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E-GUIDE SERIES

BILL S-243

A NATIONAL STRATEGY FOR WOMEN'S HEALTH

RESEARCH. PREVENTION. INNOVATION. ACCOUNTABILITY.

Exploring Canada's historic opportunity to transform women's health through Bill S-243 and a comprehensive, evidence-based national strategy.

A CANADIAN PERSPECTIVE

Women's health is not a niche.
It is a national priority.
Better data. Better care. Better futures.

THE PURPOSE OF BILL S-243

RESEARCH
Invest in sex- and gender-based research to close critical data and knowledge gaps.

PREVENTION
Embed prevention strategies across the lifespan to improve long-term outcomes.

INNOVATION
Support innovation and digital health solutions designed by and for women.

ACCOUNTABILITY
Establish metrics, transparency, and reporting to drive measurable progress.

EQUITY
Ensure equitable access and outcomes for all women across Canada.

EMPOWERING WOMEN THROUGH KNOWLEDGE.
ADVANCING PREVENTION THROUGH INNOVATION.
BUILDING A HEALTHIER FUTURE FOR ALL.

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WOMEN-CENTRED. | EVIDENCE-BASED. | PREVENTION-FOCUSED. | FUTURE-READY.

BILL S-243

National Framework for Women's Health in Canada

A Complete Analytical Report: What It Is, Why It Matters,
If It Passes Then What — and What Success Looks Like by 2040

45th Parliament of Canada · 1st Session · Prepared May 2026

PART ONE: WHAT IS BILL S-243?

1. Bill S-243: The National Framework for Women's Health in Canada Act

Bill S-243, formally titled An Act to establish a national framework for women's health in Canada, was introduced in the Senate of Canada on December 9, 2025 by Senator Danièle Henkel. It is a Senate Public Bill currently in the 45th Parliament, 1st Session. As of May 2026, it is at second reading in the Senate.

1.1 What It Does

In plain terms: this bill requires the Minister of Health — by law — to develop, publish, and maintain a national framework for women's health. It is not a funding bill. It does not build clinics or hire doctors. What it does is create a legal obligation, a coordination architecture, and a public accountability mechanism that Canada currently does not have.

The bill directs the Minister of Health, in consultation with the Minister of Women and Gender Equality, provincial and territorial governments, Indigenous communities, and civil society, to build a framework covering five specific areas:

- Strengthening investment in health research and innovation for women
- Fostering collaboration between public systems and the private sector
- Enhancing training and education for healthcare professionals in women's health
- Strengthening primary health care services and preventative health for women at all life stages
- Deploying targeted solutions to improve access for women in rural and remote communities, equity-deserving populations, 2SLGBTQI+ women, Indigenous women, and women without consistent primary care

1.2 Key Timelines and Accountability

18 months	**Framework Report** The Minister of Health must table a full report setting out the national framework priorities and implementation strategy within 18 months of the Act coming into force, and publish it within 10 days on the Department of Health website.
5 years	**5-Year Review**

	Within five years of the initial report, the Minister must table a follow-up report on what was implemented, what was not, why, and the current state of investments in research and innovation and collaboration with provinces and territories.
Every 3 years	**Conferences** The Minister must hold an initial conference with all key stakeholders to develop the framework, and then at minimum every 3 years thereafter to review progress and obtain input on ongoing implementation.
Every meeting	**Standing Agenda** The Minister must make all reasonable efforts to ensure women's health is a standing item on the agenda at every federal-provincial-territorial health ministers meeting.

1.3 What It Requires of Consultation

The bill names specific groups the Minister must consult: the Minister of Justice, the Minister of Employment and Social Development, the Minister of Indigenous Services, representatives of all provincial and territorial governments, relevant stakeholders including self-advocates, caregivers, service providers, the medical and research communities, Indigenous communities and organizations with predominantly Indigenous leadership, and any other person or entity the Minister considers appropriate.

Critically, the bill does not infringe on provincial jurisdiction or dictate how services are delivered. It creates the structure, coordination, and leadership necessary to support provinces, territories, and Indigenous governments — not replace them.

PART TWO: WHY IT MATTERS — THE SCALE OF THE GAP

2. The Data Canada Cannot Ignore

Canada has a well-documented, multi-decade failure to treat women's health as a mainstream medical priority. The data is unambiguous: women die earlier than they should, are misdiagnosed at alarming rates, and represent the majority of Canadians living with chronic unmanaged conditions. These are not isolated failures — they are systemic, structural, and correctable.

2.1 The Research Failure

7%	**7% of CIHR Grants** Female-specific research representation in CIHR-funded grants across 15 years (2009–2023) — unchanged despite sex/gender mandates introduced in 2010.
0.83%	**Cardiovascular Disease Funding** Percentage of total CIHR funding directed to women-specific cardiovascular disease research — despite heart disease being the leading cause of premature death in Canadian women.
<5%	**Research Breadth Failure** Percentage of all CIHR grant abstracts over 15 years that mentioned studying any of the top 11 global disease burdens for women. Headache disorders received 0.002% of women's health research funding.

2.2 The Clinical Failure

50%	**Heart Attack Recognition** Of women who experience a heart attack, half have their symptoms not recognized — attributed to clinicians trained on risk models validated primarily in men. Every 16 minutes a Canadian woman dies of heart disease or stroke.
58%	**Specialist Access Gap**

	Of Canadian women who reported they could not access specialist care when they needed it in 2025. In-person specialist wait times can exceed 30 weeks.

46%	**ADHD Misdiagnosis** Of Canadian women with ADHD were misdiagnosed — typically with depression or anxiety first. Women with ADHD experience a nearly 4-year longer delay in diagnosis than men.

73%	**Work Absence** Of Canadian women aged 35–54 missed work due to health issues they could not address sooner. More than half missed work specifically because they couldn't get care in time.

2.3 The Equity Failure

30–32%	**Indigenous Women's Unmet Needs** Of off-reserve First Nations and Métis women report unmet healthcare needs in any 12-month period. Approximately 1 in 4 Indigenous people experience racism or unfair treatment within the Canadian health system.

30+ weeks	**Rural Specialist Access** Specialist wait times for women in rural Canada — compared to under 10 weeks in major urban centres for the same conditions.

2.4 The Economic Case

McKinsey Health Institute's 2025 analysis calculates that closing Canada's women's health gap could add $37 billion annually to the Canadian economy by 2040 — through reduced health costs and increased workforce participation. Cancer, cardiovascular disease, and mental/neurological conditions make up 75% of that gap.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) noted in November 2025 that Budget 2025 did not include commitments to address these needs, despite election promises — and that a $5 billion Health Infrastructure Fund allocated that year ignored the real drivers of care failure: staffing, training, and access gaps. S-243 is the policy architecture that makes those investments purposeful.

PART THREE: IF IT PASSES — THEN WHAT?

3. How Framework Legislation Without a Budget Creates Real Change

The most common and legitimate challenge to S-243 is this: if there are no funds attached, how does this actually mean anything? The answer requires understanding how policy architecture works in Canada's federated healthcare system — and what the global evidence shows.

3.1 The Legal Obligation Mechanism

Once passed, the Minister of Health is no longer choosing to work on women's health — they are required to by law. That is the difference between a press release and a statute. A government that ignores it is in breach of an Act of Parliament, which creates political, parliamentary, and public accountability consequences.

The 5-year report tabled in Parliament means that every subsequent budget cycle, the government must justify what was or wasn't funded. You cannot quietly drop the ball when the evidence of inaction is a legal document sitting in Hansard.

3.2 The Precedent: How Framework Laws Unlock Funding

The global evidence is consistent: framework legislation precedes dedicated funding, not the reverse. The mechanism is: framework passes → defines national standards → standards expose gaps in existing programs → annual budget cycles are pressured to fund the gaps (now with a legal framework as justification) → provinces align spending because the federal framework shapes what qualifies for Canada Health Transfer conditions → the 5-year report creates a public scorecard that makes underfunding politically visible.

Country	Framework Law	What Followed
Australia	National Women's Health Strategy 2020–2030 (policy, not legislation)	22 Endometriosis & Pelvic Pain clinics funded within 3 years across every state and territory
United Kingdom	Women's Health Strategy 2022 (non-legislative)	Women's Health Hubs piloted across all NHS regions within 18 months; NHS Menopause Taskforce established

United States	NIH Revitalization Act 1993 (legislative mandate for women in research)	NIH Office of Research on Women's Health established; mandatory inclusion of women in all clinical trials became law
Canada (precedent)	Canada Health Act 1984 (no direct funding, sets conditions)	Shaped every provincial health system for 40 years through transfer payment conditions — without running a single hospital

3.3 The Coordination Value

Beyond the legal mechanism, the framework creates something Canada's women's health system has never had: a single point of federal accountability, a national evidence baseline, and a structured forum where all 13 provincial governments, Indigenous organizations, researchers, clinicians, and civil society are legally required to participate on a recurring basis.

When the Minister is required to hold conferences every 3 years and make women's health a standing item at every F/P/T health ministers meeting, those are not optional conversations. They are mandated opportunities to align priorities, share evidence, and collectively pressure the budget process.

3.4 The Honest Limitation

Framework bills can also die quietly. If the Minister tables a minimal, vague framework at month 18 that satisfies the legal requirement but commits to nothing specific, the bill's practical impact is limited. The 5-year report helps — it forces public disclosure — but enforcement is ultimately political, not judicial. The bill's real leverage depends on civil society, opposition parties, and professional organizations holding the government to account on what kind of framework gets built, not just whether one exists.

The sections that follow provide the substance of what a strong, evidence-based, technology-forward framework should actually contain — in each of the five pillars.

PART FOUR: THE FIVE PILLARS — PAST, PRESENT, AND FRAMEWORK TARGETS

4. Pillar 1: Research & Innovation

The evidence base for women's health in Canada is structurally compromised. For 15 years, despite mandatory sex/gender analysis policies, the percentage of CIHR-funded grants reaching female-specific research has not changed. The result is a clinical system making decisions for women based on evidence derived largely from men.

4.1 Past, Present, and Framework Target

Past — The Failure	Present — Slow Progress	Framework Target
Clinical trials used male subjects as default; results generalized to women without validation	Sex/gender mentions in CIHR abstracts doubled 2020–2023 — female-specific research stuck at ~7%	Mandatory minimum 25–30% of CIHR grants to include female-specific or sex-disaggregated data — enforceable, not aspirational
Women's health research confined to reproductive health: pregnancy, cervical and breast cancer	Growing private FemTech research (Clue, Flo, Maven) disconnected from publicly funded systems	National Women's Longitudinal Health Study: 100,000+ participants tracked from age 18 to 85 (modelled on Australia's ALSWH)
CVD, dementia, autoimmune disease, chronic pain studied almost entirely in men	Canadian Women's Heart Health Alliance publishing condition-specific guidelines with no funding mandate	AI-ready datasets: all publicly funded research required to deposit sex-disaggregated data in machine-readable formats
CIHR introduced sex/gender mandates in 2010 — compliance not enforced, funding allocation unchanged	AI tools emerging for imaging and diagnostics — not embedded in national research agenda	Dedicated research institutes for the 5 most under-studied women's conditions: CVD, autoimmune, musculoskeletal, neurological, endometriosis
Headache disorders received 0.002% of women's health research funding over 13 years		Fast-track commercialization pathways for women's health diagnostics developed in Canada

4.2 Global Models

Country / Model	What It Does	Canada Lesson
Australia — ALSWH Longitudinal Study	57,000 women tracked since 1996 across all life stages. 1,000+ publications. Data open to global collaborators. Has directly shaped 4 national strategies.	Scale requires infrastructure investment, not just policy intent. A Canadian equivalent needs its own funding line from day one.
United States — NIH ORWH	Established 1990. Sets minimum inclusion requirements for women in all NIH-funded trials. Has its own budget, annual report, and enforcement capacity.	A parallel CIHR office — with enforcement teeth and budget control — is the institutional model Canada needs.
Sweden / Nordic — National Health Registers	Every patient interaction recorded in sex-disaggregated registers since the 1970s. Has enabled discoveries about sex-specific drug metabolism, disease timing, and treatment response impossible elsewhere.	Canada's fragmented provincial data is the barrier. A national interoperable health data standard is a prerequisite.

4.3 AI and Health Technology

By 2026, the global FemTech market will reach $75 billion with three major shifts: AI-powered diagnostics that predict health outcomes before symptoms appear, clinical-grade wearables with medical device accuracy, and unified data platforms synthesizing information across apps, devices, and health records.

- AI-driven trial design: Novel ML modelling can simulate female-specific cohort outcomes before clinical trial recruitment, reducing cost and time to female-validated findings
- NLP research gap mapping: AI scanning 30 years of published literature to identify where sex-disaggregated evidence exists vs. is missing — generating a real-time women's health evidence gap map
- Federated data infrastructure: Federated learning allows AI models to train on data distributed across provinces without centralizing sensitive patient records — solving Canada's data sovereignty problem
- FemTech data integration: Establishing a regulatory pathway for device and app data (Clue, Apple Health, AliveCor) to enter research databases with consent — the UK NHS-FemTech partnership is the model

5. Pillar 2: Professional Training & Education

The most consequential women's health failure happens at the moment of clinical encounter. Clinicians trained on male-derived evidence, male-pattern symptom checklists, and risk models validated on men make diagnostic errors every day — not from negligence, but from a structurally broken training system.

5.1 Past, Present, and Framework Target

Past — The Failure	Present — Slow Progress	Framework Target
Medical curricula built on research conducted almost entirely on male subjects; female-specific presentations treated as 'atypical' deviations	Some medical schools adding women's health modules — not standardized across provinces	National women's health competency standards embedded in medical licensing requirements (CFPC, Royal College, nursing colleges)
Women experiencing heart attacks sent home from ERs — labelled as having anxiety or indigestion	IWK Foundation 2025 survey of 27,000 Maritime women documented widespread dismissal of symptoms by providers	Mandatory CME in sex-specific presentations for cardiology, ER, psychiatry, and primary care — tracked through college registries
Endometriosis average diagnosis time: 7–10 years in Canada, often after years of symptom dismissal	Growing awareness of female ADHD presentation — diagnostic criteria not yet updated in most training programs	Standardized endometriosis and pelvic pain diagnostic pathway in every province (Australia's specialist clinic model)
No standardized women's health competency requirements in medical school licensing exams	Women's health CME credits available but voluntary; no tracking or accountability	Female ADHD, autism, and neurodivergence training modules required in psychiatry and GP residencies
		Cultural safety training for practitioners treating Indigenous women — co-developed with Indigenous health organizations

5.2 Global Models

Country / Model	What It Does	Canada Lesson
UK — Women's Health Hubs (NHS)	One-stop clinics bringing together GP, gynaecology, menopause, and contraception services. Designed around female care journeys, not institutional silos. Piloted across all NHS regions 2023–2025.	The hub model requires no new buildings — can be co-located in existing primary care facilities with coordinated specialist scheduling.
Australia — 22 Endometriosis & Pelvic Pain Clinics	Following the women's health strategy, the government funded specialist clinics in every state — reducing average diagnosis delay and providing multidisciplinary care teams.	This is exactly the type of targeted investment that follows a framework law. It started with policy, not a budget line.
Sweden — Karolinska Women's Symptom Atlas	National database mapping how the top 100 conditions present differently in women vs. men. Available to all clinicians and integrated into EMR decision-support tools.	A Canadian equivalent would be transformative — fundable through CIHR and distributable through CADTH into clinical practice guidelines.

5.3 AI and Health Technology

- Female-specific clinical decision tools: AI integrated into EMRs (Epic, MEDITECH, OSCAR) flagging when a woman's symptom cluster matches under-recognized female presentations of CVD, autoimmune disorders, or ADHD — built on female-validated evidence
- Virtual patient simulation: AI-generated female patient scenarios for medical students and residents — standardizing exposure to female-specific symptom presentations that rarely appear in textbooks (already deployed in cardiac training at Stanford)
- National CME tracking platform: A federal system tracking women's health CPD credits across provinces — enabling the framework to verify compliance through physician college registry infrastructure

6. Pillar 3: Prevention & Primary Care

Every 16 minutes a Canadian woman dies from heart disease or stroke. Half of the women's health care delivery gap in Canada is driven by cardiovascular care alone. Prevention means reaching women before they arrive in crisis — with a care system that recognizes their risk factors, uses validated tools, and addresses their health across their full life span.

6.1 Past, Present, and Framework Target

Past — The Failure	Present — Slow Progress	Framework Target
CVD risk stratification tools validated on male populations — women labelled 'low risk' and sent home	Some provinces updating breast screening to start at 40 — but inconsistent nationally	Life-course prevention framework: defined care touchpoints at puberty, reproductive years, perimenopause, post-menopause, and senior years — with sex-specific standards at each stage
Screening guidelines designed for 'average' women — failing racialized women who need earlier or different screening	Menopause care a growing awareness area but no national clinical standard; most GPs not trained in HRT protocols	Female-specific CVD risk tools replacing male-derived models; mandatory in all provincial cardiac care protocols
Mental health prevention siloed from physical health: anxiety/depression treated without recognizing thyroid, autoimmune, hormonal drivers	Racialized women getting later-stage cancer diagnoses due to misaligned screening guidelines	Disaggregated screening guidelines: race/ethnicity-adjusted thresholds for breast and cervical cancer
No life-course prevention framework: women's health treated as reproductive health until menopause, then largely ignored	Rural women show higher rates of hypertension, diabetes, obesity than urban — with less access to preventive care	Integrated mental-physical health prevention: hormonal, thyroid, and autoimmune screenings bundled with mental health intake in primary care
		Menopause as a national health priority: standardized HRT guidelines, menopause-trained GP certification, pharmacy access

6.2 Global Models

Country / Model	What It Does	Canada Lesson
Denmark — Nationwide Preventive Health Checks	Universal health checks at ages 40, 50, 60, 70 with sex-specific modules. Identifies CVD risk, diabetes, and depression in women years before symptomatic presentation.	A federal-provincial agreement on life-stage health checks could be negotiated through existing Canada Health Transfer mechanisms.
UK — NHS Menopause Taskforce	National clinical standards for menopause care, GP training requirements, NHS app-integrated tracking, and removal of prescription charges for HRT. Dramatically reduced postcode lottery in menopause care.	Canada has no equivalent. Menopause is the single highest-yield, lowest-cost prevention gap to close nationally.
Finland — Integrated Digital Prevention (Kanta)	Platform links all patient records. Women receive automated, personalized prevention reminders based on age, risk factors, and life stage — integrated with GP appointment booking.	Canada's provincial EMR fragmentation is the barrier. S-243 should mandate interoperability as a framework condition.

6.3 AI and Health Technology

- Continuous cardiac monitoring: Apple Watch, AliveCor KardiaMobile, and INVU maternal monitors provide clinical-grade AF and BP data. A national program distributing these to high-risk women (rural, post-menopausal, racialized) transforms the prevention equation
- Population-level risk prediction: AI models trained on Canadian health data can flag women at high CVD, autoimmune, or cancer risk years before symptom onset — embeddable in provincial health portals to trigger proactive outreach
- AI-powered life-course health assistant: A national women's health navigation app — integrated with provincial health records — providing personalized prevention guidance and screening reminders across life stages (public-interest equivalent of Maven Clinic)

7. Pillar 4: Targeted Access

The care gap is not uniform. The worst health outcomes cluster in populations that are hardest to reach: rural and remote women, Indigenous women, racialized women, newcomers, women with disabilities, and 2SLGBTQI+ women. A national framework that does not address this structural inequality will improve outcomes for already-advantaged women while leaving the most vulnerable behind.

7.1 Past, Present, and Framework Target

Past — The Failure	Present — Slow Progress	Framework Target
Health system designed around urban, English-speaking, non-disabled, non-Indigenous women — everyone else an afterthought	Virtual care expanded during COVID — but digital divide means rural/Indigenous women least able to access it	Joyce's Principle embedded in framework: Indigenous women's right to culturally safe, non-discriminatory care with complaint and accountability mechanisms
Indigenous women experiencing documented racism within the health system — evidenced by Joyce's Principle and MMIWG inquiry	Joyce's Principle (2020) calls for Indigenous-specific health rights — still not enacted in most provinces	Rural access guarantee: any woman more than 100km from a specialist entitled to fully funded telehealth equivalent — standardized reimbursement parity model
Rural and remote women travelling 3–6 hours for specialist care; many simply do not go	Some provincial investments in culturally safe care — no national standard	Community health worker model: trained Indigenous and racialized community health workers as navigators — funded through the framework
Racialized women receiving later-stage cancer diagnoses due to screening gaps and communication barriers	Telehealth available but specialist virtual care reimbursement inconsistent; many specialists do not offer it	Mobile health units: deployable specialist care (cardiology, gynaecology, mental health) for remote communities on rotating schedules
		2SLGBTQI+ women: explicit inclusion in all clinical guideline updates; trans women's health as a distinct research and training priority

7.2 Global Models

Country / Model	What It Does	Canada Lesson
New Zealand — Maori Health Authorities	Te Whatu Ora reforms (2022) transferred health service delivery to Maori-governed entities. Outcomes improvement driven by community control, not system accommodation.	Indigenous-governed health is more effective than Indigenous-adapted mainstream care. The framework should fund First Nations and Metis health authorities to design and deliver women's care.
Norway — Telemedicine for Rural Women	National telemedicine network ensures every woman in Norway has video access to an OB/GYN within 24 hours. Specialist consultations reimbursed identically to in-person. Rural outcomes match urban.	Reimbursement parity is the single policy lever. Virtual care already exists — the problem is specialists will not offer it if it pays less.
Brazil — Community Health Worker Programme	300,000 community health agents (predominantly women from the communities they serve) conducting home visits, navigating the health system, tracking chronic conditions. Dramatic reduction in maternal mortality.	The CHW model works in high-income countries (UK's link worker programme). Canada needs this in Indigenous, northern, and newcomer communities specifically.

7.3 AI and Health Technology

- AI triage for rural access: AI-powered symptom triage (retrained on female and Indigenous health data) determines urgency, routes patients to the right care level, and eliminates unnecessary long-distance travel — must be co-developed with Indigenous communities
- Satellite-enabled virtual care: Starlink and low-earth-orbit internet has made broadband possible in remote First Nations communities. The framework should include a universal connectivity component as a prerequisite for virtual care access
- Multilingual AI health tools: LLM-based health navigation tools adapted for Indigenous languages (Cree, Ojibwe, Inuktitut) and major immigrant languages — enabling access for women for whom English or French is a barrier (models: SnehAI in India, AskNivi in Africa)

8. Pillar 5: Public–Private Collaboration

The private sector is already building women's health infrastructure at scale. By 2026, the global FemTech market will reach $75 billion. Canadian companies, employers, insurers, and digital health platforms are all active in this space — but without a national framework, that activity is fragmented, unregulated, disconnected from the public system, and often not in women's best interests. The framework's job is to channel private investment toward public health goals.

8.1 Past, Present, and Framework Target

Past — The Failure	Present — Slow Progress	Framework Target
Pharmaceutical companies historically excluded women from clinical trials (liability fears) — drug dosing based on male biology as default	Maple, Pomelo Care, and other virtual care platforms expanding women's health services — siloed from public system	FemTech regulatory pathway: Health Canada creates a women's health device and app category — expedited approval for clinical-grade FemTech with mandatory privacy and safety standards
FemTech industry treated as consumer wellness, not clinical — operating outside health regulation and public funding	Health Canada beginning to develop guidance on digital health tools — without a women's health lens	Voluntary employer standards: federal government publishes a Women's Health Workplace Standard with tax incentives for employers meeting coverage thresholds
No public-private data-sharing frameworks for women's health — private apps sitting on massive datasets disconnected from public health systems	Some major Canadian employers adding menopause and fertility benefits — not sector-wide	Public-private data trust: FemTech companies contribute anonymized data to national research database in exchange for regulatory recognition and market access
Employer benefits not designed around women's health: coverage absent for menopause care, fertility, endometriosis management	Canadian FemTech startups operating without a national market or public system integration	Canadian women's health innovation fund: co-investment model (federal + private) backing made-in-Canada women's health diagnostics
		Procurement standards: provincial health systems required to give preference to sex-validated medical devices in procurement

8.2 Global Models

Country / Model	What It Does	Canada Lesson
UK — NHS-FemTech Partnership	NHS SBRI Healthcare programme co-funds FemTech R&D with NHS deployment pathways. Companies get clinical validation; NHS gets cutting-edge tools at negotiated rates.	CIHR and ISED could co-administer a direct equivalent — with Health Canada providing regulatory fast-track as the third leg.
US — Maven Clinic Model	Virtual women's and family health platform used by 2,000+ employers. Covers fertility, pregnancy, menopause, mental health. Demonstrable ROI: reduced preterm births, fewer ER visits.	A Canadian equivalent (public-private hybrid, provincially insured) serving rural and northern populations is entirely buildable.
EU — European Health Data Space	EU regulation enabling cross-border, consent-based health data sharing for research. Creates a massive sex-disaggregated dataset that accelerates women's health research across 27 countries.	A Canadian equivalent — even federal-provincial — would be transformative. The technology exists (federated learning); the governance framework is what is missing.

8.3 AI and Health Technology

- AI cervical and breast cancer screening: AI-assisted cytology and mammography now match expert radiologist accuracy in detecting early-stage cancers — enabling high-volume, low-cost screening in clinics and pharmacies. Could expand Canada's breast screening capacity 3–5x without additional radiologist training
- Ovarian cancer biomarker detection: Nanotech-enhanced ML tools capable of detecting ovarian cancer biomarkers through blood and urine — previously only detectable through invasive procedures at late stage. Could close the most lethal gap in Canadian women's cancer screening
- Federated learning infrastructure: Allows AI models to train on data distributed across hospitals and provinces without centralizing sensitive data. Vector Institute and SickKids already using federated learning in pediatric research — women's health is the obvious next application

PART FIVE: WHO DOES WHAT — PLAYERS ACROSS ALL FIVE PILLARS

9. The Full Player Map

Bill S-243 names specific actors who must be consulted. But consultation is the floor, not the ceiling. This section maps every key player to concrete actions they can take across all five pillars — making clear that the framework is a coordination mandate for an entire ecosystem, not a task list for the Minister of Health alone.

9.1 Minister of Health (Federal)

The bill's legal owner. Controls CIHR grant criteria, Health Canada regulatory processes, and federal-provincial transfer conditions. This is an ownership role, not a coordination role.

Action	Research	Training	Prevention	Access	Private Sector
Establish Office of Women's Health within Health Canada with dedicated budget and annual report	Commission National Women's Health Evidence Review; direct CIHR on enforceable sex-disaggregated funding minimums	Lead national women's health competency standards process across professional colleges	Direct PHAC to develop a national life-course prevention standard; mandate female-specific CVD risk tools	Negotiate rural access and telehealth parity standards into Canada Health Transfer conditions	Commission FemTech regulatory pathway through Health Canada digital health office; lead employer standards consultation
Negotiate women's health benchmarks into F/P/T health ministers standing agenda	Fund Canadian Women's Longitudinal Health Study as a federal investment (not CIHR competition)	Work with medical colleges to embed women's health in national licensing examination	Commission national menopause care clinical standard in partnership with SOGC and CFPC	Fund rural connectivity component as prerequisite for virtual care access policy	Launch co-investment innovation fund with ISED for made-in-Canada women's health diagnostics

9.2 Minister of Women and Gender Equality

Named explicitly as a co-developer of the framework. Holds the gender equity lens across government and has cross-departmental authority Health Canada alone does not have.

Action	Research	Training	Prevention	Access	Private Sector
Apply GBA+ to every element of the framework — ensuring policies work for diverse women, not the 'average' woman	Push CIHR to fund research on violence, poverty, and housing as women's health determinants	Lead employer engagement strategy and Women's Health Workplace Standard development	Ensure mental health funding through Health Canada addresses gendered drivers (caregiving, economic precarity, trauma)	Advance Joyce's Principle: coordinate with Minister of Indigenous Services on legislative implementation	Co-lead Women's Health Workplace Standard: paid menopause leave, fertility benefits, equal mental health parity
Include women's health outcomes in departmental results frameworks across Employment, Indigenous Services, Housing	Ensure research funding addresses social determinants unique to racialized, newcomer, and 2SLGBTQI+ women	Develop training standards for cultural safety in women's healthcare — with Indigenous women's organizations	Lead integration of gender-based violence screening into primary care prevention pathways	Fund community health workers in newcomer and racialized communities through Status of Women funding	Use gender lens to ensure FemTech standards protect, not exploit, women's data

9.3 Provincial and Territorial Health Ministers

Healthcare is delivered provincially. The federal framework creates standards; provinces determine how those standards become actual care. Without provincial buy-in, the framework is a document. The standing agenda item requirement is the key enforcement mechanism.

Action	Research	Training	Prevention	Access	Private Sector
Adopt provincial Women's Health Action Plans with measurable targets and annual public reporting	Mandate sex-disaggregated data reporting in all provincial health data collection	Adopt national clinical competency standards into provincial medical licensing and CME requirements	Reform provincial breast and cervical screening guidelines to include race/ethnicity-adjusted thresholds	Reform virtual care reimbursement to achieve full parity with in-person for all specialist consultations	Develop provincial FemTech integration strategy: which tools are publicly funded, which are employer-funded
Fund provincial endometriosis and pelvic pain specialist clinics (Australia's 22-clinic model)	Align CIHR-funded research programs with identified provincial health data gaps	Establish women's health modules in provincial medical school curricula — not elective, embedded	Fund provincial women's health preventive care hubs co-locating GP, gynaecology, and mental health	Fund deployable mobile specialist health units for remote communities on rotating schedules	Align provincial drug formularies with national menopause and women's health standard — making HRT accessible province-wide

9.4 CIHR (Canadian Institutes of Health Research)

Controls where Canada's medical research money goes. The 15-year data showing 7% of grants reaching women-specific health is, in part, a CIHR failure. The framework gives political cover to reform this — and makes CIHR the institution best positioned to build the national women's health data infrastructure.

Action	Research	Training	Prevention	Access	Private Sector
Implement mandatory 25–30% of project grant funding to include female-specific or sex-disaggregated analysis — with grant-hold mechanism for non-compliance	Launch dedicated funding programs for 5 highest-burden under-funded conditions: CVD, autoimmune, endometriosis, neurological, mental health	Fund training for researchers in women's health methodology and sex-disaggregated study design	Fund prevention science research: sex-specific risk factors, biomarkers, and early detection methods for women	Fund health services research on access barriers for Indigenous, rural, and racialized women	Co-invest with ISED in women's health commercialization fund; fund FemTech clinical validation studies
Fund Canadian Women's Longitudinal Health Study: 100,000+ participants, open data, 40-year tracking	Build national women's health data standard enabling interoperable, sex-disaggregated provincial health data sharing	Develop curriculum grants for medical schools and residency programs adding women's health competencies	Fund research on sex-specific disease prevention timelines and optimal life-stage intervention points	Fund Indigenous women's health research co-governed and co-owned by Indigenous communities (OCAP principles)	Establish women's health AI research priority — funding federated learning and sex-disaggregated AI model development

9.5 Indigenous Communities and Organizations

The bill requires consultation. But consultation has failed Indigenous women in Canada. The framework must shift from consultation to co-governance. Indigenous-led health organizations must design the Indigenous women's components of the framework — not respond to what Health Canada proposes. Their role is not a seat at the table; it is co-authorship.

Action	Research	Training	Prevention	Access	Private Sector
Co-design the Indigenous women's health components of the framework — not advisory role, decision-making role	Co-govern Indigenous women's health research: OCAP principles as the standard, community data sovereignty	Develop cultural safety training for practitioners — including traditional healing integration where communities choose	Lead design of Indigenous women's preventive care models grounded in traditional wellness concepts	Design and govern Indigenous community health worker (CHW) program — navigation and cultural bridge roles	Co-develop criteria for Indigenous FemTech tools that respect data sovereignty and community values

Ensure Joyce's Principle is embedded in the framework with complaint, investigation, and accountability mechanisms	Operate Indigenous-governed women's health research programs funded through the framework	Train and deploy community health educators in women's health — culturally appropriate, language-accessible materials	Develop land-based and community-centred prevention models for Indigenous women's health	Design and deliver virtual care protocols for remote Indigenous communities — connectivity, technology, and support systems	Partner with universities and FemTech companies on Indigenous women's health data standards — community benefit as condition

9.6 Medical Colleges and Professional Regulatory Bodies

The CFPC, Royal College, CPSO, and provincial nursing and allied health colleges set curriculum, licensing requirements, and CME standards. The training pillar only becomes real if these bodies update what they require of practitioners.

Action	Research	Training	Prevention	Access	Private Sector
Develop National Women's Health Competency Framework covering sex-specific disease, female CVD, reproductive health across the life course, and cultural safety	Establish minimum annual CME hours in women's health for GPs, cardiologists, psychiatrists, and ER physicians — tracked through college registries	Embed women's health competencies in MCCQE (licensing exam) — required of all new physicians	Develop female-specific CVD and preventive care modules for GP and internal medicine residencies	Develop cultural safety competency requirements for practitioners treating Indigenous, racialized, and 2SLGBTQI+ women	Develop standards for clinician engagement with FemTech tools in practice — training on interpreting device data
Accreditation standards: require medical schools to demonstrate women's health is embedded, not optional	Postgraduate training standards for female ADHD, autism, and neurodivergence assessment in psychiatry residencies	Require endometriosis and pelvic pain training in all OB/GYN and family medicine residency programs	Mandate menopause training and HRT prescribing competency in family medicine — CFPC-led standard	Include Indigenous health history and anti-racism training in all medical school accreditation requirements	Develop CME programs on interpreting AI clinical decision support tools for women's health presentations

9.7 Private Sector — FemTech, Pharma, Employers, Insurers

The private sector is spending on women's health — but without a framework, that spending is fragmented, unregulated, and disconnected from public health goals. The framework creates the conditions where private investment amplifies public goals rather than working in parallel.

Action	Research	Training	Prevention	Access	Private Sector
FemTech companies: contribute anonymized, consent-based data to national women's health research database in exchange for expedited Health Canada regulatory review	Pharmaceutical companies: report sex-disaggregated clinical trial data to Health Canada as a condition of drug approval — no more male-default dosing	Employers: adopt Women's Health Workplace Standard with paid menopause leave, fertility benefits, and mental health parity — tax credit as incentive	Insurers: align coverage with framework-defined priorities including endometriosis treatment, HRT, mental health parity, and preventive screenings	Digital health companies: invest in satellite and broadband connectivity for rural and remote communities as part of CSR commitments aligned with the framework	Co-invest in Canadian women's health virtual care network — publicly accessible for unattached patients, commercially operated, publicly regulated
Fund and deploy AI diagnostic tools for women's health (cervical/breast screening, ovarian cancer biomarkers) in partnership with Health Canada for public system integration	Pharmaceutical sector: fund sex-disaggregated post-market surveillance — tracking how drugs perform differently in women in real-world conditions	Workplace wellness programs: fund women's health education in workplaces — particularly for endometriosis, menopause, and mental health	Private insurers: fund employer-based preventive care programs aligned with national life-course framework	Telehealth companies: offer subsidized virtual specialist access for rural and unattached patients through framework partnership	Co-fund federated learning infrastructure with Vector Institute and CIHR — making AI women's health models possible without compromising data sovereignty

9.8 Patient Advocates and Self-Advocates

The 5-year accountability report is the bill's enforcement tool — but it only bites if patient advocacy organizations are empowered to measure, document, and publicize what wasn't done. They are the civil society layer without which framework legislation dies quietly.

Action	Research	Training	Prevention	Access	Private Sector
Formal co-authorship of the framework and the 5-year review — not post-hoc comment	Commission independent shadow research reports measuring CIHR funding progress against framework targets	Co-develop physician training materials with medical colleges — ensuring patient experience informs curriculum	Co-design life-stage prevention guidelines with PHAC — ensuring they reflect women's lived realities	Document and publish access gaps for rural, Indigenous, and racialized women — feeding the 5-year accountability report	Develop consumer standards for FemTech products used by women — privacy, accuracy, and clinical validity criteria

Annual public dashboard tracking progress across all five pillars — co-maintained with Health Canada, published in plain language	Maintain an independent evidence gap registry: conditions and populations still without adequate women's health evidence	Train women as advocates within the health system — knowing their rights, how to navigate diagnostic pathways, and how to escalate dismissal	Lead community-based prevention programs in partnership with PHAC — peer-to-peer women's health education	Operate Indigenous women's advocacy programs — Joyce's Principle implementation, complaint support, system navigation	Evaluate FemTech tools for women's best interests — independent testing and public reporting on privacy, accuracy, and equity

PART SIX: WHAT DOES SUCCESS LOOK LIKE BY 2040?

10. Vision for 2040: Goals, Targets, and How We Ensure They Are Met

Success by 2040 is not abstract. It is measurable, trackable, and achievable if the framework is built with ambition and held accountable through the mechanisms the bill creates. The following goals are drawn from the current evidence base, global comparators, and what the health technology landscape makes genuinely possible within 15 years.

10.1 The 2040 Scorecard by Pillar

Pillar	Baseline (2025)	Target (2040)	How We Measure It
Research & Innovation	7% of CIHR grants female-specific; 0.83% of funding to women's CVD research; no national women's health data infrastructure	25–30% of CIHR grants include female-specific or sex-disaggregated analysis; national longitudinal cohort of 100,000+ women operational; Canada in top 5 OECD nations for women's health research output	Annual CIHR grant sex-disaggregation audit published; percentage of female-specific grants tracked and reported in 5-year review; longitudinal cohort enrollment and publication rate tracked by Health Canada
Training & Education	No national women's health competency standard; voluntary CME; endometriosis diagnosis delay of 7–10 years; 78% of women's MI symptoms missed	National women's health competency embedded in all medical licensing; mandatory CME tracked through college registries; endometriosis diagnosis delay reduced to under 2 years nationally; MI symptom recognition rate above 85%	MCCQE women's health component scores tracked; CME completion rates by specialty through college databases; endometriosis diagnosis delay tracked by CIHI; cardiac outcomes data disaggregated by sex in CIHI annual report
Prevention & Primary Care	No life-course women's health standard; CVD risk tools male-derived; menopause care unstandarized; inconsistent	National life-course prevention framework operational in all provinces; female-specific CVD risk tools standard of care; national menopause care	Life expectancy in good health gap between Canadian women and men narrowed to within 5%; female CVD mortality rates by province tracked in PHAC annual report; HRT prescription rates by province tracked; cancer

	cancer screening guidelines nationally	standard published and implemented; breast cancer screening starting at 40 nationally	stage-at-diagnosis data disaggregated by sex and ethnicity
Targeted Access	32% of Indigenous women with unmet needs; 30+ week rural specialist wait times; Joyce's Principle not enacted in most provinces; Indigenous women experiencing healthcare racism	Unmet healthcare needs for Indigenous women reduced to match non-Indigenous women nationally; rural specialist wait times equivalent to urban through telehealth parity; Joyce's Principle enacted federally and in all provinces; zero tolerance enforcement mechanism operational	Annual Statistics Canada Indigenous health survey tracking unmet needs disaggregated by sex; provincial telehealth utilization and reimbursement parity rates tracked by CIHI; Joyce's Principle complaint and resolution data published annually; racism in healthcare incidents reported and investigated
Private Sector & Innovation	No FemTech regulatory framework; no public-private data trust; employer benefits ad hoc; no made-in-Canada women's health industry strategy	Health Canada FemTech approval pathway operational; national women's health data trust with 5+ FemTech company participants; Women's Health Workplace Standard adopted by 50%+ of federally regulated employers; Canadian FemTech sector among top 10 globally by investment	FemTech approvals and adverse event reports published annually by Health Canada; data trust participation and publications tracked; employer standard adoption rates tracked by ESDC; ISED annual innovation sector report includes women's health as a tracked category
System-Wide Outcome	Canadian women spend 24% more time in poor health than men; $37B annual economic loss; systemic diagnostic bias documented	Gap in time spent in poor health between Canadian women and men reduced by at least 50% (from 24% to 12% or less); $20B+ annual economic gain unlocked; AI-assisted, female-validated diagnostics standard of care in all major Canadian health systems	Annual McKinsey/PHAC women's health gap index tracking DALYs, economic participation, and health system access; CIHI Women's Health Report Card published every 2 years; patient experience survey data disaggregated by sex, race, geography, and Indigenous identity tracked nationally

10.2 The Five Conditions for Success

Setting goals is necessary but insufficient. The following five structural conditions must be met for the 2040 targets to be achievable — and each can be built into the framework itself.

Condition 1: Enforcement, Not Aspiration

Every target in the framework must have an owner, a deadline, and a consequence for non-compliance. The bill's 5-year report creates the baseline accountability mechanism. The framework itself should specify what happens when provinces or institutions fail to meet standards — whether through withheld transfer payment conditions, public reporting, or independent ombudsperson oversight. Aspirational language without consequence is the graveyard of Canadian health policy.

Condition 2: Sustained Civil Society Monitoring

The 5-year report to Parliament must be accompanied by an independent shadow report from patient and civil society organizations. Groups like Women's Health Collective Canada, the Canadian Women's Heart Health Alliance, Endometriosis Network Canada, and Indigenous women's health organizations must have dedicated, sustained funding to monitor, document, and publish their own assessment of implementation progress. Without this, governments can self-report success with no external check.

Condition 3: Data Infrastructure Before Data Promises

Every 2040 target depends on data that Canada currently cannot collect. Without national sex-disaggregated health data that is comparable across provinces, and without a longitudinal women's health cohort, there is no way to know if progress is real. The framework must treat data infrastructure — the interoperable provincial health data standard, the CIHR longitudinal study, the women's health data trust — as foundational investments, not downstream benefits. They must be funded in the first budget cycle after the framework is tabled.

Condition 4: Indigenous Co-Governance, Not Consultation

The 2040 targets for Indigenous women cannot be achieved by a framework designed by Health Canada and delivered to Indigenous communities. The evidence is unambiguous: Indigenous-led and Indigenous-governed health programs produce better outcomes. Every element of the framework affecting Indigenous women — from research protocols to access programs to training standards — must be co-designed and co-governed with First Nations, Metis, and Inuit organizations. This is not a values preference; it is an evidence-based implementation requirement.

Condition 5: Technology Integration with Equity Guardrails

The AI and health technology landscape offers transformative tools — but those tools will replicate and amplify existing inequities if deployed without deliberate equity design. Every AI diagnostic tool adopted under the framework must demonstrate performance equivalence across sex, race, age, and geography. Every FemTech tool integrated into the public health system must meet the same privacy and clinical validity standards as regulated medical devices. And the digital divide — which means rural and Indigenous women are currently the last to benefit from health technology — must be addressed as a precondition, not an afterthought.

10.3 The 2040 Accountability Architecture

The bill creates two statutory accountability moments: the 18-month framework report and the 5-year implementation review. For the 2040 vision to be real, those mechanisms need to be augmented by a broader accountability architecture:

Mechanism	Who Owns It	What It Tracks
Annual Women's Health Indicators Report	Health Canada + Statistics Canada	Sex-disaggregated health outcomes, access, and research funding — publicly available, machine-readable
CIHI Women's Health Report Card (biennial)	Canadian Institute for Health Information	Provincial comparisons on clinical outcomes, diagnosis delays, and access equity — enabling public accountability by province
Civil Society Shadow Report (5-year)	Women's Health Collective Canada + coalition	Independent assessment of framework implementation — parallel to the Minister's statutory report
CIHR Sex-Disaggregation Audit (annual)	CIHR Board	Percentage of project grants meeting the sex-disaggregation standard — published and compared year over year
FemTech Safety and Equity Annual Report	Health Canada Digital Health Office	FemTech approvals, adverse events, equity performance, and data trust participation — market transparency
Indigenous Women's Health Sovereignty Review	First Nations, Metis, Inuit health organizations	Progress on Joyce's Principle, Indigenous-governed program implementation, and unmet needs data — community-owned and published
Parliamentary Standing Committee Review	House of Commons / Senate Health Committee	Annual scrutiny of framework progress — with Minister of Health appearance as a standing requirement, not optional

10.4 What 2040 Feels Like: The Human Measure

Behind every statistic in this report is a person. By 2040, if this framework succeeds:

- A woman in rural Saskatchewan experiencing chest pain and shortness of breath is assessed using a female-specific risk tool, receives an AI-assisted ECG reading through her AliveCor device, and is connected to a cardiologist via video within 4 hours — not 4 weeks
- An Indigenous woman in northern Ontario has access to a community health worker from her own community who speaks her language, understands her health history, and can navigate the health system on her behalf — without her having to travel 6 hours for a specialist
- A teenage girl showing signs of ADHD — inattentive presentation, emotional dysregulation, chronic underachievement — is assessed using female-validated diagnostic criteria and diagnosed before she has spent a decade being treated for depression she doesn't have
- A 52-year-old woman experiencing perimenopause symptoms — brain fog, sleep disruption, cardiovascular changes — walks into her GP and receives a standardized, evidence-based assessment followed by an informed conversation about HRT, because her doctor was trained and licensed to have it
- A researcher applying to CIHR for a grant on cardiovascular disease in women does not need to fight for the relevance of her work — because sex-disaggregated data is mandatory in every grant, and the national women's health data infrastructure gives her a longitudinal cohort to work with
- A woman receiving a FemTech app recommendation from her province's digital health portal knows that the app has been clinically validated, that her data is protected under the national women's health data trust, and that its algorithms were trained on data that included women who look like her

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This report was compiled from parliamentary records, peer-reviewed research, Statistics Canada data, and global policy analysis.
Key sources: CIHR, McKinsey Health Institute, Statistics Canada, Heart & Stroke Foundation of Canada, Canadian Women's Heart Health Alliance, Women's Health Collective Canada, IWK Foundation, SOGC, CMAJ, BMJ, Parliament of Canada LEGISinfo, and the bill text S-234/S-243 (45th Parliament, 1st Session).