HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

45th PARLIAMENT, 1st SESSION

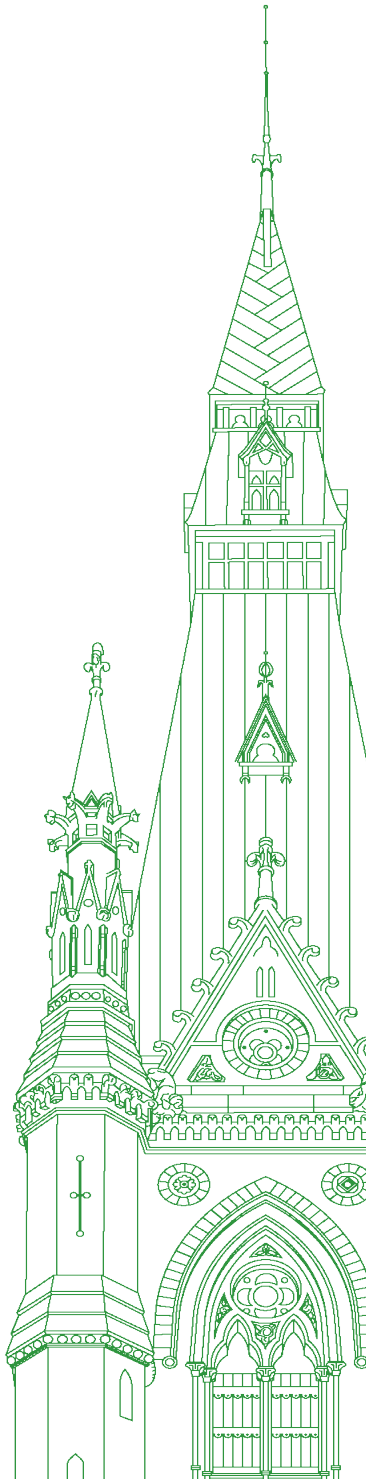
Standing Committee on the Status of Women

EVIDENCE

NUMBER 054

PUBLIC PART ONLY - PARTIE PUBLIQUE SEULEMENT

Wednesday, November 4, 2026



Chair: Dominique Vien

Standing Committee on the Status of Women

Wednesday, November 4, 2026

● (1630)

[*Translation*]

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

Good afternoon, everyone. Welcome to meeting number 54 of the Standing Committee on the Status of Women.

The committee is resuming its study of the labour force impacts of menopause and perimenopause.

As you know, this meeting is taking place in hybrid format.

[*English*]

I would like to remind the 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.

[*Translation*]

If you are in the room and you wish to speak, please raise your hand. For those on Zoom, please use the “raise hand” function. If you wish to speak, activate your mike, and please mute yourself when you are not speaking.

A reminder that all comments from members and witnesses should be addressed through the chair; however, we're quite flexible, as you will see.

[*English*]

I will now welcome our witnesses. From the Menopause Foundation of Canada, we have Janet Ko, president and co-founder, and Trish Barbato, co-founder and director.

Welcome.

We will begin with an opening statement, which I understand will be shared between the representatives from the foundation.

Ms. Ko, the floor is yours.

Janet Ko (President and Co-Founder, Menopause Foundation of Canada): Good afternoon, Chair and members of the committee. Thank you for bringing the menopause discussion to the highest levels of the Government of Canada.

My name is Janet Ko. I am the president and co-founder of the Menopause Foundation of Canada, a national non-profit advocating for the support women need to thrive during all stages of menopause. I'm joined today by Trish Barbato, MFC co-founder and board chair.

The Menopause Foundation of Canada was established in 2022 and is widely recognized as the go-to consumer resource for trusted, evidence-based information. Our work is guided by a 12-member medical advisory board with the country's leading menopause experts. We have helped to shape the national conversation on menopause through two landmark reports: “The Silence and the Stigma: Menopause in Canada” and “Menopause and Work in Canada”, which generated more than 2.3 billion media impressions and earned us 30,000 subscribers.

We begin our remarks today with a simple but powerful truth: Reaching menopause is a privilege. It arrives in women's prime of life, when they have earned wisdom, experience and strength, and when they have outstanding contributions to make. That is the promise. Today, more Canadian women are in that chapter than ever before. Women over 40 make up one-quarter of Canada's population and one-quarter of its workforce, the largest share in our nation's history. They are in their peak working years.

Too many are reaching this stage without the information, care and support they need to thrive. Menopause is an important health transition, one we've neglected for far too long. There are more than 30 potential symptoms that can begin a decade before a woman's final period and last for years after. Women will spend up to 40% of their lives in a stage of menopause, yet one in two feel unprepared. Care is hard to find and the stigma is still strong. The data tells only part of the story: The experiences of indigenous, Black and racialized women, newcomers and gender-diverse people remain deeply understudied.

Critically important for the work of this committee, when the symptoms of menopause go unaddressed, they become a barrier to women reaching their full potential and Canada pays the price. Unmanaged menopause symptoms cost our economy $3.5 billion every year. Employers lose $237 million in productivity and 540,000 workdays. Women lose too—$3.3 billion in income through reduced hours, lesser roles or leaving work altogether. Countless others scale back caregiving, volunteer leadership and community engagement. These are contributions that never appear in economic statistics but sustain the fabric of Canadian life.

My personal experience isn't unusual. At 48, I was a senior vice-president at the height of my career. I was exhausted. I couldn't sleep. I had brain fog, night sweats and heart palpitations that sent me to the emergency room. I thought I was burnt-out. I walked away from a top job and took lesser roles that allowed me to better manage my health. When I finally got treatment and felt like myself again, I decided that no other woman should lose the years I spent searching for answers, so I co-founded the Menopause Foundation of Canada to create positive, lasting change.

We need to recognize that menopause is more than a health issue. It is a workforce issue, an economic issue and a public policy issue. That's why the labour impacts this committee is studying are so critical. Canada has an exciting opportunity to lead the world in how we support menopause. Our recently launched menopause policy agenda for Canada is the blueprint. It sets out seven practical, achievable priorities for federal, provincial and territorial governments. Today, we'll show you how it can transform menopause care and support, and build a stronger economy.

Now I will hand it over to Trish.

● (1635)

Trish Barbato (Co-Founder and Director, Menopause Foundation of Canada): Good afternoon, Chair and members of the committee. I'm Trish Barbato, co-founder of the Menopause Foundation of Canada.

We believe menopause is the missing link to why more women are not breaking the glass ceiling. My primary objective from a young age was to become the CEO of a publicly traded company. Unfortunately, when that opportunity arose, I had to decline because my menopause symptoms were debilitating and I could not get proper treatment, despite my privilege and ability to advocate for myself. This experience left me incensed and deeply motivated to help drive change for Canadian women.

Janet and I will review the seven priorities outlined in our menopause agenda.

Our first priority is to train providers. This is the greatest barrier for women today. They cannot get the help they need. We must make menopause education a mandatory core competency in medical and nurse practitioner training. Federally, we are asking for a national quality standard on menopause care.

Second, Canada must close care gaps. For-profit menopause businesses are growing quickly in Canada, but safe, evidence-based menopause care should never depend on a person's ability to pay. We call on governments to fund specialized menopause clinics, expand virtual menopause care and improve access to nurse practitioners. We are calling for a proactive mid-life menopause health check.

Third, we need to pay clinicians fairly. A thorough menopause consultation means working through symptoms that touch sleep, mood, vaginal and urinary health, bone health, cardiovascular risk and sexual health. Often, these come all at once. We are asking that governments support high-quality care by creating dedicated menopause billing codes, funding virtual and gynecological care appropriately.

Fourth, we need access to treatment. Menopause medication should be a core component of any national pharmacare expansion. The outdated serious warning and precautions label on very safe vaginal estrogen should be removed. Commonly used medications in menopause, including transdermal estrogen, should be on public formularies without restrictions. Pharmacists' scope of practice should be expanded to prescribe local vaginal estrogen and substitute equivalent menopause hormone therapy products. New menopause medications should be expedited, and we need approval for a regulated, female-dose testosterone product.

Fifth, we must fund the science. Women spend 40% of their lifespan in menopause, yet menopause research is minimal. We need dedicated menopause research funding streams and an increase in the national women's health research initiative investment, including increased research to understand menopause in underrepresented groups, such as indigenous and racialized women.

Sixth, we must support workers—and this is where we will spend more time. Employers are far ahead of other areas in our agenda because they have realized that supporting women during this period is the right thing to do, and it supports their bottom line. We are calling for the inclusion of menopause as a named, prohibited ground of discrimination in federal human rights regulation. We are asking for the creation of a policy guide for employers under federal human rights legislation, similar to the one that exists for pregnancy.

Along with this legislative change, we want to share our experience with a campaign that shows that employers have an appetite to drive menopause inclusivity. Why is this? They know they must. Five million working women in Canada are over 40. Those aged 45 to 55—right when most reach menopause—are the fastest-growing segment. They are skilled. They are capable. They are experienced and form a high-value cohort that employers cannot afford to lose, yet more than half a million workdays are lost each year to unmanaged symptoms.

More than 250 employers have signed on to our award-winning Menopause Works Here campaign across multiple sectors and nine provinces, representing an estimated one million Canadian workers. These include leading organizations like Sun Life, Bank of Montreal, PwC, Ikea, Metrolinx and Horizon Health. At the campaign's core is the idea that becoming menopause-inclusive in a workplace is not a heavy lift. It means considering menopause across the talent management and employee experience, just as employers have done before with pregnancy and mental health. It is not about special treatment. It is about looking at it through a new lens.

We recommend four key actions.

The first is about culture and communication—breaking the taboo of menopause at work. For example, Cooke Aquaculture, a seafood company in New Brunswick, kicked things off through an education-sharing session with best practices and resources.

● (1640)

Second, review policies, from health and safety to training and development and more, making sure that menopause is considered in them, just as I did as the CEO of Arthritis Society Canada.

Third, consider reasonable accommodations within existing frameworks. This is different for every employer, but could include things like breathable uniforms, AI note-taking for people with brain fog or flexible break times.

Fourth, review benefits programs and ensure coverage of hormonal and non-hormonal benefits. The Bank of Montreal did and added benefits enhancements like pelvic floor physiotherapy.

Menopause is on employers' agendas, but this is just the start. Much more must be done to reach all workers. One of our asks is that the federal government make menopause-inclusive workplace action plans mandatory for large employers, similar to what's been done in the U.K.

I will pass it back to Janet.

[*Translation*]

The Chair: Ladies, I gave you a lot more time for your opening statement than originally allotted because you are the only witnesses for this part of the meeting. I would like us to start our conversation, otherwise we will run out of time. I know members love talking with you, and so you're definitely going to have a chance to come back to the remarks you did not have time to address.

Thank you, ladies, for your remarks.

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

[*English*]

Kelly DeRidder (Kitchener Centre, CPC): Thank you.

Ms. Ko, your work at the Menopause Foundation has highlighted the impact that menopause can have on women in the workforce.

For women who want to continue building their careers, what are the most practical things that employers can do to support them in both large and small businesses, which may have different sets of resources?

Janet Ko: We've created, through our Menopause Works Here program, a menopause-inclusive workplace playbook that has five simple actions employers can take. These can be large employers or small employers. Resource variation is built into it.

The single biggest thing an employer can do is break the stigma by having an education and awareness session. If they don't have resources to bring somebody in, they can simply point people to evidence-based resources on our website or link to one of our excellent webinars called “Menopause Illuminated”. That's a starting point.

Employers can look at their benefits and make sure that they're comprehensive. These are simple things they can do to make a big difference. We have heard from employers who are surprised at how easy it can be to crack open the conversation and do a few things that are very meaningful for their workforce.

Kelly DeRidder: You mentioned that you even thought it was burnout, and you didn't realize that you were actually entering menopause. I think many women would have a very similar story. They're entering menopause at the same time as they are really at the top of their careers, so it could be attributed to burnout in a lot of cases.

How do women make sure that they're educating themselves and getting the information they need so they aren't assuming that they're working themselves too hard and realize that they are actually going through menopause?

● (1645)

Janet Ko: We're doing a great deal to close the menopause knowledge gap. You're quite right. So many women—one in two—are unprepared. They have these low levels of understanding of the changes that are happening in their own bodies. Having evidence-based sources of information—we have a number of things on our website, such as menopause essentials and a symptom tracker—and raising that awareness through media activity and the work of this committee are going to be very significant.

We are in a very different place than we were when we launched the Menopause Foundation of Canada, and it was so hard to have this conversation. The conversation has cracked open. We're now at a point where we need to take action, which is why we're very grateful for the opportunity here.

Kelly DeRidder: Thank you so much.

Ms. Barbato, we've heard that women struggle to get appropriate menopause care, and you even brought up the issue yourself, because of gaps in provider knowledge, access to treatment and affordability.

From your perspective, what's the single biggest barrier preventing women from getting the care they need?

Trish Barbato: It's the education of physicians, hands down.

Women face barriers every single day going to their family physicians. They're undertreated and they go back dissatisfied, and these women are busy. They do not have time to go back to the doctor, find another doctor or get a specialist referral.

The lack of knowledge is not their fault. They were not educated in medical school. That curriculum was taken out based on the women's health initiative, where there were risks that were identified. They've been debunked now, but it's had decades of negative impacts for women. We are now trying to catch up with the education of physicians and nurse practitioners.

Kelly DeRidder: To follow that up, there's no education platform specifically focusing on menopause today. That would be the biggest change we need to make. It's making sure that family physicians are trained and knowledgeable in menopause.

Do you think that would have the biggest impact on ensuring that women have proper care?

Trish Barbato: Yes, it would.

There has been a proliferation of for-profit menopause clinics. They are there because there's such a huge gap and women are desperate to be heard, to be listened to, to be understood and to get help.

This affects 100% of the population. Not everyone will get pregnant, but everyone's going to go through this. We cannot have a universal health system where doctors don't know how to treat menopausal women. It's outrageous.

Kelly DeRidder: You just brought up a very practical solution—I thank you very much for that—to make sure that women who can't afford to go to the specialized clinics get the care they need moving forward when they're facing menopause.

I want to thank you so much for your work and for highlighting what we, as women, go through later on in our careers and in our lives. I'm actually starting to question myself. Am I burnt-out, or am I going through menopause? I don't know. Thank you. I'm going to go to your website and I'm going to educate myself.

Thank you for being here today.

[*Translation*]

The Chair: Thank you, Mrs. DeRidder.

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

[*English*]

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

Through you, welcome to Janet and Trish. I've had many conversations with you, but it's a privilege to have you here today to answer some of these most important questions for us.

The foundation's 2023 report, “Menopause and Work in Canada”, with an economic analysis by Deloitte, estimated that unmanaged symptoms cost the Canadian economy $3.5 billion a year. This is due to lost income, lost productivity and lost workdays.

Can you talk a bit about this? What is behind these figures and what do they show about the effect of menopause on women's careers, employers and the economy? Can you talk a bit about what's missing from these estimates?

Trish Barbato: I'm going to say a bit about the data itself.

We worked with Leger Canada, which surveyed women and asked questions about work and productivity. The number of women who said they were fired because of their menopause or who had to quit because they took so many days off is the data that Deloitte used as its base. It also used many labour reports and Statistics Canada data, and then it did a sensitivity analysis against data that was available in both the U.K. and the U.S.

It's important to say that from our many conversations with Deloitte as we developed this, it is an underestimate. They were extremely confident about this number. They believe it is much higher. I think that's an important point for this committee to know.

The numbers tell a story that has been part of the taboo and stigma. Women have had to deal with this on their own. They felt very alone, and they certainly were not bringing it up at work. That stigma and that difficulty still exist today.

This is about employers embracing this as part of the strong frameworks they already have. Small, medium and large employers have frameworks to work with employees. We have strong labour codes in this country. It's just that they have never thought about menopause. Many may not even know, as Janet didn't even know she was in perimenopause. It's about introducing this into a framework that already exists. We know employers are nodding their heads and saying, “Yes, we get it and we want to do this,” because we've had so much success with our Menopause Works Here campaign.

One other item I want to point out that I think is extremely important is the burden that rests on the shoulders of women. We have spoken to women who are entrepreneurs or are independent contractors. They have—

● (1650)

[*Translation*]

The Chair: Ms. Barbato, I'll stop you there for a few seconds.

[*English*]

Trish Barbato: Yes.

The Chair: We don't have interpretation.

[*Translation*]

Ms. Larouche, I can hear the interpretation.

Andréanne Larouche (Shefford, BQ): I don't know whether that's because the interpreters are working remotely, but there was a lag at the beginning of the statement, and then there was a pause. I'm wondering about that, because the fact that interpreters are working remotely is causing lags. I just wanted to point that out.

The Chair: Thank you for that information.

Go on, Ms. Barbato.

[*English*]

Trish Barbato: I was just going to finish by saying that the burden on women is immense. When they have to take short-term disability or long-term disability, not take a promotion, go to part time from full time or quit the job completely, or when they are terminated because of their menopause symptoms, the burden is on the woman. The burden is on her income, her ability to have the Canada pension later in life and her retirement income. There is so much weight from that cost.

Juanita Nathan: I just want to follow up with this. What does this mean for employers? How are they losing out because of menopause?

I know you talked a bit about stigma. Back in the day, when women were young and wanted to start a family, that was considered a stigma. They were always afraid that they may not be employed because they knew they would go through pregnancy and would be out of work for a year.

How is menopause similar, or is there a kind of stigma associated with it—that women will go through this? Are we afraid to educate employers on this?

Janet Ko: Yes, I'd say a couple of things.

To the first part of your comment, in terms of how employers are losing out on this, organizations are always looking for high performance. They're looking to attract and retain top talent. You cannot afford to lose one quarter of your population or to have one quarter of your workforce not performing at their best. That's why we've had so much support for our Menopause Works Here campaign. Organizations recognize the significant benefit to making sure that they're closing the knowledge gap, providing women with evidence-based information so that if they are having any issues, they can take action. Creating that dialogue is incredibly beneficial to companies.

We did some research with the B.C. Nurses' Union, and we discovered, through working with them, that 50% of nurses in Canada are females over the age of 40. In that research, it was quite clear that those nurses were self-accommodating. They were moving away from bedside care.

Cracking open this conversation, then, is incredibly important so that women understand the changes happening in their bodies and make the decisions that will support them in staying in the workplace, and so that their companies can support people at all stages of life.

This is no different from what's been done for pregnancy, for mental health or for people who might have substance abuse and addictions. We have the framework. We have the tools in place. We just need to look at it through the lens of a menopausal woman.

I'm happy to talk about stigma as well, but I'll pause there.

● (1655)

Juanita Nathan: Thank you.

[*Translation*]

The Chair: Thank you very much, Ms. Nathan. Time is flying. I know that's frustrating.

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

Andréanne Larouche: Thank you, Madam Chair.

I wish to thank Ms. Ko and Ms. Barbato, the two representatives from the Menopause Foundation of Canada, for participating in this study today.

Ladies, what I have gathered from your testimony so far is that it's extremely important to talk about menopause, break the stigma around it, and above all, view it as a normal stage, just like any other stage in a woman's life, such as the start of menstruation or a pregnancy. These are normal stages. Thank you for joining us and talking about the importance of breaking the stigma associated with menopause and raising general awareness about this issue.

That said, Ms. Barbato, you were cut off before you could talk about a final recommendation. I will therefore give you this opportunity to wrap up your opening statement.

[*English*]

Trish Barbato: I think that's okay. We were just going to conclude, so I think you can proceed.

[*Translation*]

Andréanne Larouche: Okay. I thought you had a final recommendation.

[*English*]

Janet Ko: The last recommendation was on breaking the stigma. It might be helpful, since we've been talking about stigma, to talk about our last recommendation.

Menopause has been shrouded in secrecy, long-rooted in ageism and sexism, and it's clouded with misinformation. We're asking for a national menopause awareness campaign, like they have in Australia, and for age-appropriate menopause education in schools. That was the seventh recommendation that we had in our menopause blueprint for Canada.

[*Translation*]

Andréanne Larouche: Indeed, Ms. Barbato was going to give you the floor, I presume to conclude with a few remarks on this last recommendation. Thank you for doing so.

Recently, in early October, you called for action with the release of your menopause policy agenda for Canada. You outlined the seven recommendations in the policy in a public statement.

Did you communicate with the media at the time because you knew it was important for the government to hear what you had to say, and you needed to have your recommendations and your call for action to be heard? What were the reasons behind your media release?

[*English*]

Janet Ko: As advocates, our goal is to raise awareness of the impact of menopause on women in society. We have all been misled to think that this is something that is natural—which, of course, it is—but menopause is a significant health transition. The symptoms can be long-lived. It will begin earlier than you think and last longer than you think. You will spend 40% of your life in a stage of menopause. Those symptoms of menopause might go unmanaged because women might be confused about those symptoms. Then they try to get help from a health care provider who has no education, no training and no confidence to provide the treatment. The women may be in the workplace, and they're afraid to go to their managers and say, “I'm having a bit of a challenge with brain fog. Can I use an AI note-taker?”

That costs the Canadian economy $3.5 billion every year. As my colleague Trish said, we know that this is a conservative estimate. We need to pay attention. If Canada wants to thrive, we cannot say that we support women and that we care about gender equality if we are not willing to pay attention to half of the population in the most productive years of their lives. Women lose, and the country loses. It's incredibly important that we take action.

The purpose of our campaign is to raise awareness of that and to apply pressure to governments—federally and provincially—because women are demanding better lives. We want to thrive at this stage of our life. We're just getting started, and we have so much to contribute. It is a health equity issue and an age and gender equality issue that must be addressed.

● (1700)

[*Translation*]

Andréanne Larouche: You were quite right to make that statement. The Standing Committee on Health, for example, found that there is a paucity of research on women's health. The committee conducted a study on that topic.

The federal budget is coming up soon. Many of your demands require investment, including to support better treatments and better care and to compensate certain professionals that have an awareness of this issue. Obviously, some of the demands involve money.

We know the federal government oversees drug approvals and research; however, health care falls under the jurisdiction of Quebec and the provinces. We are getting close to the budget, which will be tabled tomorrow. Today, the government of Quebec issued a clear demand for the current health transfer agreement, which is set to expire next spring, to be renewed and to include a minimum annual growth rate of 5%. In short, the government of Quebec is calling for increased health transfers.

How can more investment in health care systems across the country help women access better care?

[*English*]

Janet Ko: Yes, absolutely, we need to invest in health systems. One of the things we're asking for is virtual care. We need virtual menopause platforms. It's great that we have some provinces that have opened menopause clinics, but those clinics should be used for the individuals who have the most challenging cases.

[*Translation*]

The Chair: Thank you, Ms. Ko.

That's all the time for Ms. Larouche.

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

[*English*]

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

Throughout this study, we've heard that menopause extends beyond hormonal changes and can affect a woman's psychological, emotional and social well-being. Where should education about these symptoms begin?

Janet Ko: Education is very important for women at this stage of life. Raising awareness of this and trying to break some of the stigma and taboo associated with it are very important. That is why we're calling for that national campaign, which the federal government can implement. We're calling for action plans for large employers because what's happening on the workplace front is that employers are actually helping to close the menopause knowledge gap. They know that the more women understand this stage of life, the more quickly they can take action if they happen to be struggling.

I do education sessions all the time. I'm blown away by the number of women who come up to me afterwards and say, "I'm 44. My doctor has told me I'm too early, but I have all of these symptoms that you've been talking about." That awareness leads to power in taking action to do the things that you need to do to be able to support yourself and to thrive.

Kathy Borrelli: Those of us who have already gone through menopause look around us. We have friends and family who have experienced the same period in life. We see some people who have no symptoms at all, some who have fewer and some who are almost debilitated and unable to work.

What factors do you believe cause these differences?

Janet Ko: I won't speak from the medical side of things, but the research and our own research show that three out of four women experience symptoms that interfere with their daily lives. In our menopause and work report, women reported an average of seven to eight symptoms that they experience. I think that many women who say they didn't have any symptoms aren't aware of the broad range of symptoms associated with menopause. You'll have somebody who is having significant genitourinary symptoms, and they don't connect that with the fact that they've had this loss of estrogen.

I believe that more women have more symptoms, but there is a smaller percentage—I think most medical professionals would say that maybe one in four women have very few symptoms—and we need more research and more science on why.

Kathy Borrelli: Thank you.

Trish Barbato: Notwithstanding that, there are risks. There are cardiovascular risks. There are bone risks and osteoporosis risks. There are risks associated with women losing estrogen. It's very important that regardless of whether you have or do not have symptoms, you are aware of the risks.

● (1705)

Kathy Borrelli: I'm with you, and as a registered nurse, I understand those things. I understood what was going on with my family, friends and me when we were experiencing symptoms or when we weren't having symptoms.

In a previous meeting on this study, one of the professionals—I'm sorry as I don't recall the person's name—felt that we needed to train women, teach women and inform women early in their lives that they needed to take better care of their health in order to have a smoother menopause.

Does anyone here agree with that? Do either of you agree with that?

Janet Ko: We are calling for more education early on so women understand that this is coming, for sure, but I think it's also a bit of a myth and almost a little bit of a negative thing for women to be told that if you just took better care of yourself, when you got to this stage of life, it would be so much easier for you. We're a good example—

Kathy Borrelli: I'm not suggesting that at all. I'm suggesting an orchestrated plan to get information to women in their younger years about the eventualities, what can allay some of the more serious symptoms and what to watch for. You mentioned heart health. You mentioned bone health. It's those kinds of things. I think it would be valuable to advocate for education and the spreading of information like that to women at an earlier time in their lives rather than always putting the onus on the employer once the situation has occurred.

We're talking a lot today about what companies should do, what the government should do—

[*Translation*]

The Chair: Thank you, Mrs. Borrelli.

[*English*]

That's all the time you have.

Kathy Borrelli: Okay.

[*Translation*]

The Chair: Ms. Lambropoulos, you have the floor for five minutes.

Emmanuella Lambropoulos (Saint-Laurent, Lib.): Thank you very much, Madam Chair.

[*English*]

I'd like to thank both witnesses for being here with us today.

You outlined your seven priorities, which, of course, span all levels of government, or at least the federal, provincial and territorial governments.

First of all, I'm wondering if you have a suggestion as to how the federal government can encourage other levels of government to adopt these priorities as well.

Trish Barbato: I think there's always influence that the federal government could have. In pharmacare in B.C., for example, HRT is going to be paid, so hormone therapy is going to be paid, and in Manitoba as well. There are levers within provincial and federal agreements that could be utilized. There have been others, for example, in the U.S., where one of the states mandated that medical schools must have curriculum related to menopause. I think there are definitely levers around these.

There are many recommendations in our seven that are squarely federal. For example, we're asking for a federal quality standard that relates to menopause. We are asking for a number of Health Canada-related changes around treatment so women have access to the medications they need. Research through CIHR is squarely a federal area. There is opportunity around workplaces as well. There are many recommendations within the policy agenda that are squarely federal. Also, we feel that there is influence that could be made provincially and territorially.

Emmanuella Lambropoulos: Would you be able to send that to our committee in more detail—if you haven't already—so we know exactly what recommendations you have for Health Canada and all of that?

Trish Barbato: Yes.

Emmanuella Lambropoulos: Thank you.

You spoke a lot about employers and the fact that some of them are doing great, because they realize that it's affecting their bottom line, but not all of them are necessarily doing what they need to do for menopausal women to have equality in the workplace. You mentioned that sometimes there are menopause policies in place, but they don't always translate into support for employees. I believe you might have said that.

Can you explain what needs to happen and what they should be doing to make sure their policies are being implemented and followed?

Trish Barbato: Basically, most companies have policies. It's likely those policies do not mention menopause at all. There's just no mention of it. They've never thought about it. They didn't know it was related to their workforce. We're asking for those employers to review existing policies, which will differ among organizations.

For example, in my organization, after doing training and reviewing all of our policies, we simply inserted “menopause” into existing policies, so that people actually saw the word and were thinking about it. Some of the things we're saying are very simple for employers to do.

● (1710)

Emmanuella Lambropoulos: What supports would you say are the most important for employers to include in these policies for menopausal women? Which ones will make the biggest difference for them?

Trish Barbato: I think it's around accommodation. They need to understand that menopause is part of that framework of accommodation, so that they are thinking about what they can do for their female employees who are going through this and what symptoms could be impacting their work. Women don't understand their symptoms, and certainly employers don't understand what symptoms are showing up in the workplace. I think those are important areas.

As Janet said, it's just communicating. These employers are having education sessions on menopause and staff love it—the females and the men. Just doing that breaks the stigma, breaks the taboo and puts the conversation up front.

Emmanuella Lambropoulos: Just to be clear, what role does the federal government play in encouraging these employers to change their policies and make sure this is included?

Trish Barbato: In the U.K., they have mandated menopause action plans. We're asking for the same thing for large employers of over 500. They have a menu. They don't have to do everything, but they have to do two from a list of things. One is reviewing policies, reviewing your benefits and having an education session. Your plan is relatively....

Both Janet and I are senior executives. We know how much work it is for human resources with all of the regulations. We want this to be easy.

Emmanuella Lambropoulos: In terms of insurance companies, who often—

The Chair: You have two seconds.

Emmanuella Lambropoulos: Thank you very much.

[*Translation*]

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

Andréanne Larouche: Ms. Ko and Ms. Barbato, thank you for your participation in today's committee meeting. It's extremely enlightening.

We are looking for solutions here. I think a lot has been said about the importance of raising public awareness. However, I would like to follow up on the issue of treatments.

You have called for more money for research. However, we frequently see media headlines about the shortage of estradiol transdermal patches and other drugs. What are your recommendations to prevent these types of shortages? Does that mean investing in more treatments or ensuring other solutions are available? What steps are you calling for to help address this issue?

[*English*]

Trish Barbato: There are immediate things.

Janet, go ahead.

Janet Ko: We're both impacted by these shortages.

Just imagine how frustrating it is for a woman who has taken several years to finally find a health care provider who gives her treatment. She's on a treatment where she's stable and comfortable, and then all of a sudden there's a shortage. She goes to her pharmacist. In many places, the pharmacist isn't even allowed to do a transition and substitute a different patch.

That's something we're calling for in our menopause policy agenda for Canada. It's to expand the scope of practice for pharmacists to allow them to immediately make a change or a switch for a woman, so she doesn't have to go back to her doctor, who's already struggling with providing one prescription and then has to figure out what the substitution for that is.

The FDA in the U.S. just approved a generic patch to help with this shortage issue in the United States. If there's anything that Health Canada could do to expedite a generic patch or require a certain supply to be on hand in Canada, that would be very helpful.

We know that this is not something that's easy to solve, but the impact of these shortages—which are global—on women is significant.

[*Translation*]

Andréanne Larouche: Do you have a couple of other countries you could recommend to the committee?

The Chair: I'm sorry, Ms. Larouche, but your time is up. Being committee chair can be a harsh role, as I constantly have to cut everyone off. My apologies.

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

● (1715)

[*English*]

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

Thank you very much for coming.

I'm still going through menopause. I don't know how many years I've been going through it. I've lost count. I sleep with a fan beside me, with a fan in the ceiling. I don't know what the hell's going on. I'm always hot.

I really appreciate this study because I don't think we do enough to better understand this.

I have a question for both of you.

We talked about education. Regarding the medical profession and the knowledge required to become a doctor, do you feel there is enough medical school education to understand menopause in women?

Janet Ko: We know the answer to that is definitely not.

Physicians receive little to no menopause education, which leaves them ill-equipped. They lack the knowledge, training and confidence to provide the care and support women need. This is why our menopause policy agenda for Canada is calling for mandatory education—not an elective—for all physicians and nurse practitioners. It's not just about family physicians. We should have cardiologists, psychologists, endocrinologists and a broad range of physicians.... It all touches women because menopause is a full-body experience. Often, women are seeing various practitioners who really do need to understand.

When I went to the emergency room for heart palpitations, it was great that the doctor ruled out...and my heart was fine. It would have been wonderful if that doctor had said, “By the way, you're at a certain age,” asked me a few questions and said, “This is a standard symptom of menopause.”

Anna Roberts: It's interesting that you say this, because I had the same situation when I went to the hospital. I had heart palpitations. They said, “Oh, you're just over-anxious.” I was like, “Okay, whatever.” They knew nothing about helping me through it.

One of the things I found, in my previous life as a branch manager.... At the time, I was a single mom. I lost my husband very young. I was always afraid to bring this forward because it was so important, as a single parent, to hold on to my job and to have an opportunity to advance.

Do you think things have changed and shifted in today's society? I'm probably the oldest one here. Do employers understand the important needs of women in menopause, and how they can better work with them?

Janet Ko: It's starting to change. We have to recognize that this is a conversation that is just beginning in Canada. The leading workplaces are definitely there. The stigma is real, however, and that's why we need to break it.

There are many examples I can share in terms of organizations. One organization embraced this in a big way. The CEO was the one who said, “I look around at my high-performing talent and many of them are women at this stage of life. I can't afford to lose them. I want us to have this open dialogue.” Another woman was an SVP in a company doing deals and transactions. She brought this forward in her organization. There was an education session, and she shared her story. Later, when she was doing a transaction, she had a hot flash at the deal table. Because her colleagues were sensitized to it, she was able to pause and say, “I'm having a hot flash. I'm going to grab some water.” She was gone for a minute. When she came back, everything was fine. The deal was closed.

Breaking that stigma allows women to not be afraid of repercussions and to not be embarrassed to go to their manager and say, “I'm having a few hot flashes right now. Could I start later?” or “I have this heavy uniform, and it's causing a problem for me. Can we go to a breathable fabric?” This is not a heavy lift for employers and makes a big difference, but the stigma exists. Women are still afraid because we know it's a double-edged sword. Ageism pervades our lives. It's hard to climb the corporate ladder or be in the workplace as a woman of a certain age.

We're talking about menopause in the workplace this way: Organizations have a talent management process—an employee experience. You are not doing anything new. You are considering this through the lens of a mid-life working woman.

Anna Roberts: One of the things I'm appalled about is the fact that we spend more money researching male-dominated diseases—not that menopause is a disease.

What can the government do to increase funding to ensure that the research is there for menopause?

● (1720)

[*Translation*]

The Chair: I'm sorry, Mrs. Roberts, but your time is up.

[*English*]

Anna Roberts: It's a good thing I love you.

[*Translation*]

The Chair: Ms. Ménard, you have the floor for five minutes.

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

Ms. Ko and Ms. Barbato, thank you for being with us. You're not the first witnesses to appear as part of this study, which is drawing to a close. We are trying to cover all possible populations of women. We have given many examples of women with prospects for leadership positions who may be impacted by menopause.

If you have some data to share with us, I would now like us to focus on professional environments where women are overrepresented. I am thinking in particular of the care industry. You gave us the example of nurses. I was also thinking of teachers and early childhood educators. Some sectors are still dominated by women. We can therefore probably surmise that in some sectors, perimenopause has impacts on women in positions of leadership and on the workforce as a whole.

Do you have any information to share with us on this subject?

[*English*]

Trish Barbato: Janet and I have both worked in health care for a long time. We always think about the frontline staff and the personal support workers who are managing two and three jobs to have enough money. Nurses, teachers...they all have very little accommodation.

I talked to a union rep just the other day who talked about mandatory breaks at an exact certain hour. If you're bleeding like crazy, you can't wait for that break. You have to go right away. There are a lot of challenges, especially with the sectors you mentioned: highly unionized and very difficult to accommodate.

As Janet mentioned about the work we did with the nurses, we really heard that loud and clear. They are trying to manage things themselves. I cannot agree with you more that this is an area of focus, because they do so much for us—for citizens. Teachers, nurses and personal support workers are at the front lines of care, but they have roles in very strongly unionized environments. The unions also need to start to help break the stigma and to bring negotiations to their contracts that allow for greater accommodation at this stage of life.

[*Translation*]

Marie-Gabrielle Ménard: Do you have anything to add, Ms. Ko, or has that covered the question?

[*English*]

Janet Ko: I think the only thing I would add is that the solutions are in our menopause policy agenda for Canada.

When you think about those frontline workers Trish referenced, they're the ones who don't have the time. If they go to a walk-in clinic and that doctor at the walk-in clinic does not understand menopause and does not offer them a solution, they don't have time to track one down or find another physician.

Governments must fund publicly funded virtual care so that people can quickly and easily gain access to the care and support they need. The solutions are in our policy agenda. We just need to act. We have the data. We know what the problem is. The problem is very clear and very obvious. We don't need to talk about it anymore. We just need to take the actions to close these gaps.

[*Translation*]

Marie-Gabrielle Ménard: A few days ago we heard from Dr. Whittingstall, a researcher and expert from Université de Sherbrooke, and we were quite captivated by what he had to say. He did not bash other types of research when he highlighted the gap between the amount of money allocated to perimenopause and menopause in the country and the money devoted to researching other types of diseases—not that menopause is a disease.

We are looking for recommendations that can be implemented at the federal level. The federal government is not responsible for health care; however, research may fall within its jurisdiction. We clearly understood from your argument that various medical professions may not have adequate training. However, we have also heard that training people requires data. You need research, and therefore you must have content to present. Our understanding is that research is lagging behind.

Apart from research institutions, do you see another role for a different group of researchers?

● (1725)

[*English*]

Trish Barbato: I think it's about the existing pathways, such as the Canadian Institutes of Health Research, for example, having a more mandatory menopause lens. It doesn't even have to be a trial on menopause or research, but they can't ignore menopause.

[*Translation*]

The Chair: That concludes the time allotted for this first panel.

Ms. Ko and Ms. Barbato, I want to sincerely thank you for making time to testify today. Have a great evening.

We will suspend for a few minutes to bring in our next guests.

● (1725)

_____(Pause)_____

● (1730)

The Chair: I call the meeting back to order.

[*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 to take full advantage of the time allotted for questions and answers.

[*Translation*]

If you wish to speak, please raise your hand. We're used to that. That applies to those who are on Zoom.

If you are participating by video conference, click on the microphone icon to activate your mike and please mute yourself when you are not speaking.

You had a brief insight into how this works. It's very friendly. The chair doesn't intervene a lot, except to cut people off.

[*English*]

I will now welcome our witnesses. Dr. Ela Veresiu, associate professor of marketing, is appearing as an individual.

[*Translation*]

From the Society of Obstetricians and Gynaecologists of Canada, we have Dr. Nicholas Leyland, president, and Dr. Diane Francœur, chief executive officer.

It's great to see you again, madam.

[*English*]

We will begin with opening statements.

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

Dr. Ela Veresiu (Associate Professor of Marketing, Schulich School of Business, York University, As an Individual): Thank you, Madam Chair and members of the committee, for the opportunity to speak today.

My research examines how markets across both the public and private sectors can better serve under-represented consumer groups, including aging women in general and, in particular, women experiencing perimenopause and menopause. Together with my co-investigator, Professor Marie-Agnès Parmentier from HEC Montréal, and our research assistants, I am currently conducting a multi-year study of the emerging menopause market in Canada. According to a 2025 PwC report, the menopause market "spans pharmaceuticals, care delivery, device and diagnostics, consumer health—

[*Translation*]

The Chair: I'm sorry to cut you off, Dr. Veresiu. Ms. Larouche and I have interpretation, but there is audio feedback. I don't know if the sound from the interpreter's camera is too loud. It could be that. We have audio feedback, and so we're going to try to resolve that.

Go on please, Dr. Veresiu.

[*English*]

Dr. Ela Veresiu: The menopause market "spans pharmaceuticals, care delivery, device and diagnostics, consumer health, and payer and employer solutions." This research is funded by a SSHRC insight grant and began with fieldwork at the inaugural National Menopause Show in Toronto in 2024. As principal investigator, my research was temporarily interrupted by my second maternity—

[*Translation*]

The Chair: I'm sorry to cut you off again, Dr. Veresiu. This time it's not because of audio feedback, but because we don't have interpretation entirely.

Andréanne Larouche: That's another impact of having remote interpretation.

The Chair: Yes, that's right.

We will resume and conduct a test. If it doesn't work, I will suspend for a moment.

[*English*]

Dr. Ela Veresiu: To date, we have conducted participant observation and ethnographic interviews at the 2024, 2025 and 2026 National Menopause Show and completed 17 in-depth interviews with exhibitors. Accordingly, the observations shared today should be understood as preliminary and emerging findings.

So far, we have identified three key risks within this rapidly expanding new market that may affect Canadian women in the workforce.

The first risk is that commercial businesses may impose a so-called "pink tax" on menopause-related products and services. Historically, products marketed to women, particularly in the beauty and personal care sectors, have been priced higher than comparable products marketed to men. As the menopause market expands into a broader range of mid-life health and wellness products, including vitamins and supplements, for example, there is a risk that it may become financially inaccessible to some women. This could create inequities in access, particularly for those who are already facing economic constraints.

Second, many businesses are offering a wide variety of products and services that appear to address the symptoms of menopause rather than the underlying causes of those symptoms. Our preliminary findings suggest that the growth of this market is in part a response to gaps in the health care system. If women had broader access to comprehensive, evidence-based menopause care, the consumer market surrounding menopause might be smaller or at least structured differently.

At the menopause shows, for example, we observed rows of booths offering online private platforms promising personalized care plans and vendors promoting everything from dietary supplements to bath salts.

This leads to the third risk, which is that women may lack the consumer education to determine which products are the safest and most effective for them. We find that trade shows can help legitimize and institutionalize an emerging market. However, they can also create an environment of information overload in which consumers might struggle to distinguish credible medical advice from marketing claims. Many women are left uncertain about which messages to trust.

What women in the workforce need most is reliable access to medical expertise, up-to-date information and treatments that address the underlying causes of menopausal symptoms rather than an overwhelming array of lifestyle products that primarily offer symptomatic relief.

Based on our preliminary findings, I recommend increased and up-to-date education and awareness initiatives for both employees and employers regarding menopause and its effects in the workplace. I also recommend greater investment in our health care system, including ensuring that physicians and nurse practitioners receive appropriate training and up-to-date knowledge about perimenopause and menopause. Finally, policy-makers may wish to explore workplace accommodations and menopause-specific leave provisions to better assist women during this life stage.

Thank you for your time.

● (1735)

[*Translation*]

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

You were great. The interpretation issues did not affect you at all, so bravo and thank you.

[*English*]

Dr. Leyland, the floor is yours for five minutes, please.

Dr. Nicholas Leyland (President, Society of Obstetricians and Gynaecologists of Canada): Thank you very much.

My name is Nicholas Leyland. I am the president of the Society of Obstetricians and Gynaecologists of Canada. Thank you for the opportunity to speak with you today on behalf of the society and the women we serve.

It's really been great to listen to the Menopause Foundation of Canada's speakers, Janet and Trish. Much of what they were talking about is in my introductory discussion because it is all about appropriate care for women, access to care, education and the issues around workplace accommodations for women.

My mother, a single mother and a single woman, was always telling me that women are much smarter than men, and I believe her. I've really tried hard during my entire career to address a lot of the inequities in women's health. I, as a man, see them all the time. My male colleagues are just unable to see them.

Menopause therapy and menopause education are certainly among the big issues we have to deal with, in terms of both research and workplace accommodations. We, the SOGC, did a large analysis of more than 13,000 women across Canada to find out what their thoughts were about this particular issue. We found that there are lots of guidelines and information, but they're not consistently getting to the providers so that they can utilize them appropriately. These gaps are in provider education, difficulties with payment for very long appointments and doctors not being able to provide the time that's necessary for these patients.

Seventy per cent of the women identified education as a priority for nurse practitioners, family physicians and specialists. We as gynecologists and specialists do have the information, but there aren't enough of us and we're so busy with so many other things that it's very difficult to deal with all aspects of menopause care. We need to look to the primary care providers—nurse practitioners, family physicians and pharmacists—to be able to provide that.

Basically, that's not happening right now. Many of the medical students get six weeks of obstetrics and gynecology care. I can tell you that they don't get a lot of well-woman care or menopause education during that period of time. That has to change.

We strongly recommend that.... We, as the SOGC, are dealing with a lot of the chairs of family medicine and chairs of obstetrics and gynecology across the country to make it clear that medical school training really needs to change, as does nurse practitioner training.

I also work at McMaster University, which is the bastion of evidence-based medicine. The care needs to be based on the best available science.

Treatment needs to be affordable. We heard about all the different options to make it easier for women to access the medications if they need that. All the other ancillary support may include physiotherapy, urogynecologic issues, psychologists and these sorts of things, because there's often a difficulty in recognizing what are mental health issues, what are symptoms of menopause and how they interact. It's very important to understand that reliable information is an essential part of care.

The survey that I alluded to found that 82% of people go to online sources for their menopause information. That can be quite variable. It's often misleading and inaccurate and can be advice from paid influencers on social media. This can undermine informed treatment decisions, delay access to care and actually cause harm to some patients—

● (1740)

The Chair: Dr. Leyland, that's all the time you have.

Dr. Nicholas Leyland: Thank you.

[*Translation*]

The Chair: We are going to start our conversation with the members. If at any time you have something to add, please feel free to do so.

[*English*]

Ms. Roberts, you have six minutes, please.

Anna Roberts: Thank you very much, Madam Chair.

I'm going to ask the doctors my first question.

First of all, Dr. Leyland, your mother raised you well.

Roughly two-thirds of people diagnosed with Alzheimer's disease are women, according to Statistics Canada as of 2024. Statistics Canada also reports that dementia is six times more prevalent in those over the age of 80 compared to those between the ages of 65 and 79. However, the studies in the United States and United Kingdom have shown that there may be a connection, especially between the effects and timing of menopause, and dementia and Alzheimer's. This is especially important considering we have an aging population in Canada. As we all know, by 2030, the aging population is going to be 25% of Canadians.

Have you seen any research on this connection in Canada, and are you aware of the potential connections? What can we do to address the potentially higher incidence of dementia and Alzheimer's in women?

Dr. Nicholas Leyland: This is a complicated question because estrogen deficiency does have something to do with some women developing this. However, it's a much more complex disease than just estrogen deficiency alone.

There's not a lot being done in Canada with respect to that, and we've already heard about the deficiencies in women's health across the board in terms of research. It is important that the timing hypothesis does seem to find some benefit in improving women's response to the development of dementia. However, there are genetic issues and all kinds of other things that may be associated with it.

Therefore, hormones are not a panacea for a lot of things, but they are very important.

Anna Roberts: Can I get your thought on that, Dr. Francoeur?

[*Translation*]

Dr. Diane Francoeur (Chief Executive Officer, Society of Obstetricians and Gynaecologists of Canada): Yes, absolutely. I'll answer you in one word: hope.

There's a great deal of hope on that front. Even though the science on the link between estrogen deficiency, brain fog and ultimately dementia is still in its infancy, from a financial standpoint alone, we have been forced to start taking an interest in that research. On average, women die at the age of 88, and this is a good thing. However, if they develop dementia, the associated costs are tremendous for our health care system. As such, we need to work with those data. This research is often fundamental and much more costly, but it is extremely important. In addition, I think that you have all acknowledged the fact that Canada has a paucity of research on women's health. That's one of the topics that needs to be dissected on every front. New drugs are giving us a lot of hope in this area.

● (1745)

[*English*]

Anna Roberts: Thank you very much for that. I know that earlier this week we had some witnesses who claimed there is a connection between women who have menopause and Alzheimer's and dementia. As a woman, I think that's very scary.

We need to do more research. Am I correct in assuming that?

Dr. Nicholas Leyland: That is correct, but the research has shown that it's probably only if it's started very soon after menopause that it has any impact at all. Again, however, it's not a panacea for it, and starting it later is not beneficial.

Anna Roberts: We have gaps in education. You mentioned earlier that there are not enough doctors or obstetricians. What can we do to motivate more individuals to go into that field? As we know, women tend to outlive men. How can we encourage more Canadian students to take on that role?

Dr. Nicholas Leyland: Actually, women are the majority of obstetricians and gynecologists in Canada now. However, that's another complex question because it is a demanding specialty. It's often difficult, right at the time when women are planning their own families, to continue that process. Leaving the profession can be problematic for them, depending on how long they're out.

Anna Roberts: It's interesting. I remember one time—when I was in my previous career—we were going through a robbery. At the same time, I was going through a hot flash. The police officer was wondering what was going on with me, and I was too embarrassed to say that I was having a hot flash.

I think we have to get away from that. We have to move away from the mindset that it's a stigma. As women, we have to be okay to talk about it. For the research, in terms of what we can do, what would you expect the government to do and how much funding do you think would be necessary to help research this particular issue with menopause?

Dr. Nicholas Leyland: It's not so much how much funding. It's more so what the percentage is in the CIHR. Funding right now for women's health issues is 7%. You make up 51%—

The Chair: Thank you, Dr. Leyland.

[*Translation*]

Thank you, Mrs. Roberts.

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

[*English*]

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

Thank you to the witnesses for being with us today.

Here's just a bit of my own background. I started menopause at 38—early onset—and didn't get out of it until 58. It was lots of fun for the whole family. I worked in a male-dominated engineering environment where there was no such thing as accommodation.

In looking at what is out there today, I have heard from other stakeholders who have experience with menopause that if you go with your symptoms untreated for decades it can have an impact on your mortality and your overall health. Could you comment on that, Dr. Leyland?

Dr. Nicholas Leyland: Yes, definitely. There's lots of information on what you experienced: premature ovarian insufficiency or early menopause. There's an increase in cardiovascular risk, osteoporosis and hip fracture—you name it.

There are lots of disadvantages to not having appropriate supportive therapy at the right time. That also includes making sure that young women in their teen years are getting enough calcium and vitamin D, as well as iron and that sort of thing, when they start menstruating. There's lots of evidence that earlier menopause or surgical menopause does impact on long-term health issues.

Marilyn Gladu: Excellent.

The next topic I want to speak to is related to the range of products that are out there and the way women are getting their information online. Some things are treating the symptoms and not the root cause. Some things are just foo-foo dust and they're not really treating anything.

Let me start with you, Dr. Veresiu. Can you talk about this whole area and how people can be more informed about what is going to work, what is not and what is treating a symptom versus a root cause?

● (1750)

Dr. Ela Veresiu: Yes, absolutely.

I wholeheartedly agree with the colleagues who have spoken before that we need better education for our practitioners, pharmacists, physicians and nurse practitioners in order for them to be the first point of contact of where menopausal women and consumers get their information, rather than having to go to social media influencers and consumer events, where you do have a mix of doctors and nurse practitioners, but the medical profession should be the front line for information, rather than influencers or businesses that have entered the so-called menopause market.

Marilyn Gladu: I fully agree.

Dr. Leyland, can you answer that same question?

Dr. Nicholas Leyland: Yes. Basically, I'm very concerned about evidence-based medicine and the fact that even physicians can be misled or influenced in their own minds when they're providing private care or benefiting from compounded medications. We know that Health Canada and all of the guidelines across the world do not recommend compounded medications, because they can't be standardized. They haven't been investigated appropriately at this point.

I think we have to be really careful about who we're talking to. Is it online? Has the physician group or whatever health care group been properly educated? That's a big part of our job.

Marilyn Gladu: I have questions about the different symptoms and how they might be treated. You talked about estrogen deficiency. What is a good treatment to address that?

Dr. Nicholas Leyland: When estrogen goes down, and it can be in the perimenopause or during menopause when it's really low, the option is for patients to have hormone replacement of some kind. We strongly recommend transdermal hormones that bypasses the liver, which lowers the risk of thromboembolism and other risks.

Marilyn Gladu: Is there any treatment for night sweats?

Dr. Nicholas Leyland: Again, for night sweats, we want to make sure that they are actually hot flashes related to estrogen deficiency. If they are, it's definitely beneficial to utilize hormone replacement therapy. If the woman still has a uterus, they need to get some progesterone at the same time.

Marilyn Gladu: What about brain fog? What's the treatment for brain fog?

Dr. Nicholas Leyland: Again, taking the history is so important to understand, because menopause affects proper sleep. We have to ask all of the questions for what may be leading to some of the issues of brain fog. In my experience, many patients do respond to hormone replacement therapy. I don't want to always say hormone replacement therapy, because there are non-hormonal options that patients may look at, and lifestyle changes are really important. All of the sleep hygiene issues, including screens at bedtime, are really important.

Marilyn Gladu: That's excellent. I was asking for a friend. Thank you for your responses.

[*Translation*]

The Chair: Thank you, Ms. Gladu.

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

Andréanne Larouche: Thank you, Madam Chair.

We've come to the last panel for this very interesting study that speaks to so many women. We'll see the recommendations that will stem from all these testimonies.

Earlier, my colleague spoke about influencers. I don't know if we can attribute this to the work of an influencer, but in Quebec, we were lucky to have the *Loto-Méno* series. I have a feeling that it made a difference, simply by talking about menopause and eliminating the stigma and the taboos associated with menopause.

It's fascinating, because we talked at length about the issue of treatments and drugs with the previous panel, and what is covered and not covered. Something big happened after that series, because Véronique Cloutier got things done with the then Quebec minister of health and social services, who made bioidentical drugs available for women. These drugs would now be covered by RAMQ, or the Régie de l'assurance maladie du Québec.

We can therefore see the impacts of eliminating stigma and opening up this conversation, even if only certain drugs are covered, for example, in systems like Quebec's, which has its own drug insurance regime. What difference can that make in a woman's life?

That question is for you, Dr. Leyland, or for you, Dr. Francoeur.

● (1755)

Dr. Diane Francoeur: Yes, I am quite familiar with *Loto-Méno* because I was involved in it. It simply changed the lives of obstetricians and gynecologists, because people were finally talking about this issue, and women finally had access to drugs. One thing that we've not talked about so far—the Menopause Foundation of Canada touched on it briefly—is the fact that women get ripped off all the time, especially due to disinformation. They are sold dreams, applications, teas, spices, vitamins and so forth. Unfortunately, what they need is access to drugs, which are costly for those without coverage.

Quebec has a drug insurance regime. We are very fortunate, because the drugs are covered for everyone. What used to cost $100 a month is now covered by our various insurance providers or by RAMQ. That was an extraordinary change. There was all that issue of bioidentical, biosimilar and so on. The so-called transdermic hormones, whether in the form of gels or patches, are covered in full for all women in Quebec. That was wonderful.

We hope other influential personalities will call on provincial ministers of health. Véronique Cloutier really made a difference. You know, when British Columbia was the first province to adopt the PharmaCare plan, which offered free contraception, the return on investment was so great that women also got free access to transdermal products.

As such, there are solutions. I think the federal government can help us by setting minimum requirements for all women. Earlier, we spoke about new drugs for women who have had breast cancer and can't be put on hormones. The drugs are very effective, but costly.

Which is worse: lacking access to drugs or being unable to afford drugs? Both situations are equally challenging.

Andréanne Larouche: That's quite an interesting study. Obviously, there were media reports about it. There were groups that called for a national policy, an action plan on menopause. I'm talking about groups that issued a media statement recently, in October.

However, we're also trying to differentiate that, because the subject touches on health. Officially, health care is delivered by Quebec and the provinces, whereas other areas fall under the federal government. I spoke about the minister of health in my previous question.

I will now talk about the new Quebec Minister of Finance, who has made two key demands, because we are in a pre-budget period. He called out the federal government on health transfers. I will come back to what the federal government can do later, but the fact is, we are part of the administration.

Based on what we have heard so far, people are calling for better care. They want physicians to spend more time with patients, because menopause is complex. It's not a matter of a 20-minute appointment, where you speak about one issue and leave others out. The Minister of Finance is asking for a minimum annual growth rate of 5% in health transfer, and above all, he's calling on this to be representative. That's because the health transfer agreement is set to expire next spring. Thereafter, the annual growth rate will be 5%.

How can health transfers and injecting money into health care systems improve treatment for women?

Dr. Diane Francoeur: Health transfers are complex, and that's a matter for elected representatives to speak to. We do medicine; you do politics.

If we look at that solely from an economic standpoint, like Ms. Trish Barbato and Ms. Janet Ko showed, we can't afford to lose women. Eighty-five per cent of obstetricians and gynecologists are women. If all of them get to 50, who will take care of complicated deliveries at night in the Far North? There will be nobody. We must therefore keep the workforce as a whole. From a financial standpoint alone, if we take the time to conduct economic studies, like the Menopause Foundation of Canada has done, we will be able to demonstrate that investing in treatment will keep these women in the workforce. Earlier, there was a conversation about early menopause. These women will be able to contribute to the Canadian economy, and above all, could help alleviate the labour shortage facing all the provinces.

● (1800)

The Chair: Thank you, Dr. Francoeur.

That's all the time we have.

I would like to add a brief personal note. I don't normally do so, but I would like to thank Ms. Véronique Cloutier. Thank you very much, Ms. Cloutier. I am very grateful.

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

[*English*]

Kathy Borrelli: Thank you, Madam Chair.

Dr. Leyland, I was so interested to hear you comment, when you were answering another question, on how important it is that young women in their teens and twenties consume proper nutrients—a sufficient amount of, say, calcium and vitamin C.

How would these young women know that? Do you think we should be doing more education with women younger in life so they can better prepare themselves for menopause—be in a healthier state when those years come and better able to battle the symptoms of menopause?

Dr. Nicholas Leyland: The short answer is yes. It's a lot of education around women's health issues.

I've spent my career dealing with endometriosis in various ways and developing surgical programs and multidisciplinary.... It's the same thing. The problem is that there's a delay in women getting to the right practitioner for menopause therapy or for endometriosis diagnosis and management. We need to educate young women about menstruation—what is normal and not normal. If they're losing days at school, that's not normal. They need to see somebody who understands the disease.

We need to educate people on their health care—how to address physicians and not necessarily be too intimidated to ask the right questions and ask for the right answers.

Kathy Borrelli: What could the government do? What would you suggest could be done so that young women get the information they need to improve their health and better prepare themselves?

Dr. Nicholas Leyland: This is a provincial issue—education and the curricula.

In my province, Ontario, this has been problematic of late. Young women need to understand sexuality, contraception, menstruation and all these different issues in order to protect their own health. We need to be directing our attention to the provincial ministers of education.

Kathy Borrelli: I realize it's complicated, because here we are at a federal table talking about treatment and processes that should be happening at the provincial level. We've also talked a lot today about what should be mandated in the workplace.

Young women work too. Some people want it mandated that employers consider women going through menopause. Should we mandate that the education be done at the workplace? I'm not suggesting that's the case, but if we can't intervene at the federal level to make sure young women get the education they need, then what other suggestions or tools do we have here?

Dr. Nicholas Leyland: We're getting a bit out of my area of expertise, but my opinion would be that we need to reduce the stigma about all of the issues around health care for women.

When I used to bring videos home and I'd be doing a thing, my young daughter would say, “God, don't show me that.” If my wife and I were talking about menstruation—she worked in my office—my daughter would say that she didn't want to hear about it. We explained to her that there was nothing to be ashamed of about talking about these things, and I think she got it after a while.

We need to get that message across to all young and older women. They have the right not to have any of these issues stigmatized.

● (1805)

Kathy Borrelli: I'm going to switch it up a bit, and I'm going to ask you, Dr. Leyland, this next question.

Can natural health products such as vitamins, minerals, iron supplements, omega-3s, probiotics or fibre supplements help support the health and well-being of a woman early in her life and then through menopause?

Dr. Nicholas Leyland: My undergraduate degree was in nutrition before medical school. Not too many people do that. Nonetheless, it's difficult to recommend supplements, depending on the nature of the issues. Most people—

[*Translation*]

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

That's all the time we have.

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

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

[*English*]

Thank you very much to the witnesses for being here. It's been such an interesting set of conversations, and we've saved the best for last. Thank you very much for helping us round out this set of conversations.

I want to start with the SOGC.

We know that racialized, indigenous and Black women can have and face additional barriers in terms of having their symptoms recognized. Have we started to do the work in this area around menopause in terms of making sure that there's culturally competent care? What does that look like? Do you have any recommendations on this piece?

Dr. Nicholas Leyland: Canada now has such a broad population from other countries with different languages that we have to ensure that information is available in the appropriate language and appropriately translated so that they're quite accurate.

We spoke at the Federation of Medical Women of Canada recently, and this is an issue that came up. We need to do a lot better as a medical profession to be able to deal with many of the issues that the indigenous population have had to suffer with. Older white guys with grey hair, way back when, had an attitude toward women and our indigenous population that was just reprehensible.

At this point, the SOGC and other groups are really trying to address marginalized patients, women in particular, and racialized patients, though there is a lot more that we can do.

Chi Nguyen: Additionally, women living in rural communities may not have as ready access. Do you have any recommendations there? Are there perhaps some online or virtual platforms that you would recommend that provide the right kind of information?

Go ahead, Madame Francoeur.

Dr. Diane Francoeur: I cannot. Just this year, we did a module for indigenous women in menopause, but there's a huge lack of data. We applied for a grant, so we pray every night before we go to bed to be able to work on menopause with diversity.

Not only do they not have the information, but they don't have access and they don't know people who respect their culture.

We know that there's a big decrease if you compare the numbers of women who will go and get a mammogram done. It's so low in all these different communities. Something needs to be done, so we are participating on a research grant with CIHR on that, and it should help us to have numbers.

[*Translation*]

Chi Nguyen: Thank you very much.

[*English*]

On the question of women living in rural communities, is there anything SOGC would like to add, in terms of access?

Dr. Nicholas Leyland: It is very problematic in many countries—Australia, Canada and even parts of the United States. Women wanting to have their baby close to home is very difficult because it's often very difficult to know whether you're going to have a problem until you're in labour or close to going into labour. Then we have the big challenge and the costs of having to move people from rural and northern areas down to hospitals. That's not ideal, but we haven't come up with the perfect solution yet.

Chi Nguyen: Thank you.

Earlier in today's testimony, two experts talked about increased roles, capacity or scope for pharmacists in terms of potentially prescribing responses.

I was wondering if you could talk about an expanded role for allied health professionals, and whether you see a place for this in the health system, given that we know we have a shortage of doctors across the country. Is there a role you would recommend?

Dr. Nicholas Leyland: That's interesting because this fight between medical doctors and apothecaries in Great Britain has been going on for a couple of hundred years. My view is that we should expand the scope of practice simply because we need more people who have the expertise.

Who better than pharmacists? They understand a lot of the aspects of pharmacology, whereas we don't have as much training in that.

● (1810)

Chi Nguyen: I think I have time for one last question.

[*Translation*]

The Chair: You have three seconds left, Ms. Chi.

[*English*]

Chi Nguyen: Ms. Veresiu, you talked a little about the pink tax. I know we've done work on a menstrual equity strategy. That means we aren't seeing a pink tax on those products.

Do you have any advice, as we move forward—examples of what that might look like in the menopause context?

Dr. Ela Veresiu: In the menopause context, it would be about looking at specific vitamins, supplements and—

The Chair: I'm sorry, Dr. Veresiu.

[*Translation*]

Your time is up.

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

Andréanne Larouche: Oh, that is brutal.

Dr. Veresiu, I don't have a lot of time left, but I'll give you 30 seconds to wrap up what you were going to say about this pink tax and the link with menopause.

[*English*]

Dr. Ela Veresiu: Thank you very much.

It should be about making supplements and medicine specific to women available—those not covered by any form of insurance. This should be looked at more closely to see whether there is a pink tax attached to it. Further studies need to be done.

At the same time, there is a proliferation of private clinics offering menopause help, but a lot of women may not have the financial means to access those. This was touched upon in the previous hour. I think it deserves further attention.

Thank you.

[*Translation*]

Andréanne Larouche: That's right. One group, among others, would have liked to contribute, but they did not have an opportunity to do so. This group on natural health contacted us. I wonder what role they could play. We will follow up.

Dr. Francoeur, as I was telling you, we want to come up with solutions. Yes, we are talking about education, but that falls under Quebec. In fact, health care per se also falls under Quebec and the provinces. However, the federal government oversees drug approvals. We have seen media reports about a shortage of estrogen patches. There is also the issue of research. We know that a mere 7% of funding is allocated to research. I am drawing a parallel between this study and a study I undertook on women's health with the Standing Committee on Health.

Can you tell me, in under 45 seconds, what the federal government could do better when it comes to drug approvals and research?

Dr. Diane Francoeur: I would like to say a few words to share some good news. We work with Health Canada, and I was extremely pleased last week, because we had a meeting to discuss the shortage of patches, and within 10 minutes, we all agreed that this should be classified as a tier 3 drug shortage. That designation means they are going to procure generic patches from the United States. Before that, they spent hours relentlessly trying to prove that if women were not doing well, changing their medication would not work. However, we reached consensus within 10 minutes. They sent us a lovely letter, and we were super happy and celebrated our good relationships.

Andréanne Larouche: What is the state of research?

Dr. Diane Francoeur: Research requires funding. Yes, it's complex, but—

The Chair: Thank you, Dr. Francoeur. I'm sorry to cut you off.

[*English*]

Ms. Borrelli, go ahead for five minutes, please.

Kathy Borrelli: Thank you very much, Chair.

I want to get back to Dr. Leyland.

I found it very interesting that you said in your previous answer to my question that you first specialized in nutrition before you became a gynecologist. I think that's fascinating because whenever I wanted to talk to a physician about nutrition or suggestions for vitamins or what foods to eat, they just looked at me blankly saying, “I don't know. Maybe you could see a specialist about that”—a nutrition counsellor or whatnot.

Would you suggest that doctors, besides studying more about menopause in medical school, should also have some education about nutrition and how people can benefit from proper nutrition, and then teach them to teach their patients?

Dr. Nicholas Leyland: Definitely.

When I started in medical school, we had one course in the first year, and it was very limited. The problem with megavitamin therapy or large amounts of omega-3 and that kind of thing is that there isn't sufficient evidence yet, but lack of evidence doesn't mean that they're bad things. There are many benefits to omega-3 supplementation, but you can also look at your diet and figure out how to get the most benefit from a healthy diet as well. That's what I learned after four years in undergrad, but that's a short form.

● (1815)

Kathy Borrelli: Thank you.

Dr. Francoeur, do you believe we should educate our youth about the importance of digestive health, sleep, stress, stress management, nutrition and physical activity to help reduce potential health concerns and thereby perhaps decrease the amount or severity of symptoms they might have when they go into menopause?

[*Translation*]

Dr. Diane Francoeur: Definitely. Women are somewhat sandwiched in between. Their children are now teens, and their aging parents need caregivers. As a result, they constantly look after everyone, while neglecting their own needs.

I have another piece of good news to share with you, since we're the last panel you're having on perimenopause and menopause. We had a public conference in Gatineau last Sunday, and women could attend online or in person. Some 260 participants attended in person in Gatineau and 3,500 signed up online. We spoke about healthy lifestyle habits, nutrition and personal care before and when menopause starts. We also spoke about mindfulness and mental decluttering to reduce the impact of brain fog, as well as resting and having healthy habits. Obviously, that's the first step. There's no doubt about that. Afterwards, if things are not going well and they have more severe symptoms, they will need medication. When that happens, we are there to give them advice. Women are extremely receptive. They were very keen during the conference. It was amazing.

[*English*]

Kathy Borrelli: Did I hear you right? Did you say 3,500 respondents?

Dr. Diane Francoeur: Yes.

Kathy Borrelli: That's incredible. I'm sure that could speak to the need that women have for information and not just their curiosity but their drive to learn how to improve their health and to learn more about menopause and symptoms. That is fabulous. If we could reproduce that across the nation and in various cities.... This is what I keep asking my questions about in this committee: How do we get that information out?

I'm so happy you provided that service.

[*Translation*]

Dr. Diane Francoeur: That's the plan. We started to do that in Quebec, in French. It's still up on our website, if you'd like to check it out online. It's called Tempête hormonale. We are going to go to the west and the Maritimes next. In short, we are going to go everywhere. It's accessible online free of charge. We have great experts in Canada and they are very generous with their time. They spent three hours answering questions from women. It was extraordinary. We will have a similar conference in English, so don't worry. We are going to go to other places, because we hope to reach all women across Canada. When we did the survey—

The Chair: That brings us to the end of this round for Mrs. Borrelli.

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

[*English*]

Juanita Nathan: Thank you, Madam Chair.

Thank you to all the witnesses who are here today. I have had the privilege of listening to Dr. Leyland and Dr. Francoeur previously, as part of my research.

I'll direct this question to Dr. Leyland.

From a medical perspective, where are the biggest gaps in how menopause and perimenopause are diagnosed and treated across Canada? How do they affect a woman's ability to stay working?

Dr. Nicholas Leyland: The biggest gaps are in professionals' understanding of perimenopause and in menopause management.

I see this because in Ontario we have the Ontario telehealth network. I can do online consultations. In fact, I have three of them sitting and waiting for me now. They're all about menopause.

The diagnosis of issues around perimenopause is not well understood by any of the clinicians. These are all nurse practitioners as well. There's a huge gap there.

What was the last part of your question?

● (1820)

Juanita Nathan: I was just asking how this affects women's ability to keep working.

Dr. Nicholas Leyland: If the women aren't getting the proper care they deserve and would benefit from, many of them are obviously going to end up leaving the workforce—without the proper care. It is really important that we resolve this issue across Canada in some manner, both the potential workplace legislation issues as well as proper education for providers and access to education for the women themselves.

Juanita Nathan: Thank you.

I'll direct my next question to Dr. Francoeur.

How do the warnings and labels on menopause treatments affect care? What gaps are there in the treatments available in Canada?

Dr. Diane Francoeur: There was big damage from black box warnings after the WHI study. Unfortunately, the side effects lasted for way too long.

Now I would say that we have a more open mind, especially with the new products. We have products that have fewer side effects. We talked about thrombosis. We talked about the liver problems. Sometimes we need to use medication off the targeted indication, but it's rare. Women need to trust us. For some of them, when you've tried everything, you might go in a direction...and sometimes off label, but it is really safe.

I was talking about the meeting last weekend. We had a priority for health care providers because we love everyone: pharmacists, nurses, nurse practitioners, GPs and OB/GYNs. Things are moving. There are new drugs, and there are new indications. We used to not talk about perimenopause. Now we know that it can start 10 years before. We just update the knowledge. This is where we're going to sometimes tell them that they can go and prescribe it because it's safe. They need more education to keep it alive. The data is really there. That's what we're working on.

Juanita Nathan: You're saying that the warnings should be reviewed against current evidence.

Dr. Diane Francoeur: Yes. For example, we used to say no to hormones for women who had breast cancer. Now, there sometimes can be some exceptions. The vaginal products are safe. We used to say, "No, absolutely not."

The science is evolving. We have new studies that are reassuring. Nevertheless, we're there to help, not to affect anyone. That's why we have to be safe. At the same time, we have to be there to reassure women about the safety of these new medications.

Juanita Nathan: What should women know about bioidentical hormones?

Dr. Diane Francoeur: They're the best.

[*Translation*]

The Chair: Thank you, Ms. Nathan and Dr. Francoeur.

Those were the closing remarks.

I would like to thank all the witnesses. This was a really great study. All the women around the table did not shy away from talking about the menopause. We need to sustain and intensify this dialogue. We need to speak up about this issue. There is nothing embarrassing about this, but it's a frustrating experience. I have no doubt that all the testimony we heard will be useful.

Thank you very much, Dr. Francoeur. It's always a pleasure to see you.

Thank you very much, Dr. Leyland and Dr. Veresiu.

I will adjourn the meeting so we can go in camera.

[*Proceedings continue in camera*]

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