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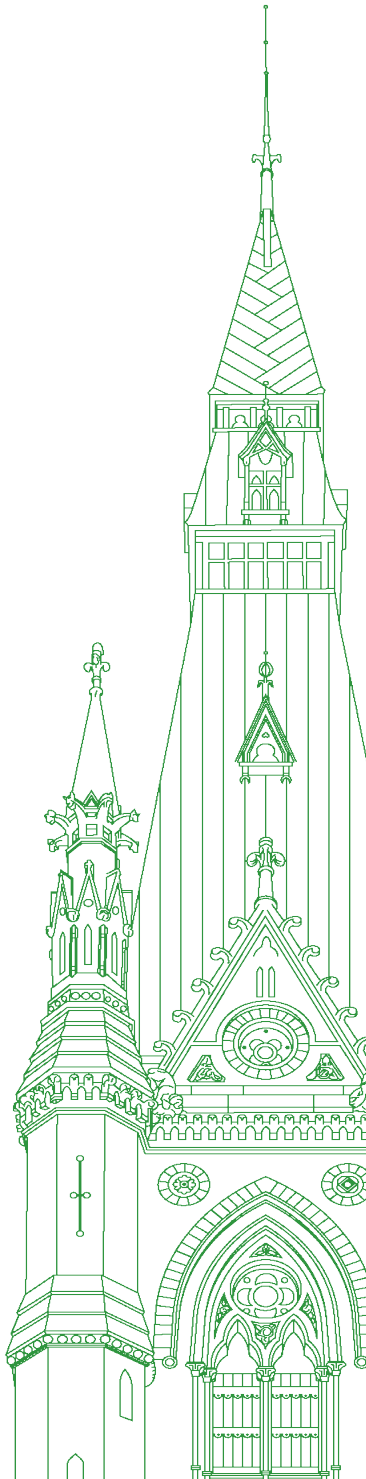
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Chair: Dominique Vien

Standing Committee on the Status of Women

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● (1630)

[*English*]

The Vice-Chair (Emmanuella Lambropoulos (Saint-Laurent, Lib.)): I call this meeting to order.

[*Translation*]

Welcome to meeting number 50 of the Standing Committee on the Status of Women.

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

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. To ensure that the meeting runs smoothly, 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. If you're participating by video conference, click on the microphone icon to activate the microphone. Please mute yourself when you aren't speaking. If you wish to speak, please raise your hand. If you're on Zoom, please use the “raise hand” function.

[*English*]

I would like to remind witnesses that committee members may ask questions in either French or English. If you 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.

As well, I have a reminder that all comments should be addressed through the chair.

I will now welcome our witnesses.

Appearing as an individual, we have Dr. Lori Brotto, professor, Department of Obstetrics and Gynaecology, University of British Columbia.

[*Translation*]

We're also joined by Dr. Lyne Desautels, a family physician.

[*English*]

We also have with us, from Med Melanin, Yvonne Osagie, CEO.

Welcome. We will begin with opening statements. I have a yellow card that I'll put up when there is one minute remaining and a red card that I'll put up when there are 30 seconds remaining.

Dr. Brotto, you have the floor for five minutes.

Thank you.

Dr. Lori Brotto (Professor, Department of Obstetrics and Gynaecology, University of British Columbia, As an Individual): Thank you so much for inviting me to speak with you today.

I want to acknowledge that our work at the University of British Columbia and the Women's Health Research Institute is situated on the traditional, ancestral and unceded territory of the Coast Salish peoples, and the Musqueam, Squamish and Tsleil-Waututh nations.

Thank you, Madam Chair and members of the committee, for this invitation to speak with you today. Most Canadian women between 25 and 54 are in the paid workforce. That means almost every woman in this country will go through perimenopause and menopause while she is working, yet we have remarkably little data in Canada on what this means for her job, her career and her income. Today, I'll share findings from HER-BC, a study our team at UBC and the Women's Health Research Institute led of more than 2,000 women in British Columbia aged 39 to 60. Our team has published some of the top-line findings from this survey already, including the range and severity of menopause symptoms and the impacts on quality of life and mental health.

In the study, we found that 80% of our sample, which was largely representative of the B.C. population, had at least one menopause-related symptom that was interfering in their life. We found that over half the women with severe symptoms were not receiving any treatment at all for their symptoms, and we found that the severity of vasomotor symptoms, what we commonly classify as hot flashes and night sweats, is directly related to the severity of mental health symptoms, including anxiety and depression.

What I want to share with you today are our not-yet-published data from the study based on analysis that was a collaboration with economists at the Vancouver school of economics. These results are not yet peer-reviewed, and they are a snapshot in time, but three key messages stand out.

First, menopause is quietly reshaping women's careers. More than one in five women in our study told us that in just the past six months, menopause symptoms had forced a change in their working life. About one in six had cut back on their hours; one in 10 had turned down a promotion; about one in 20 had quit, retired early or changed their jobs; and one in four had missed work because of symptoms related to menopause in the past year.

The more severe the menopause symptoms, the bigger the impact. Among women with low symptom scores, 7% reported a career disruption, but among those with high symptom scores, it was nearly 40%. Of the 16 women who had been laid off or fired, 88% of them had severe menopause-related symptoms. We also asked about productivity without mentioning menopause at all, and the pattern held. Among women with few symptoms, one in four said that they had been less productive at work, and among women with severe symptoms, it was nearly three in four.

The second key message is that this impact is largely invisible in standard economic statistics. When we looked at whether women were employed, how many hours they worked, or what they earned, the difference was small. This doesn't mean that menopause doesn't matter. It means that women are absorbing it. A promotion turned down doesn't show up in this year's paycheque. It shows up over the next decade and in her pension. Women with the most severe symptoms and disabilities were the least likely to complete our survey, so if anything, our findings are an underestimate.

The third key message was that the burden falls hardest on women with the least protection. For women in temporary, contract or self-employed work, the link between menopause symptoms and career disruption was nearly twice as strong as for women in permanent jobs. These are the same women who are least likely to have paid sick leave. In our study, over 90% of permanent employees had it, compared to only 40% of women in non-permanent jobs and only 20% in the self-employed group.

Two other findings from our survey really matter. The symptoms most strongly tied to work disruption were not hot flashes. They were low mood, anxiety, irritability and exhaustion—in other words, the mental health and cognitive symptoms. For women still having periods, heavy and painful bleeding added to the burden that they faced.

What can be done in response to these findings? I offer four suggestions.

● (1635)

One, let's measure it. Canada has no national data that follow menopause symptoms, work and earnings over time. Statistics Canada—

The Vice-Chair (Emmanuella Lambropoulos): I apologize, Dr. Brotto, but I will have to cut you off, as the five minutes are up and we are on a strict timeline. You will be able to answer these questions when you're answering MPs.

[*Translation*]

Dr. Desautels, you have the floor for five minutes.

Lyne Desautels (Family Physician, As an Individual): Good afternoon.

Thank you for giving me this opportunity to discuss an issue close to my heart. This issue is women's health, both in their professional lives and in our society.

I've been a general practitioner for over 30 years. I'm also a speaker and a co-author of two books on menopause. These books are *Mieux vivre la ménopause*, co-written with Isabelle Huot, and *Ma santé, mes hormones* , which was published on September 16 of this year. In this book, we discuss the impact of perimenopause on women's professional lives.

My journey has led me to develop an interest in integrative medicine, prevention and healthy longevity. At the heart of this approach lies a conviction. To provide effective support for a woman, we must understand how her symptoms, physiology and daily life are interconnected. This has led me, for over 20 years, to focus on women's hormonal health, particularly during perimenopause and menopause. Behind the symptoms of fatigue, insomnia and mental health challenges lies a person trying to understand what's happening to her. She's a woman who embraces her responsibilities but who no longer quite recognizes herself as she navigates this period of hormonal change.

Perimenopause and menopause aren't diseases. They constitute a major hormonal transition that warrants understanding and support. Hormonal fluctuations can disrupt sleep, mood—as we've heard—physical well-being and intimate relationships. Some women will go through this period with few difficulties, while others will feel the impact on both their relationships and their performance at work. So, it's important.

Sex hormones play a role in a number of multisystemic functions. Their gradual decline affects metabolism, so all the biochemical reactions in a woman's body that serve to produce energy, including at the cellular level. We must look beyond the reproductive years when it comes to these hormones if we want to talk about prevention. That's why I advocate for a comprehensive and personalized approach to health. We must focus on the individuals and on the patients. We must listen, assess, explain and work with each woman to develop personalized care tailored to her situation.

The problem lies in the fact that it's currently too difficult to access this support. For some women, the process of finding an available and trained professional, obtaining reliable information, discussing treatment options and receiving follow-up care can turn into a real obstacle course. Women have the right to be informed. To make informed choices, they need people to listen to them and hear them. This takes time. In today's medical landscape, it's difficult to make this happen. They shouldn't need to burn themselves out and fight in order to get help. Imagine having to lead a meeting after multiple nights of interrupted sleep, teaching students while experiencing hot flashes—I've been there—or providing care while dealing with chronic fatigue. This may be a temporary challenge for women, but it can affect how others perceive them, particularly in terms of their skills and commitment in the workplace.

In 2023, the Menopause Foundation of Canada carried out an analysis on symptom management, which is allegedly tied to—get this—about 540,000 lost workdays each year in Canada. Between 50% and 75% of women in perimenopause will experience symptoms, while 30% of them will have severe symptoms. Between 10% and 20% of these women will see a decline in their productivity. One in ten menopausal women will leave her job because her symptoms become too severe or because they affect her quality of life too much.

That said, I would like to propose three priorities. First, we need to improve training for health care professionals and the information provided to the public about perimenopause, which can begin as early as the mid-thirties.

Second, we need to improve access to assessments for personalized care based not only on evidence but also on clinical experience.

● (1640)

Third, we need to support workplaces by informing managers and educating both managers and employees. It's about confidentiality and respect. Flexibility is key, and accommodations should be made whenever possible.

The Vice-Chair (Emmanuella Lambropoulos): Thank you, Ms. Desautels. Your time is up.

[*English*]

I will now turn the floor over to Ms. Osagie.

Yvonne Osagie (Chief Executive Officer, Med Melanin): Thank you, Chair and members of the committee.

My name is Yvonne Osagie. I'm the CEO of Med Melanin. We're a preventative digital health platform designed to support underserved women and caregivers to be better advocates when they go to the doctor and to teach women to be heard in rooms in which they have historically not been heard.

Imagine it's 7:40 in the morning. A woman is on her way to an eight o'clock shift at a long-term care home. She slept for about two hours after waking up at 1:00 a.m. drenched in her own sweat, and then she had to get up at 5:30 to get her kids out the door. This was the fourth night in a row this week. She gets on her feet and then starts her 12-hour shift of caring for other people's parents. She's a bit slower that day; she's been a bit slower for a while, and she has started to notice it. Her supervisor has noticed it as well.

There's nothing in this story that's within the woman's control.

In multinational studies of women aged 40 to 65, Canada has the highest rates of menopause-related sleep disruption measured anywhere in the world, at about 67%. This is where our national numbers go quiet. We say menopause costs the economy about $3.5 billion and 540,000 lost workdays, and those figures are real, but they also undercount. A lost workday is a woman who did not go into the office, but the figures do not count the woman who did go but whose productivity was impacted, the woman who could not afford to miss a shift or the woman who will always have to show up.

The second thing is that this burden is not carried equally. SWAN, the Study of Women’s Health Across the Nation, has followed American women through the menopause transition for about 25 years. It found that Black women reported the longest duration of vasomotor symptoms of any group studied.

We are not without Canadian evidence. A national study of 1,000 Canadian women commissioned by benefits insurer GreenShield found that 40% of racialized women did not know where to seek care, and only about one in three had ever discussed their symptoms with a health professional, compared with roughly half of women overall. She's less likely to know what is happening to her and less likely to raise it, and she will often minimize her own symptoms.

Everything we're discussing about workplace policy resets at an accommodation system level. An accommodation requires a request; a request requires a diagnosis, and a diagnosis requires a clinician. How does she get one? An estimated 5.9 million adults in the country don't have a family doctor or a nurse practitioner. However, for those who do have one, an estimated 41% of Canadian medical schools do not incorporate menopause education. If there's no provider, no diagnosis, no documentation, no accommodation and no data, every line breaks harder for the woman I just described.

There is new research out of Norway and Sweden called “The Menopause ‘Penalty’”. It found that earnings in Norway fall 7.4% by the fourth year after menopause is diagnosed. The same researchers also found something hopeful, which is that awareness and access to care increased in Sweden, with diagnoses rising by 29% and treatment rising by 50% when awareness was at the forefront. The entire benefit went to the women without a college education, which puts into place the socio-economic status.

There are three things I want us to think through.

First, measure it properly. Canada's first national menopause study of real scope is being built. The question for this committee is whether it's designed to disaggregate by race, by immigration status, by occupation or by sector. SWAN's original study excluded women who had surgical menopause, primarily Black and Hispanic women, and had to go back and make that adjustment. As Canadians, we have the opportunity to do that up front.

Second, fix the whole chain, not only the last link. Require menopause education in medical and nursing training. It's not optional. Pay clinicians for the time diagnosis takes, with the right incentives in the system. Cover medication, because the safest forms of hormone therapy are often the ones basic plans will not cover, which makes treatment a benefit of having a good job.

Third, build workplaces that do not require a woman to disclose in order to work while protecting every woman who does disclose with ventilation, cooling, predictable schedules and real breaks for folks who do shift work. Make these available to everyone so that they don't have to be requested by anyone. Create a low-friction route for women who do come forward, because they should not need a specialist letter to get a desk fan.

On the topic of the law, menopause is not named anywhere in Canadian legislation, but the grounds are, and they are the foundation on which we can get started. Sex, age and disability are protected, and the duty to accommodate is already attached to them. The foundation exists. What does not exist is that indication—the precedent of menopause.

The Ontario Human Rights Commission—

● (1645)

The Vice-Chair (Emmanuella Lambropoulos): Thank you so much, Ms. Osagie. I know that you'll be able to continue when you're answering the questions.

I appreciate your testimony—all of you.

Now we will begin rounds of questions. We will start with a round of six-minute questions, and I'll pass the floor to MP Roberts.

You have the floor for six minutes.

Anna Roberts (King—Vaughan, CPC): Thank you, Madam Chair. You're doing a great job.

Thank you very much to the witnesses for being here. It's an important study for all of us, and I can tell you that I'm one of those ones struggling with menopause, and I'm way beyond that age. I have hot flashes all the time. I don't know why. They drive me crazy.

I'm going to ask a question. I know it's a $3.5-billion annual impact to the Canadian economy, and I understand that lost income from women is $3.3 billion. One in ten women leaves the workforce, and $237 million is lost to the employers.

I'll ask all of you to give me your response to this question: Are we doing enough at the federal level to ensure that we are putting more funds and more action to educate both the employer and the employees about the situation? That's a lot of money. A lot of women are single women, and a lot of them are supporting their families. That's a lot of lost income. It's going to cost us all.

We'll start with Dr. Desautels, and then we'll move around.

● (1650)

[*Translation*]

Lyne Desautels: I'm happy that you asked me that question.

Funding is really a major issue. There are inequalities at the provincial level. I practise in Quebec, where I've set up private clinics that I fund out of my own income to try to make them accessible. I would have liked to receive grants to make things more affordable for women.

I've also established multidisciplinary work teams, giving nurses and nurse practitioners the scope to practise, as mentioned. I believe that we need to team up with a variety of health care professionals. For women to regain their power to make decisions on their health and hormonal health, we must inform them, listen to them and hear them. However, a great deal of educational work remains to be done.

I run an educational platform on hormonal health. I've published two books and I'm trying to spread the word. However, some recommendations also limit the ability of our health care professionals to become more open to the reality on the ground and to what women are actually experiencing. We need to get back to this. We need to carry out proper clinical assessments and not just follow restrictive recommendations that make care inaccessible to many women.

[*English*]

Anna Roberts: Thank you.

I'll go to Dr. Lori Brotto to give her an opportunity.

You said there were four recommendations. You didn't get a chance to finish. I'm going to give you that chance.

Dr. Lori Brotto: Thank you, MP Roberts. I'm sorry to hear that the hot flashes are continuing. You're in very good company; let me just say that.

There are four recommendations that come out of our very robust research.

One is that we need to measure this. Canada has no national data following menopause symptoms and work and earnings over time. The Menopause Foundation survey was excellent, but it was a single snapshot in time. We need to build this into our Stats Canada surveys.

The second thing is that we need to close the gap for precarious workers so that sick time and income supports reach women in those contract and self-employed roles, because menopause symptoms follow them too.

Third, we need to name menopause explicitly in the federal workplace and human rights guidance so that federally regulated employers understand their duty to accommodate.

The last thing I'd recommend—and this is very in line with Dr. Desautels—is to invest in care, including mental health care and menopause-informed primary care so that women can get their symptoms treated before they get back to work. Again, vasomotor symptoms are very important, but what we heard and what we see in the data is that it's the cognitive symptoms—word finding, attention, brain fog and mental health—that seem to contribute the most to those workplace impacts.

Anna Roberts: Thank you for that.

I'll go to Yvonne.... I'm not even going to try to pronounce that name because I know I'll mess it up.

What are some of the dangers with the misdiagnosis for women of colour? You talked about how it impacts them—endometriosis and the rest of it. What kind of impact...?

You only have a short time to answer that. I know because she gave me the yellow flag.

Yvonne Osagie: That's okay.

We start to see the impact in how women describe it. That is part of what's missed. If a patient doesn't have the terminology to say, “I'm having brain fog”, maybe they'll say, “I've just been excessively tired” or “I need my fan at all times.” They won't have the exact terminology. If they don't have it and they're stuck with a 15-minute appointment slot, they have to maximize it as much as possible, and it just continues to get pushed down the line, unfortunately.

To answer your original question, about accommodation and what that support can realistically look like, part of it is hybrid work. We've moved away from that in 2026, when it was probably one of the most effective things to support people in desk-related work. In terms of shift work, it's the inability for women to voice that they have menopause for fear that it will impact their career or impact—

● (1655)

The Vice-Chair (Emmanuella Lambropoulos): Thank you, Ms. Osagie. That's the end of MP Roberts' time.

The floor goes to MP Nguyen.

Chi Nguyen (Spadina—Harbourfront, Lib.): Thank you very much, Madam Chair.

I'd like to give a huge thank you to the witnesses for joining us today. This is such an important study.

First, Dr. Brotto, could you tell us when this peer-reviewed material might become publicly available or if we're allowed to have access to some of these findings? If you could share them with the committee, that would be very helpful. Do you have a sense of when that will be published?

Dr. Lori Brotto: Absolutely. The entire report, with the findings, as an unpublished report is on the Women's Health Research Institute website. If you go to whri.org and search “menopause”, it will take you right to the *HER-BC* report.

As noted, we also have a number of peer-reviewed publications coming out. We've had three published so far. The peer-reviewed publication on the workplace data is not published yet. We anticipate that it should be out by the end of this calendar year.

Chi Nguyen: Each of you started to speak a bit about workplace accommodations and ways in which employers could make adaptations. I wonder if you could add a little more colour and reflection. Have you seen some very strong best practices or approaches that have made it easier for women to step back or take the pause they need in order to manage their symptoms?

Perhaps I could start with Ms. Brotto.

Dr. Lori Brotto: I'm based in British Columbia, and one thing we've seen is the expansion of benefit plans to include many of the common specialized providers, such as massage therapy and mental health providers, given that those tend to be some of the specialists, in addition to primary care and those who prescribe hormones and from whom women seek help. This is an important gender-specific and life-stage-specific thing that can be very easy for workplaces to do: Make sure they have coverage for the specialists who are delivering evidence-based care.

[*Translation*]

Chi Nguyen: I'll try to speak in French.

Dr. Desautels, could you also comment on this issue regarding the workplace?

Lyne Desautels: Yes.

I've personally developed models to make this accessible, but I believe that education is key. I think that we need to educate women so that they learn to pay attention to themselves, listen to the language of their bodies and trust themselves. We also need to teach health care professionals to take a more comprehensive approach. As I said, this isn't a disease and the symptoms affect multiple systems.

I'm really glad that we talked about mental health. One of the main reasons for consultations during perimenopause isn't irregular periods, but rather irritability, premenstrual syndrome and anxiety. These mental health issues have a major impact on the quality of life of women, on their relationships and also on their work.

I think that we need to start educating women so that they can pay attention to what's happening in their bodies and become aware of it. That way, they will understand the impact of hormonal changes. I call it the “living laboratory”. The human body never lies and the language of the body is important. Awareness and knowledge put women in a better position to discuss these issues with their health care providers. A great deal of work must be done to dispel myths and educate patients, the general public and health care providers. We need to team up with a variety of health care professionals. In my view, the multidisciplinary approach is extremely important.

[*English*]

Chi Nguyen: Thank you.

Ms. Osagie, you started to describe a low-friction opportunity for those in workplaces such that they have to physically be there. Could you tell me a bit about some of the insights you have from recommendations such as that?

Yvonne Osagie: I'm sorry. I think I missed a bit in the beginning.

Chi Nguyen: Sure. I wanted to hear more about how you described a low-friction opportunity as the easiest, so people didn't have to disclose. Can you tell me a little more about what that could look like?

Yvonne Osagie: Absolutely.

Some companies have tried this in terms of menstrual care, with people taking one day off a month. I have seen that rejected in the U.K.

It's that low-friction piece, wherein someone doesn't have to disclose. It could be something with accommodation and support for everybody. If they're doing shift work, this could be having ventilation and having coordinated breaks that they can have inside their appointments. It could be having hybrid work for those it's applicable to, and that may not be applicable in all spaces.

It could be having a dedicated professional there so that they can have that conversation. In a lot of spaces, many women may not be comfortable talking about their health care in a workplace environment, but they would be comfortable talking about it with a health care professional. They would be comfortable talking about it with a counsellor.

If you provide that service and say it is offered to everybody, it doesn't feel as though they've isolated themselves and they're automatically saying that, by using this service, “I have menopause and therefore it will impact my career.” If you make it available to everybody, that's when the optionality and support can be provided.

● (1700)

Chi Nguyen: Thanks very much for your time today. I really appreciate your responses.

The Vice-Chair (Emmanuella Lambropoulos): Thank you, MP Nguyen.

The floor goes to Madame Larouche.

[*Translation*]

You have the floor for six minutes.

Andréanne Larouche (Shefford, BQ): I would like to thank the witnesses for joining us today. I also want to thank you for trying to educate us, because we hear all sorts of things.

Fortunately, people are talking about this matter more and more. In Quebec, we had *Loto-Méno*, which really tried to break down certain taboos and even to make the issue seem less alarming, despite the seriousness of the documentary. We've recently seen newspaper headlines about issues such as the lack of supply of estrogen patch treatments or the mounting evidence of the impact on the labour market and the losses that this entails. Thank you for giving us hope.

Ms. Osagie, in your remarks, you pointed out that symptoms may subside over time and that solutions are available. Ms. Desautels, you said that this isn't a disease, but a hormonal disruption. I'll wrap up my opening remarks here. Thank you.

For my first questions, I'll start with you, Ms. Desautels. You touched briefly on your third priority, which concerned raising awareness in the workplace. I'll give you the opportunity to elaborate on that point.

Lyne Desautels: I've already been invited by certain organizations and companies that run educational programs or that invest in this approach. I've given presentations to both managers and employees. This opens up a discussion. It also makes people aware of what's happening and what can happen when hormonal changes occur.

We shouldn't feel guilty. We need to keep in mind that this phase is a hormonal transition and that solutions are available, such as hormone therapy. However, we can also do many other things, such as adjusting our lifestyle habits, managing stress more effectively, getting better sleep and eating a healthier diet. These steps can change the entire course of the unavoidable perimenopause phase and reduce its symptoms.

We can teach women about the many things that they can do, such as how to prepare for a doctor's appointment. We discuss this in the book *Ma santé, mes hormones*, a practical guide that provides tips for women.

We also need to remain open to different perspectives. Menopause is often viewed in a highly negative light. I'm glad that you brought this up. It's a transition, but it can be celebrated in certain communities, such as indigenous communities. The role of women changes in society and the perception of menopause varies by culture. A negative stigma means that women will experience more symptoms. This has been demonstrated.

So we can do many things, such as providing education, giving practical tools and changing lifestyle habits. This can alleviate symptoms and help women navigate this unavoidable transition with fewer symptoms and less reliance on medication. It's extremely sad to see women labelled with diagnoses. If we treat the cause of hormonal imbalances and restore hormonal balance during this life transition, we can reduce symptoms, alleviate the impact on the workplace and lessen the effects, which can be quite significant and severe for some women.

● (1705)

Andréanne Larouche: I love you, Ms. Desautels, I love you. Thank you so much for reminding us that, in some cultures, getting your first period and pregnancy are seen as steps in a woman's life. It brings tears to my eyes. Thank you.

I'll now turn to you, Ms. Osagie. You spoke about pregnancy as a precedent. Since you didn't have time to finish your opening remarks, I'll let you do so now.

[*English*]

Yvonne Osagie: I was finding a way to tie it back to that, so that's perfect.

We have Canadian legislation right now that focuses on human rights in Canada, federally and provincially. There is a precedent that came out, I think, in the early 2000s that referenced pregnancy specifically. That precedent was added to the policy. It didn't enable us to create whole new legislation, but if we publish a policy that connects with existing legislation, it can be done in a reasonable time frame.

A big part of what I try to focus in on is trying to make things really realistic and plausible in a short time frame so that in the time we're waiting to get these things done, not as many women are impacted or affected in that care. Part of this means that we're measuring, we're training and we're treating her before the crisis.

There are a few things, based on how the conversation has been going today, that might be worthwhile for us to consider.

The first is inquiring about community health support with different initiatives. You can support those within the community.

The second is ERGs within certain forms of employment. They might be a good way for us to enter in from a workshop perspective.

The third that we've brought through is that there's a lot of misinformation with regard to menopause and perimenopause. Having educational campaigns is within our reach, and we can actually get this done. We can do them in a way so that they're use language that resonates with different communities, so maybe you won't use the words “brain fog” but you'll say you're having trouble remembering something, or you'll talk about excessive sweating in a way that resonates with the person and doesn't make them feel embarrassed or as though it's only them. You bring the community in there.

There are some new benefits that actually—

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much, Ms. Osagie. We are a few seconds over the time already, but thank you for your testimony.

[*Translation*]

Thank you, Ms. Larouche.

[*English*]

We will be going to our second round of questions. We will begin with MP Borrelli.

You have five minutes.

Kathy Borrelli (Windsor—Tecumseh—Lakeshore, CPC): Thank you, Chair.

As a woman who has already experienced menopause, and as a registered nurse, I have spoken with many women who have had different experiences going through the process.

I was very interested to hear from Dr. Lyne Desautels that public education during perimenopause is really important. My thoughts have been—and you can tell me whether I'm on the right track—that women who have a better level of health, physical fitness, grounding and good nutrition may have an easier time with menopause.

Is that something we can teach or explain to women to get the news out and prepare them for perimenopause and menopause? How would you do that?

[*Translation*]

Lyne Desautels: I love your question, because we have work to do.

When we talk about menopause, we immediately think of older women. However, we have work to do. We need to prepare young women to manage their stress and adopt better lifestyle habits. Hormonal changes begin in the mid-thirties. We shouldn't wait until we reach menopause or perimenopause and experience many symptoms.

We can do many things to alleviate or manage the impact of symptoms that develop gradually. We lead a lifestyle marked by cortisol and chronic stress. We're also at a slightly higher risk because of endocrine disruptors and the environment. Our lifestyle makes us slightly more prone to a hormonal imbalance. Women also use contraception for long periods, which leads to a poorer hormonal reserve over the long term. The number of pregnancies is also lower. We know that this affects the hormonal reserve, the impact of the hormones, the protective benefits that women derive from certain sex hormones and healthy longevity.

All this takes preparation. We need to be aware of things and to know what to do. We need to recognize the signs, pay attention to ourselves and reflect on these issues starting in our mid-thirties. We need to educate our young women so that they understand their bodies and their menstrual cycles. Women experience cycles throughout their lives and will go through changes. We need to do this work. We shouldn't just focus on women in menopause, but on young women as well. They need to understand the impact of hormones on their health as they get older. A 20-year-old woman's reality is different from the reality that she'll face at age 30, 40 or 50.

This is the preventive aspect. The more we take action to mitigate the effects of hormonal imbalances early on, the less severe the consequences and the better our long-term health.

● (1710)

[*English*]

Kathy Borrelli: Thank you so much.

For so many years, women have spoken about experiencing symptoms without knowing whether they may be related to perimenopause. What are the main barriers preventing women from receiving a timely and accurate diagnosis?

Who would like to answer? Very well. Thank you, Dr. Brotto.

Dr. Lori Brotto: Thank you for the question.

Unfortunately, we've lost about two decades of adequately training our health care providers. In part, it was due to a very large landmark study that was published in 2002. Although the study itself was excellent, the reporting out on the findings of the study led to a real scare that hormones cause breast cancer. That scare was felt among women using hormones, health care providers and, really, everyone. It made the front page of The New York Times.

We've lost 20 years by not educating our health care providers. That tide has changed, as we are now seeing in our medical schools across the country.

I'm involved in the menopause curriculum at the University of British Columbia. It's now required teaching for our medical undergraduates. This means that every doctor, regardless of whether they're going to be an OB/GYN, an endocrinologist or a psychiatrist, will get some training on menopause. That's not the case across the country, but as I said, the tide is changing.

That's where some of the bottleneck is, because we have—

The Vice-Chair (Emmanuella Lambropoulos): Thank you, Dr. Brotto. That's the end of MP Borrelli's time.

Thank you, MP Borrelli.

The floor goes to MP Nathan. You have five minutes.

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

Thank you all for being here today to answer these questions for us so that we can have a better understanding of the subject.

Dr. Lori, can I ask you to continue with the answer you were trying to give so that we can get the full scope of it?

Dr. Lori Brotto: I certainly don't want to criticize our health care providers, because I'm one of them, but the reality is that they have not been adequately trained. In fact, we have a situation in which women are showing up to their health care provider appointments with more information than their health care providers know about the safety of different treatments, what is evidence-based and what is not.

I am attending remotely from at the Menopause Society's annual meeting, and there are 3,000 people in the next room. This is a sold-out audience of people hungry to know about menopause education. My hope is that after the meeting, a lot of this knowledge will be disseminated to health care providers and women, because again, knowledge is power.

Juanita Nathan: My follow-up question is, what can the government do to retain women in their workplaces? What do you feel is in our power?

Dr. Lori Brotto: One of the recommendations we made, following the HER-BC findings that I reported earlier, is to make sure that we explicitly name menopause federally as a human right in human rights guidance, much in the same way as in the U.K., so that federally regulated employers understand their duty to accommodate. That's one thing.

Another thing is, if we come back to education, we can educate federal workers as well. No one is immune to menopause symptoms, yet most women feel quite embarrassed and will never talk to an employer about their symptoms. More education in the workplace, including for federal employees, would be one of our recommendations.

● (1715)

Juanita Nathan: Thank you.

Ms. Osagie, you talked a bit about how menopause is not found in any Canadian law. Can you elaborate on that? I think this is where you ended your comments.

Yvonne Osagie: It's a bit like what Lori was saying, which is the fact that we have legislation right now that references gender, sex and disabilities, and there's precedent that focuses in on this for pregnancy, but there's no precedent that focuses on menopause. This is the opportunity we have to make that policy change or make the adjustment needed so that we can see something you can take back to employers and say, “This is a policy. We need to make sure that we're following it.”

One thing I will say, to continue with your question, is that if we have mandated accreditation for health care providers.... It goes back to not fixing, but to adjusting the past few decades so that it doesn't feel like as much. Even though we have new health care providers coming to the system, which is amazing, and they have this knowledge, we can still have existing health care providers have the same knowledge and adjust it accordingly.

Something else that I think is within reach is having a billing code associated with menopause. If we have the incentive around that, you're going to have more support. Because appointments are only 15 minutes long and symptoms are so complicated, it's really hard to get them in during the initial appointment, especially if a patient naturally minimizes their symptoms. However, if we have policy that addresses this, and then we have them supported, saying, “Okay, how can we incorporate this into the appointments?”, this slowly teaches the patient the language to use and teaches health care providers what they should look out for in these different appointments.

Juanita Nathan: Thank you for that.

My final question is for Dr. Lyne. What are the gaps in public care that lead women to seek private menopause care? What would help them get this care through the public system?

[*Translation*]

Lyne Desautels: The overlooked resource in the public sector is a lack of time. In order to practise comprehensive medicine and carry out a proper clinical assessment of the impact of hormonal imbalances on women's health, we need questionnaires and trained staff. It would make perfect sense to provide grants to clinics staffed by trained nurses.

I've trained a number of nurses because I believe in teamwork. I've encountered some resistance. We're trying to develop assessment protocols with strong guidance and excellent clinical supervision—

The Vice-Chair (Emmanuella Lambropoulos): Ms. Desautels, sorry for interrupting you, but Ms. Nathan's time is up.

[*English*]

Thank you, MP Nathan.

[*Translation*]

I'll give the floor to Ms. Larouche for two and a half minutes.

Andréanne Larouche: Thank you, Madam Chair. You're doing a good job, that's for sure.

I asked Ms. Desautels and Ms. Osagie some questions.

Ms. Brotto, the report that you sent us includes a statistic that caught my attention and piqued my curiosity. In order to manage menopausal symptoms, in the past year, 43.5% of respondents consulted at least one provider of complementary health services. These providers were most often massage therapists, naturopaths, mental health professionals, physical therapists and acupuncturists.

I recently met with representatives from the natural health products industry. What role do these products play as a supplement to traditional medicine?

[*English*]

Dr. Lori Brotto: Thank you, MP Larouche. Your question is very timely. As I mentioned, I'm currently at the Menopause Society meeting. The entire morning was dedicated to a four-hour session on lifestyle medicine, which includes such things as supplements, nutrition, alcohol, sleep, mental health, etc. The literature was reviewed quite thoroughly.

What we learned and what we know is that there is a lot of evidence for exercise in managing many of the symptoms. We consider it “level 1 evidence”, which means the biggest kind of well-controlled studies, for managing things like hot flashes and night sweats, but also mood and some of the brain fog or cognitive symptoms. Far less research has been done on some of the supplements and complementary and alternative medicine. These are things that people understandably go to, but there's not a lot of evidence to support them. We need more research in that area.

As for all the research coming out of the next three days of this academic society meeting, my hope is that it gets disseminated out to women, because there is a lot of misinformation when women turn to online sources.

● (1720)

[*Translation*]

Andréanne Larouche: Yes, that's right. It must be said that this is one of the overlooked blind spots, even in this committee. I hope we can still take it into account. I hope there will be a brief from representatives of the natural health products sector that we can take into account in our report, as I think we will have to focus on that as a complement to traditional medicine.

Ms. Desautels, did you want to add anything?

Lyne Desautels: In my book *Ma santé, mes hormones*—

The Vice-Chair (Emmanuella Lambropoulos): I'm sorry. Ms. Larouche's time is up. Thank you very much.

I give the floor to Mr. Tolmie for five minutes.

[*English*]

Fraser Tolmie (Moose Jaw—Lake Centre—Lanigan, CPC): Thank you.

Also, thank you to this committee for allowing me to be here. I'd like to start off by saying that I was brought up in a single-parent home and I'm a single father of two young women. This committee is very important, as is the work you're doing here, and I'm grateful.

I'd like to ask the witnesses—and I thank you for being here today—as a male employer, what can I do better for my female employees who are experiencing menopause and perimenopause? What are the things that I can do within my office that would make their environment better?

I'll start off with Ms. Brotto, please.

Dr. Lori Brotto: Thank you very much, MP Tolmie.

I'm going to give you a very simple recommendation, and that is to bring an expert into the workplace to talk about menopause and mandate that 100% of your staff attend.

Fraser Tolmie: Okay. That's a very simple answer, and I appreciate that.

Let's walk through this scenario, because I'd like to get to you, Dr. Desautels.

We have a woman who goes to a doctor. The physician tells her she's going through menopause or perimenopause. She comes back into her workplace and maybe she shares that. Then there's this stigma: “Stay away from that person.” In some office environments, jokes may go through them.

An informed workplace was brought up. How do we do this in uninformed workplaces?

Doctor, you can go ahead. You've been jumping at the bit to do it. Go ahead. You can answer.

[*Translation*]

Lyne Desautels: I just wanted to tell you that the House of Commons has invited me twice to give talks as part of its health and wellness program. It's very helpful, for both men and women, to start a conversation, to talk about it and to understand the impact of all this. We also need to open the door to a broader discussion, so that people don't feel singled and so that stigma doesn't take hold.

To foster this understanding, people need to understand the situation. This still involves educational programs or workplace workshops. There are plenty of ideas, and I could talk about them until tomorrow morning. However, I think it's important to really invest in programs and workplaces. I even organized a lecture on menopause and men, to explain to men what happens in a woman's body. If you are interested, I would be happy to present it to you.

[*English*]

Fraser Tolmie: Thank you very much. I appreciate that, and I'm sure we'll be circling back with you.

As a male employer—and there are other male employers out there—I think we need to be better informed. Let me ask you this question: How many male advocates are there out there for this?

It's great that women are advocating on behalf of themselves, but there has to be a breakthrough, and men have to listen. They have to step up to the plate, to share this and to say, “Okay, this is something we're experiencing and this is something we need to deal with in our workplaces.”

Yvonne—I'm sorry, but I'm just going to ask you this question by your first name—would you like to share something about this? I think it is something you're passionate about.

● (1725)

Yvonne Osagie: I am passionate about it. In regard to advocacy, there are two ways you can think about it. One is starting young. If you start making women's health feel like a separate thing, whereby this is a girl's thing and that's a boy's thing, and you've separated it by gender or biology, then you lose the opportunity for everyone to be informed.

Oh, I think I have 30 seconds left. Okay.

Really quickly, it would be effective to have that support and education when people are in school, when they're really young, and then to have the education not just in the workplace but also in employee resource groups. This is when people will feel safe enough. Men will be able to ask some questions and not feel, for lack of a better word, “uncomfortable” asking about it, or feel that it's not their place to talk about it. They'll be surrounded by other people who deal with that and will have conversations.

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much, MP Tolmie and witness.

[*Translation*]

We'll move on to Ms. Ménard for five minutes.

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

I'd like to thank all the witnesses. This isn't always the case, but in recent weeks, all of us elected officials have been looking forward to this committee's meetings. We are passionate about the subject, and your expertise is very enlightening.

I will now move on to something we haven't discussed much yet.

Ms. Osagie, women are not a monolithic block. It may be dangerous to view them that way. Are there groups of women who are harder to reach when it comes to prevention and education? Could the government play a role in ensuring that coverage is truly national and reaches all groups of women?

[*English*]

Yvonne Osagie: Absolutely. A lot of the studies that have been done don't include a lot of indigenous women. That is one thing we need to take into consideration. The studies that have been done outline the distinctions in Black communities or Hispanic communities, in which they're forced into menopause because of hysterectomies. Those are recommended a lot when people have fibroids, which are very common in our community.

How do you reach them? Part of it isn't just speaking their language; it's providing the support in a place that's accessible. Community health centres exist across Ontario. There are different versions of community health centres across the country in which you can provide that type of initiative and support. Working throughout the system, when you have a lot of kids who would tell their mom about a workshop or initiative happening in school, you've trained them young and they've worked their way up, which is amazing.

Also, women tend to minimize their symptoms. You start to see that a lot more in specific communities. I like to think of a pain scale when someone describes their pain. If you start to describe it by the impacts it has to the quality of life and use that same terminology for menopause and perimenopause, now you've given them their own words to use to advocate for their care. You've also given them words for their health care providers: This is impacting my quality of life at a 10 versus a one. How do I know that? I'm having difficulty getting out of bed. I've tried for the past few hours, and I just can't do it.

When you put that terminology into place, you can slowly start to see those adjustments and support for the community.

[*Translation*]

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

Dr. Brotto, as you said, there are thousands of people behind you who are focused on this issue.

I'd like to shift the conversation to a completely different topic, and I'm curious to see if you have anything to add. We live in an increasingly digital world. Artificial intelligence is shaping a lot of things. Do these new tools have a role to play in better supporting women who are going through perimenopause and menopause?

I don't know if you've given any thought to this question, which I'm addressing to you, but the other witnesses here can also respond if there's time.

[*English*]

Dr. Lori Brotto: Thank you for raising this issue.

There are two things happening. Women are not getting their needs met through typical routes, so they are turning online. The Menopause Society presented this morning that over 60% of midlife women are turning to Instagram for their primary source of information around menopause. This is happening. Simultaneously, what's happening is that it's an unregulated space. Anyone can put anything on Instagram or social media.

This is a place in which we can step up. We can provide support for people who are doing the research, who are experts in the field and who have access to evidence-based information. We can make sure their information is reaching those populations, including the hard-to-reach populations—women with lower literacy levels, women who are not on social media, racialized populations and women who don't speak English.

This could be an incredible thing for the government to do. Support those digital platforms to make sure the right information is getting to the women who can benefit the most from it.

● (1730)

[*Translation*]

Marie-Gabrielle Ménard: Dr. Desautels, do you have anything to add to that?

Lyne Desautels: Absolutely. I funded and worked to develop an educational platform precisely to ensure that accurate information is shared. We live in a world where information is not controlled and where there's a lot of misinformation. There are also still many myths and resistance to understanding hormone therapy, the role of hormones in health, and anything to do with integrative approaches or functional medicine, which places greater emphasis on identifying the causes of symptoms rather than just treating the consequences. There is a tremendous amount of work to be done; we need to be heard and listened to.

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much, Ms. Desautels. That concludes the allotted time for this panel.

On behalf of the committee, I want to thank all the witnesses for joining us. If you have anything else to add, you can do so by email. Thank you again.

We will suspend for a few minutes to bring in the next panel.

● (1730)

_____(Pause)_____

● (1735)

The Vice-Chair (Emmanuella Lambropoulos): I call the meeting back to order.

[*English*]

I'd like to welcome to the committee all of our witnesses.

Appearing as individuals, we have Dr. Heather Edgell, associate professor, school of kinesiology and health science, York University; Dr. Kevin Whittingstall, director, department of medical imaging and radiation sciences, Université de Sherbrooke; and Dr. Nese Yuksel, co-founder and chief health and operating officer, Effica Health.

We will begin with opening statements. Cards will be used, as you probably saw before, for one minute left and for 30 seconds left.

Dr. Edgell, the floor is yours for five minutes.

Dr. Heather Edgell (Associate Professor, School of Kinesiology and Health Sciences, York University, As an Individual): Thank you very much for this invitation.

My name is Heather Edgell. I'm a researcher and associate professor at York University specializing in cardiovascular and autonomic physiology, with particular expertise in the influence of sex hormones, both naturally occurring and pharmaceutical, and in the physiological outcomes of menopause.

I'd like to focus my remarks today on the three broad areas in which we can improve the experience of menopause and perimenopause in the Canadian workforce: education, research and workplace accommodation.

The first is education. Menopause is a normal physiological transition, but “normal” does not mean inconsequential. The hormonal changes of perimenopause and menopause can affect multiple physiological systems, yet many people enter perimenopause with surprisingly little understanding of what is happening to their bodies. Their colleagues and managers may know even less.

This knowledge gap has consequences in the workplace. When an employee develops disrupted sleep, physical or cognitive fatigue, difficulty concentrating, temperature intolerance, headaches or heart palpitations, these symptoms can affect how she functions at work. If neither the employee nor the workplace recognizes that menopause may be a contributing factor, these experiences can be misinterpreted as a reduction in competence, resilience or commitment to the job. We need better public and academic education about menopause, but we also need education specifically designed for health care providers, employers, managers and occupational health professionals.

Second, Canada needs more research. We know considerably less about female physiology than we should. Historically, women have been under-represented in many areas of biomedical research. Even when women have been included, reproductive hormonal status has not always been adequately considered. Perimenopause deserves particular attention, because this is not simply a state of low estrogen. It is a period of substantial variability of many sex hormones. We need to understand much more about how this transition affects the human body and an individual's capacity to tolerate both physiological and psychological stress.

There is a much more specific research question that is especially important for this committee. Many symptoms associated with menopause and perimenopause have considerable overlap with symptoms experienced by people living with many chronic conditions, such as myalgic encephalomyelitis, postural orthostatic tachycardia syndrome, long COVID and even post-concussion syndrome. These can include fatigue, cognitive difficulty or brain fog, sleep disturbances, headaches, heart palpitations, dizziness, temperature dysregulation, and reduced tolerance for physical or cognitive exertion.

This overlap raises an important question that, at present, we cannot answer. What happens when a person already living with one of these conditions enters perimenopause or vice versa? This is particularly notable since all of these conditions affect women to a greater degree than men. Hormonal changes may exacerbate an existing condition; the chronic condition may make the menopausal transition more difficult, or symptoms from one may be incorrectly attributed to the other.

We urgently need research that examines these interactions, rather than studying menopause and chronic illness in separate silos. This is particularly important from a labour force perspective, which brings me to the third point: workplace accommodation.

Accommodation does not necessarily mean major structural change, nor should it assume that all menopausal women require assistance. Many do not. For those who do, relatively modest measures may make an enormous difference: flexibility in scheduling, opportunities for remote or hybrid work when appropriate, access to temperature control, uniform requirements, the ability to take breaks, flexibility following severely disrupted sleep and recognition that symptoms may fluctuate from day to day. Menopause is not experienced uniformly, and workplace responses should not inadvertently stereotype women or suggest that reaching mid-life makes someone less capable.

My recommendations are to educate people, health professionals and workplaces; invest in research into the physiology of perimenopause and menopause, particularly their interaction with chronic conditions and their consequences; and support flexible, evidence-based workplace accommodations that allow people experiencing significant symptoms to remain productive members of the workforce.

Menopause is inevitable, but losing skilled and experienced women from the workforce because we have failed to understand it or accommodate it is not.

Thank you.

● (1740)

The Vice-Chair (Emmanuella Lambropoulos): Thank you, Dr. Edgell.

The floor is yours, Dr. Whittingstall, for five minutes.

Dr. Kevin Whittingstall (Director, Department of Medical Imaging and Radiation Sciences, Université de Sherbrooke, As an Individual): Madam Chair and members of the committee, thank you for the opportunity to appear before you today.

My name is Kevin Whittingstall. I am the director of the department of medical imaging and radiation sciences at the Université de Sherbrooke. I hold a Ph.D. in physics; I held a Canada research chair in neurovascular coupling, and currently, I hold an institutional research chair in cerebrovascular imaging. For more than two decades, my research has focused on the human brain.

Early in my career, much of my work centred on developing new technical methods for visualizing the brain's blood vessels. About 10 years ago, however, the direction of my research changed dramatically. The first turning point occurred when my wife became pregnant with our first child. During that experience, I became intrigued by the phenomenon often referred to as “pregnancy brain” and assumed that there would be substantial scientific literature explaining how such dramatic hormonal changes affect brain function. To my surprise, there was not.

At around the same time, a brilliant young graduate student in my lab made a striking observation. Normal hormonal fluctuations across a single menstrual cycle were associated with measurable changes in blood flow to the brain. This was a profound realization. If hormonal changes occurring over just a few days could influence the brain's vascular system, then what might happen during a major hormonal transition, such as menopause? Those experiences led me to redirect my research program towards better understanding how female hormones influence the brain and its blood vessels, particularly in the context of menopause.

Our findings, together with others, support the emerging view that menopause is not simply a reproductive milestone but a critical neurological inflection point of accelerated neurovascular aging, with increased risks of stroke, cognitive decline and dementia. However, despite affecting virtually every woman, menopause has received only a fraction of the scientific attention devoted to other major health conditions. Based on CIHR funding data, diabetes research received approximately 15 times more funding than menopause research over the past decade. The consequence is predictable: One field is supported by decades of evidence, clinical guidelines and public awareness, while the other remains defined by unanswered questions.

My recommendation to the committee is simple: Invest in menopause research. Greater investment would strengthen two pillars that are essential to this committee's goal.

First, it would accelerate the development of evidence-based therapies and interventions that support women throughout the menopausal transition. Recent findings, including our own, suggest that menopausal hormonal therapy and a woman's lifetime exposure to endogenous ovarian hormones may benefit brain health. At the same time, menopause is not a one-size-fits-all experience. State-of-the-art approaches in brain imaging, genetics and artificial intelligence, combined with longitudinal studies that follow the same woman throughout the menopausal transition, will offer unprecedented opportunity to understand what is happening, who is most vulnerable and who is most likely to benefit from treatment.

Second, research will provide the evidence needed to transform education. Every year, Canada graduates thousands of neuroscientists, psychologists and physicians, yet many complete their training with little to no education on how menopause may affect the brain. The reason is simple: Education can evolve only as quickly as the science that informs it. Without a robust body of scientific evidence, education remains fragmented, misconceptions persist and misinformation flourishes. As a result, the neurological impacts of menopause remain, at best, poorly understood and, at worst, normalized to the point of being overlooked.

The good news is that some of the most important scientific discoveries have come from asking questions that others assumed not be asked. Canada has the expertise, infrastructure and talent to answer them. The research we invest in today will shape how menopause is understood, treated and accommodated in the workplace for decades to come.

Thank you.

● (1745)

The Vice-Chair (Emmanuella Lambropoulos): Thank you, Dr. Whittingstall.

The floor goes to you, Ms. Yuksel. You have five minutes.

Dr. Nese Yuksel (Co-Founder, Chief Health Officer and Executive Vice-President, Effica Health, As an Individual): Thank you, Madam Chair and members of the committee, for the opportunity to contribute to this important study.

My name is Nese Yuksel. I'm a professor emerita at the University of Alberta, a recent past president of the Canadian Menopause Society, and co-founder and chief health and operating officer of Effica Health. I have nearly 30 years of clinical experience in menopause care.

Through my clinical and research work, I have seen first-hand how menopause symptoms affect a woman's ability to function at work. Such symptoms as sleep disruption, hot flashes, night sweats, fatigue, and mood and cognitive changes can affect workplace performance, with many of these beginning during perimenopause. In one of my studies, we found that menopause affected work primarily through presenteeism, although absenteeism was still an issue. Women continue showing up, but symptoms affect their productivity.

The good news is that effective treatments and evidence-based guidelines are available. As a guideline author, I have seen how the evidence has evolved, yet too many women still struggle to access care. When women cannot access appropriate care, symptoms continue to affect their function and ability to work.

The committee has heard about workplace accommodations, awareness and education. The Menopause Foundation of Canada has recently released its national menopause policy agenda outlining seven important recommendations. I would like to build on these by focusing on how we deliver health care. Workplace accommodations and education are necessary, but they alone are not enough. Women also need timely access to menopause care. This requires us to rethink how health care professionals work together, how we fund care and how technology can support them.

First, we need to rethink how we organize and deliver menopause care. We need interdisciplinary models that bring together family physicians, pharmacists, nurses and nurse practitioners, each contributing their expertise and working to their full scope of practice. For example, the Menopause Foundation of Canada recommends expanding pharmacist roles, including prescribing vaginal estrogen therapy and adjusting prescription medications. The same principle applies to nurses, nurse practitioners and other health care professionals. With appropriate training and care pathways, each can contribute meaningfully to menopause care.

Second, funding reform and care delivery reform must go hand in hand. The foundation has recommended improved physician compensation for comprehensive menopause care, including dedicated billing codes. This is important, but we also need funding approaches that support different ways of delivering care. Menopause is more than a single symptom. It requires adequate assessment, patient education, shared decision-making, treatment and ongoing follow-up. We should explore alternative approaches, including block funding for integrated care programs, that support the entire care pathway. This means ensuring that physician compensation is accompanied by resources that allow family physicians to integrate nurses, nurse practitioners, pharmacists and other health care professionals into their care models.

Third, technology can make care more efficient, coordinated and accessible. Digital assessments can collect and organize patient information before consultations. Clinical intelligence programs can help health care professionals apply evidence-based guidelines to individual patients, while AI-enabled tools can reduce administrative burden, allowing clinicians to spend more time delivering care. Importantly, technology must support, not replace, clinical judgment with appropriate validation and oversight.

Fourth, we need greater investment in menopause research. As a former full professor and researcher, I know how difficult it has been to secure funding for menopause research. A recent Canadian study examining 15 years of CIHR grants found that only 16 grants focused on post-menopause. This is less than 0.2% of all CIHR grants. We need more menopause research, but we also need implementation research to understand how best to translate existing evidence into accessible, effective care. I encourage federal collaboration with provinces and territories to evaluate innovative, publicly funded care models.

In closing, supporting women through menopause requires action in both workplaces and health care. We need to move beyond awareness and policy recommendations to implementation. Unless we improve access to timely, effective care, women will continue to struggle with symptoms that affect their quality of life and ability to work.

Thank you very much.

● (1750)

The Vice-Chair (Emmanuella Lambropoulos): Thank you, Dr. Yuksel.

We will now begin with our rounds of questions. The first round is for six minutes.

MP Roberts, go ahead.

Anna Roberts: Thank you, Madam Chair.

Thank you very much to the witnesses. This is an important subject. I'm really pleased you're here, so thank you.

My first question is for Kevin Whittingstall.

You mentioned blood flow in the brain. You mentioned brain fog as a common symptom. We know that dementia affects more women than men. Two-thirds of persons with Alzheimer's disease are women. How is this associated with menopause? Is it co-related?

Dr. Kevin Whittingstall: This is an excellent question. We often view certain pathologies in the brain as being related to the development of some proteins or different types of injuries, but we forget that, despite representing only 2% of the body's mass, the brain requires 20% of the body's budget for blood flow. If that blood flow is interrupted over a long period of time, the brain starts to suffer. With more research, we have to start looking at whether menopause is a primary risk factor for explaining the sex disparity in diseases such as dementia and Alzheimer's.

Anna Roberts: Does menopause also affect heart disease in women?

Dr. Kevin Whittingstall: We find that estradiol and progesterone seem to reinforce blood vessels not only in the brain but also in the body. As those levels begin to decrease, the elasticity and the stiffness of the arteries begin to change. As the inner lumen of the vessel changes, so does the risk for stroke or infarcts. I think there is a connection between what we're seeing in the blood vessels of the brain and what we're seeing in the heart.

Anna Roberts: That's interesting. Thank you for that.

My next question is for Dr. Edgell.

Can you briefly explain POTS to us, and can you explain how it and long COVID might affect older women?

Dr. Heather Edgell: Sure.

POTS, or postural orthostatic tachycardia syndrome, or lung—

Anna Roberts: I'm glad you said that.

Dr. Heather Edgell: They are both more prevalent in women as compared to men, but that doesn't mean they're exclusive to women as compared to men.

POTS, for example, does tend to get a bit better around menopause. However, that's not exclusive. Some people get their diagnosis in and around menopause, so there are some correlations there. However, the causation hasn't been shown by any stretch of the imagination.

The symptoms of menopause, perimenopause, POTS and long COVID do have considerable overlap, such as brain fog, fatigue, etc. Therefore, if somebody does have POTS or long COVID and they approach the years of perimenopause, how do they distinguish whether they have those conditions or perimenopause? Do we even know if one worsens the other? We don't know. We have no idea whether they are exacerbated, additive or anything like that.

This is why I'm suggesting more research into the area; it's so that we can dissect the two or at least try to figure it out. Maybe somebody's hormonal replacement therapy might help treat what is assumed to be their long COVID or POTS, but we just don't know.

● (1755)

Anna Roberts: I always thought it was listening to my husband—that's why I have brain fog.

No, I'm sorry. That's not very nice of me.

Dr. Yuksel, do you feel that more education for pharmacists on menopause and menopause-related symptoms, especially with regard to menopause medication, would be helpful for patients?

Dr. Nese Yuksel: Oh, absolutely. Thank you for the question.

Yes, any education for our health care providers, including pharmacists, is a benefit. I've been teaching for 20-some years—

Anna Roberts: You don't look a day over 21.

Dr. Nese Yuksel: Thank you.

I have been teaching. I had a whole course on women's health. I have been teaching on menopause for that many years, trying to get our pharmacists educated. I've worked very closely with the Canadian Pharmacists Association to bring education for menopause.

There's a lot of interest in providing education, and there's a lot of interest in supporting pharmacists in their practices, especially with the scope of practice expanding so much for pharmacists across Canada. It has really evolved, which is great to see, so it's about having enough education to support them so that they understand and can support patients right when they're dealing with it as far as prescriptions go or having more education on the different options.

Anna Roberts: Do you feel that there would be a benefit when family doctors are also aware of it? I remember when I started, and I'm still going through it. They offer you medications, but then they don't offer the associated risks. Is there a natural way of helping females going through menopause rather than prescribed medication?

The Vice-Chair (Emmanuella Lambropoulos): That's the end of your time, unfortunately. Thank you, MP Roberts.

The floor goes to MP Nathan. You have six minutes.

Juanita Nathan: Thank you, Madam Chair.

I want to thank the witnesses for being here.

My first question is for Dr. Kevin Whittingstall. Have you found any other research similar to yours out there?

Dr. Kevin Whittingstall: Unfortunately, no.

Juanita Nathan: You'll be the one person with this research, then.

Do any other countries...?

Dr. Kevin Whittingstall: Certain countries have put a lot of effort into promoting brain research across menopause. Germany, in particular, has made a concerted effort. The great news is that in the last two years, there have been two major initiatives. One is in the United States. The other one I'm forgetting at the moment.

The interest is there. Now it's Canada's turn to show that we can do just as well, if not better.

Juanita Nathan: Thank you so much.

I'll go to Dr. Yuksel. I wanted to talk a bit about the medication.

What are some of the barriers women face when getting the medications they need, whether they're hormonal or non-hormonal? They could be cost, drug coverage or Health Canada-approved drugs.

Can you talk a bit about that?

Dr. Nese Yuksel: The first barrier is access to practitioners and physicians who will prescribe hormone therapy or non-hormonal options.

The second barrier is the differences in coverage of what's on formularies across Canada. B.C., with its pharmacare, now provides publicly funded hormone therapy, but it's not consistent across all the different provinces.

The other difference that's a barrier is how the types of hormone therapy vary in terms of what is covered on drug benefit lists. Where I come from, in Alberta, we have quite a lot covered on the drug benefit list. Other provinces may not have such things as transdermal products, which could be a benefit for women who have risks of blood clots, heart disease or other effects, such as migraines and those types of things. That definitely becomes an issue.

Women who don't have a private plan—in Alberta, they might not have the coverage—are going to have to pay out of pocket. That's another barrier for women. Some of the non-hormonals are not covered at this point in time. We have some very new non-hormonal medications that just came on the market, and they would not be covered except through private plans.

● (1800)

Juanita Nathan: How do warnings and product labelling on menopause treatments affect prescribing? Do you think physicians are a bit reluctant to prescribe them or women are reluctant to take them?

I'm talking about the black box warnings in the U.S. We've talked about warnings here.

Dr. Nese Yuksel: That's a very good question about the risks. There's a lot of fear, among both health providers and patients, about using hormone therapy, especially since the Women’s Health Initiative study in 2002. That's caused fear up until now.

There are also labelling issues. For example, as you know, the FDA removed the labelling for the risks of vaginal estrogen therapy in the black box warning. We still have issues with that as far as not having this addressed in Canada to the same extent is concerned. That's going to scare people, because with vaginal estrogen therapy, there is not the risk of things like blood clots, and you don't really get systemic levels in the same way. That's why it's pretty safe to use, but this is an issue, and it could scare people away from using vaginal estrogen therapy.

Juanita Nathan: What do you think Canada could learn from other countries on access to menopause treatment? Is this the same for other countries, or are they more liberal with the medications they have?

Dr. Nese Yuksel: It varies from country to country. The opportunity is for some products that we don't have. We don't have a testosterone product in Canada. In Australia, they have a gel for women. We don't have one for women in Canada. A lot of times, we end up using the male alternative or compounding to prescribe. The variety of options may be a limitation for some women.

Each country is a bit different as far as access to products goes, but it's the number of different products we have.

Juanita Nathan: Thank you for your answers.

I have one more minute. I have a really quick question for Dr. Edgell.

I know you've done a study on shift work and women's health mid-life. Can you talk a bit about that? What are the major findings in your study?

Dr. Heather Edgell: With Hala Tamim, who was the principal investigator on that, we did this study—

The Vice-Chair (Emmanuella Lambropoulos): I apologize. This will have to end here.

Thank you, MP Nathan.

Juanita Nathan: Can I ask her to submit a written answer to that?

The Vice-Chair (Emmanuella Lambropoulos): Yes, absolutely.

Juanita Nathan: If you don't mind, please do that. Thank you.

The Vice-Chair (Emmanuella Lambropoulos): You can submit an email.

[*Translation*]

The floor is yours, Mr. Perron. You have six minutes.

Yves Perron (Berthier—Maskinongé, BQ): Thank you very much, Madam Chair.

I thank the witnesses for being with us today.

Ms. Edgell, I'll give you 30 seconds to respond to the last question you were just asked.

[*English*]

Dr. Heather Edgell: To answer your question, the study found that shift work influences the age of natural menopause. There is an interaction between shift work and menopause, so for today's topic, those who are working shift work have an earlier age of natural menopause, and that has negative consequences for cardiovascular health. That's the short and sweet version.

[*Translation*]

Yves Perron: Will there be an acceleration of the aging process in the human body in general?

[*English*]

Dr. Heather Edgell: It would cause premature menopause.

[*Translation*]

Yves Perron: What really struck me in your opening statement was when you made a connection between the various symptoms that can be triggered by menopause, the fact that these symptoms are present in different diseases, and that there could therefore be an interaction—perhaps even a positive one—in terms of medication. Have there been any studies on this or is there nothing available?

[*English*]

Dr. Heather Edgell: There are no studies on that, to my knowledge.

[*Translation*]

Yves Perron: Absolutely nothing.

[*English*]

Dr. Heather Edgell: Not to my knowledge.

[*Translation*]

Yves Perron: Okay.

You say that we need to improve education for the public, health professionals and so on. However, to provide better education, we need information. What I understand from your three statements is that there is a very significant gap in terms of research and evidence.

Am I on the right track?

● (1805)

[*English*]

Dr. Heather Edgell: Absolutely.

[*Translation*]

Yves Perron: Mr. Whittingstall, you mentioned, among other things, the annual amount allocated to diabetes research. If you had to give a rough estimate, how much should the federal government invest in research specifically on menopause to start getting conclusive results? I know this may be difficult to answer.

Dr. Kevin Whittingstall: Thank you very much for the question.

Over the past 10 years, according to my calculations, the Canadian Institutes of Health Research has provided $300 million in funding for diabetes research projects. For menopause, the figure is $20 million.

If we compare everything that's been achieved in terms of information and research on diabetes over 10 years with $300 million, what do we expect to achieve with $20 million over 10 years?

Yves Perron: That's ridiculous.

Dr. Kevin Whittingstall: I think it's time for the funding levels to be at least on par.

Yves Perron: That's a minimum.

As for your medical imaging studies, I understand that you also conducted some on menopausal women. What have you observed in general?

Dr. Kevin Whittingstall: Our study focuses on women before and after hormone therapy. The results are still very preliminary, but I can tell you that the hormone therapy used in this study is not only effective, but it also seems to have a positive effect on the brain.

Yves Perron: Thank you very much.

Ms. Yuksel, you also spoke at length about symptoms. You talked about presenteeism: women who aren't doing well, but who, like everyone else, get up in the morning and tell themselves they have to go to work, even though they are less productive. That leads to a series of secondary factors—not the physical symptoms the woman experiences, but other factors of a social nature or related to performance and judgments made in the workplace.

That ties in somewhat with what we were saying—the need for better information and the need to educate employers. What can the federal government do about that?

What we're looking for are specific recommendations for the government. This isn't straightforward, as the research is just beginning, but it will take years to have the results. In practical terms, I understand—and I assume that the committee members will agree—that we should adopt recommendations to fund research, but beyond that, what can we do to help, starting tomorrow, the women who are in this situation and experiencing difficulties in the workplace?

I also invite the other witnesses to feel free to speak.

[*English*]

Dr. Nese Yuksel: For information for women, especially in the workplace, to help employers, the federal government could work closely with the provinces as well to encourage workplace accommodations. It could also work with the Menopause Foundation of Canada, for example, or the Canadian Menopause Society and like organizations, which have the advocacy and the ability to provide that education.

For example, the Menopause Foundation of Canada has on its policy agenda working with workplaces to include accommodations and education about the impact on the workplace for women, as well as employers.

[*Translation*]

Yves Perron: I appreciate you bringing up the existence of the provinces, as this matter involves jurisdictional issues, which will not be straightforward.

We'll come back to that.

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much, Mr. Perron. That concludes your time.

[*English*]

We will now go to the second round. The floor goes to MP Borrelli for five minutes.

Kathy Borrelli: Thank you, Chair.

I want to say thank you to the witnesses. This has been a very productive day of study at this committee, with excellent questions from all around the table.

Thank you, everyone.

Something has come to mind for me. It's not in my notes, so I'm going to be talking off the top of my head.

I've noticed that the scare of using hormone therapy has come up twice. I think that began in the early 2000s. I'm a person who came out of that time and I have many friends and relatives who went through the whole experience of menopause without any hormone therapy.

Now we've heard from Dr. Whittingstall how menopause can really affect the workings of the brain, and we've heard from Dr. Edgell how menopause can really affect women's cardiovascular systems. There are thousands of women who are in their seventies and eighties and have never had hormone treatment.

Is there anything they can do now to make changes to improve the eventual outcomes later in their lives, because they haven't had hormone treatment?

This question is for anyone.

● (1810)

Dr. Heather Edgell: Diet and exercise are always good treatments. A lot of what happens in menopause is that your fight-or-flight system gets activated, so things like a nutritious diet and exercise bring the sympathetic activity down, and that's going to be beneficial to your cardiac health and your cerebrovascular health.

In the earlier session, natural products came up. There will be some holistic treatments and natural treatments that will probably be very beneficial.

Kathy Borrelli: Thank you.

Dr. Whittingstall.

Dr. Kevin Whittingstall: I don't think I have the expertise or the knowledge to comment on that, but thank you.

Kathy Borrelli: Okay. Thank you.

How about Dr. Yuksel?

Dr. Nese Yuksel: I would add that, as far as looking at all the lifestyle and behavioural health is concerned, it's your exercise, your nutrition and your daily habits, but also making sure that you get your screening and making sure that you're doing all the healthy things you would normally do.

What I wanted to mention regarding hormone therapy is that there is a role for hormone therapy during a time when a woman is most symptomatic. What we don't know is whether that's going to prevent anything in the long term. I wouldn't be worried if you didn't take it or if you did. That's what I wanted to reassure you about.

Kathy Borrelli: Okay. Thanks so much.

Do you know what? I was really intrigued by a question MP Roberts had that couldn't get answered at the end of her time.

The question, MP Roberts, was about natural treatments. Would you like to rephrase that question for us?

Anna Roberts: Sure. My question was about whether there are natural treatments that women can take as opposed to hormone replacement.

Dr. Nese Yuksel: Per the recommendations from the Canadian guidelines—the SOGC guidelines—for menopausal symptoms, one of the best complementary therapies is cognitive behavioural therapy. It has been shown to help with hot flashes, as well as with sleep, mood and all the symptoms. That is a really good approach. There are also mindfulness and other approaches within that. There's a lot on lifestyle factors. The guidelines talk about how to improve symptom management, including such things as quitting smoking, as well as some other factors.

For natural remedies, especially natural health products, the problem is the quality of the studies that have been done. There is some evidence for things like phytoestrogens, soy-based products that have estrogen-like effects, but for a lot of the natural health products, we don't have quality evidence to support them. It depends on making sure you don't have any risk if you're taking them and talking to a clinician who can really help you understand if there is any benefit to them.

Kathy Borrelli: Thanks so very much.

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much, MP Borrelli.

We'll move to MP Nguyen.

You have five minutes.

Chi Nguyen: Thank you very much, Madam Chair.

I thank the witnesses for joining us today. Hearing your testimony has been a bit mind-blowing.

Dr. Whittingstall, the research work you're doing is really compelling and important. I want to start by asking you, what are the next lines of query you're going to be following? If you had $300 million to invest in these questions, how would you focus your attention?

● (1815)

Dr. Kevin Whittingstall: Well, if there's $300 million on the table, then maybe we'll take it—

Voices: Oh, oh!

Dr. Kevin Whittingstall: In biomedical science, we usually have two types of studies. They're called “cross-sectional” and “longitudinal”.

For cross-sectional studies, we take a group of women who are labelled as being in menopause versus those not being in menopause. We've done those in the past and they've served us well. In the future, especially in the context of menopause, every woman has to be followed for several years. It has to be a longitudinal assessment, because the trajectories, I suspect, are going to be so different.

If we want to learn about menopause or perimenopause, we have to make these measurements on more of a serial basis. The issue is that it can go anywhere from five to seven or 10 years. The funding is of course going to be quite significant, but that's where we should go if we want to make inroads.

Chi Nguyen: Thanks very much.

Dr. Yuksel, you spoke about your interdisciplinary work and your work with pharmacists.

I wonder if you could speak to the kind of whole-of-systems change we'll need, given that we know there are already so many pressure points in our health care systems in every province in this country. How do we meet the huge demand that will exist if more women understand the life changes that are coming their way? Do you have any advice there in terms of best practice?

Dr. Nese Yuksel: One of the things we have really thought of in starting Effica Health, for example, which I'm a co-founder of, is having the technology supports to provide the type of care, and then having an interdisciplinary approach in which you can take the time, because menopause care takes time. There's good assessment and there are all the symptoms. When you're thinking that there are 34 symptoms of menopause, how do you look through all of that, talk about benefits and risks, and help a woman decide on the fear factor of hormone therapy? It all takes time.

Really, it's about funding the ability to have that time and how we can make that efficient. The best efficiency is to have the technology support with the right providers in an interdisciplinary approach. You can then have a regulated nurse, a pharmacist or a nurse practitioner who does a lot of that assessment, education and informed decision-making, with physician support as well, if there's prescribing or ordering labs and some of those factors. It's to bring all of that together. That's what we've done at Effica Health to still have a publicly insured menopause clinic within that.

Chi Nguyen: Thank you.

Dr. Edgell, I want to ask you this: You also spoke a bit about managing chronic conditions and that there are some similarities there. You also talked about lifestyle factors. There's a bit of an equity lens around this: You'll be able to afford good, nutritious food and know what these pieces are. I'm wondering whether you could comment on what public education could do in terms of supporting that and how we could address some of those equity barriers.

Dr. Heather Edgell: We need both public education and academic education. For undergrads across the world, they need to learn more about menopause and some intersectionality with chronic conditions—even basic physiology. Then, from public health...public health is not my expertise, but we need to have more brochures in doctors' offices, educating people about menopause and some of the symptoms that overlap with some of the chronic diseases that exist.

Chi Nguyen: Thank you for your time.

The Vice-Chair (Emmanuella Lambropoulos): Thank you, MP Nguyen.

[*Translation*]

Mr. Perron, you have the floor for two and a half minutes.

Yves Perron: Thank you, Madam Chair.

Ms. Yuksel, I'll come back to what we were discussing earlier when you referred to jurisdictional issues. Obviously, health care falls largely under provincial jurisdiction.

I was looking for measures the federal government could take, and one such measure would be to increase transfers to the provinces to give them more financial means. The pressure on health care systems was mentioned recently, and this could help alleviate it.

Do you think an increase in funding would be beneficial, in general?

● (1820)

[*English*]

Dr. Nese Yuksel: Yes. It's not just the funding but the way we deliver care at that point. The difficulty is that, at this point in time, the way we compensate physicians is not enough to provide the adequate care for menopause. We need more time, and we need effective time. What we need are models that allow family physicians to also bring other health providers, such as nurses and pharmacists, into that model to support the care, because some of that care can be done by other providers. It's not just “Here are the funding supports to do that” but also “How do we want to deliver that care in the provinces?”

[*Translation*]

Yves Perron: [*Inaudible—Editor*] about a multidisciplinary group, where a number of specialties could be involved in patient care.

[*English*]

Dr. Nese Yuksel: I'm sorry. I didn't quite catch that.

[*Translation*]

Yves Perron: You're talking about a multidisciplinary group, which would include doctors from different specialties, a social worker or someone with a background in kinesiology, for example, who could provide more comprehensive care for the individual. That's my understanding.

[*English*]

Dr. Nese Yuksel: It's both. There is the general care for menopause. For example, we could have digital intake. A lot of that information could be provided. We could have a nurse, pharmacist or nurse practitioner assess that initially, provide that decision-making and support, and then see the family physician within that. That is just the general support.

Absolutely, we could have other disciplines, and one thing we're doing is behavioural health—

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much. This brings us to the end of Monsieur Perron's time.

[*Translation*]

Thank you very much.

[*English*]

MP Tolmie, the floor is yours for five minutes.

Fraser Tolmie: Thank you very much to our witnesses.

I noticed that you were in the gallery for the first hour, so I do appreciate your sitting and attending here today.

We've talked about research and the need for more research, and we've talked about other countries. Who are we behind in research, and are we ahead of anybody in research in this area?

Dr. Edgell, go ahead.

Dr. Heather Edgell: That's a hard question.

Fraser Tolmie: I like asking the tough questions.

Dr. Heather Edgell: In terms of the chronic conditions, there's almost no research out there for things like long COVID and ME/CFS, so really, I don't think anybody is ahead of the game on those particular conditions. If we started funding those, that would definitely make us world leaders, especially if we looked at menopause at the same time. We would be the only ones doing it, so I think that would be a great step forward.

Maybe a former Canada research chair could speak more to this.

Dr. Kevin Whittingstall: We're still early in the game. In terms of the neurological impacts of perimenopause and menopause, the time is now. Everyone is interested in it.

As I said, we have all the expertise in this country to do it. We can be the first.

Fraser Tolmie: Thank you. That segues into my next questions.

We've talked about a woman who's getting kids ready, going to work and then dealing with the work. We haven't really talked about stress. Can we bring that up and share what the impacts are and how that affects...? Have you seen anything in your research or in your observations about the impact of stress on women dealing with menopause and perimenopause?

Dr. Nese Yuksel: I'll start.

Stress plays a huge part in that.

I've been working in a menopause clinic for 25 to 30 years. What we describe to women is that there's always going to be stress in their lives that they're going to have to deal with. They might be able to manage. Then perimenopause hits, and those hormones start fluctuating all over. Now it's more difficult to manage that stress level.

It impacts completely. It impacts how we see our symptoms, how we feel and our perception of how bad our symptoms are. Stress is going to add to the way we think—the brain fog and the cognition—and affect how we work in the workplace.

● (1825)

Fraser Tolmie: I know that I'm going to run out of time, but we heard in your testimonies about different provinces having different prescriptions and medications. Talk to me about provincial alignment. All health care is on a provincial level. What do you need to see from provinces in this and the interaction in order to get proper medications and proper prescriptions?

Dr. Nese Yuksel: Provincial alignment should be that all different products should be available, especially the hormone therapy. We should have transdermal patches and gels available, and cost should not be an issue.

The non-hormonal options that have just come on the market are really great options, especially for women who are breast cancer survivors, for example. We should be looking at covering all of those options. They should be on all the drug benefit lists. Ideally, they would be covered as in B.C.'s pharmacare, with the supports as part of.... They're freely available for all women in B.C.

Fraser Tolmie: I'm coming to the end of my time. I feel as though I'm on a soccer pitch. The chair's giving me the red card. I've never had the red card, by the way, just the yellow card. Here we go. I just got it.

We have limited funds. What's the best thing that we can do under the circumstances right now without any money? I'm not saying we don't want to give you money. I'm just asking what we do under these circumstances.

Dr. Kevin Whittingstall: We teach it.

Dr. Heather Edgell: I was going to say the same thing: education first.

I love research. I want to do research forever, but education should be first if we're limited.

Dr. Nese Yuksel: I would agree.

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much, MP Tolmie.

Now the floor goes to MP Nathan.

Juanita Nathan: Thank you, Madam Chair. I'll be splitting my time with Marie-Gabrielle.

Dr. Yuksel, you've talked a lot about education. Physicians will be the first line, I think, that women go to in order to get education at this point.

I don't know if you were listening to the first panel. The professor was saying that they have developed a new curriculum at UBC.

How do we make sure that all schools will follow and adopt something like that? What would be required for this to happen?

Dr. Nese Yuksel: The Canadian Menopause Society has done a lot of work in ensuring that physician education is addressed. One of the ways of addressing it is to have a national menopause curriculum that could be easily implemented in any medical program. It could also be implemented in any nursing, nurse practitioner or pharmacist program so that they would all get that same level of education. Therefore, one way is a national menopause curriculum that allows for that type of education.

The other approach is ensuring that we have ongoing educational programs for our practitioners who are currently in practice—continuing education. This last year, the Canadian Menopause Society had its conference. Attendance was double or triple what it normally is. It sold out, actually. There is a lot of interest, but we need programs to support all of our practitioners.

Juanita Nathan: Thank you.

Really quickly, Dr. Edgell, which features of the physical work environment matter most for women during menopause? I'm talking about temperature, ventilation, breaks and things like that. What did you find in your study with regard to shift work and menopause?

Dr. Heather Edgell: That's a difficult question. It's complicated, because everybody is different. Every woman will be different. It has to be individualized. Some will have hot flashes. Some will have brain fog. I don't think there's an easy answer to that particular question. It comes down to communicating with your manager and getting appropriate individual accommodations per person.

Juanita Nathan: Okay.

What do you need particularly employers and practitioners to understand about heart health? Was your study very conclusive, or was there another study that correlated this?

● (1830)

Dr. Heather Edgell: I don't think the particular study you're referring to brought heart health into it, but in general, an earlier age of natural menopause is...I'm going to say “worse”, but that's a poor choice of words. It has worse outcomes for your cardiovascular health. The longer you have circulating endogenous hormones, the healthier your cardiovascular system is. Whatever you can do to prolong the period from menarche to menopause, that's healthier for you.

Juanita Nathan: Thank you so much.

Go ahead, Marie-Gabrielle.

[*Translation*]

Marie-Gabrielle Ménard: Thank you, respected colleague.

Dr. Edgell, I'll use a term, but I'm not sure if it's the right one.

You talked a lot about accommodations that can be provided in the workplace. Do you think there's something unfair about asking women to shoulder this individual responsibility of having to negotiate, so to speak, with an employer? Women are sometimes asked to reveal a part of their private lives, which is a particular burden.

[*English*]

Dr. Heather Edgell: It can be a burden, but education of the managers will make it a little easier to communicate. For example, if you have an accommodation, it depends on your circumstances, but you don't necessarily need to tell your manager why you need that accommodation. You can tell your doctor that. Then maybe the doctor writes a note saying you need a fan or a different uniform or something like that. Maybe we can remove some of the social burden by getting the doctors involved to write a letter saying that you need this, so you get this, instead of having an awkward conversation.

[*Translation*]

Marie-Gabrielle Ménard: Thank you. I am asking you the question because we are responsible at the federal level for the Canada Labour Code. Some witnesses have actually told us about this umbrella, which could be an important tool for depersonalizing the issue. Workplaces would then be responsible for providing accommodations that wouldn't have to be negotiated on a case-by-case basis.

I see you nodding, Dr. Yuksel—

The Vice-Chair (Emmanuella Lambropoulos): Thank you very much, Ms. Ménard.

[*English*]

This brings us to the end of our panel today—

Anna Roberts: Madam Chair, can I say something quickly? I'm sorry.

The Vice-Chair (Emmanuella Lambropoulos): Go ahead.

Anna Roberts: I apologize.

I wanted to share this with you three, because I really appreciate your coming here. I have a quick story. I had a teller once who was going through menopause. She was being robbed, and she went nuts on the robber: “I've had a bad day. I'm going through menopause. If you think you're going to rob me, I'm going to jump over this counter and give you a beating.”

He took off.

Voices: Oh, oh!

Anna Roberts: I'm sorry. I just had to tell you that.

The Vice-Chair (Emmanuella Lambropoulos): Thank you.

Panellists, thank you for coming in. If you have anything you'd like to add, you can send in a written response by email to FEWO.

This brings the meeting to an end. Thank you.

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