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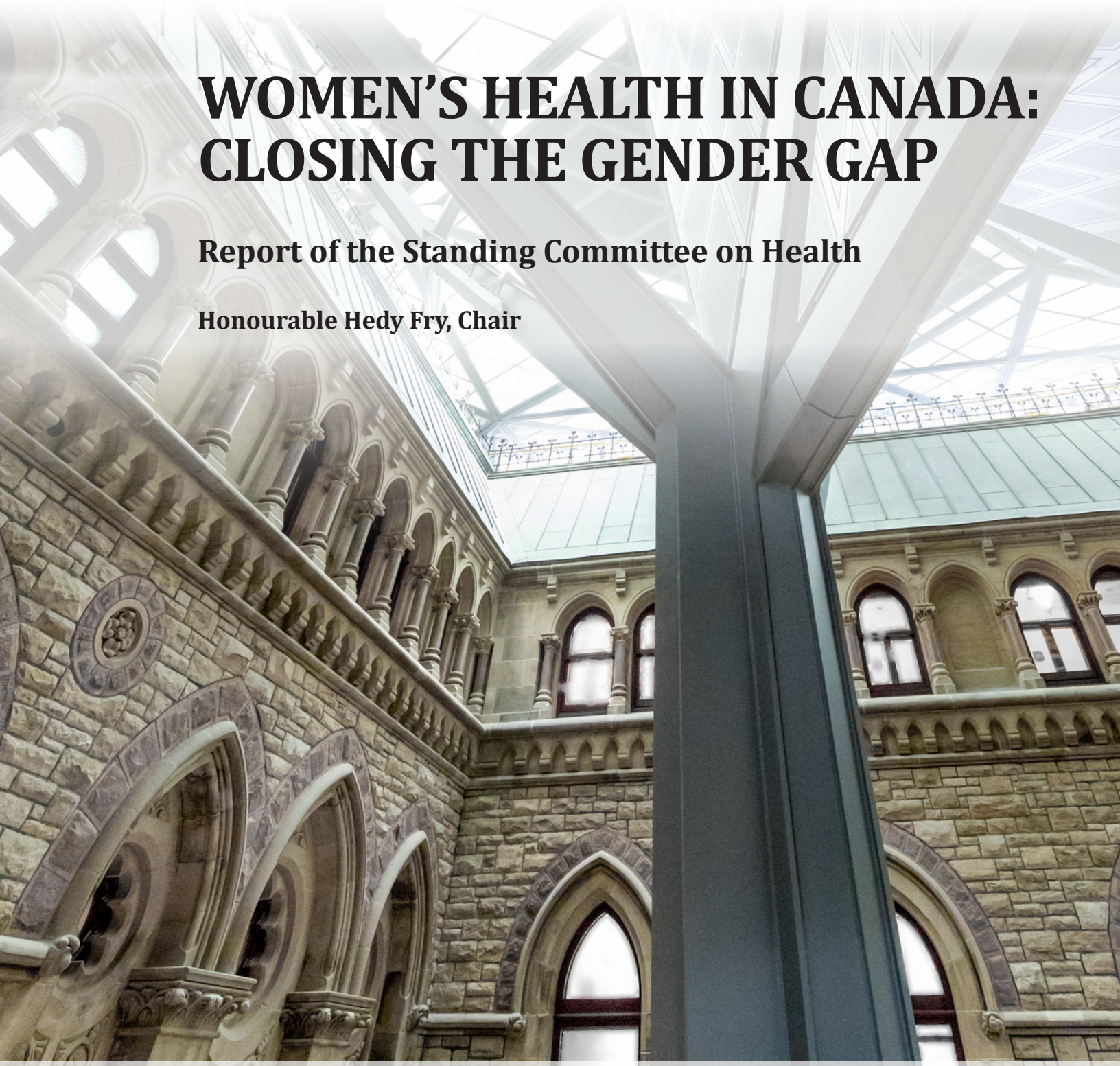

WOMEN'S HEALTH IN CANADA: CLOSING THE GENDER GAP

Report of the Standing Committee on Health

Honourable Hedy Fry, Chair

NOVEMBER 2025
45th PARLIAMENT, 1st SESSION

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NOTICE TO READER

Reports from committees presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

SECOND REPORT

Pursuant to its mandate under Standing Order 108(2), the committee has studied women's health and has agreed to report the following:

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SUMMARY

Women's health, when compared with that of men, is less well funded, studied and understood. As a result, women are more likely to be under- or misdiagnosed and to receive ill-suited treatments, all of which leads to poorer health outcomes. The persistent gender gap in health care and research is detrimental to women and costly for society.

The House of Commons Standing Committee on Health (committee) undertook a study on women's health, focusing on four priority topics:

- endometriosis and other gynecological conditions;
- women and cancer, including breast cancer screening and gynecological cancers;
- women's mental health, including perinatal mental health and the mental health impact of trauma; and
- women's health research.

Although these topics are distinct, they share themes that underpin gender inequity in health. The evidence gathered for the study highlights the numerous ways that sex and gender can influence health. For example, physical and physiological differences between the sexes can influence disease prevalence and the safety and efficacy of treatments, while preconceived notions about gender and women's bodies can influence care. Further, women's health experiences are diverse. The intersection of sex and gender with race, age, sexual orientation, disability and other factors can lead to disparate health outcomes between different groups of women.

Recognizing the importance of achieving gender equity in health, the committee makes 16 recommendations to address pressing issues in women's health. In implementing these recommendations, the federal government would be taking concrete steps to improve the well-being of women across the country and ultimately eliminate gender inequity in health.

LIST OF RECOMMENDATIONS

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the House of Commons or the Government. Recommendations related to this study are listed below.

WOMEN'S HEALTH IN CANADA: CLOSING THE GENDER GAP

INTRODUCTION

There is a persistent gender gap in health care and research in Canada. Although women make up half the population and have health needs that can differ in significant ways from those of men, health care and research have traditionally defaulted to the male body. Women's health is less well studied and understood compared to that of men. As a result, women are more likely to be under- or misdiagnosed and to receive ill-suited treatments, all of which leads to poorer health outcomes.

A search of online records between 1994 and 2022 revealed that the House of Commons Standing Committee on Health (committee) itself had not studied women's health in that 28-year time span. The committee therefore adopted the following motion on 16 May 2022:

> That, pursuant to Standing Order 108(2), the committee undertake a study on women's health; that the committee report its findings and recommendations to the House; and that, pursuant to Standing Order 109, the committee request that the government table a comprehensive response to the report.[1]

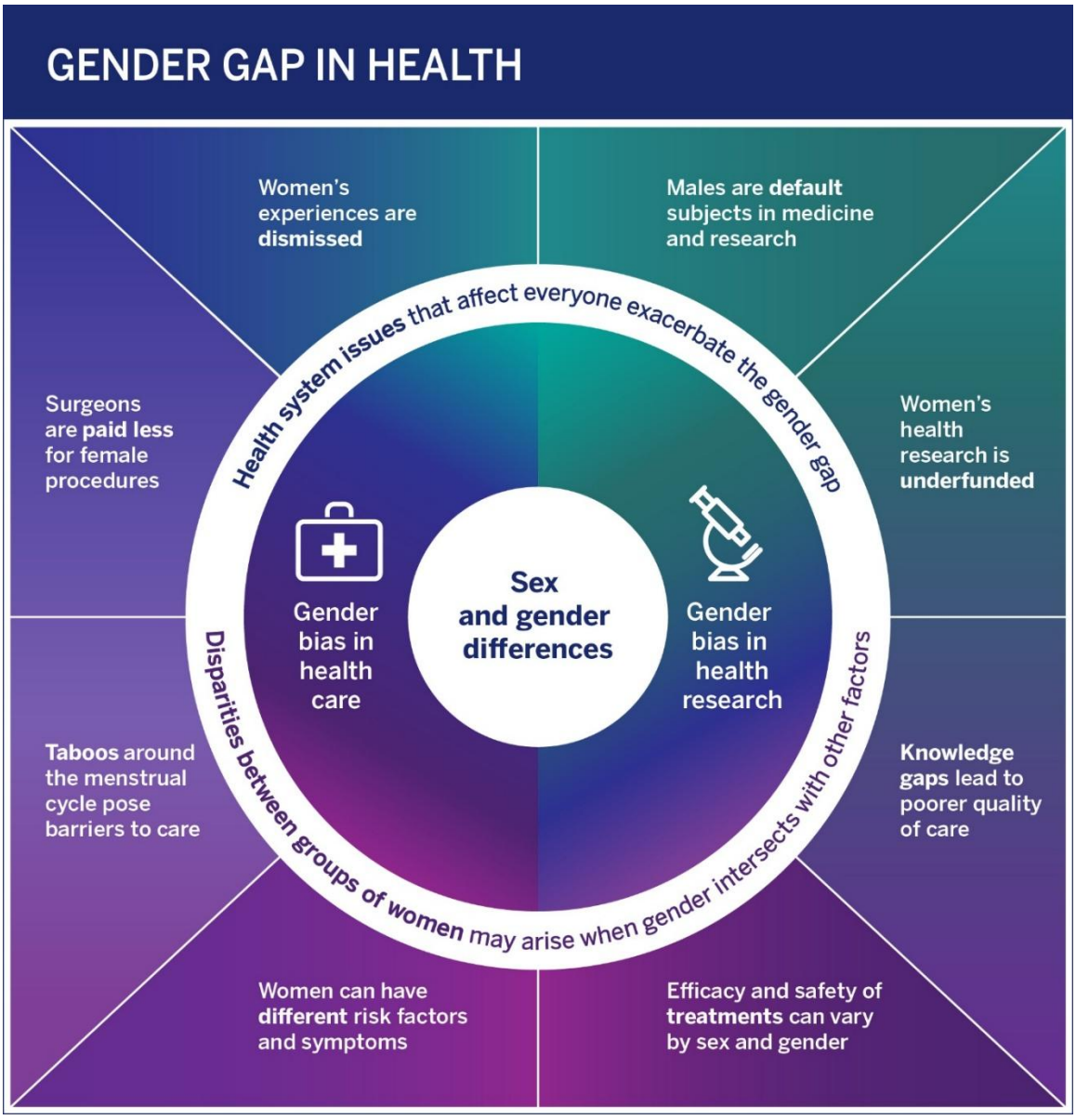
Between 27 November 2023 and 2 May 2024, the committee held 8 meetings on women's health during which it heard from 43 witnesses. Witnesses included health professionals, patient advocacy groups, academics and other stakeholders. The committee also received 69 briefs. The study focused on four priority topics: endometriosis and other gynecological conditions, women and cancer, women's mental health and women's health research. The topics are distinct, yet they share themes that underpin gender inequity in health. The first part of this report outlines those themes to contextualize the gender gap in health. The second part summarizes the evidence on the four focus topics and presents the committee's recommendations to the federal government to address the concerns raised during the study.

1 House of Commons, Standing Committee on Health (HESA), *Minutes of Proceedings*, 16 May 2022.

THE GENDER GAP IN HEALTH: A THROUGH LINE IN THE EVIDENCE

The testimony and briefs revealed an amalgamation of complex factors that contribute to the gender gap in health, as illustrated in Figure 1.

Figure 1—The Gender Gap in Health



Source: Prepared by the Library of Parliament.

Sex, Gender and Health

Sex and gender can influence health in a variety of ways. The Canadian Institutes of Health Research (CIHR) explains the distinction between the two terms thus:

> **Sex** refers to a set of biological attributes in humans and animals. It is primarily associated with physical and physiological features including chromosomes, gene expression, hormone levels and function, and reproductive/sexual anatomy. Sex is usually categorized as female or male but there is variation in the biological attributes that comprise sex and how those attributes are expressed.
>
> **Gender** refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. It influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society. Gender identity is not confined to a binary (girl/woman, boy/man) nor is it static; it exists along a continuum and can change over time.[2]

Some health conditions, such as endometriosis and gynecological cancers, are sex-specific. Others, like multiple sclerosis, breast cancer and certain mental health conditions, disproportionately affect women compared to men. Women are also more likely to experience intimate partner violence and sexual assault. Further, the same health conditions may affect men and women differently; risk factors or symptoms can vary by sex. The symptoms of a heart attack, for example, present differently in women compared to men and, as a result, may go unrecognized.[3]

Physical and physiological differences between the sexes can also influence the safety and efficacy of treatments. Medical devices, for instance, are often designed for the male body and thus may not be suitable for women. Such differences by sex or gender are widespread. Regarding this point, a Health Canada official made the following statement:

> When it comes to differences in diagnoses, treatment and symptom identification, it's hard to find a disease or condition that wouldn't be affected by these circumstances. That's why we conduct sex and gender analyses in all our work.[4]

2 Canadian Institutes of Health Research, *What is gender? What is sex?*.

3 HESA, *Evidence*, 27 November 2023, 1130 (Cindy Moriarty, Director General, Health Programs and Strategic Initiatives, Department of Health).

4 HESA, *Evidence*, 27 November 2023, 1130 (Cindy Moriarty, Director General, Health Programs and Strategic Initiatives, Department of Health).

Gender Bias in Health Care and Research

Gender bias within the health care system and in medical research is detrimental to women's health. Men's bodies have, to this day, been used as the default in medicine and research, and women-focused health research has been perpetually underfunded, which limits health care providers' understanding of women's health. These knowledge gaps contribute to misdiagnoses, the minimizing or misunderstanding of women's symptoms, and poorly targeted treatments.

Preconceived notions about gender and women's bodies can also influence care. For example, taboos surrounding menstruation and the normalization of painful periods contribute to delayed diagnoses for people with endometriosis.[5] A further manifestation of the gender bias in health care can be seen in surgery remuneration rates: surgeons are paid less for procedures typically performed on female patients compared to similar ones performed on male patients (e.g., hysterectomy versus prostate removal).[6] Additionally, women who work in the health care system can experience systemic discrimination, such as unequal workload between women and men physicians, which can affect their mental health.[7]

Intersectionality and the Gender Gap

Women's health experiences are diverse. The intersection of sex and gender with race, age, sexual orientation, disability and other factors can lead to disparate health outcomes between different groups of women. For example, Indigenous women, racialized women, women living with low income, and gender-diverse people face not only a gender gap but also discrimination in the health care system, which can lead to poorer care.[8] One brief submitted to the committee further discussed the ways in which such discrimination can itself intersect with other factors, as exemplified by the experiences of Black women in Canada, who have poorer health outcomes as a result of anti-Black racism.[9]

5 HESA, *Evidence*, 29 November 2023, 1945, 2000 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

6 HESA, *Evidence*, 15 February 2024, 1155, 1220 (Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, as an individual).

7 Dr. Kathleen Ross, Canadian Medical Association, *Women's Health Study*, Brief submitted to HESA.

8 HESA, *Evidence*, 15 February 2024, 1105 (Dr. Ambreen Sayani, Scientist, as an individual).

9 Bukola Salami et al., *Improving Black Women's Health in Canada*, Brief submitted to HESA, April 2024.

Impacts of Cross-Cutting Health System Issues on the Gender Gap

Issues that cut across the health care system, such as workforce shortages and barriers to accessing primary care, affect people of all genders. For women, these problems can compound their specific health issues, widening the gender gap. For example, rural areas tend to have less access to health care than urban centres. Consequently, women diagnosed with cancer who live in rural areas can face unique challenges in obtaining supportive services;[10] they may, for instance, need assistance with financial resources, child care, or time off work to travel to a distant clinic.

Societal Impact of the Gender Gap in Health

Finally, the gender gap in health imposes broader societal costs. The committee heard that, of the conditions that disproportionately affect women, endometriosis and multiple sclerosis alone each cost Canada billions of dollars annually, notably through health system expenditures and lost productivity.[11] Healthier women are better able to participate in working life, which can increase economic productivity. Thus, all of society benefits from closing the gender gap in health.

FOCUS TOPICS

For this study, the committee gathered evidence on four specific topics:

- endometriosis and other gynecological conditions;
- women and cancer, notably breast cancer screening and gynecological cancers;
- women's mental health, including perinatal mental health and the mental health impact of trauma; and
- women's health research.

10 HESA, *Evidence*, 15 February 2024, 1105, 1215 (Dr. Ghadeer Anan, Medical Oncologist, as an individual).

11 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada); and HESA, *Evidence*, 2 May 2024, 1255 (Pamela Valentine, President and CEO, MS Canada).

Endometriosis and Other Gynecological Conditions

The committee heard that at least 1 in 10 women in Canada of reproductive age are affected by endometriosis.[12] This chronic reproductive health condition "occurs when tissue that is similar to the lining of the uterus forms lesions, cysts and deep nodules on other parts of the body, including the ovaries, bowel and bladder."[13] The committee received briefs from people living with endometriosis describing the significant impact the condition has on their health and well-being.[14] It is associated with menstrual disturbances, pelvic pain and infertility. Symptoms—notably severe pain—can lead to missed school or workdays. Endometriosis can affect sexual, urinary and bowel function, and mental health. Furthermore, it imposes an economic burden on the health care system and society in general: it costs the Canadian economy an estimated $2.5 billion annually, mostly as the result of lost productivity.[15]

Gaps in Access to Care

Despite the prevalence and negative impacts of endometriosis, access to care in Canada is "poor."[16] The committee heard that, relative to certain peer countries, Canada has also been slow to make progress on research, early diagnosis and surgical treatment.[17] According to Dr. Catherine Allaire, co-chair of EndoAct Canada, patients wait "an average of at least five and as long as 20 years to receive a diagnosis."[18] Afterwards, they wait 6 to 18 months to see a specialist, and yet another 6 to 24 months for surgical management.[19] Such delays have led some to seek care outside Canada, incurring considerable out-of-pocket costs. Certain populations are disproportionately affected by gaps in endometriosis care, particularly people living in rural and remote communities and racialized groups. Dr. Elaine Jolly, professor emeritus in the Department of Obstetrics and

12 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

13 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

14 Maggie Archibald, *My Journey with Endometriosis*, Brief submitted to HESA; and Tracey Lindeman, *Impact of Endometriosis*, Brief submitted to HESA.

15 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

16 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

17 HESA, *Evidence*, 29 November 2023, 1930 (Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa, as an individual).

18 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

19 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

Gynecology at the University of Ottawa, attributed such inequities in access, in part, to the limited number of centres of excellence, which are located in major urban centres.[20]

The testimony and briefs also highlighted an unmet need for multidisciplinary care—notably allied health care—for people living with endometriosis. Obstetrician-gynecologist Dr. Fiona Mattatall declared that treating chronic pain in endometriosis patients requires multidisciplinary teams, yet "many aspects of these [teams] are poorly supported in Canada."[21] For example, patients who would benefit from pelvic floor physiotherapy but who are not covered under a private plan are "left to looking on YouTube for videos."[22] Drs. Andrew Zakhari and Dong Bach Nguyen, from the Endometriosis Centre for the Advancement of Research and Surgery at McGill University Health Centre, advocated for more support for multidisciplinary care teams and, particularly, for publicly funded physiotherapists, nutritionists, psychologists and nurses within centres specializing in endometriosis treatment.[23]

Role of Gender Bias

The witnesses and briefs highlighted how gender bias creates barriers to care for people living with endometriosis. Dr. Catherine Allaire outlined the profound and longstanding nature of this bias:

> Historically and to this day, endometriosis symptoms have been dismissed as just part of being a woman or a bad period. This is rooted in the widespread normalization of women's pain and neglect of conditions that affect women and leads to delays in diagnosis and treatment as well as adverse outcomes.[24]

Dr. Allaire also spoke of the persistent "taboo about discussing menstruation."[25] Such taboos play a part in restricting awareness of endometriosis among women and health

20 HESA, *Evidence*, 29 November 2023, 1930 (Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa, as an individual).

21 HESA, *Evidence*, 29 November 2023, 1940 (Dr. Fiona Mattatall, Obstetrician Gynaecologist, as an individual).

22 HESA, *Evidence*, 29 November 2023, 2050 (Dr. Fiona Mattatall, Obstetrician Gynaecologist, as an individual).

23 HESA, *Evidence*, 29 November 2023, 1950 (Dr. Andrew Zakhari, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery, McGill University Health Centre); HESA, *Evidence*, 29 November 2023, 2115 (Dr. Dong Bach Nguyen, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery, McGill University Health Centre); and Dr. Andrew Zakhari and Dr. Dong Bach Nguyen, McGill University Health Centre - Endometriosis Centre for the Advancement of Research and Surgery, *Study on Women's Health – Endometriosis and Gynecological conditions*, Brief submitted to HESA, 29 November 2023.

24 HESA, *Evidence*, 29 November 2023, 1945 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

25 HESA, *Evidence*, 29 November 2023, 2000 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

care providers. Low awareness of the condition contributes to delays in diagnosis.[26] It can also prevent new researchers from entering the field to study the condition.[27] Consequently, some witnesses called for investments in education and awareness initiatives among health care professionals and the public, particularly in medical and high schools.[28]

The committee heard that gender bias also influences funding, resource allocation and awareness with respect to women's health. According to Dr. Mattatall, gynecology has not received the same level of recognition as obstetrics:

> All too often, women's health is reduced to maternal health only … and there is no place for advocacy for non-pregnant women's health issues, such as contraception, heavy periods, pelvic pain, menopause or pelvic organ prolapse.[29]

One consequence of this imbalance is inequitable access to operating rooms, such that surgeries for endometriosis patients are further delayed. As Dr. Jolly explained, "[f]unding is prioritized to obstetrics, leaving gynecological problems struggling to have clinics and OR [operating room] time."[30]

26 Kate Wahl, Katie Luciani and Liane Belland, EndoAct Canada, The Endometriosis Network Canada and Canadian Society for the Advancement of Gynecologic Excellence, *Endometriosis in Canada*, Brief submitted to HESA.

27 HESA, *Evidence*, 29 November 2023, 2015 (Kate Wahl, Executive Director, EndoAct Canada).

28 HESA, *Evidence*, 29 November 2023, 1930 (Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa, as an individual); and HESA, *Evidence*, 29 November 2023, 2000 (Dr. Catherine Allaire, Co-chair, EndoAct Canada). See also Kate Wahl, Katie Luciani and Liane Belland, EndoAct Canada, The Endometriosis Network Canada and Canadian Society for the Advancement of Gynecologic Excellence, *Endometriosis in Canada*, Brief submitted to HESA.

29 HESA, *Evidence*, 29 November 2023, 1940 (Dr. Fiona Mattatall, Obstetrician Gynaecologist, as an individual).

30 HESA, *Evidence*, 29 November 2023, 1930 (Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa, as an individual).

Funding for Research and Awareness

Several witnesses and briefs called for investments in research on endometriosis.[31] Dr. Zakhari stressed that the condition is underfunded, particularly when compared to other chronic conditions:

> In 2022, there were approximately $4 per patient per year allocated to endometriosis research compared to $31 for diabetes or $130 for Crohn's disease, which affects less than 1% of the population.[32]

In September 2023, the Minister of Health announced over $1.6 million in funding "to improve awareness of endometriosis, access to vital Sexual Reproductive Health (SRH) services and reduce barriers to care by developing resources for people living with endometriosis and health care providers."[33] In general, witnesses saw this as a positive first step but argued that further funding was needed to address gaps in diagnosis and treatment. In the words of Dr. Allaire, "[I]t certainly may not be enough money, but it's certainly a start."[34]

Several witnesses called for a national action plan on endometriosis,[35] noting that Canada could learn from the plans developed by peer countries such as France, Australia and

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31 HESA, *Evidence*, 29 November 2023, 1935 (Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa, as an individual); HESA, *Evidence*, 29 November 2023, 1950 (Dr. Andrew Zakhari, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery, McGill University Health Centre); Kate Wahl, Katie Luciani and Liane Belland, EndoAct Canada, The Endometriosis Network Canada and Canadian Society for the Advancement of Gynecologic Excellence, *Endometriosis in Canada*, Brief submitted to HESA; and Dr. Andrew Zakhari and Dr. Dong Bach Nguyen, McGill University Health Centre - Endometriosis Centre for the Advancement of Research and Surgery, *Study on Women's Health – Endometriosis and Gynecological conditions*, Brief submitted to HESA, 29 November 2023.

32 HESA, *Evidence*, 29 November 2023, 1950 (Dr. Andrew Zakhari, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery, McGill University Health Centre).

33 Health Canada, *Government of Canada strengthens access to sexual and reproductive services for people living with Endometriosis*, 26 September 2023.

34 HESA, *Evidence*, 29 November 2023, 2000 (Dr. Catherine Allaire, Co-chair, EndoAct Canada).

35 Kate Wahl, Katie Luciani and Liane Belland, *Endometriosis in Canada*, Brief submitted to HESA; HESA, *Evidence*, 29 November 2023, 1950 (Dr. Dong Bach Nguyen, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery, McGill University Health Centre); HESA, *Evidence*, 29 November 2023, 1945 (EndoAct Canada, Kate Wahl, Executive Director); and HESA, *Evidence*, 29 November 2023, 1935 (Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa, as an individual).

Denmark. For some, a critical first step would be to work with patients and content experts to better understand the current challenges and priorities.[36] To quote Dr. Jolly:

> [N]ow is the time to study endometriosis fully and to make policy decisions that will advance the prevention, care and treatment of women facing this chronic condition. All women have the right to live full, productive lives that are pain free.[37]

Therefore, the committee recommends:

Recommendation 1

That the Government of Canada develop a national action plan on endometriosis, in collaboration with provinces and territories and Indigenous governing bodies, as well as people living with endometriosis, clinicians and researchers, to address gaps and barriers that hinder awareness, diagnosis and treatment.

Recommendation 2

That the Government of Canada increase funding for research that supports innovation and discovery with respect to the diagnosis and treatment of endometriosis.

Women and Cancer

The Canadian Cancer Society points out that "[c]ancer affects males and females differently,"[38] notably owing to differences in biology, risk factors and health behaviours. On average, men and women have a similar overall risk of developing cancer in their lifetimes (45% and 44%, respectively).[39] However, certain cancers are sex-specific (e.g., gynecological cancers), while others are more common in females than in males (e.g., breast and thyroid cancers).[40] Moreover, women are more frequently caregivers,

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36 HESA, *Evidence*, 29 November 2023, 2130 (McGill University Health Centre, Dr. Andrew Zakhari, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery); and HESA, *Evidence*, 29 November 2023, 1945 (EndoAct Canada, Kate Wahl, Executive Director).

37 HESA, *Evidence*, 29 November 2023, 1935 (Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa, as an individual).

38 Canadian Cancer Statistics Advisory Committee in collaboration with the Canadian Cancer Society, Statistics Canada and the Public Health Agency of Canada, *Canadian Cancer Statistics, 2023*, November 2023.

39 Canadian Cancer Statistics Advisory Committee in collaboration with the Canadian Cancer Society, Statistics Canada and the Public Health Agency of Canada, *Canadian Cancer Statistics, 2023*, November 2023.

40 Darren R. Brenner et al., for the Canadian Cancer Statistics Advisory Committee, "Projected estimates of cancer in Canada in 2024," *Canadian Medical Association Journal*, Vol. 196, No. 18, 13 May 2024.

providing "vital, unpaid, practical, physical and emotional support to loved ones," including supporting people with cancer.[41]

The sections that follow outline the gender issues raised by witnesses and in briefs with respect to barriers to cancer care, cancer prevention, breast cancer screening and gynecological cancers.

Barriers to Care and Unmet Needs

A common thread throughout the testimony was the observation that women across Canada are contending with gaps and inequities in access to effective prevention, diagnosis, screening and treatment of cancers. Barriers to accessing cancer care disproportionately affect women from marginalized and underrepresented groups, such as Indigenous peoples, racialized communities, people living with low income, gender-diverse individuals, women with obesity, and those living in rural and remote areas. These barriers lead to poorer health outcomes. Scientist Dr. Ambreen Sayani noted that "not all women have the same risk of dying from cancer. Such factors as racism, sexism, ableism, classism and ageism can be the difference between life and death from cancer."[42] She proposed several recommendations, including diversifying the health care workforce and enhancing the provision of culturally and linguistically sensitive care.

Some witnesses called attention to geographic inequities in access to cancer care. For example, Dr. Ghadeer Anan, a medical oncologist, discussed how women with cancer living in rural areas have limited access to supportive services, like accommodation and child care during treatment, as well as physiotherapy and mental health care. She described the challenge as follows:

> The problem is not having access to surgery, chemotherapy or radiation. The problem is having access to extra supports, which are just as important. … That's when it matters whether you live in an urban or a rural setting.[43]

The consequences of inadequate supportive care are stark, as Dr. Anan explained:

> I am seeing an increasing number of women who are unable to go back to their jobs and normal lives after the completion of their treatments, and even having to go on

41 HESA, *Evidence*, 15 February 2024, 1120 (Helena Sonea, Director, Advocacy, Canadian Cancer Society).

42 HESA, *Evidence*, 15 February 2024, 1105 (Dr. Ambreen Sayani, Scientist, as an individual).

43 HESA, *Evidence*, 15 February 2024, 1105 (Dr. Ghadeer Anan, Medical Oncologist, as an individual).

disability due to treatment long-term effects that are not managed properly due to the lack of resources in rural areas.[44]

Regarding this point, the committee heard calls for health care equity throughout Canada. In the words of Dr. Jessica McAlpine, professor and division head, Division of Gynecologic Oncology, University of British Columbia: "We must change the current reality in this country that how you are treated depends on where you're diagnosed and must instead ensure equity for all."[45] Witnesses recommended notably that women with cancer be offered more financial supports, including child care and free accommodation for those who must travel for care, and extended employment insurance benefits that reflect the actual length of treatment.[46]

The testimony also called for more equitable access to genetic testing. The committee heard that despite the potential benefits of genetic testing for identifying individuals who have an elevated risk for breast or ovarian cancers, access to such genetic testing is not equitably available to women across Canada.[47] Tania Vrionis, chief executive officer of Ovarian Cancer Canada, noted, for example, that there were regional variations in criteria and wait times and that certain racial and ethnic groups were less likely to be referred for genetic testing and more likely to receive inconclusive genetic test results.[48]

Reducing Alcohol and Tobacco Use

Representatives from the Canadian Cancer Society advocated for revisions to the Government of Canada's alcohol and tobacco control policies to help prevent cancer among women. In 2024, lung cancer was projected to be slightly more common among females than males (with incidence rates of 64.9 and 63.4 per 100,000, respectively).[49] Even though deaths from lung cancer have been trending downwards, it remains the

44 HESA, *Evidence*, 15 February 2024, 1105 (Dr. Ghadeer Anan, Medical Oncologist, as an individual).

45 HESA, *Evidence*, 12 February 2024, 1610 (Dr. Jessica McAlpine, Professor and Division Head, Division of Gynecologic Oncology, University of British Columbia, as an individual).

46 HESA, *Evidence*, 15 February 2024, 1140 (Dr. Ambreen Sayani, Scientist, as an individual); and HESA, *Evidence*, 15 February 2024, 1150, 1240 (Dr. Ghadeer Anan, Medical Oncologist, as an individual).

47 HESA, *Evidence*, 6 December 2023, 1950 (Jacques Simard, Full Professor, Department of Molecular Medicine, Université Laval, as an individual); HESA, *Evidence*, 6 December 2023, 2010 (Dr. Steven Narod, Senior Scientist, as an individual); and HESA, *Evidence*, 12 February 2024, 1615 (Tania Vrionis, Chief Executive Officer, Ovarian Cancer Canada).

48 HESA, *Evidence*, 12 February 2024, 1615 (Tania Vrionis, Chief Executive Officer, Ovarian Cancer Canada).

49 Darren R. Brenner et al., for the Canadian Cancer Statistics Advisory Committee, "Projected estimates of cancer in Canada in 2024," *Canadian Medical Association Journal*, Vol. 196, No. 18, 13 May 2024.

leading cause of cancer death in females (24% of all cancer deaths).[50] The committee heard that, in Canada, 72% of lung cancer cases and 30% of cancer deaths result from the smoking of tobacco.[51] Furthermore, tobacco has been linked with 16 types of cancer among women, including cervical cancer and ovarian cancer.[52] Consequently, the Canadian Cancer Society argued for a comprehensive strategy to reduce tobacco use among women and girls, including measures such as increasing taxes on tobacco products, recovering the costs of Canada's tobacco strategy from tobacco and vaping companies, reducing youth vaping, and banning flavours in tobacco and vaping products.[53]

The committee also heard concerns about alcohol consumption and the associated risk of cancer among women. Alcohol is linked with at least nine types of cancers, including breast cancer.[54] Women may be more vulnerable to the harms of alcohol use because of biological and social factors.[55] Nevertheless, around 40% of the public is unaware that alcohol consumption can increase cancer risk,[56] according to Ciana Van Dusen, advocacy manager at the Canadian Cancer Society. Moreover, about one in five women between the ages of 15 and 54 reported consuming over six standard drinks of alcohol per week in 2019, a level associated with long-term health impacts.[57] The Association pour la santé publique du Québec indicated that alcohol marketing sometimes specifically targets women, thereby potentially shaping gendered consumption patterns.[58]

The committee was informed of various strategies that the federal government could undertake to address the harms of alcohol consumption among women, including

50 Darren R. Brenner et al., for the Canadian Cancer Statistics Advisory Committee, "Projected estimates of cancer in Canada in 2024," *Canadian Medical Association Journal*, Vol. 196, No. 18, 13 May 2024.

51 HESA, *Evidence*, 15 February 2024, 1120 (Helena Sonea, Director, Advocacy, Canadian Cancer Society).

52 HESA, *Evidence*, 15 February 2024, 1215 (Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society).

53 HESA, *Evidence*, 15 February 2024, 1120 (Helena Sonea, Director, Advocacy, Canadian Cancer Society); and Helena Sonea, Canadian Cancer Society, *Study on women's health*, Brief submitted to HESA, March 2024.

54 Helena Sonea, Canadian Cancer Society, *Study on women's health*, Brief submitted to HESA, March 2024.

55 Gabrielle Desjardins and Kim Brière-Charest, Association pour la santé publique du Québec, *Alcohol use among women: Reducing alcohol's impact on women's health*, Brief submitted to HESA, 14 March 2024; and Canadian Centre on Substance Use and Addiction, *Women's health*, Brief submitted to HESA, October 2022.

56 HESA, *Evidence*, 15 February 2024, 1125 (Ciana Van Dusen, Advocacy Manager, Prevention, Canadian Cancer Society).

57 HESA, *Evidence*, 15 February 2024, 1125 (Ciana Van Dusen, Advocacy Manager, Prevention, Canadian Cancer Society).

58 Gabrielle Desjardins and Kim Brière-Charest, Association pour la santé publique du Québec, *Alcohol use among women: Reducing alcohol's impact on women's health*, Brief submitted to HESA, 14 March 2024.

education and awareness campaigns,[59] mandatory labels on all alcoholic products,[60] restrictions on alcohol marketing and sponsorship,[61] and reporting requirements for alcohol companies,[62] as well as implementation of the planned 4.7% increase of the federal alcohol excise duty, to help offset the social costs of alcohol products.[63]

Therefore, the committee recommends:

Recommendation 3

That the Government of Canada, in collaboration with provinces, territories and Indigenous governing bodies, study ways to increase clear, consistent and comprehensive health messaging through multiple channels about the risks related to alcohol consumption.

Recommendation 4

That the Government of Canada, in collaboration with provinces, territories and Indigenous governing bodies, study measures to reduce vaping in young women.

Recommendation 5

That the Government of Canada, in collaboration with provinces, territories and Indigenous governing bodies, study ways to enhance cessation, mass communication, youth prevention and other programs to reduce tobacco use.

Breast Cancer Screening

The evidence highlighted the importance of early detection of breast cancer. One in eight women living in Canada will be diagnosed with breast cancer in their lifetime.[64]

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59 Gabrielle Desjardins and Kim Brière-Charest, Association pour la santé publique du Québec, *Alcohol use among women: Reducing alcohol's impact on women's health*, Brief submitted to HESA, 14 March 2024; and Helena Sonea, Canadian Cancer Society, *Study on women's health*, Brief submitted to HESA, March 2024.

60 Helena Sonea, Canadian Cancer Society, *Study on women's health*, Brief submitted to HESA, March 2024.

61 Association pour la santé publique du Québec, *Alcohol use among women: Reducing alcohol's impact on women's health*, Brief submitted to HESA, 14 March 2024; and Helena Sonea, Canadian Cancer Society, *Study on women's health*, Brief submitted to HESA, March 2024.

62 Helena Sonea, Canadian Cancer Society, *Study on women's health*, Brief submitted to HESA, March 2024.

63 HESA, *Evidence*, 15 February 2024, 1125 (Canadian Cancer Society, Ciana Van Dusen, Advocacy Manager, Prevention).

64 Breast Cancer Society, *Breast Cancer Statistics*, May 2024.

Screening through mammograms (i.e., low-dose X-rays of the breast) allows for the detection of breast cancer before symptoms appear. According to Breast Cancer Canada, when breast cancer is diagnosed at an early stage, treatments are less invasive and result in better outcomes.[65]

Witnesses raised concerns regarding the 2018 national guideline for breast cancer screening issued by the Canadian Task Force on Preventive Health Care (task force) and, in particular, the task force's decision not to recommend routine breast cancer screening for women in their 40s.[66]

In May 2024, the task force released a draft version of its updated guideline, which was criticized by advocacy groups such as Dense Breasts Canada, Breast Cancer Canada and the Canadian Cancer Society.[67] The committee undertook a separate study to explore breast cancer screening guidelines in Canada in greater depth and presented an initial report to the House of Commons on 19 June 2024.[68] For further discussion and recommendations on breast cancer screening, please see the committee's final report entitled *Saving More Lives: Improving Guidance, Increasing Access and Achieving Better Outcomes in Breast Cancer Screening*.[69]

Gynecological Cancers

Gynecological cancers encompass cervical, endometrial, vulvar, vaginal and ovarian cancers. Together, they represent 10% of cancer deaths in women.[70] These cancers have a devastating impact on women in Canada, as illustrated by the following statements from the testimony:

65 Breast Cancer Canada, *Study on Women's Health*, Brief submitted to HESA, 25 March 2024.

66 HESA, *Evidence*, 6 December 2023, 1955 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual); HESA, *Evidence*, 6 December 2023, 2000 (Dr. Paula Gordon, Doctor, Dense Breasts Canada); and HESA, *Evidence*, 6 December 2023, 2005 (Jennie Dale, Co-founder and Executive Director, Dense Breasts Canada).

67 Dense Breasts Canada, *Concerns about the 2024 draft breast screening guidelines*; Breast Cancer Canada, *New national breast cancer screening guidelines lack patient voice, clarity and distinction between screening and diagnosis*, 30 May 2024; and Canadian Cancer Society, *New national breast screening guidelines miss the mark*, 30 May 2024.

68 HESA, *Breast Cancer Screening Guidelines*, Twentieth Report, 1st Session, 44th Parliament, June 2024.

69 HESA, *Saving More Lives: Improving Guidance, Increasing Access and Achieving Better Outcomes in Breast Cancer Screening*, Twenty-third report, 1st Session, 44th Parliament, December 2024.

70 HESA, *Evidence*, 12 February 2024, 1605 (Gillian Hanley, Associate Professor, Department of Obstetrics and Gynaecology, University of British Columbia, as an individual).

- "Endometrial cancer is the fourth-most common cancer in women. About 8,500 Canadian women will be diagnosed each year. The incidence of endometrial cancer has been on the rise for over 10 years."[71]

- "Eight women a day are diagnosed with ovarian cancer in Canada, with 75% of those being diagnosed as late stage. Ovarian cancer's five-year survival rate is only 44%. Four out of the eight women diagnosed today will not be here in five years. There is no screening test. There is no definitive diagnostic test. There are few treatment options available. Women deserve better."[72]

- "[A November 2023 report] identified cervical cancer as the fastest-growing cancer in women, with incidence rising at a rate of 3.7% per year since 2015. Frankly, to me this is shocking, because women should have easy access to effective cervical cancer prevention strategies in Canada."[73]

The testimony and briefs drew attention to specific issues related to gynecological cancers—namely, funding, access to care and knowledge dissemination, education and awareness, and prevention and early detection of cervical cancer.

Funding

Despite their disease burden, gynecological cancers receive relatively less funding than other cancers. For example, dedicated funding for endometrial cancer is "rare,"[74] according to Dr. Shannon Salvador, president-elect of the Society of Gynecologic Oncology of Canada. She described the role that gender bias plays in this funding inequity:

> Historically, women's cancers have been orphaned from the traditional cancer care models, so in the 1970s the gynecologic oncology subspecialty was created to care for women with cancers of the Fallopian tube, ovary, uterus, cervix, vulva and placenta. Unfortunately, these cancers have long been, and often still are, deemed a women's

71 HESA, *Evidence*, 15 February 2024, 1110 (Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, as an individual).

72 HESA, *Evidence*, 12 February 2024, 1615 (Tania Vrionis, Chief Executive Officer, Ovarian Cancer Canada).

73 HESA, *Evidence*, 12 February 2024, 1620 (Dr. Shannon Salvador, President-Elect, The Society of Gynecologic Oncology of Canada).

74 HESA, *Evidence*, 12 February 2024, 1620 (Dr. Shannon Salvador, President-Elect, The Society of Gynecologic Oncology of Canada).

> issue. Funding for clinical care and research has not kept pace with other more common cancers, such as colorectal, breast or lung cancers.[75]

To address this inequity, witnesses advocated for increased funding for research on gynecological cancer to reflect its disease burden, in addition to dedicated funding to translate this research into practice. Tania Vrionis described the positive results of the Government of Canada's targeted investments for ovarian cancer research in 2019. She recommended continued and increased "investment in innovative, highly focused, comprehensive national research into this disease."[76]

Therefore, the committee recommends:

Recommendation 6

That the Canadian Institutes of Health Research allocate targeted funding for research on gynecological cancers, particularly ovarian, endometrial and cervical cancer, and ensure that the funding reflects their disease burden.

Access to Care and Knowledge Dissemination

Access to care can vary by geographic, socioeconomic and other factors. Even when researchers discover effective treatments or prevention measures for gynecological cancers, these interventions may not be equally accessible to all women in Canada. Dr. Andrea Simpson, an obstetrician-gynecologist at St. Michael's Hospital, explained for example that robotic surgery could address surgical challenges for endometrial cancer patients with obesity, yet access to this type of surgery is inequitable across the country.[77] Additionally, Dr. Jessica McAlpine described a molecular classification system developed by Canadian researchers to help guide the clinical management of endometrial cancer patients. Although the World Health Organization has adopted this system, molecular testing is not available for all women in Canada,[78] and Dr. McAlpine therefore argued for increased funding to implement such testing equitably across Canada.

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75 HESA, *Evidence*, 12 February 2024, 1620 (Dr. Shannon Salvador, President-Elect, The Society of Gynecologic Oncology of Canada).

76 HESA, *Evidence*, 12 February 2024, 1620 (Tania Vrionis, Chief Executive Officer, Ovarian Cancer Canada).

77 HESA, *Evidence*, 15 February 2024, 1110 (Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, as an individual).

78 HESA, *Evidence*, 12 February 2024, 1610 (Dr. Jessica McAlpine, Professor and Division Head, Division of Gynecologic Oncology, University of British Columbia, as an individual).

In a similar vein, early Canadian research supported the safety, feasibility and effectiveness of opportunistic salpingectomy in preventing ovarian cancer.[79] This procedure, which involves removing the Fallopian tubes while the patient is already undergoing another abdominal surgery, is now a recommended practice in several countries worldwide. However, uptake of opportunistic salpingectomy in Canada remains variable outside of British Columbia. According to Gillian Hanley, associate professor in the Department of Obstetrics and Gynaecology at the University of British Columbia, this low uptake is a missed opportunity for prevention. She estimated that if an opportunistic salpingectomy had been performed on each of the 80,000 Canadians who had undergone tubal ligation or hysterectomy without Fallopian tube removal between 2017 and 2020, 1,000 cases of ovarian cancer could have been prevented.[80] Ms. Hanley stated that more funding is needed to enable implementation science to better disseminate research advances like opportunistic salpingectomy.

Other suggestions to improve access to care included increasing remuneration to hospitals and surgeons who perform complex surgeries for gynecologic cancers[81] and creating rapid-access clinics for streamlining diagnosis.[82] The Society of Gynecologic Oncology of Canada also cited workforce shortages in gynecologic oncology as a barrier to access to care, calling for expanded training opportunities.[83] Dr. Salvador explained that, among all surgical cancer specialties, gynecologic oncology is uniquely comprehensive, since "[d]iagnosis, surgery, systemic treatments, surveillance and palliative care are all done by one physician."[84]

Therefore, the committee recommends:

79 HESA, *Evidence*, 12 February 2024, 1605 (Gillian Hanley, Associate Professor, Department of Obstetrics and Gynaecology, University of British Columbia, as an individual).

80 HESA, *Evidence*, 12 February 2024, 1605 (Gillian Hanley, Associate Professor, Department of Obstetrics and Gynaecology, University of British Columbia, as an individual).

81 HESA, *Evidence*, 15 February 2024, 1115 (Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, as an individual).

82 HESA, *Evidence*, 15 February 2024, 1200 (Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, as an individual).

83 Dr. Shannon Salvador, Society of Gynecologic Oncology of Canada, *Study on Women's Health – Women's Cancers*, Brief submitted to HESA, 12 February 2024; and HESA, *Evidence*, 12 February 2024, 1620 (The Society of Gynecologic Oncology of Canada, Dr. Shannon Salvador, President-Elect).

84 HESA, *Evidence*, 12 February 2024, 1620 (Dr. Shannon Salvador, President-Elect, The Society of Gynecologic Oncology of Canada).

Recommendation 7

That the Government of Canada, in collaboration with provinces, territories and Indigenous governing bodies, invest in implementation science to help ensure that knowledge of advances in the prevention, diagnosis, screening and treatment of gynecological cancers is effectively transferred across Canada.

Education and Awareness

The committee was told that both health care providers and the public are unfamiliar with the symptoms of some gynecological cancers. Diagnosis of ovarian cancer is difficult because the symptoms are vague and non-specific. Since primary care plays a central role in the diagnostic pathway, the inability of providers to recognize symptoms and order appropriate tests is a barrier to diagnosis.[85] Ovarian Cancer Canada therefore recommends that primary care providers be offered training and support to help them identify and respond to ovarian cancer symptoms.[86]

In the context of endometrial cancer, Dr. Andrea Simpson pointed out the need for increased public awareness of the early signs of disease. These signs, which include "abnormal uterine bleeding, such as heavy or irregular menstrual periods, or any vaginal bleeding after menopause,"[87] are not well known to the public. Dr. Simpson suggested that information on abnormal bleeding could be integrated into a standardized high school curriculum on menstrual disorders.

Recommendation 8

That the Government of Canada, in collaboration with provinces, territories and Indigenous governing bodies, implement national education campaigns on gynecological cancers, including on early signs of ovarian and endometrial cancer.

Prevention and Early Detection of Cervical Cancer

Of the gynecological cancers, only cervical cancer has screening tests that allow for early detection, before symptoms appear. Most provinces and territories have an organized cervical cancer screening program, and some offer opportunistic screening, as needed,

85 HESA, *Evidence*, 12 February 2024, 1620 (Valérie Dinh, Regional Director, Québec, Ovarian Cancer Canada).

86 Tania Vrionis, Ovarian Cancer Canada, *Women's Health Study*, Brief submitted to HESA, 25 January 2024.

87 HESA, *Evidence*, 15 February 2024, 1110 (Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, as an individual).

through primary care providers.[88] Cervical cancer is also preventable through immunization against human papillomavirus (HPV). Certain strains of HPV are associated with a high risk of cervical cancers; HPV vaccines that protect against infection with these strains can therefore help to prevent cervical cancer. All provinces and territories offer school-based HPV vaccination programs.[89]

Given the availability of these preventive measures, the World Health Organization has called for the global elimination of cervical cancer.[90] To this aim, the Canadian Partnership Against Cancer has set three priorities for Canada: improve HPV vaccination rates; implement HPV primary screening; and improve follow-ups of abnormal screening results.[91] In 2019, the federal government announced a $10-million investment in research to eliminate cervical cancer.[92] This funding supported research on HPV vaccination and screening methods.

Regrettably, the committee heard that Canada is falling behind in its goal to eliminate cervical cancer. In fact, cervical cancer rates are increasing in Canada, as Ciana Van Dusen noted:

> After a 30-year decline, cervical cancer is now the fastest increasing cancer in females, with most cases occurring in women under 50. This rise is explained by lower uptake in screening and vaccination against the human papilloma virus, or HPV.[93]

Further, Dr. Salvador identified equity issues regarding access to screening for cervical cancer:

> [O]ur most vulnerable populations are in locations that do not have an organized province-wide screening program yet, or easy access to health care professionals who offer screening, leading to disparities in identification and treatment of these precancerous cervical lesions.[94]

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88 Canadian Partnership Against Cancer, *Cervical cancer screening in Canada: 2021/2022*.

89 Canadian Partnership Against Cancer, *HPV immunization policies*.

90 World Health Organization, *Cervical Cancer Elimination Initiative*.

91 Canadian Partnership Against Cancer, *Action Plan for the Elimination of Cervical Cancer in Canada, 2020–2030*.

92 Canadian Institutes of Health Research, *Government of Canada invests $10 million in research to eliminate cervical cancer*, 4 June 2019.

93 HESA, *Evidence*, 15 February 2024, 1120 (Ciana Van Dusen, Advocacy Manager, Prevention, Canadian Cancer Society).

94 HESA, *Evidence*, 12 February 2024, 1620 (Dr. Shannon Salvador, President-Elect, The Society of Gynecologic Oncology of Canada).

Dr. Salvador and the Society of Gynecologic Oncology of Canada suggested various actions that the Government of Canada could take to reverse rising trends in cervical cancer rates and improve access to screening, such as raising public awareness of HPV vaccination; improving access to primary care professionals who offer screening; and expanding access to HPV self-testing.[95]

The committee heard about the benefits of HPV testing compared to the Pap test. HPV testing is considered more effective at detecting cervical cancer and may reduce barriers to screening because it can be done at home through self-testing.[96] Notably, it could help improve access to screening for women who live in rural and remote communities, who do not have a primary care provider or who have a history of trauma.[97] In 2021, all jurisdictions in Canada used the Pap test as a primary mode of screening, although many planned to switch to HPV testing.[98]

Some witnesses highlighted barriers to the implementation of self-testing. According to Ciana Van Dusen, "swabs used for HPV tests currently have an indication that they must be conducted by a health care professional,"[99] restricting their use for at-home testing. Moreover, Dr. Anna N. Wilkinson asserted that the task force's 2013 guideline on cervical cancer screening hinders the expanded use of HPV screening:

> The last time the cervical guidelines were updated was 10 years ago. In the interim, the whole world has moved to HPV-based screening. That's where we should be. We are handcuffed back to 10 years ago with the old guidelines.[100]

According to the task force, the updated guideline will be published in 2025.[101]

Therefore, the committee recommends:

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95 Dr. Shannon Salvador, Society of Gynecologic Oncology of Canada, *Study on Women's Health – Women's Cancers*, Brief submitted to HESA, 12 February 2024; and HESA, *Evidence*, 12 February 2024, 1620 (Dr. Shannon Salvador, President-Elect, The Society of Gynecologic Oncology of Canada).

96 HESA, *Evidence*, 15 February 2024, 1120 (Ciana Van Dusen, Canadian Cancer Society, Advocacy Manager, Prevention).

97 HESA, *Evidence*, 12 February 2024, 1655 (Dr. Jessica McAlpine, Professor and Division Head, Division of Gynecologic Oncology, University of British Columbia, as an individual).

98 Canadian Partnership Against Cancer, *Cervical cancer screening in Canada: 2021/2022*.

99 HESA, *Evidence*, 15 February 2024, 1120 (Ciana Van Dusen, Canadian Cancer Society, Advocacy Manager, Prevention).

100 HESA, *Evidence*, 6 December 2023, 2035 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual).

101 Canadian Task Force on Preventive Health Care, *Cervical Cancer (Update)*.

Recommendation 9

That the Government of Canada, in collaboration with provinces, territories and Indigenous governing bodies, implement public awareness campaigns, among other initiatives, to help increase uptake of human papillomavirus (HPV) vaccination and cervical cancer screening.

Women's Mental Health

Women experience a disproportionate burden of certain mental health conditions, such as anxiety and depression, and have specific mental health needs. For instance, mood problems may fluctuate with the menstrual cycle, requiring particular treatments or medication, and perinatal mental health conditions may dictate different treatment decisions during pregnancy and lactation.[102] Additionally, women are more likely to experience abuse and assault, which increases their risk of developing certain mental health disorders. Factors like poverty, isolation after immigration, and caregiver stress can also increase a woman's risk for mental illness and impede access to care.[103] More broadly, women's mental health affects not only their own well-being but also that of their families and children.[104] The information gathered on women's mental health for this study centred on two areas: perinatal mental health, and trauma and mental health.

Perinatal Mental Health

The committee heard that perinatal mental health should be considered a public health priority.[105] The testimony highlighted the prevalence and adverse consequences of perinatal mental health disorders, stressing their impact on both maternal and child health. The perinatal period extends from conception to 12 months after birth. Perinatal mental health disorders such as depression and anxiety affect as many as 20% of pregnant and postpartum people and are among the most common childbirth

102 HESA, *Evidence*, 8 April 2024, 1600 (Dr. Simone Vigod, Professor and Head, Department of Psychiatry, University of Toronto, Women's College Hospital, as an individual).

103 HESA, *Evidence*, 8 April 2024, 1600 (Dr. Simone Vigod, Professor and Head, Department of Psychiatry, University of Toronto, Women's College Hospital, as an individual).

104 HESA, *Evidence*, 8 April 2024, 1600 (Dr. Simone Vigod, Professor and Head, Department of Psychiatry, University of Toronto, Women's College Hospital, as an individual).

105 HESA, *Evidence*, 8 April 2024, 1540 (Tina Montreuil, Associate Professor and Scientist, Montreal Antenatal Well-Being Study, Québec Alliance for Perinatal Mental Health).

complications.[106] Additionally, suicide is a leading cause of maternal death in high-income countries. Marginalized and underrepresented groups are disproportionately affected by these mental health issues.[107] Beyond their effects on parental well-being, maternal depression and anxiety entail consequences for children. For the child, the conditions are associated with an increased risk of preterm birth; low birth weight; social, emotional and behavioural difficulties; and mental health issues in adolescence and into adulthood.[108]

Nichole Fairbrother, clinical associate professor in the Department of Family Practice at the University of British Columbia, discussed lesser-known postpartum mental health issues, such as postpartum thoughts of infant-related harm, as well as perinatal anxiety and obsessive-compulsive disorder. She told the committee that unwanted, intrusive thoughts of harming infants are common. According to her research, these thoughts

> are not associated with an increased risk of violence toward the infant. They are, however, associated with significant distress and an increased risk of mental health difficulties, the most common of which are obsessive-compulsive disorder and depression.[109]

Lack of awareness of the phenomenon among the public and health care providers is problematic, said Ms. Fairbrother, because it can contribute to parental distress and result in unnecessary referrals to child protective services. Further, because of historical trauma and ongoing discrimination, Indigenous parents may be at once more reluctant to disclose intrusive thoughts of child harm and more likely to face discrimination if they do so.[110]

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106 HESA, *Evidence*, 8 April 2024, 1540 (Tina Montreuil, Associate Professor and Scientist, Montreal Antenatal Well-Being Study, Québec Alliance for Perinatal Mental Health).

107 HESA, *Evidence*, 8 April 2024, 1535 (Catriona Hippman, Postdoctoral Research Fellow, BC Reproductive Mental Health Program, BC Women's Hospital and Health Centre, as an individual); and HESA, *Evidence*, 8 April 2024, 1540 (Tina Montreuil, Associate Professor and Scientist, Montreal Antenatal Well-Being Study, Québec Alliance for Perinatal Mental Health).

108 HESA, *Evidence*, 8 April 2024, 1540 (Tina Montreuil, Associate Professor and Scientist, Montreal Antenatal Well-Being Study, Québec Alliance for Perinatal Mental Health).

109 HESA, *Evidence*, 11 April 2024, 1110 (Nichole Fairbrother, Clinical Associate Professor, Department of Family Practice, University of British Columbia, as an individual).

110 HESA, *Evidence*, 11 April 2024, 1155 (Nichole Fairbrother, Clinical Associate Professor, Department of Family Practice, University of British Columbia, as an individual). See also, Nichole Fairbrother et al., University of British Columbia Perinatal Anxiety Research Laboratory, *Postpartum harm thoughts and their relation to infant safety and mental health*, Brief submitted to HESA, 30 April 2024.

Access to Perinatal Mental Health Care

The committee heard that there are large gaps in access to perinatal mental health care, despite the prevalence of perinatal mental health issues. Dr. Ryan Van Lieshout, associate professor in the Department of Psychiatry and Behavioural Neurosciences at McMaster University, told the committee that "as few as one in 10 pregnant and postpartum persons are able to access evidence-based care in this country."[111] Dr. Van Lieshout listed some of the circumstances creating barriers to this care:

- primary care physicians' unfamiliarity with the topic, particularly with respect to medication safety during pregnancy and lactation; and
- a lack of access to evidence-based psychotherapies, driven by a shortage of health care providers.[112]

Witnesses made various suggestions for increasing access to perinatal mental health care in Canada, such as creating a national strategy for perinatal mental health (like strategies that have been adopted in Australia and the United Kingdom)[113] and training public health nurses or recovered peers to deliver psychotherapeutic interventions.[114] In addition, Dr. Van Lieshout recommended the development of national structured care pathways—that is, "integrated systems that involve the detection of mental health problems, direct patients to the right resources at the right time, and provide treatment and follow-up."[115] He noted the ongoing efforts of the Canadian Network for Mood and Anxiety Treatments to develop national guidelines on perinatal mental health problems that could be used to develop care pathways and train frontline professionals.

111 HESA, *Evidence*, 8 April 2024, 1555 (Dr. Ryan Van Lieshout, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, as an individual).

112 HESA, *Evidence*, 8 April 2024, 1555 (Dr. Ryan Van Lieshout, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, as an individual).

113 HESA, *Evidence*, 8 April 2024, 1655, 1730 (Catriona Hippman, Postdoctoral Research Fellow, BC Reproductive Mental Health Program, BC Women's Hospital and Health Centre, as an individual); and HESA, *Evidence*, 11 April 2024, 1250 (Liisa Galea, Senior Scientist and Treliving Chair, Women's Mental Health, Centre for Addiction and Mental Health).

114 HESA, *Evidence*, 8 April 2024, 1555 (Dr. Ryan Van Lieshout, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, as an individual).

115 HESA, *Evidence*, 8 April 2024, 1555 (Dr. Ryan Van Lieshout, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, as an individual). See also Dr. Ryan Van Lieshout, *Perinatal mental health*, Brief submitted to HESA.

Screening for Perinatal Mental Illness

Some witnesses expressed concern over the limited access across Canada to early detection measures for maternal depression and anxiety. Speaking on behalf of the Québec Alliance for Perinatal Mental Health, Tina Montreuil advocated for routine screening for mental health issues during pregnancy, pointing to its potential for improving early detection of postpartum mental health conditions and associated economic benefits. Her research showed that a lack of routine screening results in an annual cost in Canada of about $6.7 billion.[116]

Catriona Hippman and other members of the BC Reproductive Mental Health Program called for an urgent revision of the task force's guideline on screening for perinatal depression. They argued that the recommendation against routine, standardized screening fails to reflect evidence that supports universal screening, results in missed cases, and perpetuates health inequalities by forcing women to advocate for their own care. In Ms. Hippman's view, the guideline prioritizes speculative harms over documented benefits and patient perspectives.[117]

For her part, Nichole Fairbrother argued that further research is required to identify accurate and reliable screening tools for perinatal anxiety disorders and to determine the impact of such screening on mental health outcomes for patients with perinatal depression and anxiety.[118]

Therefore, the committee recommends:

Recommendation 10

That the guideline on perinatal depression screening issued by the Canadian Task Force on Preventive Health Care be reviewed by an expert panel of diverse stakeholders, and

116 HESA, *Evidence*, 8 April 2024, 1545 (Tina Montreuil, Associate Professor and Scientist, Montreal Antenatal Well-Being Study, Québec Alliance for Perinatal Mental Health). See also Tina Montreuil, Québec Alliance for Perinatal Mental Health, *Proactive Family-Centered and Trauma-Informed Care in the Perinatal Mental Health*, Brief submitted to HESA, 13 April 2023.

117 HESA, *Evidence*, 8 April 2024, 1535 (Catriona Hippman, Postdoctoral Research Fellow, BC Reproductive Mental Health Program, BC Women's Hospital and Health Centre, as an individual); and Catriona Hippman et al., BC Reproductive Mental Health Program, *Screening for perinatal depression in Canada*, Brief submitted to HESA, 3 October 2023.

118 HESA, *Evidence*, 11 April 2024, 1110 (Nichole Fairbrother, Clinical Associate Professor, Department of Family Practice, University of British Columbia, as an individual).

that the task force re-evaluate that guideline accordingly, to ensure that perinatal depression is more effectively screened and treated as a public health priority.

Recommendation 11

That the Government of Canada work towards increasing research to identify accurate and reliable screening tools for perinatal anxiety disorders and to assess the impact of mental health screening on mental health outcomes for both perinatal depression and anxiety.

Recommendation 12

That the Government of Canada study international examples to assess the benefits of developing a national strategy on perinatal mental health.

Recommendation 13

That the Government of Canada, in collaboration with provinces, territories and Indigenous governing bodies, work towards raising public awareness of perinatal anxiety.

Trauma and Mental Health

Women are disproportionately affected by physical, emotional and sexual abuse and assault. Consequently, they are at increased risk for mental health conditions that can develop following trauma, including depression, anxiety and post-traumatic stress disorder (PTSD). Among women who live with a mental illness, over half report having experienced prior trauma.[119] A theme that emerged from the evidence was the need to improve access to trauma-informed services for women who have experienced violence, including non-state torture and sexual violence.

Non-State Torture

Linda MacDonald and Jeanne Sarson, co-founders of Persons Against Non-State Torture, distinguish between “abuse” and “torture.” Linda MacDonald defined non-state torture as

119 HESA, *Evidence*, 8 April 2024, 1600 (Dr. Simone Vigod, Professor and Head, Department of Psychiatry, University of Toronto, Women’s College Hospital, as an individual).

> torture that occurs in the domestic or private sphere in relationships perpetrated within families and in human trafficking, prostitution, pornographic exploitation, and violent groups and gangs. …
>
> Non-state actors, as defined by the UN Security Council, are any individuals or entities "not acting under the lawful authority" of the state.[120]

Jeanne Sarson described some of the profound impacts of torture: victims may dissociate (mentally disconnecting from their thoughts, feelings and identity); lose senses, such as the ability to see in colour; or self-harm or self-medicate as a coping mechanism.[121] Nevertheless, the committee heard that women who have experienced torture often do not receive proper mental health care, in part because the normal responses to torture can be misinterpreted as mental illness.[122]

Persons Against Non-State Torture calls on the Government of Canada to criminalize torture perpetrated by non-state actors as a "torture crime"; recognize "non-state torture victimization-traumatization informed care"; and ensure that education on violence against women includes non-state torture victimization.[123] In the words of Jeanne Sarson:

> Women cannot mentally heal when social-political injustice dehumanizes them as persons with no legal right to truth-tell, when they are not treated with dignity, when they are disbelieved and when they are not protected from non-state torture.[124]

Sexual Violence

The committee was informed of the connection between sexual violence, PTSD and other mental health disorders. Sexual assault has been associated with the development of PTSD and other mental health conditions, including generalized anxiety disorder, major depressive disorder, suicidal ideation, self-harm behaviours, eating disorders and obsessive-compulsive disorder. Compared with male survivors, women who experience sexual trauma are more likely to develop PTSD, and their symptoms are more likely to

120 HESA, *Evidence*, 11 April 2024, 1125 (Linda MacDonald, Co-Founder, Persons Against Non-State Torture).

121 HESA, *Evidence*, 11 April 2024, 1135 (Jeanne Sarson, Co-Founder, Persons Against Non-State Torture).

122 HESA, *Evidence*, 11 April 2024, 1125 (Linda MacDonald, Co-Founder, Persons Against Non-State Torture).

123 HESA, *Evidence*, 11 April 2024, 1130 (Jeanne Sarson, Co-Founder, Persons Against Non-State Torture). See also Jeanne Sarson and Linda MacDonald, Persons Against Non-State Torture, *On women's health: mental health*, Brief submitted to HESA, 31 March 2024.

124 HESA, *Evidence*, 11 April 2024, 1130 (Jeanne Sarson, Co-Founder, Persons Against Non-State Torture).

last longer.[125] For women from marginalized communities, such as LGBTQ+ communities, racialized and Indigenous peoples, and people with disabilities, the impacts of violence intersect with discrimination and can exacerbate health disparities.[126]

The testimony highlighted the need for sufficient core funding for trauma-informed services and sexual assault centres, particularly those that assist girls. The Kawartha Sexual Assault Centre, for example, has no funding to support people under 16 years of age who experience assault. Jocelyn Enright, coordinator at the Kawartha Sexual Assault Centre, observed that victims of childhood sexual assault are at increased risk of being sexually assaulted later in life, and earlier intervention would mitigate mental health impacts. She advocated for increased investments in trauma-informed services and prevention initiatives, including education for boys about gender-based violence, as well as increased core funding for sexual assault centres. Additional funding, she said, would allow centres to go beyond offering "the bare minimum [of] band-aid solutions to women, often long after the harm has taken place," and harness the "power of prevention in creating lasting change."[127]

Therefore, the committee recommends:

Recommendation 14

That the Government of Canada collaborate with the provinces and territories to increase funding for sexual assault centres.

Recommendation 15

That the Government of Canada work towards increasing targeted research opportunities to both improve the experience of care for women with mental illness today and develop prevention and cures for the women of the future.

125 HESA, *Evidence*, 11 April 2024, 1120 (Jocelyn Enright, Coordinator, Community Engagement, Communications, and Fundraising, Kawartha Sexual Assault Centre).

126 Jennifer Dunn, London Abused Women's Centre, *Violence against women and girls*, Brief submitted to HESA, 15 April 2024.

127 HESA, *Evidence*, 11 April 2024, 1120 (Jocelyn Enright, Coordinator, Community Engagement, Communications, and Fundraising, Kawartha Sexual Assault Centre).

Women's Health Research

The testimony on women's health research pointed to three main issues: gender disparity and funding; data sharing; and gender and the health workforce.

Gender Disparity and Funding

The gender gap in health research was a recurrent concern across the testimony. In the words of Liisa Galea, senior scientist and Treliving Family Chair in Women's Mental Health at the Centre for Addiction and Mental Health, "[w]omen's health research has been undervalued, understudied and underfunded."[128] Some witnesses cited examples of the paucity of research on women's health. For instance, although three-quarters of people living with multiple sclerosis are women, a review found that very few studies on this condition (about 350 out of over 100,000) have specifically examined women's health questions.[129] The studies that did look at women's health were limited in other aspects: they did not reflect a lifespan approach or the diversity of women (as most participants were white), most focused on pregnancy, and few addressed menopause.

Government officials told the committee about federal actions to address gaps in women's health research, notably the National Women's Health Research Initiative[130] and CIHR's policies to promote the integration of sex and gender into research. Tammy Clifford, acting president of CIHR, indicated for instance that over 90% of health research proposals now integrate sex and gender, owing to the efforts of that funding body over the past decade.[131] Nonetheless, witnesses stressed that still more must be done to achieve gender parity in Canadian health research. Ms. Galea explained that CIHR's 90% estimate was based on a box that researchers must check and that the actual proportion of funded research addressing women's health is much lower. According to an analysis of over 8,000 Canadian grants from 2009 to 2020, less than 6% of federal

128 HESA Health, *Evidence*, 11 April 2024, 1115 (Liisa Galea, Senior Scientist and Treliving Chair, Women's Mental Health, Centre for Addiction and Mental Health).

129 HESA, *Evidence*, 2 May 2024, 1245 (Dr. Ruth Ann Marrie Professor, Department of Medicine, Max Rady College of Medicine, University of Manitoba, as an individual).

130 HESA, *Evidence*, 27 November 2024, 1110 (Angela Kaida, Scientific Director, Institute of Gender and Health, Canadian Institutes of Health Research).

131 HESA, *Evidence*, 27 November 2023, 1110 (Tammy Clifford, Acting President, Canadian Institutes of Health Research).

grants went to women's health research, and this number drops to 4.4% if female breast cancer is excluded.[132]

Gender disparity in medical research topics leads to a lack of knowledge about women's unique health experiences and how these differ from men's. This knowledge gap, in turn, creates challenges in diagnosing and treating disease in women. For example, one study has found that, across a large number of diseases, women are diagnosed more than three years later than men.[133] To address this disparity, witnesses called for targeted funding for women's health research, including in the areas of gynecological cancers, breast cancer, endometriosis, menopause, women's mental health and multiple sclerosis. Ms. Galea recommended "ring-fenced funding for women's health in general" to protect the funding and encourage multidisciplinary research.[134] Such investments can result in pivotal discoveries that advance women's health. Dr. Deborah Money gave the example of a "bold" trial that found that one of the first HIV drugs could be used during pregnancy to prevent mother-to-infant transmission,[135] while Pamela Valentine, president and CEO of MS Canada, lauded the research breakthrough that found a link between the Epstein-Barr virus and the development of multiple sclerosis.[136]

The testimony also highlighted the importance of examining not only what research is being funded but also which researchers receive funding and how funding is distributed. Some witnesses emphasized the need to adequately support trainees and early- and mid-career researchers, noting that women researchers tend to prioritize women's topics.[137]

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132 HESA Health, *Evidence*, 11 April 2024, 1115, 1140 (Liisa Galea, Senior Scientist and Treliving Chair, Women's Mental Health, Centre for Addiction and Mental Health). See also Tori N. Stranges et al., "Are we moving the dial? Canadian health research funding trends for women's health, 2S/LGBTQ + health, sex, or gender considerations," *Biology of Sex Differences*, Vol. 14, 15 June 2023.

133 HESA, *Evidence*, 11 April 2024, 1115 (Liisa Galea, Senior Scientist and Treliving Chair, Women's Mental Health, Centre for Addiction and Mental Health).

134 HESA, *Evidence*, 11 April 2024, 1140 (Liisa Galea, Senior Scientist and Treliving Chair, Women's Mental Health, Centre for Addiction and Mental Health).

135 HESA, *Evidence*, 2 May 2024, 1250 (Dr. Deborah Money, Professor and Head, Department of Obstetrics and Gynaecology, University of British Columbia, as an individual).

136 HESA, *Evidence*, 2 May 2024, 1255 (Pamela Valentine, President and CEO, MS Canada). See also Benjamin Davis, Multiple Sclerosis (MS) Society of Canada, *Women's Health Study*, Brief submitted to HESA, 9 September 2022.

137 HESA, *Evidence*, 2 May 2024, 1315 (Dr. Deborah Money, Professor and Head, Department of Obstetrics and Gynaecology, University of British Columbia, as an individual); and HESA, *Evidence*, 2 May 2024, 1320 (Dr. Ruth Ann Marrie, Professor, Department of Medicine, Max Rady College of Medicine, University of Manitoba, as an individual).

Therefore, the committee recommends:

Recommendation 16

That the Government of Canada increase targeted funding for women's health research, including through the National Women's Health Research Initiative. Such research should reflect the diversity of women in Canada, particularly underrepresented and underserved populations.

Data Sharing

Several witnesses identified legislative or regulatory barriers to data sharing between provinces and territories, viewing them as a hindrance to women's health research. For instance, Dr. Ruth Ann Marrie, professor in the Department of Medicine at the University of Manitoba, described the complex and time-consuming nature of administrative procedures for data collection:

> I had one study that needed 13 regulatory approvals to do one study in one province. This adds to costs, it reduces the productivity that we have for the amount of research dollars invested and it limits our ability to do things that are relevant on a national scale.[138]

Similarly, Dr. Money stated that it is very difficult to establish an accurate, national picture of women's health conditions, delineated by factors such as geography, racial or cultural background, or first language, without the ability to link data from different jurisdictions. She identified legislation as a key barrier, telling the committee, "[w]e are not permitted to share data without enormously complicated agreements."[139] As such, she supported a national, coordinated approach to data sharing.

Gender and the Health Workforce

To address the gender gap, women in the health workforce must be better studied, according to Neeru Gupta, professor in the Department of Sociology at the University of New Brunswick. She told the committee that women's experiences as health care

138 HESA, *Evidence*, 2 May 2024, 1325 (Dr. Ruth Ann Marrie, Professor, Department of Medicine, Max Rady College of Medicine, University of Manitoba, as an individual).

139 HESA, *Evidence*, 2 May 2024, 1325 (Dr. Deborah Money, Professor and Head, Department of Obstetrics and Gynaecology, University of British Columbia, as an individual).

providers are understudied and undervalued.[140] Four out of five health care providers are women, yet research on the health workforce does not commonly feature gender-based analysis. Ms. Gupta recommended scaling up such research with a focus on several key areas, notably gender occupational segregation, workplace safety for women and women's pay in the health sector.[141] In its brief, the Canadian Federation of Nurses Unions also called for research on the health effects of night shifts, while expressing concerns regarding workplace violence, mental health issues and burnout among members of this female-dominated profession.[142]

INVESTING IN WOMEN'S HEALTH CARE

A recurring theme in the testimony centred on underfunding in women's health care. For instance, the committee heard calls for additional investment in:

- access to allied health professionals, such as physiotherapists, nutritionists and psychologists, to ensure that women have comprehensive care for endometriosis;[143]
- the training of health care professionals dedicated to gynecological cancers;[144]
- prevention and early detection of cancer, which is currently less well funded than other aspects of the cancer care continuum;[145]
- capacity for robotic surgery, particularly given its utility in facilitating surgeries for women with obesity;[146]

140 HESA, *Evidence*, 2 May 2024, 1240 (Neeru Gupta, Full Professor, Department of Sociology, University of New Brunswick, as an individual). See also Neeru Gupta, *Ending the neglect of women's health research involves ending the neglect of women in health workforce research*, Brief submitted to HESA, May 2024.

141 HESA, *Evidence*, 2 May 2024, 1310 (Neeru Gupta, Full Professor, Department of Sociology, University of New Brunswick, as an individual).

142 Linda Silas, Canadian Federation of Nurses Unions, *Women's health study*, Brief submitted to HESA.

143 HESA, *Evidence*, 29 November 2023, 1950 (Dr. Andrew Zakhari, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery, McGill University Health Centre).

144 HESA, *Evidence*, 12 February 2024, 1620 (Dr. Shannon Salvador, President-Elect, The Society of Gynecologic Oncology of Canada).

145 HESA, *Evidence*, 15 February 2024, 1220 (Dr. Ambreen Sayani, Scientist, as an individual).

146 HESA, *Evidence*, 15 February 2024, 1115 (Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, as an individual).

- access to perinatal mental health care, notably evidence-based talk therapy;[147] and

- access to mental health care for survivors of sexual assault.[148]

Further, in a joint brief, the Canadian Society for the Advancement of Gynecologic Excellence, EndoAct Canada and The Endometriosis Network Canada recommended that transfer funding agreements include provisions for endometriosis, particularly to enable improvements in access to expert surgical and multidisciplinary care.[149]

CONCLUSION

Women's health issues directly affect half the country's population, yet the historical and current understudying and undervaluing of women's experiences and health needs have created a gender gap in health. This gap is detrimental to women and all of society. The evidence received for this study demonstrates the importance of achieving gender equity in health. In this report, the committee has made recommendations to address pressing issues in four key areas of women's health: endometriosis, cancer, mental health and health research. These recommendations aim to improve the well-being of women across the country and ultimately close the gender gap in health.

147 HESA, *Evidence*, 11 April 2024, 1245 (Nichole Fairbrother, Clinical Associate Professor, Department of Family Practice, University of British Columbia, as an individual).

148 HESA, *Evidence*, 11 April 2024, 1120 (Jocelyn Enright, Coordinator, Community Engagement, Communications, and Fundraising, Kawartha Sexual Assault Centre).

149 Kate Wahl, Katie Luciani and Liane Belland on behalf of the Canadian Society for the Advancement of Gynecologic Excellence (CanSAGE), EndoAct Canada and The Endometriosis Network Canada, *Endometriosis in Canada*, Brief submitted to HESA.

APPENDIX A:
LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee's webpage for this study.

44th Parliament – 1st Session

Organizations and Individuals	Date	Meeting
Canadian Institutes of Health Research	2023/11/27	91
Tammy Clifford, Acting President		
Angela Kaida, Scientific Director, Institute of Gender and Health		
Department of Health	2023/11/27	91
Ed Morgan, Director General, Policy, Planning and International Affairs Directorate		
Cindy Moriarty, Director General, Health Programs and Strategic Initiatives		
Suki Wong, Director General, Mental Health Directorate		
Public Health Agency of Canada	2023/11/27	91
Annie Comtois, Executive Director, Centre for Chronic Disease Prevention and Health Equity		
Shannon Hurley, Associate Director General, Centre for Mental Health and Wellbeing		
Mark Nafekh, Director General, Centre for Health Promotion		
As an individual	2023/11/29	92
Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa		
Dr. Fiona Mattatall, Obstetrician Gynaecologist		
EndoAct Canada	2023/11/29	92
Dr. Catherine Allaire, Co-chair		
Kate Wahl, Executive Director		

Organizations and Individuals	Date	Meeting
McGill University Health Centre	2023/11/29	92
Dr. Dong Bach Nguyen, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery		
Dr. Andrew Zakhari, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery		
As an individual	2023/12/06	94
Dr. Steven Narod, Senior Scientist		
Jacques Simard, Full Professor, Department of Molecular Medicine, Université Laval		
Dr. Anna N. Wilkinson, Medical Doctor		
Dense Breasts Canada	2023/12/06	94
Jennie Dale, Cofounder and Executive Director		
Dr. Paula Gordon, Doctor		
As an individual	2024/02/12	101
Gillian Hanley, Associate Professor, Department of Obstetrics and Gynaecology, University of British Columbia		
Dr. Jessica McAlpine, Professor and Division Head ,Division of Gynecologic Oncology, University of British Columbia		
Ovarian Cancer Canada	2024/02/12	101
Valérie Dinh, Regional Director, Quebec		
Tania Vrionis, Chief Executive Officer		
The Society of Gynecologic Oncology of Canada	2024/02/12	101
Dr. Shannon Salvador, President-Elect		
As an individual	2024/02/15	103
Dr. Ghadeer Anan, Medical Oncologist		
Dr. Ambreen Sayani, Scientist		
Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto		
Canadian Cancer Society	2024/02/15	103
Rob Cunningham, Senior Policy Analyst		
Helena Sonea, Director, Advocacy		
Ciana Van Dusen, Advocacy Manager, Prevention		

Organizations and Individuals	Date	Meeting
As an individual	2024/04/08	108
Catriona Hippman, Postdoctoral Research Fellow, BC Reproductive Mental Health Program, BC Women's Hospital and Health Centre		
Dr. Ryan Van Lieshout, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University		
Dr. Simone Vigod, Professor and Head, Department of Psychiatry, University of Toronto, Women's College Hospital		
Québec Alliance for Perinatal Mental Health	2024/04/08	108
Tina Montreuil, Associate Professor and Scientist, Montreal Antenatal Well-Being Study		
As an individual	2024/04/11	109
Nichole Fairbrother, Clinical Associate Professor, Department of Family Practice, University of British Columbia		
Centre for Addiction and Mental Health	2024/04/11	109
Liisa Galea, Senior Scientist and Treliving Family Chair, Women's Mental Health		
Kawartha Sexual Assault Centre	2024/04/11	109
Jocelyn Enright, Coordinator, Community Engagement, Communications, and Fundraising		
Persons Against Non-State Torture	2024/04/11	109
Linda MacDonald, Co-Founder		
Jeanne Sarson, Co-Founder		
As an individual	2024/05/02	113
Neeru Gupta, Full Professor, Department of Sociology, University of New Brunswick		
Dr. Ruth Ann Marrie, Professor, Department of Internal Medicine, Max Rady College of Medicine, University of Manitoba		
Dr. Deborah Money, Professor and Head, Department of Obstetrics and Gynecology, University of British Columbia		

Organizations and Individuals	Date	Meeting
MS Canada	2024/05/02	113
Pamela Valentine, President and CEO		

APPENDIX B: LIST OF BRIEFS

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's webpage for this study.

44th Parliament – 1st Session

Action Canada for Sexual Health and Rights

Alliance for Gender Justice in Migration

Alzheimer Society of Canada

Amodu, Oluwakemi

Appavoo, Shushiela

Archibald, Maggie

Arthritis Society Canada

Association pour la santé publique du Québec

Bailey, Paul

BC Coalition of Experiential Communities

BC Reproductive Mental Health Program

Beautycounter

BGC Canada

Borgfjord, Jennifer

Breast Cancer Canada

Bridge2Future

Canadian Association of Social Workers

Canadian Cancer Society

Canadian Centre on Substance Use and Addiction

Canadian Chiropractic Association

Canadian Collaborative for Stillbirth Prevention

Canadian Federation of Nurses Unions

Canadian Medical Association

Canadian Menopause Society

Canadian Physiotherapy Association

Canadian Society for the Advancement of Gynecologic Excellence

Canadian Task Force on Preventive Health Care

Caswell, Cathy

Centre for Addiction and Mental Health

Dale, Jennie

Edmonton Zone Medical Staff Association

Egale Canada

EndoAct Canada

Environmental Defence Canada

Farber, Shira

Fédération des Kinésiologues du Québec

Fertility Matters Canada

Filate, Woganee

Fondation Olo

Gordon, Paula

Gupta, Neeru

Hanley, Gillian

Hart, Gaynor

Heart and Stroke Foundation of Canada

Holland, Carolyn

Holness de Hiller, Ariadne

Hologic

Huntsman, David

King, Regine

Kraft, Rosilene

Kwadrans, Natalie

Ladha, Tehseen

Leader, Arthur

Lehman, Jeanne

Lindeman, Tracey

London Abused Women's Centre

Louis-Bayliss, Amy

Manitoba Interdisciplinary Lactation Center

McAlpine, Jessica

McGill University Health Centre

McKinstry, Nancy

McTeer, Maureen

Menopause Foundation of Canada

Montreal Antenatal Wellbeing Study

MS Canada

Muslim Advisory Council of Canada

Northern Birthwork Collective

Olson, Marj

Olukotun, Mary

Ordre des diététistes-nutritionnistes du Québec

Organon

Ospina, Maria Beatriz

Ovarian Cancer Canada

Persons Against Non-State Torture

Poole, Nancy

Power Stones Jewelry

Québec Alliance for Perinatal Mental Health

Regroupement Les Sages-femmes du Québec

Regroupement pour la Valorisation de la Paternité

Renzaho, Andre

Research and Education for Solutions to Violence and Abuse

Réseau des Centres de Ressources Périnatales du Québec

Richter, Solina

Salami, Bukola

Sandhu, Manvir

Seely, Jean

Sekyi-Otu, Ato

Shaw, Sarah Naomi

Slight, Annie

Society of Obstetricians and Gynaecologists of Canada

Stuart, Gavin

The Endometriosis Network Canada

The Society of Gynecologic Oncology of Canada

Tremblay Dionne, Érick

Tunde-Byass, Modupe

University of British Columbia Perinatal Anxiety Research Laboratory

Van Lieshout, Ryan

Wellington, Craig

Wilcox, Sherry

Wilkinson, Anna

Women's Legal Education and Action Fund

Women's Rights Matter

Woo, Michelle

Yaffe, Martin

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 4 and 6) from the 45th Parliament, 1st Session and (Meetings Nos. 91, 92, 94, 101, 103, 108, 109, 113 and 124) from the 44th Parliament, 1st Session is tabled.

Respectfully submitted,

Hon. Hedy Fry
Chair

Supplementary Opinion of the Conservative Party of Canada

Conservative Members of the Standing Committee on Health thank the witnesses who appeared during the Committee's study on women's health. Their testimony identified important matters that impact the health of women in Canada.

While we support the substance of the report and its recommendations, we are concerned that the report does not fully reflect important issues that were raised during the study.

In our supplementary report, we highlight three main areas that we believe were insufficiently addressed. These include the shortage of healthcare professionals, rising crime and violence against women, and the current government's ongoing failure to deliver meaningful results.

Shortage of Doctors, Nurses, and Healthcare Professionals

With approximately 6.5 million Canadians without a family doctor, women are being denied timely access to the important care and treatments identified in this study. The report does not adequately connect women's health outcomes to the shortage of healthcare professionals in Canada. A shortage of doctors, nurses, and healthcare providers severely limits the ability of women to access assessment, diagnosis, and surgery.

Dr. Jessica McAlpine referred to this as a crisis in her testimony, she stated, "We also have a crisis, which has been mentioned by many of the members already, of a shortage of family physicians."[1]

Conservatives believe this shortage is a direct result of the Liberal government's failure to license internationally trained physicians, including Canadians who studied medicine abroad, so they can treat patients. According to the College of Physicians and Surgeons of Canada, at least 13,000 internationally trained physicians currently in Canada are not working as doctors. Additionally, according to a briefing provided to the Minister of Health by Health Canada, there are currently at least 80,000 healthcare professionals in Canada who are not working in their field.

Conservatives believe immigration policy must align with Canada's healthcare capacity, and that qualified internationally trained physicians already in Canada should be supported to get licensed and treating patients. Failing to address the barriers imposed by licensing and regulatory bodies that are blocking qualified healthcare professionals from working, is failing to support women's health.

[1] HESA, *Evidence*, 12 February 2024, 1720 (Dr. Jessica McAlpine, Professor and Division Head, Division of Gynecologic Oncology, University of British Columbia, As an Individual)

Conservatives urge the federal government to provide national leadership by implementing a standardized credential recognition process in addition to national licensure, in order to address the workforce shortage negatively impacting healthcare for women in Canada.

Crime

The committee heard testimony about the impact that crime has on both the physical and mental health of women. This included targeted violence, sexual assault, and intimate partner violence. Since 2015, violent crime has increased by 55%, total sexual assaults are up 76%, and the number of female victims of intimate partner violence has increased by 38.6%. This alarming increase in crime is having a significant impact on the health of women in Canada.

Witnesses urged the government to increase penalties for violent crime. For example, Persons Against Non-State Torture noted that Canada's current Criminal Code is an "injustice" to victims and dehumanizes women by failing to recognize the severity of violence and torture faced by women. [2]

Conservatives believe that the Liberal government's soft-on-crime policies such as Bill C-5 and Bill C-75 from the 44th Parliament are responsible for the increase in crime, particularly by violent, repeat offenders. Women are disproportionately impacted by intimate partner violence. We urge the government to repeal catch-and-release laws that allow violent repeat offenders to threaten the lives of women while out on bail instead of serving sentences in jail. Conservatives believe more action needs to be taken to protect women from violence. We urge the government to get tough on crime in order to protect the wellbeing, health, and lives of women across Canada.

Additionally, Conservatives believe urgent action is needed to address the alarming rise in assaults on healthcare workers. According to Canadian Federation of Nurses Unions stated, "In Manitoba, there were 812 workers' compensation claims accepted in 2024 for nurses who were the victims of assault and violent acts, compared to 298 in 2015. In British Columbia, there were 507 violence-related accepted workers' compensation claims in 2024, compared to 344 in 2016." No one should fear violence when providing care.

That is why Conservatives support amending the Criminal Code to require courts to treat assaults against health-care professionals and first responders as an aggravating factor during sentencing.

Historical Failures to Deliver

[2] HESA, *Evidence*, 11 April 2024, 1135 (Ms. Linda MacDonald, Co-Founder, Persons Against Non-State Torture)

The committee heard from witnesses who expressed concern about the Liberal government's failure to deliver on commitments relating to women's health despite more than 10 years in government. For example, Dense Breasts Canada, testified that the Liberal government failed to fulfil campaign promises relating to women's health in a timely manner. "A commitment was made during an election campaign that the government would address better guidelines, and after the election, it did not address the guidelines," stated Ms. Jennie Dale, when speaking about the screening guidelines for breast cancer.[3]

Conservatives believe that the current government continues to overpromise and underdeliver on policies intended to improve women's health in Canada. We urge the government to fulfil its promises and measure outcomes to improve the health of women across Canada.

[3] HESA, *Evidence*, 06 December 2023, 2005 (Ms. Jennie Dale, Co-founder and Executive Director, Dense Breasts Canada)

Supplementary Report: Study on Women's Health

Standing Committee on Health

Bloc Québécois Position

The Bloc Québécois wishes to reaffirm its support for the recommendations aimed at improving women's health in Canada, particularly in the areas of research, prevention, awareness, and screening. Many proposals in the report reflect concerns widely expressed by grassroots groups and specialists consulted during the study, especially in the areas of endometriosis, gynecological cancers, perinatal health, and mental health.

However, the Bloc Québécois considers it essential to emphasize that any lasting improvement in women's health services must involve a structural strengthening of health funding, in full respect of the constitutional jurisdiction of Quebec and the provinces.

In this regard, the Bloc believes that health funding remains insufficient, and that adding federal conditions or constraints to transfers can only complicate the implementation of necessary solutions on the ground.

Quebec and the provinces are best placed to determine their health priorities, organize their service networks, fund programs that meet the needs of their populations, and adapt their interventions according to their demographic, social, and territorial realities. Quebec, the provinces, and Indigenous governments understand their challenges better than anyone. The federal government's role should be financial support, not central planning.

Accordingly, the Bloc Québécois recommends that the final report clearly state that: health transfers must be increased significantly, on a recurring basis, and above all, without conditions. This is the only way to allow provinces, particularly Quebec, to effectively improve access to care, reduce waitlists, and implement services adapted for women, notably for issues such as endometriosis, screening, perinatal mental health, and support for survivors of sexual violence.

While the federal government can play a useful role in funding research and disseminating information, it should not replace the authorities responsible for delivering care.

The Bloc Québécois therefore remains committed to the idea that real progress in health depends primarily on:

- full respect for constitutional jurisdiction,
- increased transfers,
- and the freedom for Quebec and the provinces to use these resources according to their own national priorities.