WRITTEN SUBMISSION

House of Commons Standing Committee on the Status of Women

Study on the Labour Force Impacts of Menopause and Perimenopause

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1. Purpose

I was honoured to be invited to appear before the Committee on 11 June 2026, and I am grateful for the further invitation to comment in writing. This submission answers questions that fall within my area of work. Menovate delivers corporate talks for employees, HR teams and leaders, and a six-video e-learning course watched at a desk and easily deployed to a company's learning platform, with versions for men, HR, advocates, people leaders and women in the transition.

2. Where to start: education and training *Ms. Vien*

These are not interchangeable, and both are required. Education is for everyone. It allows women to recognise what is happening to them and seek the support and treatment they need, it gives everyone else the context to respond, and it breaks the stigma so the conversation can be opened at work. Training is for managers and leaders, to support those going through it. Neither works alone: a woman who has been educated and feels ready to raise it, to a manager who does not know the subject or what the company offers, leaves that conversation worse off. Both are set up to fail.

It cannot be one session; the stigma took decades to build.

3. On legislation

My recommendation is that every employer in Canada, of any size, be required to have a formal menopause policy and accommodation plan. This will not happen voluntarily at the pace required to prevent women leaving the workforce now.

Canada should go further than the United Kingdom, which requires only employers with 250 or more staff to publish Menopause Action Plans under the Employment Rights Act 2025, mandatory from 2027. That threshold would exclude many Canadian employers.

4. What good looks like *Ms. Ménard, Ms. Nguyen*

- Recurring education for employees and training for managers, not a single session.
- Formalised accommodations set out in a policy document, so everyone receives the same support.
- A senior woman at the company saying publicly that she is going through it.
- A menopause community, funded and supported by HR, where women can talk openly among themselves.
- A named contact who is not the employee's direct manager.
- Men in the room. Half of most workforces will never experience menopause but will work with, manage or live with people who do.

5. Accommodations that fit the workplace *Ms. Nathan*

Accommodations must fit the workplace; what works in an office does not transfer to a factory floor or a hospital ward. In an office that could mean flexible start times, working from home after a difficult night, and control over temperature and desk placement.

Outside the office the same needs require different answers: uniform and dress code flexibility; guaranteed access to breaks, cold water and washrooms; somewhere private to change; and predictable scheduling, with consultation before shifts change.

6. Measurement *Ms. Cody, Ms. Tesser Derksen*

A national estimate exists. The Menopause Foundation of Canada, with analysis by Deloitte Canada, put the annual cost of unmanaged menopause at $3.5 billion: $3.3 billion on women in lost income and $237 million on employers in lost productivity, across 540,000 lost working days a year. Women carry roughly fourteen times the cost. Sick leave taken before a woman understands what is happening to her sits inside that figure and is almost never recorded as menopause related.

Employer-level data barely exists. A few Canadian employers are beginning to gather it. Without it, when a woman resigns at 51 it is recorded as ordinary turnover. Employers should ask at two points: at exit, and in the survey, they already run, covering symptoms, accommodations wanted, and the education and training people need.

7. Research and a regulatory gap

The Committee has heard that research already exists but is not reaching clinicians. That is true. There is also a second gap: much about menopause has never been studied at all. The Lancet published the top ten unanswered menopause research questions in December 2024, drawn from surveys across 42 countries. Two of the top four concern cognition and sleep, the symptoms that directly affect a woman's ability to work. Canada should fund against that agenda rather than start from scratch. Female-specific health research has accounted for roughly 7% of funded Canadian health research grants over fifteen years, a share that has barely moved. Seven percent, for a transition every woman will go through and one that costs this country $3.5 billion a year. McKinsey puts the wider opportunity from closing Canada's women's health gap at $37 billion annually by 2040. That must change, and not marginally.

There is also a concrete regulatory gap. Canada has no testosterone product approved for use in women, so clinicians who prescribe it must use formulations licensed for men and ask women to divide a male dose by eye. Four countries have licensed testosterone formulated for women — Australia, New Zealand, South Africa and, most recently, the United Kingdom — and all four licensed the same product. It is time Canada did the same.

Supply falls under the same jurisdiction. There have been repeated shortages and several discontinuations of estradiol products in Canada since 2017, including the patch shortage now affecting several provinces. Demand has risen as coverage expanded, without a matching increase in supply. Improving affordability without securing supply simply moves the barrier.

8. Clinician training and the drift to private care

Clinicians are not being trained for this. A US study of medical residents found one in five had received no menopause teaching, and only 6.8% felt adequately prepared to manage it. I am not aware of equivalent Canadian data, which is itself part of the problem. Many practising physicians also qualified before the evidence on hormone therapy was revised, and some still decline to prescribe.

The consequence is the quiet privatisation of menopause care in Canada. Good care has increasingly moved to private providers, most established in the past two years. They are filling a gap that should not exist, but when the informed, unhurried appointment is the one you pay for, access depends on income. A woman who cannot afford private care should still receive competent care.

Workplace education is not a substitute for clinical care or training and should not be treated as one. But while the system catches up, an employer can reach thousands of women with evidence-based material, including women who cannot get a timely appointment.

9. Recommendations

1. Establish minimum workplace standards for menopause education and training, delivered recurrently to employees, managers and leaders, and including men.
2. Require every employer in Canada, regardless of size, to have a formal menopause policy and accommodation plan. Voluntary adoption will not move quickly enough, and a 250-employee threshold would exclude most Canadian workplaces.
3. Ensure equitable, affordable access to care that is not unduly withheld, so that competent care does not depend on the ability to pay privately. This requires menopause in the medical curriculum and in continuing professional development. British Columbia made menopausal hormone therapy free under PharmaCare Plan NP from 1 March 2026, and Manitoba also covers it; women elsewhere pay. Health Canada should review the testosterone products licensed in four comparable jurisdictions and address the recurring estradiol shortages.
4. Fund Canadian research against the published international priorities, alongside national data collection and a public awareness campaign; Australia has committed $12.8 million over two years to its first. Federally regulated employers should be required to capture menopause in engagement surveys and exit interviews.

Menopause is inevitable. Women leaving the workforce because of it is not.

References: Menopause Foundation of Canada, Menopause and Work in Canada (2023), analysis by Deloitte Canada · Menopause Priority Setting Partnership, Top ten menopause research priorities, The Lancet, 21 December 2024 · Kling JM et al., Mayo Clinic Proceedings, February 2019 · McKinsey Health Institute, Closing the Women's Health Gap: Canada's $37 Billion Opportunity · Biology of Sex Differences (2025) · UK Employment Rights Act 2025 · BC PharmaCare Plan NP, 1 March 2026 · Drug Shortages Canada · Australian Government, national menopause campaign, 2025-26 Budget · UK MHRA approval of AndroFeme · FEWO Evidence, Meetings 44 and 45.