% are men. This reflects the ongoing predominance of women in occupations that have been traditionally female-dominated, including public health nurses (the larges occupational group), and other public health professionals, such as dietitians and health promoters. While the survey gave employees the option of identifying as gender diverse, transgender, and Two-Spirit, none identified as such. An additional 3% (6 people) chose not to answer this question.

SEXUAL ORIENTATION

About 4% of respondents indicated that they identify as lesbian, gay, bisexual, queer, questioning, or Two-Spirit, while 92% identify as heterosexual. Four percent of employees chose not to answer this question.

The Census of Canada does not ask questions about sexual orientation.

Sexual Orientation, Permanent Full-Time and Part-Time Employees, Workforce Census.



ADDITIONAL ANALYSIS

Additional analysis of the data shows that:

- 54% of racialized employees had fewer than 5 years of service with the Health Unit, compared with 28% of White employees.
- Racialized employees have a younger age profile than their White counterparts. 38% percent of racialized employees and 19% of White employees are under the age of 35; 51% of racialized employees and 56% of White employees are aged 35 to 54; and 6% of racialized employees and 21% of White employees are aged 55 and older.
- Racialized employees represent 9% of public health nurses, far below their 28% representation among all nurses in Ontario. Furthermore, racialized people represent only 8% of leadership staff.
- While they represent 82% of all employees, women constitute only 64% of those in leadership positions.
- Persons with disabilities are well represented among all occupational groups, other than in leadership positions.
- While racialized employees represent 14% of permanent employees, they represent 27% of temporary and casual employees. They represent 36% of the COVID-19 staff hired and 33% of the administrative and support staff. In addition, 50% of the temporary and casual non-unionized administrative and support staff are racialized.
- All of the equity-seeking groups have a higher representation among casual and temporary employees compared with their representation among the permanent full-time workforce, except persons with disabilities. For Indigenous and racialized employees, their representation in temporary positions is double that of their representation in permanent positions. For those who identify as LGBTQ2S+, their representation is over three times their representation in permanent positions.

RECOMMENDATIONS

Based on these findings, the following recommendations have been made:

Recommendation 1: It is recommended that MLHU continue to work with unions to strengthen protocols to appropriately accommodate employees, which may mean accommodating employees across bargaining units and reviewing existing collective agreement language to addresses this point.

Recommendation 2: It is recommended that the Health Unit continue to provide supervisors and managers with access to training to ensure that they understand their legal obligations and are appropriately accommodating employees with disabilities.

Recommendation 3: It is recommended that MLHU continue to educate employees about mental health, with a focus on reducing stigma around mental health, increasing supports to employees, and equipping managers to support and accommodate employees.

Recommendation 4: It is recommended that the Health Unit undertake intentional and measurable efforts to increase the representation of Indigenous peoples and racialized people in its workforce.

Recommendation 5: It is recommended that MLHU explore the allocation of entry-level positions, including student positions, specifically for Indigenous peoples and racialized people.

Recommendation 6: It is recommended that Employee Resource Groups be created for Indigenous and racialized employees to allow them to provide input into MLHU actions intended to create more diverse and inclusive work environments.

Recommendation 7: It is recommended that the Health Unit ensure that managers are aware of their legal duty to provide religious accommodation to employees and what that means (e.g., time off for religious observance, accommodation of dietary restrictions, shift scheduling, and scheduling of meetings).

Recommendation 8: It is recommended that MLHU continue to offer multifaith prayer spaces and that MLHU conduct a survey of employees to ensure that these spaces are located in areas that are accessible to the employees who need it and that the locations and procedures to access these spaces are communicated to new and existing employees.

Recommendation 9: It is recommended that strategies be developed to create a more welcoming and positive workplace for employees regardless of gender identity and gender expression.

Recommendation 10: It is recommended that MLHU undertake a positive space campaign that includes delivering training and making resources available to assist managers, supervisors, and employees with creating safe and welcoming environments for those who identify as LGBTQ2S+.

Recommendation 11: It is recommended that MLHU focus on hiring more Indigenous and racialized people into positions of public health nurses.

Recommendation 12: It is recommended that MLHU launch a follow-up Workforce Census in 4 to 5 years to determine the success of the implementation of the recommendations outlined in this report and to increase the survey response rates for groups where response rates were low. In this next census, it is also recommended that MLHU adopt outreach strategies to reach the employees who did not respond to the 2021 census.

PART A: INTRODUCTION

1. Background

The Diversity and Inclusion Assessment is a key part of Middlesex-London Health Unit's (MLHU, the Health Unit) ongoing commitment to health equity. The assessment consists of two parts: an Employment Systems Review (ESR) and a Workforce Census. The ESR was completed in early May 2021. The Workforce Census is summarized in this report.

The results of the ESR and Workforce Census will enable MLHU to develop an Equity, Diversity, and Inclusion Action Plan that will not only help to ensure that the employees of the Health Unit better reflect the diverse community served but will also support all employees to contribute their best to the organization.

The goals of the Diversity and Inclusion Assessment are to:

- Understand the composition of the current workforce and how employees self-identify
- Inform the revision, enhancement, and/or development of current and future policies and practices in order to foster an equity-oriented and inclusive workplace culture
- Identify and respond to the experiences and expectations of diverse groups within the workplace with respect to inclusion, access, equity, engagement, and eliminating discriminatory practices
- Inform efforts to further develop an equity-oriented and inclusive workplace culture that prevents and responds to the existence of discrimination and oppression to engage, encourage, and support all employees to realize their full potential in the workplace, and
- Identify potential recommendations to address the identified issues.

Turner Consulting Group Inc. was contracted in December 2018 to conduct this Diversity and Inclusion Assessment. This work was delayed in 2019 because of uncertainty surrounding the potential merging of health units by the provincial government. It was delayed again in early 2020 because of the onset of the COVID-19 pandemic.

The Workforce Census collects specific demographic data on employees to establish a baseline for the diversity of the Health Unit's workforce, compared with the diversity of the community served, and to increase employees' sense of inclusion.

The census will provide the data to support evidence-based decision making. By better understanding who its employees are, the Health Unit will be able to identify gaps in

representation, enabling it to create programs, priorities, and resources to foster the growth of a more diverse workforce and an inclusive workplace for all employees.

Collecting and analyzing data that identifies people on the basis of race, disability, sexual orientation, and other identities is permitted, and in fact encouraged, by the Ontario *Human Rights Code* (the Code). The Ontario Human Rights Commission (OHRC) has found that "data collection can play a useful and often essential role in creating strong human rights and human resources strategies for organizations."[1]

The focus of a workforce census is on assessing the representation of the groups identified by the 1984 Royal Commission on Equality in Employment as experiencing persistent and systemic discrimination in employment, namely women, racialized people (or visible minorities), Indigenous peoples, and persons with disabilities. More recently, members of the LGBTQ2S+[2] community have also been identified as a group that experiences systemic barriers in employment. As such, this group, along with those who practice non-Christian religions, is also included in the equity efforts of many organizations. Employees who belong to these groups are collectively referred to throughout this report as "Indigenous peoples and members of the equity-seeking groups."

The OHRC notes that collecting and analyzing workforce data can be an effective and often essential tool for assessing whether people's rights under the Code are being or might potentially be infringed. Where underrepresentation exists or barriers to hiring and advancement have been identified, organizations have a duty to take corrective action to make sure that the Code is not being breached and will not be breached in the future.[3]

The OHRC requires that the data be collected in a way that follows accepted data collection techniques and abides by privacy and other applicable legislation. The OHRC also requires that the data be collected for a purpose that is consistent with the Code, such as:[4]

- Monitoring and evaluating potential discrimination
- Identifying and removing systemic barriers
- Lessening or preventing disadvantage, and

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[1] Ontario Human Rights Commission. (2009, November 26). *Count me in! Collecting human rights-based data*. http://www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data

[2] This is a shortened acronym that incorporates anatomical sex, sexual orientation, and gender identity and is meant to refer to the entire lesbian, gay, bisexual, trans, queer, questioning, intersex, pansexual, Two-Spirit, and asexual communities, otherwise referred to as LGBTQQIP2SAA.

[3] Ontario Human Rights Commission. (2009, November 26). *Count me in! Collecting human rights-based data*. http://www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data/2-when-collecting-data-good-idea

[4] Ibid.

- Promoting substantial equity for people identified by Code grounds.

The key questions to be answered by this Workforce Census are the following:

- What is the current demographic makeup of Health Unit employees?
- What is the representation of employees in various demographic groups, including disability, religion/faith, Indigenous identity, racial identity, gender identity, and sexual orientation?
- How does the diversity of the Health Unit workforce compare with that of the residents living in Middlesex-London?

2. The Demographic Context

Middlesex-London is a growing community, with more people, jobs, and services expected to come to the region in the coming years. This increase has been fueled by rising housing prices in Toronto, with many people moving farther away from the city in search of affordable housing. This growth will be further fuelled by the COVID-19 pandemic, with Toronto experiencing a record population loss as more people move away from the city in response to work-from-home options becoming increasingly available.

Fuelled largely by immigration, Ontario's racialized population is growing at a faster rate than the provincial population and is making up an increasingly larger proportion of the provincial population. The same is true of the racialized population in the Middlesex-London community.

Table 1. Rate of Population Growth, Indigenous, Racialized, and Total Population (2006–2016).

	Indigenous Population			Racialized Population			Total Population	
Year	#	% of Population	Rate of Growth Since 2006	#	% of Population	Rate of Growth Since 2006	#	Rate of Growth Since 2006
ONTARIO								
2006	242,490	1.8%		2,745,200	21%	—	12,851,821	—
2016	374,395	2.8%		3,885,585	29%	42%	13,448,494	5%
MIDDLESEX-LONDON HEALTH UNIT COMMUNITY								
2006	6,580	1.6%	—	48,915	12%	—	422,333	—
2016	11,145	2.4%	69%	76,460	17%	56%	455,526	8%

Source: Statistics Canada, Census of Canada, 2006, 2016.

As Table 1 shows, between 2006 and 2016 the racialized population in Ontario grew by 42% (from 2,745,200 to 3,885,585), while the population of the province grew by only 5% (from 12,851,821 to 13,448,494). As such, the racialized population increased from 21% of Ontario's population in 2006 to 29% of the provincial population in 2016.

The table also shows that Middlesex-London is growing at a faster rate than the provincial population overall; Middlesex-London grew by 8% between 2006 and 2016, while the provincial population grew by only 5% during this time.

Furthermore, Middlesex-London's racialized population grew by 56%, from 48,915 to 76,460 individuals, growing from 12% of the population in 2006 to 17% in 2016.

During that same period, Middlesex-London's Indigenous population grew by 69%, from 6,580 to 11,145 individuals, increasing from 1.6% of the community to 2.4%.

Because of Statistics Canada's persistent undercounting of the Indigenous population, MLHU also conducted a community-drive survey for Indigenous peoples in London.[5] The Our Health Counts London study found that there are more than twice the number of Indigenous people in London than was estimated by Statistics Canada (22,673 and 29,361).

The Indigenous community has been identified as one of the fastest-growing populations in Canada. Statistics Canada also projects that the racialized population will continue to grow at a faster rate than the general population, resulting in racialized people representing a larger proportion of the population over the coming years. While the growth of the racialized population will be fueled largely by immigration, a growing proportion of racialized people are Canadian-born. In 2011, about 31% of racialized people in Canada were born here.[6]

Statistics Canada projections show that the provincial population will approach 18 million by 2036, with the racialized population increasing to 48% of the population.[7] No projections on the growth of Middlesex-London's racialized population are available.

3. The Workforce Census

3.1 The Survey

This work was led and supported by the Health Equity and Indigenous Reconciliation Team. The Diversity and Inclusion Advisory Committee, consisting of staff from various divisions and levels of the organization, including representatives from both unions, also provided input into the census questions and reviewed and provided input into the draft report.

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[5] Southwest Ontario Aboriginal Health Access Centre. (n.d.). *Our Health Counts London*. https://soahac.on.ca/our-health-counts/

[6] Statistics Canada. (2016, September 15). *Immigration and ethnocultural diversity in Canada*. https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm

[7] Statistics Canada. (2017, January 25). *Immigration and diversity: Population projections for Canada and its regions, 2011 to 2036*. https://www.statcan.gc.ca/pub/91-551-x/91-551-x2017001-eng.htm

The census questions were designed to focus on the groups that experience systemic and persistent disadvantage in the labour market. The questions were designed to allow for a direct comparison of the composition of the Health Unit's workforce to the 2016 Statistics Canada Census data and other relevant data sources.

Additional data on age, length of service, occupation, and type of employment was collected to assist in the analysis of the demographic data and thus identify any barriers to hiring and advancement within the organization.

The survey consisted of 13 questions and took respondents less than 10 minutes to complete. The completion of the Workforce Census was voluntary, and participants could choose not to participate in the census in its entirety. If they chose to participate in the census, they were able to opt out of answering any of the questions by selecting the response "I prefer not to answer." Employees were also able to exit the survey at any time.

3.2 Privacy Protections

An online survey service provider (Survey Monkey) was used to host the online census and capture the data. Survey Monkey encrypts all data in transit and provides a high level of security for the storage of the data. Furthermore, only authorized employees from Turner Consulting Group Inc. were able to access the data on password-protected computers.

Additional steps also have been taken to ensure that individual employees cannot be identified in this report. First, smaller work units have been grouped with other units. Where fewer than 10 employees identified as belonging to a particular identity group, the data has been grouped with other categories. For example, because a small number of people responded that they practise various non-Christian faiths such as Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism, they have been grouped into one category.

3.3 Administration of the Survey

A high survey response rate is critical to painting an accurate picture of the diversity of the workforce — the more employees who complete the survey, the more accurate the snapshot will be.

Key to a high survey response rate is how the survey is administered. The goal of the survey administration strategy is to ensure that all employees know about and are able to complete the survey. Critical to achieving this goal is a communications strategy that informs all employees about the census, addresses their concerns, and encourages them to participate in this important organizational initiative. As such, a communications strategy

was developed to ensure that all MLHU employees were informed about the census prior to its launch and could have their questions about the census answered.

Employees were informed about the census using various communication tools before and after the launch of the census. Emails were sent to all staff to introduce the census, and reminder emails were sent to encourage them to complete the census. The census was announced through an email sent by the Chief Nursing Officer. One reminder was email sent by the Medical Officer of Health and another by the Chief Nursing Officer. The Manager, Health Equity and Indigenous Reconciliation also sent emails to the managers to remind them to encourage participation within their teams. In addition, two townhall meetings were used to remind staff of the census. The consultant attended one of the townhall meetings to provide staff with an overview presentation of the census.

The emails also provided staff with the link to the Diversity and Inclusion Assessment website, hosted by the consultant, which provided further information on the census, answered frequently asked questions, and provided information on how employee privacy and confidentiality would be maintained.

In addition, posters were printed and distributed for display at MLHU's primary offices to announce the census initiative, the date of the census, and the website employees could visit for further information. As nearly all employees were working from home because of the pandemic, electronic communication was prioritized.

Census Week was designated as April 23 to 30, 2021. On that day, an email was sent from the Chief Nursing Officer, and the lead of this project, to all employees with a link to the online survey. Staff were also given time at the weekly townhall meeting on both April 23 and 30 to complete the census.

3.4 Analyzing the Data

Preparation and analysis of the data occurred in three stages: data vetting, data entry, and data analysis.

Data vetting and recoding are important steps that ensure that the data collected through the census can be analyzed. Data vetting involved reviewing answers to the census questions and ensuring that the information provided was sufficiently accurate. If someone wrote in a response to a question that fit into a preestablished category, the answer was recoded into the correct category. For example, if they wrote in "Catholic" in response to the question about faith or religion, the answer was categorized as Christian.

The goal of the census was to identify areas of underrepresentation for Indigenous peoples and members of the equity-seeking groups and any potential barriers to their hiring and advancement. As such, areas of underrepresentation are identified and recommendations made for where the Health Unit should focus its attention. However, the recommended actions have not been prioritized in this report. Instead, MLHU should consider the recommendations from this report and those in the ESR report, along with available resources, related activities, and strategies, in order to prioritize them and develop an implementation plan. So, while the consultants have analyzed the data to identify what the issues are and how they can be addressed, it is up to MLHU to determine the specific actions to be taken and when these actions will be implemented.

In our analysis, we also comment on the proportion of survey respondents who chose not to answer a particular question. These responses give potential insight into the perspectives of those with marginalized versus dominant identities. First, those with marginalized identities may have chosen not to answer particular questions because of fear of disclosure. In this context, marginalized identities can include those with hidden identities, such as people who identify as LGBTQ2S+, have a non-evident disability, identify as Indigenous, or practise a non-Christian religion. They may choose not to self-identify as belonging to a particular group out of fear that disclosure could have negative repercussions on their current and future job prospects within the organization.

In addition, employees may be part of the dominant group and may have misunderstandings about the purpose of the census (e.g., I'm going to lose my job if I don't identify with a marginalized identity). They may also feel offended that they are asked to identify their race, gender identity, sexual orientation, and so on. As such, high rates of refusing to answer particular questions are noted, as this information provides the Health Unit with insight as to where additional education about workplace equity, diversity, and inclusion may be needed.

3.5 Retaining the Data

This survey represents a snapshot of the composition of the organization as of April 2021. The database will be retained by Turner Consulting Group for 1 year following the completion of this report, which gives the Health Unit the opportunity to request any additional analyses of the data. At the end of the 1-year period, the database will be deleted.

4. Survey and Response Rates

4.1 Survey Rate

Section A of the Workforce Census asked employees whether they wished to participate in the census. If they chose not to participate, employees were given the opportunity to share why.

While participating in the survey was voluntary, all employees were asked to complete this section of the census to allow MLHU to determine the extent to which all employees received the census and were provided with the opportunity to complete it. This question also provides an opportunity to better understand why employees might have chosen not to participate in the census.

The survey rate represents the number of employees who confirmed that they received the survey, whether or not they completed it. The goal was to achieve a survey rate of 100%, meaning that all employees knew about and indicated that they had the opportunity to complete the survey. Unfortunately, we are unable to account for the employees who received the survey, chose not to participate, but also chose not to return the paper survey or chose not to indicate their non-participation on the online survey.

The formula for calculating the survey rate is as follows:

$$\text{Survey rate} = \frac{\text{Number of employees that completed Section A whether or not they participated in the census}}{\text{Total number of MLHU employees}} \times 100$$

The survey was administered to all Health Unit employees. Of the Health Unit's total of 671 permanent, temporary, and casual employees, 493 indicated that they received and were given the opportunity to participate in the census. This is a survey rate of 73%. Of those who received the survey, 6 (1%) indicated that they did not want to participate.

4.2 Response Rate

The response rate is the proportion of employees who chose to participate in the survey by answering at least one of the questions. The Canadian Human Rights Commission has identified that a survey response rate of 80% provides a more accurate reflection of the composition of an organization's workforce.

The response rate was calculated as follows:

$$\text{Response rate} = \frac{\text{Number of employees who participated in the survey by answering at least one question}}{\text{Total number of MLHU employees}} \times 100$$

As Table 2 shows, the response rate for Health Unit employees varies greatly by employment type, from a low of 21% for permanent casual employees to a high of 86% for permanent full-time employees.

Table 2. Response Rate by Employment Type, Workforce Census.

Employment Type	Total Employees #	Survey Respondents #	Response Rate %
Permanent full-time	236	204	86%
Permanent part-time	23	14	61%
Permanent casual	19	4	21%
Temporary (full-time, part-time, casual, and student or volunteer)	393	223	57%
Prefer not to respond	—	4	—
TOTAL	**671**	**449**	**67%**

The differences in response rate by employment type reflect the fact that some groups of employees are inherently harder to communicate with and engage, including employees who don't have daily access to a computer as well as casual employees who may only work a few hours a week.

Given the low response rate for permanent casual and temporary employees, the focus of this analysis is the permanent full-time and part-time employees, who had an overall response rate of 84%.

PART B: SUMMARY OF THE DATA

5. Demographic Overview

5.1 Disability

The Workforce Census asked employees to identify whether they have a disability, and if so, to specify the type of disability.

The survey described a person with a disability as someone with a long-term or recurring physical, mental, sensory, psychiatric, or learning challenge. Examples of disabilities include:

- Learning disability (e.g., dyslexia, ADHD, etc.)
- Mental health disability (e.g., depression, bipolar, anxiety, PTSD, etc.)
- Physical disability or health condition (e.g., vision loss (uncorrected by glasses), hearing loss (uncorrected by a hearing aid), speech difficulties, mobility issues, chronic pain, epilepsy, amputation, multiple sclerosis, etc.)
- Developmental disability (e.g., autism spectrum disorder, brain injury, cerebral palsy, spina bifida, etc.), and
- Any other disability affecting the ability to work and/or to perform activities of daily living.

As shown in Table 3, 20% of survey respondents reported having a disability, while 75% reported that they do not and 5% chose not to answer this question.

Table 3. Persons with Disabilities, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees	
	#	%
Person with a disability	43	20%
Person without a disability	163	75%
Prefer not to answer	10	5%
TOTAL	**216**	**100%**

The 2017 Canadian Survey on Disability (CSD) is a national survey of Canadians aged 15 and over whose everyday activities are limited because of a long-term condition or health-related problem.[8] The CSD provides comprehensive data on persons with disabilities, including information on disability types and severity, employment profiles, income,

[8] 2016 Statistics Canada Census data on disability is not available, as this question is not asked in the Census. Instead, special surveys are conducted periodically to assess the extent to which Canadians experience disability.

education, and other disability-specific information. The CSD definition of disability includes anyone who reported being limited in their daily activities owing to a long-term condition or health problem.[9] The CSD provides data at the national and provincial levels, but not at the city level. As such, data specific to the prevalence of disability in the Middlesex-London population is not available.

The CSD found that 20% of Ontario's working-age population (25 to 64 years) reported having a disability.[10] As such, the proportion of survey respondents with a disability (20%) is comparable to the proportion within the provincial working-age population.

Individuals who identified that they had a disability were then asked to specify the type of disability. As employees may have more than one disability, survey respondents were able to check all that apply.

Employees' responses indicate that mental health and physical disabilities are the most common type of disability experienced by MLHU employees — 12% reported a mental health disability, while 9% of survey respondents reported having a physical disability or health condition. In addition, about 3% of all survey respondents reported having a learning, developmental, or other type of disability.

Table 4. Persons with Disabilities, Type of Disability, Permanent Full-Time and Part-Time Employees, Workforce Census.

Type of Disability	Permanent Full-Time and Part-Time Employees	
	#	%*
Mental health disability	25	12%
Physical disability or health condition	19	9%
Learning, developmental, and other disabilities	7	3%
Prefer not to answer	1	0.5%
Total reporting a disability	**43**	**20%**
TOTAL	**216**	**—**

*Individual percentages add up to more than 21% owing to multiple responses.

Implications and Recommendations

With 20% of survey respondents reporting some form of disability, the Health Unit must ensure that both managers and employees understand MLHU's legal obligation to provide accommodation under the Ontario *Human Rights Code.* It is also important to ensure that unions are aware of their obligations, as they have a duty to assist in an employer's

[9] Morris, S., Fawcett, G., Brisebois, & Hughes, J. (2018, November 28). *A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017.* Statistics Canada. https://www150.statcan.gc.ca/n1/pub/89-654-x/89-654-x2018002-eng.htm

[10] Statistics Canada. (2012). *Canadian* Survey *on Disability, 2012*. http://www.statcan.gc.ca/pub/89-654-x/89-654-x2015001-eng.htm

attempts to accommodate employees. Case law has made it clear that when an employee is unable to fulfill the duties of their position, the search for alternatives must be extensive, including, as a last resort, looking for accommodation outside the bargaining unit. The Supreme Court of Canada has held that a union has a duty to cooperate with an employer's accommodation attempts, even if it means going outside the terms of the collective agreement.[11]

In addition, with reports of mental health disability outnumbering those of physical disability, the Health Unit may want to consider strengthening efforts to reduce stigma around mental health, increasing supports to employees, equipping managers to support employees, and creating a more welcoming and inclusive work environment.

Recommendation 1: It is recommended that MLHU continue to work with unions to strengthen protocols to appropriately accommodate employees, which may mean accommodating employees across bargaining units and reviewing existing collective agreement language to address this point.

Recommendation 2: It is recommended that the Health Unit continue to provide supervisors and managers with access to training to ensure that they understand their legal obligations and are appropriately accommodating employees with disabilities.

Recommendation 3: It is recommended that MLHU continue to educate employees on mental health, with a focus on reducing stigma around mental health, increasing supports to employees, and equipping managers to support and accommodate employees.

5.2 Indigeneity and Racial Identity

The survey asked employees to respond to two questions about whether they identify as being of North American Indigenous ancestry and the race with which they identify, regardless of place of birth or ethnicity.

Table 5 provides the responses in the categories of North American Indigenous, White/European, and racialized. Because of their small numbers, the racial subgroups have been grouped together under the category of racialized.

[11] Anand, G. (n.d.). *The boundaries of the duty to accommodate: How far does an employer have to go?* Canadian Association of Counsel to Employers. CACE 5th Annual Conference. https://businessdocbox.com/Human_Resources/69589195-By-gita-anand-miller-thomson-llp-with-the-assistance-of-adrienne-campbell.html

Table 5. Indigenous and Racialized Population, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees		Middlesex-London Health Unit (2016 Census) [12]
	#	%	%
North American Indigenous	<5	<2%	2.4%
White/European	177	82%	80%
Racialized	31	14%	17%
Prefer not to answer	4	2%	—
TOTAL	**216**	**100%**	**100%**

Compared with their representation in the population of Middlesex-London, Indigenous peoples are slightly underrepresented in the MLHU workforce — fewer than 2% of employees who responded to the survey identify as Indigenous compared with 2.4% of the residents of Middlesex-London.

Similarly, racialized people are underrepresented in the MLHU workforce — 14% of survey respondents identified as racialized, compared with 17% of the residents of Middlesex-London. This is a gap of 6 individuals.

By contrast, 82% of survey respondents identified as White, which is slightly higher than their representation of 80% of the residents of Middlesex-London.

Implications and Recommendations

This data shows that MLHU needs to do more to increase the representation of Indigenous and racialized employees to reflect the diversity in the community served.

Recommendation 4: It is recommended that the Health Unit undertake intentional and measurable efforts to increase the representation of Indigenous peoples and racialized people in its workforce.

Recommendation 5: It is recommended that MLHU explore the allocation of entry-level positions, including student positions, specifically for Indigenous peoples and racialized people.

Recommendation 6: It is recommended that Employee Resource Groups be created for Indigenous and racialized employees to provide input into MLHU actions intended to create more diverse and inclusive work environments.

[12] Statistics Canada. (2016). *Community profile*.

5.3 Religion/Faith

The Workforce Census asked MLHU employees to identify which faith, religion, or belief group they identify with.

Table 6. Religion or Faith Group, Permanent Full-Time and Part-Time Employees, Workforce Census.

Religion/Faith Group	Permanent Full-Time and Part-Time Employees		Middlesex-London Health Unit (2011 National Household Survey) [13]
	#	%	%
Atheism / Agnosticism / No religious affiliation	61	28%	30%
Christianity	129	60%	64%
Non-Christian faiths, including Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism	14	7%	6%
Prefer not to answer	11	5%	—
TOTAL	**215**	**100%**	**100%**

Compared with the religious diversity of Middlesex-London, a similar proportion of MLHU employees reported being atheist, agnostic, or having no religious affiliation (28% of survey respondents versus 30%). A slightly smaller proportion (60%) of MLHU employees reported being affiliated with Christianity compared with the proportion of Middlesex-London residents who identified that way (64%). A similarly small proportion (7%) of MLHU employees identified with a non-Christian religion (e.g., Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism) compared with the proportion of the community served that identified that way (6%).

Of all the demographic questions, this question had the highest non-response rate — 5% of survey respondents chose not to identity their religion or faith.

Implications and Recommendations

In 2011,[14] most Canadians reported some religious affiliation. However, over time, the Census shows that there have been dramatic changes to the religious affiliation reported

[13] Statistics Canada. (2011). *Community profile*. https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3544&Data=Count&SearchText=middlesex&SearchType=Begins&SearchPR=01&A1=All&B1=All&Custom=&TABID=1

2011 National Household Survey data is used here, as religion is asked on the Canadian Census every 10 years. As such, data from the 2016 Census is not available. Note also that in 2011 the Government of Canada replaced the Census with a National Household Survey. The Census was reinstated for 2016.

[14] The Census asks questions on religion every 10 years. As such, the 2011 National Household Survey provides the most recent data available.

as well as an increase in the proportion of the population that reports no religious affiliation. Immigration continues to gradually change the religious diversity within Canada. As the country of origin of immigrants has shifted, so too has the religious composition of the Canadian population.

As such, the trend toward increasing religious diversity will continue for decades to come. While data specific to the Middlesex-London community is not available, Statistics Canada projections show that the proportion of people who report having no religion will increase to 35% in 2036, while the proportion of those affiliated with non-Christian religions could almost double by 2036 to between 13% and 16% of Canada's population.[15] Muslims are expected to make up half of this group.

The Census data shows that most residents of Middlesex-London (64%) are affiliated with Christianity. The number of residents who belong to other religions — including Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism — is growing. Collectively, these religious groups account for more than 1 in 10 Canadians (11%) as of 2011, up from 4% in 1981.[16] In Middlesex-London, residents who reported an affiliation with a non-Christian faith represented 6% of the population.

The Census also shows an increase in the number of people who reported that they have no religious affiliation. Before 1971, fewer than 1% of Canadians reported no religious affiliation. In the 2011 National Household Survey, 30% of Middlesex-London residents reported no religious affiliation. It should be noted that those who reported no religious affiliation are not necessarily absent of spiritual beliefs. Instead, they may not identify with a particular religious group. In fact, 80% of Canadians say that they believe in God.[17]

The growing number of employees who report being affiliated with non-Christian religions raises the need for the Health Unit to ensure that religious accommodation is provided, which goes beyond the policy of giving days off for religious observance to include dress, prayer space, and adjusted shifts.

Recommendation 7: It is recommended that the Health Unit ensure that managers are aware of their legal duty to provide religious accommodation to employees and what that

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[15] Morency, J., Malenfant, E. C., & MacIsaac. (2017, January 25). *Immigration and diversity: Population projections for Canada and its regions, 2011 to 2036.* https://www150.statcan.gc.ca/n1/pub/91-551-x/91-551-x2017001-eng.htm

[16] Pew Research Center. (2013, June 27). *Canada's changing religious landscape.* http://www.pewforum.org/2013/06/27/canadas-changing-religious-landscape/

[17] Baha, S. A. (2015). The spirituality of atheist and "no religion" individuals in the millennial generation: Developing new research approaches for a new form of spirituality. *The Arbutus Review*, *6*(1): 63–75.

means (e.g., time off for religious observance, accommodation of dietary restrictions, shift scheduling, and scheduling of meetings).

Recommendation 8: It is recommended that MLHU continue to offer multifaith prayer spaces and that MLHU conduct a survey of employees to ensure that these spaces are located in areas that are accessible to the employees who need it and that the locations and procedures to access these spaces are communicated to new and existing employees.

5.4 Gender / Gender Identity

The Workforce Census asked employees to identify their gender identity. Gender identity is a person's internal and individual experience of gender, which may not correspond to their biological sex assigned at birth.

As Table 7 shows, the vast majority of employees are women (82%), while 15% are men. This reflects the ongoing predominance of women in occupations that are traditionally female-dominated, including public health nurses (the larges occupational group) and other public health professionals, such as dietitians and health promoters.

Table 7. Gender / Gender Identity, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees		Middlesex-London Health Unit (2016 Census)[18]
Gender	**#**	**%**	**%**
Woman	176	82%	51%
Man	32	15%	49%
Gender Diverse / Transgender / Two-Spirit	—	—	—
Prefer not to answer	6	3%	—
TOTAL	**214**	**100%**	**—**

While the survey gave employees the option of identifying as gender diverse, transgender, and Two-Spirit, none identified as such. An additional 3% (6 people) chose not to answer this question.

While the 2016 Census of Canada collected data on gender, it did not allow Canadians to identify a gender other than "woman" or "man." As such, no Census data is available on Canadians who identify as gender diverse or transgender.[19]

[18] Statistics Canada. (2016). *Community profile*.

[19] The 2021 Census will be the first time that transgender Canadians are counted.

Implications and Recommendations

While no survey respondents reported that they identify as gender diverse, transgender, or Two-Spirit, it is important to ensure that the workplace is welcoming and inclusive of existing employees who identify this way and simply chose not to self-identify on the survey, as well as future gender-diverse employees.

Recommendation 9: It is recommended that strategies be developed to create a more welcoming and positive workplace for employees regardless of gender identity and gender expression.

5.5 Sexual Orientation

The census asked employees to identify their sexual orientation. It provided the options of bisexual, gay, heterosexual/straight, lesbian, queer, questioning, and Two-Spirit. If a survey respondent did not identify with one of these sexual orientations, employees were able to write in their sexual orientation.

Table 8. Sexual Orientation, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees	
Sexual Orientation	**#**	**%**
Lesbian, Gay, Bisexual, Queer, Questioning, Two-Spirit	9	4%
Heterosexual/Straight	196	92%
Prefer not to answer	9	4%
TOTAL	**214**	**100%**

Because the number of people who reported that they identify as lesbian, gay, bisexual, queer, questioning, or Two-Spirit was small, their responses are grouped into one category. About 4% of respondents indicated that they identify as lesbian, gay, bisexual, queer, questioning, or Two-Spirit, while 92% identify as heterosexual. Four percent of employees chose not to answer this question.

The Census of Canada does not ask questions about sexual orientation. As such, we must rely on other population surveys for an estimate of the LGBTQ2S+ population. One estimate comes from the 2014 Canadian Community Health Survey (CCHS), which was the first Statistics Canada survey to include a question on sexual orientation.[20] The CCHS found that 3% of Canadians aged 18 to 59 self-identified as gay, lesbian, or bisexual (1.7% self-identified as gay or lesbian and 1.3% as bisexual).[21] This survey also employed a conservative approach to measuring sexual orientation, asking only whether a person was

[20] This survey resulted in limited provincial estimates and does not provide estimates for cities.

[21] Statistics Canada. (2015). *Canadian Community Health Survey, 2014*. https://www.statcan.gc.ca/eng/dai/smr08/2015/smr08_203_2015

gay, lesbian, or bisexual. Therefore, it likely underestimates the representation of those who do not identify as heterosexual.

Another estimate of the size of the LGBTQ2S+ population comes from a 2012 Forum Research poll, which found that 5% of Canadians aged 18 and over identify as lesbian, gay, bisexual, or transgender.[22] Again, given the limited categories, this poll likely also underestimates the representation of those who do not identify as heterosexual.

Studies in other countries, which worded questions differently, estimate a gay, lesbian, and bisexual population of between 1.5% and 7%.[23] One 2011 study found that approximately 3.5% of the U.S. population is gay, lesbian, or bisexual and 0.3% is transgender.[24]

Using these estimates, survey respondents who identify as LGBTQ2S+ appear to be well represented in the MLHU workforce.

Implications and Recommendations

Given that the question on sexual orientation had one of the highest non-response rates (4%), there may be employees who either don't feel safe disclosing their identity or who are heterosexual and don't feel comfortable answering this question.

Recommendation 10: It is recommended that MLHU undertake a positive space campaign that includes delivering training and making resources available to assist managers, supervisors, and employees with creating safe and welcoming environments for those who identify as LGBTQ2S+.

6. Additional Analysis

6.1 Age and Years of Service of Racialized and White Employees

Graph 1 compares the years of service of racialized and White employees.

The data shows that 54% of racialized employees had fewer than 5 years of service with the Health Unit, compared with 28% of White employees. This data suggests that increased hiring of racialized employees took place in the past 5 years. It may also indicate that racialized staff hired more than 5 years ago have not remained with the organization.

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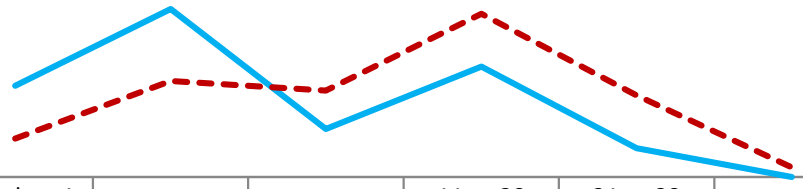
[22] Carlson, K. B. (2012, July 6). The true north LGBT: New poll reveals landscape of gay Canada. *National Post*. http://news.nationalpost.com/news/canada/the-true-north-lgbt-new-poll-reveals-landscape-of-gay-canada

[23] Rogers, S. (2010). *Gay Britain: Inside the ONS statistics.* The Guardian, DataBlog. http://www.guardian.co.uk/news/datablog/2010/sep/23/gay-britain-ons

[24] Gates, Gary J. (2011). *How many people are lesbian, gay, bisexual, and transgender?* The Williams Institute. https://www.schoolnewsnetwork.org/attachments/Gates-How-Many-People-LGBT-Apr-2011.pdf

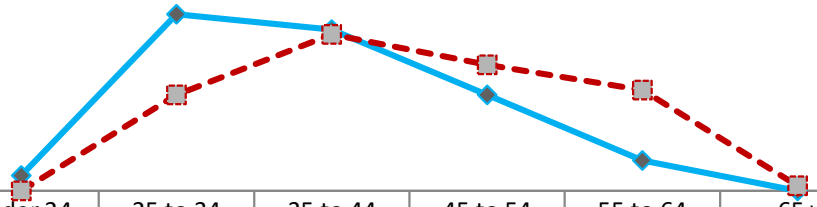
Graph 1. Years of Service, Racialized and White Employees, Permanent Full-Time and Part-Time Employees, Workforce Census.



	Less than 1 year	1 to 5 years	6 to 10 years	11 to 20 years	21 to 30 years	30+
Racialized employees	19%	35%	10%	23%	6%	0%
White employees	8%	20%	18%	34%	17%	2%

Graph 2 shows that racialized employees have a younger age profile than their White counterparts. Thirty-eight percent of racialized employees and 19% of White employees are under the age of 35; 51% of racialized employees and 56% of White employees are aged 35 to 54; and 6% of racialized employees and 21% of White employees are aged 55 and older.

Graph 2. Age, Racialized and White Employees, Permanent Full-Time and Part-Time Employees, Workforce Census.



	Under 24	25 to 34	35 to 44	45 to 54	55 to 64	65+
Racialized employees	3%	35%	32%	19%	6%	0%
White employees	0%	19%	31%	25%	20%	1%

The data suggests that while the Health Unit has been doing more to hire racialized employees in the past 5 years, more needs to be done to increase the representation of racialized people in the MLHU workforce to better reflect the population served. Furthermore, MLHU needs to ensure that it creates work environments that are inclusive, respectful, and responsive to the needs of people from diverse backgrounds. This will ensure that MLHU not only recruits employees from diverse backgrounds, but also retains them.

6.2 Occupation

Also important to this analysis is the diversity within the various occupational groups.

Table 9. Representation of the Equity-Seeking Groups by Occupation, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Women	Racialized People	LGBTQ2S+	Persons with Disabilities
Public Health Program Staff: Public Health Nurse, Community Health Nursing Specialist, Immunizer (nurse)	99%	9%	6%	23%
Public Health Program Staff: Dental Assistant, Dental Hygienist, Dietitian, Epidemiologist, Program Evaluator, Family Home Visitor, Health Promoter, Public Health Inspector, Tobacco Enforcement Officer, Test Shopper, Vector-Borne Disease Coordinator and/or Field Technician, Librarian, Outreach Worker, Physician	75%	20%	3%	20%
Public Health Program Staff:* Contact Tracer, Contact Tracer Lead, Case Investigator Lead, Immunizer (non-nurse), Screener, Greeter/Navigator, Reconstitutioner, Post-Vaccination Staff	—	—	—	—
Administrative and Support Staff: Administrative Assistant, Data Analyst, Clinical Team Assistant, Program Assistant, IT staff (e.g., Network / Telecommunications Analyst, Desktop / Applications Analyst), Corporate Trainer, Online Communications Coordinator, Client Service Representative, Receiving and Operations Coordinator, Marketing Coordinator	76%	21%	—	24%
Administrative and Support Staff: Finance Staff, Non-Union Human Resource Staff, Executive Assistant, Senior Executive Assistant	83%	—	—	25%
Leadership Staff: Chief Executive Officer, Medical Officer of Health, Associate Medical Officer of Health, Chief Nursing Officer, Director, Senior Manager, Manager, Supervisor	64%	8%	—	11%
	82%	**14%**	**3%**	**20%**

*Only a small number of permanent employees indicated that they work in this occupational group. As such, no analysis has been conducted for this occupational group.

Among permanent employees, women represent nearly all nurses and a smaller proportion of the other occupational groups. Most notable is that while they represent 82% of all employees, women constitute only 64% of those in leadership positions.

Racialized employees represent 14% of all employees; they make up 20% of non-nursing public health program staff and 21% of unionized administrative and support staff. However, they represent only 9% of public health nurses. This is far below their 28% representation among all nurses in Ontario. Furthermore, racialized people represent only 8% of leadership staff.

Those who identify as LGBTQ2S+ appear to be employed only among permanent public health staff.

Persons with disabilities are well represented among all occupational groups, other than leadership positions. While it is unknown what contributes to this high representation in these occupations, job demands that lead to illness or injury may be a contributor. Additionally, while it is also unknown why there is low representation in leadership positions, the current societal model of leadership, which does not lend itself to accommodations, may be a contributor.

Because of the small number of Indigenous employees, they have not been included in this analysis by occupation.

Recommendation 11: It is recommended that MLHU focus on hiring more Indigenous and racialized people into public health nurse positions.

Table 9. Representation of the Equity-Seeking Groups by Occupation, Temporary and Casual Employees, Workforce Census.

	Women	Racialized People	LGBTQ2S+	Persons with Disabilities
Public Health Program Staff: Public Health Nurse, Community Health Nursing Specialist, Immunizer (nurse)	93%	9%	7%	17%
Public Health Program Staff: Dental Assistant, Dental Hygienist, Dietitian, Epidemiologist, Program Evaluator, Family Home Visitor, Health Promoter, Public Health Inspector, Tobacco Enforcement Officer, Test Shopper, Vector-Borne Disease Coordinator and/or Field Technician, Librarian, Outreach Worker, Physician	75%	8%	8%	8%
Public Health Program Staff: Contact Tracer, Contact Tracer Lead, Case Investigator Lead, Immunizer (non-nurse), Screener, Greeter/Navigator, Reconstitutioner, Post-Vaccination Staff	73%	36%	8%	10%
Administrative and Support Staff: Administrative Assistant, Data Analyst, Clinical Team Assistant, Program Assistant, IT staff (e.g., Network / Telecommunications Analyst, Desktop / Applications Analyst), Corporate Trainer, Online Communications Coordinator, Client Service Representative, Receiving and Operations Coordinator, Marketing Coordinator	83%	33%	10%	14%
Administrative and Support Staff: Finance Staff, Non-Union Human Resource Staff, Executive Assistant, Senior Executive Assistant	75%	50%	17%	—
Leadership Staff: Chief Executive Officer, Medical Officer of Health, Associate Medical Officer of Health, Chief Nursing Officer, Director, Senior Manager, Manager, Supervisor	—	—	—	—
	69%	**27%**	**11%**	**13%**

Women constitute 69% of temporary and casual employees, 93% of public health nurses, and a smaller proportion of those in the other occupational groups.

While racialized employees represent 14% of permanent employees, they represent 27% of temporary and casual employees. They represent only 9% of public health nurses and 8% of other public health program staff. However, they represent 36% of the COVID-19 staff hired and 33% of the administrative and support staff. In addition, 50% of the temporary and casual non-unionized administrative and support staff are racialized.

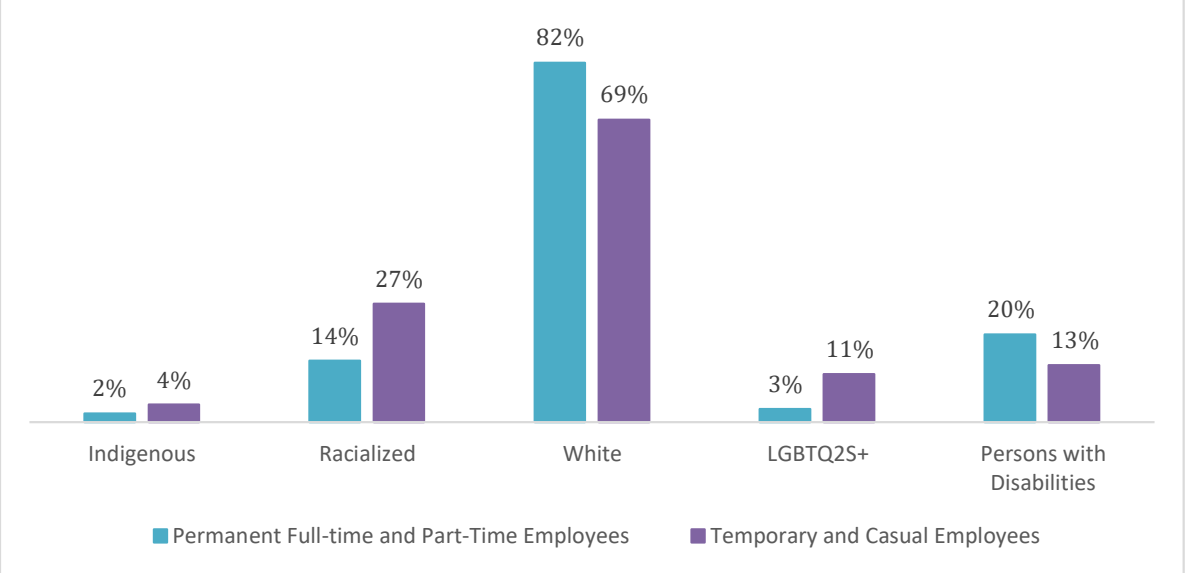
Among temporary and casual employees, those who identify as LGBTQ2S+ are better represented among all occupational groups (other than leadership staff).

A smaller proportion of persons with disabilities are employed on a temporary and casual basis (13%) than among permanent positions (20%); their representation is also lower in each occupational group for those who are temporary and casual as opposed to permanent employees.

6.3 Casual and Temporary Employees

Another important area of consideration is the overall increase in precarious employment in the labour market, with racialized people and Indigenous peoples less likely to be employed in full-time permanent positions. Their White counterparts therefore have a higher representation among permanent employees than among temporary and casual employees. In addition, those who identify as LGBTQ2S+ are also more likely to be employed on a temporary and casual basis.

Graph 3. Permanent Full-Time and Part-Time Versus Temporary Employees, Workforce Census.



Graph 3 compares the representation of various groups within casual, occasional, and temporary positions (both full time and part-time) relative to their representation among permanent employees. As the data shows, all the equity-seeking groups have a higher representation among casual and temporary employees than among the permanent full-time workforce, except persons with disabilities. For Indigenous and racialized employees, their representation in temporary positions is double that of their representation in

permanent positions. For those who identify as LGBTQ2S+, their representation is over three times their representation in permanent positions.

This data shows that the Health Unit has done a good job of hiring from a diverse pool of talent for a range of temporary and casual positions. While contract employment can lead to more stable employment, members of these groups tend to face barriers to moving into permanent positions.

Additional Recommendations

In addition to the recommendations made throughout this report, the following recommendation is made.

Recommendation 12: It is recommended that MLHU launch a follow-up Workforce Census in 4 to 5 years to determine the success of the implementation of the recommendations outlined in this report and to increase the survey response rates for groups where response rates were low. In this next census, it is also recommended that MLHU adopt outreach strategies to reach the employees who did not respond to the 2021 census.