

LEADING BEYOND THE GAP:

Closing the Women's Health Gap in Canada

Blueprint for Action

February 2026



Context on the Blueprint for Action

McKinsey & Company Canada (McKinsey) is proud to have been a knowledge partner to Women's Health Collective Canada (WHCC) on a pro bono basis, providing the data and analysis that underpins this report. The work is based on publicly available data and insights from the McKinsey Health Institute's knowledge base, supplemented by the expertise of our collaborators to develop a fact-based approach aimed at addressing the women's health gap in Canada.

This document is the property of the WHCC and should not be used or shared in whole or in part without expressed written consent. It should not be interpreted as tax, health, legal, or policy guidance.



WHCC contributors

Amy Flood
Daniel St. Germaine
Sharlene Rutherford (AWHF)
Marie-Hélène Laramée (MUHC)
Jennifer Gillivan (IWK)
Sandra Sualim (WCHF)
Cally Wesson (BCWHF)
Dr. Tamil Kendall (PWHR)
Dr. Lori Brotto (WHRI)
Dr. Sofia Ahmed (WCHRI)
Dr. Rulan Parekh (WCH)

McKinsey Canada contributors

Dr. Marie-Renée B-Lajoie
Laurie Lanoue
Liza Vityuk
Sandrine Devillard
Marie Woindrich
Alley Adams
Natasha Boyd
Jolien Vonck
Liela Touré
Èvane Amico

The authors of this report would like to thank the experts across Canada whose expertise shaped the development of the Blueprint



McGill University
Health Centre
Foundation

Dr. Julia Burnier
Dr. Nadia Giannetti
Dr. Annie Leung
Dr. Nancy Low
Dr. Dong Bach Nguyen
Dr. Reitan Ribeiro
Dr. Vanessa Tardio
Dr. Basile Tessier-Cloutier
Dr. Andrew Zakhari



Dr. Sofia Ahmed
Dianne Balon
Dr. Colleen Norris
Dr. Jane Schulz
Sandra Stabel



Dr. Tania di Renna
Dr. Paula Harvey
Dr. Iliana Lega
Dr. Kelly Metcalfe
Dr. Dana Ross
Dr. Allison Sekuler
Dr. Simone Vigod
Dr. Sheila Wijayasinghe

BC WOMEN'S
HEALTH
FOUNDATION



Dr. Lori Brotto
Cheryl Davies
Dr. Stephanie Fisher
Dr. Deborah Money
Dr. Roanne Preston
Dr. Paul Yong



IWK Foundation

Dr. Christina Atkinson
Emma Beukema
Dr. Justine Dol
Valerie Malone
Dr. Maria Migas
Dr. Shawna O'Hearn

Other

Dr. Tamil Kendall
(Partnership for Women's
Health Research Canada –
PWHR)
Chantal Gagné
(Desjardins)
Dr. Christine Faubert
(Heart & Stroke Canada)

We need to act now for Canada and the world

Canada can close its critical women's health gap and shape global progress by mobilizing a coordinated pan-Canadian approach

Canadian women spend 24% more of their lives in poor health¹, driven by conditions that affect women differently, disproportionately, and uniquely compared to men. Closing this gap could contribute an estimated \$37B to Canadian GDP by 2040¹ – **and give back one week a year of good health to each Canadian woman, enriching their families and our communities²**.

This report builds on input from WHCC and 30+ Canadian experts to identify key actions that can move Canada above and beyond the women's health gap. Canada has sufficient scale to lead by accelerating existing investments and talent within its optimally-sized ecosystem to enable coordination, accountability and outsized impact. Only a pan-Canadian, coordinated approach can drive the momentum needed to move from traction to action.

Canadian women are underserved due to gaps in the current healthcare ecosystem that require coordinated action to resolve

Women have long been under-researched, under-counted, and under-funded, causing a lack of gender-disaggregated data to inform innovation and care pathways. Our medical institutions and society require cultural change to recognize women's health as a priority, cascading into system changes (e.g., primary care, incentive systems), healthcare provider education and funding decisions. Limited public awareness slows diagnosis and constrains funding towards innovation. Our Canadian ecosystem needs to scale solutions to counterbalance constraints in the system (e.g., labour shortages, capacity limits).

We need to act now across 4 systemic change pillars and targeted interventions in 5 priority conditions accounting for >75% of the women's health gap

1. **We know** – Standardize data and mandate sex-disaggregated research
2. **We care** – Institutionalize and scale sex-specific care and equitable access to preventive and diagnostic care
3. **We invest** – Scale research funding and Canadian's women's health innovation
4. **We empower** – Empower women to take charge of their own health, support women's career journeys, and elevate women's philanthropy

These systemic actions are complemented by **targeted interventions for specific conditions** that affect women differently (cancer, cardiovascular diseases), disproportionately (brain and mental health disorders) or uniquely (hormonal health and menopause, chronic pelvic pain).

We can catalyze action and inspire global progress to address women's health

Canada can become a leader in women's health. We need to 6x scale and accelerate women's health research and care delivery. This requires clear action from all constituents: governments, employers, and private and philanthropic investors must jointly commit sustainable funding to women's health to move beyond the gap and lead the way globally. Stakeholders need to come together in coordinated ways, with transparent, accountable, and measurable targets, to build a better future together. Canada needs to mobilize our population – from the Maritimes to the Rockies – to stack hands in support of every woman and, in turn, our families, communities, and country. Canada can emerge as a global leader and champion as women's health is a \$1 trillion dollar opportunity worldwide.

1. "Closing the women's health gap: Canada's \$37 billion opportunity," McKinsey & Company (2025)

2. McKinsey Health Institute data (2025)

The Blueprint is informed by research and complemented with 40+ expert interviews and 150+ public sources

NOT EXHAUSTIVE

McKinsey Health Institute

ORIGINAL MHI RESEARCH ON GLOBAL HEALTH DATA

Forecasts of disease burdens

up to **2040**

60+

Diseases¹ reviewed

180+

Interventions² analyzed

CANADA-SPECIFIC ANALYSIS AND REPORT



Expert interviews

40+

Interviews conducted with industry experts across Canada



Public sources

80+

Formal reports and white papers

30+

Research articles and peer-reviewed journals

20+

Public health databases

20+

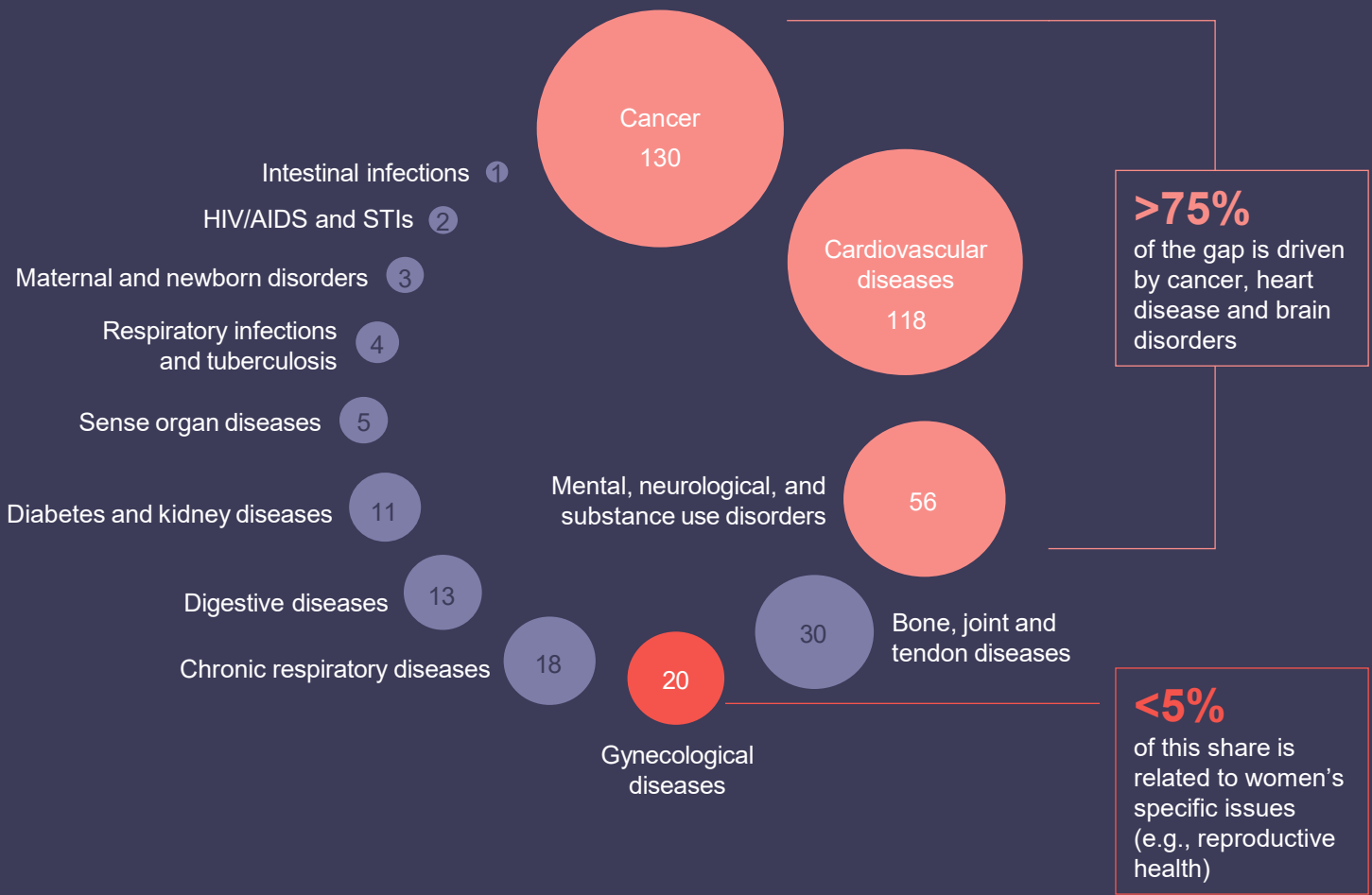
Press releases

1. Accounting for >85% of women's global disease burden
 2. Based on guidelines from leading institutions such as the World Health Organization (WHO) and journals such as The Lancet

As published by the McKinsey Health Institute: Canadian women spend 24% more of their lives in poor health

Closing this gap could contribute an estimated \$37B to Canadian GDP by 2040

Gap in efficacy and care delivery, by 2040¹, thousands of disability-adjusted life years (DALY)



1. Neglected tropical diseases had an expected impact of zero DALYs by 2040 and so is not shown.
Source: "Closing the women's health gap: Canada's \$37 billion opportunity," McKinsey Health Institute (2025)

We can make Canada the world leader in women's health

We act.

Make Canada the leading nation in women's health, driving cultural change to empower women in their own health journey

Make this possible for ALL women, ensuring all benefit from equitable, culturally responsive health care regardless of geography or background

- 1 Elevate WHCC and PWHR to coordinate a pan-Canadian strategy on women's health** through strong governance, unified stakeholders, accountability, and transparency



We know.

- 2 Standardize data**

Standardize sex- and gender- disaggregated data across discovery and early-stage research, trials, and care to ensure sufficient female-specific data



- 3 Mandate sex-disaggregated research**

Mandate sex- and gender-disaggregated research and equitable trial participation as a condition for research funding, with ethics boards oversight compliance



We care.

- 4 Institutionalize sex-specific care**

Formalize sex-specific clinical care pathways across major disease areas (e.g., cancer, cardiovascular), supported by clinical guidelines and integration into electronic health records



- 5 Expand equitable access**

Advance equitable access to preventive and diagnostic care for women through expanded community-based screenings, culturally safe services, and digital models (e.g., virtual follow-ups, menopause screeners)



- 6 Embed sex and gender in education**

Incorporate sex and gender considerations in health education across medicine, accreditation, and training, starting with five priority conditions



We invest.

- 7 Scale research funding**

Expand women's health research funding by Canada's public research funders and philanthropic grants, including growing the National Women's Health Research Initiative (NWHRI)



- 8 Promote innovation**

Scale Canadian's women's health innovation to catalyze investment (e.g., VC, PE, regional banks, accelerators), formalizing partnerships and collaboration between public and private industry



We empower.

- 9 Empower women for their health**

Equip women to take charge of their health through national education platforms and campaigns in partnership with patient advocacy bodies



- 10 Support women's career journeys**

Support women's career journeys through women-specific health and benefit policies across employers (e.g., benefits audits, flexible return-to-work, employer incentives tied to health outcomes)

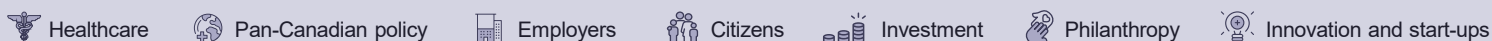


- 11 Elevate women's philanthropy**

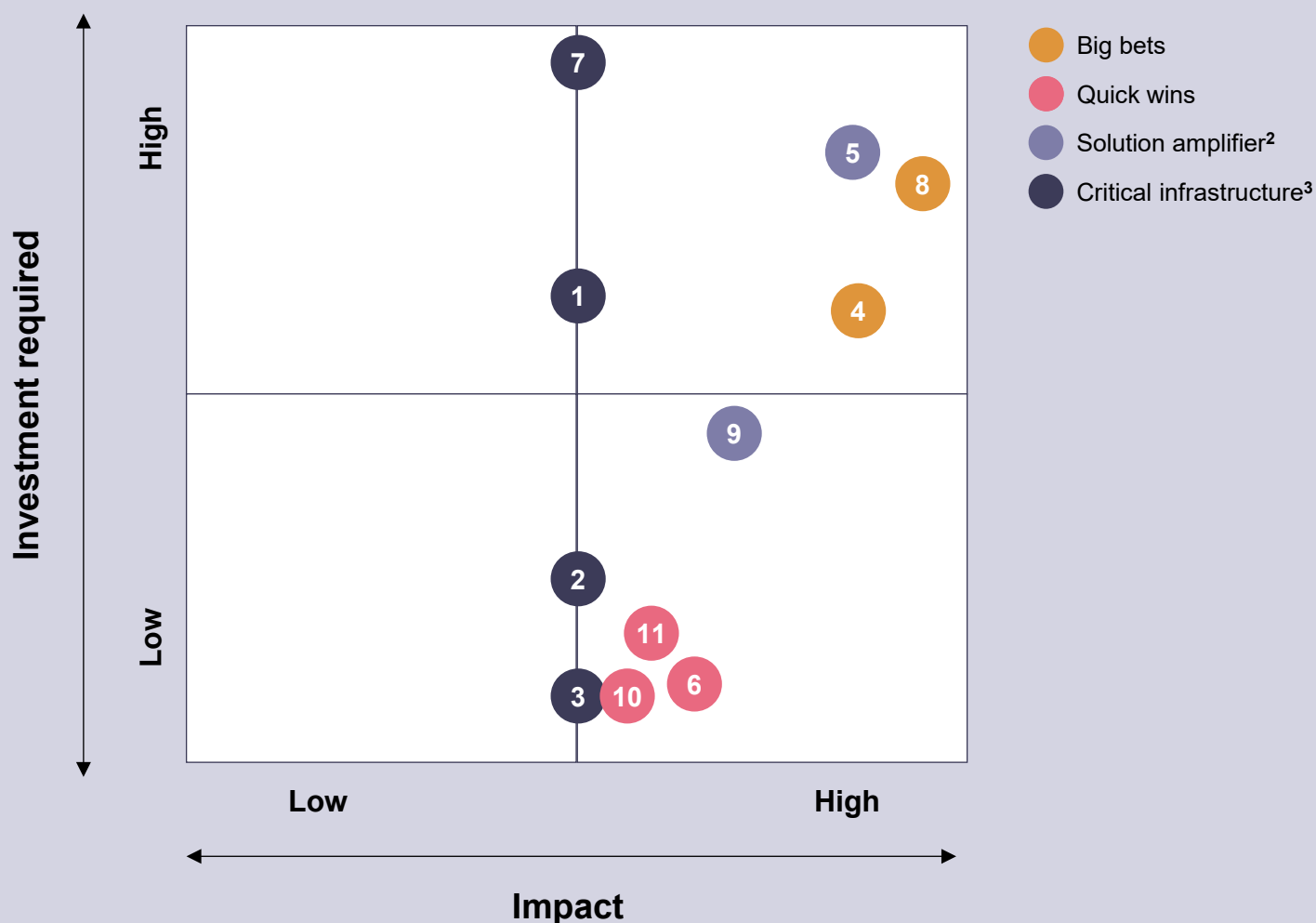
Accelerate women's philanthropic participation by strengthening the networks, platforms, and incentives that empower women to invest



All stakeholders must collaborate



These 11 cross-cutting actions will require investments of \$330-390M and could reduce the women's health gap by an estimated 110-145k DALY¹



1. Thousands of disability-adjusted life years. Range excludes impact of enabling critical infrastructure given their cross-cutting nature
2. Enables more efficient use of health system resources to achieve higher impact (incl., realization of cost-efficiencies)
3. Infrastructure that does not create direct impact but is critical to enable other cross-cutting actions

Detailed impact and investment by initiative

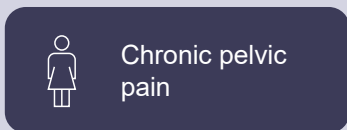
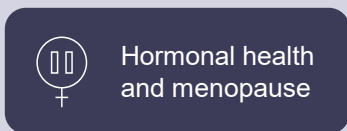
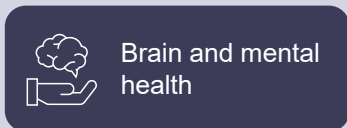
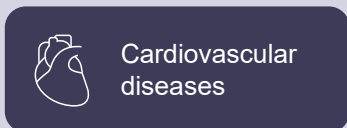
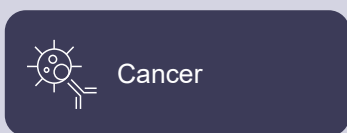
HIGH-LEVEL ESTIMATE

	Action ¹	Impact, k DALY ²	Investment, \$/ year
We know.	1 Elevate WHCC and PWHR to coordinate a pan-Canadian strategy on women’s health through strong governance, unified stakeholders, accountability and transparency	n/a ³	40-50
	2 Standardize sex- and gender- disaggregated data across discovery and early-stage research, trials, and care to ensure sufficient female-specific data	n/a ³	5-7
	3 Mandate sex- and gender-disaggregated research and equitable trial participation as a condition for research funding, with ethics boards oversight compliance	n/a ³	1-2
We care.	4 Formalize sex-specific clinical care pathways across major disease areas (e.g., cancer, cardiovascular), supported by clinical guidelines and integration into electronic health records	26-34	40-45
	5 Advance equitable access to preventive and diagnostic care for women through expanded community-based screenings, culturally safe services, and digital models (e.g., virtual follow-ups, menopause screeners)	25-30	60-75
	6 Embed sex- and gender-based health education across medicine, accreditation, and training	10-11	1-3
We invest.	7 Scale research funding on women’s health within CIHR, National Women’s Health Research Initiative (NWHRI), and philanthropic grants	n/a ³	100-110
	8 Scale Canadian’s women’s health innovation to catalyze investment (e.g., VC, PE, regional banks, accelerators) in women’s health, formalizing partnerships and collaboration between public and private industry	26-34	60-65
We empower.	9 Equip women to take charge of their health through national education platforms and campaigns in partnership with patient advocacy bodies	14-21	22-26
	10 Support women’s career journeys through women-specific health and benefit policies across employers (e.g., benefits audits, flexible return-to-work, employer incentives tied to health outcomes)	3-4	1-2
	11 Accelerate women’s philanthropic participation by strengthening the networks, platforms, and incentives that empower women to invest	6-9	2-3
	Total	110-145k	330-390

1. Detailed sizing assumptions outlined in Methodology appendix. There are numerous additional benefits that women may gain (e.g., supplementary income, investment returns, community engagement). Sizing estimates are intended solely to illustrate one possible approach to quantification
2. Thousands of disability-adjusted life years. Range excludes impact of enabling critical infrastructure given their cross-cutting nature
3. Infrastructure that does not create direct impact but is critical to enable other cross-cutting actions

Five conditions were prioritized with input from industry experts to define what can meaningfully close the women's health gap in Canada

Conditions



Rationale

Accounts for 75% of the Canadian women's health gap

Impacts +95% of Canadian women over the course of their lives

Is broadly under-researched and misunderstood

We recognize that all conditions affect women uniquely, disproportionately, or differently.

These five priority areas were identified based on contribution to the women's health gap and historical neglect in traditional women's health topics (e.g., pregnancy)

As heard from industry experts...

“ We need to unleash Canada. The country has so much potential, but **we have endless committees and layers of regulation hampering innovation.**

There is a big whitespace in women's health. Corporations and insurance players are only just starting to come in to fill the gap **since it hasn't been addressed yet.**

Clinicians are inherently innovative, but lack time, infrastructure and commercialization pathways. **We need interdisciplinary teams** with engineers, clinicians, businesspeople **to move from ideas to commercialization and adoption.**

Nobody is coming but us – we have to do this as Canadians, for Canadians.”

Each of the five priority conditions will require specific, targeted actions to close the women's health gap



Cancer prevention and treatment



Cardiovascular diseases



Brain and mental health conditions

EMERGING THEMES

Research is the most critical driver of the women's health gap in cancer. Female underrepresentation in early-stage and clinical studies limits understanding of sex-specific biology and treatment response, impacting innovation

Limited data and evidence have constrained innovation, slowing progress in developing effective diagnostics, screening infrastructure, and therapies for women

Women are often misdiagnosed or undertreated for CVD because risk factors, symptom presentation, and treatment response differ from those documented in men

Research and innovation gaps remain significant, with only one-third of CVD trials including women, constraining the development of effective diagnostics and therapies tailored to female symptoms

Women experience higher rates of mental and neurological disorders, yet symptoms are often underrecognized and care pathways insufficiently tailored. Gendered factors (e.g., hormonal transitions, caregiving roles) contribute to distinct disease patterns and delayed diagnoses

Women are less likely to access timely or adequate treatment, facing access barriers and limited gender-responsive support

CLOSING THE GAP REQUIRES...

Expanding funding (philanthropic, as well as public and private investment) to accelerate research and innovation focused on women's cancer outcomes

Defining sex-specific care guidelines and pathways, and expanding research into women-focused CVD care to improve treatment efficacy and care delivery

Expanding access to women-centered mental health and neurological care through dedicated care pathways and targeted investment in innovation, ensuring equitable diagnosis, treatment and recovery, as well as building broader front-line capabilities for initial trauma-informed care



Hormonal health and menopause



Chronic pelvic pain

EMERGING THEMES

Education and access to care are the most critical drivers in women's menopause and hormonal health. The stigma around menopause contributes to low awareness of symptoms and understanding of treatment options

Women often go undiagnosed and undertreated for menopause symptoms due to shortages in primary care practitioners and treatment options, and lack of awareness within the medical and broader community

The stigma around menstruation is a key driver of the health gap in CPP, as most women go undiagnosed due to the normalization and dismissal of pelvic pain

Diagnostic care is also a driver, as those who get diagnosed experience significant delays due to a lack of primary care practitioners' awareness of CPP.

Once diagnosed, there is no definitive treatment, yet interdisciplinary care can support women with the associated chronic pain

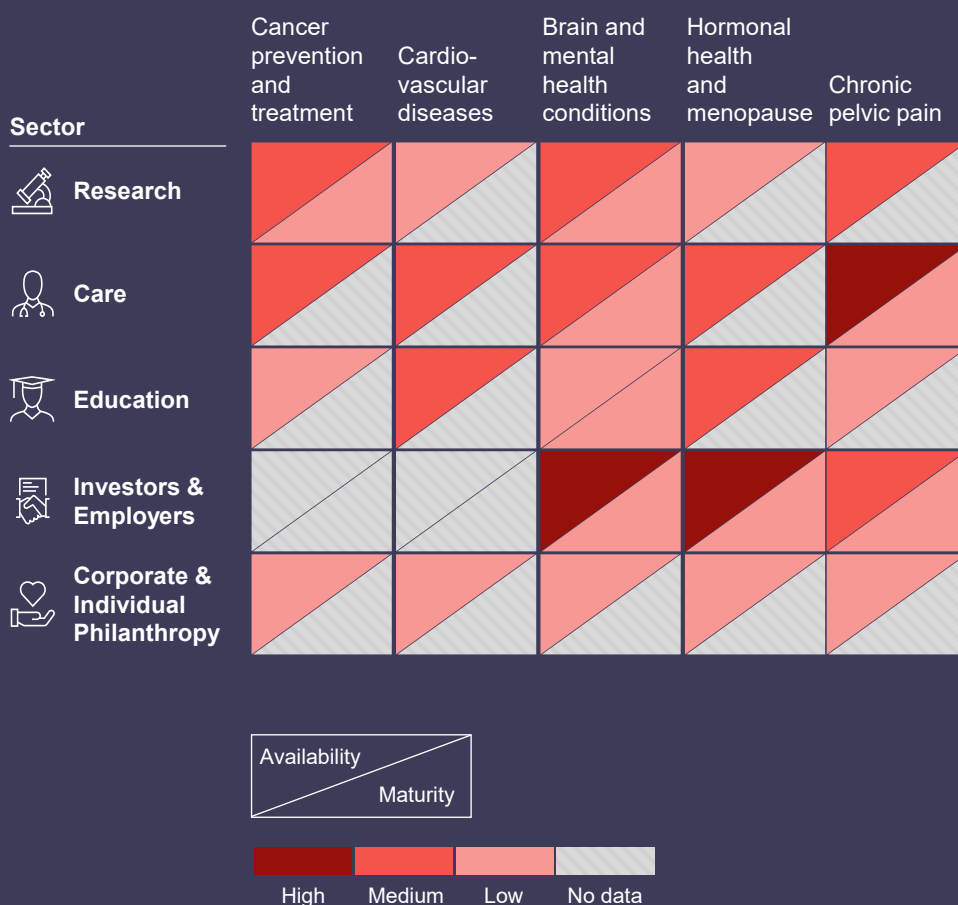
CLOSING THE GAP REQUIRES...

Launching a national community education campaign to break the stigma with simultaneous investment in hormonal care and primary care access and provider education, as well as improving workplace support through women-specific policies

Growing research and structuring an interdisciplinary approach to care including primary care, gynecology, mental health and more, while simultaneously spreading awareness through community campaigns

The availability and maturity of Canadian data on women's health varies across disease areas and sectors

Assessments are directional, as of the end of 2025



Key findings

Data remains limited yet is most available in research and care. Barriers to data availability include women's health not being consistently prioritized and research findings not being published publicly.

Data maturity is low with major gaps across disease areas. Women's health data must be better leveraged to drive policy, funding, care and education.

DEFINITIONS

Data Availability¹

Data exists on the women's health gap, highlighting unique and disproportionate outcomes for women compared with men

Data Maturity²

Women's health data is systematically tracked, analyzed, and used to inform policy, funding, and care

1. Data availability measured as: N/A: No publicly available information exists in Canada; Low: Limited publicly available data in Canada but not reported by sex; Medium: Data is available in Canada but not consistently reported by sex; High: Data is available in Canada and consistently reported by sex
2. Data maturity measured as: N/A: Data is not included in existing approaches to policy/funding/care; Low: Sex/gender recorded inconsistently; Medium: Sex/gender recorded consistently but inconsistently incorporated into policy/funding decisions; High: Sex and gender are consistently disaggregated and used to inform policy, funding and care decisions

Closing the women's health gap in **cancer** in Canada

Canadian women face an unequal burden from cancer

#1

cause of death for women in Canada¹. Women experience **higher rates** of sex-agnostic cancers (e.g., lung) and experience higher lifetime risk for gender-specific cancers (e.g., breast, ovarian) than men (e.g., prostate)²

61%

of the women's health gap in Canada is driven by the **lack of innovation and data³**

33%

of Canadian women's health gap is driven by **cancer** (in DALY⁷). Closing it could add **~\$3B to Canada's GDP³**



1. "Leading causes of death, total population (age standardization using 2021 population) - Dataset" Statistics Canada (2025)
2. "Breast Cancer Statistics" and "Prostate Cancer Statistics" Canadian Cancer Society (2025)
3. "Blueprint to Close the Women's Health Gap: How to Improve Lives and Economies for All" World Economic Forum & McKinsey Health Institute (2025)
4. "Women in clinical trials: a review of policy development and health equity in the Canadian context" International Journal for Equity in Health (2019)
5. "Breaking the Silence on Gynaecological Cancers: Empowering Canadian Women to Take Action" GSK Canada (2025)
6. Organization websites and annual reports
7. Disability-adjusted life years (DALY)

Gaps in the current healthcare ecosystem...

...require action to close

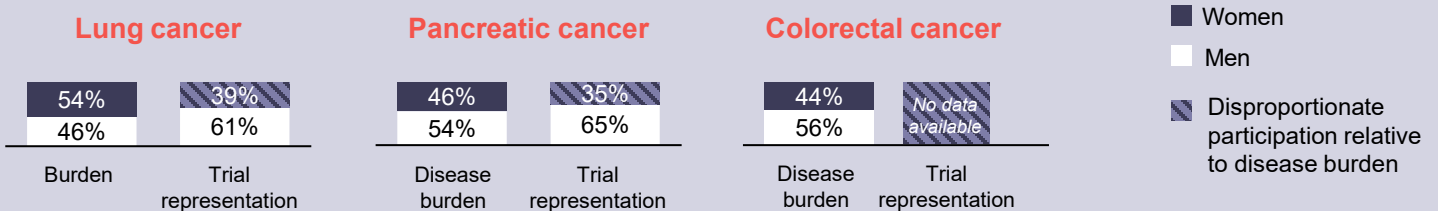
1 **Under-representation in early-stage research**, limiting understanding of cancer in the female biology

Incentivize women participation in studies with focused funding to women-only studies where relevant

2 **Clinical trial participation consistently below disease burden**, limiting understanding of treatment efficacy across cancers³

Mandate trial representation proportionate to the disease burden and support research institutions to improve participation through tailored outreach

Proportion of women's enrollment in oncology trials (2003-2016) and disease prevalence by gender (2019), Canada⁵



3 **Tracking and reporting difficulty** due to inconsistent gender reporting and decentralization of research data

Enforce sex and gender-disaggregated reporting prior to randomization

4 **Delayed diagnoses lowering chances of survival** due to screening and testing (26% of the gap²), patients' knowledge of early symptoms (80% lack knowledge of uterine cancer symptoms⁴) and care providers' knowledge of women-specific symptoms

Scale diagnostic innovations (e.g., screening capabilities) and promote early diagnosis, leveraging existing infrastructure

5 **Fewer breakthrough innovations** (e.g., surgical procedures, medicines, and treatments) due to complexity of female-specific cancers and limited research base

Coordinate interdisciplinary support to scale diagnostic and treatment innovations

6 **Unequal philanthropic funding** with male-specific cancer organizations (e.g., prostate) receive 2x more philanthropic funding⁶

Drive targeted fundraising for women-specific cancer foundations leveraging patient voices to amplify key messages

1. "Leading causes of death, total population (age standardization using 2021 population) - Dataset" Statistics Canada (2025)

2. "Breast Cancer Statistics" and "Prostate Cancer Statistics" Canadian Cancer Society (2025)

3. "Blueprint to Close the Women's Health Gap: How to Improve Lives and Economies for All" World Economic Forum & McKinsey Health Institute (2025)

4. "Women in clinical trials: a review of policy development and health equity in the Canadian context" International Journal for Equity in Health (2019)

5. "Breaking the Silence on Gynaecological Cancers: Empowering Canadian Women to Take Action" GSK Canada (2025)

6. In 2024, two major male-specific cancer foundations (Movember Canada, Ride for Dad) raised ~2x as much as with three major female-specific cancer foundations (Breast Cancer Canada, Ovarian Cancer Canada, Rethink Breast Cancer), raising ~\$23.6M vs. ~\$11.4M.

Sources: Organization websites and annual reports

7. Disability-adjusted life years (DALY)

Closing the women's health gap in cardiovascular diseases (CVD) in Canada

Canadian women face an unequal burden from cardiovascular diseases

1

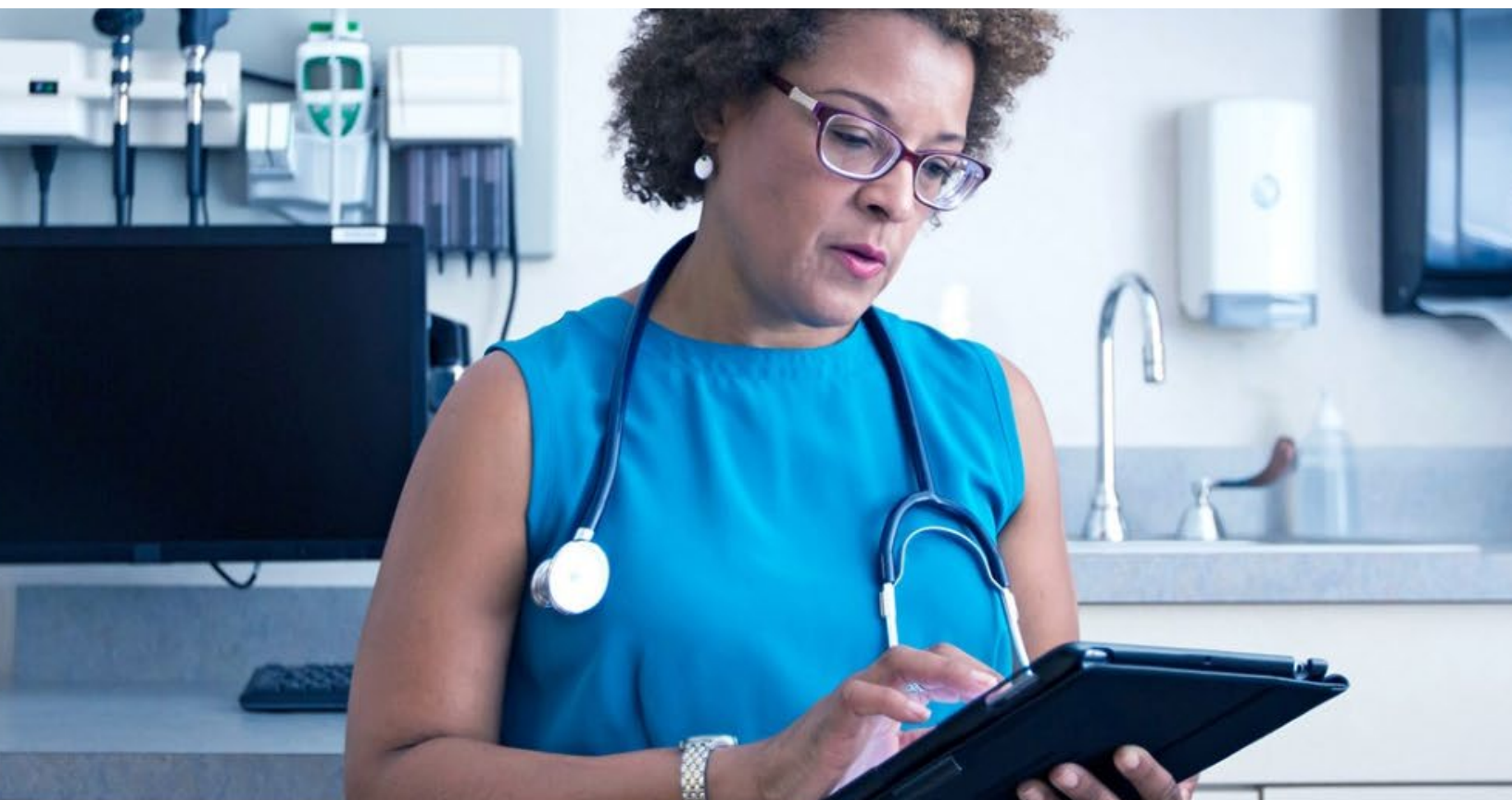
Canadian women die every 20 minutes from heart disease¹. In 2019, 20% more women than men died of heart failure, and 32% more women than men died of stroke in Canada²

60%

of the women's health gap in Canada is driven by the **lack of innovation and data³**

29%

of the **Canadian women's health gap** is driven by cardiovascular diseases. Closing it could add **~\$2B to Canadian GDP³**



1. "Ms. Understood: Heart & Stroke 2018 Report" Heart & Stroke Foundation (2018)
2. "System failure: Women's heart and brain health are at risk" Heart & Stroke Foundation (2023)
3. "Closing the women's health gap: Canada's \$37 billion opportunity," McKinsey & Company (2025)
4. "Participation of Women in Cardiovascular Trials From 2017 to 2023" Jama Network (2025) – note that data represents participation across Canada and Mexico

Gaps in the current healthcare ecosystem...

require action to close

1 **Lack of understanding and recognition of women-specific CVD symptoms**, causing women to be misdiagnosed or experience delays in diagnosis

Incorporate research findings into cardiology training materials to educate current and incoming care practitioners on women’s symptoms

2 **Limited research and under-reporting of CVD treatment** safety and efficacy to inform treatment specific to women

Identify surgical and pharmacological treatments that address needs of female CVD patients and fund initiatives to fill gaps

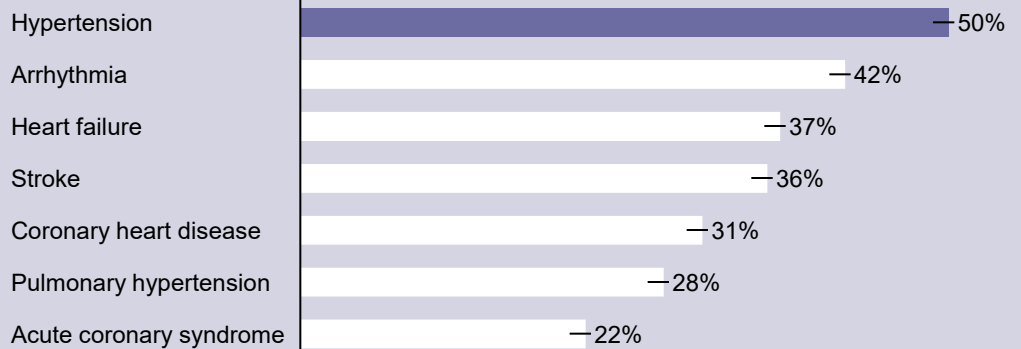
3 **Under-representation in clinical trials** causing limited effectiveness of existing treatments

Increase women’s participation in clinical trials by partnering with research institutions and CVD foundations to raise awareness of trials, empower women with CVD conditions to participate, and enforce reporting on outcomes by sex and gender

Female representation in CVD clinical trials, 2017-2023⁴



■ Insufficient representation



4 **Limited innovation of breakthrough treatments** driven by gaps in evidence specific to women’s CVD experiences and ongoing reliance of male-dominated treatment criteria

Support CVD innovation by partnering with research institutions, grant-makers and investors to fund innovations from discovery to scale and adoption

5 **Lack of community or patient awareness of women-specific CVD symptoms**, causing women to be unaware of their specific symptoms and delay seeking treatment

Partner to launch national campaigns to inform the public of women-specific CVD symptoms

1. “Ms. Understood: Heart & Stroke 2018 Report” Heart & Stroke Foundation (2018)
 2. “System failure: Women’s heart and brain health are at risk” Heart & Stroke Foundation (2023)
 3. “Closing the women’s health gap: Canada’s \$37 billion opportunity,” McKinsey & Company (2025)
 4. “Participation of Women in Cardiovascular Trials From 2017 to 2023” Jama Network (2025) – note that data represents participation across Canada and Mexico

Closing the women's health gap in brain and mental health disorders in Canada

Canadian women face an unequal burden from mental and brain disorders

3-5x

higher mortality for women compared to men for neurological diseases such as dementia, epilepsy, and Parkinson's¹

~5%

higher rates of poor mental health, anxiety and depression for Canadian women vs men²

74%

of the Canadian women's health gap stems from gaps in care delivery³

15%

of the Canadian women's health gap is driven by brain and mental health disorders. Closing it could add **~\$6B Canadian to GDP**⁴



1. Canadian Chronic Disease Surveillance System (2023-2024)
2. "The State of Mental Health in Canada: Gender in the Spotlight" Canadian Mental Health Association (2024)
3. McKinsey Health Institute data (2025)
4. "Closing the women's health gap: Canada's \$37 billion opportunity," McKinsey & Company (2025)
5. "The gender health gap: Its impact on working women in Canada" Sun Life (2024)

Gaps in the current healthcare ecosystem...

require action to close

1 **Limited sex- and gender-disaggregated data from mental health research and clinical trials**, hindering understanding of women’s specific symptom presentation and treatments

Enforce sex- and gendered reporting of mental health trials

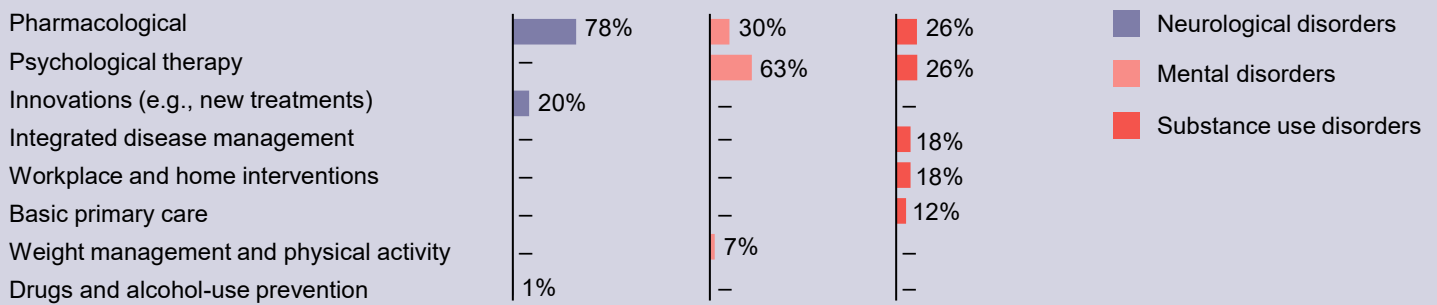
2 **Generalization of brain and mental health symptoms across genders** causing women to be underdiagnosed or experience delayed diagnoses for brain and mental health disorders

Document women-specific symptoms for brain and mental health and incentivize use in Canadian medical schools and healthcare facilities

3 **Pharmacological interventions contribute the most to the gap in treatment** (26-30% for substance and mental disorders, 78% for neurological conditions³), indicating opportunities to improve care delivery through proper diagnosis and management

Research sex-specific nuances to existing pharmacological treatments and optimize women’s access to effective interventions (e.g., tailored dosages)

Portion of DALY gap for women by intervention type in Canada, 2019³



4 **Patient education mechanisms are often insufficient** (10% of women have unmet mental health needs compared with 6% of men²), leaving women uninformed about treatment options and available support services

Scale treatment pathways leveraging digital solutions (e.g., virtual trauma training to meet patient needs)

5 **Leading cause of workforce disability leave in Canada** (i.e., brain and mental health conditions drive 40% of benefits claims for women vs. 30% for men⁵), impacting the Canadian workforce and productivity

Advise employers and benefits providers on adequate mental health coverage for women and tactics to educate on early risk factor identification and prevention

1. Canadian Chronic Disease Surveillance System (2023-2024)
 2. “The State of Mental Health in Canada: Gender in the Spotlight” Canadian Mental Health Association (2024)
 3. McKinsey Health Institute data (2025)
 4. “Closing the women’s health gap: Canada’s \$37 billion opportunity,” McKinsey & Company (2025)
 5. “The gender health gap: Its impact on working women in Canada” Sun Life (2024)

Closing the women's health gap in hormonal health and menopause in Canada

Hormonal health affects all Canadian women yet remains overlooked

~95%

of Canadian women experience menopause symptoms, with 25% seeking treatment due to severity¹

~80%

of Canadian women are affected by premenstrual syndrome²

72%

of the Canadian women's health gap stems from gaps in hormonal therapies

\$3B

in lost income for women due to a reduction of hours and/or pay or leaving the workforce due to menopause⁴

5%

of the Canadian women's health gap is driven by menopause and hormonal health. Closing it could add **~\$4.5B** to Canada's GDP⁵



1. Canadian Menopause Society (2025)
2. "Hormonal contraceptive use and prevalence of premenstrual symptoms in a multiethnic Canadian population," BMC Women's Health (2017)
3. McKinsey Health Institute data (2025)
4. "Menopause and Work in Canada", Menopause Foundation of Canada (2023)
5. "Closing the women's health gap: Canada's \$37 billion opportunity," McKinsey & Company (2025)
6. "The Silence and the Stigma: Menopause in Canada", Menopause Foundation of Canada (2022)
7. "Research finds that few women receive diagnosis of perimenopause or menopause", Evernorth Health Services (2025)
8. "The gender health gap: Its impact on working women in Canada", Sun Life (2024)

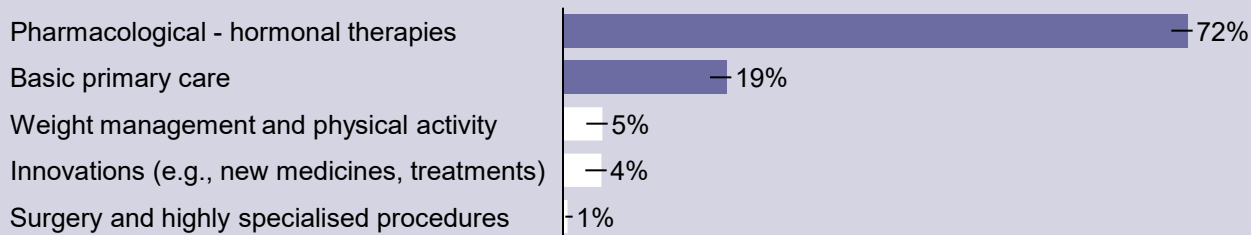
Gaps in the current healthcare ecosystem...

require action to close

- | | |
|---|--|
| <p>1 Stigma limits awareness among Canadian women about broad range of symptoms (hot flashes had 84% awareness compared to urinary tract infections with 18% awareness among women⁶)</p> | <p>Partner with foundations to launch community campaigns on menopause symptoms and care, leveraging existing infrastructure (e.g., mammogram letters)</p> |
| <p>2 Primary care shortages and diagnostic delays cause women to go undiagnosed (US study reports only 8% of women with confirmed diagnoses⁷) and therefore either untreated or unadvised on menopause symptoms</p> | <p>Ensure access to primary care for women, including family physicians, nurse practitioners, women-specific support resources (e.g., hotlines)</p> |
| <p>3 Limited menopause training for care practitioners causing physicians to not proactively provide advice, and when they do, it is found to be unhelpful</p> | <p>Require primary care providers to discuss menopause with female patients over 40</p> |
| <p>4 Symptoms go undertreated (38% of Canadian women felt their symptoms were undertreated⁶) due to misconceptions and barriers to hormone therapy interventions (contributing to 72% of the gap³)</p> | <p>Identify barriers to access HRT and partner with stakeholder groups (e.g., care providers) to close gaps

Partner with the CPA to devise a plan to address the HRT shortage in Canada</p> |

Portion of DALY gap for women by intervention type for gynecological diseases in Canada, 2019³



- | | |
|--|--|
| <p>5 Negligible funding to support research or awareness likely due to the stigma and perception that “every women goes through it”</p> | <p>Mobilize government, philanthropy, and corporate funding for menopause research and awareness</p> |
| <p>6 Insufficient workplace support (77% of women want more support for menopause⁶), contributing to lost productivity (~10% leaving or planning to leave due to symptoms⁸)</p> | <p>Define adapted benefits and workplace policies and partner with insurers and employers to close gaps</p> |

1. Canadian Menopause Society (2025)
2. “Hormonal contraceptive use and prevalence of premenstrual symptoms in a multiethnic Canadian population,” BMC Women's Health (2017)
3. McKinsey Health Institute data (2025)
4. “Menopause and Work in Canada”, Menopause Foundation of Canada (2023)
5. “Closing the women’s health gap: Canada’s \$37 billion opportunity,” McKinsey & Company (2025)
6. “The Silence and the Stigma: Menopause in Canada”, Menopause Foundation of Canada (2022)
7. “Research finds that few women receive diagnosis of perimenopause or menopause”, Evernorth Health Services (2025)
8. “The gender health gap: Its impact on working women in Canada”, Sun Life (2024)

Closing the women's health gap in chronic pelvic pain (CPP) in Canada

Canadian women suffer due to chronic pelvic pain being misunderstood

The impact of CPP is misunderstood and under-researched, making its contribution to the women's health gap and impact on Canadian GDP unknown.

70%

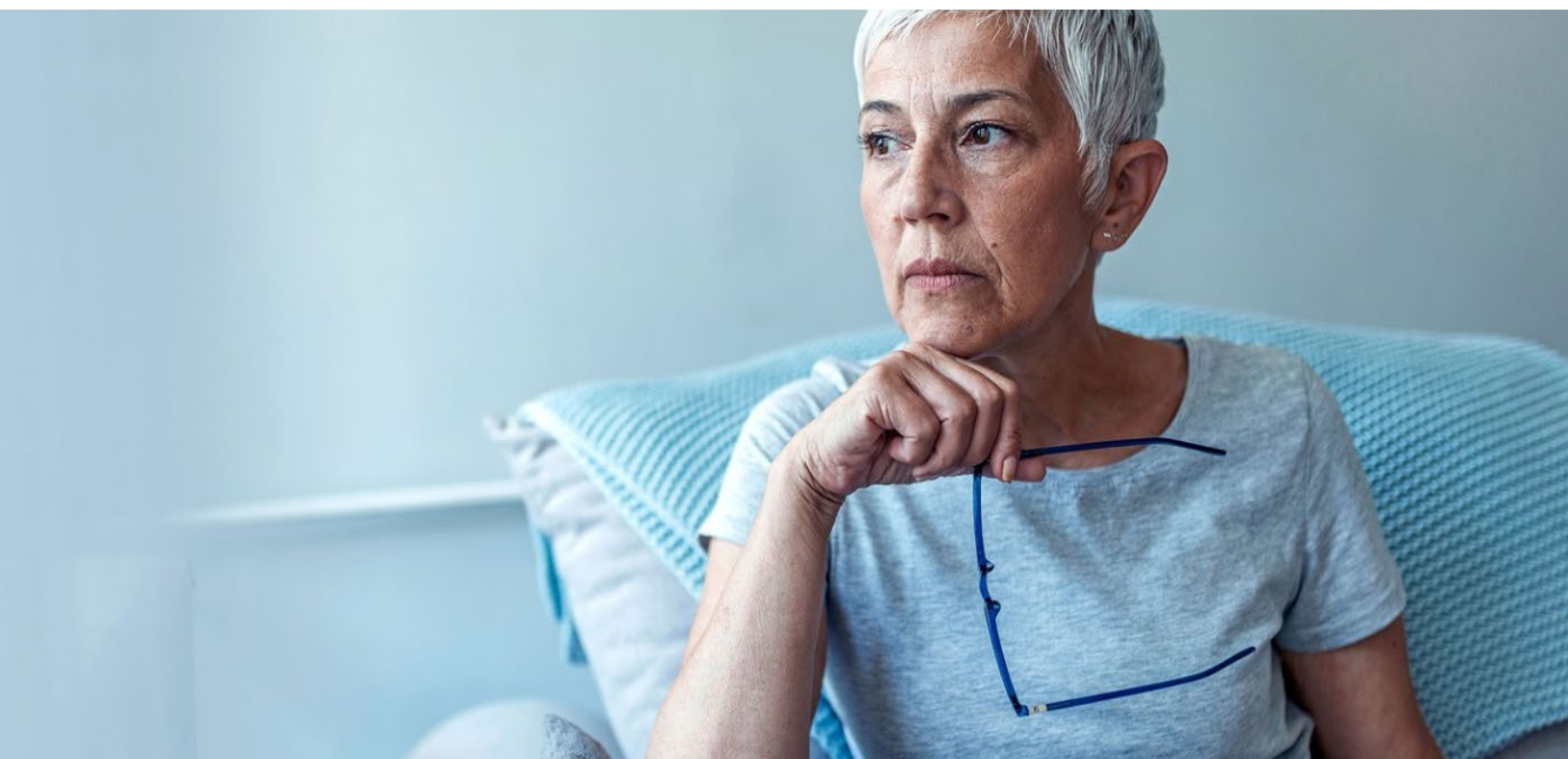
of Canadian women have uterine fibroids by the age of 50¹

10-15%

of Canadian women have Polycystic Ovary Syndrome (PCOS)²

10%

of Canadian women have endometriosis, accounting for 50% of all CPP³



1. "The Management of Uterine Leiomyomas," Journal of Obstetrics and Gynaecology Canada (2015)
2. "Diagnosis and management of polycystic ovarian syndrome," Canadian Medical Association Journal (2024)
3. "Endometriosis Overview," Society of Obstetricians and Gynaecologists of Canada (2025)
4. "Prevalence, Symptomatic Burden, and Diagnosis of Endometriosis in Canada: Cross-Sectional Survey of 30 000 Women" Journal of Obstetrics and Gynecology Canada (2020)
5. Based off a search of keywords in the ClinicalTrials.gov database (as of 18/11/2025)
6. Endometriosis in Canada: It Is Time for Collaboration to Advance Patient-Oriented, Evidence-Based Policy, Care, and Research" Journal of Obstetrics and Gynecology Canada (2021)

Gaps in the current healthcare ecosystem...

require action to close

1 **Stigma around women’s reproductive systems and aging (e.g., menstruation, incontinence)** causing normalization and dismissal of prolonged pain or medical needs before seeking care (~3-year delay between symptom onset and consultation⁴)

Launch social media campaigns to start conversations about pelvic health

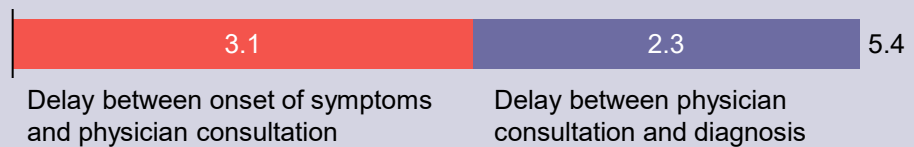
Partner with organizations to educate targeted segments about relevant CPP topics (e.g., school boards and menstrual health, care homes and incontinence)

2 **Low awareness among healthcare professionals** causing prolonged diagnostic wait times after seeking care and receiving diagnosis (~2 years⁴)

Support medical schools to incorporate CPP into curricula

Mandate care providers to routinely ask about menstruation and CPP symptoms

Years to diagnosis for endometriosis in Canada, 2020⁴



3 **Shortages in primary care, specialists and diagnostic tools** contributing to diagnostic and treatment delays (3-6 months for specialist appointment and 12 months for surgical or interdisciplinary care treatment⁶)

Define playbook to coordinate inter-disciplinary care across required providers (e.g., gynecologists, psychotherapy)

4 **Growing research area yet still behind** other diseases, with no definitive cause or treatment identified for most CPP conditions

Motivate research institutions to direct funding towards research on diagnostic and treatment pathways

Ongoing clinical trials in Canada by disease type, 2025⁵



5 **Emerging innovations to address diagnostic and care gaps** requiring investment to scale

Generate large-scale financing for maturing CPP innovations by aligning corporate and private funding incentives

1. “The Management of Uterine Leiomyomas,” Journal of Obstetrics and Gynaecology Canada (2015)
 2. “Diagnosis and management of polycystic ovarian syndrome,” Canadian Medical Association Journal (2024)
 3. “Endometriosis Overview,” Society of Obstetricians and Gynaecologists of Canada (2025)
 4. “Prevalence, Symptomatic Burden, and Diagnosis of Endometriosis in Canada: Cross-Sectional Survey of 30 000 Women” Journal of Obstetrics and Gynecology Canada (2020)
 5. Based off a search of keywords in the ClinicalTrials.gov database (as of 18/11/2025)
 6. Endometriosis in Canada: It Is Time for Collaboration to Advance Patient-Oriented, Evidence-Based Policy, Care, and Research” Journal of Obstetrics and Gynecology Canada (2021)

To close the women’s health gap, interventions need to reflect disparities across Canada’s diverse communities

Canada’s population has a unique makeup with many diverse communities, including immigrant (23%)¹, rural (18%)², Indigenous (5%)³, and Black heritage (4%)⁴ populations

Women’s health differs significantly across these communities, shaped by social, cultural, and geographic factors

Closing the women’s health gap requires addressing these distinct experiences and needs of Canadian women



Commonalities among female communities⁴

PATIENT EXPERIENCE

Cultural stigma perpetuating knowledge gaps and impacting care seeking behavior

Reports of systemic discrimination and racism affecting diagnoses and outcomes

Socioeconomic disadvantages (e.g., poverty)

CARE DELIVERY

Lack of culturally relevant educational materials

Limited representation of subgroups across medical staff

Long waitlists due to lack of medical staff and **geographical barriers** to accessing care

DATA

Lack of sizeable health datasets that include disaggregated, race- and ethnicity-specific data



High-level provincial dynamics

EAST CANADA

Highest recorded cancer incidence and CVD prevalence (esp., NL, QC and NS), likely linked to

- **Aging population**
- Higher prevalence of **risk factors** (e.g., obesity)
- **Barriers to care** in rural communities

CENTRAL & WEST CANADA

Highest recorded mental health disorder prevalence (esp., AB and ON), likely linked to

- High drug and alcohol **abuse**
- **Housing affordability** challenges
- **Unmet mental health service needs**, esp., among First Nations and rural youth

Note: findings are directional and not comprehensive, intended to highlight key distinctions to inform the implementation of interventions to close the women’s health gap in Canada

1. Population born outside Canada; “Focus on Geography Series, 2021 Census of Population”, Statistics Canada (2022)

2. “Rural population (% of total population) – Canada,” World Bank Group (2024)

3. “Indigenous Peoples Statistics in Canada,” Made in CA (2025)

4. “Black History Month... By the numbers,” Statistics Canada (2025)

5. Selected subset of analysed communities includes Indigenous, immigrant and Black women. Additional communities include (but not limited to) underhoused/unhoused women, women in prison, undocumented women, gender diverse individuals, elderly women, women from lower socio-economic backgrounds

Selected actions to close the gap for all women

Develop targeted interventions to reduce systemic discrimination and socioeconomic inequity

Close critical evidence gaps by improving the collection, standardization, and use of disaggregated, race- and ethnicity-specific data

Tailor prevention and treatment paths to subgroups

Launch campaigns to educate public (e.g., healthy nutrition) and reduce cultural stigma

Reduce barriers to care (e.g., reduction of geographical barriers, enhanced awareness of available services, increased subgroup representation in medical staff)

Invest in population-specific health research and training (incl., cultural safety training)

In order to close the women's health gap, Canada can define what it takes to be successful

How we can be successful

1. **Articulate a compelling change story using the power of patient voices** to communicate the moral and economic imperative behind closing the gap
2. **Channel each stakeholder's unique strengths toward areas of outsized impact and foster ownership** to propel continued commitment and investment
3. **Create depth of influence through enduring, targeted partnerships** across government, philanthropy and corporations, rather than chasing a breadth of outreach and "spreading ourselves too thin"
4. **Drive a cultural transformation to normalize women's health** in Canada by fueling conversations about women's health topics and empowering women and their communities to take charge and prioritize their health journeys
5. **Track and share outcomes to enforce accountability**, codifying and exporting best practices to create momentum and reinforce our global leadership

“

Nobody else is coming. Our grandmothers fought for the right to vote; our mothers fought for professional recognition – it is our generation's duty to make this better, for ourselves and future generations.

”



The Women's Health Collective
Canada would like to express
deep gratitude to Desjardins for
their commitment to building
positive change for Canada

