



A CANADIAN SERIES

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WOMEN, HEALTH & INNOVATION



E-GUIDE SERIES

CARDIOVASCULAR HEALTH

IN CANADA

2026 eUpdate:
PAST, PRESENT & FUTURE

The latest research, innovations & solutions for women's heart health across every province—today and for generations to come.



PAST

Where We've Been
Lessons from the past that shaped today's understanding.



PRESENT

Where We Are Now
Current research, data & innovations driving change.



FUTURE

Where We're Going
Emerging innovations & breakthroughs to watch.



- ✓ Empowering women through knowledge.
- ✓ Advancing heart health through innovation.
- ✓ Building a healthier future for all.

BY

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WOMEN-CENTRED.



EVIDENCE-BASED.



PREVENTION-FOCUSED.



FUTURE-READY.



DISCLAIMER

This e-guide is for educational and informational purposes only. It does not replace medical advice, diagnosis, or treatment. Statistics and research cited are drawn from Health Canada, Statistics Canada, the Heart and Stroke Foundation of Canada, the Canadian Women's Heart Health Alliance (CWHHA), the Canadian Chronic Disease Surveillance System (CCDSS), and peer-reviewed literature. Women experiencing symptoms of heart attack or stroke should call 911 immediately.

Heart Attack Warning Signs in Women — Call 911 Immediately

Women often experience heart attack symptoms that differ from the 'classic' chest-clutching presentation. Warning signs include: unusual or extreme fatigue (days before the attack); shortness of breath (with or without chest discomfort); chest pressure, squeezing, tightness, or pain; discomfort or pain in the neck, jaw, shoulder, arms, or upper back; nausea, indigestion, or abdominal discomfort; breaking out in a cold sweat; light-headedness or fainting. Do not wait. Call 911. In Canada, early signs of a heart attack are missed in 78% of women (Heart and Stroke Foundation, 2023).

EXECUTIVE SUMMARY

Cardiovascular disease (CVD) is the leading cause of premature death in Canadian women. Every 16 minutes, a woman in Canada dies from heart disease or stroke. Yet cardiovascular disease continues to be perceived — by the public, many clinicians, and policymakers — as primarily a man's disease. This misperception costs women their lives.

24,000 Canadian women die of heart disease every year — nearly five times more than die from breast cancer (Canadian Women's Heart Health Centre, University of Ottawa Heart Institute). CVD costs the Canadian economy \$21.2 billion annually in direct and indirect costs (Heart and Stroke Foundation of Canada). And 80% of premature heart disease and stroke cases are preventable (Heart and Stroke Foundation).

Women's cardiovascular disease is biologically and clinically different from men's. Women experience different symptoms, different underlying mechanisms, different risk factor profiles, and different responses to the same treatments. The diagnostic tools, clinical guidelines, and risk assessment models used by most Canadian cardiologists were developed and validated primarily in men — and continue to miss, misdiagnose, and undertreat women at every stage of care.

The defining paradox of 2026

Women are more likely than men to die from their first heart attack. They wait longer in emergency departments. They are less likely to be prescribed evidence-based medications. They are less likely to be referred for cardiac rehabilitation. And they remain underrepresented in virtually every major cardiovascular clinical trial. This is not biology — it is a system that has not been designed with women in mind. That is the problem this e-guide exists to help solve.

KEY CANADIAN STATISTICS

The Numbers Behind the Crisis

Mortality and Prevalence

24,000

Canadian women die of heart disease every year

Nearly 5× more deaths than from breast cancer — yet breast cancer receives far more public awareness funding (Canadian Women's Heart Health Centre, 2024)

Every 16 minutes

a woman in Canada dies from heart disease or stroke

This is the most powerful statistic in Canadian women's cardiovascular health — and remains largely unknown to the public (Heart and Stroke Foundation 2023)

\$21.2 billion

total annual cost of cardiovascular disease to Canada

Direct medical costs plus indirect costs from lost earnings — making CVD the single most costly disease in Canada (Heart and Stroke Foundation)

8.2%

of Canadian adults living with diagnosed ischemic heart disease (2023–2024)

Canadian Chronic Disease Surveillance System data — ischemic heart disease is the most common heart disease type; women's rates increase sharply after menopause

80%

of premature heart disease and stroke cases are preventable

Heart and Stroke Foundation of Canada — the evidence for prevention is stronger in cardiovascular health than in almost any other disease category

The Diagnosis and Treatment Gaps

- ◆ Early signs of a heart attack were missed in 78% of women in a 2023 Heart and Stroke Foundation of Canada report — compared to far lower rates in men
- ◆ Women are more likely than men to die from their first heart attack — a direct consequence of later diagnosis, different symptom presentation, and delayed treatment
- ◆ Stroke prevalence is higher in women than men: 3.3% versus 2.7% (Cureus, 2024 meta-analysis on gender disparities in CVD)
- ◆ Women are more likely to survive a stroke than men — but more likely to die in the years following, partly because they live longer and develop late complications
- ◆ About 25% of Canadian adults aged 20+ are living with diagnosed hypertension — with prevalence in women exceeding men after age 60 (Health Canada, CCDSS 2023–2024)
- ◆ Women treated with antihypertensive medications show higher systolic blood pressures than men on equivalent treatment — suggesting current dosing protocols are calibrated to male physiology (Canadian Women's Heart Health Alliance ATLAS)

Research and Representation Gaps

- ◆ The majority of cardiovascular clinical trials continue to enrol predominantly male participants — the physiological differences discovered in women are largely extrapolated from male data
- ◆ Diagnostic algorithms including the Framingham Risk Score were developed without adequate representation of women, non-white, and lower-income populations
- ◆ MINOCA (Myocardial Infarction with Non-Obstructive Coronary Arteries) affects women disproportionately but is frequently misdiagnosed because coronary angiograms appear normal
- ◆ Spontaneous Coronary Artery Dissection (SCAD) — a largely female condition causing heart attack primarily in younger women — was only formally recognized as a distinct clinical entity in the past decade

✓ **Fact-check note:** *The \$21.2 billion CVD cost figure is from the Heart and Stroke Foundation. More recent data from a 2024 publication puts the combined cost of CVD, stroke, and vascular cognitive impairment significantly higher when comorbidities are included. Cardiovascular disease is the most economically costly category of disease in Canada — more than cancer, more than mental illness, and more than musculoskeletal conditions.*

SEX AND GENDER DIFFERENCES IN CARDIOVASCULAR DISEASE

Understanding sex and gender differences in cardiovascular disease is not academic — it is clinically critical. Women and men differ in heart size, vessel anatomy, plaque composition, symptom presentation, hormonal biology, response to treatments, and psychosocial risk profiles. Failing to account for these differences means applying a diagnostic and therapeutic framework built on male physiology to female patients.

Anatomical and Physiological Differences

- ◆ Women's hearts are smaller than men's, with smaller coronary arteries and different microvascular architecture — making standard angiography and stress testing less sensitive for detecting disease in women
- ◆ Plaque in women's arteries tends to erode differently than in men — women more commonly develop diffuse plaque distribution rather than obstructive single-vessel blockages, missing standard CAD detection criteria
- ◆ Left ventricular remodelling in response to hypertension is more pronounced in women — women with hypertension exhibit higher propensity for concentric hypertrophy than men (Dalhousie/Mayo 2024, JACC Advances)
- ◆ Takotsubo cardiomyopathy (stress cardiomyopathy) disproportionately affects women — triggered by acute emotional or physical stress, and more commonly presenting in post-menopausal women
- ◆ MINOCA (Myocardial Infarction with Non-Obstructive Coronary Arteries) and INOCA (Ischemia with Non-Obstructive Coronary Arteries) affect women far more than men, representing a genuinely different disease mechanism

Symptom Presentation — Why Women Get Missed

The 'classic' heart attack presentation — sudden, crushing chest pain radiating to the left arm — describes a male presentation pattern. Women are more likely to experience:

- ◆ Unusual fatigue, sometimes for days or weeks before a cardiac event
- ◆ Shortness of breath, with or without exertion, with or without chest discomfort
- ◆ Pressure, tightness, or squeezing rather than sharp pain in the chest

- ◆ Pain or discomfort in the neck, jaw, upper back, or both arms
- ◆ Nausea, indigestion, abdominal discomfort, or vomiting
- ◆ Light-headedness, dizziness, or fainting

Why 'atypical' is the wrong word

Medical literature routinely labels women's heart attack symptoms as 'atypical' — implying deviation from a norm. But these symptoms are not atypical. They are typical for women. The term 'atypical' reflects a diagnostic framework built on male physiology. The Canadian Women's Heart Health Alliance and a 2024 paper in *JACC Advances* explicitly call for retiring this language. Women's symptoms are different from men's — but they are not abnormal. Renaming them 'non-obstructive' or 'sex-specific' rather than 'atypical' is both scientifically and clinically correct.

Risk Factor Differences — What Hits Women Harder

- ◆ Type 2 diabetes: confers significantly higher cardiovascular risk in women than in men — women with diabetes lose the cardioprotective effect of oestrogen, creating a disproportionate risk amplification
- ◆ Smoking: tobacco use carries a 7-fold increased risk for CVD in women under 55 years — a higher multiplier than in equivalent-aged men (Canadian Women's Heart Health Alliance ATLAS)
- ◆ Depression and anxiety: strongly associated with CVD in women — more so than in men; particularly in younger women, anxiety and depression are independent CVD risk factors
- ◆ Autoimmune and inflammatory conditions (lupus, rheumatoid arthritis, psoriasis): far more prevalent in women and significantly associated with accelerated cardiovascular disease
- ◆ Psychosocial stress and caregiving roles: associated with higher incidence of stress-induced cardiomyopathies and adverse cardiovascular outcomes in women specifically
- ◆ Chemotherapy for breast and gynaecological cancers: cardiotoxic treatments create a distinct population of women with treatment-induced cardiovascular disease — cardiology is an emerging subspecialty

CARDIOVASCULAR RISK ACROSS A WOMAN'S LIFESPAN

Women's cardiovascular risk is not linear. It is shaped by reproductive biology, hormonal transitions, and life-stage-specific events that create distinct windows of opportunity for prevention — and distinct windows of vulnerability that the health system frequently misses.

Reproductive-Age Women (Ages 20–40)

- ◆ Early menarche, irregular cycles, and polycystic ovary syndrome (PCOS) are associated with higher long-term cardiovascular risk — PCOS affects 8–13% of reproductive-age women and independently increases CVD risk
- ◆ Oral contraceptive use combined with smoking dramatically increases stroke and MI risk — women who smoke should not use combined oral contraceptives
- ◆ Spontaneous Coronary Artery Dissection (SCAD) most commonly presents in women aged 30–50 — often following extreme physical exertion, emotional stress, or in the peripartum period; standard cardiac guidelines miss it

Pregnancy as a Cardiovascular Stress Test

- ◆ Hypertensive disorders of pregnancy (preeclampsia, gestational hypertension) affect up to 16% of pregnancies and are one of the strongest independent predictors of future CVD in women
- ◆ Women with preeclampsia have a 2–3× higher lifetime risk of heart disease and stroke — yet most leave hospital postpartum without cardiovascular follow-up or counselling
- ◆ Gestational diabetes doubles the lifetime risk of type 2 diabetes and significantly accelerates cardiovascular risk — with a higher proportion of the risk manifesting as CVD rather than just metabolic disease
- ◆ Peripartum cardiomyopathy — a form of heart failure that develops in late pregnancy or in the months following birth — is underdiagnosed and carries significant mortality risk
- ◆ A prospective study of Canadian women with preexisting CVD found that 50% of serious cardiac events during pregnancy were preventable with optimal pre-conception cardiac health management (Canadian Women's Heart Health Alliance ATLAS)

Perimenopause and Menopause — The Critical Transition

Menopause represents the single most important cardiovascular transition in a woman's life. The decline of oestrogen at menopause removes a major cardioprotective influence — explaining why women's cardiovascular disease rates, which are lower than men's before menopause, converge with and ultimately exceed men's rates by the eighth decade.

- ◆ Heart attack rates among women aged 35–54 are rising — a trend attributed to worsening risk factor profiles at younger ages, with clinicians in Canada reporting seeing high blood pressure in women in their 40s far more frequently than a decade ago (Dr. Paula Harvey, Women's College Hospital)
- ◆ Premature menopause (before age 40) and early menopause (before age 45) are independent cardiovascular risk factors — associated with doubled risk of coronary heart disease
- ◆ Vasomotor symptoms (hot flashes, night sweats) are associated with adverse cardiovascular markers and accelerated vascular ageing — not merely menopausal discomfort
- ◆ The timing of hormone therapy initiation ('the timing hypothesis') matters significantly: initiating menopausal hormone therapy within 10 years of menopause onset appears cardioprotective; initiating it more than 10 years after menopause may increase risk
- ◆ Most Canadian women are not counselled about the cardiovascular implications of menopause by either their cardiologist or their gynaecologist — a systemic gap identified by Dr. Paula Harvey (Women's College Hospital) and the CWHHA

Menopause is a cardiovascular event, not just a hormonal one

The cardiovascular community is increasingly recognising menopause as a transition that requires proactive cardiovascular risk stratification, lifestyle modification counselling, lipid management review, and — in appropriate candidates — discussion of menopausal hormone therapy. Women who reach their cardiologist only after a cardiovascular event in their 60s or 70s have missed the primary prevention window that menopause represents. Canada needs menopause-informed cardiology built into every women's health clinic.

CARDIO-OBSTETRICS — A NEW SUBSPECIALTY FOR A CRITICAL GAP

Cardio-obstetrics is the subspecialty addressing the intersection of cardiovascular disease and pregnancy — one of the fastest-growing fields in women's cardiovascular health globally. It recognises pregnancy as a cardiovascular stress test that reveals underlying vulnerabilities and creates future risk, and that women with pre-existing heart disease require specialised interdisciplinary care throughout the reproductive period.

Why It Matters in Canada

- ◆ Cardiovascular disease is now the leading indirect cause of maternal mortality in Canada — with cardiac complications accounting for more maternal deaths than most obstetric causes
- ◆ Women with congenital heart disease (CHD) — the most common serious birth defect, with improved survival into adulthood — are now navigating pregnancy in increasing numbers, requiring specialised cardio-obstetric care
- ◆ Hypertensive disorders of pregnancy affect up to 16% of pregnant women in Canada and independently predict lifetime cardiovascular risk (JACC 2024 review)
- ◆ The CARPREG II (Cardiac Disease in Pregnancy) risk score — developed by Canadian researchers at the University of Toronto — is now an international standard for risk stratification in pregnant women with heart disease
- ◆ Peter Munk Cardiac Centre and Women's College Hospital in Toronto are among Canada's leading centres for cardio-obstetric care — a model that needs expansion nationally

The Systemic Gap

The vast majority of women who experience hypertensive disorders of pregnancy, gestational diabetes, or peripartum cardiomyopathy are discharged from the obstetric system without cardiovascular follow-up, risk stratification, or counselling. Their cardiologists — if they have one — are not informed about pregnancy complications that profoundly shape lifetime cardiovascular risk. The obstetric system and the cardiovascular system do not talk to each other. Cardio-obstetrics exists to bridge that gap.

✓ **Fact-check note:** *The CARPREG II score is a genuine Canadian innovation. Developed at the University of Toronto, it provides validated risk stratification for pregnant women with heart disease across 14 risk predictors. Its international adoption demonstrates Canada's capacity to lead in women's cardiovascular research — but the domestic implementation gap between research and clinical practice remains wide.*

THE PRESENT: CANADA'S 2026 CARDIOVASCULAR LANDSCAPE

Canada is navigating a moment of genuine tension in women's cardiovascular health: the science is advancing faster than the system is adopting it. Women-specific cardiovascular care has moved from an academic interest to an operational imperative — driven by accumulated evidence of systematic under-diagnosis, treatment gaps, and preventable deaths.

National Progress — What Has Changed

- ◆ The Canadian Women's Heart Health Alliance (CWHHA) — launched with a landmark multi-chapter ATLAS in 2020–2021 — has catalysed a national conversation about sex- and gender-specific cardiovascular care, producing the most comprehensive Canadian evidence synthesis on women's CVD
- ◆ Women-specific cardiac clinics are expanding: University of Ottawa Heart Institute's Canadian Women's Heart Health Centre, Women's College Hospital's Cardiovascular Programme, Peter Munk Cardiac Centre's Women's Cardiovascular Health program, and BC's emerging women's heart health programs
- ◆ Cardio-obstetrics is gaining institutional recognition — with dedicated programs at tertiary centres in Toronto and Ottawa
- ◆ AI-enabled cardiac imaging, wearable monitoring, and remote patient management are beginning to reach clinical practice — with particular promise for detecting the subtle vascular changes associated with women's CVD
- ◆ The Heart and Stroke Foundation's 2023 report directly called out the missed diagnosis crisis for women — increasing public and clinical awareness of the gender gap in cardiovascular care

What Has Not Changed — The Persistent Gaps

- ◆ Women remain underrepresented in cardiovascular clinical trials — the evidence base continues to be generated predominantly from male participants
- ◆ Diagnostic criteria for MINOCA, INOCA, SCAD, and microvascular coronary disease remain inconsistently applied in Canadian hospitals
- ◆ Pregnancy complications are still not systematically incorporated into cardiovascular risk assessment at family physician and cardiologist levels

- ◆ Menopause cardiology remains absent from most women's primary care encounters — women are not routinely counselled about cardiovascular risk at menopause
- ◆ Rural, remote, Indigenous, and racialized women face compounded access barriers — despite bearing higher cardiovascular risk

ACCESS, EQUITY, AND WHO GETS LEFT BEHIND

Geographic Inequity

Women's cardiac clinics are concentrated in urban academic centres — Toronto, Ottawa, Vancouver, and Montreal. Women in rural Saskatchewan, Nunavut, Northern Ontario, and Atlantic Canada may have no access to a cardiologist with women's cardiovascular health expertise. Telehealth and virtual cardiology consultations have expanded since 2020 but remain inconsistently available for specialist cardiac care.

Racial and Ethnic Disparities

- ◆ South Asian women in Canada have the highest rates of atherosclerotic CVD, hypertension, and stroke among all ethnic groups — both men and women — but receive care through diagnostic and risk tools not validated for their physiology (CWHHA ATLAS)
- ◆ Afro-Caribbean Canadian women have the highest rates of stroke and hypertension among ethnic groups in Canada, and higher rates of physical inactivity and obesity compared to the overall population
- ◆ Chinese Canadian women have the lowest incidence of CVD of all ethnic groups, but longer Canadian residency is associated with increasing CVD risk — suggesting acculturation effects
- ◆ No Canadian CVD clinical guidelines or scientific statements are currently specific to ethnicity — a gap the CWHHA has identified as a research priority

Indigenous Women and Cardiovascular Disease

Indigenous women in Canada experience cardiovascular disease through the compounding effects of colonialism, forced displacement, intergenerational trauma, food insecurity, limited access to preventive care, and systemic racism in health systems. Indigenous Peoples experience higher rates of hypertension, diabetes, obesity, and smoking — all major cardiovascular risk factors — at younger ages than the general population.

- ◆ Type 2 diabetes prevalence is significantly higher among First Nations, Métis, and Inuit populations — with diabetes carrying a disproportionate cardiovascular risk multiplier for women
- ◆ Geographic barriers for remote and fly-in First Nations communities mean that cardiovascular events (MI, stroke) may not receive time-critical intervention — ambulances, cardiac catheterization labs, and stroke centres are simply not accessible
- ◆ Indigenous women experience systemic racism in emergency department encounters — delays in care, dismissal of pain, and inadequate assessment are documented in qualitative and quantitative research
- ◆ Traditional food systems, land-based activity, and community-based healing practices represent genuine protective factors — but are being eroded by colonisation's ongoing effects

The intersection of Indigenous health and cardiovascular disease

Innovation in Indigenous women's cardiovascular health cannot mean importing urban clinical models onto remote communities. It must mean funding Indigenous-led health centres, culturally safe cardiac screening programs, community health representatives, telehealth with language support, and integration of traditional knowledge with evidence-based medicine. Canada has made commitments to reconciliation — implementing them in cardiovascular health is a concrete and urgent test.

INNOVATION: TECHNOLOGY RESHAPING WOMEN'S HEART HEALTH

AI-Enabled Cardiac Diagnostics

Artificial intelligence applied to cardiac imaging (echocardiography, CT, MRI), ECG interpretation, and risk stratification represents the most significant diagnostic innovation of the past decade. AI algorithms can detect subtle structural and functional changes in the heart that human readers miss, and pattern-recognition across large datasets is identifying sex-specific cardiovascular signatures. Key applications include:

- ◆ AI-powered echocardiographic analysis detecting left ventricular hypertrophy patterns more common in women with hypertension
- ◆ ECG-based AI algorithms predicting cardiovascular risk from routine 12-lead ECGs — with early studies suggesting sex-specific predictive patterns
- ◆ CT calcium scoring and coronary CTA algorithms calibrated for the diffuse plaque patterns more common in women
- ◆ Risk stratification models incorporating pregnancy history, menopause timing, autoimmune disease, and psychosocial stress — the sex-specific risk factors absent from Framingham

Wearables and Remote Monitoring

- ◆ Consumer wearables (Apple Watch, Fitbit, Oura Ring) can detect atrial fibrillation, continuous heart rate monitoring, sleep quality, and activity levels — all relevant cardiovascular indicators for women
- ◆ Clinical-grade remote patient monitoring platforms (Cloud DX, Biofourmis) enable continuous blood pressure, ECG, and vital sign monitoring for high-risk cardiac patients at home — particularly valuable for post-partum cardiac surveillance
- ◆ Continuous glucose monitoring integrated with cardiovascular risk tracking is emerging as a tool for women with gestational or type 2 diabetes — a high-risk cardiovascular population

Cardio-Obstetrics Digital Tools

- ◆ Risk stratification apps based on CARPREG II for pregnant women with heart disease
- ◆ Postpartum blood pressure monitoring platforms for women with hypertensive disorders of pregnancy — enabling extended remote surveillance of the highest-risk post-partum cardiovascular population
- ◆ Integration of electronic health record systems to flag obstetric complications (preeclampsia, gestational diabetes, peripartum cardiomyopathy) and trigger cardiovascular follow-up pathways

Precision Medicine and Pharmacogenomics

Women metabolise cardiac medications differently than men — including aspirin, statins, beta-blockers, and anticoagulants. Pharmacogenomic approaches tailoring medication type and dose to sex, ethnicity, and genetic profile represent a medium-term innovation with significant implications for closing the treatment efficacy gap between men and women.

ORGANIZATIONS AND COMPANIES TO WATCH

Organization / Platform	What It Does	Why Watch
Heart & Stroke Foundation of Canada	National charity funding cardiovascular and stroke research, prevention programs, and public awareness — with growing focus on sex and gender differences	The 2023 report explicitly naming the missed-diagnosis crisis for women represents a shift toward gender-responsive advocacy. Watch for policy influence on national CVD guidelines.
Canadian Women's Heart Health Alliance (CWHHA)	National network of clinicians, researchers, and advocates developing the ATLAS — Canada's most comprehensive evidence synthesis on women's CVD — and driving sex- and gender-specific guideline change	The ATLAS chapters (2020–2021) are the definitive Canadian reference for sex-specific CVD evidence. The Alliance is the leading force for systemic change in Canadian women's cardiovascular care.
Canadian Women's Heart Health Centre (Ottawa Heart Institute)	Dedicated clinical program at the University of Ottawa Heart Institute — the first program in Canada specifically designed for women's cardiovascular care	A clinical model for what women-centred cardiac care looks like when it's built from the ground up. The 24,000 deaths figure comes from this centre. Expansion nationally is the goal.
Women's College Hospital (Toronto)	Academic hospital dedicated to women's health — Cardiovascular Programme under Dr. Paula Harvey provides leadership in menopause cardiology, diagnostic innovation, and sex-specific care	A bellwether institution for Canadian women's health. Dr. Harvey's public commentary on rising heart attack rates in younger women has shaped national attention to this trend.
Peter Munk Cardiac Centre (Toronto)	University Health Network's cardiac centre — housing one of Canada's leading cardio-obstetrics programs and cardiac imaging research programs	The CARPREG II score was developed here. One of Canada's most important sites for women's CVD research and complex cardio-obstetric care.
Cloud DX	Canadian digital health company providing remote patient monitoring solutions — blood pressure, heart rate, pulse oximetry, ECG	Remote monitoring technology for high-risk cardiovascular patients including post-partum women with hypertensive disorders. Represents Canadian health-tech innovation in CVD management.
Dialogue	Canadian virtual care and workplace wellbeing platform — employee health and chronic disease management through employer benefits	Cardiovascular risk management (hypertension, diabetes, metabolic health) through employer benefits channels — reaching women who might not otherwise access preventive cardiovascular care.
Maple	Canadian on-demand virtual care platform connecting patients with physicians and specialists	Virtual cardiology consultations expanding access for rural and remote women who lack access to specialist care in their communities.

Provincial Snapshots

Women's Cardiovascular Innovation Across Canada

Province / Territory	Innovation Focus	Key Watch Areas
British Columbia	Women's cardiac clinics, prevention programs, digital health, remote monitoring, and First Nations Health Authority cardiovascular programs	Indigenous women's CVD access; telehealth cardiology for rural communities; menopause cardiology integration
Alberta	Integrated cardiac and metabolic care, AI-enabled diagnostics, rural telehealth, and sex-specific cardiac programs	Digital access across rural regions; PCOS and metabolic CVD in younger women; Indigenous women's cardiovascular equity
Saskatchewan	Rural telehealth cardiology, community-based prevention, and primary care cardiovascular risk management	Extreme rural access barriers; Indigenous women's CVD; cardiac rehabilitation access; gestational hypertension follow-up
Manitoba	Community-based CVD prevention, Indigenous cardiovascular health, and cardiac rehabilitation access	Highest Indigenous population proportion of any province; traditional food and activity as protective factors; systemic racism in cardiac care
Ontario	CWHHA research hub, Women's College Hospital, Peter Munk Cardiac Centre, cardio-obstetrics programs, AI diagnostics, and Ontario Structured Psychotherapy-adjacent cardiac-mental health links	MINOCA and SCAD recognition in ER settings; menopause cardiology in primary care; cardiac rehabilitation gender equity
Quebec	Virtual cardiology, digital-first chronic disease management, Francophone cardiovascular health equity, and workplace wellness platforms	Francophone access to women's cardiac information; immigrant and racialized women's CVD; perinatal cardiac care pathways
New Brunswick	Telehealth cardiology, primary care cardiovascular risk integration, and rural access programs	Acute rural access gap; cardiac rehabilitation availability; women's hypertension management
Nova Scotia	Community cardiovascular prevention, Dalhousie University cardiovascular research, and coastal community access	Hypertensive heart disease research (Dalhousie/Mayo 2024); rural and coastal women's access; cardiac rehabilitation
Prince Edward Island	Primary care CVD prevention, virtual specialist access, and small-system integration	Small health system with limited specialist access; virtual cardiology; maternal cardiovascular follow-up
Newfoundland & Labrador	Remote access, telehealth cardiology, community-based prevention, and Indigenous cardiovascular health	Extreme geographic access barriers; Labrador Indigenous women's CVD; cardiac rehabilitation
Yukon	Northern telehealth, Indigenous cardiovascular health, and virtual specialist access	Remote Indigenous women's CVD; traditional food as protective factor; cardiac crisis access times

Northwest Territories	Indigenous cardiovascular wellness, telehealth, community health workers, and metabolic health programs	Highest proportion of Indigenous population; colonialism's cardiovascular effects; metabolic disease and CVD intersection
Nunavut	Inuit-led cardiovascular wellness, community health programs, and telehealth with cultural safety	Highest rates of risk factors; food insecurity and CVD; Inuit-specific cardiac care needs; language and cultural barriers in cardiac emergency care

THE FUTURE: 2026–2030 OUTLOOK

1 — Menopause Cardiology Will Become Standard of Care

The next five years will see menopause emerge as a primary cardiovascular prevention window. Every woman entering perimenopause should receive cardiovascular risk stratification, lifestyle optimisation counselling, lipid management review, and — where appropriate — discussion of menopausal hormone therapy's cardiovascular risk-benefit profile. This will require cross-specialty collaboration between cardiologists, gynaecologists, and primary care providers.

2 — Pregnancy Complications Will Trigger Lifelong Cardiovascular Surveillance

Canada will develop standardised systems to flag cardiovascular risk in women who have experienced preeclampsia, gestational diabetes, peripartum cardiomyopathy, and SCAD. These women need structured follow-up programs, risk-factor management, and annual cardiovascular reviews — beginning no later than six weeks postpartum and continuing for life.

3 — AI Will Detect Women's CVD Earlier

Sex-specific AI algorithms for cardiac imaging and ECG interpretation will enter clinical practice in major Canadian centres by 2027–2028. The opportunity is significant: AI pattern recognition on the diffuse, non-obstructive, microvascular disease patterns common in women may fundamentally change the diagnostic landscape for MINOCA, INOCA, and early hypertensive heart disease.

4 — Clinical Trials Will Achieve Sex Parity

Regulatory pressure in Canada (following US and EU leads) will increasingly require sex-stratified analysis and reporting in cardiovascular clinical trials. This will gradually rebuild the evidence base — but the full benefit of sex-parity in trials will take another decade to translate into updated clinical guidelines.

5 — Prevention Will Move Earlier and Further Upstream

The future of women's cardiovascular health in Canada will be defined not by better treatments for established disease — but by earlier identification of risk, earlier intervention in the reproductive years, and lifestyle medicine that reaches women before their first cardiac event.

POLICY RECOMMENDATIONS

For Federal and Provincial Governments

- ◆ Fund sex- and gender-specific cardiovascular guidelines — updating Canadian Cardiovascular Society guidelines to include sex-specific diagnostic criteria for MINOCA, INOCA, SCAD, and microvascular coronary disease
- ◆ Mandate sex-stratified reporting in all publicly funded cardiovascular clinical trials and registries
- ◆ Invest in rural and remote cardiac telehealth — ensuring women in every province and territory have access to specialist cardiovascular care within clinically relevant timeframes
- ◆ Create a national women's cardiovascular health action plan — modelled on the CWHHA ATLAS recommendations, with implementation accountability

For Health Systems and Hospitals

- ◆ Implement structured cardiovascular follow-up protocols for all women discharged with a diagnosis of preeclampsia, gestational hypertension, gestational diabetes, or peripartum cardiomyopathy
- ◆ Train emergency department staff in the recognition of atypical (female-pattern) heart attack presentations — the 78% missed-diagnosis rate is a quality and safety emergency
- ◆ Establish women's cardiac clinics in regional centres across all provinces — not only in the largest academic hospitals
- ◆ Integrate menopause cardiovascular risk counselling into all women's primary care encounters for women aged 40–60

For Employers and Benefits Advisors

- ◆ Include cardiovascular risk reduction in workplace wellness programs — specifically targeting the metabolic, stress, and lifestyle risk factors most prevalent in employed women
- ◆ Fund cardiac rehabilitation access for women — rates of cardiac rehabilitation completion are significantly lower in women than men, in part due to scheduling barriers, childcare, and programme design
- ◆ Design menopause benefits that include cardiovascular risk assessment and lifestyle medicine — the connection between menopause and heart health remains absent from most benefit designs

RESOURCES AND ORGANIZATIONS

Emergency — Call 911 for Heart Attack or Stroke Symptoms

Heart attack and stroke are medical emergencies. Do not drive yourself to hospital. Call 911 immediately if you experience unusual fatigue, chest discomfort, shortness of breath, jaw or neck pain, nausea, or sudden severe symptoms. Do not wait for symptoms to 'pass.'

Key Canadian Organisations

- ◆ Heart and Stroke Foundation of Canada: heartandstroke.ca — prevention, research funding, public advocacy
- ◆ Canadian Women's Heart Health Alliance: cwhha.ca — the definitive Canadian resource for sex-specific CVD evidence and advocacy
- ◆ Canadian Women's Heart Health Centre (Ottawa): ottawaheart.ca/womens-heart — clinical programs and patient education
- ◆ Women's College Hospital Cardiovascular Programme (Toronto): womenscolleghospital.ca — clinical care and research
- ◆ Peter Munk Cardiac Centre: torontomu.ca/pmcc — cardio-obstetrics and research excellence

Key Research and Data Sources

- ◆ CWHHA ATLAS (2020–2021, peer-reviewed multi-chapter series in CJC Open) — the definitive Canadian evidence synthesis on women's CVD across 10 chapters
- ◆ Health Canada CCDSS Cardiovascular Data 2023–2024: canada.ca — current national prevalence and hospitalization data
- ◆ Heart and Stroke Foundation 2023 Report on Women's Heart Health: heartandstroke.ca/articles
- ◆ Circulation, JACC, JACC Advances: peer-reviewed journals for sex-specific CVD research updates

About Women, Health & Innovation

Women, Health & Innovation is Baljit Sidhu's strategic Canadian platform advancing evidence-based innovation in women's health. This e-guide series — Volume 2 of the Canadian series — provides the most current research, statistics, and innovation landscape for decision-makers working to advance women's cardiovascular health across Canada. Published by the Farm Fairy Foundation. Visit: womenhealthinnovation.org · farmfairyfoundation.org

*“The future of women’s cardiovascular health in Canada
will be defined by earlier recognition,
better prevention, culturally safe access,
AI-supported care, and a systems-level approach
to women’s health that no longer treats us as an afterthought.”*



— **Baljit Sidhu**

Founder & President, Farm Fairy Foundation

Global Chair, Women’s Health & Innovation

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This e-guide is for educational purposes only and does not constitute medical advice. Call 911 if you are experiencing heart attack or stroke symptoms.