The Black Women's Institute for Health
Health for ALL Black Women

BLACK WOMEN IN HEALTHCARE LEADERSHIP: BARRIERS AND PATHWAYS IN THE GREATER TORONTO AREA

A Report by The Black Women's Institute for Health (BWIH)

We cannot heal our community in a system that refuses to care for its healers.

Every day, Black women carry the weight of care through hospital halls, clinic rooms and healthcare spaces, offering hope even as they endure racism, exclusion, and exhaustion. Our hands steady the work, our voices lift others, yet we remain unseen in leadership and unsupported in struggle.

Still, we persist, determined to build a future where those who heal are finally cared for, valued, and free to lead.

ACKNOWLEDGEMENTS

The Black Women's Institute for Health (BWIH) gratefully acknowledges funding from the **Workforce Collaborative,** whose support made this initiative possible. We are indebted to the many Black women who generously shared their experiences, trauma, expertise, and hopes for change.

Your voices are at the centre of this report.

Workforce Funder Collaborative

WE ALSO WISH TO THANK AND RECOGNIZE OUR COMMITTEE FOR THEIR EXPERTISE, FEEDBACK, AND RECOMMENDATIONS:

Koko Bate Agborsangaya – Healthcare Researcher and Policy Advisor

Elsie Amoako – Founder and Executive Director, MinoCare and Mommy Monitor

Mame Antwi – Program Manager, Women's Health in Women's Hands

Dr. Tope Adefarakan, PhD – Assistant Professor, Black Canadian Studies, University of Toronto, Community Educator, Africentric/Black Feminisms Expert

Liz Arnason – Principal Consultant, Arnason Consulting, Founder of Ase Community Foundation

Dr. Josephine Etowa, PhD, RN, RM, FWACN, FAAN, FCAN, FCAHS – Full Professor, Canada Research Chair (Tier 1) in Advancing Black Women's Health, University of Ottawa

Amma Gyamfowa – Founder and Clinical Director, Womanist Healing Counselling Services

Koko NyeBessi – Community Health Advocate

Deborah Owusu-Akyeeah – Gender Equity Policy Specialist

Dr. Oluwabukola Salami, PhD, RN, BScN, MN, FCAN, FAAN – Full Professor and Tier 1 Canada Research Chair in Black and Racialized Peoples' Health, University of Calgary

Dionne Sinclair – Vice President, Clinical Operations and Chief Nursing Executive, Centre for Addiction and Mental Health (CAMH)

Shequita Thompson – Executive Director, STR Consulting; Equity, Diversity and Inclusion Consultant; Community Leader

Lorraine Thomas – Manager, Inclusion, Diversity, Equity Accessibility and Anti-Racism (IDEAA)

We appreciate the many ways this committee contributed to shaping our analysis and recommendations.

WE ALSO THANK THOSE INVOLVED IN RESEARCH FORMATION AND SURVEY DEVELOPMENT:

Ford Global Group – Research design support

Mégan Bernard – Report Design

BWIH TEAM:

Kearie Daniel – Executive Director

Colleen Irowa – Director of Programs

Vanessa Ebhohimhen – Digital Storyteller

This report is a reflection of your dedication, vision, and belief in a healthier future for Black women in healthcare and beyond.

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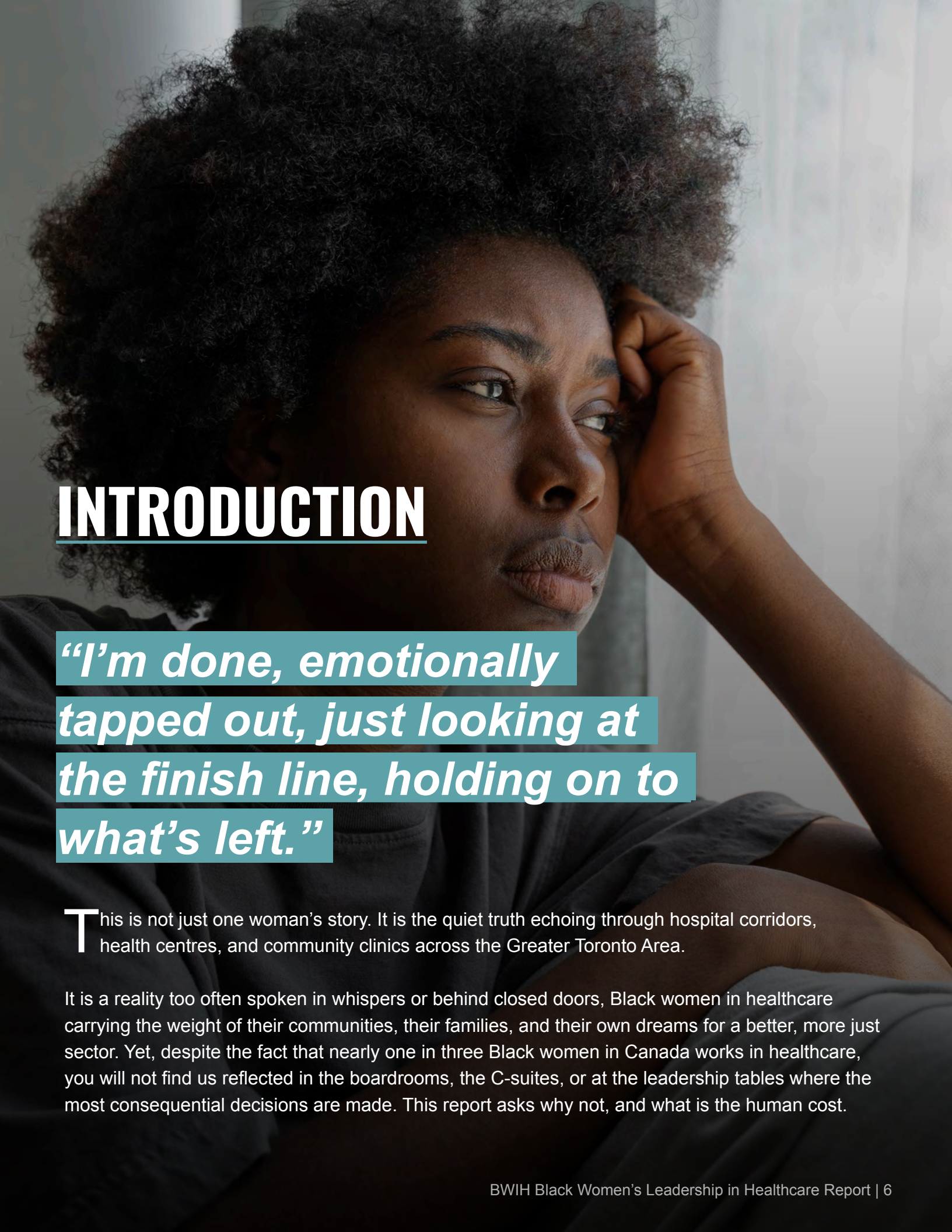
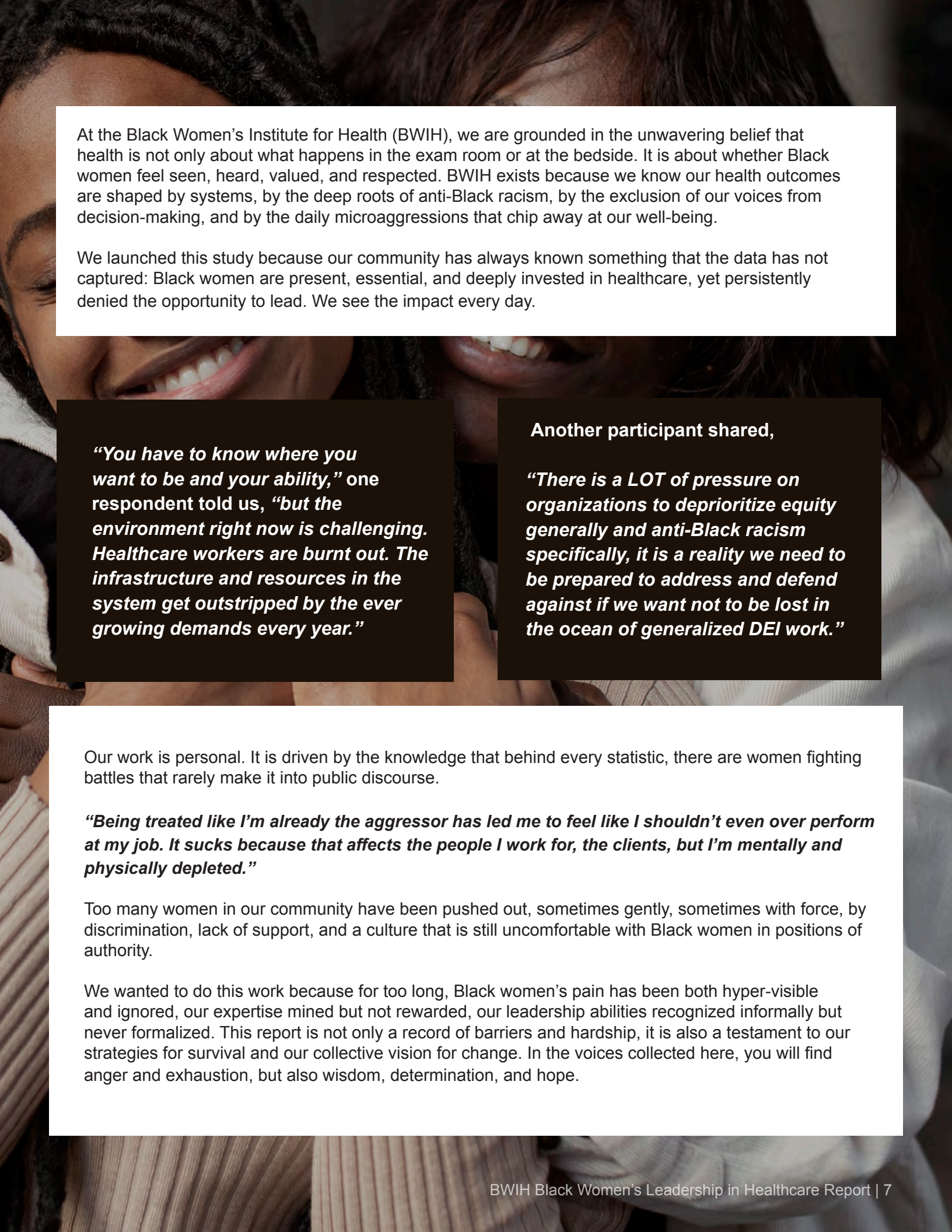


INTRODUCTION

“I’m done, emotionally tapped out, just looking at the finish line, holding on to what’s left.”

This is not just one woman’s story. It is the quiet truth echoing through hospital corridors, health centres, and community clinics across the Greater Toronto Area.

It is a reality too often spoken in whispers or behind closed doors, Black women in healthcare carrying the weight of their communities, their families, and their own dreams for a better, more just sector. Yet, despite the fact that nearly one in three Black women in Canada works in healthcare, you will not find us reflected in the boardrooms, the C-suites, or at the leadership tables where the most consequential decisions are made. This report asks why not, and what is the human cost.



At the Black Women's Institute for Health (BWIH), we are grounded in the unwavering belief that health is not only about what happens in the exam room or at the bedside. It is about whether Black women feel seen, heard, valued, and respected. BWIH exists because we know our health outcomes are shaped by systems, by the deep roots of anti-Black racism, by the exclusion of our voices from decision-making, and by the daily microaggressions that chip away at our well-being.

We launched this study because our community has always known something that the data has not captured: Black women are present, essential, and deeply invested in healthcare, yet persistently denied the opportunity to lead. We see the impact every day.

"You have to know where you want to be and your ability," **one respondent told us,** ***"but the environment right now is challenging. Healthcare workers are burnt out. The infrastructure and resources in the system get outstripped by the ever growing demands every year."***

Another participant shared,

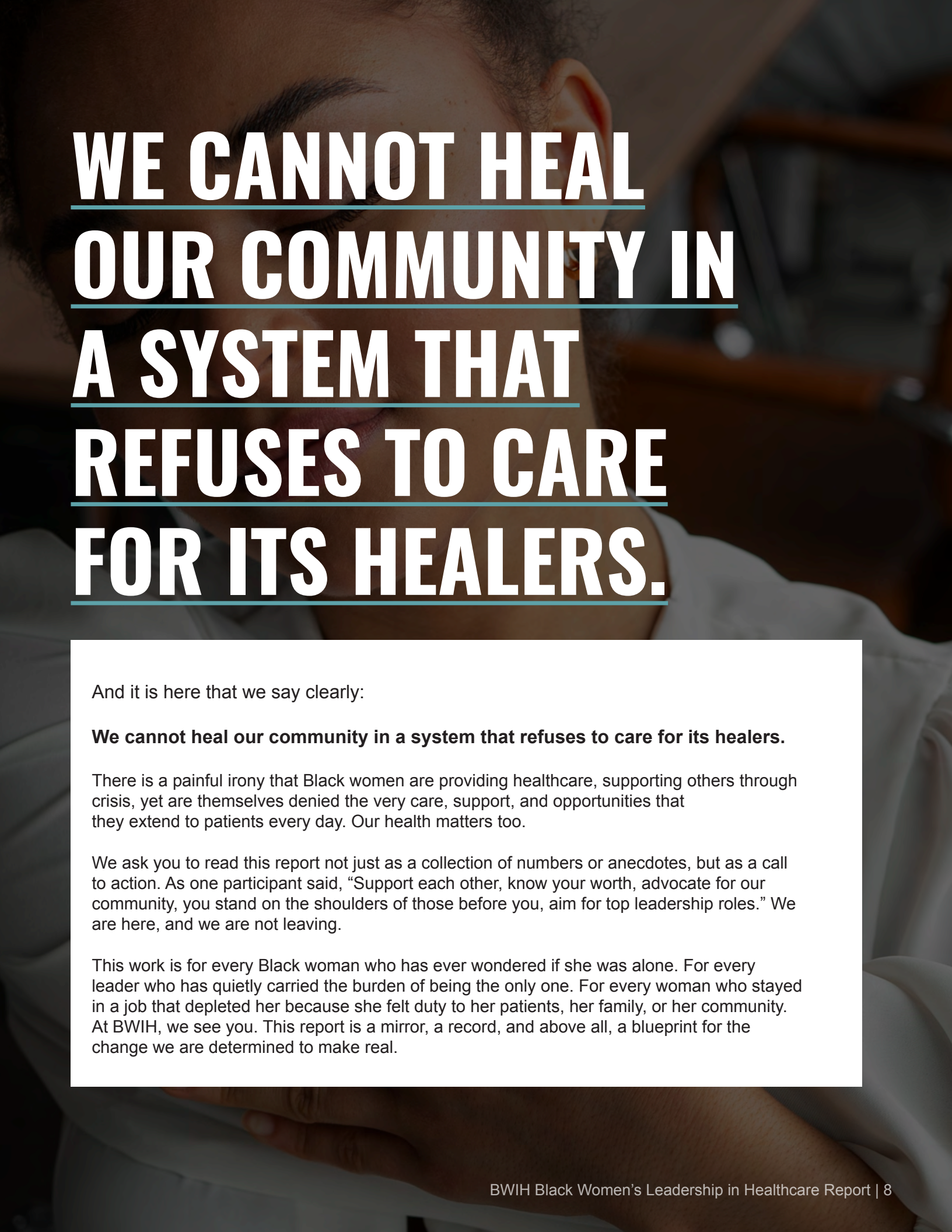
"There is a LOT of pressure on organizations to deprioritize equity generally and anti-Black racism specifically, it is a reality we need to be prepared to address and defend against if we want not to be lost in the ocean of generalized DEI work."

Our work is personal. It is driven by the knowledge that behind every statistic, there are women fighting battles that rarely make it into public discourse.

"Being treated like I'm already the aggressor has led me to feel like I shouldn't even over perform at my job. It sucks because that affects the people I work for, the clients, but I'm mentally and physically depleted."

Too many women in our community have been pushed out, sometimes gently, sometimes with force, by discrimination, lack of support, and a culture that is still uncomfortable with Black women in positions of authority.

We wanted to do this work because for too long, Black women's pain has been both hyper-visible and ignored, our expertise mined but not rewarded, our leadership abilities recognized informally but never formalized. This report is not only a record of barriers and hardship, it is also a testament to our strategies for survival and our collective vision for change. In the voices collected here, you will find anger and exhaustion, but also wisdom, determination, and hope.



WE CANNOT HEAL OUR COMMUNITY IN A SYSTEM THAT REFUSES TO CARE FOR ITS HEALERS.

And it is here that we say clearly:

We cannot heal our community in a system that refuses to care for its healers.

There is a painful irony that Black women are providing healthcare, supporting others through crisis, yet are themselves denied the very care, support, and opportunities that they extend to patients every day. Our health matters too.

We ask you to read this report not just as a collection of numbers or anecdotes, but as a call to action. As one participant said, “Support each other, know your worth, advocate for our community, you stand on the shoulders of those before you, aim for top leadership roles.” We are here, and we are not leaving.

This work is for every Black woman who has ever wondered if she was alone. For every leader who has quietly carried the burden of being the only one. For every woman who stayed in a job that depleted her because she felt duty to her patients, her family, or her community. At BWIH, we see you. This report is a mirror, a record, and above all, a blueprint for the change we are determined to make real.

EXECUTIVE SUMMARY

This report documents the experiences of Black women working in the healthcare sector across the Greater Toronto Area, drawing on detailed survey responses from **125 women** as part of the ***Voices Unheard*** project. Despite making up a significant part of the healthcare workforce, Black women remain largely absent from leadership roles and continue to face entrenched barriers that undermine their professional growth and wellbeing.

Our findings reveal a sector in crisis for Black women. Nearly half of respondents reported leaving a job or switching careers due to limited opportunities for advancement, and almost as many described being pushed out or forced to leave positions as a direct result of discrimination, bias, or a lack of support. Seventy-two percent identified the absence of Black women in leadership as a defining obstacle, while more than half reported experiences with microaggressions, tokenism, and being denied access to mentorship and sponsorship. These patterns are persistent across job types, from nurses and social workers to personal support workers and administrators.

The emotional and psychological toll of these barriers is profound. Only one third of participants described their mental health as good, while nearly one in five reported having struggled with thoughts of self-harm, a rate almost seven times higher than the national average for white women in Canada. Feelings of burnout and emotional exhaustion were nearly universal among respondents, and were especially prevalent among those who experienced discrimination or felt forced out of their roles. Importantly, these issues do not fade with seniority or experience, as women in mid and senior career levels reported similar struggles.

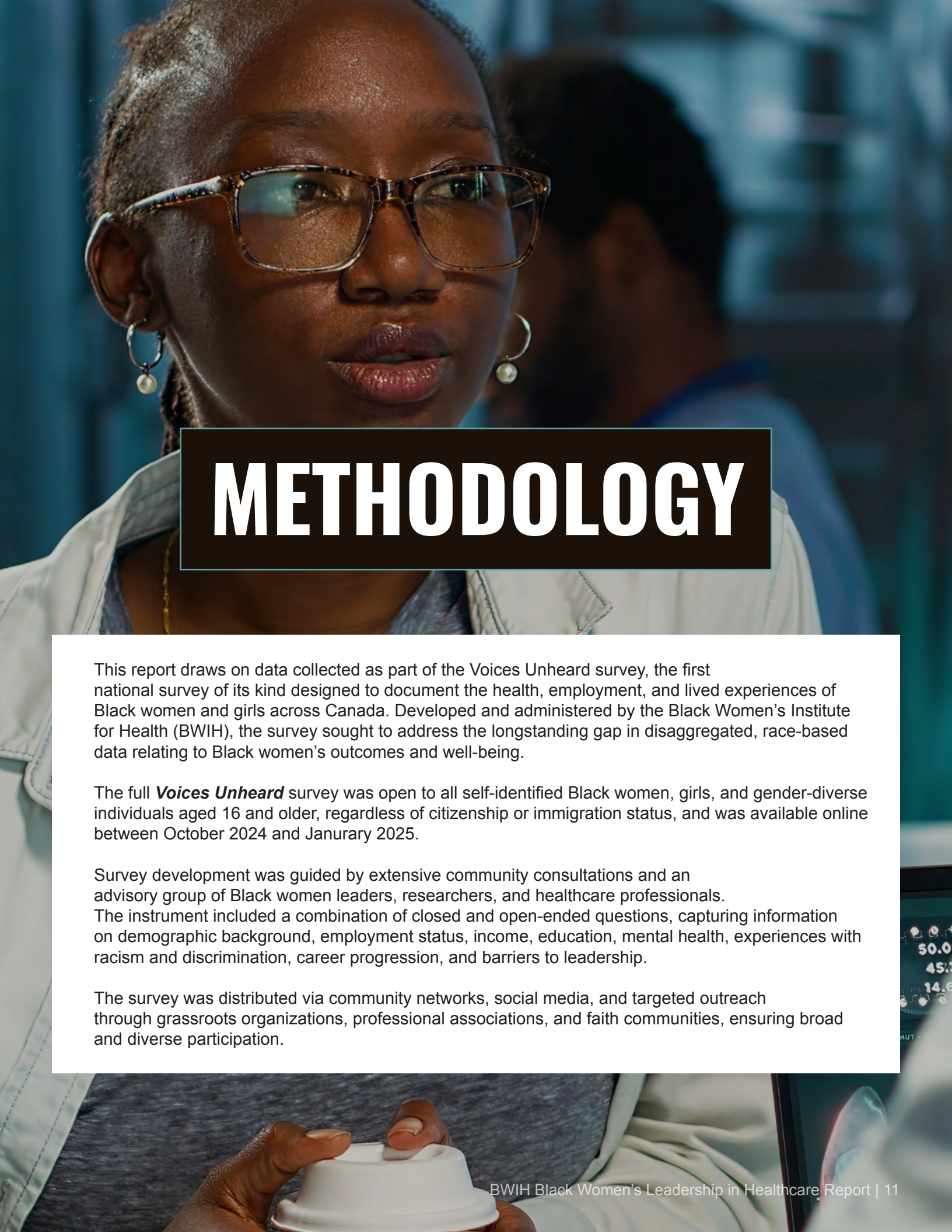
Our analysis shows that discrimination, exclusion, and lack of opportunity are not simply personal hardships, but deeply rooted structural failures within the sector. These challenges, combined with ongoing financial pressures, job insecurity, and the expectation to support both community and family, leave many Black women feeling isolated and unsupported, even as they remain committed to the health of others. While this report focuses on Black women as a whole, our findings make it clear that the most severe barriers are faced by those whose identities intersect, such as women living with disabilities, newcomers, or those with additional marginalized identities.

These intersections create unique and compounding challenges for career progression, workplace well-being, and access to leadership.

The implications are urgent. If the healthcare system is to provide equitable care and meet the needs of Ontario's increasingly diverse population, organizations must take decisive action to address anti-Black racism at all levels, prioritize intersectional approaches, and centre the experiences of Black women, not only as workers but as leaders.

This report calls for immediate, decisive action. We recommend that healthcare organizations develop and fully implement robust anti-racism policies, create transparent promotion pathways, invest in culturally relevant mentorship and mental health supports, and ensure that Black women's voices and lived experiences shape policy and decision-making at every level. The data make clear that sector-wide transformation is necessary for equity and for the sustainability of healthcare itself.

We present these findings with urgency and purpose. The stories and statistics in this report reflect the realities that Black women face every day, and demand that leaders across the healthcare system move beyond acknowledgment to meaningful, measurable change.



METHODOLOGY

This report draws on data collected as part of the Voices Unheard survey, the first national survey of its kind designed to document the health, employment, and lived experiences of Black women and girls across Canada. Developed and administered by the Black Women's Institute for Health (BWIH), the survey sought to address the longstanding gap in disaggregated, race-based data relating to Black women's outcomes and well-being.

The full ***Voices Unheard*** survey was open to all self-identified Black women, girls, and gender-diverse individuals aged 16 and older, regardless of citizenship or immigration status, and was available online between October 2024 and Janurary 2025.

Survey development was guided by extensive community consultations and an advisory group of Black women leaders, researchers, and healthcare professionals. The instrument included a combination of closed and open-ended questions, capturing information on demographic background, employment status, income, education, mental health, experiences with racism and discrimination, career progression, and barriers to leadership.

The survey was distributed via community networks, social media, and targeted outreach through grassroots organizations, professional associations, and faith communities, ensuring broad and diverse participation.

A total of 1,300 respondents completed the national survey. For this report, we focus on a purposeful sub-sample: the **125 respondents** who both live in the Greater Toronto Area and reported currently working in the healthcare sector. Responses from these **125 women** provide a unique and critical window into the experiences of Black women in one of Canada's largest and most diverse urban regions, and within an industry where Black women are both highly visible as frontline workers and deeply underrepresented in positions of power. All quantitative data were analyzed using descriptive statistics.

For key questions, such as those relating to mental health, discrimination, career advancement, and push out, responses were further cross-tabulated to identify core patterns and correlations. Open-ended responses were reviewed and thematically coded, allowing for the inclusion of direct quotes and qualitative insights to deepen understanding and bring context to the quantitative findings. The analysis presented here is intentionally disaggregated and intersectional, centring the voices and realities of Black women in the GTA healthcare sector. All participant data were anonymized, and the findings are presented to honour privacy and confidentiality while amplifying the stories and lived expertise that drive this work.

This report reflects both the strengths and limitations of community-based, self-report survey methods. While the findings cannot be generalized to all Black women in the sector, the consistency and depth of the responses highlight systemic trends and urgent concerns that demand further attention and action from healthcare leaders and policy-makers.

LIMITATIONS

While this report provides a critical and unprecedented window into the experiences of Black women working in healthcare in the Greater Toronto Area, several methodological limitations should be considered.

First, the survey relies on self-report data, which means that all responses reflect each participant's own perceptions, memory, and willingness to disclose sensitive information. While anonymity was prioritized to support honest sharing, some respondents may have chosen not to answer or may have underreported experiences due to fear of recognition, stigma, or emotional fatigue.

Second, the recruitment strategy was community-driven and depended on digital access, community partnerships, and word-of-mouth. As a result, the sample may over-represent those who are most connected to community organizations or who are more motivated to participate due to particularly strong experiences, positive or negative, in healthcare settings. Those who are less connected, more isolated, or who face language and literacy barriers may not be fully represented in these findings.

Third, although the survey included foundational questions on employment, income, education, mental health, and experiences of discrimination, the need to keep the instrument accessible and not overly burdensome meant that some areas could not be explored in as much depth as would be ideal. For example, the survey did not always collect detailed longitudinal histories of workplace experiences, nor did it ask follow-up questions that could clarify causation or the sequence of key life and career events.

The survey instrument could not fully capture the complexity of intersectional factors such as disability, migration history, or caregiving responsibilities. It was also not possible to examine organizational differences by specific employer or workplace setting, nor to document policy impacts in detail. In some areas, including suicidal ideation and mental health, additional probing questions would have helped clarify how workplace experiences, personal supports, and broader systemic factors interact over time.

ENVIRONMENTAL SCAN: THE EXPERIENCES OF BLACK WOMEN IN HEALTHCARE IN CANADA AND ONTARIO

Black women have always been integral to the Canadian healthcare sector, yet their experiences, challenges, and underrepresentation in leadership roles remain poorly documented in the public record. To situate the findings of this report within the broader context, we conducted a thorough environmental scan of existing Canadian data on Black women in healthcare, focusing on Canada as a whole, Ontario, and the Greater Toronto Area. This section summarizes the most current, relevant evidence from government, academic, and reputable non-profit sources.

NATIONAL OVERVIEW: REPRESENTATION AND CHALLENGES

Recent research from Statistics Canada confirms that Black workers are slightly overrepresented in care occupations compared to non-care roles. According to the 2021 Census and related analyses, 4% of care workers in Canada identified as Black, compared to 3 % among non-care workers **(Statistics Canada, "The Changing Face of Care Work: National Insights," 2022).** However, the data does not routinely disaggregate by gender and occupation, meaning that statistics specific to Black women are still rare in the public domain.

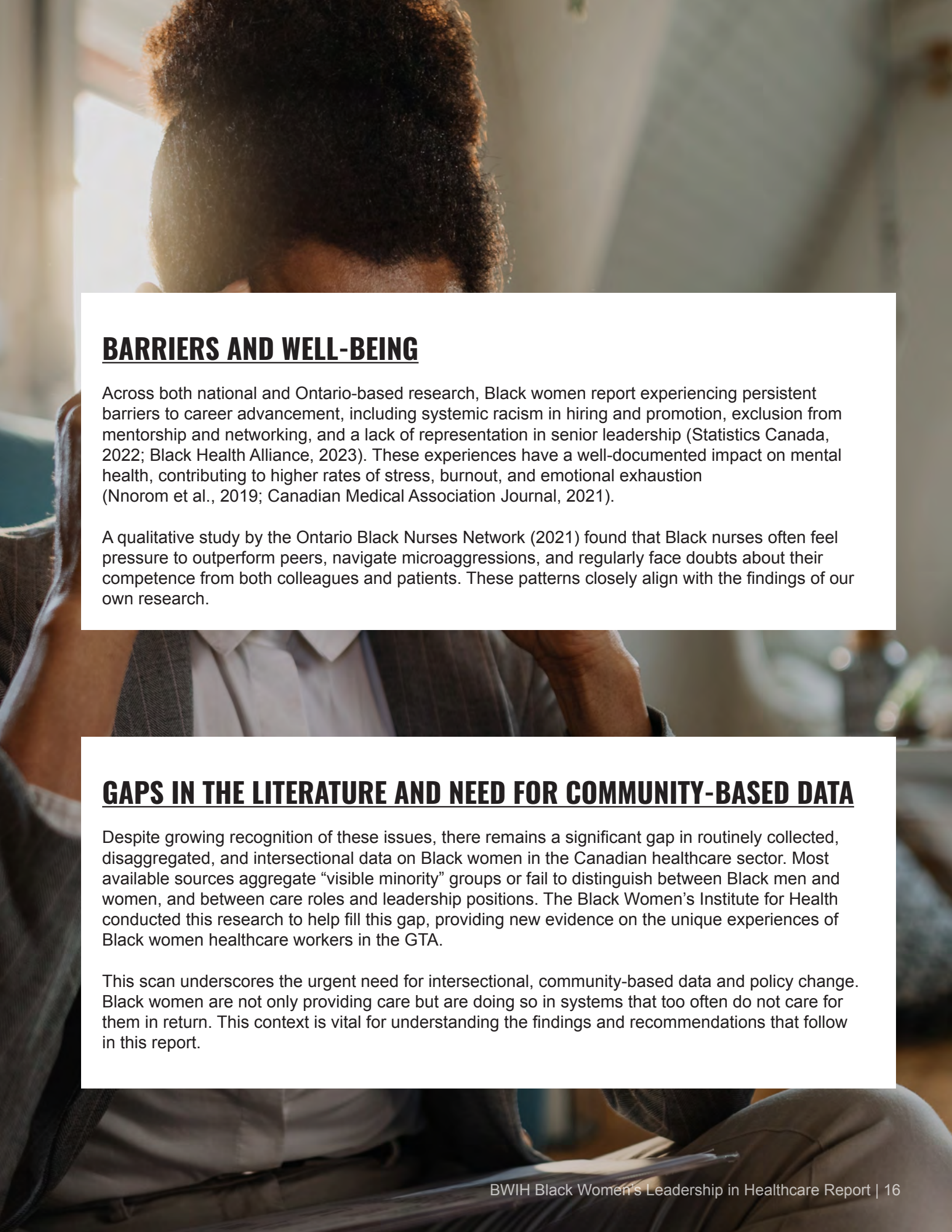
Available qualitative research and sector reports highlight a consistent pattern: Black women in healthcare are more likely to experience workplace discrimination, microaggressions, and barriers to advancement. A national review published in the Canadian Journal of Nursing Leadership (Nnorom et al., 2019) underscores that Black nurses and healthcare workers in Canada face "overt and covert forms of anti-Black racism," with reported impacts on mental health, job satisfaction, and professional mobility.

ONTARIO AND THE GREATER TORONTO AREA: PROPORTION AND EXPERIENCE

While Ontario is home to the largest Black population in Canada, precise figures on the proportion of Black women in healthcare roles remain limited. Using the 2021 Census, Statistics Canada reports that, in Ontario, Black individuals are overrepresented in care occupations compared to their proportion in the overall labour force. Four percent of care workers in Ontario identified as Black (Statistics Canada, 2022), though again, disaggregated data by gender is not routinely published.

Custom analysis of Statistics Canada's Table 98-10-0330-01 (2021 Census) can provide a more detailed breakdown by visible minority status and occupation, but as of the writing of this report, a single published statistic for Black women specifically in Ontario's healthcare workforce has not been released. Despite this gap, community-based research and qualitative studies indicate that Black women are a significant and essential part of the sector, especially in roles such as nursing, personal support, and allied health professions.

In the Greater Toronto Area, a 2023 report by the Black Health Alliance and Sinai Health identified that Black women are highly represented in frontline care positions but remain underrepresented in management and executive roles (Black Health Alliance & Sinai Health, "Building Equitable Pathways," 2023).



BARRIERS AND WELL-BEING

Across both national and Ontario-based research, Black women report experiencing persistent barriers to career advancement, including systemic racism in hiring and promotion, exclusion from mentorship and networking, and a lack of representation in senior leadership (Statistics Canada, 2022; Black Health Alliance, 2023). These experiences have a well-documented impact on mental health, contributing to higher rates of stress, burnout, and emotional exhaustion (Nnorom et al., 2019; Canadian Medical Association Journal, 2021).

A qualitative study by the Ontario Black Nurses Network (2021) found that Black nurses often feel pressure to outperform peers, navigate microaggressions, and regularly face doubts about their competence from both colleagues and patients. These patterns closely align with the findings of our own research.

GAPS IN THE LITERATURE AND NEED FOR COMMUNITY-BASED DATA

Despite growing recognition of these issues, there remains a significant gap in routinely collected, disaggregated, and intersectional data on Black women in the Canadian healthcare sector. Most available sources aggregate “visible minority” groups or fail to distinguish between Black men and women, and between care roles and leadership positions. The Black Women’s Institute for Health conducted this research to help fill this gap, providing new evidence on the unique experiences of Black women healthcare workers in the GTA.

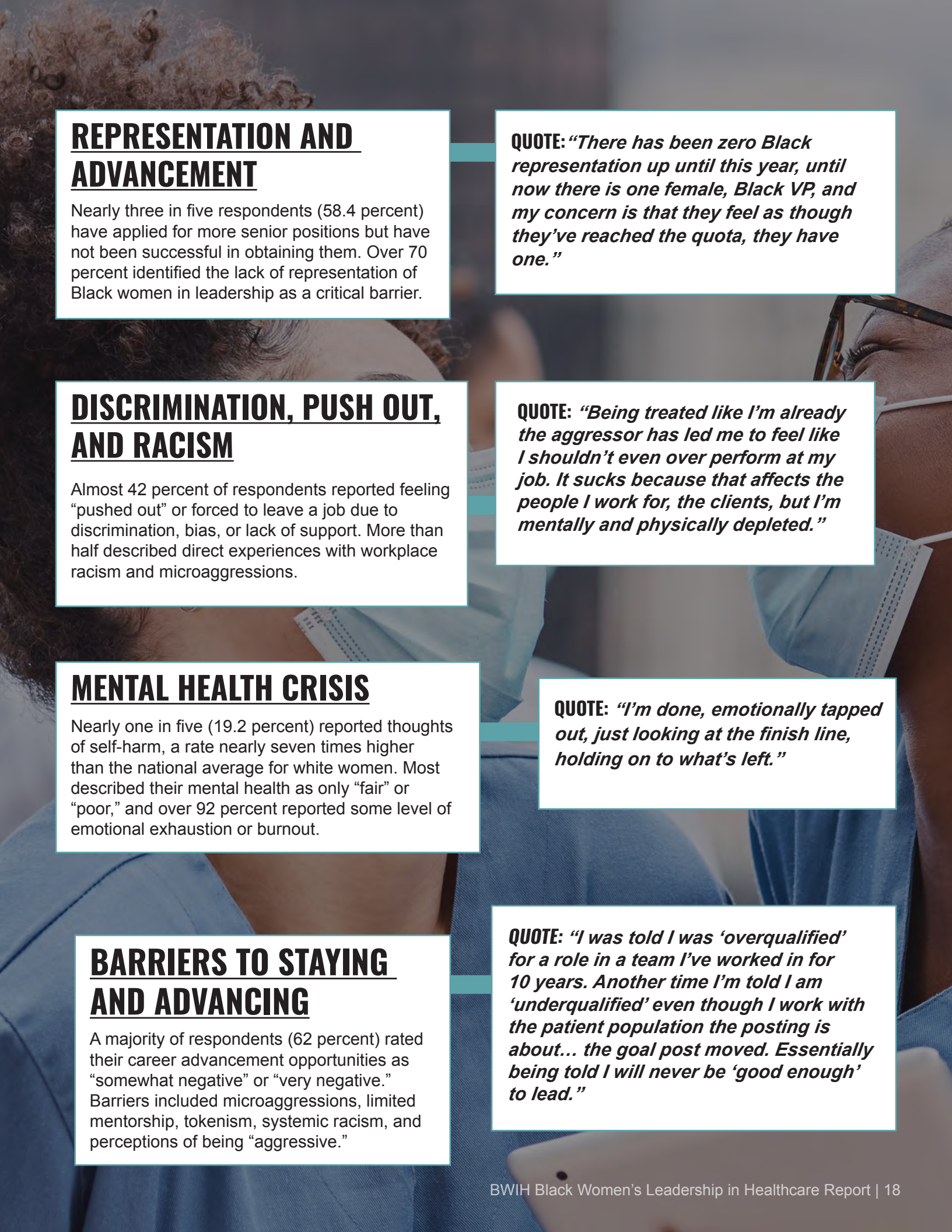
This scan underscores the urgent need for intersectional, community-based data and policy change. Black women are not only providing care but are doing so in systems that too often do not care for them in return. This context is vital for understanding the findings and recommendations that follow in this report.

KEY FINDINGS: THE REALITIES OF BLACK WOMEN IN HEALTHCARE

KEY FINDINGS: WHAT THE DATA TELLS US

Black women in the Greater Toronto Area are the invisible backbone of healthcare, present in every role from frontline care to management. Yet, as this report reveals, their journeys are marked by exclusion, systemic inequity, and a relentless demand to “prove” themselves in institutions that too often fail to recognize or support them. Despite being essential to patient care, Black women’s contributions, ambitions, and well-being remain undervalued.

The following key findings, grounded in the voices of women who live these realities, shed light on both the scale of the problem and the urgent need for sector-wide transformation.



REPRESENTATION AND ADVANCEMENT

Nearly three in five respondents (58.4 percent) have applied for more senior positions but have not been successful in obtaining them. Over 70 percent identified the lack of representation of Black women in leadership as a critical barrier.

QUOTE: ***"There has been zero Black representation up until this year, until now there is one female, Black VP, and my concern is that they feel as though they've reached the quota, they have one."***

DISCRIMINATION, PUSH OUT, AND RACISM

Almost 42 percent of respondents reported feeling "pushed out" or forced to leave a job due to discrimination, bias, or lack of support. More than half described direct experiences with workplace racism and microaggressions.

QUOTE: ***"Being treated like I'm already the aggressor has led me to feel like I shouldn't even over perform at my job. It sucks because that affects the people I work for, the clients, but I'm mentally and physically depleted."***

MENTAL HEALTH CRISIS

Nearly one in five (19.2 percent) reported thoughts of self-harm, a rate nearly seven times higher than the national average for white women. Most described their mental health as only "fair" or "poor," and over 92 percent reported some level of emotional exhaustion or burnout.

QUOTE: ***"I'm done, emotionally tapped out, just looking at the finish line, holding on to what's left."***

BARRIERS TO STAYING AND ADVANCING

A majority of respondents (62 percent) rated their career advancement opportunities as "somewhat negative" or "very negative." Barriers included microaggressions, limited mentorship, tokenism, systemic racism, and perceptions of being "aggressive."

QUOTE: ***"I was told I was 'overqualified' for a role in a team I've worked in for 10 years. Another time I'm told I am 'underqualified' even though I work with the patient population the posting is about… the goal post moved. Essentially being told I will never be 'good enough' to lead."***

RESILIENCE, SURVIVAL, AND UNSEEN LABOUR

Many Black women remain in jobs that are unfulfilling or even harmful, due to economic necessity, commitment to patients or community, and lack of safer alternatives.

***QUOTE:** "Job does not define you. You can be replaced. Look for mentors who look like you and also have similar interests. Be supportive of other Black women in the workplace."*

WHAT WOULD MAKE A DIFFERENCE

Respondents identified what needs to change: stronger anti-racism policies, bias-free promotion, mentorship, and more inclusive workplaces.

***QUOTE:** "Build a support network and access them as you try to navigate the healthcare spaces. Don't be afraid to speak up. Say something when you see something."*

A SECTOR-WIDE CALL TO ACTION

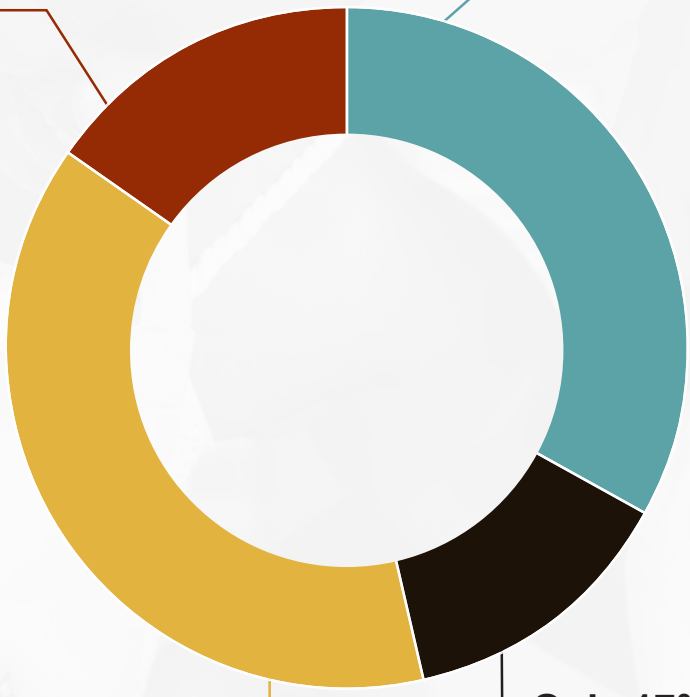
The barriers Black women face in GTA healthcare are not isolated, but systemic. Their testimonies challenge healthcare leaders and institutions to act now.

***QUOTE:** "Support each other, know your worth, advocate for our community, you stand on the shoulders of those before you… aim for top leadership roles."*

KEY FINDINGS:

41.6% of Black women in the GTA healthcare sector have been pushed out or forced to leave a job due to discrimination, bias, or lack of support.

19.2 % have struggled with thoughts of self-harm.



Nearly half (48%)

have left a job or switched careers due to a lack of advancement opportunities.

Only 17%

rated their career advancement experience as positive, while 62 percent reported negative or very negative experiences.

Major barriers include microaggressions, lack of representation in leadership, tokenism, systemic racism, and exclusion from mentorship.

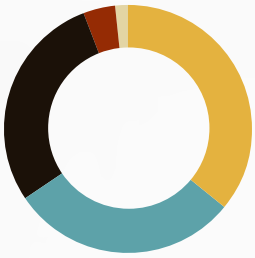
Despite the toxicity, many stay out of financial necessity, hope for change, or commitment to community.

These findings make clear the urgent need for targeted, systemic solutions and sector-wide accountability.

RESPONDENT PROFILE: BLACK WOMEN IN GTA HEALTH

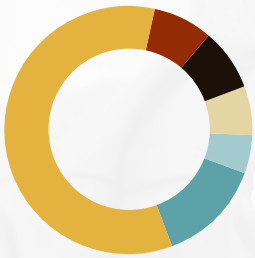
RESPONDENT PROFILE: BLACK WOMEN IN GTA HEALTHCARE

LEVEL OF EDUCATION



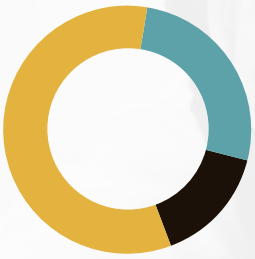
- **Bachelor's degree (university):** 36.0%
- **College diploma or certificate:** 29.6%
- **Post-graduate degree** (Master's, PhD): 28.8%
- **High-school diploma or equivalent:** 4.0%
- **Some high school (no diploma):** 1.6%

EMPLOYMENT STATUS



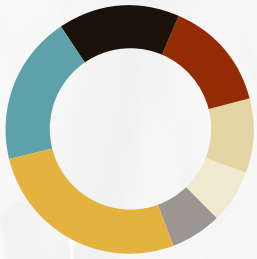
- **Full-time, permanent:** 59.2%
- **Full-time, contract:** 8.0%
- **Part-time, permanent:** 8.0%
- **Retired:** 6.4%
- **Self-employed:** 4.8%
- **Other statuses:** 13.6% combined

MARITAL STATUS



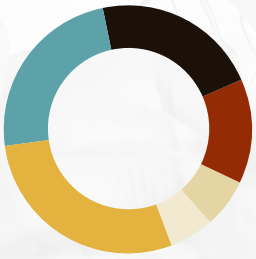
- **Married or common-law:** 56.0%
- **Single, never married: 25.6%**
- Separated or divorced: 14.4%

HOUSEHOLD INCOME



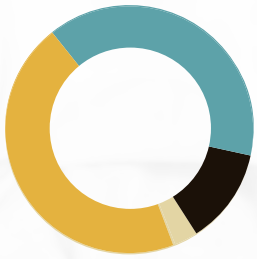
- **$100,000–$149,999:** 27.2%
- **$50,000–$74,999:** 19.2%
- **$150,000–$199,999:** 16.0%
- **$75,000–$99,999:** 14.4%
- **Less than $25,000:** 9.6%
- **$200,000 or more:** 7.2%
- **$25,000–$49,999:** 6.4%

RELIGION



- **Protestant Christian:** 48.8%
- **Other Christian:** 40.8%
- **Catholic:** 36.8%
- **Spiritual but not religious:** 23.2%
- **Muslim:** 11.2%
- **No religious affiliation:** 9.6%

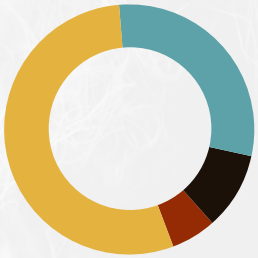
IMMIGRATION STATUS



- **Canadian citizen by naturalisation:** 44.0%
- **Canadian citizen by birth:** 38.4%
- **Permanent resident:** 12.0%
- **Temporary resident:** 3.2%

RESPONDENT PROFILE: BLACK WOMEN IN GTA HEALTHCARE

HOUSING SITUATION



- **Own home/condo:** 52.8%
- **Rent (private market):** **28.8%**
- **Rent (subsidised/co-op):** 9.6%
- **Living with family/friends, no rent:** 5.6%

LENGTH OF TIME IN CANADA

- **More than 20 years:** 49.6%
- **11–20 years:** 24.8%
- **6–10 years:** 14.4%
- **0–5 years:** 8.0%
- **All my life:** 3.2%

CURRENT ROLE IN HEALTHCARE SECTOR

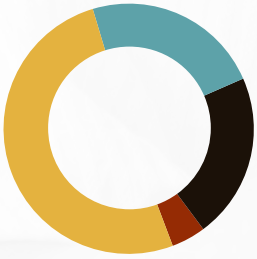
- **Registered Nurse:** 16.8%
- **Other/mixed duties:** 20.0%
- **Clinical Social Worker:** 7.2%
- **Mental-health counsellor:** 6.4%
- **Personal Support Worker:** 5.6 %

Other roles included administration, paramedic, medical assistant, senior leadership, environmental services.

LENGTH OF TIME IN CURRENT POSITION

- **1–3 years:** 36.8%
- **4–7 years:** 25.6%
- **More than 10 years:** 19.2%
- **8–10 years:** 13.6%
- **Less than 1 year:** 4.8%

CAREER LEVEL



- **Mid-level:** 46.4%
- **Senior-level:** 20.8%
- **Entry-level:** 19.2%
- **Executive/C-suite:** 4.0%

VISIBLE AND INVISIBLE: THE PARADOX OF BLACK WOMEN'S EXPERIENCES IN HEALTHCARE

One of the most consistent and troubling findings in our data is the paradoxical experience of being both highly visible and painfully invisible in healthcare workplaces. Black women repeatedly described how they are subjected to heightened scrutiny, surveillance, and expectations about their professionalism and behaviour, yet are simultaneously overlooked when opportunities for advancement, leadership, or recognition arise.

VERBATIM RESPONSES FROM SURVEY PARTICIPANTS:

"I am always watched, judged, and expected to be perfect, but when it comes to moving up or being included, it's like I am not even there."

"Everything I do is under a microscope, but when there are opportunities or decisions, I am overlooked every time."

"I am always the first to be called out if something goes wrong, but never the first considered for leadership or recognition."

"Being Black means I have to be twice as good to be seen as half as capable, but when it is time for advancement, I am invisible."

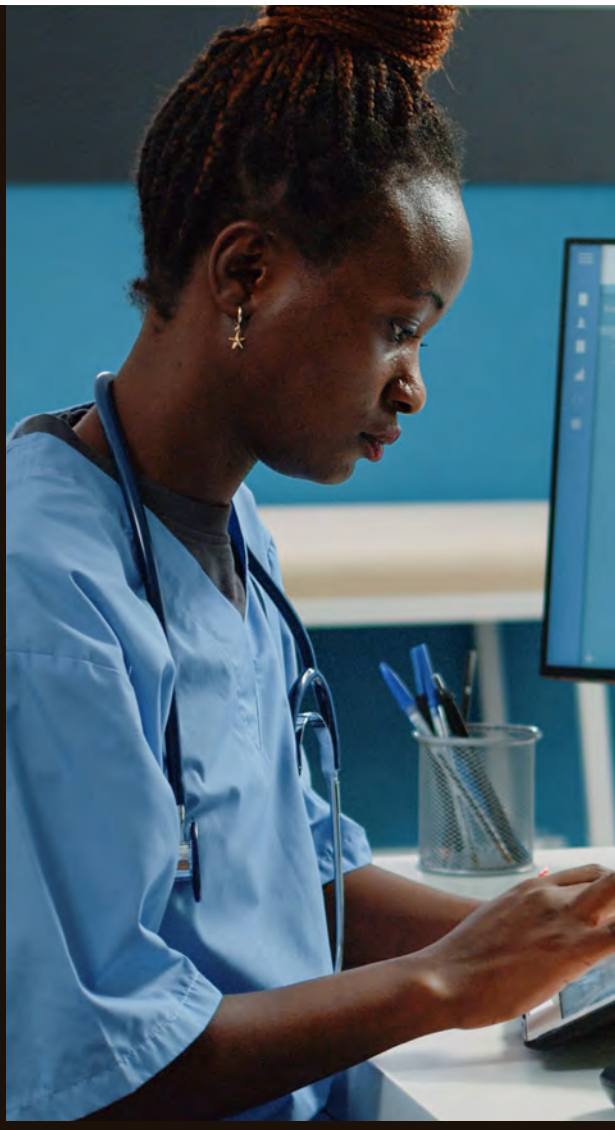
Respondents also highlighted the phenomenon of "quiet quitting" as a direct response to this paradox. Rather than fully disengaging from their job or leaving the sector entirely, many Black women describe remaining at their posts but withdrawing from committee work, social activities, and voluntary initiatives. This withdrawal is a form of self-preservation, a way to protect themselves from further harm and avoid additional scrutiny.

"I don't put my hand up for committees or extra projects anymore, because I know my input won't be valued, and I'm tired of fighting to be heard."

"I do my job and go home. I used to want to contribute more, but now I just try to protect my peace."

This cycle not only impacts the well-being of Black women but also comes at a cost to organizations. The loss of engagement, ideas, and leadership from Black women who are sidelined or discouraged from participating fully is a missed opportunity for meaningful change and true inclusion.

In sum, being visible in all the ways that increase risk and pressure, while invisible in all the ways that matter for advancement and belonging, is a central and damaging theme for Black women working in healthcare. Addressing this paradox is essential for creating environments where Black women can thrive and lead.



HIRING INTO ENTRY-LEVEL POSITIONS IS NOT ENOUGH

It is not enough for organizations to simply hire more Black women into entry-level or administrative positions. The impact and influence required for true change come from increasing Black women's representation in leadership roles. Focusing on density at the lowest rungs of the workforce, or aiming to simply meet census-based quotas, does not address the deeper systemic barriers at play. For example, hiring multiple Black administrative staff may increase representation numbers, but hiring and supporting even a handful of Black women into senior leadership has far greater impact on culture, policy, and outcomes.

Critically, the danger of aligning hiring practices to census statistics is that it allows organizations to declare "success" while avoiding the structural change that only comes from building a critical mass of Black women leaders. As one committee member observed, two Black women in leadership out of ten may be proportional, but does not shift the culture or power dynamics in the ways that five out of ten would.

When Black women are pushed out or feel forced to disengage from workplace life for their own self-preservation, they lose out on the opportunity to build the social capital, relationships, and visibility needed to advance. Conversely, when Black women are kept in stagnant or unsupported roles, they are not given the strategic opportunities to be seen by decision-makers and to grow their influence within the sector.

These findings make clear the urgent need for targeted, systemic solutions and sector-wide accountability.

LEADERSHIP BLOCKAGES AND RACISM

LEADERSHIP BLOCKAGES AND RACISM

Barriers to Advancement:

- Lack of representation in leadership: **72.0%**
- Microaggressions/subtle racism: **59.2%**
- Limited mentorship/sponsorship: **56.0%**
- Systemic racism in hiring/promotion: **46.4%**
- Tokenism: **39.2%**
- Intersectional discrimination: **24.8%**

VERBATIM RESPONSES:

"I was repeatedly passed over for promotions in the hospital… I have definitely experienced tokenism throughout my professional career and I am often the only Black person in academic or leadership circles."

"The expectation of doing more work, turn out excellent quality work not being acknowledged as your white counterparts are mediocre at best. Little to no advancement to executive roles because in the hospital system of senior and executive leader ship, there has been zero black representation up until this year until now there is one female, black VP, and my concern is that they feel as though they've reached the quota."

PUSH OUT AND LACK OF MOBILITY

- **41.6%** felt “pushed out” or forced to leave a position due to discrimination, bias, or lack of support.
- **48%** have left a job or switched careers due to lack of advancement opportunities.
- **58.4%** have applied for senior positions and not been successful.

VERBATIM RESPONSES:

“I was let go from a job along with all the other Black women on the team.”

“I was told I was ‘overqualified’ for a role in a team I’ve worked in for 10 years. Another time I’m told I am ‘underqualified’ even though I work with the patient population the posting is about… Essentially being told I will never be ‘good enough’ to lead.”

MENTAL HEALTH CRISIS

- **19.2%** have struggled with thoughts of self-harm (7 times the rate of white women nationally).
- **20.0%** rate their mental health as "Poor," and **8.0%** as "Very Poor."
- **46.4%** frequently experience emotional exhaustion or burnout.

VERBATIM RESPONSES:

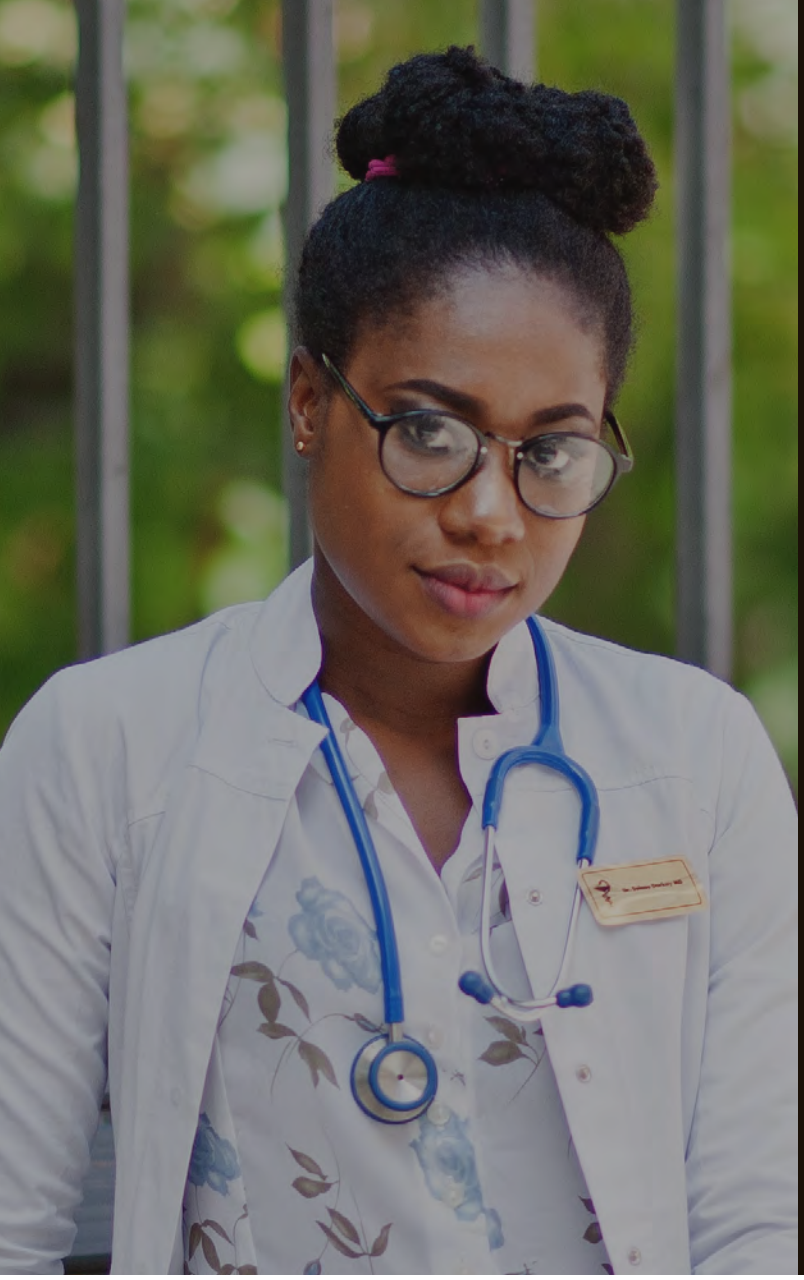
"Push to burnout and depression, had to leave position for my mental health."

"Being treated like I'm already the aggressor has led me to feel like I shouldn't even over perform at my job. It sucks because that affects the people I work for, the clients, but I'm mentally and physically, depleted."

"I'm done emotionally tapped out just looking at the finish line holding on to what's left."

CORRELATIONS:

Those who reported being pushed out or experiencing workplace discrimination had much higher rates of poor or very poor mental health and emotional exhaustion.



WHY WOMEN STAY

- ✓ Despite hostile conditions, many women remain in healthcare due to:
- ✓ Financial necessity
- ✓ Job security or seniority
- ✓ Lack of safer alternatives
- ✓ Commitment to community or clients
- ✓ Hope for sector change

VERBATIM RESPONSES:

"If you are seeking improvements or advancements within your role, and this has not happened within the first 3–4 years, leave. Don't wait, and hope that things will get better or assume that you are not qualified enough. You get stuck."

"Job does not define you. You can be replaced. Look for mentors who look like you and also have similar interests."

CAREER ADVANCEMENT AND LEADERSHIP FOR BLACK WOMEN IN HEALTHCARE

CAREER ADVANCEMENT AND LEADERSHIP: STATISTICAL SUMMARY

The findings from our Voices Unheard GTA healthcare sample paint a stark picture of how systemic barriers continue to shape the professional experiences of Black women. Nearly two out of every three Black women in the GTA healthcare workforce describe their career advancement opportunities as negative or very negative. Almost half have left a job or switched careers because advancement was blocked. Professional growth is often not determined by hard work or qualifications, but instead shaped by institutional barriers, discrimination, and a lack of meaningful support.

While national data has shown that Black women are overrepresented in frontline healthcare roles and vastly underrepresented in leadership *(Statistics Canada, 2022; Black Health Alliance & Sinai Health, 2023)*, it is important to clarify that in our sample of 125 Black women in the GTA, 4.0 percent reported being in executive or C-suite positions and **20.8%** held senior-level roles. This is not necessarily representative of all of Ontario or Canada. The often-cited figure that “only about **1%** of health sector leadership roles are held by Black women” comes from referenced literature, not our GTA-specific data.

Nationally, **48%** of white women rate their advancement opportunities as positive or very positive, according to the 2021 Health Professionals Survey. In our GTA sample, less than **17%** of Black women reported positive or very positive experiences with advancement opportunities.

Even more telling are the reasons women in our survey consider leaving healthcare. Among those considering departure, the majority point to burnout and mental health strain **(71.1%)**, lack of advancement opportunities **(60.5%)**, workplace discrimination or racism **(55.3%)**, and inadequate compensation **(47.4%)**. These numbers show the compounding pressures faced by Black women in the sector.

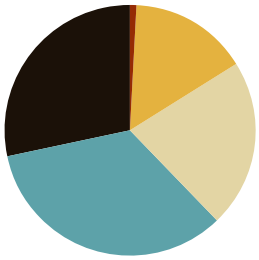
While only **27%** of white Canadian healthcare workers cite discrimination as a factor for leaving or disengaging **(Statistics Canada, 2022)**, over half of Black women in our GTA study list it as a primary concern. For Black women, workplace stress is not just about workload or patient demand, but about surviving in environments that are often hostile or indifferent to their wellbeing and ambitions.

When asked what would encourage them to stay in the sector, most women highlighted the need for stronger anti-racism and equity policies, bias-free promotion pathways, culturally relevant mentorship, competitive compensation, and a workplace culture that truly values Black women. These findings echo the calls from national and provincial studies for systemic change to address the unique barriers Black women face.

It is important to underscore that these findings do not simply reflect isolated experiences, but point to an ongoing pattern that requires urgent intervention. Both our data and external research show that systemic racism and structural barriers have real and measurable effects on the careers, health, and well-being of Black women in healthcare.

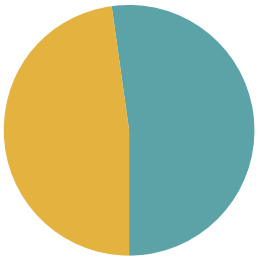
STATISTICAL SUMMARY FROM GTA HEALTHCARE RESPONDENTS

HOW WOULD YOU RATE YOUR OVERALL EXPERIENCE WITH CAREER ADVANCEMENT OPPORTUNITIES?



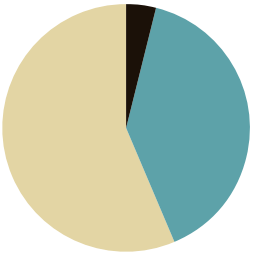
- **Very positive:** 1.6%
- **Somewhat positive:** 15.2%
- **Neutral:** 21.6%
- **Somewhat negative:** 33.6%
- **Very negative:** 28.0%

HAVE YOU EVER LEFT A JOB OR SWITCHED CAREERS DUE TO A LACK OF ADVANCEMENT OPPORTUNITIES?



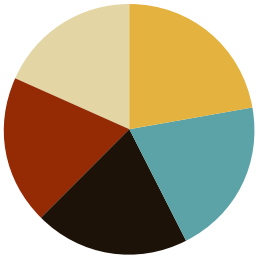
- **Yes: 48.0%**
- **No: 52.0%**

ARE YOU CONSIDERING LEAVING HEALTHCARE IN THE NEXT 1–2 YEARS?



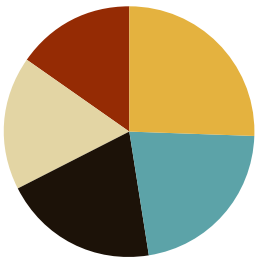
- **Very positive:** 1.6%
- **Somewhat positive:** 15.2%
- **Neutral:** 21.6%

PRIMARY REASONS FOR CONSIDERING LEAVING (AMONG THOSE WHO ARE):



- **Burnout or mental health strain: 71.1%**
- **Lack of advancement opportunities: 60.5%**
- **Workplace discrimination or racism: 55.3%**
- **Inadequate compensation: 47.4%**
- **Work-life balance: 42.1%**

WHAT CHANGES WOULD ENCOURAGE YOU TO STAY?



- **Stronger anti-racism and equity policies: 68.0 %**
- **Bias-free promotion pathways: 62.4%**
- **Formal mentorship for Black women: 60.8%**
- **Competitive compensation: 59.2%**
- **More inclusive workplace culture: 55.2%**

IMPACT ON MENTAL HEALTH

The mental health crisis among Black women working in healthcare in the Greater Toronto Area is unmistakable, and our data makes clear that this is not an isolated or individual problem. The numbers, the stories, and the comparisons to broader Canadian trends point to an urgent need for change.

PREVALENCE OF SELF-HARM THOUGHTS

One of the most troubling findings from this study is that nearly one in five Black women healthcare workers in the GTA reported struggling with thoughts of self-harm.

- Have you ever struggled with thoughts of self-harm?
  - **Yes: 24 respondents (19.2%)**
  - **No: 101 respondents (80.8%)**

This is an alarming rate. For context, the most recent available national data from Statistics Canada (2021) shows that the prevalence of suicidal ideation among white women in Canada is approximately **2.8%**.

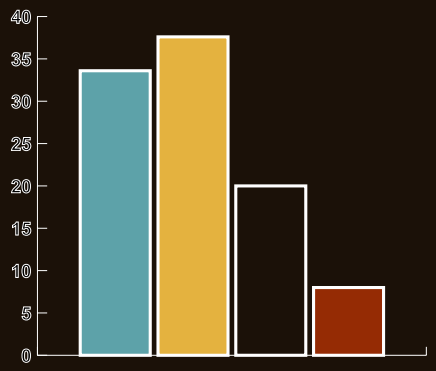
While self-harm and suicidal ideation are not identical, this comparison highlights the profound and disproportionate mental health impacts faced by Black women in healthcare in our region.

OVERALL MENTAL HEALTH AND EMOTIONAL STRAIN

When asked to describe their overall mental health, only a minority of respondents rated it as **"Good" (33.6%),** with most describing it as **"Fair" (37.6%)**, **"Poor" (20.0%),** or **"Very Poor" (8.0%)**. These figures are consistent with the open-ended stories of exhaustion, isolation, and psychological distress found throughout the survey responses.

OVERALL MENTAL HEALTH:

- GOOD: 33.6%
- FAIR: 37.6%
- POOR: 20.0%
- VERY POOR: 8.0%



FREQUENT ANXIETY AND BURNOUT

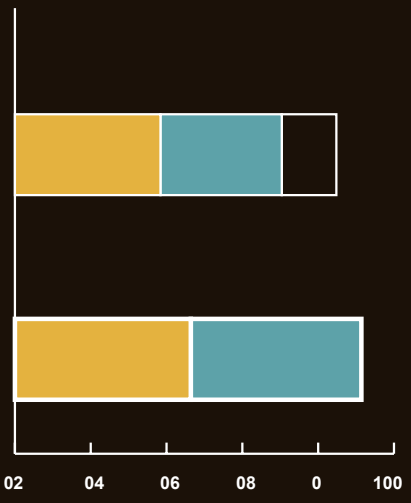
Experiences of anxiety and emotional exhaustion are almost universal. Nearly half of respondents said they **"often"** or **"always"** feel anxious or worried, and over **90%** reported at least occasional emotional exhaustion or burnout.

FEELINGS OF ANXIETY OR WORRY:

- SOMETIMES: 38.4%
- OFTEN: 32.0%
- ALWAYS: 14.4%

EMOTIONAL EXHAUSTION OR BURNOUT:

- OCCASIONALLY: 46.4%
- FREQUENTLY: 45.6%



KEY FACTORS IMPACTING MENTAL HEALTH

From the quantitative data and the powerful qualitative responses, the roots of this crisis are clear:

Chronic workplace discrimination and racism: Micro-aggressions, being overlooked for promotions, and daily disrespect are common experiences.

Career barriers and "push out": Over **41%** reported being pushed out or forced to leave a job due to discrimination, bias, or lack of support.

Isolation and lack of support: Many women described being the only Black woman in their department or workplace, leading to persistent isolation.

Structural and economic pressure: The need to support families and lack of alternative job opportunities keeps many women in harmful environments.

Stigma and access barriers: Fears about stigma and the lack of culturally safe mental health supports often prevent women from seeking help. care—not only for patients, but for the Black women at the heart of our healthcare system.

Certainly, here is a **tidied-up and more cohesive version** of your section on Black women in healthcare leadership, preserving all the essential content, insights, and verbatim responses while improving the flow and reducing repetition:

BLACK WOMEN IN HEALTHCARE LEADERSHIP — BEYOND THE TITLE

"I always feel like I have to prove myself twice as much. The higher you go, the lonelier it becomes, and the less support there is."

Black women who reach senior leadership positions in healthcare describe a journey marked by perseverance, sacrifice, and constant scrutiny. While many are proud of their accomplishments, their narratives reveal that the path to leadership is far from smooth, and challenges do not end with a promotion. In fact, new forms of marginalization often emerge at the highest levels.

Many senior leaders reported being **"the only one"** at the table, sometimes the only Black person, and often the only Black woman. This visibility comes with unique pressures: expectations to represent all Black staff, to take on diversity initiatives, and to serve as mentors, regardless of workload or personal interest. As one leader put it, ***"There is so much pressure to perform, to represent, and to be perfect all the time. Any mistake feels amplified."***

Despite holding advanced titles, several women described how their ideas and expertise were regularly discounted or questioned, even when their credentials far exceeded those of their peers. One respondent wrote, ***"My input is taken as optional, or as just a diversity point of view, not as expertise."*** This frequent dismissal leads some women to self-censor or withdraw from discussions, a pattern of self-preservation that ultimately reduces their influence and satisfaction at work.

Isolation is another recurring theme. The higher up they move, the more disconnected they feel, with fewer peers who can relate to their experiences or provide support. ***"It can feel very lonely at this level. I look around and there is nobody who looks like me, nobody I can really talk to about what it's like,"*** one director shared.

Barriers to real power persist even at the top. Some women hold senior titles, yet describe their decision-making power as restricted, especially when advocating for equity or challenging the status quo. They spoke of hitting a **"glass cliff,"** being promoted into roles where failure was almost inevitable, or being given responsibility without the necessary authority, resources, or institutional support. ***"You are given the title, but not the resources or authority to really make changes,"*** explained one respondent.

The emotional and mental toll of leadership is evident. Many leaders admitted to burnout, exhaustion, and ongoing anxiety about their position and performance. Some said they considered leaving but felt compelled to stay to keep the door open for others.
"I have thought about quitting more times than I can count, but I stay because someone has to be here."

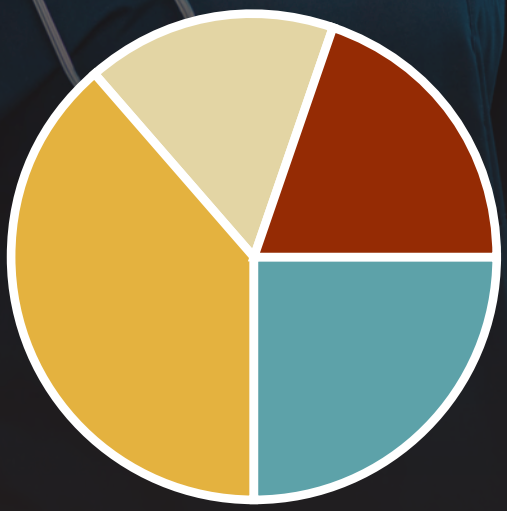
Despite these barriers, many leaders feel a profound sense of responsibility to those coming behind them. They continue to mentor, to advocate for systemic change, and to serve as role models, often at great personal cost. As one participant explained, ***"I stay because I want the next generation to have it easier, but sometimes I wonder if anything is changing."***

QUANTITATIVE FINDINGS CONFIRM THESE PATTERNS:

Senior leaders and executives made up approximately 24.8% of the GTA healthcare respondents.

Of these women, 31.2% rated their mental health as "poor" or "very poor," only slightly lower than the rate among non-senior staff (35.7%).

48.1% of senior leaders rated their mental health as "fair," with only 20.7% reporting "good" or "very good" mental health.



KEY BARRIERS AND QUALITATIVE THEMES IDENTIFIED BY SENIOR LEADERS:

LACK OF MENTORSHIP AND SPONSORSHIP:

"There is no one above me who looks like me or wants to support my growth. Sponsorship is something I never had access to."

ORGANIZATIONAL CULTURE AND SYSTEMIC BIAS:

"Decisions are still made in closed rooms. The old guard protects its own, and it is hard to break into those circles." "You have to work twice as hard to be seen as half as good. The standards are different, even if they say otherwise."

TOKENISM AND ISOLATION:

"I am expected to represent all Black people, but when I speak up I am labelled difficult or aggressive." "It feels like they want my face for the website but not my voice at the table."

MICROAGGRESSIONS AND DOUBLE STANDARDS:

"People question my authority in subtle ways. My decisions are challenged more often than my white peers." "I get left out of informal networks and conversations where the real decisions happen."

BURDEN OF REPRESENTATION AND EMOTIONAL LABOUR:

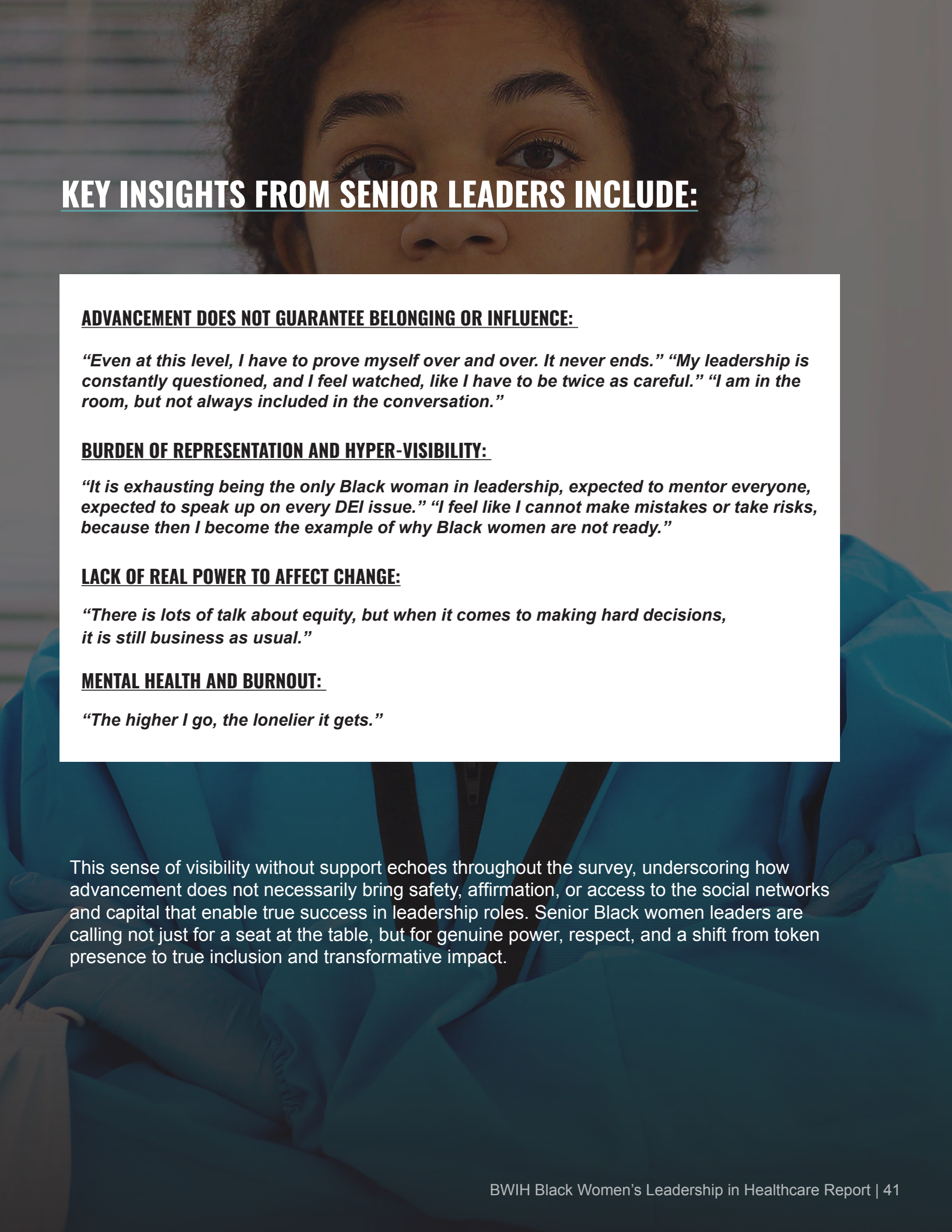
"I am called on to handle all the 'diversity' issues on top of my job. It is exhausting." "The emotional burden of trying to make it better for others, while surviving it yourself, is very real."

LACK OF TRANSPARENT AND FAIR ADVANCEMENT PATHWAYS:

"There is no clear pathway for promotion, and the process is not transparent. It feels arbitrary."

PRESSURE TO CONFORM TO EUROCENTRIC LEADERSHIP NORMS:

"I have to downplay who I am, my culture, and even my ideas to fit in. Leadership is coded white and male."



KEY INSIGHTS FROM SENIOR LEADERS INCLUDE:

ADVANCEMENT DOES NOT GUARANTEE BELONGING OR INFLUENCE:

"Even at this level, I have to prove myself over and over. It never ends." "My leadership is constantly questioned, and I feel watched, like I have to be twice as careful." "I am in the room, but not always included in the conversation."

BURDEN OF REPRESENTATION AND HYPER-VISIBILITY:

"It is exhausting being the only Black woman in leadership, expected to mentor everyone, expected to speak up on every DEI issue." "I feel like I cannot make mistakes or take risks, because then I become the example of why Black women are not ready."

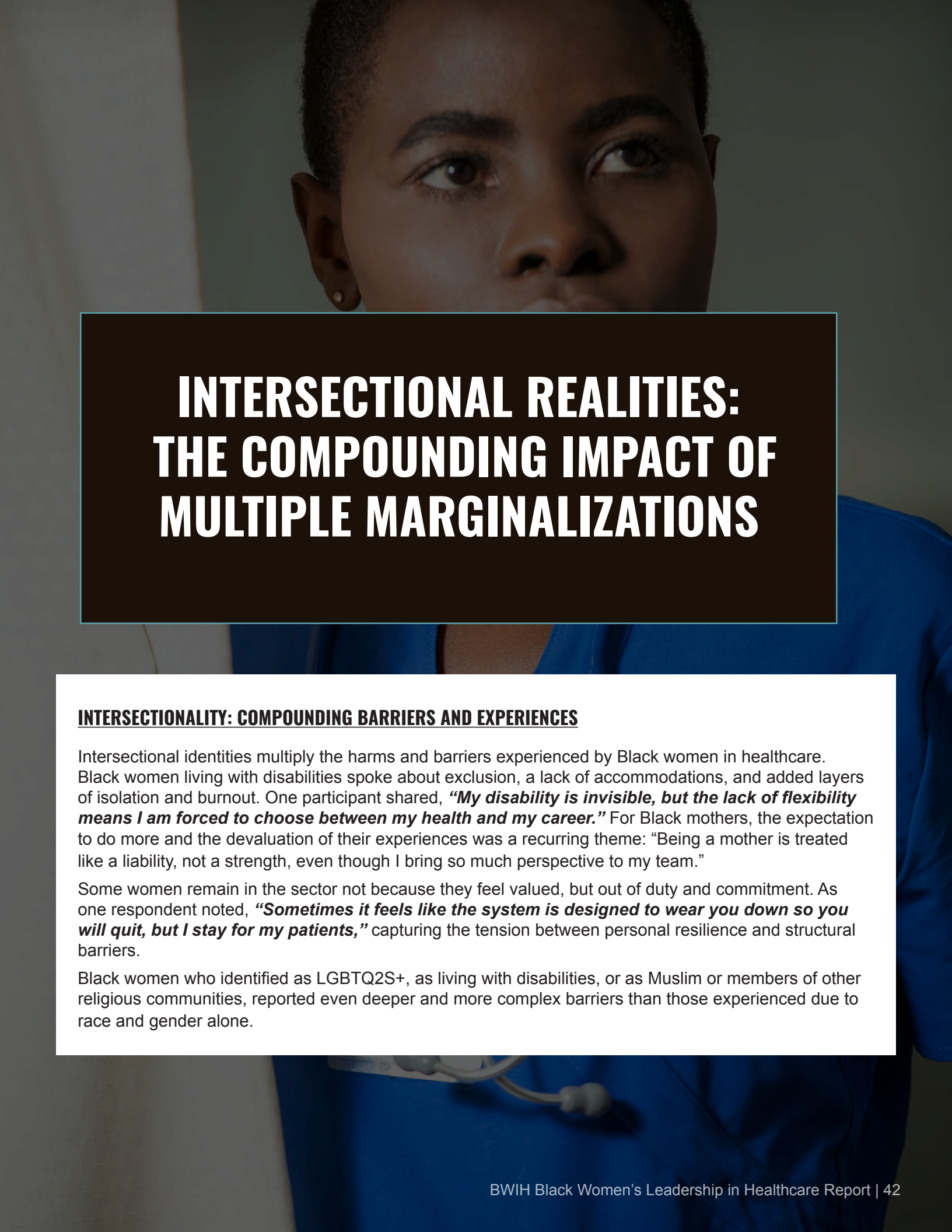
LACK OF REAL POWER TO AFFECT CHANGE:

"There is lots of talk about equity, but when it comes to making hard decisions, it is still business as usual."

MENTAL HEALTH AND BURNOUT:

"The higher I go, the lonelier it gets."

This sense of visibility without support echoes throughout the survey, underscoring how advancement does not necessarily bring safety, affirmation, or access to the social networks and capital that enable true success in leadership roles. Senior Black women leaders are calling not just for a seat at the table, but for genuine power, respect, and a shift from token presence to true inclusion and transformative impact.



INTERSECTIONAL REALITIES: THE COMPOUNDING IMPACT OF MULTIPLE MARGINALIZATIONS

INTERSECTIONALITY: COMPOUNDING BARRIERS AND EXPERIENCES

Intersectional identities multiply the harms and barriers experienced by Black women in healthcare. Black women living with disabilities spoke about exclusion, a lack of accommodations, and added layers of isolation and burnout. One participant shared, ***"My disability is invisible, but the lack of flexibility means I am forced to choose between my health and my career."*** For Black mothers, the expectation to do more and the devaluation of their experiences was a recurring theme: "Being a mother is treated like a liability, not a strength, even though I bring so much perspective to my team."

Some women remain in the sector not because they feel valued, but out of duty and commitment. As one respondent noted, ***"Sometimes it feels like the system is designed to wear you down so you will quit, but I stay for my patients,"*** capturing the tension between personal resilience and structural barriers.

Black women who identified as LGBTQ2S+, as living with disabilities, or as Muslim or members of other religious communities, reported even deeper and more complex barriers than those experienced due to race and gender alone.

DISABILITY:

About **13.6%** of respondents self-identified as living with a disability. These women reported significantly poorer mental health than those without disabilities: **38.2%** rated their mental health as poor or very poor, compared to 26.3% of those without disabilities. They described unique barriers to advancement, often feeling that their needs were minimized or misunderstood, and some were denied accommodations. One woman stated, “As a Black woman with a disability, I am always seen as a burden, not a leader. I feel like I have to work twice as hard just to be considered for the same opportunities.”

LGBTQ2S+:

Seven point two percent of respondents identified as LGBTQ2S+. These respondents highlighted the challenge of navigating homophobia or transphobia layered on top of anti-Black racism and sexism. Some described a lack of culturally safe spaces or fear of coming out at work. Mental health scores were lower for LGBTQ2S+ respondents, with **41%** rating their mental health as poor or very poor. As one respondent shared, “It’s hard enough being a Black woman here, but as a queer person too, it feels like there is nowhere to just be myself. I’m always hiding a part of who I am.”

MUSLIM AND OTHER RELIGIOUS IDENTITIES:

While the survey did not collect detailed religious breakdowns, several women noted being visibly Muslim, for example, wearing hijab, or practising another marginalized faith. These women described facing religious discrimination, sometimes in addition to racism and sexism, and occasionally being excluded from workplace culture or advancement opportunities. One participant explained, “I have been passed over for leadership roles because people make assumptions about my religious practices. It’s another thing to fight for, on top of everything else.”

Other Marginalizations (Newcomer Status, Single Parenthood):

Several respondents highlighted the extra burdens of being a newcomer to Canada or balancing single parenthood, describing barriers to networking, mentorship, and advancement. As one shared, “As an immigrant, I am not only trying to prove myself as a Black woman, but also as someone who does not have the ‘right’ connections. It’s exhausting.”

KEY TAKEAWAYS:

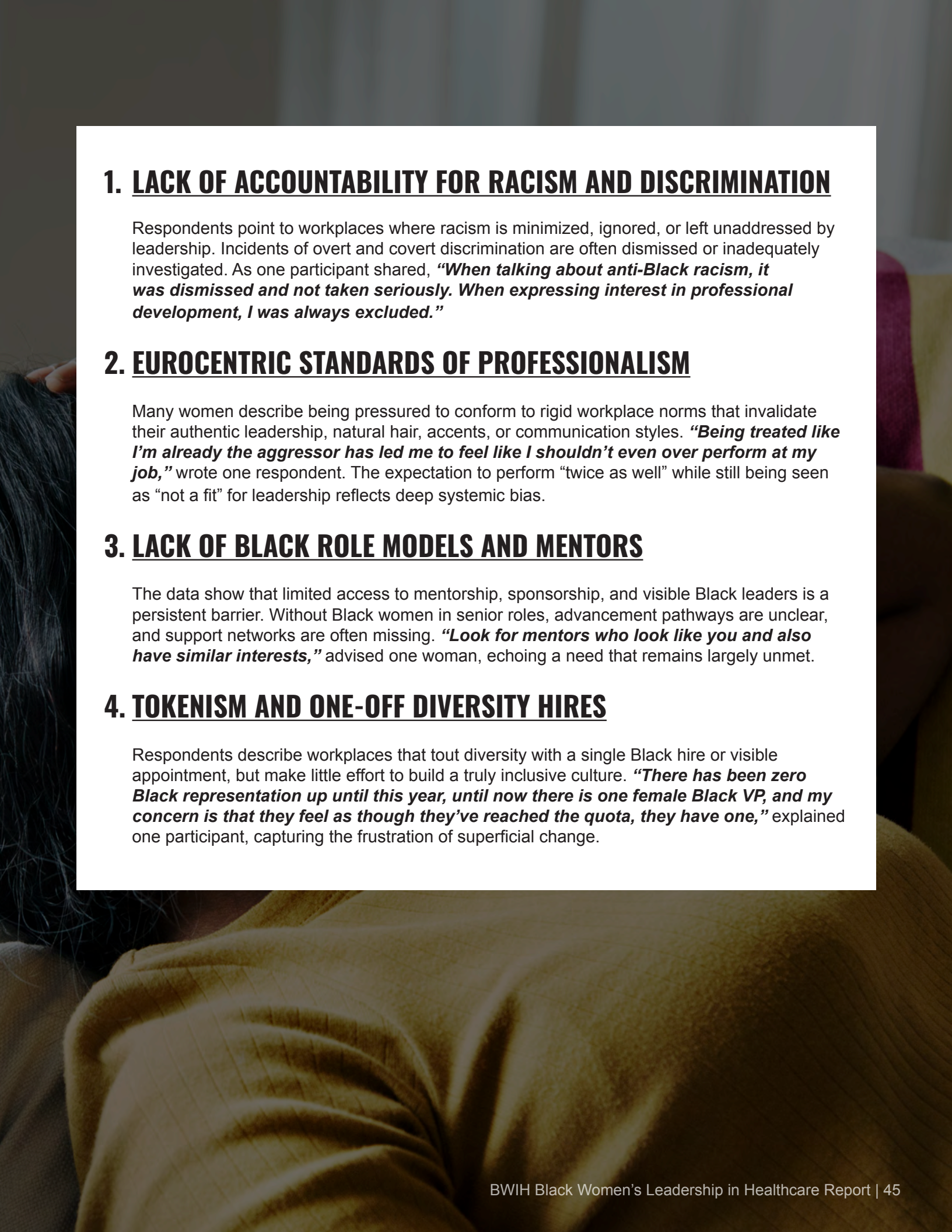
Black women with intersecting marginalized identities, including disability, LGBTQ2S+ status, religious minority, newcomer status, or single parenthood, experience the highest rates of poor mental health, discrimination, and stalled advancement.

The barriers faced are not merely additive, but multiplicative—each identity compounds the challenges, making real inclusion and advancement even more difficult.

Targeted supports and policies are urgently needed to address the full range of intersectional experiences, not just race and gender alone.

ROOT CAUSES: WHAT THE DATA AND VOICES REVEAL

The convergence of push out, discrimination, stalled advancement, and mental health impacts is not coincidental. Instead, these outcomes are the result of entrenched anti-Black racism, intersecting gender barriers, and the cumulative effects of economic and organizational failures. The data and the lived experiences of Black women in the GTA healthcare sector make these root causes unmistakably clear.



1. LACK OF ACCOUNTABILITY FOR RACISM AND DISCRIMINATION

Respondents point to workplaces where racism is minimized, ignored, or left unaddressed by leadership. Incidents of overt and covert discrimination are often dismissed or inadequately investigated. As one participant shared, ***"When talking about anti-Black racism, it was dismissed and not taken seriously. When expressing interest in professional development, I was always excluded."***

2. EUROCENTRIC STANDARDS OF PROFESSIONALISM

Many women describe being pressured to conform to rigid workplace norms that invalidate their authentic leadership, natural hair, accents, or communication styles. ***"Being treated like I'm already the aggressor has led me to feel like I shouldn't even over perform at my job,"*** wrote one respondent. The expectation to perform "twice as well" while still being seen as "not a fit" for leadership reflects deep systemic bias.

3. LACK OF BLACK ROLE MODELS AND MENTORS

The data show that limited access to mentorship, sponsorship, and visible Black leaders is a persistent barrier. Without Black women in senior roles, advancement pathways are unclear, and support networks are often missing. ***"Look for mentors who look like you and also have similar interests,"*** advised one woman, echoing a need that remains largely unmet.

4. TOKENISM AND ONE-OFF DIVERSITY HIRES

Respondents describe workplaces that tout diversity with a single Black hire or visible appointment, but make little effort to build a truly inclusive culture. ***"There has been zero Black representation up until this year, until now there is one female Black VP, and my concern is that they feel as though they've reached the quota, they have one,"*** explained one participant, capturing the frustration of superficial change.

5. BURDEN OF REPRESENTATION

Black women report being expected to “represent” all Black people, answer for systemic problems, or shoulder extra responsibilities for diversity initiatives, even as they remain marginalized from real decision-making. ***“I am often the only Black person in academic or leadership circles,”*** shared one respondent, ***“and I spend a lot of time providing mentorship to more junior Black professionals, because it is very important for me to be the visible role model for others that I never had myself.”***

6. COMPOUNDED STRESS FOR INTERSECTIONAL IDENTITIES

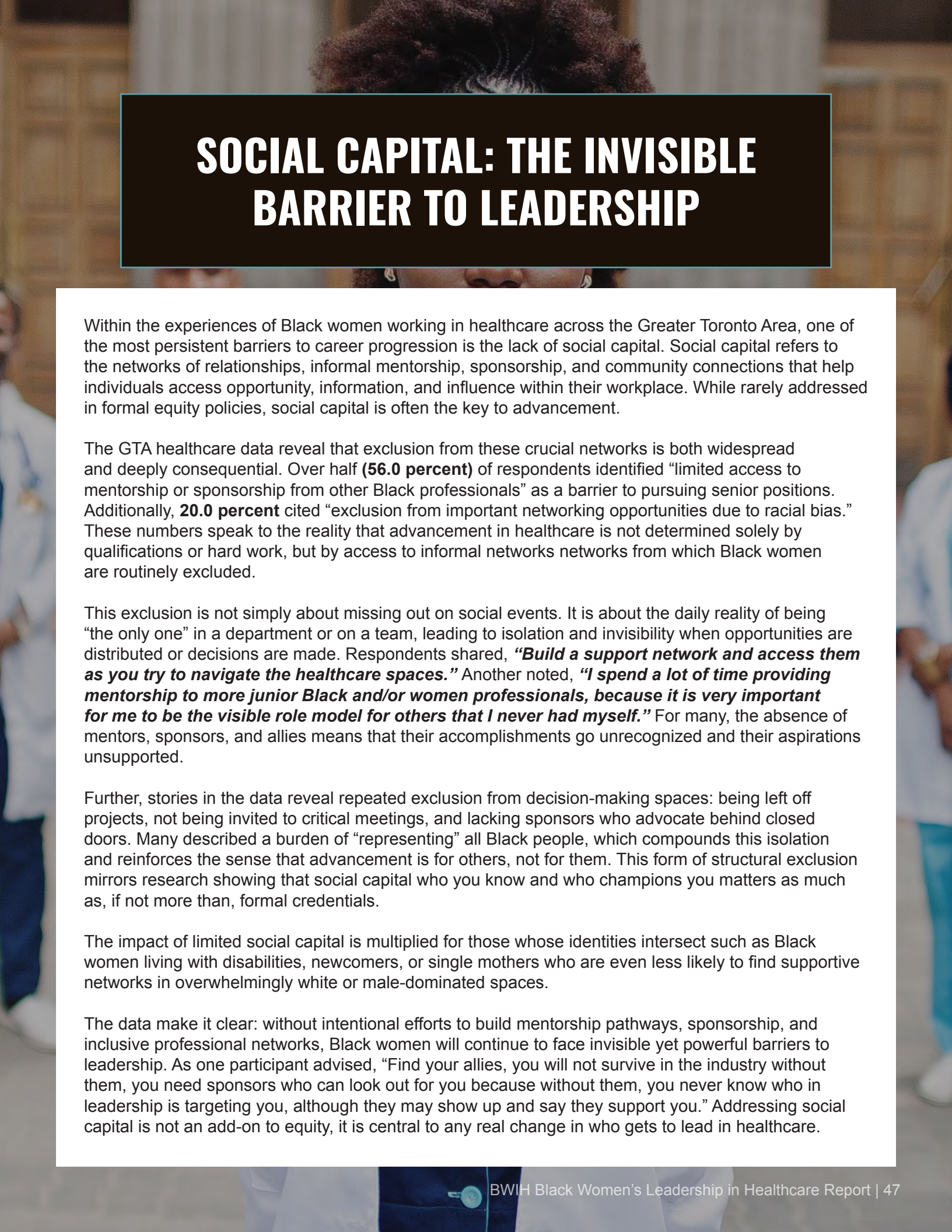
Women living with disabilities, newcomers to Canada, single mothers, and others with multiple marginalized identities experience unique and layered barriers. ***“Anti-Black racism is hard, but when coupled with disability, it becomes very insidious. Healthcare is already inherently ableist,”*** wrote one woman. These intersections deepen feelings of exclusion, stress, and vulnerability.

7. ECONOMIC AND STRUCTURAL PRESSURES

Financial necessity, job security, and lack of alternative opportunities mean that many Black women feel forced to remain in unhealthy workplaces. ***“Burnout, emotional fatigue, and the psychological toll of repeated push out can make the idea of switching jobs overwhelming,”*** the report reveals. The cost of leaving is high, and the options elsewhere are often no better.

8. ORGANIZATIONAL CULTURE AND LEADERSHIP FAILURES

Many women described a workplace culture that protects status quo power structures, devalues Black expertise, and is slow to respond to calls for equity. ***“There is a LOT of pressure on organizations to de-prioritize equity generally and anti-Black racism specifically,”*** one respondent noted, reflecting the wider social and political climate.



SOCIAL CAPITAL: THE INVISIBLE BARRIER TO LEADERSHIP

Within the experiences of Black women working in healthcare across the Greater Toronto Area, one of the most persistent barriers to career progression is the lack of social capital. Social capital refers to the networks of relationships, informal mentorship, sponsorship, and community connections that help individuals access opportunity, information, and influence within their workplace. While rarely addressed in formal equity policies, social capital is often the key to advancement.

The GTA healthcare data reveal that exclusion from these crucial networks is both widespread and deeply consequential. Over half **(56.0 percent)** of respondents identified "limited access to mentorship or sponsorship from other Black professionals" as a barrier to pursuing senior positions. Additionally, **20.0 percent** cited "exclusion from important networking opportunities due to racial bias." These numbers speak to the reality that advancement in healthcare is not determined solely by qualifications or hard work, but by access to informal networks networks from which Black women are routinely excluded.

This exclusion is not simply about missing out on social events. It is about the daily reality of being "the only one" in a department or on a team, leading to isolation and invisibility when opportunities are distributed or decisions are made. Respondents shared, ***"Build a support network and access them as you try to navigate the healthcare spaces."*** Another noted, ***"I spend a lot of time providing mentorship to more junior Black and/or women professionals, because it is very important for me to be the visible role model for others that I never had myself."*** For many, the absence of mentors, sponsors, and allies means that their accomplishments go unrecognized and their aspirations unsupported.

Further, stories in the data reveal repeated exclusion from decision-making spaces: being left off projects, not being invited to critical meetings, and lacking sponsors who advocate behind closed doors. Many described a burden of "representing" all Black people, which compounds this isolation and reinforces the sense that advancement is for others, not for them. This form of structural exclusion mirrors research showing that social capital who you know and who champions you matters as much as, if not more than, formal credentials.

The impact of limited social capital is multiplied for those whose identities intersect such as Black women living with disabilities, newcomers, or single mothers who are even less likely to find supportive networks in overwhelmingly white or male-dominated spaces.

The data make it clear: without intentional efforts to build mentorship pathways, sponsorship, and inclusive professional networks, Black women will continue to face invisible yet powerful barriers to leadership. As one participant advised, "Find your allies, you will not survive in the industry without them, you need sponsors who can look out for you because without them, you never know who in leadership is targeting you, although they may show up and say they support you." Addressing social capital is not an add-on to equity, it is central to any real change in who gets to lead in healthcare.

QUOTES FROM RESPONDENTS:

"I have experienced racism and discrimination in every role I have had in healthcare."

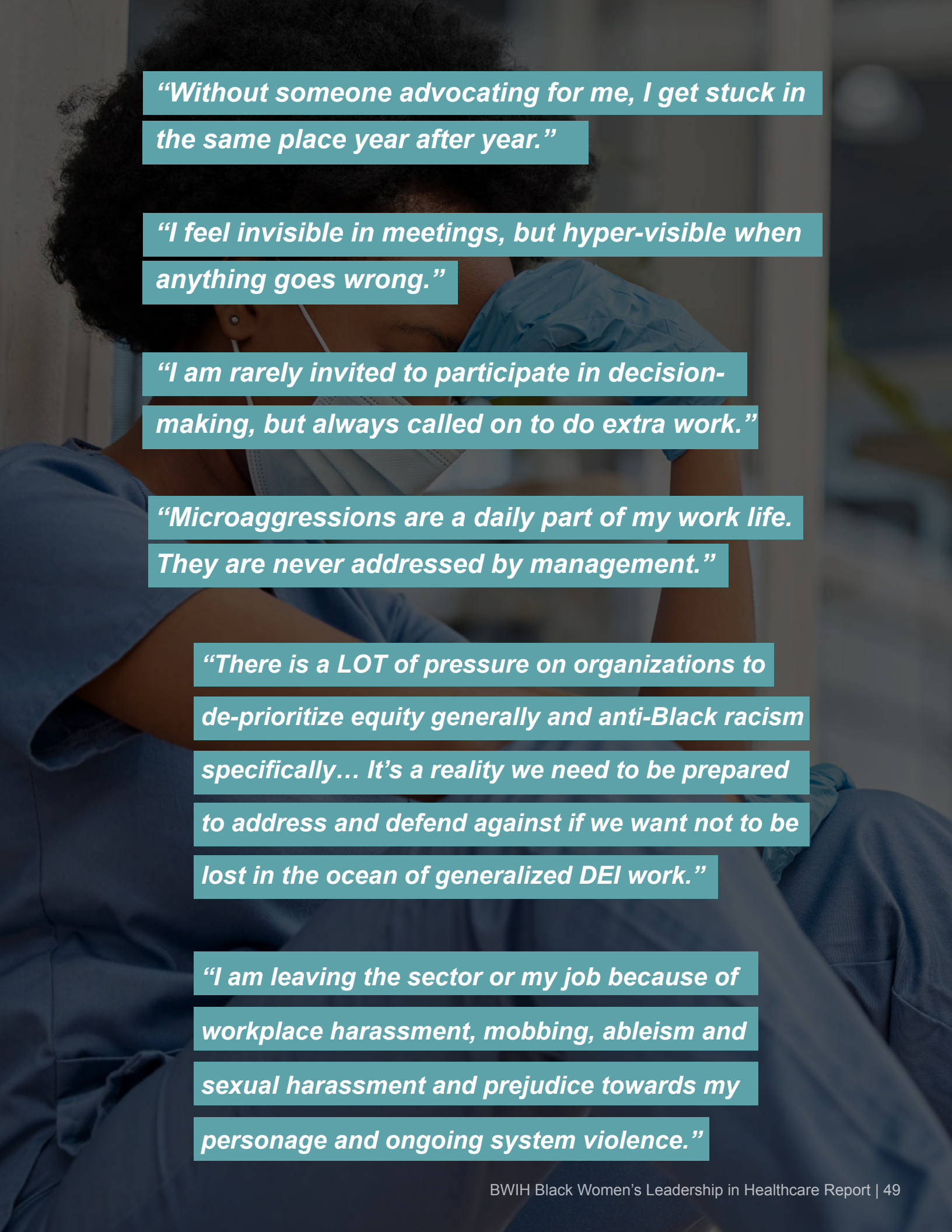
"I am overlooked for opportunities and promotions even when I am more qualified."

"I have seen less qualified colleagues promoted over me."

"The path to leadership is not the same for Black women."

"Being passed over for advancement has made me question my value."

"There are no mentors who look like me. It feels lonely."



"Without someone advocating for me, I get stuck in the same place year after year."

"I feel invisible in meetings, but hyper-visible when anything goes wrong."

"I am rarely invited to participate in decision-making, but always called on to do extra work."

"Microaggressions are a daily part of my work life. They are never addressed by management."

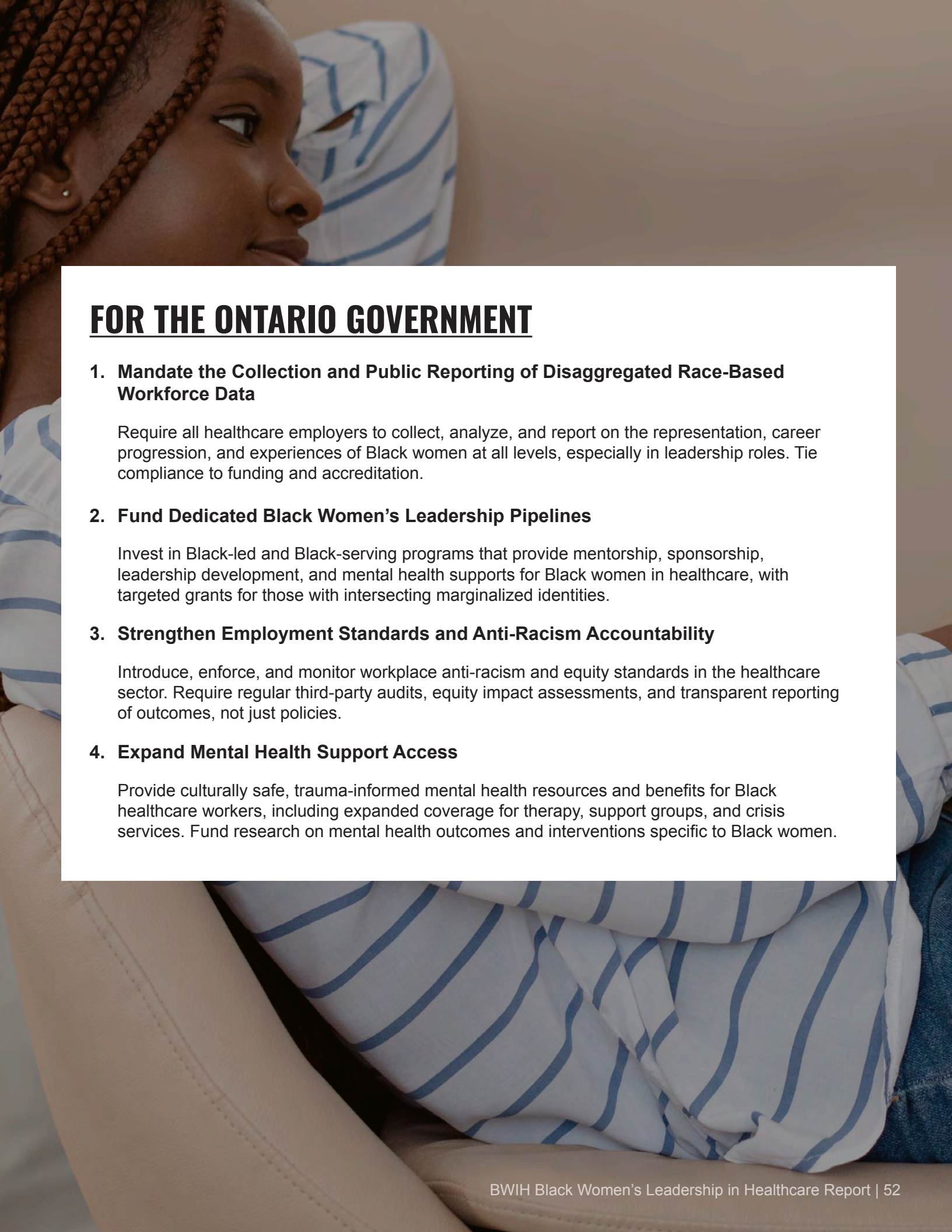
"There is a LOT of pressure on organizations to de-prioritize equity generally and anti-Black racism specifically… It's a reality we need to be prepared to address and defend against if we want not to be lost in the ocean of generalized DEI work."

"I am leaving the sector or my job because of workplace harassment, mobbing, ableism and sexual harassment and prejudice towards my personage and ongoing system violence."

"I have experienced racism and discrimination in every role I have had in healthcare."

These experiences are echoed by dozens of others in the survey, who described cycles of exhaustion, trauma, and feeling undervalued, even as they continued to provide care to others.

RECOMMENDATIONS



FOR THE ONTARIO GOVERNMENT

1. **Mandate the Collection and Public Reporting of Disaggregated Race-Based Workforce Data**

   Require all healthcare employers to collect, analyze, and report on the representation, career progression, and experiences of Black women at all levels, especially in leadership roles. Tie compliance to funding and accreditation.

2. **Fund Dedicated Black Women's Leadership Pipelines**

   Invest in Black-led and Black-serving programs that provide mentorship, sponsorship, leadership development, and mental health supports for Black women in healthcare, with targeted grants for those with intersecting marginalized identities.

3. **Strengthen Employment Standards and Anti-Racism Accountability**

   Introduce, enforce, and monitor workplace anti-racism and equity standards in the healthcare sector. Require regular third-party audits, equity impact assessments, and transparent reporting of outcomes, not just policies.

4. **Expand Mental Health Support Access**

   Provide culturally safe, trauma-informed mental health resources and benefits for Black healthcare workers, including expanded coverage for therapy, support groups, and crisis services. Fund research on mental health outcomes and interventions specific to Black women.

FOR HOSPITALS AND HEALTHCARE FACILITIES

1. **Implement Transparent Promotion Pathways and Sponsorship**

   Develop clear, bias-free criteria for advancement and promotion. Establish formal sponsorship and mentorship programs that prioritize Black women, with executive sponsors accountable for progress.

2. **Advancing True Representation: Building Critical Mass of Black Women in Healthcare Leadership**

   Hiring Black women into entry-level or administrative positions alone does not shift the balance of power or address systemic inequities in healthcare institutions. Organizations must prioritize elevating Black women into senior leadership roles, not just increasing hiring density at lower levels. Focusing on hiring quotas that simply match census statistics is insufficient and may reinforce existing barriers, as proportional representation without a critical mass fails to challenge underlying systems of bias.

   To create meaningful and sustainable change, organizations should:

   - Set explicit and measurable targets for Black women's representation at all levels of leadership, with particular emphasis on executive, board, and decision-making roles.
   - Track and publicly report progress beyond hiring numbers, focusing on career advancement, promotion, and retention of Black women in leadership.
   - Evaluate the impact of representation by ensuring a critical mass of Black women in leadership, rather than making token appointments that maintain the status quo.
   - Invest in mentorship, sponsorship, and succession planning that deliberately supports Black women's career trajectories, ensuring they are strategically positioned to be seen and to advance.
   - Recognize that when Black women disengage or leave due to lack of advancement, organizations lose out on their talent, leadership potential, and the social capital necessary for real organizational change.

3. **Build Inclusive Workplace Cultures**

   Move beyond one-off training to ongoing, mandatory anti-Black racism and intersectionality education, led by experts and Black women themselves. Embed accountability for inclusion and equity into leadership evaluations and pay.

4. **Prioritize Culturally Safe Mental Health Supports**

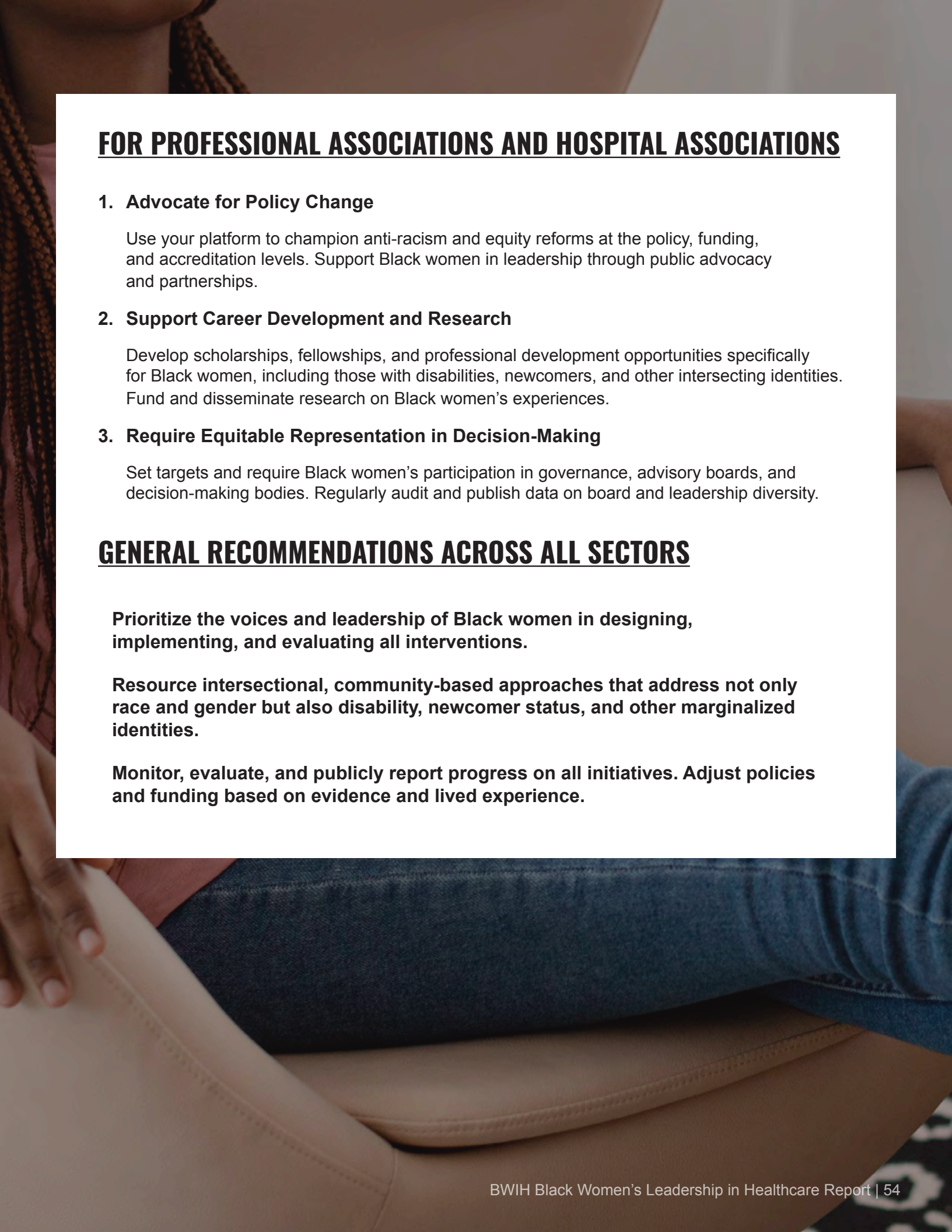
   Partner with Black mental health professionals and organizations to provide accessible support services for Black women employees. Regularly assess and respond to workplace stressors unique to Black women.

5. **Establish Peer Support and Affinity Networks**

   Resource Black employee resource groups, peer networks, and affinity spaces where Black women can access community, share information, and develop social capital.

6. **Adopt Zero-Tolerance Policies for Racism and Discrimination**

   Enforce swift and transparent processes for addressing all forms of discrimination, harassment, and retaliation. Publicly report outcomes and provide restorative pathways for those impacted.



FOR PROFESSIONAL ASSOCIATIONS AND HOSPITAL ASSOCIATIONS

1. **Advocate for Policy Change**

   Use your platform to champion anti-racism and equity reforms at the policy, funding, and accreditation levels. Support Black women in leadership through public advocacy and partnerships.

2. **Support Career Development and Research**

   Develop scholarships, fellowships, and professional development opportunities specifically for Black women, including those with disabilities, newcomers, and other intersecting identities. Fund and disseminate research on Black women's experiences.

3. **Require Equitable Representation in Decision-Making**

   Set targets and require Black women's participation in governance, advisory boards, and decision-making bodies. Regularly audit and publish data on board and leadership diversity.

GENERAL RECOMMENDATIONS ACROSS ALL SECTORS

Prioritize the voices and leadership of Black women in designing, implementing, and evaluating all interventions.

Resource intersectional, community-based approaches that address not only race and gender but also disability, newcomer status, and other marginalized identities.

Monitor, evaluate, and publicly report progress on all initiatives. Adjust policies and funding based on evidence and lived experience.

CONCLUSION

This report is both a mirror and a window: it reflects the reality that too many Black women working in healthcare across the Greater Toronto Area are navigating systems that undermine, exhaust, and undervalue them, even as they are called to be healers for others. The data is clear. The voices are unmistakable. Black women are not only essential to the care and functioning of our communities, but are also enduring a level of push out, mental health strain, and career stagnation that is simply unacceptable.

At the Black Women's Institute for Health, we know this work is far from finished. The first comprehensive survey of its kind in Canada, this report marks a beginning, not an end. We are committed to repeating this survey every two years. We will collect the data, the stories, and the hard truths from Black women in healthcare and track progress with transparency and rigour. We will work to ensure that each new report is a tool for advocacy, accountability, and systems change.

We remain deeply concerned for Black women working in healthcare who, despite their qualifications, experience, and dedication, continue to face daily indignities, barriers, and bias. Yet we also see in these pages a vision for something better, a system where leadership is truly representative, where mentorship and advancement are realities for all, and where care is reciprocal. Our hope is rooted in the wisdom and strength of Black women themselves, who have always known the way forward.

We invite healthcare leaders, policymakers, funders, and our wider community to join us in this work. Let this report be the catalyst that finally moves us from words to action, from performative allyship to transformative change. We will keep building the evidence, supporting each other, and holding the system to account. We are not going anywhere.

We close with the words of a respondent whose experience speaks for so many:
"Lift up your voice and speak up. Hold your head up high and do not succumb to the inadequacies, insecurities, and idiosyncrasies of the workplace designed to deny Black women opportunities at every bend and turn. Most of all, claim your rest and relaxation from the start and set clear boundaries that communicate your time is sacred and precious."

This is not just our story. This is our call to action. And we will answer it...together.

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