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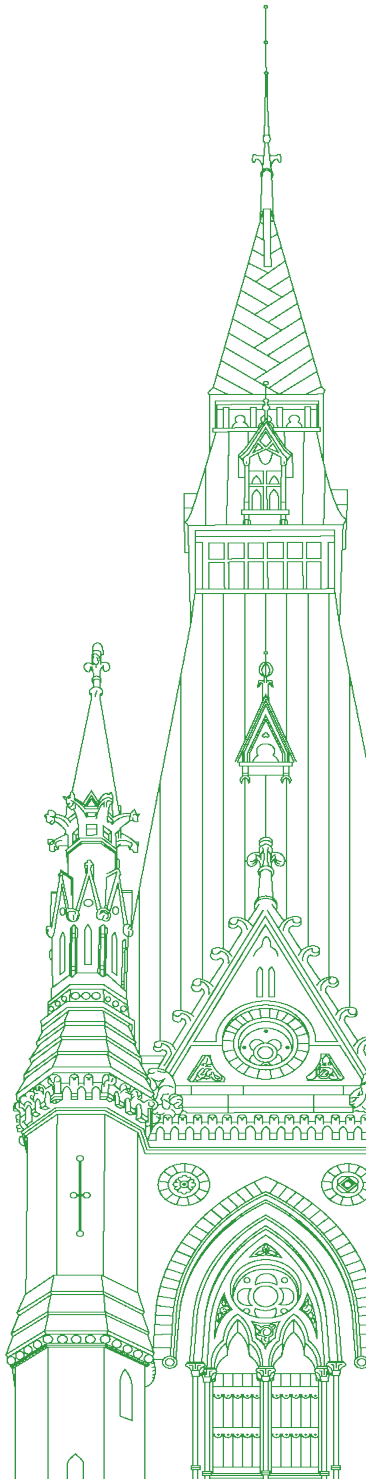

Chair: Dominique Vien

Standing Committee on the Status of Women

Thursday, June 11, 2026

● (1545)

[*English*]

The Vice-Chair (Marilyn Gladu (Sarnia—Lambton—Bkejwanong, Lib.)): I call this meeting to order.

Welcome to meeting number 44 of the House of Commons Standing Committee on the Status of Women.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Tuesday, January 27, the committee will begin its study of the labour force impacts of menopause and perimenopause.

Members are attending in person in the room and remotely using the Zoom application.

I'll make a few comments for the benefit of members and witnesses.

Please wait until I recognize you before speaking. For those participating on Zoom, click on the microphone icon to activate your mic, and please mute yourself when you're not speaking. You can choose French, English or floor for interpretation on the bottom. If you wish to speak, raise your hand, or use the “raise hand” function if you're on Zoom.

Committee members are going to ask questions in both official languages, so I'd like to recommend that the witnesses pick their interpretation now. Please address all comments through the chair.

Now we're going to welcome our witnesses.

We have Pnina Alon-Shenker, associate professor, Toronto Metropolitan University; Roberta Heale, full professor, Laurentian University; and Amy Flood, executive director, Women's Health Collective Canada.

We'll begin with opening statements.

Ms. Alon-Shenker, the floor is yours for five minutes.

Pnina Alon-Shenker (Associate Professor, Toronto Metropolitan University, As an Individual): Thank you, Madam Chair, and thank you to the members of the committee for the opportunity to speak today.

My name is Pnina Alon-Shenker, and I'm an associate professor at Toronto Metropolitan University. I have studied age discrimination in the workplace for more than a decade. My most recent work, co-authored with Professor Asher Alkoby, addresses the gaps in legal protections for menopausal workers. This study was shared with the committee prior to this meeting.

Although available data suggest that menopause affects a large segment of Canadian workers, employment and labour laws remain largely silent on menopause. In the absence of explicit legal protections, employer-initiated menopause policies are rare, and menopausal workers encounter barriers to meaningful participation in the labour market. Indeed, women's labour force participation declines significantly as they age. This decline may be caused by a variety of factors, but there is some evidence to suggest that these include menopause-related challenges.

We found that there are very few litigated cases in Canada on menopause at work. The cases we discussed confirm previous findings that workers often lack the knowledge of what they experience and what they need, and when they do, the absence of inclusive workplace policies, together with persistent stigma, prevent them from seeking or receiving appropriate accommodation.

Menopause is often perceived as a personal problem rather than a human rights issue. Further, discrimination claims are reactive in nature, and they often mark a breakdown of the employment relationship in ways that are difficult to restore. Raising awareness through education of workers, employers, health professionals and adjudicators is critical not only for ensuring that such claims are brought forward and that they succeed, but also for preventing discriminatory practices in the first place.

The dearth of case law in this area is unsurprising. Menopause and its effects on women's health are still understudied. There is a substantial knowledge gap, lack of awareness and stigma surrounding menopause. Survey data show that unmanaged symptoms and the challenges experienced by menopausal workers contribute to reduced working hours, job loss and premature exit from the workplace. The impact on employers and the economy is also significant, including lost productivity and difficulty retaining top talent.

Other countries, such as the U.K. and Australia, have recognized the economic and social significance of these challenges and have conducted comprehensive parliamentary studies informed by extensive consultation with stakeholders. We are pleased to see that the Standing Committee on the Status of Women has now embarked upon a similar initiative. The U.K. and the Australian experiences make clear that there is no one solution that fits all workers and sectors, and that the way forward requires the introduction of integrated and coordinated measures to support menopausal workers.

Our study underscores the importance of exploring a multifaceted regulatory approach that would increase awareness, support employers' interest in retaining and attracting talent, effectively address stigma and silence and protect workers' choice and autonomy at work.

Indeed, Canada would benefit from a comprehensive national strategy that would promote the introduction of proactive regulatory measures and be accompanied by awareness-raising and education campaigns to break the silence surrounding menopause at work. Proactive regulatory measures that we recommend in particular include the introduction of workplace policies, menopause training, paid leave of absence and a stronger right to request flexible work arrangements.

Further, we argue that there is an important expressive value in explicitly recognizing menopause under human rights legislation at the intersection of age, sex and disability. This could help raise awareness, facilitate the development of menopause-related workplace policies, promote proactive duty to remove barriers, and create a clearer pathway to accommodation requests and more inclusive workplaces.

Finally, our review of other jurisdictions observed a normative shift towards a universal right to workplace accommodation. Focusing on the actual need for accommodation regardless of the individual's physical or mental condition would ensure the effective removal of social and environmental barriers that restrict meaningful participation in society of all Canadians.

● (1550)

Indeed, research shows that women wish to remain active in the labour market and are often able to do so with simple and inexpensive support and adjustments.

This approach would also help address concern—

The Vice-Chair (Marilyn Gladu): Could you wrap up your comments? Thank you.

Pnina Alon-Shenker: Can I finish the last sentence?

The Vice-Chair (Marilyn Gladu): Yes.

Pnina Alon-Shenker: This approach would also help address the concern that designing menopause-specific measures may inadvertently reinforce stigma and prejudice.

Thank you so much for your consideration of these matters.

The Vice-Chair (Marilyn Gladu): Thank you so much. I'm sorry, but we are very tight for time with these votes today.

Ms. Heale, the floor is yours for five minutes.

Roberta Heale (Full Professor, Laurentian University, Centre for Research in Occupational Safety and Health): Thank you very much for inviting me here today.

I have been a nurse practitioner for close to 27 years, and I'm a full professor at Laurentian University. I continue to practise as a nurse practitioner, and I opened the Virtual Menopause Clinic four years ago.

I've learned that women in mid-life undergo profound physiological changes that result in a whole host of symptoms. Every woman is different, and the symptoms they experience and the severity of them can vary considerably, but perimenopause and menopause symptoms impact all areas of a woman's life—most definitely, work.

Many of my patients have told me the impacts of these symptoms. Comments like, “If you hadn't treated me, I would have had to quit work,” prompted me to develop a pan-Canadian survey to gather data about this experience. The survey is still live, but the preliminary findings are concerning: 47% of the survey participants reported that they've missed work because of symptoms; 45% have reduced work hours; 43% have taken sick time or vacation time to manage their menopause symptoms; and 31% are considering leaving their work.

Overall, the findings are not surprising. Menopause symptoms significantly impact work. In addition, most workplaces lack policy, awareness or accommodations. The findings mimic what we know. Up to 10% of women leave the workforce because of menopause symptoms. These are their peak earning years, so it's going to have an impact on them financially for the rest of their lives. The cost to women is enormous.

The cost to organizations and employers is huge, with an estimated $237 million annually lost to menopause care and symptoms, and an estimated cost to organizations of up to $50,000 to replace senior employees.

We can't talk about menopause at work without talking about the barriers to receiving care in menopause. The lack of accessibility to knowledgeable menopause care providers is very common. Accessibility to affordable treatment is a barrier, and more and more women are turning to private pay. Hopefully, when all provinces have direct remuneration for NPs, this will solve part of the problem. If a woman doesn't have drug benefits or coverage for things like counselling, they have to pay out of pocket, and that menopause treatment is prohibitive. It's very expensive.

There are other related issues. The ongoing black box warnings on vaginal estrogen products have been removed by the FDA in the U.S. but remain in Canada. This contributes to the confusion and the tsunami of information and misinformation that women experience about menopause care, as well as the hesitancy of some providers to provide them with actual care.

There are many strategies that could be considered at the federal level. First, continue to prioritize menopause hormone therapy in the national pharmacare plan and trigger reviews of products so that the approvals are aligned with evidence. Next, continue to ensure that all jurisdictions develop direct remuneration for NPs to help reduce costs for women. Also, consider the establishment of regional centres of excellence—I know there are a few across the country right now—to train health care providers and create public education programs, with the goal being to move menopause care back into primary health care.

Another is to consider menopause as an issue of equity. Again, the U.K. has legislation to eliminate discrimination against women when, related to their symptoms, they need to adjust their work. Advocate for workplace environment standards, such as policy frameworks that emphasize things like physical workspace adjustments, ventilation or even just access to appropriate washroom facilities. Review national health workplace strategies, such as in England and Scotland, which support menopausal transition in the workplace—strategies such as employers signing pledges to implement formal menopause policies. Finally, consider funding and developing a national clinical guideline, which truly reflects current evidence and practice, for the management of women during the menopause transition.

Menopause at work impacts millions of women. Providing care to women during the menopause transition has shown me how much needs to be done to ensure optimal workplace environments during this critical stage.

I look forward to the report from this committee.

Thank you.

● (1555)

The Vice-Chair (Marilyn Gladu): Thank you so much.

Ms. Flood, you have the floor for five minutes.

Amy Flood (Executive Director, Women's Health Collective Canada): Thank you very much. Good afternoon, everyone.

My name is Amy Flood. I'm the executive director of the Women's Health Collective Canada.

Women's Health Collective Canada is a national alliance of five of the leading women's health and research institutes, which are working together to advance women's health through research, advocacy, education and coordination of national action.

Thank you for the opportunity to represent women's health research, the topic of menopause and its importance to the workplace and productivity. Bringing people together across health, research, innovation and policy is exactly how progress happens in women's health. That's why conversations like this matter.

Women's health remains underfunded, under-researched and, too often, misunderstood. In Canada, we are 51% of the population, 47% of the workforce and are forecasted to own nearly 50% of our country's wealth by 2030, yet only 7% of health research funding is dedicated specifically to women's health.

For decades, clinical trials and research were largely designed around male bodies with male norms. While policies have evolved to require the inclusion of women, gaps in evidence and care persist today. This results in a system that has never been fully designed for women and we see the consequences. Women are waiting years for diagnoses. They are misdiagnosed or they are living with untreated conditions that affect not only their health, but their ability to fully participate in the workforce and in life in general.

These are not isolated issues. They are systemic outcomes of decades of underinvestment. They show up every day. Women account for most adverse drug reactions, and this is linked to how medications have historically not been tested on women. Nearly half of adolescent girls are missing school or activities due to menstrual health challenges, and 40% of mothers are considering leaving the workforce during the postpartum period.

At the same time, women are living longer than men, but spending 24% of that time in poor health. The majority of that 24% of time in poor health is during the critical working years.

Hormones and the hormonal transition through perimenopause and menopause are one of the largest drivers of the women's health equity gap in Canada. Approximately 10 million women in Canada are over the age of 40, encompassing those in perimenopause, menopause and post-menopause. Perimenopause symptoms are showing up earlier in women today. Health care providers report seeing women in their late thirties and forties experiencing perimenopausal symptoms such as irregular periods, hot flashes, brain fog and mood swings.

An estimated one in 10 women steps away from the workforce due to unmanaged menopause symptoms. Forty per cent of women in their sixties still experience menopause symptoms. It is estimated that menopause symptoms cost the Canadian economy approximately $3.5 billion annually. Employers incur around $237 million each year due to lost productivity. Women face $3.3 billion in lost income stemming from reduced work hours, decreased pay or exiting the workforce entirely. Menopause-related symptoms lead to approximately 540,000 lost work days per year in Canada. Of working women, 32% reported that their menopause symptoms negatively affected their job performance. Factors contributing to these trends were increased stress levels, environmental toxins, endocrine disruptors, diet and lifestyle changes, hormone treatments, etc.

Menopause research in Canada is critically needed. Governments need strong data to create health campaigns and funding programs for menopause care. Canada is behind countries like the U.K., which is making menopause a public health priority. We lack Canadian-specific data. We lack knowledge in health care. There's limited research on the long-term effects of menopause hormone therapy and treatments. There is a lack of mental health and menopause support in the workforce. We lack knowledge in the workplace and the economy.

A 2024 report by the Women's Health Research Institute found that a third of women's work performance was affected by their symptoms, yet their workplaces lacked the policies to support them.

We're asking that employers consider these top six things to help women through their menopause transition.

Normalize the workplace conversation. Create a culture where menopause can be discussed openly and without stigma. Education awareness helps employees feel supported and reduces the barriers to seeking help.

Train managers. Equip your leaders with the knowledge and confidence to understand menopause symptoms. Have supportive conversations and provide appropriate accommodations when needed.

● (1600)

Offer flexibility. Flexible work arrangements, including hybrid work-adjusted schedules and flexibility for medical appointments, can help manage symptoms while remaining productive and engaged.

Enhance benefits and support.

The Vice-Chair (Marilyn Gladu): Could you wrap up your comments? Thank you.

Amy Flood: The cost of support is far less significant than the cost of short-term and long-term disability.

Support research and evidence-based menopause solutions.

The Vice-Chair (Marilyn Gladu): Thank you very much. I'm sorry about that. We're pinched for time.

We're going to start our first round of questions with Madam Vien.

You have six minutes.

[*Translation*]

Dominique Vien (Bellechasse—Les Etchemins—Lévis, CPC): Thank you very much, Madam Chair.

I'm so happy that these three women are here with us today. I was one of those who advocated for this cause, but I didn't have to do it for long, because my colleagues around the table understood. Many of us are in perimenopause or menopause. We've experienced certain problems and felt various symptoms.

When I started asking questions myself, I realized that few people around me, even those in the medical community, were able to answer them. I've also seen many people experiencing anxiety because of what they were going through. Why is that? It's because they didn't talk about it. It's true, we don't talk about it. However, the more we keep silent on this, the more women will remain on the sidelines and go through this all alone. The workplace won't change.

My first questions will be for Ms. Alon-Shenker.

If I understand correctly, you're interested in the workplace. We naturally think of brain fog, for example, which means that women can no longer be as quick as they used to be in terms of performance or memory. They struggle to find the right words, they feel guilty, they don't talk about it much and they try to hide it. They may be afraid of losing their job or missing out on a promotion. All three of you said that there was a lack of information and research on this.

Let's start with the immediate environment. How can we change the workplace to ensure that managers and colleagues are informed so that women feel much better received and have an easier time of it? We mustn't forget the union either.

● (1605)

[*English*]

Pnina Alon-Shenker: Absolutely. Thank you so much for the question. I think it's really important.

I and others have experienced that. I'm thinking about the people who are not lucky enough to have flexibility in their workplace, whereas professionals and office workers have much more flexibility. There are people who need to be physically available at a certain time, in a certain workplace. Without that.... Only adjustments in the workplace can help.

The problem starts earlier, as Madam Chair identified. The knowledge gap—the idea that some workers are not even aware that what they're experiencing is menopause.... There are some symptoms that are not much connected to one another, and you don't know how to put your finger on it, whether it is menopause. Once you realize it is menopause, is it a personal problem that affects your performance at work, or is it a human rights issue that deserves the attention of unions and employers, in the sense of requesting accommodation? There's no discussion around that because it's taboo and there's a lot of embarrassment and reluctance to share information with the human resources office or employers in a lot of workplaces—

[*Translation*]

Dominique Vien: I'm sorry to interrupt you, Ms. Alon-Shenker, but where or with whom should we start?

Do we need legislation or regulations?

Should the minister responsible for labour issues be involved? I myself held that portfolio at the provincial level, but I was perhaps less aware of this issue at the time, since I wasn't in the same situation.

Where should we start?

[*English*]

Pnina Alon-Shenker: From the review we have done, in the study, there is nothing in the legislation that directly, explicitly mentions menopause. You can make some connections within the existing protections, but there is nothing.... Yes, I'm in favour of legislation.

First and foremost, there has to be more research on the impacts of menopause on women in the workplace. Then there has to be a campaign to increase awareness among the general public, inform health care professionals and help women understand what they're experiencing. There has to be more awareness in the workplace. For example, in the U.K., the recommendation of a parliamentary committee was to appoint a menopause ambassador. The U.K. government adopted that recommendation and appointed a menopause employment champion who works with stakeholders and recommends best practices and policies.

I would even go further and mandate a menopause policy in the workplace, because when it comes through voluntary compliance.... We don't say, “compliance”. In other areas, we have had bad experiences with respect to trusting what employers can do.

[*Translation*]

Dominique Vien: Thank you very much, Ms. Alon-Shenker. I don't have a lot of time. That's the frustrating part of committee work.

Ms. Flood, you mentioned hormones and hormone therapy. Ms. Heale, you also mentioned them. In Quebec, we often hear about bioidentical hormones. A very interesting documentary called *Loto-Méno* has really raised women's awareness of the symptoms. Some women even watched the documentary with their husbands or partners.

In Quebec, hormone therapy is free for women. What's the current situation in Canada regarding free access to hormone therapy?

The question is for all three witnesses.

[*English*]

The Vice-Chair (Marilyn Gladu): Unfortunately, that's the end of the six minutes, but I would invite all of the witnesses, if they have comments to respond here, to please send them to the clerk. The committee would be very happy to get them.

Now we'll go to Ms. Nathan for six minutes.

Juanita Nathan (Pickering—Brooklin, Lib.): Thank you, Madam Chair. Through you, my first question is for Professor Alon-Shenker.

Professor, when I introduced this study, one of the things I heard repeatedly from women and advocates on this matter was that they often did not know whether they had any right to ask for support at work.

From the perspectives of human rights and labour law, do you believe that Canada's existing legal framework adequately protects workers experiencing menopause and perimenopause? Are women falling through gaps in our current accommodation system? I know that women normally quietly reduce their hours or just stop working altogether. They'll make up excuses so as not to go to work.

I want to ask you for your perspective on that.

● (1610)

Pnina Alon-Shenker: I think our existing laws inadequately protect women and do not encourage them to come forward with their requests.

We have human rights legislation, and it does address prohibited grounds that could be relevant to menopause, including disability, age and sex, but our system is very reactive, in the sense that only once a person has been adversely affected by discrimination they may file a complaint. The system is very individualized, so we are relying, in terms of enforcement, on an individual victim filing a complaint and arguing their case.

When there are no policies in the workplace that address the issue of menopause—a process of requesting accommodation—women lack the knowledge, are reluctant and even, as surveys suggest, hide their symptoms. Hiding symptoms could be very dangerous in terms of health and safety and can, as you mentioned, lead to a premature exit from the workplace.

Certainly, I don't think we're doing enough. I think it's important to establish a pathway—explicit rules, explicit processes—similar to what we have in federal legislation with regard to requests for flexible work arrangements. There's a process, you know it exists and you know you can request. There's a process for the employer to either accept or reject the request, with reasons.

Yes, there can be policies with regard to adjustments and support for menopause symptoms.

Juanita Nathan: Thank you for that response.

You're saying that it's more so the policies and we have to explicitly recognize them. It's less about legislation and more about implementation of awareness among employers.

Pnina Alon-Shenker: I think it's about legislation, and legislation can work in various ways.

First, legislation can mandate a policy in the workplace. In the U.K., for example, they mandate an action plan. Just as with equity legislation, you need an action plan. Show us how you implement and promote a menopause-inclusive environment. How do you review your current policies, amend them and remove barriers? This could be done through legislation because you mandate those action plans or provide some model policies that workplaces need to follow.

Another way to legislate is to explicitly recognize menopause as a prohibited ground. Pregnancy is recognized explicitly under sex. Menopause or other reproductive health conditions are not, so it's not clear. Is it under age? Is it a disability? Some symptoms may qualify as a disability.

In the case law, we moved from the medical model of disability to the social model of disability, which doesn't look at the medical condition of the person but looks at the barriers in the workplace. Menopause works in that way. Even if menopause is not considered a disability because it's a normal, common life stage that every middle-aged woman will go through, society or workplaces still perceive that as an impairment, to some extent. There's some stigma around that. There's prejudice. When they don't provide adequate supports and adjustments, these women are adversely affected.

Legislation has a huge role here, absolutely.

Juanita Nathan: Thank you so much for that.

I'll move on to Ms. Heale.

I want to talk about how well the health care professionals are educated on this. In school, when they go through their medical training, how much time is spent on explaining this to them? As we know, most physicians are male doctors. I just want to know, from your experience, how this is treated.

● (1615)

The Vice-Chair (Marilyn Gladu): I'm very sorry, but you're at the end of your six minutes.

I invite you, Ms. Heale, to respond to the clerk in writing.

[*Translation*]

Ms. Larouche, you have the floor for six minutes.

Andréanne Larouche (Shefford, BQ): Thank you very much, Madam Chair.

[*English*]

The Vice-Chair (Marilyn Gladu): I'm sorry, but the bells are ringing.

Do I have unanimous consent of the committee to continue until we get to the end of Madam Larouche's questions?

Some hon. members: Agreed.

Laila Goodridge (Fort McMurray—Cold Lake, CPC): Just to confirm, we will still end the meeting at 5:30.

The Vice-Chair (Marilyn Gladu): That is correct.

You may continue, Madam Larouche.

[*Translation*]

Andréanne Larouche: Thank you very much, Madam Chair.

I want to thank Ms. Flood, Ms. Alon-Shenker and Ms. Heale for joining us today on this important study.

I think this study has even broader implications. To me, it's a study on the place reserved for women in our society—for aging women. It's more than just a matter of menopause. That's how I see it. Perhaps it's because, before I was elected, I was a project manager working to raise awareness of elder abuse and elder bullying. People will ask me what the connection is. It's that we were talking about ageism. To me, the inability to recognize and adapt to what aging women are going through, and making those "out of the way, you old bag" comments, is a form of ageism. The fact that we're trying to make them invisible in our society—whether on our screens, in businesses or anywhere else—worries me a great deal.

Fortunately, in Quebec, we have a great ambassador, Véronique Cloutier, who made an exceptional series called *Loto-Méno*. The episode titles really remind me of what you said in your opening remarks. Véronique compares perimenopause and menopause to the lottery, since you don't know whether you're going to experience three, 10 or 30 symptoms. The title of the first episode is "The void". The second episode is entitled "Personal problem or societal problem?" Should we simply see this as our own problem, or should we look at it from a broader perspective and push companies to adapt? The third episode is entitled "What do we do now?"

It has to do with medication and our health care system. Obviously, we are members of Parliament at the federal level, and everything related to direct patient care and medical school education falls under the jurisdiction of Quebec and the provinces. However, when it comes to research, medications and treatments, there is a connection with the federal government.

We can certainly discuss workplace adaptation again, because I'm interested in that as well, but I want to follow up on the question raised by my colleague Ms. Vien, even though I know you'll be sending us some documents.

Where are we at in terms of research and drug approvals? My colleague mentioned bioidentical hormones, for example.

[*English*]

Roberta Heale: I'm sorry. Was that directed to me?

[*Translation*]

Andréanne Larouche: I addressed all three witnesses, but you can start, Ms. Heale, if you'd like.

If they wish, the other witnesses may add to your response.

[*English*]

Roberta Heale: The landscape for treatment for perimenopause and menopause is growing. We have a variety of very effective treatments that are, thankfully, non-hormonal as well as hormonal.

Some of the issues are accessibility. We have to consider that some women will not want or will not be able to take these medications. As well, there are other treatment options that are very effective—cognitive behavioural therapy for vasomotor symptoms, for example—yet all of those treatments, unless the patient has coverage, will be paid for out of pocket, and they're all very expensive.

Sleep is a huge issue, and hormones are not necessarily the treatment for that. Again, the treatments—cognitive behavioural therapy for insomnia—can be extremely expensive.

You've hit the nail on the head. It's so complex. There are so many facets to it. It's not just vasomotor symptoms; it's a whole host of things that are sometimes addressed with what we have and, sometimes, need other treatments.

● (1620)

Amy Flood: Yes. If I may add to that, I also feel that, oftentimes—and I believe, Pnina, you spoke to this—women are misdiagnosed. They are showing up with symptoms that are a result of perimenopause and menopause but they're not being recognized as such, so they are being prescribed SSNRIs and anti-anxiety and depression medication, when, in fact, hormone therapy, started earlier, would have been the right first line of defence. Because there's not enough research in the actual symptoms and the linkage to perimenopause and menopause during that hormonal transition, the actual prescribing of treatment is inaccurate to begin with.

Also, I would say that insurance companies are reluctant to carry treatments for menopause and perimenopause because of the costs associated. However, the costs associated with short-term and long-term disability are actually much greater and are a much larger risk. There are very much limited research studies on the long-term safety and effectiveness of hormone therapy. There's also a lot of research emerging showing that it's highly beneficial for other areas in the long-term life of women, such as Alzheimer's and dementia.

We just do not know enough about the effectiveness of the treatments due to the efficacy gap. Things have not been treated on women or tested on women to begin with, and therefore are misdiagnosed, misunderstood and misinformed. This is a root problem beginning with research and data that's disaggregated by sex.

[*Translation*]

Andréanne Larouche: Thank you.

I have 20 seconds left.

Ms. Alon-Shenker, do you have anything to add?

[*English*]

Pnina Alon-Shenker: I'm fine. I'm not doing research on the health care system, so I don't want to comment on that. I think I've commented enough for now.

The Vice-Chair (Marilyn Gladu): Okay. If you have any other comments, you can send them to the clerk.

I understand there is unanimous consent to continue, so we'll go to Ms. Goodridge for five minutes.

Laila Goodridge: Thank you, Madam Chair.

Thank you to all of the witnesses for being here today.

Ms. Flood, I really appreciate how you put down the details surrounding the women's research piece. It's something that I have been very passionate about and have brought forward in a lot of different spaces, because it is one of the big challenges. We're hearing about the workforce impacts, but, perhaps, if people had a better understanding of what they were going through, there wouldn't be the workforce impacts if it were actually being acknowledged and treated properly.

The only thing I can compare it to is being pregnant. In the moments before you realize you're pregnant, you think you're going crazy because you're terribly emotional. Once you realize that you're pregnant, you stop thinking you're crazy because you realize that it's just your emotions going a bit wild because of the hormones. You're not actually crazy; you're just pregnant. This is that circular space here.

How much research is being done, funded by the Government of Canada, in the space of perimenopause and menopause?

Amy Flood: I can't speak specifically to that. All I can say is that only 7% of research funding is being attributed to women specifically. When you take oncology out of that, it is only 3%.

I don't know the actual dedicated research for perimenopause and menopause. There is also, obviously, the transition from menstruation to pre-perimenopause, to perimenopause, to menopause and beyond. They're starting to see and identify this as a longer-term journey than just perimenopause and middle age in its own right.

Laila Goodridge: Are there any schools leading the research when it comes to perimenopause and menopause, from a health perspective in Canada?

Amy Flood: I can speak specifically to the research institutes within my collective. They are associated with the universities in their areas.

The Women's Health Research Institute in B.C., the Women and Children's Health Research Institute in Alberta, the Women's College Hospital Foundation, the MUHC in Montreal and, now, the IWK in the Maritimes all have projects on menopause and how it's linked specifically, through hormonal transition, to other major areas of burden, such as cardiovascular disease, brain and mental health disorders and other chronic disorders that arise as a result of that hormonal transition.

The affiliated universities are University of Alberta, University of Toronto, University of B.C., McGill University and two universities on the east coast.

● (1625)

Laila Goodridge: Thank you.

Ms. Heale, are there any tools available to diagnose whether someone is in perimenopause, and what do they look like?

Roberta Heale: Yes, there definitely are.

The Canadian Menopause Society and their members have worked to put together algorithms and treatment options for health care providers. There's one in particular I can think of. MQ6 has a link for women for information.

These are great resources but sort of fledgling and not across the board in terms of accessibility or usability for health care providers.

Laila Goodridge: I'm not sure if this would be better directed to Ms. Flood or to you, Ms. Heale. If a woman is thinking they may be in perimenopause, what should their next step be? What should they do?

Roberta Heale: I would suggest that they see their health care provider, but I think, unfortunately, many health care providers don't have the knowledge base, and women are turned away. They don't understand the symptoms and most often will go to social media.

That's been my experience. The amount of misinformation women have is phenomenal. They seek help in other places.

Laila Goodridge: Ms. Flood, do you have anything to add?

Amy Flood: I would concur. I think the lack of research is contributing to the lack of knowledge.

Also, there is no constant state for hormones, so you can't benchmark where a hormone level is to understand whether you're entering or exiting perimenopause or menopause. All you can do is correlate the level of symptomology to...and deduce where you are at and where you are predicted to go based on age and your cycle.

There is very much a lack of training, knowledge and education. Research is the number one port of call.

The Vice-Chair (Marilyn Gladu): Thank you.

Now we'll go to Madam Ménard for five minutes.

[*Translation*]

Marie-Gabrielle Ménard (Hochelaga—Rosemont-Est, Lib.): Thank you, Madam Chair.

Ladies, your testimony is so enlightening. We're taking notes at lightning speed. Please know that you're speaking to a captivated and passionate audience.

We're focusing here on perimenopause and menopause. We know these are two chapters in the lives of girls and women. Girls, starting as young as eight or nine years old now, go through experiences and physical symptoms that will eventually change. We've discussed pregnancy, motherhood, perimenopause and menopause.

We fully understood that physiological changes in women are often misunderstood. However, we're here at the federal level, and we're trying to adopt the best possible practices while respecting jurisdictional boundaries.

Do you think awareness campaigns to demystify these issues would be a worthwhile approach?

As you have all said, people don't talk about menopause. If we expect employers to lend a hand, we may need to take some preliminary steps first.

Would an awareness campaign by the federal government—through the Department of Health, for example, but perhaps also through other channels—be a worthwhile approach?

We're going to try to explore all possibilities as part of this study.

What are we doing about recognition, understanding and awareness? Not only is there still a stigma, but, as you said, there are also brain fog and mood changes. Here, we are women, and I think we all immediately associated these physical symptoms, which we still must contend with today, with some very crude jokes.

So I'd like you to tell us about the role of raising awareness. I'll start with you, Ms. Heale.

[*English*]

Roberta Heale: It's hugely important to have the Government of Canada promote evidence-based information. It can be done in a very collegial way, but also in a way that people will accept, understand and trust.

The women I see are feeling terrible, and they don't know what to believe. If there's something that comes from a government campaign or a public health campaign, I think that would go a long way to help support knowledge not only for the women themselves, but also for their families and the workplaces. There could be a several-pronged approach to do that.

● (1630)

[*Translation*]

Marie-Gabrielle Ménard: Thank you very much.

I would be curious to hear from the other witnesses, if they'd like to add their thoughts.

Ms. Flood, what can you add about this idea of conducting awareness campaigns and improving people's understanding of perimenopause and menopause?

[*English*]

Amy Flood: Yes, I 100% agree. I think that campaigns are necessary, evidence-based campaigns, because there is a lot of misinformation out there for women. They are turning to social media, and, nine times out of 10, that social media is ending in, “Click here. Buy this.” They're not legitimate resources, and they're not being promoted for the right reasons.

I think that a lot of the symptoms themselves are trivialized and misunderstood. You talk about it at a party, and men think, “What's so wrong with a hot flash? You get hot.” A hot flash is not a hot flash. It's a mini panic attack. Your heart is palpitating, and you start to sweat and to lose focus, while you're trying to maintain a business presentation, coach your child's rugby game or what have you.

There needs to be evidence-based information for women. There also needs to be emotion-based information for women's allies. Their husbands, brothers, partners need to know what they're going through, and it needs to be rooted in real cause and real fact.

I want to touch on what you just said about the younger girls. There are far more issues correlated to hormones, like polycystic ovarian syndrome, endometriosis, fibroids and chronic pelvic pain. If young girls knew more about their hormonal journey, they would be able to advocate for themselves, and they would get diagnosed sooner. The larger issues around fertility, and even magnifying the impact of perimenopause and menopause over your lifespan, can be prevented. This hormonal journey is so necessary and critical for more people to understand.

[*Translation*]

Marie-Gabrielle Ménard: It's cruel, but I'm out of time. However, what I'm hearing is that women are conditioned to function through pain and cope with challenges. I hope that here, we'll be able to change that.

[*English*]

The Vice-Chair (Marilyn Gladu): I'm so sorry. That's the end of your time.

[*Translation*]

Ms. Larouche, you have the floor for two and a half minutes.

Andréanne Larouche: Thank you, Madam Chair.

Ladies, if I'm not mistaken, I'll be the one to wrap up this truly fascinating hour with you. Thank you very much.

I like to make broader connections with other topics that I've previously studied. I'm going to pick up on what was said in the previous round. The Standing Committee on Health has already done a study on women's health. We found that there were indeed repercussions related to menstruation among young girls from a young age. Sometimes they have to stop what they're doing. Later in life, it's often postpartum depression that affects them.

Here again, these subjects are not discussed. A young girl can't tell her school that she had to stay home because she was in too much pain from her period. A woman can't talk about her postpartum depression either. It's not well known. Women don't talk about their menopause symptoms. More broadly, there's a gap in understanding, a taboo, and the consequences are very real. They even affect research on women's health, which is certainly insufficient.

In order to have better treatments and meaningful discussions in doctors' offices, studies have to be done and proper attention has to be paid to women's health issues, which are somewhat sidelined and considered taboo.

I see some nods. Ms. Alon-Shenker, what do you think it would take? We were talking about awareness in the previous round.

Personally, I'd like to talk about more concrete things, such as health research, which helps us find treatments and take care of women's health.

[*English*]

Pnina Alon-Shenker: I think that research and awareness come together. The research will provide you with the information to inform all of the other initiatives, starting with the campaign and moving on to legislation and other regulatory measures.

Research will provide you more evidence-based information about where we're lacking and the economic and social costs of menopausal workers leaving the workforce prematurely. This is not an individual, personal problem. It's a societal, economic issue, and this is why I think that, once—

● (1635)

The Vice-Chair (Marilyn Gladu): I'm sorry. That's the end of the time that we have today for the panel, but if you have comments that you'd like to send to the clerk, that would be great.

I want to thank all of our witnesses for their excellent commentary today.

At this point, I'm going to suspend so that we can change panels and vote.

● (1635)

(Pause)

● (1650)

The Vice-Chair (Marilyn Gladu): We are back.

I want to welcome our witnesses for the second panel.

For the benefit of those who are new, if you want to check the interpretation that you have, English, French or the floor, whichever you want to hear the questions in, that would be good. All questions will come through the chair.

Let me introduce our witnesses. We have, as an individual, Julie Drapeau, senior vice-president, sales and marketing, of Purity Life Health Products LP. We have Dr. Colleen Norris, the Cavarzan chair in women's health research at Edmonton Women's Health Research. We have Aimee Debow, the founder of Menovate.

We welcome all of you. You each will have five minutes for your opening statements.

Dr. Norris, you can begin for five minutes.

Colleen Norris (Cavarzan Chair in Women's Health Research, Edmonton Women's Health Research): Thank you very much, Madam Chair and members of the committee, for the opportunity to speak today.

My name is Dr. Colleen Norris. I'm a professor and associate dean of research at the Faculty of Nursing at the University of Alberta and the Cavarzan chair in women's health research. I lead research focused on women's health, women's cardiovascular health and the reproductive transition.

I'm here today because Canada has an opportunity to correct a major gap in women's health care that has persisted for nearly two decades. Two generations of women have been denied appropriate care during the reproductive transition due to the combined effect of the misinterpretation of the women's health initiative and a long-standing failure to recognize the critical role that estrogen plays in women's lifelong health. As a result, the menopausal transition has been treated as an isolated reproductive event rather than what it truly is, a whole-body biological transition.

When estrogen declines, the effects extend far beyond hot flashes. Vascular function changes. Bone loss accelerates. Sleep becomes disrupted. Metabolic risks increase. Mood and cognition are affected. These changes influence not only quality of life but also long-term risk for cardiovascular disease, osteoporosis, diabetes, emotional and psychological distress, cognitive changes and reduced workforce participation with increased health care utilization.

The timing of this transition matters. Women experience these changes during what is often the most demanding time in their lives. Between the ages of 40 and 55, many are contributing at the highest levels of the workforce, while at the same time caring for children, supporting aging parents and serving as leaders in their communities, yet access to care remains fragmented and inequitable.

In Alberta alone, an estimated 300,000 women aged 35 to 55 do not have access to a primary care provider. Across Canada, women increasingly face long wait times and limited access to menopause expertise. This has contributed to the rapid growth of private menopause clinics, effectively creating a two-tiered system in which women with financial means can access specialized care and others cannot.

The consequences extend far beyond individual women. Recent economic analysis estimates that closing the women's health gap could create a $37-billion opportunity for Canadians through improved workforce participation, productivity and reduced health care costs.

The good news is the solutions already exist.

With support from the Alberta primary care innovation fund, we've developed a Cycles to Cessation Clinic, one of Canada's first publicly funded, nurse practitioner-led virtual clinics specializing in the care of women in reproductive transition. The model provides comprehensive assessment, evidence-based treatment, longitudinal follow-up and evaluation of cardiovascular, metabolic, skeletal, mental and reproductive health. Early implementation has demonstrated rapid uptake, high patient satisfaction and significant unmet demand and meaningful symptom improvement. Importantly, it demonstrates that accessible publicly funded virtual primary care for mid-life women is both feasible and scalable.

My message to this committee is simple. Menopause is one day in a woman's life, defined as 12 months without a menstrual period. The reproductive transition is a decade or more. It represents one of the most important opportunities for prevention in women's health. For decades, women's biological realities during the reproductive aging have been minimized, misunderstood or ignored.

The ovaries are not simply reproductive organs. From puberty through menopausal transition, they serve as the architects of women's health, influencing virtually every major physiological system through the production of estrogen.

If Canada is serious about strengthening workforce participation, improving population health and reducing health care costs, we have to invest in evidence-based, publicly funded models of care that recognize the reproductive transition as a critical life stage in health rather than a niche reproductive concern.

Furthermore, when we provide women with the care they need during this critical transition, we can help them remain healthy, productive and thriving while strengthening families, communities, workplaces and the Canadian economy.

Thank you so much.

● (1655)

The Vice-Chair (Marilyn Gladu): Thank you very much.

Now we'll go to Ms. Drapeau.

The floor is yours for five minutes.

Julie Drapeau (Senior Vice President, Sales and Marketing, Purity Life Health Products LP, As an Individual): Thank you, Madam Chair and members of the committee.

My name is Julie Drapeau, and I'm the senior vice-president of sales and marketing at Purity Life Health Products, which is Canada's leading distributor of natural health products. We supply more than 30,000 products from over 1,000 brands to more than 7,000 retail locations across the country. We employ hundreds of Canadians, including 181 women, and support retailers, health care brands and consumers nationwide.

I'm also a woman with lived experience of perimenopause. We utilize conventional natural health products and private care. I'm here today, both as a business leader responsible for supporting a large, female workforce and as someone with lived experience.

Women in perimenopause and menopause are often at the peak of their careers. They are leading teams, managing businesses, mentoring future leaders and making a significant contribution to Canada's economy, yet many are silently struggling with symptoms that affect their sleep, cognition, energy, confidence and overall well-being. This is not simply a women's health issue. It is a workforce issue, a leadership issue and an economic issue. When women leave the workforce early, reduce their hours or take a step back from leadership opportunities due to unmanaged symptoms, employers lose experienced talent and Canada loses valuable economic contributions.

I believe there is an opportunity for Canada to lead by improving awareness and providing workplace support, manager education and access to evidence-based treatment and/or natural solutions so that women can continue to thrive and contribute to their careers.

I look forward to your questions today.

Thank you.

The Vice-Chair (Marilyn Gladu): Thank you very much.

Ms. Debow, now you have the floor for five minutes.

Aimee Debow (Founder, Menovate): Thank you, and good afternoon, Chair and members of the committee. My name is Aimee Debow, and I'm the founder of Menovate, a Canadian company that guides corporations to be menopause-inclusive through talks and e-learning courses. Thank you for undertaking this important study.

I spent more than 26 years in the corporate world. In all those years, I never once heard the word “menopause”, not once. Then I experienced perimenopause. Women spend over one-third of their lives in this menopause transition, and most of us enter it without knowing what it is, what symptoms to expect or where to seek help. I was no different—hot flashes, heart palpitations, two frozen shoulders, sleep disruption and severe brain fog, all while trying to carry a heavy corporate job. I watched as other women silently stepped back from leadership opportunities while others left the workforce entirely, not because they lacked any talent or ambition but because the workplace was just not designed to support them. That realization changed my career trajectory. That's why I founded Menovate.

Through my lived experience and my work with employers, I have heard from thousands of women across industries and levels of seniority. The challenges they describe are remarkably similar, and the support is just not there. Research shows that 10% of women are leaving their jobs because of menopause symptoms. Think about what that means—experienced employees leaving at the peak of their careers, like I did, taking decades of knowledge and leadership with them. This is not only a health issue; it's a workforce issue, a productivity issue, a financial security issue and an economic issue.

In recent years, more women are talking about menopause, more health care professionals are developing expertise, and media coverage has grown, but the efforts remain in their infancy, and Canadian workplaces have not kept up. Managers are rarely trained on how to respond. Most organizations have never had the conversation. While awareness is growing at the employee level, most executive teams still do not recognize menopause as a workplace issue.

I would like to leave this committee with four recommendations.

First, I recommend establishing minimum workplace standards for menopause awareness and education. Like workforce harassment prevention programs, organizations must be expected to provide menopause training for employees, managers and leaders. This should include topics like relevant symptoms, coping skills and how to have a conversation with your employer.

This cannot be just a one-session checkbox. The stigma around menopause has been built over decades. Meaningful change is going to take time. That also means bringing men into the room. Inclusion builds the culture where women feel safe enough to ask for what they need, get supportive responses and feel healthy enough to stay.

Second, every organization should have a formal menopause policy so support is consistent rather than manager dependent. This could include flexible work options, temperature control and break flexibility.

The third is meaningful access to care. Menopause care should become a routine component of primary care, reducing the need for women to navigate a multitude of providers before they receive an evidence-based treatment. I saw a multitude of doctors over many years before I received an accurate diagnosis. I had the luxury of seeing both OHIP-covered and private doctors. Many women cannot afford this. I have enormous respect for the private clinics doing the work, but they are filling a gap that should not exist, and it is not equitable.

My final recommendation is for dedicated Canadian research, data collection and national public awareness campaigns similar to initiatives in Australia. Canada does not consistently measure the labour force impact of menopause, and we need national data. By supporting women through menopause, we can help experienced employees remain healthy, productive and fully engaged in their careers.

Now that I've received the treatment I needed, I feel strong, empowered and energized every day to contribute. Every woman should be able to feel this way as they transition through menopause. Canada has the opportunity to be a leader in this space. Menopause is inevitable, but suffering is not, and women shouldn't have to be leaving the workforce.

● (1700)

The great news is that menopause is a solvable workforce challenge facing Canadian employers. Education, manager training, workforce flexibility and access to care can make a meaningful difference.

Thank you. I look forward to your questions.

● (1705)

The Vice-Chair (Marilyn Gladu): Thank you.

We're going to begin our first round of questions with Ms. Goodridge for six minutes.

Laila Goodridge: Thank you to all the witnesses for being here.

This is such an incredibly important topic that is definitely not studied as much as it should be. We heard about that very clearly in the last panel.

I'm going to start with you, Dr. Norris, as you're a fellow Albertan.

Could you describe some of the spectacular work that you guys are doing at the University of Alberta when it comes to this?

Colleen Norris: I was fortunate enough to get what we call the Cavarzan chair in women's health research, and I definitely got into the literature. I had always done women's cardiovascular health and couldn't figure out why we were missing things in women's cardiovascular health. The symptoms are different, and I'd been advocating, and then I got into the perimenopause literature.

One of the things I think is really important for the committee to understand is that we keep referring to menopause and educating women about menopause in the work day.

As I said, menopause is one day of your life, and I think we need to make the paradigm shift that our research has identified to make sure women are aware of what's going on in their bodies and why they need to follow through. If we frame it the same as puberty, we know the changes that occur until a girl gets her period and then what goes on after that. We need to know that as far as perimenopause and menopause is concerned.

One of the things we're in the process of creating is a digital program for women to use called AURA, which stands for awareness and understanding in reproductive aging. We've only been able to do this work thanks to the foundation that has supported us, because I can't get research dollars to do it, but it is—

Laila Goodridge: I want to clarify that. The Government of Canada has tons of money that they spend on research. Are you not able to get research dollars from the Government of Canada to do this incredibly important work?

Colleen Norris: It goes to the Canadian Institutes of Health Research committees, and they just don't see it as a priority issue.

We have only advanced—and we've been so fortunate to advance—because of the foundation for women's research in Edmonton, which is part of the collective that was talked about.

The awareness is such a key piece, so we've created this digital format that women can absolutely all get on and learn. It's about awareness and understanding. That's the key to this, because even with the workforce policies in place, women don't understand what's going on in their bodies. Three colleagues in Calgary—young women who were very productive—ended up getting MRIs, which they could afford to do. They thought they were losing their minds or they had early dementia, and it was the brain fog of perimenopause.

Until you've experienced it, as we were saying, you can't understand it. Women need to know to anticipate it and that this is what's happening.

Laila Goodridge: I'm really curious about the virtual clinic that's available in Alberta.

In our home province of Alberta, we're incredibly lucky to have a spectacular female health minister in Adriana LaGrange, who is really putting women's health out there. We'll be the first province to move to self-referrals at age 40 for mammogram screening.

I was wondering if you could describe what that virtual clinic looks like. If a woman in Alberta was going through this stage of their life, how could they access this virtual clinic?

Colleen Norris: It's called Cycles to Cessation, and if they go on cyclestocessation.ca, they will be able to access the virtual clinic. The biggest issue is it's through primary care, and it provides a 50-minute initial assessment, because in primary care in Alberta right now, you get 10 minutes for your visit and it just isn't enough time to understand what's going on in your body.

The clinic provides that, and then you're given follow-up care. We look at every aspect of a woman's life and what's happening in their metabolic health, in their cardiovascular health and in their brain health. They might end up with a prescription for hormones, but there may be other things that have to be addressed.

We were fortunate enough to get a three-year grant to test the model. We had a soft opening in February of this year. As I said, it's a virtual clinic, so you go online and book your appointment based on criteria. The most interesting thing is that we've seen over 600 women since our soft launch. We're funded for one nurse practitioner. We divided that into two half-time NPs so one could cover the other. That's what it costs for this clinic to be set up.

● (1710)

It's scalable across Canada, because NPs are prepared and ready, willing and able to do this. Right now they're all doing it privately, and we need to move them. This is public health for women in Canada.

Laila Goodridge: It's so incredibly important.

One of the big challenges we see in women's health in general is that it's understudied, underfunded, not understood, and we're supposed to just go and deal with this. Bringing attention to this is so important. Perhaps if you understand what's going on, you won't have to take the time off work because you have the ability to find ways to manage those symptoms or to know that you're not just going crazy and you can find different mitigation systems.

Ms. Debow, you're nodding your head. Do you have anything to add?

Aimee Debow: I suffered all of what you just talked about.

I held an executive role and would be in front of meetings on projects that I knew, lived and breathed, and I could remember nothing when I would go up to present. It was horrifying. I did believe I had dementia. I had all the tests for it. When I would go to a doctor, for years nobody said that it was perimenopause. I did have the MRIs. I had all of the tests. Nobody put all of those pieces together. I did it myself, and I had to go back—

The Vice-Chair (Marilyn Gladu): I'm so sorry, but that's the end of the time. If you have additional comments, of course, you can send written comments to the clerk.

We're going to move to Ms. Nguyen for six minutes.

Chi Nguyen (Spadina—Harbourfront, Lib.): Thank you so much to the witnesses for being here today.

This is such an important study. My colleague just noted how misunderstood it is and mentioned the lack of research we have in the women's health space. This is going back some time ago, but the women's centres of excellence program was a Liberal red book promise in 1993. It established the centres of excellence. We actually have a foundation of doing really important work. It was on pause for some years and has come back now through the women's health research initiative with $20 million over five years. The work continues, and we need more of it to make sure that we understand the implications for women's health.

I think about the evolution of talking about periods in the workplace. We now need to have this conversation about menopause, because women continue to be in the workplace.

I want to thank all of you for the work that you're doing to try and address these pieces.

Ms. Norris, can you talk more about the idea of NPs leading these models? In the first panel, we heard about one that was happening. Where do you think there might be some gains? Are there provinces that are interested in using NPs and funding them publicly in order to meet the demands?

Colleen Norris: There have been changes in the Canada Health Act to make way for NPs to be funded, because if it's care that is offered publicly, then you can't privately charge for that. That's going to affect menopause and perimenopause care in Canada, because the clinics are everywhere. We probably have 15 private clinics in Edmonton alone. The issue is you have to pay, and we are not getting close to getting the population that we're trying to reach as far as this care is concerned.

I think of all of the women who are in the service economy and are going through these symptoms and have no chance of getting any kind of treatment or the care that they deserve. The NPs can provide that care. It's a salary. It's not a fee-for-service model. It's a really simple and economically feasible model. We've set up the online format, and it's secure. I think it's the answer.

Chi Nguyen: Thank you very much, Dr. Norris.

Ms. Debow and Ms. Drapeau, both of you have experience on the HR side and the workplace piece.

Ms. Drapeau, I wonder if you could talk about some of the best practices you're using in your own company.

Ms. Debow, what are some of the leading sectors or industries that are thinking about this and are coming at this in a way that we should be thinking about it?

Julie Drapeau: On our side, we've been very active in the past year because of what I've been through and the fact that I faced a time when I had to play my role because I could not recognize myself anymore. It opened up that discussion with our HR group to start a group called Level-Up at our company and to invest in professionals to come and educate women and men we invite to participate and to educate them about what it is and what's going to happen. Also, it was pretty good to have men there because they could understand not only for the employees around them, but also for their wives at home.

We implemented that because that piece of education—and we've talked about that a lot—is huge. It's important for women themselves to understand what's going on because that education isn't out there. You have to go private most of the time, which I had to do myself. I wanted our employees to benefit from that, because we are building these leaders to replace us someday. We have 30-year-old people coming in, and we want to give them the tools so that when they get to that stage, they're solid, and they know what's going on. We've implemented that.

We also pay for private access for the senior level in our company to give them those tools. In addition, we also provide a service called Maple, where they have access to a doctor online.

Again, the key piece here is education, because you can get access to a doctor, but if they're not understanding or supportive, then that's where we're stuck. That's why I'm here today, to really stress that to you.

Thank you.

● (1715)

Chi Nguyen: Ms. Debow, could you comment very quickly? I know we don't have a lot of time.

Aimee Debow: Yes, I agree that it's education, but it really starts in corporations by talking about it and calling out what is actually happening. Most times when I show up in a company, it is the first time the word “menopause” is being uttered in the company. Just breaking the silence and talking about it helps break the stigma.

There are many things the best-in-class companies are doing. They have chat groups set up internally. They have accommodations that are formalized, putting policies in place and reviewing their benefits to see what benefits actually exist to cover women in menopause. Most of the time, a lot of them are there, but they're just not linked to the fact that they support menopause.

There are so many things that can be done, but honestly, it's about bringing in educators like me. I have these e-learning tools that allow different people in the company to become educated and then start talking about it, especially to have a senior leader stand up and be an advocate, be willing to say, “I've gone through it,” so it's okay for the average employee to then feel comfortable to have that conversation with their boss.

The Vice-Chair (Marilyn Gladu): That's excellent.

[*Translation*]

Ms. Larouche, you have the floor for six minutes.

Andréanne Larouche: Thank you very much for your testimony today, Ms. Drapeau, Ms. Norris and Ms. Debow. I am taking notes and, clearly, we'll need to formulate recommendations based on what you're telling us.

I'd like to start by addressing a very economic—but also concerning—issue. It was mentioned by the previous panel of witnesses: For a variety of reasons, women have to stop working and find it hard to keep up with men's work pace. As a result, the amount a woman can accumulate for her retirement will not be the same. It may be because she has to extend her maternity leave due to postpartum depression. It may be because she is forced to stop working at the beginning of her career due to menstrual pain. It may be because she becomes perimenopausal or menopausal just as she reaches the peak of her career, at the very time she should be earning a high salary in a position she has long coveted and for which she has worked her entire life.

Some women don't make it. People have biases. They don't get the promotions that others are getting, simply because they've reached this stage in their lives. This even has consequences on women's finances and economic empowerment later on when they reach retirement age.

Can you tell us a little more about the impact of all this on the economy and even on women's finances?

I'd like to invite Ms. Debow to go first. Then, Ms. Drapeau and Ms. Norris can add their comments.

[*English*]

Aimee Debow: There are two sides to the economics.

The first, of course, is women leaving, quitting. They are also taking time off work or they're stepping down. They'll take part-time work. There is 100% an economic impact to the female and their future. That's what I talked about, their long-term financial viability.

The second side to it is the corporations. Amy Flood talked about this a little bit earlier. Women are leaving their jobs. Think about what happens when a woman leaves her job. It then has to be posted. It has to be backfilled. They have to pay to replace them. Their teams are disrupted. There is a huge cost when a woman leaves and has to be replaced.

Many women going through perimenopause, like me, and menopause take sick leave. I took multitudes of sick leave because of it. There's that cost as well. There's also the productivity impact.

If companies would be willing to support women and get them that access, as we just heard, that some companies are willing to pay for so that women can get care, it would actually be so much cheaper. They're going to pay to support their women to get the care, and they then have this amazingly productive woman who's not taking sick leave and not leaving in the midst of her career and at the height of her contribution. Menopause is a very double-edged sword.

● (1720)

[*Translation*]

Andréanne Larouche: Ms. Drapeau, would you like to add anything, particularly about the fact that we keep hearing that senior women are often in financially precarious situations?

[*English*]

Julie Drapeau: We definitely experience that in our workforce.

In the previous panel, some big numbers were mentioned. To state them and bring them back here, the Menopause Foundation of Canada estimates that menopause costs the Canadian economy approximately $3.5 billion annually, which includes $237 million in employer productivity losses.

To answer your question, on the women's side, if women who go into retirement can't continue with the level of revenue they had, they're dependent on the system. Again, they're still in need of care and they can't get that care. They're rolling into government support, while if they were helped right out of the gate, they would not rely only on the government but would be flourishing and helping the younger generation grow and continuing their leadership in replacing them. That's where we see it.

Colleen Norris: Can I respond?

One of the groundbreaking things I found out when I was looking through the literature on this and trying to understand it myself is that in this age, in perimenopause, your eggs and your follicles start decreasing in your late thirties. That's when the estrogen levels actually start changing. You'll have spikes and peaks and valleys. It's these spikes and valleys that cause all of these symptoms.

Another thing I read that just blew me away was that, as we said, it is the most stressful time of a woman's life. They're managing everything at the same time. Your brain prioritizes the production of cortisol over estrogen. At the same time that your levels are doing crazy things, you're also producing lots of cortisol, which means that you're under stress, which everyone is in this world.

It's understanding that. The women need to understand that. Part of our treatment is figuring out how to turn off your sympathetic nervous system so that you're not under stress all the time. There are really good methods to do that and there's evidence behind it, but women just don't even know about it.

The Vice-Chair (Marilyn Gladu): Thank you so much. Unfortunately, that's the end of our time for today.

I apologize to the witnesses for the delay because of the votes. If you have something else that you want to add, please send the written response to the clerk.

Go ahead, Madam Larouche.

[*Translation*]

Andréanne Larouche: It's 5:24 p.m., Madam Chair. We said we would end the meeting at 5:30 p.m. Could we each ask one last question?

[*English*]

The Vice-Chair (Marilyn Gladu): There's some committee business to address here.

You may have seen the budget which was circulated. We added a day to the shelter study. The estimate of $2,000 for the budget was sent around. Do I have the support of the committee to approve that budget?

Some hon. members: Agreed.

The Chair: All right. That's approved. At this point, I think that's everything.

I know people have planes to catch, but thank you again to the witnesses.

I will now adjourn.