QUALITY STANDARDS

Menopause

Care for People During Perimenopause and Menopause

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Ontario Health

Scope of This Quality Standard

This quality standard addresses care for people of all ages who are experiencing perimenopause or menopause (which includes people in postmenopause), including early or surgically induced menopause. The quality standard focuses on the identification, assessment, and management of symptoms at any stage and in all health care settings.

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and care partners know what to ask for in their care
- Help clinicians know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards and their accompanying patient guides are developed by Ontario Health in collaboration with clinicians, patients, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca.

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care looks like for people who are experiencing perimenopause or menopause.

Quality Statement 1: Education for Clinicians

People experiencing perimenopause and menopause receive care from a clinician who has the knowledge and skills needed to provide evidence-based menopause care. Clinicians stay current with the knowledge and skills needed to provide evidence-based menopause care.

Quality Statement 2: Identification and Assessment of Perimenopause and Menopause

Starting at age 40, people who will experience perimenopause and menopause are asked about menopause-associated symptoms to enable the early identification and assessment of perimenopause and menopause.

Quality Statement 3: Evidence-Based Information for People Experiencing Perimenopause or Menopause

Starting at age 40, people who will experience perimenopause and menopause receive evidence-based information about perimenopause and menopause from their clinician.

Quality Statement 4: Management of Vasomotor Symptoms

People experiencing vasomotor symptoms during perimenopause and menopause are offered menopausal hormone therapy as first line treatment, following an assessment of risks, benefits, contraindications, and individual needs and preferences. People who have contraindications to menopausal hormone therapy or who do not desire it are offered other evidence-based treatment options, including non-hormonal medications and nonpharmacological treatments.

Quality Statement 5: Management of Non-Vasomotor Symptoms

People experiencing non-vasomotor symptoms (including those related to genitourinary syndrome of menopause, sexual health, mental health, sleep, and cognition) during perimenopause and menopause are offered evidence-based treatment options and have their contraceptive needs addressed.

Quality Statement 6: Appropriate Referral to a Clinician with Expertise in Menopause

People experiencing perimenopause or menopause receive assessment and treatment from their primary care clinician and, if clinically indicated, are referred to a clinician with expertise in menopause.

Table of Contents

Notes on Terminology

The terminology used to define the stages of menopause varies across the literature[1]; we have made the following choices for this quality standard:

- *Perimenopause* – also called "the menopause transition" – refers to the time before menopause.[1] This stage begins when people experience persistent variation of 7 or more days in the length of their menstrual cycles.[2] The duration of this stage varies, but it can last up to 10 years for some,[3] and during this time menopause-associated symptoms may occur. People in perimenopause do not need to wait until they are in menopause to receive evidence-based care.
- Clinically, the term *menopause* refers to a single day – the date on which 12 months have passed since a person's last menstrual period – and *postmenopause* refers to the time from this day until the end of life.[4] However, the term *menopause* is commonly used to refer to both menopause and postmenopause,[4] and we have used it this way in this quality standard. Menopause-associated symptoms can continue for several years into postmenopause.[5]

We have used *menopause care* to refer to care for people at any stage of menopause, including perimenopause, menopause, and postmenopause. We have used *menopausal hormone therapy* as the preferred term (instead of *hormone replacement therapy*); ovarian hormones do not need to be routinely "replaced" in people who experience menopause at the average age.[6]

The term *people experiencing perimenopause and menopause* is inclusive of all people who will experience perimenopause and menopause, including women, Two-Spirit people, trans men, and nonbinary people assigned female at birth. Gender-diverse people experience inequities in accessing appropriate menopause care,[7] and such inequities negatively affect their health outcomes and experiences with the health care system. All people who experience perimenopause and menopause deserve quality care. In alignment with Ontario Health's strategic priority to reduce the health inequities experienced by 2SLGBTQIA+ communities, we have used gender-inclusive language throughout this quality standard.

Why This Quality Standard Is Needed

Menopause is the natural and important health transition from reproductive to nonreproductive status, and the clinical definition of menopause is the absence of a menstrual period for 12 consecutive months.[8] People experience menopause at a mean age of 51.4 ± 3.3 years, and about 90% experience natural menopause between the ages of 45 and 55 years.[9,10] On average, perimenopause begins 4 years before a person's last menstrual period,[11] although it can start as early as 10 years before.[3] Premature ovarian insufficiency (i.e., when menopause occurs before age 40 years) or early menopause (i.e., when menopause occurs between the ages of 40 and 44 years) can occur spontaneously, be surgically induced by oophorectomy, or result from chemotherapy and radiation.[10]

Menopause occurs as a result of diminishing reproductive hormones and loss of ovarian follicular function, leading to the end of menstrual cycles.[3] With reduced estrogen levels (i.e., hypoestrogenism),[12] people may experience a variety of symptoms, such as vasomotor symptoms (e.g., hot flashes or night sweats[10,13,14]) and genitourinary syndrome of menopause (e.g., vaginal dryness[10,13]; pain or discomfort with sexual intercourse[10]; vulvovaginal discomfort or irritation[10]; or discomfort, pain, or urgency with urination[10,15]). Vasomotor symptoms are the most common, affecting 80% of people experiencing menopause and lasting for a median of 7 years after the last menstrual period.[16] Other symptoms can include changes in mood (e.g., depressive symptoms[10] or anxiety[13,14]), musculoskeletal symptoms (e.g., joint and muscle pain[10,13,14]), sexual difficulties,[10,13,14] sleep disturbances,[13,14] changes in weight and/or body fat distribution,[14] and difficulties with concentration or memory.[13,14]

People experiencing perimenopause and menopause should receive high-quality care based on the best available evidence. However, lack of awareness about menopause-associated symptoms is widespread, and people have limited access to knowledgeable clinicians who can provide evidence-based menopause care.[4,17] Among Canadians who took part in a survey about menopause in 2022, 46% said that they felt unprepared for this life transition and 55% felt that they should have learned about it earlier in life.[4] Furthermore, perimenopause is an important window of opportunity for preventative care,[18] because it is associated with increased risk of cardiovascular disease and bone loss.[14,19] If people can better understand and prepare for this critical life stage, they may feel more empowered to make informed decisions about their care, optimize lifestyle factors, and improve their overall health.

Clinicians' varying levels of knowledge about and comfort with menopause management also has implications for the care people receive. Menopause-associated symptoms are often mistakenly attributed to other conditions, leading to incorrect treatment and delayed care.[20] Some clinicians and trainees report discomfort with their level of knowledge about treatment options, avoidance of unfamiliar clinical issues, and a feeling of being unprepared to provide menopause care.[21] Over a third of respondents to the Canadian menopause survey (38%) said that their clinician had undertreated their menopausal symptoms, and only 27% reported that their primary care clinician had initiated a conversation about menopause.[4] Although recent clinical practice guidelines have recommended menopausal hormone therapy as first-line treatment for vasomotor symptoms (emphasizing individualized assessment of risk factors such as age),[13] clinicians still report hesitation in prescribing it.[22,23] Further, primary care clinicians' lack of knowledge and comfort in providing perimenopause and menopause care leads to unnecessary and inappropriate referrals for specialty care, contributing to long wait times.[24] A Canadian study has estimated that gynecology referrals incur a median wait time of 86 days; 75% of patients waited up to 142 days.[25]

Inadequate care for perimenopause and menopause has substantial social and economic effects. Symptoms can cause strain on relationships with partners, families, and friends.[26,27] An estimated 10% of people permanently leave their careers as a result of debilitating menopause symptoms.[28] Moreover, Canada loses an estimated $3.5 billion each year due to loss of productivity, loss of income, and missed days of work as a result of menopause-associated symptoms.[28]

Little evidence is available detailing inequities in the perimenopause and menopause experience in Ontario. Data from the United States have shown that Black people are 60% more likely to experience

bothersome and frequent vasomotor symptoms compared to White people,[29] but that they are half as likely to start menopausal hormone therapy.[30]

Given the proportion of the Ontario population that will inevitably experience perimenopause and menopause, and given the variation in care that people receive, this quality standard represents an important opportunity to identify and address gaps, and to promote high-quality, evidence-based menopause care.

Measurement to Support Improvement

The Menopause Quality Standard Advisory Committee identified 4 overarching indicators to monitor the progress being made toward improving care for people experiencing perimenopause and menopause in Ontario. These indicators are intended for use by those looking to implement the Menopause quality standard, including clinicians working in regional or local roles.

The committee did not identify any provincially measurable indicators because provincial data sources on menopause are limited, as is the ability to identify people experiencing perimenopause or menopause. When data sources or methods are developed that can accurately identify people in perimenopause, the committee will reconsider provincial measures of success for this quality standard.

Indicators That Can Be Measured Using Only Local Data

- Percentage of clinicians who have the knowledge and skills to provide treatment to people experiencing symptoms of perimenopause or menopause, including evidence-based menopausal hormonal therapy, non-hormonal medications, and nonpharmacological treatments
- Percentage of people aged 40 years or older who receive evidence-based information about perimenopause and menopause from their clinician
- Percentage of people experiencing perimenopause or menopause whose primary care clinician refers them to a clinician with expertise in menopause care when clinically indicated
- Percentage of people who report that their quality of life has improved since receiving menopause care

Quality Statement 1: Education for Clinicians

People experiencing perimenopause and menopause receive care from a clinician who has the knowledge and skills needed to provide evidence-based menopause care. Clinicians stay current with the knowledge and skills needed to provide evidence-based menopause care.

Source: Advisory committee consensus

Definition

Clinician who has the knowledge and skills: People experiencing perimenopause or menopause should not have to search for a clinician with the knowledge and skills to provide evidence-based menopause care; all clinicians should be able to provide this care. Knowledge and skills can be gained from formal or informal training, which can include the review of clinical practice guidelines and other evidence, continuing medical education, conferences, and other opportunities for self-directed learning. Clinicians should possess an understanding of the following:

- How to identify, assess, and treat menopause-associated symptoms during perimenopause and menopause[31]
- How perimenopause is associated with major physiological changes and presents an important window of opportunity to proactively optimize health, as well as the importance of taking time to discuss patients' current health status and the long-term implications of menopause[14,31]
- The evidence-based information that should be shared with people experiencing perimenopause or menopause (see quality statement 3)
- How to provide culturally appropriate care for people from racialized groups, and how to address the systemic barriers to high-quality health care that people from racialized groups commonly experience (e.g., racism, discrimination, stigma)[32]
- The influence of intersecting identities and experiences (e.g., trauma, health literacy, culture, race, ethnicity, socioeconomic status, gender identity, and sexual orientation) on menopause experiences and access to care
- When to refer to or seek advice from a clinician with expertise in menopause (see quality statement 6)

Rationale

Many clinicians have not had an opportunity to obtain the knowledge and skills they need to provide evidence-based menopause care; medical schools and postgraduate training curriculums do not routinely offer adequate training on this topic. Consequently, some clinicians have difficulty recognizing menopause-associated symptoms and offering appropriate treatment options.[33] Instead, they may attribute symptoms to other ailments (e.g., depression or a gynecological condition) without recognizing the context of perimenopause or menopause, leading to inappropriate treatment.[33] Moreover, some clinicians may hesitate to prescribe menopausal hormone therapy because of outdated research that inaccurately described associated risks – research that has since been reanalyzed and refuted (see quality statement 4).[34]

People who will experience perimenopause and menopause spend approximately a third of their lives navigating this phase of life. In a Canadian survey of people who sought medical advice for menopause, most respondents said that they saw their primary care clinician as their most trusted source of information and advice.[4] However, 72% of respondents also said that the advice they received was not helpful or only somewhat helpful. A qualitative study from the United Kingdom found that people who sought care for menopause-associated symptoms felt dismissed by their primary care clinician and were referred to menopause specialists who had long wait times and without receiving initial care.[33] Not surprisingly, some people feel that they have no choice but to turn to private clinics, where they must pay out of pocket and may risk receiving care that is not evidence-based. Others, for whom out-of-pocket payments is not an option, may feel that they have to suffer through their symptoms and endure the consequences for their quality of life and overall health.

It is critical that clinicians acquire the knowledge and skills necessary to provide comprehensive menopause care and that the health system enable opportunities for training so that clinicians can confidently identify menopause-associated symptoms, offer evidence-based treatment options, and help people optimize their health and well-being.

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

Your primary care clinician should have the knowledge and skills they need to provide menopause care. You should not have to look to other sources for information or care. Your clinician may get advice from a menopause specialist or refer you to a specialist if needed.

For Clinicians

Ensure that you have the knowledge and skills you need to provide evidence-based menopause care. Seek out and engage in educational opportunities if you need them. Primary care clinicians: Seek advice from or refer to a clinician with expertise in menopause when clinically indicated.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place for clinicians to acquire the training necessary to provide evidence-based menopause care. Ensure the availability of menopause-related training and resources for clinicians.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of clinicians who have the knowledge and skills needed to offer evidence-based menopause care (potential stratification: primary care clinicians and specialists)
- Percentage of people experiencing symptoms of perimenopause or menopause report receiving health care that is culturally appropriate and free from racism and discrimination

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 2: Identification and Assessment of Perimenopause and Menopause

Starting at age 40, people who will experience perimenopause and menopause are asked about menopause-associated symptoms to enable the early identification and assessment of perimenopause and menopause.

Sources: National Institute for Health and Care Excellence, 2024[10] | Advisory committee consensus

Definitions

People who will experience perimenopause and menopause: This includes women, Two-Spirit people, trans men, and nonbinary people assigned female at birth.

Menopause-associated symptoms: Menopause-associated symptoms, which result from hypoestrogenism (i.e., estrogen deficiency),[12] may begin during perimenopause or menopause, vary from minor to severe, and occur over short or long periods of time.[10] They can include:

- Changes in menstrual cycle[10,14]
- Vasomotor symptoms, such as hot flashes or night sweats[10,13,14]
- Symptoms of genitourinary syndrome of menopause, such as vaginal dryness[10,13]; discomfort with sexual intercourse[10]; vulvovaginal discomfort or irritation[10]; discomfort, pain, or urgency associated with urination[10,15]; or frequent urinary tract infections[35]
- Effects on mood, such as depressive symptoms[10] or anxiety[13,14]
- Musculoskeletal symptoms, such as joint and muscle pain[10,13,14]
- Sexual difficulties, such as low sexual desire[10,13,14]
- Sleep disturbances[13,14]
- Changes in weight and/or body fat distribution[14]
- Difficulties with concentration or memory[13,14]

People from certain racial or ethnic groups may experience symptoms at a younger age.[10] Cultural factors may affect how people experience or describe their symptoms.[36]

Identification and assessment: Identification of perimenopause or menopause is based on the menopause-associated symptoms that the person is experiencing.[10] Examples of tools that can be used to support a conversation about symptoms include the Menopause Quick 6 (MQ6) and the Menopause Rating Scale.

For some people, menopause can begin earlier than age 40 years; this is referred to as "premature ovarian insufficiency." A diagnosis of premature ovarian insufficiency is made after considering the person's clinical and family history, their menopause-associated symptoms (including no or infrequent periods and taking into account whether they have had a hysterectomy), and elevated levels of follicle-stimulating hormone on 2 blood samples taken 4 to 6 weeks apart. Premature ovarian insufficiency should not be diagnosed on the basis of a single blood test. If the diagnosis is uncertain, the person may be referred to a clinician with expertise in menopause (see quality statement 6).[10]

Laboratory and imaging tests are not indicated for most people, unless their symptoms are suggestive of an alternative diagnosis.[37,38] The following laboratory and imaging tests should *not* be used to identify perimenopause or menopause:

- Anti-Müllerian hormone[10]
- Inhibin A[10]
- Inhibin B[10]
- Antral follicle count[10]
- Ovarian volume[10]
- Estradiol (except in people under age 40 years with suspected premature ovarian insufficiency; people who have had a hysterectomy; or people who use an intrauterine device)[10]
- Follicle-stimulating hormone (except in people under age 40 years with suspected premature ovarian insufficiency; people aged 40 to 45 years who are experiencing menopause-associated symptoms, including changes in menstrual cycle; people who have had a hysterectomy; or people who use an intrauterine device)[10]

It can be difficult to identify perimenopause or menopause in people who are taking hormonal treatments (e.g., treatments for heavy menstrual bleeding[10] or oral contraceptives[38]). If clinically appropriate, it may be suitable for people to stop hormonal treatments temporarily to enable the accurate assessment and identification of perimenopause or menopause.

Rationale

The early identification of menopause-associated symptoms is crucial for timely intervention, support, and treatment. However, both patients and clinicians may be unaware of the full range of potential symptoms, leading them to misattribute symptoms to other causes.[33] People have reported that their clinician dismissed their symptoms, saying that they were too young to be experiencing perimenopause.[17] However, delayed identification results in delayed care and missed opportunities to address symptoms. As well, because menopause is associated with increased risk for bone loss and

cardiovascular disease,[14,19] delayed identification could also mean that a critical window of opportunity to optimize overall health is missed.[18]

Given the lack of awareness among the general public about menopause-associated symptoms, people may not realize that they have entered this stage if their clinicians do not start a conversation with them. In a Canadian survey, only 27% of respondents indicated that their primary care clinician had initiated a conversation about menopause.[4] Discussions are important because symptom reporting can vary greatly. Language and cultural perceptions can influence how people describe their symptoms, view menopause, determine when to seek medical attention, and advocate for themselves; in turn, these factors can influence how clinicians manage symptoms.[32,39] As well, some people may feel uncomfortable discussing certain symptoms with their clinician, such as changes related to sexual health.[33,35] Clinicians should be proactive about asking about all menopause-related symptoms, regardless of clinical presentation.

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

If you are aged 40 years or older, your clinician should ask you about whether you have any menopause symptoms. They should list all of the possible symptoms for you, so that you can talk about what you are experiencing and decide together whether you might be in perimenopause or menopause. For most people, identification of perimenopause or menopause is based on symptoms. Blood tests or imaging are not necessary.

For Clinicians

Ask people who are 40 or over about whether they have any menopause-associated symptoms to identify those who are experiencing perimenopause or menopause at the earliest opportunity. For most people, identification of perimenopause or menopause is based on symptoms; laboratory or imaging tests are not needed. Menopause is an important health transition and window of opportunity to proactively support people in optimizing their health and preventing disease. Initiate a conversation about potential symptoms even if the person is visiting for an unrelated concern. Support people in understanding all of the possible symptoms of perimenopause or menopause and be cognizant that different people may use different language to describe their symptoms. Avoid dismissing or minimizing any symptoms that people report.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place in all health settings for clinicians to identify and assess people who could be experiencing perimenopause or menopause; this includes access to assessment tools.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people aged 40 years or older who report that they can identify menopause-associated symptoms
- Percentage of people aged 40 years or older who report that their clinician proactively initiates conversations about menopause-associated symptoms

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 3: Evidence-Based Information for People Experiencing Perimenopause or Menopause

Starting at age 40, people who will experience perimenopause and menopause receive evidence-based information about perimenopause and menopause from their clinician.

Sources: National Institute for Health and Care Excellence, 2024[10] | Advisory committee consensus

Definitions

People who will experience perimenopause and menopause: This includes women, Two-Spirit people, trans men, and nonbinary people assigned female at birth.

Evidence-based information: This should include the following:

- A description of what menopause is:
  - Menopause is a natural and important health transition that usually takes place in midlife at a mean age of 51 years[9] or on average between the ages of 45 to 55 years[10]
  - Perimenopause is the time preceding menopause; it can last up to 10 years[3]
  - Menopause can happen earlier in life as a result of surgery or medical treatment, an inherited condition, or an unknown cause[10]
  - Premature ovarian sufficiency is the occurrence of menopause before age 40 years; early menopause is the occurrence of menopause between the ages of 40 and 44 years[10]
- The symptoms associated with perimenopause and menopause (see quality statement 2)
- Information about how symptoms can range from minor to severe, can be experienced over a short or long time,[10] and can negatively affect quality of life[40]
- Confirmation that perimenopause and menopause are not medical conditions that require treatment, but that associated symptoms should be treated proactively if they are affecting a person's quality of life
- Information about how menopause is associated with major physiological changes that have broader health implications, such as:
  - Changes in metabolic health[18,41] and an accelerated increase in cardiovascular risk factors,[42,43] including elevated blood pressure, cholesterol, and blood glucose levels[42,43]

  - Up to 10% loss of bone mineral density during late perimenopause and the first postmenopausal years[14,19,44]
- The importance of keeping up to date with recommended health screening for breast cancer,[10,31] cervical cancer,[31] and cardiovascular risk factors (i.e., diabetes, hypertension, cholesterol)[12]
- Information about how to optimize bone health and prevent bone loss[10]
- Information about how menopause presents a critical window of opportunity for health promotion and preventative strategies,[14,18] including lifestyle modifications that can optimize health:
  - Weight management[13-15,42,45]
  - Blood pressure management[9,42]
  - Smoking cessation[14,15,42,45,46]
  - Minimizing alcohol[14,15,45,46]
  - Engaging in regular physical activity[10,13,14,42,46,47] and strength training to maintain muscle mass[10,13,46]
  - Maintaining a healthy diet (e.g., a diet high in fibre, protein, and unsaturated fats)[13,14,42,47]
  - Limiting caffeine intake[14,15]
  - Getting sufficient sleep[42]
- Treatment options available to manage symptoms, and the benefits and risks associated with each option (see quality statements 4 and 5)[10]
- Safety concerns associated with compounded bioidentical hormone therapy – an unregulated hormone preparation marketed as an alternative to Health Canada–approved hormone therapies (see quality statement 4)[40,48]
- Information about contraception (for people in perimenopause)[10]
- Support and information about fertility for people who are likely to experience menopause as a result of medical or surgical treatment[10]

Rationale

Quality of life and overall health improve when people have a better understanding of perimenopause and menopause.[49] However, if people do not receive evidence-based information from their clinician, they must navigate the potential misinformation that is widely available on the Internet and social media,[49] an example being false claims about the safety and effectiveness of compounded bioidentical hormone therapy (see quality statement 4).[50] Sociocultural expectations and influences also shape how people in perimenopause and menopause seek information; some may view it as a taboo topic that is not to be discussed.[17] Some people may view menopause as a natural transition that does not require medicalization.[17]

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

If you are aged 40 years or older, your clinician should give you reliable information about perimenopause and menopause. The information should include what menopause is, the symptoms of perimenopause and menopause, the potential effects of menopause on your heart and bones, ways to care for your health during menopause, and treatment options for any symptoms you may have.

For Clinicians

Take a proactive approach to sharing evidence-based information with people aged 40 years or older who may be experiencing or about to experience perimenopause or menopause. Engage in discussions that help people understand perimenopause and menopause; address any misinformation that people may have acquired.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place for clinicians to offer evidence-based information about perimenopause or menopause.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people aged 40 years or older who receive evidence-based information about perimenopause and menopause from their clinician
- Percentage of people aged 40 years or older who report that the information they received from their clinician about perimenopause and menopause was useful
- Percentage of people aged 40 years or older who report that their clinician addressed their questions about perimenopause and menopause

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 4: Management of Vasomotor Symptoms

People experiencing vasomotor symptoms during perimenopause and menopause are offered menopausal hormone therapy as first-line treatment, following an assessment of risks, benefits, contraindications, and individual needs and preferences. People who have contraindications to menopausal hormone therapy or who do not desire it are offered other evidence-based treatment options, including non-hormonal medications and nonpharmacological treatments.

Sources: National Institute for Health and Care Excellence, 2024[10] | Obstetrical and Gynaecological Society of Malaysia and the Malaysian Menopause Society, 2022[14] | Society of Obstetricians and Gynaecologists of Canada, 2021[13,15,45,51]

Definitions

Vasomotor symptoms: Hot flashes or night sweats,[10,13] which can begin during perimenopause.[40] Sometimes, hot flashes can be accompanied by anxiety or heart palpitations.[13]

Menopausal hormone therapy: A first-line treatment for vasomotor symptoms that can be safely offered as a choice for people who are younger than age 60 years or less than 10 years postmenopause.[13,14,40,51] Clinicians should review recent guidelines and position statements[10,13,14,45,51] for guidance (e.g., indications, dosing) and to ensure familiarity with the latest evidence.

Menopausal hormone therapy should not be withheld for people who are in perimenopause; however, contraceptive needs and bleeding patterns must be considered when choosing an optimal therapy (see quality statement 5). Options for people in perimenopause include low-dose combined hormonal contraceptives; menopausal hormone therapy usually with a cyclical progestogen in people with oligomenorrhea; estrogen in combination with a levonorgestrel-releasing intrauterine system; or progestogen alone.[13,14]

When discussing menopausal hormone therapy as a treatment option, the following should be considered:

- Combined versus estrogen-only:
  - For people with a uterus, offer combined menopausal hormone therapy after discussing the options and identifying the one that best balances benefits and risks[10,14]
  - When offering combined menopausal hormone therapy, the choice of progestogen should favour those least likely to affect markers for cardiovascular disease[51]
  - For people with a uterus, vaginal bleeding is a common side effect of systemic menopausal hormone therapy during the first 3 months of treatment; advise people to seek help if this persists beyond 3 months[10]
  - For people who have had a total hysterectomy, offer estrogen-only menopausal hormone therapy after discussing the options and identifying the one that best balances benefits and risks[10,14,40,45]
  - Explain that taking combined or estrogen-only menopausal hormone therapy is unlikely to affect overall life expectancy[10]
- Transdermal versus oral:
  - Consider transdermal options for people who are at increased risk of venous thromboembolism[10,14] or stroke,[14] or who have comorbidities such as hypertension,[52] obesity,[14,52] dyslipidemia,[14,52] or active gallbladder disease[14]
- Cyclic versus continuous combined:
  - Cyclic menopausal hormone therapy is appropriate for people in perimenopause[14]
  - Continuous combined menopausal hormone therapy is appropriate for people who are 1 year past their final menstrual period[14]
  - Estrogen-only menopausal hormone therapy can be taken every day by people who have had a total hysterectomy[13]
- Dose and duration:
  - Use the lowest effective dosage of estrogen[10,13,51]
  - There is no recommended duration or stop time for menopausal hormone therapy; the duration should be individualized based on ongoing symptoms, benefits, and personal risks; this should be re-evaluated periodically[13,14]
  - Discuss the possible duration of treatment at initiation; at every review, discuss the benefits and risks of continuing treatment[10]
  - Explain that symptoms could return when menopausal hormone therapy is stopped; discuss the option of restarting if necessary or desired[10]
  - For people who are stopping menopausal hormone therapy, offer the choice of gradually reducing or immediately stopping treatment (gradually reducing treatment may limit the recurrence of symptoms in the short term, but there is no difference in the longer term)[10]
  - Stop systemic menopausal hormone therapy in people who are diagnosed with breast cancer[10]

Assessment of risks, benefits: The choice of menopausal hormone therapy should be individualized after considering the person's age, symptoms, medical conditions, health risks, and family history, as well as the timing of their final menstrual period.[13]

Contraindications: Contraindications to systemic menopausal hormone therapy include the following:

- Contraindications to estrogen:
  - Undiagnosed abnormal vaginal bleeding[13,40]
  - Active breast cancer, suspected breast cancer, or a personal history of breast cancer[13]
  - Active estrogen-dependent cancers or suspected estrogen-dependent cancers (i.e., endometrial, ovarian)[13,40]
  - Coronary heart disease[13,40]
  - Active venous thromboembolism or history of venous thromboembolism[13,40]
  - Active stroke or history of stroke[13,40]
  - Known thrombophilia[13,40]
  - Active liver disease[13,40]
  - Known or suspected pregnancy[13]
- Contraindications to progestogen:
  - Undiagnosed abnormal vaginal bleeding[13]
  - Active breast cancer or personal history of breast cancer[13]

People with certain contraindications may still be able to use menopausal hormone therapy.[52] For people with a contraindication or a condition that may be affected by menopausal hormone therapy, consider seeking advice on the choice of therapy from a clinician with specialist knowledge of that condition[10] or referring the person to a clinician with expertise in menopause (see quality statement 6).

Individual needs and preferences: Considers the person's values, preferences, and treatment goals, as well as the affordability of each treatment option.

Evidence-based non-hormonal medications: Non-hormonal medication options include:

- Gabapentin[13,14,45,53]
- Certain selective serotonin reuptake inhibitors and serotonin–norepinephrine reuptake inhibitors[14,45,53] (should not be offered as first-line treatment for vasomotor symptoms alone[10])
- Oxybutynin[45,53]

These treatment options may offer relief from vasomotor symptoms, but they may have their own adverse effects.[13]

Evidence-based nonpharmacological treatments: Nonpharmacological treatment options include:

- Cognitive behavioural therapy,[10,14,45,53] which can include face-to-face or remote sessions, individual or group sessions, and self-help options, depending on the person's preferences and needs[10]
- Clinical hypnosis[13,14,53]

Rationale

Vasomotor symptoms are the most common menopause-associated symptom, affecting 80% of people and lasting for a median of 7 years after the last menstrual period.[16] These symptoms have negative effects on quality of life,[13] and their presence has been independently linked with an increase in cardiovascular risk factors.[43,54,55] Early-onset and persistently frequent vasomotor symptoms have been associated with more adverse health and psychosocial issues than less frequent symptoms.[56]

Current clinical practice guidelines recommend the use of menopausal hormone therapy as first-line treatment for vasomotor symptoms for people in perimenopause or menopause.[13,14,40,51] Evidence demonstrates its benefits, such as the prevention of bone loss[40] and postmenopausal osteoporosis,[40] reductions in fracture risk in healthy postmenopausal people,[10,40,57,58] and relief of symptoms of genitourinary syndrome of menopause (see quality statement 5).[40] Still, clinicians report hesitation in prescribing it.[22,23] This hesitation has been attributed largely to the legacy of the Women's Health Initiative, an influential randomized study launched in 1998 that aimed to evaluate the effects of menopausal hormone therapy. Previously published results inaccurately described the risks associated with menopausal hormone therapy. These findings have since been reanalyzed and refuted, but uncertainty around its use persists.[34] A study published in 2018 reported that only 9.5% of eligible Canadian women were using menopausal hormone therapy, and 21.9% reported past use.[59]

If people experiencing vasomotor symptoms have contraindications or prefer not to take menopausal hormone therapy, non-hormonal medications and nonpharmacological treatment options are available. Fezolinetant, a neurokinin B antagonist, is a new non-hormonal pharmacological option for the treatment of vasomotor symptoms[53,60] that was approved by Health Canada in 2024.

Safe and effective options for the treatment of vasomotor symptoms are widely available. Collaborative, shared decision-making between clinicians and people experiencing perimenopause or menopause ensures that people are offered the opportunity to select a treatment option that best aligns with their needs and preferences.

Note: "Compounded bioidentical hormone therapy" is an unregulated hormone preparation that has been marketed as an alternative to Health Canada–approved hormone therapies. Several safety concerns exist related to its use, including minimal government regulation and monitoring, overdosing and underdosing, the presence of impurities and lack of sterility, the lack of scientific efficacy and safety data, and the lack of a label outlining risks.[40,48] Compounded bioidentical hormone

therapy is not approved by Health Canada, is not considered standard of care, and should not be offered in place of pharmaceutical-grade menopausal hormone therapy.[40,61,62]

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

If you are having hot flashes or night sweats and you would like to receive treatment, your clinician should offer you menopausal hormone therapy. If you cannot take menopausal hormone therapy or prefer not to take it, your clinician should offer you other treatment options. Your clinician should assess your overall health so you can work together to choose the treatment option that is best for you.

Your clinician may ask you how bothersome your symptoms are. Whether or not a symptom is bothersome is entirely up to you. If your hot flashes or night sweats affect your quality of life, your clinician should offer you treatment. If you try a medication and you are not feeling well on it or do not notice improvement in your symptoms, talk with your clinician to see if you can try something else.

For Clinicians

Clinical practice guidelines recommend menopausal hormone therapy as first-line treatment for vasomotor symptoms. Offer people experiencing vasomotor symptoms the option of menopausal hormone therapy following an assessment of risks, benefits, contraindications, and people's needs and preferences. Talk with people about their concerns and share evidence-based information about menopausal hormone therapy, including its safety and effectiveness. Offer evidence-based non-hormonal and nonpharmacological treatment options to those who have contraindications to menopausal hormone therapy or who prefer not to take it.

Reassure people that treatment decisions should be informed by their individual experience of symptoms and their own interpretation of how bothersome the symptoms are. For most people experiencing perimenopause or menopause, referral to a clinician with expertise in menopause is not typically necessary for consideration of menopausal hormone therapy.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place, and that educational opportunities are available, so that clinicians can appropriately offer menopausal hormone therapy or evidence-based non-hormonal or nonpharmacological treatment options to people experiencing perimenopause or menopause.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people experiencing vasomotor symptoms whose clinician offers them menopausal hormone therapy as first-line treatment
- Percentage of people experiencing vasomotor symptoms who have contraindications to menopausal hormone therapy or do not desire it and whose clinician offers them other evidence-based treatment options, including non-hormonal medications and nonpharmacological treatments
- Percentage of people experiencing perimenopause or menopause who feel involved in discussions with their clinician about their medication options, including risks, benefits, contraindications, and individual needs and preferences

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 5: Management of Non-Vasomotor Symptoms

People experiencing non-vasomotor symptoms (including those related to genitourinary syndrome of menopause, sexual health, mental health, sleep, and cognition) during perimenopause and menopause are offered evidence-based treatment options and have their contraceptive needs addressed.

Sources: National Institute for Health and Care Excellence, 2024[10] | Obstetrical and Gynaecological Society of Malaysia and the Malaysian Menopause Society, 2022[14] | Society of Obstetricians and Gynaecologists of Canada, 2021[15,45,47,63]

Definitions

Non-vasomotor symptoms: People experiencing perimenopause or menopause may experience symptoms other than vasomotor symptoms, including:

- Changes in menstrual cycle[10,14]
- Symptoms of genitourinary syndrome of menopause, such as vaginal dryness[10,13]; discomfort with sexual intercourse[10]; vulvovaginal discomfort or irritation[10]; discomfort, pain, or urgency associated with urination[10,15]; or frequent urinary tract infections[35]
- Effects on mood, such as depressive symptoms[10] or anxiety[13,14]
- Musculoskeletal symptoms, such as joint and muscle pain[10,13,14]
- Sexual difficulties, such as low sexual desire[10,13,14]
- Sleep disturbances[13,14]
- Changes in weight and/or body fat distribution[14]
- Difficulties with concentration or memory[13,14]

Evidence-based treatment options:

- For symptoms of genitourinary syndrome of menopause:
  - Non-hormonal options are readily available over the counter and include vaginal lubricants and moisturizers,[10,15] which are particularly helpful for people experiencing vaginal dryness or pain during sexual intercourse. Lubricants work by reducing friction during intercourse and can be used as needed[15]; moisturizers require regular application and provide more

continuous relief than lubricants.[15] Non-hormonal options may be suitable for those who cannot or prefer not to use hormonal options[10]

- Hormonal options are available with a prescription and include vaginal estrogen (in the form of a cream, tablet, pessary, or ring). Vaginal estrogen improves blood supply to the urogenital tissues[15]; it can be used alongside systemic menopausal hormone therapy and in combination with non-hormonal lubricants and moisturizers.[10,35] Vaginal estrogen is absorbed locally, and only a minimal amount reaches the bloodstream (compared to systemic menopausal hormone therapy).[10] Because vaginal estrogen is unlikely to have a substantial systemic effect,[10] progestogen therapy is not needed.[15] Serious adverse events from the use of vaginal estrogen are very rare.[10,14] Symptoms often return when vaginal estrogen is stopped, but treatment can be restarted if necessary[10,35]
- Other hormonal treatment options for atrophic vaginal symptoms include dehydroepiandrosterone (DHEA, also known as prasterone) ovules and ospemifene.[15] DHEA is an intravaginal treatment that can be considered if non-hormonal options or vaginal estrogen have been ineffective or not tolerated.[10] Ospemifene, a selective estrogen receptor modulator, is an oral treatment for moderate to severe dyspareunia (painful sexual intercourse) and vaginal dryness.[15] It can be considered if the use of locally applied treatments is impractical (e.g., due to disability)[10] or not desired

- For symptoms related to sexual health, such as low sexual desire:
  - To facilitate appropriate treatment, the person's symptoms should be identified as being related to desire, arousal, pain, or orgasm[63]
  - Testosterone supplementation can be offered to people with low sexual desire associated with menopause,[63] if menopausal hormone therapy alone is not effective[10]
  - Other options for managing low sexual desire in postmenopausal people include managing pain, addressing biopsychological factors, or counselling[63]
- For symptoms related to mental health, such as depressive symptoms or anxiety:
  - For people in perimenopause experiencing depressive symptoms that do not meet the criteria for a diagnosis of depression, treatment options include menopausal hormone therapy[10,47] and/or cognitive behavioural therapy,[10] which can include face-to-face or remote sessions, individual or group sessions, and self-help options, depending on the person's preferences and needs[10]
  - For people with a diagnosis of depression, refer to the Ontario Health quality standard *Major Depression: Care for Adults and Adolescents*[64]
  - For people with an anxiety disorder, refer to the Ontario Health quality standard *Anxiety Disorders: Care in All Settings*[65]

- For symptoms related to sleep:
  - An initial approach should include education about sleep hygiene, ruling out primary sleep disorders and addressing vasomotor symptoms.[47] For people with insomnia disorder, refer to the Ontario Health quality standard *Insomnia Disorder: Care for Adults*[66]
  - Menopausal hormone therapy may improve sleep in people who have vasomotor symptoms, because these symptoms are an important contributor to sleep disruption[47]
  - Other options that have shown benefit for sleep include cognitive behavioural therapy for insomnia[10,47] and aerobic exercise[47]
- For symptoms related to cognition:
  - Lifestyle modifications can be encouraged to reduce the risk of cognitive decline, such as increasing aerobic exercise, including more vegetables in the diet, and limiting the potential influence of hypertension, diabetes, and atherosclerotic disease[47]
  - Menopausal hormone therapy has not been shown to significantly improve measures of cognitive function over several years of use[47]

Contraceptive needs: Because pregnancy can still occur during perimenopause, contraceptive needs should be considered and addressed.[12] The choice of contraceptive method should be individualized and consider the effectiveness, risks, benefits, and side effects of all available methods. Certain contraceptive methods may offer benefits that also alleviate some menopause-associated symptoms.[67] Combined oral contraceptives can be considered to address irregular bleeding.[12]

Rationale

Non-vasomotor symptoms experienced during perimenopause or menopause can be distressing and affect quality of life.[68] In particular, symptoms associated with genitourinary syndrome of menopause can have substantial adverse affects on a person's daily living, quality of life,[69-71] and sexual health.[71] Unlike other menopause-associated symptoms (which usually improve with time), symptoms of genitourinary syndrome of menopause generally persist and worsen without effective treatment,[70,72] because of functional and structural changes to urogenital tissues that can be difficult to reverse.[15] Racial and ethnic disparities exist in the experience of genitourinary syndrome of menopause: in the US Study of Women's Health Across the Nation, Black people in menopause reported vaginal dryness more often than White people.[73]

Awareness of genitourinary syndrome of menopause and available treatment options is low, and this topic is not frequently discussed during clinician visits.[72] For this reason, clinicians should share information about the progressive impact of estrogen deficiency,[15] proactively inquire about symptoms in all people experiencing perimenopause and menopause,[35] and offer evidence-based treatment options. In addition to the treatment options for genitourinary symptoms listed above, pelvic floor physiotherapy may be beneficial for people experiencing pain during sexual intercourse.[15]

Other non-vasomotor symptoms during perimenopause or menopause should be addressed to optimize quality of life. Perimenopause is a particularly vulnerable period for the development

of depressive symptoms and major depressive episodes, even in people without a history of depression. Depressive symptoms are highly prevalent but often under-recognized and undertreated.[47] It is important to recognize these symptoms in the context of perimenopause or menopause so that they can be treated appropriately.[33] Symptoms related to sleep – including poor sleep quality – are also common among people in perimenopause and menopause. Cognitive symptoms, such as worsening memory or slower cognitive speed (sometimes described as "brain fog"), are an important concern for many people.[47]

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

Hot flashes are not the only symptom of perimenopause and menopause. Other symptoms include vaginal dryness, mood changes, joint or muscle pain, pain during sex, trouble sleeping, weight changes, and brain fog. Your clinician should offer a safe and comfortable environment for you to talk about your symptoms. They should talk with you about treatment options so that you can work together to choose what that is best for you. You can still get pregnant during perimenopause; your clinician should talk to you about contraception options in case you need them.

For Clinicians

Ask patients about their non-vasomotor symptoms and offer evidence-based treatment options that align with their needs and preferences. Offer a safe environment for discussion and help normalize conversation about their experiences: symptoms related to genitourinary syndrome of menopause or sexual health can be especially uncomfortable for people to talk about. Inform patients that pregnancy is possible during perimenopause and ask them about their contraceptive needs. Provide people with the information they need to engage in informed, shared decision-making about treatment options.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place, and that educational opportunities are available, so that clinicians can appropriately offer evidence-based treatment options to people experiencing non-vasomotor symptoms associated with perimenopause or menopause.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people experiencing perimenopause or menopause who report that their clinicians always or often involve them in decisions about evidence-based treatment options for non-vasomotor symptoms (including those related to genitourinary syndrome of menopause, sexual health, mental health, sleep, and cognition)

- Percentage of people experiencing genitourinary syndrome of menopause who are offered evidence-based treatment options by their clinician

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 6: Appropriate Referral to a Clinician With Expertise in Menopause

People experiencing perimenopause or menopause receive assessment and treatment from their primary care clinician and, if clinically indicated, are referred to a clinician with expertise in menopause.

Source: National Institute for Health and Care Excellence, 2024[10]

Definitions

Clinically indicated: Clinical indications for referral to a clinician with expertise in menopause include the following:

- No improvement in menopause-associated symptoms with treatment, or experiencing continued side effects[10]
- Menopause-associated symptoms and contraindications to menopausal hormone therapy[10] (see quality statement 4)
- Uncertainty about a diagnosis of premature ovarian insufficiency[10]
- Menopause-associated symptoms in a person who has taken gender-affirming hormone therapy in the past[10]

Clinician with expertise in menopause: A clinician who has the specialist knowledge, skills, and training to provide care to people with complex menopause-related needs or risk factors that may affect decision-making, such as complex medical conditions that may affect the use of certain treatments for menopause-associated symptoms.[10]

Rationale

For most people, evidence-based menopause care should be provided by their primary care clinician. However, sometimes people experiencing perimenopause or menopause may require care from a clinician with expertise in menopause, depending on their response to treatment or health history.

Given that there are often long wait times to access care from a clinician with expertise in menopause, people should be referred only when necessary and appropriate. Before referral, people should receive assessment (see quality statement 2) and treatment (see quality statements 4 and 5) from their primary care clinician, so that they do not experience delays in receiving initial care. In

some cases, a phone or secure electronic consultation between clinicians may be sufficient and may also help build capacity among primary care clinicians.

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

Your primary care clinician may need to ask for advice or refer you to another clinician who specializes in menopause. This is usually an obstetrician-gynecologist, but it might also be an endocrinologist or another primary care clinician. Before they refer you, your primary care clinician should assess you thoroughly and offer you treatment so that you do not have to wait to manage your symptoms. If you would like to ask for a referral, talk to your primary care clinician.

For Clinicians

Primary care clinicians: Assess people experiencing perimenopause or menopause and offer treatment before considering referral to a clinician with expertise in menopause. Refer when it is clinically indicated, when you feel you do not yet possess the knowledge and skills to provide appropriate care, or when your patient requests a referral. Provide a detailed referral, including the person's symptoms, treatment, and the clinical indication for referral (i.e., when symptoms do not improve with treatment or a person experiences continued side effects; when a person has menopause-associated symptoms and contraindications to menopausal hormone therapy; when there is uncertainty about a diagnosis of premature ovarian insufficiency; or when a person who has taken gender-affirming hormone therapy in the past is experiencing menopause-associated symptoms).

You may also choose to seek advice from a clinician who has expertise in menopause to inform the care you provide. In certain circumstances, it may be appropriate or even preferable for the consultation to be held virtually via telephone or other remote technology (e.g., the Ontario eConsult Program).

For Organizations and Health Services Planners

Ensure the availability of clinicians with expertise menopause. Ensure that systems, processes, and resources are in place for primary care clinicians to seek advice from these clinicians. Services may be delivered virtually via telemedicine or other technologies.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people experiencing perimenopause or menopause who receive assessment and treatment from their primary care clinician before being referred to a clinician with expertise in menopause

- Percentage of people experiencing perimenopause or menopause whose primary care clinician refers them to a clinician with expertise in menopause when clinically indicated
- Wait time between referral to a clinician with expertise in menopause care and first consultation

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Appendix 1: About This Quality Standard

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For People Experiencing Perimenopause or Menopause

This quality standard consists of quality statements. These describe what high-quality care looks like for people experiencing perimenopause or menopause.

Within each quality statement, we have included information on what these statements mean for you as a patient.

In addition, you may want to download this accompanying patient guide on menopause to help you and your family have informed conversations with your clinicians. Inside, you will find information and questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people experiencing perimenopause or menopause. They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality, evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions, available in the technical specifications. Measurement is key to quality improvement. Collecting and using data when implementing a quality standard can help you assess the quality of care you are delivering and identify gaps in care and areas for improvement.

There are also a number of resources online to help you, including:

- Our patient guide on menopause, which you can share with patients and families to help them have conversations with you and their other clinicians. Please make the patient guide available where you provide care
- Our measurement resources, including the technical specifications for the indicators in this quality standard, the “case for improvement” slide deck to help you to share why this standard

was created and the data behind it, and our measurement guide containing supplementary information to support the data collection and measurement processes

- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where clinicians can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the quality standard, which included extensive consultation with clinicians and lived experience advisors and a careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

Appendix 2: Glossary

Term	Definition
Care partner	An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person with [condition]. Other terms commonly used to describe this role include "caregiver," "informal caregiver," "family caregiver," "carer," and "primary caregiver."
Clinicians	Regulated professionals who provide care to patients or clients. Examples are nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, social workers, and speech-language pathologists.
Culturally appropriate care	Care that incorporates cultural or faith traditions, values, and beliefs; is delivered in the person's preferred language; adapts culture-specific advice; and incorporates the person's wishes to involve family or community members.[74]
Health care team	Clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, child life specialists, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.
Menopausal hormone therapy	A prescription medication containing hormones that is recommended as first-line treatment for vasomotor symptoms in people experiencing perimenopause or menopause.[13,40]
Menopause	The day on which 12 months have passed since a person's last menstrual period. The term *menopause* is commonly used to refer to both menopause and postmenopause, which refers to the time from this day until end of life.[4,5]
People who will experience perimenopause or menopause	This includes women, Two-Spirit people, trans men, and nonbinary people assigned female at birth.
Perimenopause	The time before menopause (also called "the menopause transition"[1]), which begins when people experience persistent variation of 7 or more days in the length of their menstrual cycles.[2] The duration of this stage varies, but it can last up to 10 years for some,[3] and during this time menopause-associated symptoms may occur.

Term	Definition
Primary care	A setting where people receive general health care (e.g., screening, diagnosis, and management) from a clinician who the person can access directly without a referral. This is usually the primary care clinician, family physician, nurse practitioner, or other clinician with the ability to make referrals, request laboratory testing, and prescribe medications.
Primary care clinician	A family physician (also called a primary care physician) or nurse practitioner.

Appendix 3: Values and Guiding Principles

Values That Are the Foundation of This Quality Standard

This quality standard was created and should be implemented according to the *Patient, Family and Caregiver Declaration of Values for Ontario*. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

A quality health system is one that provides good access, experience, and outcomes for all people in Ontario, no matter where they live, what they have, or who they are.

Guiding Principles

In addition to the above values, this quality standard is guided by the principles outlined below.

Acknowledging the Impact of Colonization

Clinicians should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities, as well as recognizing their strength and resilience. This quality standard uses existing clinical practice guideline sources that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

French Language Services

In Ontario, the *French Language Services Act* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 27 designated areas and at government head offices.[75]

Social Determinants of Health

Homelessness and poverty are 2 examples of economic and social conditions that influence people's health, known as the social determinants of health. Other social determinants of health include employment status and working conditions, race and ethnicity, food security and nutrition, gender, housing, immigration status, social exclusion, and residing in a rural or urban area. Social determinants of health can have strong effects on individual and population health; they play an important role in understanding the root causes of poorer health. People with a mental illness or addiction often live under very stressful social and economic conditions that worsen their mental health,[76] including social stigma, discrimination, and a lack of access to education, employment, income, and housing.[77]

Self-Management

People experiencing perimenopause or menopause and their families, care partners, and personal supports should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management.[78] Further, people should be empowered to make informed choices about the services that best meet their needs.[79] People experiencing perimenopause or menopause should engage with their clinicians in informed, shared decision-making about their treatment options. Each person is unique and has the right to determine their own path toward health and well-being.[78]

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma, the impact that traumatic experiences can have on human beings, and the potential to traumatize or retraumatize patients when providing them with care.[80,81] A trauma-informed approach does not necessarily involve addressing the trauma directly. Rather, it involves acknowledging that a person may have experienced a previous traumatic event that may contribute to their current health concerns, and taking steps to reduce opportunities for traumatization (e.g., using active strategies around consent, attending to individual patient needs, recognizing the inherent power imbalance in clinician–patient relationships, and facilitating greater patient agency and choice in all interactions).[82,83] A trauma-informed approach emphasizes the creation of an environment in which a person can feel comfortable disclosing trauma, and it involves understanding, respecting, and responding to the effects of trauma.[81-83]

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We are an agency created by the Government of Ontario to connect, coordinate, and modernize our province's health care system. We work with partners, providers, and patients to make the health system more efficient so everyone in Ontario has an opportunity for better health and well-being.

Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an *Equity, Inclusion, Diversity and Anti-Racism Framework*, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach.

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

For more information about Ontario Health, visit OntarioHealth.ca.

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