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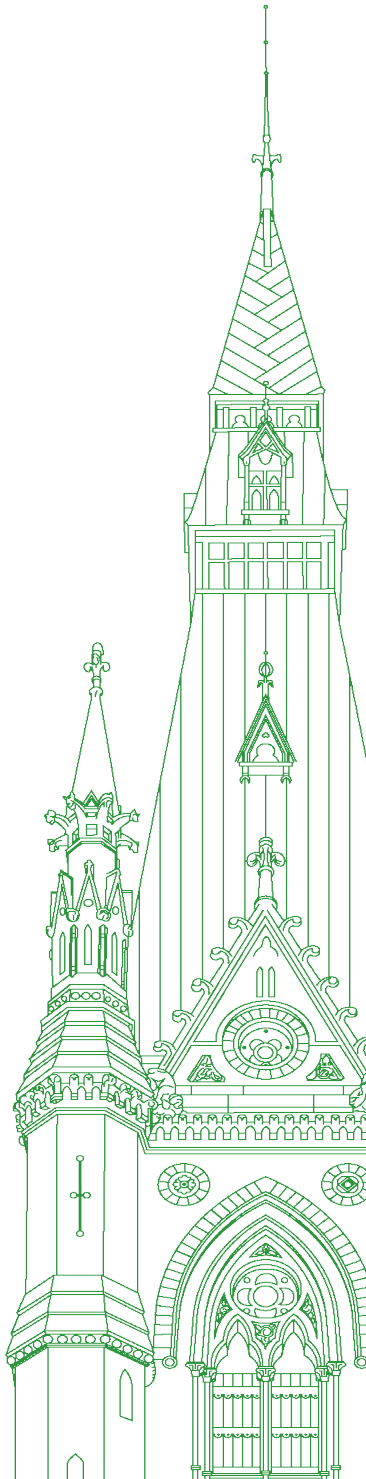

Chair: Dominique Vien

Standing Committee on the Status of Women

Tuesday, June 16, 2026

● (1100)

[*Translation*]

The Chair (Dominique Vien (Bellechasse—Les Etchemins—Lévis, CPC)): I call this meeting to order.

Welcome to meeting number 47 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, 2026, the committee will resume its study of labour force impacts of menopause and perimenopause.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. Members are attending in person in the room and remotely using the Zoom application. I would like to make a few comments for the benefit of members and witnesses.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike and please mute yourself when you are not speaking.

If you wish to speak, please raise your hand. For those on Zoom, please use the raise hand function.

For those on Zoom, at the bottom of your screen you can select the appropriate channel for interpretation: either floor, English or French. For those in the room, you can use the earpiece and select the desired channel. I would like to remind witnesses that committee members may ask questions in either French or English. If you will need interpretation, please take a moment now to prepare your earpiece and select the listening channel required in order to take full advantage of the time allotted for questions and answers.

A reminder that all comments should be addressed through the chair; however, as I always say, in order not to disrupt the flow of the discussion between members and witnesses, I intervene very rarely.

Now I'd like to welcome our witnesses.

I am pleased to welcome Dr. Sylvie Demers, family physician, appearing as an individual.

I am also pleased to welcome Dr. Shawna O'Hearn, director of the Menopause Society of Nova Scotia.

Welcome to both of you. We will start with your opening remarks.

Dr. Demers, please go ahead. You have five minutes.

Sylvie Demers (Family Physician, As an Individual): Thank you, Madam Chair.

I would like to begin by thanking the Standing Committee on the Status of Women for inviting me to participate in this study.

I've been a family physician since 1998. I'm also a biologist with a Ph.D. in experimental medicine. In January 2005, I founded a clinic specializing in hormone therapy for women, men and transgender individuals. I'm likely one of the Canadian physicians who has treated the largest number of women for issues related to premenopause, perimenopause and menopause. For the past 25 years, I have been advocating for women's access to safe and effective hormone therapy—specifically, a regimen consisting of 17β-estradiol in the form of a transdermal gel and progesterone, commonly known as "bioidentical hormone therapy for women".

I have authored four books and hundreds of scientific articles published by Les Éditions de l'Homme, including the bestseller *Hormones au féminin: Repensez votre santé*. I have also analyzed in detail the links between female hormones and vitamin D, cholesterol, cardiovascular disease and breast cancer. I was a medical expert in the acclaimed documentary *Loto-Méno*. Since May, *Loto-Méno* has helped provide Quebec women with unrestricted coverage of transdermal 17β-estradiol, or Estrogel, and micronate oral progesterone.

What struck me the most about women in perimenopause and menopause is the trivialization of their suffering. Yet the signs and symptoms of perimenopause and menopause, due in large part to the shortage of estradiol and progesterone, affect every system in the body. They are not limited to hot flashes, which affect about 80% of women. Unlike hot flashes, which may decrease or even stop over time, many consequences of a female hormone deficiency will all too often worsen: joint or muscle problems, osteoporosis, atherosclerosis, heart attack, heart palpitations, metabolic changes, genitourinary syndrome, sleep disorders, fatigue, anxiety and depression, as well as digestive disorders, to name just a few.

For many women, the lack of treatment results in time off work due to exhaustion or chronic pain. Financial insecurity then becomes the reality for many women. Female hormone therapy is recognized as the most effective treatment. It can be bioidentical or non-bioidentical.

Unfortunately, due to some confusion between these two types of hormone therapy by the Society of Obstetricians and Gynaecologists of Canada, or SOGC, access to hormone therapy remains very limited. First, the scientifically proven risks of hormone therapy are associated with oral or non-bioidentical estrogens and, above all, with progestins, not with transdermal 17β-estradiol combined with progesterone, which is known as bioidentical hormone therapy. In addition, with few exceptions, the SOGC advises against prescribing hormone therapy for preventive purposes alone, which deprives many women of preventive medicine.

In addition, the premenopausal period, when menstrual cycles are still regular, is not recognized. Yet this is a crucial period that can last more than a decade, during which women begin to be overdiagnosed, overmedicated, over-referred to mental health services and placed on disability. Contrary to popular belief, menopause doesn't last just one day. The premenopausal, perimenopausal and menopausal periods together account for about half of women's life expectancy.

It should be noted that estradiol and transdermal 17β-estradiol hormone therapy combined with progesterone is the only type of hormone therapy that can be calibrated, which makes it possible to maximize its many benefits and reduce its risks. How I treat women is increasingly recognized by many colleagues I have trained, and it is in high demand, even sought after, by women. My experience shows that, when properly prescribed, hormone therapy helps women stay in the workplace longer.

● (1105)

The Chair: Dr. Demers, unfortunately, the time is up.

You will certainly have the opportunity, along with colleagues, to finish your opening remarks.

Dr. O'Hearn, you have the floor.

[*English*]

You have the floor for five minutes.

Shawna O'Hearn (Director, Menopause Society of Nova Scotia): Thank you, Madam Chair, and members of the committee, for the opportunity to speak on this important topic today.

I appear today at the intersection of health, education and workplace leadership and as the co-founder and director of the Menopause Society of Nova Scotia. Through that work, we've focused on raising awareness, leading the annual Atlantic Menopause Show and advocating with the Nova Scotia government to establish a menopause centre of excellence.

At Dalhousie University, we've advanced workplace leadership through support groups, conferences, staff training and by partnering in the “Menopause Works Here" initiative through the Menopause Society of Nova Scotia.

Much of the discussion around menopause has appropriately focused on the medical lens and on treatment options and that remains critical. At the same time, menopause is not experienced only as a clinical issue; it also has biosocial and cultural dimensions that shape how people experience symptoms, seek support and remain engaged at work. That is why a holistic approach is essential. We need all voices, all types of work and all workers.

Menopause does not affect only office-based professionals. It affects people in all sectors including health care, education, trades, manufacturing, as well as shift workers, caregivers, part-time workers and people in precarious employment. A truly inclusive response must reflect that diversity.

Menopause is a natural life stage, but for many it brings symptoms that affect work. For some, the impact is minimal, for others, it affects attendance, performance, confidence and career progression. Because menopause is surrounded by stigma and silence, many employees struggle privately rather than asking for support. Workplace solutions can be straightforward, effective and low cost. Employers can offer flexibility for medical appointments and improve access to rest areas. They can train managers to respond respectfully and without embarrassment. They can review policies on sick leave, accommodations and shift work so that menopause is part of workforce planning. When workplaces are menopause inclusive, people stay healthier, stay employed and stay productive. Supportive workplaces reduce unnecessary strain and help retain skilled workers at a time when organizations are struggling to recruit and keep experienced staff.

This is not only about compassion. It is also about workforce sustainability, equity and sound organizational practice. We need inclusive menopause policy in language and practice, honouring trans, non-binary and intersex experiences and ensuring that indigenous, Black and racialized voices lead culturally safe solutions. I urge the committee to recommend a national research strategy on menopause. This is especially important given that Canadian research funding allocated to women's health remains only at 7%. We still have major evidence gaps on prevalence, workplace impact, accommodations, treatment access and the experience of diverse populations. A federal strategy could help close those gaps and ensure menopause is studied as a medical, workforce, equity and social policy issue.

My call to action is for Canada to move forward on three fronts: public education, workplace action and research. We need a national framework for menopause-inclusive workplaces and a coordinated research strategy that reflects the federal government's role in advancing education, advancing evidence, building knowledge and supporting innovation. Together, these steps would ensure that menopause is addressed as a serious public issue affecting health, work and economic participation. Canada has the expertise and the leadership to reduce stigma around menopause in the workplace. What we lack is the evidence.

The federal government is uniquely positioned to lead: setting national standards, funding research and equipping employers with tools and guidance. We need a holistic approach to menopause in the workplace. With action we can retain experienced workers, advance equity and build workplaces where people thrive from entry all the way through to retirement.

Thank you so much. I'm looking forward to the discussion and questions.

● (1110)

[*Translation*]

The Chair: Thank you both for your opening remarks and for sharing your thoughts with us.

We will begin the question period with the members of Parliament, more specifically with our colleague Mrs. Goodridge.

Mrs. Goodridge, you have the floor for six minutes.

Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Madam Chair.

Thank you to the witnesses for being here today.

Dr. Demers, I'll start with you.

If someone with perimenopausal symptoms comes to your clinic, what are the first steps you take? What do you do?

Sylvie Demers: A family doctor must always take a complete medical history. All aspects must be considered. Whether we're talking about premenopause, perimenopause or menopause, it affects all systems.

When a woman has muscle pain, it can be hormonal, non-hormonal or a combination of both. First, a differential diagnosis must be made. If the diagnosis is perimenopause, for example, the treatment I use is bioidentical hormone therapy. It's that simple.

Laila Goodridge: If I understand correctly, in Quebec, bioidentical hormone therapy is free.

Sylvie Demers: Yes.

Laila Goodridge: Are there other provinces in Canada that have a similar policy?

Sylvie Demers: I'm not sure enough to answer your question. I think that's the case in some places. I'm not the best person to answer your question.

Laila Goodridge: I understand.

I know that people who choose hormone therapy often have questions about the impact it could have. I'm thinking of breast cancer, for example.

Does research show that there are any repercussions?

Sylvie Demers: That's the big question. The issue of contraindications is a very important one. As I explained in my remarks, there are a lot of contraindications when it comes to hormone therapy. One of my struggles is to say that there are also many consequences to not taking hormones. By the way, I'm not advocating for women who don't want to take hormones. That's their choice, and I respect it deeply. I am not advocating for women who want to take them, but for those who are denied a prescription.

In my book *Hormones au féminin: repensez votre santé*, I talk about breast cancer, among other things. As you can well imagine, after the book was published, I saw many women who had had breast cancer and were being denied hormones. Personally, I prescribed them to these women.

My mission is very much to debunk all the myths and medical dogmas surrounding contraindications associated with hormone therapy that uses hormones different from those our bodies produce.

● (1115)

Laila Goodridge: Thank you very much.

[*English*]

Dr. O'Hearn, what does it look like for a patient in Nova Scotia if you were trying to prescribe something like a hormonal replacement therapy?

Shawna O'Hearn: I'm not a physician. I just want to emphasize that.

Laila Goodridge: I'm sorry.

Shawna O'Hearn: The conversations would be very similar to Dr. Demers' comments. You would have a discussion with your family physician and be able to find the best path for yourself.

Laila Goodridge: What is the research showing when it comes to interactions? How do women go about getting support for perimenopause and menopause? This isn't something that's often talked about in society.

Shawna O'Hearn: I think that the first point would be that it's an area that we know is under-studied, under-researched and not talked about a lot. I'm an occupational therapist, and I think Dr. Demers can speak to the experience in the family physician world.

There is limited training for our health care providers on menopause. We're doing a lot of studies on that now to understand what is being taught, where the gaps are and how we start to fill those gaps.

[*Translation*]

Laila Goodridge: Dr. Demers, I know that very few family doctors are women. Personally, I've never had a female doctor.

Do you think that, as a woman, you have the opportunity to offer a different perspective on this and to promote the benefits of treatment for perimenopause and menopause?

Sylvie Demers: I think there are a great many female doctors in Quebec. In fact, they make up the vast majority in the new Quebec cohorts. Personally, I teach a lot of women who want to become family physicians or nurse practitioners. What's happening right now in Quebec is really quite incredible.

I have to say that it's the same worldwide, not just in the U.K. We saw this last year at a meeting of the expert panel of the U.S. Food and Drug Administration, or FDA. There were about 10 experts in hormone therapy from various disciplines. They included orthopaedic surgeons, internists, cardiologists, gynecologists and urologists. They said that the situation was based more on medical dogma than evidence. Women were truly frightened by the misinterpretation of the Women's Health Initiative study, which, incidentally, is an excellent study.

The problem isn't the study itself, it's that it was overinterpreted or misinterpreted, which had disastrous consequences for women. We witnessed a kind of spectacular regression of women's rights.

The Chair: Thank you, Dr. Demers.

Mrs. Goodridge, thank you for that exchange.

Dr. Demers, you will certainly have the opportunity to talk about this study again with the next member who will speak or with another member.

Ms. Tesser Derksen, the floor is yours for six minutes.

[*English*]

Kristina Tesser Derksen (Milton East—Halton Hills South, Lib.): Thank you so much, Madam Chair.

Thanks so much for being here today.

I'm a newish member to this committee and a woman of a certain age as well, so I'm really pleased to be talking about this. I remember when my mother went through menopause, and we were really mystified by the symptoms and the changes in her personality. She was a professional nurse, so it was something that affected not only the family life at home but also her work as well. I really appreciate having this discussion.

My first question is for Dr. O'Hearn. I want to talk a bit about what's going on in the workplace. I'm going to reference a statistic from the Menopause Foundation of Canada, which found that 67% of working women would not feel comfortable speaking to a supervisor about menopause symptoms, even though 32% say these symptoms have negatively affected their workplace performance.

We had a witness here last week who talked about what she experienced as an executive woman working in a corporate environment when she was going through menopause. I think the question that arose for me was about workplace culture and what's happening in the workplace, maybe not so much from a policy perspective, because a workplace may have all the policies in place, but in terms of the culture within the workplace that's informing how managers respond and how employees feel about going to their managers.

With that in mind, I'd like to hear a bit about what your research and experience have shown with respect to workplace culture.

● (1120)

Shawna O'Hearn: Thank you so much.

That's a really important question, and it gets to some of the really critical points about the workplace.

In my own research, the data is very similar. I looked across health professionals, and it's very similar. One of the biggest pieces is around the training element. If we're going to be creating menopause-inclusive workplaces, we need to provide the training for our managers. They are the front line. They are the ones who are taking all of the information. We need to make it easier for them.

Looking at the example I used in my opening remarks, at Dalhousie University, we are doing some of that training. Training shouldn't just be for our female employees; it needs to be for everyone, for our male employees and our younger employees as well. We need to have allies within the workplace as well as those who are going through the journey, so training is critical.

The other piece is in providing those support networks. The evidence shows us how important support groups are within the workplace so you don't feel alone. You feel that you are validated when you can share your experiences. I hear that over and over again from participants in our support group and ones that I've led nationally as well. To be able to share an experience has been critical.

The third thing, and this may come up later as well, is around benefits. The evidence shows that in many of our workplaces, one in four of our employees do not know what their benefits are. If you don't know what your benefits are, how can you then access them? Those who know they have benefits don't know what it means from a menopause perspective. Back to the training, our managers really need to have training, not just on menopause but on the supports within our workplace so that we know where there are gaps and where we need to advocate for some of those changes as well.

Kristina Tesser Derksen: Thank you.

Considering that some of those initiatives are going to be more in the jurisdiction of a province, can you talk to us about your experience regionally across Canada? Have you seen patterns province to province, region to region, urban versus rural?

Shawna O'Hearn: There is work happening at the provincial government level, across many of the jurisdictions, trying to understand what this even means, bringing it up, trying to remove the silence and the stigma attached to menopause in the workplace. They are starting with the conversation, opening the door, making sure there is a discussion taking place.

Many of the jurisdictions are recognizing that there's not one answer. This is going to take a multipronged approach, which takes time. It's going to take a co-creation model with our employees. Opening that door, putting resources in place, is really important.

One last piece to that is on the leadership that takes place in the workplace. Many of the people who are taking on that role are doing it as volunteers. Who are those volunteers? They typically are women. It becomes invisible labour within the workforce. Not only do we need to bring the conversation forward, but we need to acknowledge it and make sure that it's recognized and valued and that they are supported in that place so it doesn't become an additional workload for employees, particularly female employees.

Kristina Tesser Derksen: Thank you.

You've also mentioned several times, and so has Dr. Demers, the lack of information to inform policies and best practice. It's really a question about data collection and how we're interpreting that data. Because data is really where we start and where we identify those problems, that's how we determine how it's going to affect people. Is that right?

Could you comment on the state of data collection from a national perspective? Either one of you can speak to that.

Would you like to answer that, Dr. Demers?

● (1125)

[*Translation*]

Sylvie Demers: Actually, what I'm about to say might sound a little strange, but I think there's actually quite a bit of data out there. You just have to look for it.

The Chair: Excuse me, Dr. Demers, it always seems to fall on you. The time is up. Don't take it personally.

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

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

I wanted to ask you some more questions.

First of all, thank you very much to Dr. Demers and Dr. O'Hearn for being with us today.

I'll start with you, Dr. Demers.

Dr. Demers, it's interesting to hear you say that, because we get the impression that there's a lack of data. In fact, that's what we sometimes hear.

You're saying that's not the problem. In your opinion, the data exists, but we have to look for it.

I'll let you finish your answer.

Where can we find the data?

Sylvie Demers: In fact, when I wrote about female hormones, I thought there wasn't much data. I was surprised to find that a lot of researchers are working behind the scenes. I'm speaking from a medical perspective, not in terms of financial data, among other things. I'm speaking from a medical perspective.

Of course, that's my point of view. I find there's a lot of data. That's why I've written four books. There are hundreds of scientific references. Before reinventing the wheel, we need to look at what researchers have observed over the past several decades. There's actually quite a lot of information. So we start from there and go further. I'm surprised to see that there's actually quite a lot of it.

Obviously, I think one of the most important points is to shift our perspective a bit on premenopause, perimenopause and menopause. We have to look at this from another angle, because it affects every system in the body.

So this requires a commitment. I believe we need to invest heavily in primary care, in other words, family physicians and nurse practitioners, whether through research funding or based on current developments. Often, this has been done in a somewhat piecemeal fashion, but when we put it all together, I think we get a very different perspective.

Andréanne Larouche: Okay.

As I understand it, you're saying that it's not the lack of data that's the problem, but rather trying to compile it all to get a better—

Sylvie Demers: We all agree that it's always nice to have more data. I think there's already a lot on the medical side, maybe not on the—

Andréanne Larouche: Could you tell me where the problem lies? Is it due to a lack of information?

Sylvie Demers: I'll give you my point of view based on what I have seen.

I would say there are three main reasons. The first has to do with how the medical field works. When people make recommendations, they're working in a very isolated way.

Many women's health issues have been grouped together in gynecology and obstetrics, which was entirely justified because it was thought that female hormones were linked solely to reproduction. That means that recommendations will be made mostly, but not exclusively, by obstetricians and gynecologists. They're excellent. That isn't the problem. They're essential, and they need to be part of the discussion, if you will.

However, there isn't the view that knowledge needs to be integrated. The problem is the integration of knowledge. It needs to be integrated, because a lot of researchers have looked at female hormones: cardiologists, neurologists, psychiatrists, family doctors and urologists.

Of course, there's room for research to improve hormone therapy care. However, I also think that the work should take into account what's being done on the front lines. When someone has an issue, such as shoulder tendinitis, that's related to premenopause, perimenopause or menopause, they go to see their family doctor. However, the doctor won't know whether it's related to a hormonal issue. If they have osteoporosis or depression, who are they going to see? Their family doctor.

There needs to be expertise in front line medicine, because doctors are the ones who see women, by and large. They also need to join forces with all the professionals. Having done so, I can tell you that we have much less need for specialist medical consultations. The specialists love that, because they have clear-cut issues in front of them, not issues due to hormones. When the issue is due to hormones, they don't really know.

I'll give you one example, but I could give you several.

Premenopausal patients often have heart palpitations. Doctors don't know if that's due to a lack of progesterone. They don't know. They don't learn that. The patient isn't sent to gynecology; they're sent to cardiology. The cardiologist does a thorough examination but concludes that those are benign palpitations. They aren't really sure what to make of that.

That's how it is for a lot of women with health problems who reach premenopause, when their cycles are still regular. I think that's the crux of the issue. In any case, that's what I saw. It jumped out at me. It's easy and straightforward.

● (1130)

Andréanne Larouche: Okay.

I take it that, if we had to keep in mind one recommendation, it would be about integrating knowledge.

Sylvie Demers: It would be a matter of integrating current knowledge, not reinventing the wheel. There are loads of scientific articles out there. Of course, research is always appropriate.

Andréanne Larouche: That's great.

I'm hearing a lot about it being necessary to look at the front lines.

Sylvie Demers: It's necessary. It's required, otherwise we won't get anywhere. Again, we won't get anywhere.

Andréanne Larouche: I have less than a minute left, so I'll go quickly.

We're talking about integrating knowledge, but also about raising awareness and debunking certain myths. You said you worked on the documentary *Loto-Méno*. My family doctor is a woman, but it used to be a man. He was very open to women's health issues. We're trailblazers in Quebec, thanks in particular to the documentary *Loto-Méno*.

What has changed?

Sylvie Demers: We now know that women's hormones play a role in every system. Women are always taught to see the dark side of femininity, but there's such a bright side. These hormones play a role in every system, and that's why things go so wrong when something starts to get disrupted. We women are complex.

The Chair: Thank you, Dr. Demers.

Mrs. Roberts, you have the floor for five minutes.

[*English*]

Anna Roberts (King—Vaughan, CPC): Thank you, Madam Chair.

Thank you to the witnesses.

Dr. Demers, you spoke about the complete medical history. Has there been any research done on, for example, if a female is on certain medication, how that medication interacts with the hormone medication and if it acts in a positive or negative way? For example, if you're on blood thinners, they say you shouldn't eat pineapple or you shouldn't have other fruits that would counteract the medication.

Is there any proof of that or any research that has been done on that?

[*Translation*]

Sylvie Demers: In fact, I personally use observation notebooks. For a number of years, I noted down the medications women were taking, their dosages and the effects. That's how I came to draw up a list of medications and interactions, as well as effects on effectiveness and dosage. I'm someone who will measure things.

When it comes to teaching doctors, nurse practitioners, clinical nurses or pharmacists, they're taught how to prescribe hormone therapy using art and science. It's obviously important to take into account what medications patients are taking.

My obsession, if I can put it that way, is to provide women with the safest and most effective hormone therapy possible. Everything interacts with medication, whether it's our lifestyle habits or the way we take hormones, among other things.

It's complex, but that has to remain the doctor's objective. Doctors have to be trained. It isn't that complicated, but there are still precautions to take. For example, for someone who has been prescribed thyroid hormones or someone with type 1 diabetes, it's important to take everything into account. It's the role of family doctors and nurse practitioners to have a holistic view and incorporate knowledge. The human body is complex.

[*English*]

Anna Roberts: Do you think that male doctors or female doctors are better equipped to deal with this issue?

[*Translation*]

Sylvie Demers: Right now, our training is definitely very tainted by the patriarchal approach. Students are taught that female hormones cause problems and cancer. That's still more or less the way things are seen. People always talk negatively about hormones.

I'm trying to change things, because there are always two sides to every story. Female hormones are not hormones that cause or fuel cancer; they're good hormones.

Everything has been mixed up, and there's some confusion. The stereotypes are still very sexist. Things are still very patriarchal. I prescribe testosterone to men, transgender women, transgender men and biological women. That means I'm in a good position to see people's prejudices. It's so obvious that it jumps out at you.

We have to change the perception that women are poorly designed—poor women. That's not true. There are a lot of benefits to being a woman. When women are in menopause and not doing well, it's because they're losing their good hormones. That can be treated easily by giving the right dosage of hormones. Women generally do well after that.

● (1135)

[*English*]

Anna Roberts: I know that the studies have changed. I remember going to my doctor when I was in menopause. We were told that once we were on those drugs, we had to stay on them for life. I understand that's changed now. Now the period of staying on the hormone medication is five years. Is that correct?

[*Translation*]

Sylvie Demers: Those are myths, dogma. When the 5- or 10-year period was set, it wasn't based on science at all. Things have changed a lot now.

In Quebec, the Institut national d'excellence en santé et en services sociaux has also looked at this. They released a report in October 2024. There's no longer an age for taking hormones. It's truly up to women. The institute didn't have a mandate to comment on the preventive side of hormone therapy, but it may do so in the future. It focused on how to relieve symptoms, and it limited itself to certain aspects. That said, there's no longer an age for taking hormones.

I will be brief, but what's interesting is that there are two extremely positive points. The institute recognizes that the hormone therapy I have favoured for 25 years—namely, transdermal 17β-estradiol with micronized progesterone—is the first-choice treatment. It has been recognized for a long time in Toronto, in the protocols for transgender women. It was recognized in 2019. It's coming along for women. It also recognizes that—

The Chair: Dr. Demers, there's a lot to say on the subject; there's no doubt about that. I would ask you to send us the second point you wanted to discuss in writing. Maybe one of my other colleagues will ask you about it.

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

[*English*]

Juanita Nathan (Pickering—Brooklin, Lib.): Thank you, Madam Chair.

My first question is for Dr. Demers.

We've heard testimony that menopause is not simply a health issue. We've talked throughout about that. It's also a workplace issue, an economic security issue and a gender equality issue. Many women described spending years trying to understand symptoms that were affecting every aspect of their lives, including their ability to work. Some spoke about reducing hours, turning down opportunities or leaving jobs altogether before receiving appropriate support, because they were not able to identify what was going on with them.

From your clinical perspective, how are gaps in menopause diagnosis, treatment and physicians' education affecting women's ability to remain in the workforce? What health care reforms would have the greatest impact on improving both health outcomes and economic security for women?

[*Translation*]

Sylvie Demers: It's actually very simple. We find the cause, and then we treat it.

Let us take the example of men who are treated for andropause. I'll just illustrate the kind of disparity that exists. Men will often have a decrease in testosterone levels, around two or three times lower, and that's when they will be treated. It's an indication for treatment. There's no time limit. They can start at any age, and they can continue treatment for the rest of their lives. It's their decision. They will be given a dosage of bioidentical hormones.

When it comes to women, it becomes very complicated. There's a discussion, and then there's another discussion to determine whether it's appropriate to treat them. For women, though, their hormonal levels don't decrease by two or three times; it's in the order of 20 times lower. That means that the consequences are much more severe for women than for men. In the same way as with men, women can receive their own hormones, bioidentical hormones, which can be measured out. It's very simple. It's just too simple. That's what needs to be understood.

I'm pleased, because in 2025, the United Kingdom had a great study based on the same approach, with very few differences. It's something I was unfamiliar with. I think it was a group of frontline physicians who published an article in *Menopause* about this. They arrived at results similar to mine. They came to just about the same conclusions. We know that when it comes to validity in science, everything starts with observation. The results have to be replicable. I have been providing training for a long time. I have trained hundreds of doctors and hundreds of nurse practitioners. It can be seen. It's easy to treat.

When it comes to transgender women, the recommendations we have received are straightforward. Transgender women are still prescribed 17ß-estradiol. This has been done for a long time. Conjugated estrogens would never be prescribed. According to the protocol currently in place in Toronto, all transgender women over 40 years old are told that they're going to get estradiol through transdermal patches, because it's safer. Here, there's still a dispute.

In addition, if there are cardiovascular risk factors in a woman under 40 years old, she is given transdermal doses. The dosage will be determined. The dosage will be determined in transgender women. The dosage will be determined in transgender men. The dosage will be determined in men, but when it comes to women, all of a sudden, it becomes very complicated. Why?

● (1140)

[*English*]

Juanita Nathan: Thank you.

You teach other physicians right now, and as a woman, you would have the perspectives to offer to them when you're teaching.

[*Translation*]

Sylvie Demers: I can offer them a lot of perspectives.

[*English*]

Juanita Nathan: Normally, when physicians go through school, is this taught to all of them?

[*Translation*]

Sylvie Demers: No.

[*English*]

Juanita Nathan: A lot of men are physicians, like my doctor. I know some of my colleagues inquired about this. Is it taught at all, or is it just a one-day lecture and they move on? How do they manage to teach this?

[*Translation*]

Sylvie Demers: In July 2002, the Women's Health Initiative study was published. I remember it all. I was in my office, and I had been prescribing transdermal 17ß-estradiol and progesterone for a year already, based on the evidence. Many researchers found that women were not being prescribed the right type of hormone therapy. This is nothing new. It was even found to be safer.

When that study came in, everything really stopped overnight. All of a sudden, fear took hold. There was no more progress. It was a loss of collective memory. Really, what we knew, we no longer knew. That's what happened, and we're starting to, once again—

The Chair: Thank you, Dr. Demers.

You'll probably have a chance to say a bit more about that study later.

Mrs. Roberts, you have the floor for five minutes.

[*English*]

Anna Roberts: Thank you.

[*Translation*]

The Chair: Pardon me, Mrs. Roberts, it isn't your turn. I'm sorry.

Ms. Larouche, you have the floor for two and a half minutes. How could I forget you?

Andréanne Larouche: That's fine, Madam Chair.

Thank you again, ladies, for being here today.

Dr. Demers, you mentioned a study conducted in the United Kingdom.

Are there other studies elsewhere?

Are there other places in the world that we could keep in mind, other studies that could inspire us here?

Sylvie Demers: There are many studies on bioidentical hormones.

I'm a pioneer in the serum dosage of estradiol and progesterone. I have been doing that since January 2005. I was my own teacher. There was nothing on the subject. It was always said that measuring female hormones was pointless. I went to read the literature, I checked the journals, and there was nothing on it.

There was a lot of small-scale research, though. For example, in cardiology, it was observed that when middle-aged women had a certain dosage in perimenopause, they began to suffer from hypoestrogenism and osteoporosis.

There have been small studies on high blood pressure, depression and so on. There have also been many studies on osteoporosis, particularly about protective factors. With all of that put together, many doctors around the world are now adjusting doses for hormone therapy.

The study I was talking about was a major study published in the United Kingdom that came to more or less the same conclusions as mine.

Andréanne Larouche: We have talked a lot about health.

I have just over a minute left, so I'll be quick.

This question is for both witnesses, because you both touched on the issue of economic consequences in the workplace. I'd like to come back to that. Please answer in 30 seconds each.

What measures could we suggest?

Should we add anything specific, such as employment insurance reform?

Should we make sure that women have support, training in the workplace?

What do we need to do to limit the economic impact?

Dr. O'Hearn, you can start.

[*English*]

Shawna O'Hearn: That's an important question. I would say that definitely workplace education is critical as a starting point, and the evidence shows—

[*Translation*]

The Chair: I'm sorry to interrupt you, Dr. O'Hearn.

There's no interpretation.

It has been fixed, you may continue, Dr. O'Hearn.

[*English*]

Shawna O'Hearn: Workplace education is critical, as are the support groups that I talked about within the workplace.

Australia and the U.K. are two places to look at where really great work has been happening in research on the labour force impact of menopause. I will send some of those studies to you. They are quite advanced in thinking about the conversation around menopause in the workplace, through legislation as well as through specific programming.

● (1145)

[*Translation*]

The Chair: Thank you very much, Dr. O'Hearn.

Mrs. Roberts, you have the floor.

[*English*]

Anna Roberts: Thank you, Madam Chair.

I know there are a lot of symptoms with menopause: hot flashes, night sweats, cold flashes and insomnia. There is also brain fog, weight gain, joint and muscle pain and thinning of the hair. Would this hormone treatment help prevent some of those ailments?

[*Translation*]

Sylvie Demers: In fact, even though I advocate for hormone therapy, it isn't a magic solution. There are still symptoms that I think are due to other factors. I'm speculating. However, for many women, it will indeed prevent many issues.

We also have to talk about joint pain and muscle pain. It's now official. There's a musculoskeletal syndrome linked to perimenopause and menopause. There have been studies on this. We know that it happens long before menopause. We're currently talking about perimenopause, but we actually should also be talking about premenopause. I see it when women are still having regular menstrual cycles. Typically, the musculoskeletal symptoms include shoulder tendonitis.

There can be preventive aspects related to hormone therapy, then. It isn't perfect, because there are still alterations and changes that will remain. However, if we recognize that and, from the start, work with what I think the data shows to be the best type of hormone therapy we can prescribe to women, while tailoring the dose to each individual, we can try to improve everything.

Yes, there are preventive aspects for women who start treatment early. The earlier they start, the more preventive it is.

[*English*]

Anna Roberts: If a woman has to have a hysterectomy because of endometriosis and other issues, would that trigger early menopause?

[*Translation*]

Sylvie Demers: This issue has been debated among obstetricians and gynaecologists for years, and they're now saying that it does tend to precipitate menopause by a few years. However, it's definitely still on a case-by-case basis. Take female smokers, for example.

To answer your question, it could indeed lead to early menopause, because there's slightly less vascularization in the ovaries once the uterus has been removed. However, once again, that's on a case-by-case basis.

[*English*]

Anna Roberts: We talked about muscle pains, and I kind of laugh about this because I was an athlete my whole life and played in joint men-women sports because I was a little aggressive with my sports. My son said to me the other day, “Well, you know, women aren't as strong as men, and as you get older you just don't have the same strength.” Well, believe it or not, I proved him wrong. I got him to get the glove. We went out, played baseball and came in with a red hand. Wow, so I didn't lose that muscle. Did I slow down? Yes. Did I lose the strength? Not as much. Was I a little weaker? Probably.

If those hormone medications had been offered to me, would they have helped?

[*Translation*]

Sylvie Demers: Yes, that could have helped you. A healthy lifestyle is definitely important. I always say that the basis of preventive medicine is a good hormonal balance and good lifestyle habits. Taking hormones certainly isn't a magic solution. When we were younger, we had all our hormones, and we could still have health problems. We could feel tired. It's certain that adopting good lifestyle habits continues to be important throughout our lives.

Indeed, it's also a matter of quality. We now know that estrogens and progesterone—we aren't talking about testosterone here—play a role in all musculoskeletal structures, be they bones, muscles, joints or tendons. They play a role throughout the organism, in fact.

[*English*]

Anna Roberts: Is it important as well that a doctor, male or female, understands the importance of the drug? Sometimes I hear comments like, “Oh, she's going through menopause”, “Oh, she's moody because of menopause”. I don't necessarily believe that is the case. I think there are other aspects in life to cause those feelings. Do we need to educate more doctors, especially family doctors, to understand the benefits of the medication? I've never heard the positive side of it, I'll be quite honest. This is good news for me to hear. Would it be beneficial to educate the doctors when they're going through medical school?

[*Translation*]

Sylvie Demers: I would say that this is being done in Quebec. More and more doctors are being trained, and I personally train doctors every month. There's a real movement in that direction. These doctors and nurse practitioners also provide training. There really is a movement taking hold.

I would say that there's a revolution under way in Quebec, and that's probably also true in the United Kingdom. It's happening right now. There's a reason you're conducting a study. Women are expressing dissatisfaction that they didn't express before.

● (1150)

The Chair: Thank you very much, Dr. Demers.

Ms. Ménard, you have the floor.

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

Dr. Demers and Dr. O'Hearn, thank you for being with us. As you can see, we're hanging on your every word. You have a very engaged audience.

Dr. O'Hearn, I'll start with you. I think we have to paint a somewhat bleak picture of women's career progressions in many different workplaces. When women are in their twenties and are leaving school, some employers are reluctant to give them certain positions, already thinking that the women who are interested will take time off soon to start a family. They think those women may be absent a bit more often than others in their thirties or forties. Family sometimes determines that. In their forties and fifties, progression is uncertain; menopause lies in wait.

I think that, even in 2026, our workplaces are undermined by gender bias. In your recommendations, you spoke a lot about raising awareness in the workplace.

Could you give us some examples of best practices, so that this doesn't remain a bit theoretical?

What could be effective?

When people talk about perimenopause and menopause, it gets trivialized or ridiculed. I'll spare you the dubious jokes that get shamelessly thrown at some women. There's something about that approach that I take issue with.

What could you recommend to us today?

[*English*]

Shawna O'Hearn: Thank you for the question. It's an important one.

You are correct. Gendered ageism is still alive in our workplaces and something that circles around the conversation of menopause.

I also want us to be really careful that this doesn't become an individual conversation. This is really about the workplace. It's really wonderful that this committee is looking at the impact on the workplace so that it isn't just left in the hands of an individual to navigate this.

On specific examples of work that has happened, I have mentioned the support groups and having a leader who brings together individuals who want to have those conversations. They may be allies. They also could be the members of our teams who are going through menopause. The topics may be all the topics we're talking about here today around understanding lifestyle strategies and understanding who your health care team is.

We've talked today a lot about physicians and nurse practitioners, but we also have physiotherapists, occupational therapists, dieticians, nutritionists and mental health practitioners. It's important so our teams, our staff, understand who they can be reaching out to and, as I mentioned earlier, what their benefits are, what's covered and what's not, so that we're not creating a two-tier system. If I can afford to pay for service A and somebody else can't, that's not fair either. I think those are important pieces within our workplace.

It is also really important for us to see who's missing from our conversations. I mentioned earlier that we often have the conversation around office-based professionals, but we're not looking at all of those individuals who might be in precarious work environments, who don't have benefits, who don't have supports or who are small business owners. How are we as a country supporting all of the workers out there? I'm giving you more abstracts and fewer specifics here, but it's just to say that, because the evidence focuses on those who are in very formal work structures, we forget about those on the outskirts of them.

[*Translation*]

Marie-Gabrielle Ménard: Thank you very much. That's enlightening.

Dr. Demers, I'm quoting what you said a few minutes ago: I'm fighting for safe hormone therapy. I just want to check something.

Does that imply that there's ineffective or unsafe hormone therapy right now in Canada? Can you clarify what you mean?

Sylvie Demers: We know that, for example, taking oral estrogens or non-bioidentical estrogens will increase the risk of blood clots. There are risks, and many people are exposed to them. When it comes to blood clots, that can include thrombophlebitis, pulmonary embolisms or strokes, among other things. That means it's important for it to be estradiol. It has to be bioidentical and delivered transdermally to avoid the risk of clots.

When we talk about progesterone and progestins, it's a whole thing. Progestins are responsible for the vast majority of demonstrated risks associated with hormone therapy. That makes it extremely important to use progesterone. Everything can be explained at the molecular level, if you like.

It's necessary to provide safe hormone therapy, and it's no coincidence that our own hormones are the safest. They're chemically identical.

● (1155)

Marie-Gabrielle Ménard: We have a few seconds left, if you'd like to tell us more.

I'm sorry, I'm told that's it. It's cruel.

The Chair: Thank you very much, Ms. O'Hearn, Dr. Demers. This was so interesting, truly. We could've spent the rest of the afternoon with you. It's very frustrating for me, because I have so many questions I'm not asking you.

Let's remain seated, ladies. We're awaiting our second panel of witnesses.

Thanks again to both witnesses.

I will be suspending the meeting for a few minutes.

● (1155)

_____(Pause)_____

● (1200)

The Chair: We're back for the second hour of the meeting.

Before we begin, I'd like to make a few comments for the benefit of members and witnesses.

Please wait until I recognize you by name before speaking.

For those participating by video conference, click on the microphone icon to activate your mike and please mute yourself when you're not speaking.

If you wish to speak, please raise your hand. For those on Zoom, please use the “raise hand” function.

For those on Zoom, at the bottom of your screen you can select the appropriate channel for interpretation: either floor, English or French. For those in the room, you can use the earpiece and select the desired channel.

I would like to remind witnesses that committee members may ask questions in either French or English. If you will need interpretation, please take a moment now to prepare your earpiece.

A reminder that all comments should be addressed through the chair, but since I don't want to disrupt the flow, I speak up very little, other than to end a conversation.

I will now welcome our witnesses.

From the DisAbled Women's Network of Canada, we have Evelyn Huntjens, director, indigenous initiatives.

From the Fédération des médecins omnipraticiens du Québec, we have Dr. Anne-Patricia Prévost.

From the Réseau québécois d'action pour la santé des femmes, we have Élise Brunot, director.

I believe Ms. Brunot is experiencing technical difficulties. Let's begin with the other witnesses, and then we'll move on to Ms. Brunot.

[*English*]

Welcome. We will begin with opening statements.

Mrs. Huntjens, the floor is yours for five minutes, please.

● (1205)

Evelyn Huntjens (Director, Indigenous Initiatives, DisAbled Women's Network of Canada): Thank you, Madam Chair and members of the committee, for inviting DAWN Canada to contribute to this important study.

My name is Evelyn Huntjens, director of indigenous initiatives at DAWN Canada. I also serve, in a cross-employment position, with Indigenous Disability Canada. I am pleased to speak today through the lens of disability justice, indigenous inclusion, accessibility, gender equity and human rights.

Menopause and perimenopause are often viewed as private health matters; however, the evidence increasingly shows that they are labour force issues, workplace accessibility issues, health equity issues and human rights issues.

Across Canada, women, indigenous women, deaf women, racialized women, women with disabilities, two-spirit people and gender-diverse individuals tell us that menopause remains highly stigmatized, poorly understood and inadequately supported in workplaces, health care systems and public policy.

Symptoms such as fatigue, sleep disruption, anxiety, chronic pain, sensory sensitivities, cognitive changes, memory difficulties and challenges with concentration can significantly affect workforce participation and day-to-day functioning. While menopause is a natural life transition, its impacts can be functionally disabling. Many symptoms fluctuate over time and closely resemble the barriers associated with episodic and invisible disabilities, yet menopause is rarely recognized within disability accommodation frameworks or workplace accessibility policies. This represents a significant policy gap.

According to Statistics Canada, approximately 30% of women in Canada live with a disability. Many are already managing chronic illness, pain, fatigue, mobility limitations, sensory sensitivities, caregiving responsibilities and systemic barriers before menopause symptoms begin.

Emerging Canadian research is demonstrating that menopause can exacerbate existing disabilities and chronic health conditions. Research led by Spinal Cord Injury BC found that women aging with spinal cord injuries often experience menopause in ways that intensify existing health challenges, including pain, fatigue, cognitive impacts, cardiovascular risks, bone loss and bladder dysfunction. Importantly, participants reported that menopause symptoms were frequently misunderstood, dismissed or attributed solely to their disability. As a result, many struggle to access appropriate care, workplace accommodations and support.

Despite a growing population of Canadians aging with disabilities, menopause and disability remain significantly under-researched and under-prioritized within health policy, workplace planning and research funding.

The labour force implications are substantial. Research from the Menopause Foundation of Canada estimates that menopause costs the Canadian economy approximately $3.5 billion annually, and contributes to roughly 540,000 lost work days each year. One-third of working women report that menopause negatively affects their work performance. Nearly half report feeling too embarrassed to request support or accommodations. Two-thirds say they would not feel comfortable discussing menopause with their supervisor.

Importantly, menopause often occurs during what should be the peak earning, leadership and advancement years of a person's career. Many individuals experiencing menopause are simultaneously balancing significant workplace responsibilities and caregiving responsibilities at home. When workplaces fail to provide, Canada risks losing experienced workers, leaders, mentors and institutional knowledge.

These findings reveal a broader cultural silence surrounding menopause. As menopause expert Dr. Jen Gunter has argued, the normalization of suffering and long-standing gender bias in medicine have contributed to menopause being under-researched, under-recognized and inadequately addressed, despite its significant impact on quality of life and workforce participation.

● (1210)

Research also suggests that workplace culture itself can be a barrier. Many workplaces continue to operate—

[*Translation*]

The Chair: Thank you very much. Five minutes really flies by.

Now let's welcome Élise Brunot, director of the Réseau québécois d'action pour la santé des femmes.

I believe the technical issue has been resolved. Ms. Brunot, you have the floor for five minutes.

Élise Brunot (Director, Réseau québécois d'action pour la santé des femmes): Thank you, Madam Chair.

I'm here today to talk about a topic still too often avoided here, as in most workplaces across Canada: perimenopause and menopause.

Let me be clear. Menopause is not a disease, nor is it a weakness. Millions of women and people of diverse genders experience menstruation, perimenopause and menopause—which are normal stages of their lives—and our collective tendency to ignore this at work speaks volumes about the values that still shape the workplace.

The first thing to note is that we're dealing with a systemic problem, not an individual one. For decades, research in management and occupational psychology has largely ignored the physical realities of women's lives. Sleep, fatigue and chronic stress are recognized as factors that influence work performance. Yet the bodies of women—who menstruate, who go through perimenopause and who experience menopause—have been absent from these analyses.

This reflects a workplace that has historically been built around a standard of constant availability—one that, in any case, corresponds more closely to the traditionally defined male experience. When “performance” is measured against this standard, women obviously fall short. It is not women's bodies that are the problem; it is this standard.

The Réseau québécois d'action pour la santé des femmes points out that these realities—menstruation, pregnancy, perimenopause and menopause—are systematically treated as individual obstacles, when in fact they are collective issues related to working conditions. As long as we do not change this perspective, we will continue to lose competent and experienced women.

The second point to make is that silence comes at a very high cost—first and foremost, in terms of dignity. The vast majority of the two million Canadian women workers aged 45 to 55 are going through perimenopause or menopause. Many go through this period in silence and shame. According to data from the Menopause Foundation of Canada, two out of three women do not dare to talk about it with their supervisor. Half feel embarrassed to ask for accommodations.

Why the silence? Our culture still associates menopause with ageism and devaluation. Women fear being perceived as fragile or less competent if they speak openly about their reality. The model of the “ideal worker”—always available, always high-performing, “bodiless”—still applies relentlessly to women who aspire to leadership positions.

This silence has real consequences: shame, presenteeism, gradual disengagement and premature departures. Above all, it represents a daily affront to the dignity of millions of women.

What we need is prevention, active listening and accommodations. The approach I advocate on behalf of the Réseau québécois d'action pour la santé des femmes, or RQASF, is the one the organization has championed for decades: a holistic, feminist and intersectional approach to health. In practical terms, this means three things.

First, we must not pathologize. Perimenopause and menopause are not diseases to be treated. They are normal biological processes, experienced in very different ways depending on the individuals involved, their life circumstances and their working conditions. We must first recognize them as such—normal and legitimate—before seeking to manage them.

Second, we need to listen to women. They know what they need, and they're not asking for much, really. They want to be able to talk about their experiences without being judged, have flexibility, and work in a physically accessible environment. What the surveys clearly show is that more than nine out of 10 women support these accommodations, and that employers who provide them build team loyalty and strengthen their organizational culture.

Third, we need to take structural action. It is not up to women to adapt in silence. Workplaces must adapt to the reality of half the population. Simple measures exist: prevention and awareness initiatives for all employees, flexible work policies, access to rest areas, training for managers in active listening and non-stigmatizing communication, free access to menstrual products—which are very helpful during perimenopause—health leave, and adequate group insurance coverage.

The key consideration must always be to ensure that the measures adopted do not create a new layer of the glass ceiling or new barriers to hiring.

As Canada's largest employer, the federal government has a unique responsibility and opportunity.

It can officially recognize perimenopause and menopause as occupational health realities, just as it does other health issues recognized in the Canada Labour Code.

It can train federal public service managers in an empathetic, non-stigmatizing approach to create safe environments where women can speak openly about their experiences without fear.

It can shift the responsibility for silence from the individual to the organization by making menstrual and hormonal inclusion an employer's responsibility, not a personal burden for each woman.

Finally, it can invest in prevention and research, particularly regarding working conditions that exacerbate or alleviate menopause-related symptoms.

In conclusion, I would say that changing workplace standards to include the bodily realities of women and gender-diverse individuals affected by their bodies' natural cycles is not asking for a privilege. It is demanding true equality.

● (1215)

I'm not talking about formal equality, which treats everyone the same. I'm talking about real equality, which recognizes that women have bodies and realities, and that these realities deserve to be taken into account, without shame, without taboos and without having to choose between health and career.

Thank you.

The Chair: Thank you very much, Ms. Brunot. It certainly seems as though everything is working very well on your end from a technical standpoint.

Dr. Anne-Patricia Prévost, you have five minutes for your opening remarks.

Anne-Patricia Prévost (Doctor, Fédération des médecins omnipraticiens du Québec): Thank you, Madam Chair.

Good afternoon everyone. It's a pleasure to be here.

My name is Anne-Patricia Prévost, and I'm a family physician. I serve on the board of directors of the Fédération des médecins omnipraticiens du Québec. I work in an academic setting affiliated with the Université de Sherbrooke. I am here today to offer you a perspective rooted in the clinical reality of the women we care for as family physicians.

As Ms. Brunot mentioned, perimenopause and menopause are not diseases. They are normal phases of a woman's life, just like other life transitions such as pregnancy and aging. Some women will experience symptoms severe enough to interfere with their daily functioning, including at work.

As family physicians, we must avoid two pitfalls: trivializing symptoms when they become debilitating or, conversely, systematically medicalizing a normal life transition. These, then, are our two challenges. In practice, experiences vary widely. Some women will go through this phase with few repercussions, while others will have symptoms that disrupt their sleep, cognition, mood and functional capacity. It's a very heterogeneous experience.

Women who see a doctor do so primarily because they have symptoms such as sleep disturbances, brain fog, mood swings, joint pain, night sweats and hot flashes. It is our duty to thoroughly assess the impact of these symptoms and investigate their possible causes, as there are many. Given these symptoms, there are differential diagnoses to consider.

It is also our duty, first and foremost, to promote healthy lifestyle habits among these women and to provide adequate and appropriate care. I'm thinking of a patient who thought she was experiencing burnout because she had significant sleep disturbances. Ultimately, it was related to her perimenopause. On the other hand, I had another patient who thought her symptoms of night sweats and brain fog were related to menopause when in fact she had sleep apnea. So, it's very important to take a holistic approach to properly differentiate between the various conditions associated with these symptoms.

We also observe that there's a great deal of variability in clinical knowledge. There is a lot of underdiagnosis, overdiagnosis, and a lack of understanding of symptoms. There is confusion in the media, there are myths, and there are common misconceptions. We must be wary of misinformation, the excessive commercialization of certain approaches and the proliferation of tests or treatments that have no proven benefit. Conversely, we must also ensure that women with significant symptoms do not lack access to effective treatments when indicated.

I'm now going to discuss the impact of this on work. Symptoms related to menopause or perimenopause can interfere with daily functioning. This is very real. However, these effects are often invisible, trivialized or unrecognized. Small or large adjustments can be made. Better access to care can also have a positive effect on job retention. As physicians, it is our role to support these women's functional abilities—including their participation in the workforce—when the transition becomes difficult.

I would, however, be cautious about messages that suggest women in perimenopause or menopause are less capable of working or less productive. Most continue their professional lives successfully. Rather, we must ensure that those experiencing significant symptoms do not find themselves lacking support, treatment or understanding.

To achieve this, I have a concrete plan to propose. It consists of three actions: better information, better support and better care.

First, we should improve awareness among the public, employers and managers to normalize the conversation without stigmatizing it.

Second, we should promote simple, flexible and inexpensive accommodations in the workplace.

Finally, we should improve training for professionals and ensure rapid access to relevant, high-quality, evidence-based care.

If you had to remember just one sentence today, it would be to normalize without trivializing and to support without overmedicalizing. There are women who are successfully navigating this transition. As for those experiencing significant symptoms, they should never be invisible, misunderstood or left without support.

Thank you very much for your attention.

● (1220)

The Chair: That concludes your opening remarks, Ms. Prévost.

Now let's begin our discussion.

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

[*English*]

Connie Cody (Cambridge, CPC): Thank you.

Through you, Chair, I want to thank the witnesses for coming today and talking about a topic that impacts women in the workplace and even in their retirement, when loss of work could decrease their financial contributions, so it's really good that we're having this conversation.

I'd like to direct my first questions to Dr. Prévost.

Some women prefer using natural health products, which can be costly compared to pharmaceuticals. What do you say to women who prefer natural health products but are stuck in a system where health choice becomes a financial burden?

[*Translation*]

Anne-Patricia Prévost: I think that, before using a product, women who are experiencing symptoms without knowing the cause should see a doctor to get a medical diagnosis and rule out other possible causes.

[*English*]

Connie Cody: Okay, but naturopaths or natural health practitioners often aren't covered under benefit plans. What are you hearing from women who prefer natural health practitioners and naturopaths about how that affects their ability to seek medical care? Where do you see an opportunity for change?

[*Translation*]

Anne-Patricia Prévost: My opinion remains unchanged. You need to see a doctor or primary care provider who has the necessary medical expertise to determine the source of the problem.

In my opinion, it's not ideal to turn to natural products right away without having a clear understanding of the risks, benefits and expected effects. People need to talk to a health care professional.

[*English*]

Connie Cody: Women often need to request a specialist and wait months, if not years, to get treatment for common health issues.

Why do you believe that family doctors are not trained to fully recognize key signs of menopause?

[*Translation*]

Anne-Patricia Prévost: I believe that the medical specialists, family physicians and specialized nurse practitioners who attend our academic programs receive adequate training on menopause. We use the evidence available to us. There are courses that cover menopause. I myself teach a course on menopause in my teaching unit. I would say the training is adequate.

That said, not all physicians necessarily maintain their expertise in menopause afterward. Some physicians specialize in other fields, such as musculoskeletal health, mental health or women's health, for example.

The College of Family Physicians of Canada has established clear objectives related to medical exams.

[*English*]

Connie Cody: Thank you.

I'd like to move on to Ms. Brunot.

Do you feel that we have enough trained physicians to treat and care for all the women in this country who are experiencing menopause? Does this create a backlog ultimately leading to misdiagnosis or delayed treatment?

[*Translation*]

Élise Brunot: I would tend to say that the training of health care professionals covers menstruation and menopause. There may have been biases in the past regarding how women's bodies were perceived. As I mentioned earlier, the default assumption is that something is wrong, whereas we need to shift the paradigm and prioritize support.

We're on the right track today, but it takes time to correct these preconceived notions and to listen with an open mindset, free from stigma, when seeking solutions and investigating the root causes of a problem.

All of these concepts should be incorporated into the training of health care professionals so that we can move beyond the current tendency to view these issues solely through a medical lens. As Dr. Prévost noted, we should also consider how best to raise women's awareness of healthy lifestyle practices and related measures.

So this is a field of practice that needs to be strengthened, whether in relation to menstruation or menopause. I would point this out because, after all, these are two natural phenomena that are very closely connected.

● (1225)

[*English*]

Connie Cody: Thank you.

Do you have any numbers or stats on women who are being misdiagnosed and treated for the wrong condition when going through menopause and what that cumulative cost could be? If not, why not?

[*Translation*]

Élise Brunot: No, we've never had funding to conduct surveys.

One thing is certain, though: We're constantly being approached by the general public, community groups and businesses to raise awareness about menopause and offer advice. We're appealing to common sense so that people will listen to us, discuss the topic and break down the taboos.

What we're hearing on the ground—and I want to emphasize this, because we're actually conducting research and bringing these voices from the field to the forefront—is that the vast majority of women feel they aren't being listened to. These findings are supported by surveys from the Canadian Menopause Foundation. It's difficult to speak openly about what we're going through without fearing that it will be downplayed or that it could have significant repercussions on our professional and even our personal lives.

We realize that this runs very deep. There's a sense of shame that's quite moving. There is truly a sense of vulnerability, and it's always very moving, because we understand that it's part of our lives as women. We should be able to talk about it openly.

The Chair: Thank you very much, Ms. Brunot.

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

[*English*]

Chi Nguyen (Spadina—Harbourfront, Lib.): Merci beaucoup.

I'm going to start my questions with Ms. Huntjens.

Thank you so much for being with us today. I wanted to dig in a little bit. I'm curious about whether we have good data on the intersections of disability and menopause, if that is an area of research that we should be thinking about, and if you can offer any perspectives on that.

Evelyn Huntjens: There is a lack of research when it comes to looking at the intersection of disability and menopause and, in particular, if you look at indigenous women and two-spirit individuals. A lot of first nations communities don't have the data to really look at holistic care and look at some of the barriers that are faced when accessing health care. We know we have the data that says yes, it's a social determinant of health, and how do we overcome that?

When communities are facing capacity with just the primary health care needs—when we have things like locums, and we have travel nurses, and we don't have relationships with health care workers—and you're transitioning into perimenopause and menopause, often that is something that is going to get left out because you don't have that relationship with your doctor. There's no understanding. Again, it's that silent, invisible suffering, that is taking place.

Chi Nguyen: Could you speak a little bit to any cultural practices, accommodations or ways of knowing and understanding what menopause looks like in indigenous communities? Obviously there are many versions of that, but if there's something that you'd like to share with us, that would be helpful.

Evelyn Huntjens: I think the big thing with indigenous communities is around a holistic approach. It's the emotional, the mental, the physical and the spiritual well-being. It may not just be physical symptoms, it may not just be emotional well-being, but looking at all of that together and having supports in the community to be able to recognize and provide care.

● (1230)

Chi Nguyen: Thank you, Ms. Huntjens.

I'm going to ask Dr. Prévost a question.

You spoke a little bit about social media and all of the information that's out there. I'm of a certain age, and so my Instagram feed is all filled with perimenopause. It feels like there are some of us who are having approaches and therapies and suggestions on what we should be doing.

How do we think about ensuring that Canadian women have access to high-quality, good information, especially when the noise and the disinformation is out there? What can we be doing there to support that?

[*Translation*]

Anne-Patricia Prévost: As you say, myths and misinformation are indeed major problems. Weight gain, excess cortisol and perimenopausal symptoms are issues that affect us greatly, so everyone wants to sell us natural products.

At present, there isn't enough evidence to confirm the effectiveness of natural products, aside from some positive findings regarding soy. So we need to be cautious.

What can we do? Should we regulate social media? Should we set guidelines for it? Some people even claim to be doctors when they're not, so it's very dangerous.

Furthermore, women experiencing these symptoms are in a vulnerable position, so they also tend to turn to these alternatives. That's why we need accessible health care. It's to meet women's needs.

[*English*]

Chi Nguyen: Are there any models of peer support groups that are working well in terms of sharing good information?

[*Translation*]

Anne-Patricia Prévost: I don't know, but I'm sure they're out there. There might be some forums on perimenopause and menopause.

[*English*]

Chi Nguyen: Thank you very much.

My last questions are for Madame Brunot.

I wanted to talk a little bit more about your feminist approach to this question and if there are best practices you can speak of. Are there feminist organizations that are doing this work really well from an HR perspective that we should be thinking about as good lessons and insights?

[*Translation*]

Élise Brunot: I don't know. I'm not saying there aren't any, but not to my knowledge. I think that this is evidenced by the current interest in our website's content on how employers should make accommodations for menstruation and menopause. This is a new initiative for us this year at the RQASF. We launched it in response to the many requests we've received, for example about how to address these topics in the workplace.

We do our work with the resources we have. It probably won't surprise you to hear that fewer than 20 of us work at the RQASF. We're doing our best to meet the demand.

To sum up, to the best of my knowledge, there are no such organizations, but the need is there. Obviously, the very large number of requests the RQASF receives attests to this.

[*English*]

Chi Nguyen: This is my last question.

Do any of the three witnesses have a universal policy approach or one prescription for us to think about as a recommendation to take forward?

[*Translation*]

The Chair: Please forgive me, colleague, but your time is up.

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

[*English*]

Chi Nguyen: You could share that with us as a written submission.

[*Translation*]

Andréanne Larouche: Thank you very much, Madam Chair.

Thank you, Ms. Nguyen. I also want to thank the witnesses, namely Ms. Huntjens and Ms. Brunot, as well as Dr. Prévost, for being with us today. I appreciate it.

Right from the start, at the first meeting on this study, I said that it was much broader than just the issue of menopause from a health perspective. As has been noted, there are issues that characterize women's health, ranging from menstruation through pregnancy to premenopause, menopause and perimenopause. We can see that at every stage of life, women face certain realities. When the Standing Committee on Health examined the multi-faceted issue that is women's health, it sought to demystify the subject by asking whether there was a lack of research, a lack of evidence or a lack of knowledge.

Why do we always get the impression that when it comes to women's health, it's harder to find solutions and study the issue scientifically? That's what we hear. We're not talking about the economic aspect. There are prejudices against, for example, a teenage girl who misses school and is stigmatized; a woman in her twenties trying to get her first job who is asked outright if she plans to have children; a woman in her thirties or forties who is overwhelmed by her family life; or a woman whom employers assume, during the hiring process, will also experience the effects of perimenopause or menopause in her 40s or 50s.

And yet, as you pointed out, that's often when she's at the peak of her professional career. That's when women have typically acquired all their knowledge and could also succeed in earning a higher salary to prepare for retirement.

So this study is much broader in scope, both in terms of health and finances. Again, we need to demystify what falls under the purview of health administration. Doctors' offices are largely under Quebec's jurisdiction, while research and medications fall under federal jurisdiction. So we need to untangle all of that.

Let's start with the issue of health. We heard earlier that there are studies on perimenopause and menopause, but that the problem lies in the subsequent integration of that knowledge into medical practice.

Can you confirm this information that was shared with us by the previous witnesses?

Ms. Brunot, please go ahead and respond first.

● (1235)

Élise Brunot: Yes, I agree with you.

It's clear that there's a serious lack of research on women's health and that this information needs to be communicated. What do we do with the data? How do we tackle something as far-reaching as labour policies? Beyond policies, there's the broader view of the labour market, according to which women—as we all know, I'm not telling you anything new—weren't included at the same time as men, at least not on a large scale.

There's also the fact that their bodies have been overlooked. I wouldn't want to give the impression that I'm forgetting about men, even though we are a feminist organization. I think men suffer from this as well. I wanted to make that clear. The fact is that women's bodies have been overlooked. I think this resonates with each of us when we talk about pregnancy, menstruation, menopause and, of course, all the difficulties that can be associated with menstruation.

It's something we don't really think about, actually. Women, more than anyone, are hesitant to bring this up because they're afraid of the repercussions. That's what I wanted to say.

I don't know if I'm answering your question exactly, but it's hard to put all of this into words. Do we want to take a stand or not? What will the backlash be? There's a lack of research. It's a global issue, actually. That's the reality, and that's why it's so important to talk about it today. There's still a lot of work to be done to make progress on this issue. It's very important that the women affected be able to speak out on this topic.

Andréanne Larouche: Dr. Prévost, what's your take on this?

I also have another question for you.

Are there any good international best practices that we could draw from on the health side of things?

Anne-Patricia Prévost: There's definitely research being done. We see progress in all areas. There's been progress regarding menopause, but also in terms of cardiovascular disease and diabetes.

Earlier, Dr. Demers mentioned the 2002 WHI study. After that, we switched to a treatment that was supposed to end after five years. Then they decided it wasn't useful since the dose was low.

Now we have access to other data based on age or the duration of menopause. We must continue to conduct research, of course, because that's what drives medical progress. It's true that we sometimes change our practices, but we do so for many other issues as well, ones we haven't necessarily researched. So this doesn't only apply to research on menopause.

Andréanne Larouche: Ms. Huntjens, what do you have to say about the stigma surrounding women's health and the difficulty of conducting studies on the subject? When there are studies, it's sometimes hard to integrate them properly in the field, meaning in doctors' offices.

What could be improved?

What could be done to improve data integration?

How could we make up for the lack of data, if necessary?

[*English*]

Evelyn Huntjens: I'm sorry. My earpiece isn't working.

[*Translation*]

The Chair: Ms. Larouche, you have 15 seconds left.

Ms. Huntjens, did you hear the question?

[*English*]

Evelyn Huntjens: I didn't hear the question.

[*Translation*]

The Chair: Ms. Larouche, you have the floor for 20 seconds in total.

Andréanne Larouche: Ms. Huntjens, do you think the problem is the lack of data or the lack of data integration and good practices in medical offices?

What is the main problem?

● (1240)

[*English*]

Evelyn Huntjens: If we're looking at it through a lens of indigenous women who experience perimenopause and menopause, the main problem is often a lack of trust within the health care systems that really drive that. Access to health care is a social determinant of health, and when we look at—

[*Translation*]

The Chair: Thank you, Ms. Huntjens.

[*English*]

I'm sorry. I have to interrupt you.

[*Translation*]

Mrs. Roberts, you have the floor for five minutes.

[*English*]

Anna Roberts: Thank you, Madam Chair.

Thank you to the witnesses.

My first question is for Dr. Prévost.

Have any studies been conducted on the adverse consequences of medication interacting with other medication that a woman is taking?

[*Translation*]

Anne-Patricia Prévost: In fact, there are contraindications to treatment, such as if someone has had cancer.

The drug interactions are mainly seen with natural products. We don't always know what additives are in these products. Otherwise, in addition to hormone therapy, there are other treatments for menopause-related symptoms. There may be contraindications regarding the use of certain medications. These are things that are documented in the guidelines.

[*English*]

Anna Roberts: Hormone therapy improves the quality of life for many women. A documentary report in Quebec helped make bioidentical hormones accessible to anyone who wants them.

What is the current situation in the rest of Canada?

Dr. Prévost, do you know?

[*Translation*]

Anne-Patricia Prévost: Can you repeat the question?

[*English*]

Anna Roberts: Sure.

Hormone therapy improves the quality of life for many women. We heard that from the previous panel as well. A documentary report in Quebec helped make bioidentical hormones accessible to anyone who wants them.

What is the current situation in the rest of Canada? Is that applied across all provinces or just in Quebec?

[*Translation*]

Anne-Patricia Prévost: I couldn't tell you. I'm aware of what's going on in Quebec, but I can't tell you what's going on elsewhere in Canada. I'm sorry.

[*English*]

Anna Roberts: Okay.

As a frontline family physician, are you seeing an increase in women seeking care for menopause-related symptoms? Are there sufficient health care resources available to meet the demand?

[*Translation*]

Anne-Patricia Prévost: There is an increasing number of appointments for menopause-related symptoms. We see it on the ground. People have questions, and they come to us.

As to whether access is adequate, I can say that there is a shortage of family doctors, but we are really trying to get privileged access when it comes to women's health. There are women's health clinics. In our clinics, we are accessible. We have care pathways. Women can get appointments for their symptoms.

[*English*]

Anna Roberts: In Ontario and in my riding of King—Vaughan, we hear a lot about the fact that people are on wait-lists for family physicians and we have a shortage of family physicians. As a matter of fact, York University is building a school specifically for family physicians next to the Cortellucci hospital.

What advice would you give this government to include, advance or assist with the practice? A lot of our young students have to go abroad because there's no room here in Canada for them to take that course. What advice would you provide this government to ensure we have enough family doctors for the population of 40 million-plus people?

Would anybody like to take a stab at that?

[*Translation*]

Anne-Patricia Prévost: Is your concern related to the fact that doctors are less well trained in menopause?

[*English*]

Anna Roberts: Do we have a lack of family physicians? That is my question, because I'm hearing that.

[*Translation*]

Anne-Patricia Prévost: Yes. There's a shortage of family doctors, of course.

● (1245)

[*English*]

Anna Roberts: Okay.

I have a question for Evelyn Huntjens.

Do you agree we need to advance so we can ensure the population mandate for family doctors is sufficient?

Evelyn Huntjens: I know there is an incredible shortage of doctors. We are seeing that especially within the disability community and the work that we do around having access to doctors. When it comes to issues that could be chronic or episodic, and when you don't have—

[*Translation*]

The Chair: Thank you. The time is already up.

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

[*English*]

Marilyn Gladu (Sarnia—Lambton—Bkejwanong, Lib.): Thank you, Chair.

Thank you to the witnesses for being here today.

I'm going to start off by saying I come from the perspective of having been a chemical engineer for over 32 years in a very male-dominated world, where there was zero opportunity to show any kind of weakness, so I'm really happy to hear the conversation we're having today and to see we're making some progress.

I'm going to start with Dr. Prévost.

You mentioned three aspects to better inform, better support and better care. What kind of accommodations do you expect will be needed?

[*Translation*]

Anne-Patricia Prévost: Work accommodations could involve schedules, telework and temperature. Different types of accommodation, depending on the symptoms experienced, could make things easier for women.

[*English*]

Marilyn Gladu: Excellent. Thank you so much.

Ms. Huntjens, we know there's a variety of symptoms of menopause and there are gaps in service everywhere, but are there gaps that are worse for disabled and marginalized groups or ones that perhaps impact them more?

Evelyn Huntjens: Often, with perimenopause and menopause, the symptoms can exacerbate other symptoms and go unnoticed and ignored, so I think there is a need for more flexibility in workplaces to allow for hybrid work options and to allow for rest and wellness support, temperature control, inclusive leave policies, and sensory and environmental accommodations in the workforce.

Marilyn Gladu: Excellent. Thank you.

Ms. Brunot, this is a really tough question. We've talked about sleep deprivation, fatigue, chronic stress, brain fog—all the things that can happen. You mentioned that we need to change perspectives.

How do we do that?

[*Translation*]

Élise Brunot: I'm not going to lie to you. This will clearly not happen in two seconds.

The focus right now is on what's scary, what goes wrong and how it's a weakness. We need to move away from that perspective a little bit. Once we feel that it is legitimate to experience these changes as a part of life, it already greatly changes the way people see themselves and the way they feel.

The way we are raised and how we get the knowledge will directly influence our experience of things. Fortunately, all of this is now documented, much more so in terms of menstruation than menopause, by the way. I apologize, because I talk a lot about menstruation.

We know that how we learn about menstruation matters. If it's taught positively, if we value it, women's experiences will be much less painful and difficult than if our first contact with blood in our underwear, at eight or nine years old, makes us think we're going to die. I would point out that girls are getting their first periods at a younger and younger age now. This perspective has a lasting impact on the relationship we have with our menstruation. It sounds silly, but it does. Now, it is documented.

As a result, I would tend to say that it would take a collective effort to overcome the stereotypes surrounding menopause. In addition, regarding the lack of studies, it's important to know that the few that exist also point to the positive side of menopause. They talk about a certain amount of freedom, emotional control and evolving cognitive activities.

Basically, it's really a matter of upbringing. It starts young, in the perception of the way women experience our bodies, of what we will potentially experience. It can be tough, but it can also be a great adventure.

Please note that I am not here to minimize tough experiences. It may seem so, but I'm not. I'm here to remind you that everyone's experience is different and that we really need to learn from each other on this.

● (1250)

[*English*]

Marilyn Gladu: Thank you.

It looks to me like we've heard from many witnesses on the need for awareness and education. I think the type of education that Dr. Prévost is providing to physicians who are learning under her.... If we leveraged something like that virtually, it would be great.

[*Translation*]

The Chair: I'm sorry, Ms. Gladu. I have to cut you off there.

[*English*]

Marilyn Gladu: Thank you so much.

[*Translation*]

The Chair: Thank you.

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

Andréanne Larouche: Thank you, Madam Chair.

Ms. Huntjens, once again, thank you very much for coming to speak to us. My thanks also go to Ms. Prévost and Ms. Brunot.

As I said earlier, there is a health challenge. Let's also remember that there are things the federal government can intervene in, such as research and drug approvals. However, one thing that is not up to us is how the health care system is applied.

However, I would remind you that, when we talk about the need for doctors, it also means giving the health care system more resources. On that note, we are hoping for more transfers in recognition of everything that health system specialists do. We need to give Quebec and the provinces more breathing room and more financial resources for health care.

I would like to come back to another, broader aspect that, as I said, is the economic issue.

Ms. Prévost, I understand that you proposed three recommendations: better information, better support and better training. Beyond that, let's talk about the economic effects in the workplace. Ms. Prévost, you can answer first, and if Ms. Brunot wants to add something, she can.

We've talked a lot about workplace accommodation, but also about menstrual leave more generally.

If there were menstrual leave, should we also think about providing specific leave for women who experience more serious consequences related to perimenopause and menopause?

Are there employment insurance benefits that could help women take care of themselves for a while?

Where should we start to help them economically?

Anne-Patricia Prévost: As you said, it would concern some women. I would really not be in favour of a standardized solution. We really shouldn't stigmatize this.

I think we really need to look at and document the impairments that symptoms can cause, just like any other symptom.

Andréanne Larouche: Ms. Brunot, do you want to add anything?

Élise Brunot: I completely agree with Dr. Prévost.

We have a very concrete example today. Spain has taken a step back from introducing menstrual leave.

Our own position is extremely nuanced, because we mustn't engage in stigmatization. That is, in fact, the challenge. The idea would be that health leave would be available and that menopause leave would be part of that type of leave.

We know that the issue of menstrual leave is a high-profile issue. That's to be expected. These issues require a bit of nuance and foresight.

Andréanne Larouche: I know my time is up, but I would like to talk about reform—

The Chair: Your time is up, Ms. Larouche. I'm sorry.

Mrs. Goodridge, you have the floor.

[*English*]

Laila Goodridge: Thank you, Mr. Chair.

Thank you to all the witnesses for being here today.

Ms. Huntjens, I'm going to direct some of my questions to you.

I was wondering what kind of traditional indigenous knowledge exists around the space of menopause and perimenopause. Oftentimes, I feel like we have traditional knowledge, plants and medicine, and they aren't necessarily incorporated into western medicine and beliefs. Oftentimes we can learn from that. I know I used and had the benefit of having an indigenous midwife for the birth of my two boys. I got to learn about different herbs and stuff like that. Is there any space where we can learn about menopause and perimenopause that comes from the indigenous lens of the traditional knowledge?

Evelyn Huntjens: Yes. There's a focus on the emotional, spiritual and physical well-being of the individual that takes a holistic approach to well-being rather than looking at it just from a western perspective of a medical condition and treating it as a medical condition. There are traditional medicines that support with symptoms, but it's also being able to have that spiritual, emotional and mental well-being looked at as well.

● (1255)

Laila Goodridge: That's wonderful.

Are you aware of any spaces where there is research into indigenous women's health and incorporating traditional knowledge into the treatment of perimenopause or menopause in Canada or around the world?

Evelyn Huntjens: Australia has done a lot of work looking at menopause and perimenopause, and they've also looked at indigenous populations. Countries like the U.K. and Australia are quite farther ahead on some of the research into menopause and perimenopause. Some of those frameworks could be really—

Laila Goodridge: Is it specific to the traditional knowledge of indigenous people?

Evelyn Huntjens: I don't know that there's research being done. I know that individual communities will look at some of their medicines to support perimenopause and menopause. The communities believe that a community works and includes everyone together, so they often have different views of disability. When it comes to health impacts such as perimenopause and menopause, it could be treated very differently in different communities across Canada based on the local medicines and on how they support their communities. There is not a one-size-fits-all approach.

Laila Goodridge: I wasn't implying that there would be a one-size-fits-all approach. We have a variety of different spaces. I'm very fortunate that I get to be the member of Parliament for Fort McMurray—Cold Lake. That covers both Treaty 6 and Treaty 8 territories. There are differences between the two different first nations and how they approach some of these pieces.

I have been really touched to see the intergenerational sharing of information, the respect of elders and those kinds of conversations that perhaps don't necessarily happen in society as a whole. I've been blessed personally to have indigenous elders share with me some of their traditional ways of carrying babies when they're sick or different spaces like that that have really helped me in doing my job and being a mom.

If there's an opportunity for you to share even just your community and some of what they do, that would be spectacular for this committee.

Evelyn Huntjens: I don't have any specifics when it comes to perimenopause and menopause on specific treatments. I live outside of my first nation, so I don't have that care. Often when people leave communities.... Unfortunately, through colonization, my grandparents left our community, so I don't have that connection with my community. I do know, from working with first nations communities and the holistic approach that's taken, that there is care given, and the types of—

[*Translation*]

The Chair: Thank you, Ms. Huntjens.

We have one speaker left, Ms. Nathan. She will have the floor for five minutes.

Afterwards, the committee members will have to stay here for two short minutes, since we have decisions to make.

Ms. Nathan, the floor is yours.

[*English*]

Juanita Nathan: Thank you, Madam Chair. Through you, I'll direct this question to Ms. Brunot.

I'm very conscious that not every woman has the same ability to navigate menopause. A professional with paid sick leave, workplace flexibility and extended health benefits may have options that are simply unavailable to someone who's working shift work or multiple jobs or in precarious employment. There's a risk that many of the solutions we discuss will benefit women who already have access to workplace supports, while leaving behind those facing the greatest economic pressure.

How do menopause experiences differ for women working in low-income, precarious, frontline or shift work? What policies would help ensure that these women are not left behind?

● (1300)

[*Translation*]

Élise Brunot: I'll try to give a brief answer to that question, which is obviously very general.

I would say that we need to listen to these women's voices. We need to open up discussions in the workplace. That is what we will always advocate for. When a workplace is interested in the issue and contacts us, our first recommendation is to set up a workplace committee and tell women that what they say will not be judged.

We're advocating for that. We're trying to start from what women say and set up something in the workplace that's consistent with the workplace itself.

It's hard to standardize practices. We see workplaces, completely individually and through pilot projects, implementing ways to support women in terms of menstruation and menopause.

In short, I would say that we need to listen to women.

[*English*]

Juanita Nathan: If you could create policies for this that govern all of Canada, or if you could legislate, what would that look like?

[*Translation*]

Élise Brunot: I wasn't expecting that question.

I would say that education has to come first. I would tend to say that, whatever extremely specific decisions are made regarding legislation, nothing can be done without properly educating, I might add, the entire population.

When we talk about a pilot project for distributing menstrual products in schools and workplaces, we always say the same thing. You can set up whatever you want, but if no awareness is raised among the entire population to show the merits of these measures, to make women's voices heard and to ensure that the people who aren't concerned adhere to what's being put in place, it can't work.

We're talking about something so ingrained that we need to free our voices, raise awareness, take the time to discuss it, challenge ourselves and assess what is being put in place. That's very important as well. You don't just implement something and then say it's done. It needs to be assessed on a regular basis. We have to adjust as needed to ensure that no one is left behind.

Put that way, it obviously seems like a big job. We know we can't snap our fingers and it's done.

[*English*]

Juanita Nathan: Thank you.

Dr. Prévost, how do broader social determinants of health shape women's menopause experience? What policy area, beyond health care, should government be examining?

[*Translation*]

Anne-Patricia Prévost: Again, we need to avoid stigmatization and standardization.

Personally, I completely agree with Ms. Brunot. There needs to be awareness and education. That's where we should go first, before trying to legislate or put policies in place. That's what will make us change our approach and our culture and make us more sensitive. That will really be the winning approach.

[*English*]

Juanita Nathan: Thank you.

The last question is for Ms. Huntjens. Several population studies have found significant gaps in data concerning marginalized populations, making it very difficult to develop targeted policies and supports—

[*Translation*]

The Chair: Ms. Nathan, I'm sorry, but I'm going to have to cut you off. It goes so fast.

Witnesses, we would have liked to get your opinion on a lot of things. I've interrupted you many times, and I apologize. We would like to receive in writing any comments you were unable to complete or any information you deem relevant.

Members, I won't keep you for long. You know that we sometimes receive confidential or anonymous briefs. Confidential briefs are not made public.

Is there agreement to accept them?

Voices: Agreed.

The Chair: That's great.

We will accept the anonymous briefs if you agree, but we will not publish them.

I forgot to thank our witnesses. Ladies, you've been amazing, and thank you so much. Time is so short. We'll see you soon.

In terms of the schedule for the fall, we have to schedule it now because we're finishing this week.

Do you agree that we should devote our first meeting in the fall to committee business to determine what studies we'll do following the menopause study?

We could then give drafting instructions for the report on the shelter study, then move on to the report on senior women. We have scheduled two meetings to study the report together. The third element is to finish the two missing meetings for the menopause study.

The first meeting will therefore be devoted to committee business to determine our next study. Then we'll look at the report on seniors and, lastly, the menopause study.

Ms. Ménard, you have the floor.

● (1305)

Marie-Gabrielle Ménard: Thank you, Madam Chair.

I should know that, but I don't have the schedule in front of me.

Have we finished our meetings with witnesses about the shelters?

The Chair: No, we're continuing the shelter study on Thursday.

Marie-Gabrielle Ménard: That's great, so we'll be done in September.

The Chair: Yes, that's right.

Marie-Gabrielle Ménard: That's great.

The Chair: That's why we'll be able to give the necessary drafting instructions for the report on shelters at the first meeting.

We will determine the subject of the next study, and we will also work on instructions to the analysts for the report on shelters.

Is that okay?

Voices: Agreed.

The Chair: Okay.

You were really amazing, as usual.

The meeting is adjourned.