



Women's Health is Workforce Health

What the data shows and how organizations
can respond with care and clarity in 2026



Contents

A research-grounded look at why women's health has become a structural workforce issue, what the evidence shows it is costing employers, and how integrated infrastructure produces a measurable retention and cost advantage.

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The workforce has already changed. The infrastructure has not.

Women now represent nearly half the US labor force and drove two-thirds of US job growth between 2024 and 2026. The organizational infrastructure designed to support their health has not kept pace, with their workforce presence, their documented health needs, or the measurable cost of leaving those needs unaddressed.

\$400B

Annual GDP impact globally from four conditions disproportionately affecting working women: menopause, PMS, endometriosis, migraines.

6.5%

Projected rise in employer health benefit costs per employee in 2026, the highest jump since 2010.

60%

Of senior-level women report feeling frequently burned out, at the career stage organizations need them most.

5.5×

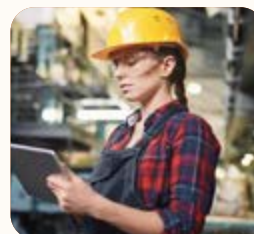
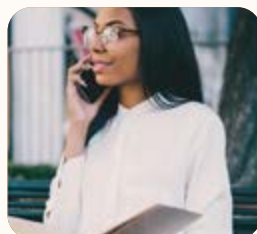
More likely employees are to leave when mental health does not feel supported at work.

What this paper covers

Drawing on 2025–2026 data from the McKinsey Health Institute, World Economic Forum, Mayo Clinic Proceedings, the Bureau of Labor Statistics, WebMD Health Services, and other independent research, this paper makes a structural argument: the costs of inaction on women's health are large, growing, and concentrated in line items most benefits strategies were never designed to capture.

Part 1 examines the workforce context driving this moment. **Part 2** documents the costs organizations are currently absorbing. **Parts 3 and 4** present the evidence on integrated support, what a full-lifecycle approach looks like in practice, and what HR leaders can do now.

Work has changed, and so have the needs of the people in it. Supporting women's health at every stage of their careers is not just forward thinking anymore, it's fundamental.



Where the cost is hiding

Caregiving-related productivity losses average **\$5,600 per caregiving employee annually**, before burnout and healthcare cost premiums are factored in.¹⁶ Only **24 percent** of women know their employer offers clinician access for menopause care, even when it exists.⁸ The benefits gap and the awareness gap compound each other.

The conditions driving the highest claims among working-age women are among the most preventable with earlier, integrated care, and among the most expensive when they finally surface in claims data. Rising 2026 deductibles mean women are absorbing more of those costs personally at exactly the moment those needs are most acute.

Where the advantage is

Organizations that build integrated women's health infrastructure now while most competitors are still assembling point solutions, will have a measurable advantage in retention rates, healthcare cost trajectories, and leadership pipeline depth over the next three to five years.

92%

of LifeSpeak members say access makes them more likely to stay with their employer.¹⁸

97%

say it helps them manage stress and prevent burnout.¹⁸

58%

of women with access to menopause-related benefits report a positive effect on work performance.⁸

What HR leaders should take from this paper

The infrastructure question is no longer whether to address women's health — 83 percent of employers say they will implement at least one women's health strategy this year.⁷ The question is whether that strategy is a single point solution or an integrated approach designed for the full arc of a career. The first organizations to make that shift will define the new standard.





PART 1

The workforce story 2026 is writing.

Women drove two-thirds of US job growth between 2024 and 2026.
The organizational response, in most cases, has not kept pace.

A consumer revolution in women's health is reshaping what employees expect at work.

Women's health has become one of the largest, fastest-growing categories in the global economy. The global women's health market is on track to reach \$57 billion in 2026, nearly doubling to \$91 billion by 2035.¹ Women's digital health is expanding at more than 20 percent annually. Venture capital poured \$2.6 billion into femtech in 2024 alone.² Menopause clinics have waitlists months long. Fertility tracking, perimenopause education, postpartum mental health, endometriosis communities, these are topics that had no mainstream language a decade ago now have bestselling books, sold-out retreats, and millions of engaged followers.

To understand why this moment arrived when it did, one fact is worth naming. For most of modern medical history, the default research subject was male. Women were largely excluded from clinical research trials in the United States until the early 1990s. Treatments, diagnostics, and health guidance were built on that foundation.

What is happening in consumer health right now is, in significant part, women filling that gap themselves — because the institutions around them never fully did. **That expectation does not clock out when work begins.**

The household behind the employee

Women manage a disproportionate share of their household's health logistics: pediatric appointments, specialist coordination for aging parents, insurance follow-ups, prescription management. In many households, a woman is the primary health decision-maker for everyone around her, often while her own needs go unaddressed.

When an employer builds something designed to support a woman's health rather than just her output, it can be one of the few times an institution has directed that care toward her. Organizations that do this well create conditions where women are more likely to stay, perform, and advance. The ones that do not leave a gap that benefits surveys will eventually document.

1 in 4

women has considered quitting or has quit her job in the past 12 months.³

~50%

of working women report feeling burned out.⁶

41%

of employees say employers should actively support women's health, including menstruation and menopause.³

Women are the primary growth engine of the US labor market.

The gender gap in labor force participation hit its lowest recorded level in early 2026.⁴ Two-thirds of the 1.2 million jobs added between February 2024 and February 2026 went to women.⁵ Women now represent nearly half of the total US labor force, concentrated heavily in health care, education, and professional services — the sectors most organizations depend on for institutional continuity.

The question is whether the organizations that depend on them have built the infrastructure to match.

Two-thirds of US job growth (Feb 2024 – Feb 2026) went to women

Share of net new US jobs added, by gender

Women — 66%

Men — 34%

Source: Indeed Hiring Lab analysis of BLS data, March 2026.⁵

The expectation gap

At precisely the moment women's workforce presence has reached a historic high, and at the same moment consumer culture has raised women's expectations of institutional support to a new standard, organizational commitment to women's advancement has contracted sharply.

Only 50 percent of companies now cite women's career advancement as a high priority. In the post-pandemic years, that number was 70 percent. Active allyship is at a four-year low. Cultural barriers to women's progression grew by seven points year over year. Flexibility, the structural accommodation that most directly sustained women's participation through the pandemic recovery, is being pulled back across industries.⁶

Women who work mostly remotely are already significantly less likely to receive promotions or sponsorship than their male counterparts in equivalent roles. As return-to-office pressure intensifies in 2026, that penalty compounds in ways organizations are only beginning to measure.

Meanwhile, 83 percent of employers say they will implement at least one women's health strategy this year.⁷ Most of those strategies are single-condition, single-moment point solutions — a menopause benefit here, a postpartum resource there, a fertility coverage expansion added to a footnote.

Women's workforce participation has never been higher. The infrastructure to support it has never been further behind.

The women your benefits strategy was not designed for.

Five women. Different roles, different stages, different decades. All of them are delivering. What it costs them rarely shows up in performance reviews. It shows up later — in attrition, burnout, and lost leadership capacity.



AGE 26

Jasmine — managing pain in silence

Eight months into her first real leadership role, managing endometriosis that costs her two or three days of genuine cognitive focus every month. She has never mentioned it at work. She has already run the calculation on whether disclosing it would help or hurt her career, and landed firmly on hurt.



AGE 26

Priya — performing at full capacity, privately under strain

A senior product manager running a team of seven, three rounds into IVF while keeping it entirely invisible to her employer. She books clinic appointments as external meetings. She is still delivering. The margin she used to bring to Friday strategy sessions is gone, and she is the only one in the room who knows why.



AGE 26

Maya — carrying dual roles without margin

A marketing director with three kids under eight, four months back from maternity leave. Still breastfeeding on her lunch break, coordinating school pickups, fielding calls from home on deadline days, running on five hours of sleep. She was passed over for a high-visibility project she would have led before she left. She has not said anything.



AGE 26

Sandra — questioning capacity at peak experience

A regional director at a financial services firm. For the past eight months she has been waking at 3am, losing words mid-sentence in presentations, moving through a cognitive fog she has no name for. Nobody in her organization has ever talked about perimenopause as a business issue. She has started to wonder whether a less visible role might be easier to manage.



AGE 26

Diane — leading while carrying everything else

VP of operations, managing a team of 40 through a restructure while coordinating care for a mother with early-stage dementia and raising two teenagers at home. She handles her mother's specialist appointments and insurance calls in the gaps between her own working days. She is the institutional memory of her division — and exactly the person a competitor with smarter caregiving benefits would recruit without a second thought.

These are not cautionary tales. They are the real workforce.

Distributed across your org chart, carrying institutional knowledge and team capacity alongside the weight of everything nobody asked about. What accumulates in the invisible margins of their working lives surfaces, months or years later, as mid-career attrition, thinning senior pipelines, and turnover rates that appear in year-end reviews without a satisfying explanation.

The cost of that gap does not arrive as a crisis. It arrives as Priya going through the motions in a Friday strategy session she used to lead. As Sandra removing herself from the running for a promotion she has earned. As Diane taking a call from a competitor's recruiter on a Tuesday afternoon, not because she wants to leave, but because someone finally asked how they could help.

The awareness problem inside the benefits problem

Even when relevant benefits exist, women often do not know about them. Only **24%** of women know if their employer offers clinician access for menopause care, even when it exists.⁸ Low awareness is a strategy failure, not a program gap, and it is one of the cheapest gaps to close.



PART 2

What the gap is costing.

Menopause registers as productivity loss, not claims cost. Caregiving shows up as turnover. Mental health arrives as disengagement before it becomes medical spend. The accounting categories were never designed to capture it whole.

Four conditions. \$400 billion. Almost never counted in benefits cost modeling.

Health benefit costs per employee are expected to rise 6.5 percent in 2026, the highest increase since 2010.⁹ Without intervention, employers were facing closer to 9 percent. Two consecutive years of costs surpassing projections have left many organizations starting 2026 at a structural disadvantage.

A 2025 analysis by the McKinsey Health Institute and World Economic Forum identified four conditions that are underrecognized, under-researched, and disproportionately shaping women's health across their working years: **menopause, premenstrual syndrome, migraines, and endometriosis.**¹⁰ Together, they represent an estimated \$400 billion in annual GDP impact globally. Each one is present in organizations today, rarely named in a performance conversation, and almost never counted in the cost accounting that determines benefits strategy.

\$400B in annual GDP impact, globally

Estimated impact of four conditions disproportionately affecting working women

TOTAL: ~\$400B / YEAR

Menopause

\$120B

Migraines

\$80B

PMS & Endometriosis
(combined)

~\$200B

Each condition is present in most organizations today. Almost none of them appear in benefits cost modeling.

Menopause is the largest single share — and it touches roughly 20% of today's workforce simultaneously. Migraines are 3.25× more likely in women than men, frequently with a hormonal component. PMS affects 20–40% of reproductive-age women; endometriosis affects 1 in 10 women aged 15–45.

Source: McKinsey Health Institute & World Economic Forum, Blueprint to Close the Women's Health Gap (2025).¹⁰

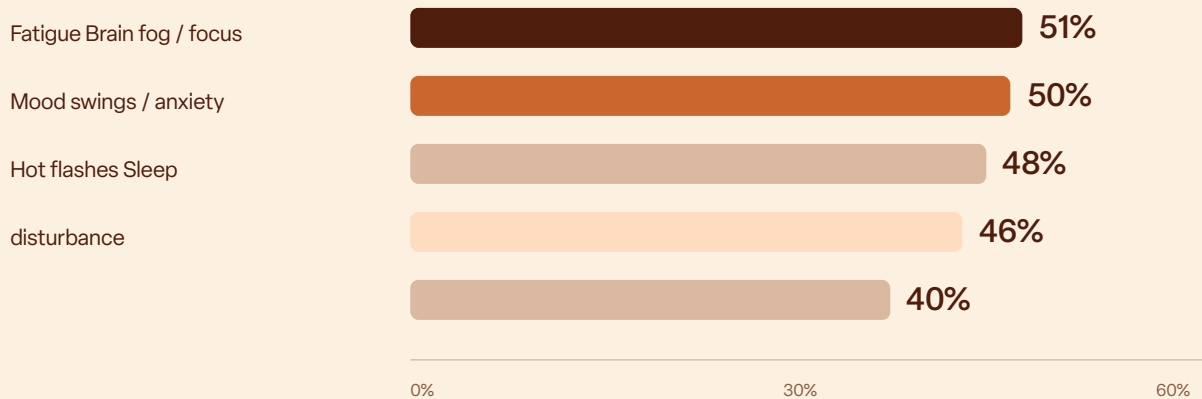
The conditions driving the highest healthcare claims among working-age women — chronic stress, untreated hormonal transitions, caregiving-related burnout, and delayed mental health support — are among the most preventable with earlier, integrated care. They are also among the most expensive when they finally surface in claims data.

Menopause is not a niche issue. It is a leadership retention issue.

Twenty percent of today's workforce is currently navigating perimenopause or menopause.¹¹ The McKinsey Health Institute estimates menopause represents **\$120 billion in annual GDP impact** in the women's health gap worldwide.¹⁰ For US employers specifically, the largest study to date — published in **Mayo Clinic Proceedings** — calculated the direct productivity cost at approximately **\$1.8 billion annually**.¹¹ That figure covers full-time working women aged 45 to 60 only, and excludes costs associated with reduced hours, loss of employment, early retirement, or changing jobs. The true number is larger.

Nearly 9 in 10 women navigating menopause report at least one workplace challenge

% reporting each symptom impacting work performance



Nearly half of women navigating menopause conceal symptoms at work out of fear of professional consequences.

Source: WebMD Health Services *Menopause in the Workplace Survey*, October 2025.⁸

A woman entering perimenopause is typically in her mid-to-late 40s or early 50s, which means she is also, in most organizations, at the peak of her institutional knowledge, professional network, and strategic judgment. Organizations treating menopause support as a longevity investment rather than a one-off accommodation protect leadership capacity that took decades to build.

The women who burn out in their late 40s and 50s are frequently not the ones who stopped trying. They are the ones who tried the hardest, for the longest time, without any support structure around them.

Three additional hormonally connected conditions, rarely tracked, almost always present.

The productivity cost of women's health extends well beyond menopause. These are not the only drivers, but three additional hormonally connected conditions — each affecting millions of women during their prime working years — represent a significant and frequently uncounted share of the total impact.

23 days

Premenstrual syndrome.

Average days of lower productivity per year across affected women. PMS affects 20–40% of women of reproductive age globally.¹⁰

1 in 10

Endometriosis.

Women aged 15–45. More than 190 million globally — likely an underestimate given persistent diagnostic gaps.¹⁰

3.25×

Migraines.

Women are this much more likely than men to experience migraines, frequently with a hormonal component. ~\$80B annual global GDP impact.¹⁰

A 2025 systematic review of 37 studies covering 72,567 working women found that severe menstrual disorders are associated with an average of **8.9 days of impaired work or absenteeism annually**.¹² Together with PMS and endometriosis, they add up to a working reality that has no line in the healthcare budget and rarely surfaces in a performance conversation.

All three conditions share one organizational characteristic: they are managed privately, without accommodation, without conversation, and without any entry in the cost accounting that would make them visible to the people responsible for workforce strategy.

In an organization, this looks like...

...the senior analyst who rearranged her presentation schedule without explanation. The director who took a half day without filing for sick leave. The team lead who delivered her project review at partial capacity and said nothing.

The cost is real. The cause is invisible.



Compounding disadvantages, arriving simultaneously.

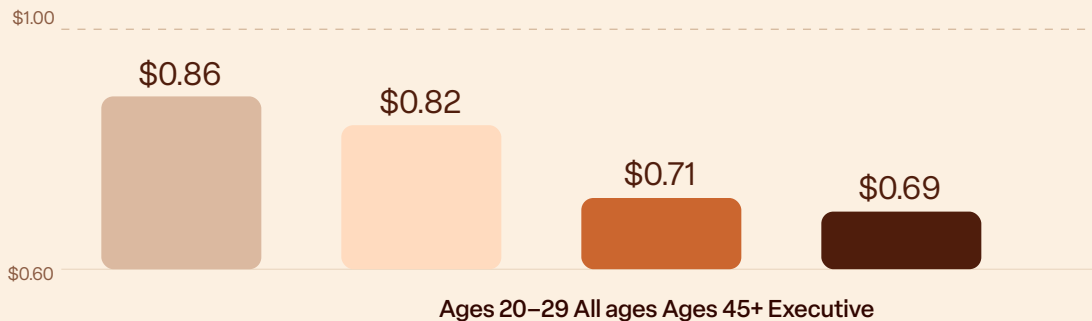
The 2026 Payscale Gender Pay Gap Report found that the uncontrolled gender pay gap has widened.¹³ Women now earn \$0.82 for every dollar earned by men — down from \$0.83 last year. Equal Pay Day fell later in 2026 than it did two years ago. Progress has not just stalled. It reversed.

The motherhood penalty sharpens the picture

Mothers earn \$0.74 for every dollar earned by fathers on an uncontrolled basis. Women without children earn \$0.90. Over a 40-year career, the uncontrolled pay gap translates to **more than \$1 million in lost earnings per woman**. That is the financial context in which women are also being asked to absorb rising out-of-pocket healthcare costs in 2026.

The pay gap widens precisely when health pressures peak

Womens earnings for every \$1.00 earned by men, by age band (uncontrolled)¹



The years when menopause, caregiving, and mental health pressures peak are also the years pay gap widens most.

Source: Payscale, *Gender Pay Gap Report 2026*.¹³



Caregiving is a health and retention problem, not a scheduling problem.

The International Labor Organization estimated that **708 million women worldwide** were outside the labor force due to unpaid care responsibilities in 2023, compared to 40 million men.¹⁴ Among women aged 25 to 54 who are out of the labor force, roughly two-thirds cite care as the primary reason. A 2026 Catalyst survey found that 42 percent of women who had voluntarily left jobs cited caregiving, including childcare costs, as a primary driver.¹⁵

\$5,600

in lost productivity per caregiving employee, per year — before burnout and healthcare cost premiums.¹⁶

\$4.2K – \$20K

added per affected employee, annually, from caregiving-related burnout.¹⁷

16%

of caregivers have already left a job because the weight became unmanageable.¹⁷

50–200%

of annual salary — the cost to replace each one.

In a 1,000-person organization where one in four employees is a caregiver (in some industries that number climbs to three in four), the financial exposure accumulates well before anyone has filed a single leave claim. Many of the women carrying the heaviest caregiving loads are simultaneously navigating their own health transitions.



The caregiving conversation has long been framed as a scheduling problem. It is a health and retention problem that shows up in claims data, turnover reports, and productivity numbers, often without any connection being drawn between them.

Mental health costs arrive as disengagement before they become claims.

Nearly half of all working women report feeling burned out. Among senior women, that number reaches **60 percent**.⁶ Employees are **5.5 times more likely to leave** their job when mental health does not feel supported.¹⁸ The US loses between \$200 and \$300 billion annually to untreated mental health conditions.¹⁹

Hormonal transitions affect mood, sleep, and cognitive function in ways that are gradual, episodic, and easy to misattribute. A woman in early perimenopause may chalk up months of disrupted sleep to general stress. She may attribute unexpected anxiety in a high-stakes meeting to self-doubt. In the absence of a name for what is happening, the symptoms become a story she tells herself about her own capabilities — and she starts recalibrating her ambitions downward.

That internal recalibration rarely shows up in performance reviews or engagement surveys. It surfaces, months or years later, in a resignation that surprises everyone except the person submitting it.

How these costs actually show up

It's not always obvious, and it doesn't fit nearly under a line item.

- ◆ Menopause costs register as productivity losses, not claims costs.
- ◆ Caregiving losses show up as turnover, not health spend.
- ◆ PMS, endometriosis, and migraines do not appear in any attendance record.
- ◆ Mental health costs arrive as disengagement before they become medical claims.

These costs operate at two levels: organizational and individual. For women, they compound over time as the pay gap widens gradually enough that each year's change looks incremental in isolation.

The most decision-relevant risk is not direct medical cost alone. **It is hidden talent loss.** The missed promotions, the reduced participation, the quiet career recalibrations that accumulate into year-end numbers without explanation.

Together, these cost lines describe an organization absorbing a structural tax on its workforce that is almost certainly larger than any single benefits leader has calculated, because the accounting categories were never designed to capture it whole.

The 2026 advantage.

Organizations that build integrated infrastructure now, while most competitors are still assembling point solutions, will have a compounding advantage in retention, healthcare cost trajectories, and leadership pipeline depth.

Women's health is at the same inflection point mental health was a decade ago.

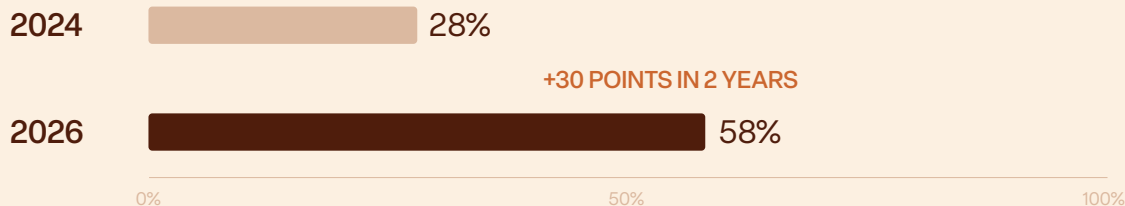
A decade ago, mental health carried the same stigma in organizational settings that menopause carries today. Organizations that built real mental health infrastructure early found themselves with a measurable retention and cost advantage that competitors spent years trying to close. Women's health broadly is at that same inflection point in 2026.

What the evidence shows.

Business Group on Health data shows that **58 percent of large employers** will provide menopause support programs in 2026, up from 28 percent in 2024.⁷ Fifty-five percent will offer postpartum depression services, and 36 percent will cover doula services.⁷ Employer strategy is expanding from fertility coverage alone toward the full arc of women's health.

Menopause programs more than doubled in two years

% of large employers offering menopause support programs



Source: Business Group on Health. 2026 Employer Health Care Strategy Survey.⁷

The impact is measurable: among women with access to menopause-related benefits, **58 percent report a positive effect on work performance.**⁸ The evidence on which specific workplace interventions produce the best long-term outcomes is still developing. What is well-established is the set of conditions that make outcomes better or worse: **access, accommodation, manager awareness, and flexibility.**

92%

of LifeSpeak members say access makes them more likely to stay with their employer.¹⁸

97%

say it helps them manage stress and prevent burnout.¹⁸

90.5%

report fewer doctor or therapist visits with consistent access.¹⁸

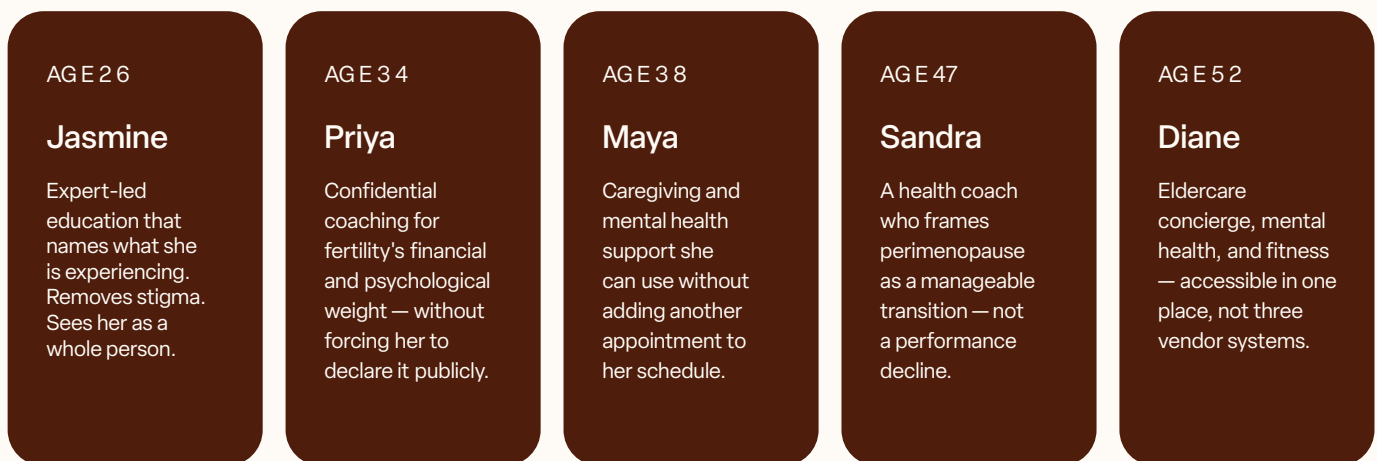
From Jasmine to Diane — what an integrated approach looks like in practice.

Women's health needs do not arrive as isolated events. They arrive as a continuous arc, shifting in nature and intensity across a full career. An integrated approach means having something meaningful to offer at every stage.

Most workplace menopause conversations get this wrong: **menopause can happen at any age**. Up to 20 percent of individuals experience early menopause. Premature ovarian insufficiency can begin as young as the early 20s. Surgical menopause — from hysterectomy or cancer treatment — can arrive at any point in a career. A benefits strategy built exclusively for women in their 50s will miss a substantial portion of the people who need it most.

Support for every stage on a woman's health journey

Mapping the examples in Part 1 to the support that meets them where they are.



Managers, if they are educated about what is going on, will be way more understanding. Women in leadership positions might give their female employees an opportunity to talk and explain the symptoms they are experiencing, and conversely share similar experiences. Being open in a supportive environment can certainly help— but we still have a long way to go.

DR. SOPHIE GRIGORIADIS, MD, PHD, FRCPC · SUNNYBROOK HEALTH SCIENCES CENTRE

The ambition is not accommodation. It is normalization — a workplace where women can thrive during every stage of their working lives without having to choose between their health and their career.

Seven steps grounded in the evidence — actionable wherever you are starting.

The research is clear on what conditions produce better outcomes: **access, accommodation, manager awareness, and flexibility**. The following steps are designed to be actionable regardless of where an organization is starting from.

01

Audit what you already have.

Only 24 percent of women know if their employer offers clinician access for menopause care. Map current benefits against the full arc of women's health needs and identify the gap between what exists and what employees know is available. Low awareness is a strategy failure, not a program gap.

02

Calculate what you are already absorbing.

Build a cost estimate that accounts for productivity losses from menopause, caregiving, and untreated mental health — not just direct claims. The conditions driving the highest costs rarely appear in healthcare data. They appear in turnover reports, absenteeism records, and disengagement scores.

03

Extend support to family members.

Women are the primary health decision-makers in most households. A benefit that reaches only the employee misses the full population carrying caregiving load. Solutions that extend access to family members address the dual-role reality that most point solutions ignore.

04

Training managers, not just HR.

Educated managers create the conditions for women to name what they are managing and access support earlier. Manager training on hormonal health, caregiving demands, and mental health is not a culture initiative — it is a risk mitigation strategy with a direct impact on retention.

05

Consolidate fragmented point solutions.

Most women's health strategies in 2026 are single-condition. A woman navigating perimenopause and caregiving simultaneously needs her employer to see those needs as connected. Integrated infrastructure delivers better outcomes and reduces the administrative burden of managing multiple vendor relationships.

06

Measure what matters beyond claims.

Track enrollment rates, utilization, absenteeism trends, and mid-career attrition among women alongside traditional claims data. The costs in this paper are largely invisible to standard reporting frameworks. Expanding what you measure expands what you can manage.

07

Share this research.

Share Part 2 with Finance for cost context. Share Part 3 with your CHRO for the retention and pipeline argument. Share the Executive Summary with leadership for a one-page overview of the opportunity.

PART 4

The business case for moving now.

The first organizations to make this shift will define the new standard.

The numbers do not begin and end in a spreadsheet.

The 2026 labor market data, the consumer women's health surge, rising healthcare costs, documented burnout and caregiving strain, and the widening pay gap that compounds every other pressure — these are a single story about a workforce that has never been more consequential and never been more underserved by the systems built to support it.

Organizations that address this now, while most competitors are still treating women's health as a niche benefits category, will have a measurable advantage in retention rates, healthcare cost trajectories, and leadership pipeline depth over the next three to five years.

But the numbers do not begin and end in a spreadsheet.

Jasmine is still reorganizing her week around a condition she has never named at work. **Priya** is still booking clinic appointments as external meetings. **Maya** is proving herself again after mat leave, managing three kids and a full leadership role on five hours of sleep, waiting for someone to ask if she is okay. **Sandra** is still wondering whether a less visible role would be easier to manage. **Diane's** phone is still ringing with calls she handles in the gaps between her own meetings — and a competitor has already started thinking about what it would take to recruit her.

What happens next for each of them is not inevitable. It depends, in part, on what the organizations reading this decide to do.

When employers support women's health across the full arc of a career, they build the conditions for women to stay longer, perform better, and advance further. That is a business outcome. It is also a human one.

My hope is that in five years, supporting women through every health transition at work is not a progressive topic. It is simply what good organizations do — integrated, normalized, and designed so that women can follow their ambitions through every stage of their working lives.

BRIANNE FLAHERTY · LICENSED CLINICAL COUNSELOR & HEALTH COACH, LIFESPEAK

The question is no longer whether this matters. It is which organizations will act before the cost becomes impossible to ignore.

What LifeSpeak **delivers.**

Real support for women, at every stage of life.

MENTAL HEALTH FITNESS & NUTRITION PARENTING & CAREGIVING SUBSTANCE USE

Women's health is not a single moment or milestone. It spans decades of change, shifting responsibility, and everyday demands that are too often invisible in the workplace. LifeSpeak is an evidence-based digital health and wellness solution built for your entire workforce, all genders, family members, and life stages, and when the focus turns to women's health, it delivers.

For women dealing with everything from hormonal shifts and mental health to caregiving pressures and physical wellbeing, LifeSpeak provides something that has historically been hard to find at work: support that reflects their lives. Our wellness tracks can work together as a comprehensive foundation, or individually to complement and strengthen a strategy already in place. Either way, the experience is built to flex around where your people are, not where you need them to be.

Each track brings credentialed expert guidance, on-demand resources, and optional 1:1 coaching to the moments that matter most. All of it available 24/7 through the app or web portal, to employees and their family members alike.

Because good wellbeing support does not stop at the office door, and neither do we.



“Meeting women where they are, whether navigating family planning, managing menopause, or balancing mental health, means creating benefits that truly fit their lives. It's not just about care; it's about showing that their health is the backbone of a thriving, future-focused workplace.”

**AMANDA MARTELL DIRECTOR OF HR,
LIFESPEAK**

Built for the realities women navigate at work.

LifeSpeak's women's-health resources are developed and delivered by leading clinicians, researchers, and practitioners who specialize in the conditions and life stages working women navigate every day.



Dr. Sophie Grigoriadis

MD, PhD, FRCPC
Head of Women's Mood and Anxiety Clinic, Sunnybrook Health Sciences Centre



Dr. Jerilynn C. Prior

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Endocrinologist and women's health expert



Dr. Carly Crewe

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ER Physician, Women's Mental Health Consultant



Dr. Rebecca Berliner

MD, CCFP
Specialist in women's health



Dr. Sophie Bostock

PhD
Sleep specialist



Dr. Ariel Dalfen

MD
Psychiatrist and author



Nishta Saxena

MSc
Registered Dietitian and Nutritionist



Brianne Flaherty

Licensed Clinical Counselor
LifeSpeak Health Coach

Featured experts cover a range of topics across women's health, including mental and emotional wellbeing during hormonal transitions, fitness and nutrition tailored to pregnancy, postpartum, and menopause, and strategies for managing workplace stress.

A glimpse of the women's health resources inside.

A sample of the women's health specific resources available across LifeSpeak's tracks, grouped into the three areas where women's health needs most often surface at work: mental health, physical health, and caregiving.

Mental health

Mental Health Through Infertility

PMS and PMDD: What's Normal and What's Not

Mental Health Issues During Pregnancy

Physical health

Strength in Movement: Managing PCOS Through Exercise

Hormones: Understanding Their Influence on Weight

Menopause, Stress, and How They Impact Your Sleep

Caregiving

Embracing Self-Care as a Caregiver

Caregiving: Learning Your Boundaries and How to Say No

How to Be Enough for Yourself While Caregiving

SPOTLIGHT

The Womens Hormonal Health Series'

Led by LifeSpeak expert **Jodi Sussner**, fitness and mindset coach, this flagship series provides science-backed strategies to help women manage symptoms, maintain energy, and feel their best at work and in daily life.

Perimenopause Program

Strength training and stress reduction to help women manage hormonal fluctuations and build resilience to fatigue, brain fog, and anxiety.

Post-Menopause Program

A targeted approach to muscle preservation, joint mobility, and bone density for long-term wellbeing.



Give the women in your workforce the support to **stay, perform, and thrive.**

When employers support women's health across the full arc of a career, women stay longer, perform better, and lead. Three ways to start:

1

Book a discovery call.

30 minutes with our team. Walk through the solution, member outcomes data, and what implementation looks like for an organization of your size.



lifespeak.com/coffee-chat

2

See our impact data.

Member outcomes, engagement, and retention figures across nearly 1,000 organizations and 14 million families worldwide.



lifespeak.com/our-impact

3

Share this report.

Go through the checklist on page 20 with your benefits community or share the full report with your colleagues, managers, or CHRO.



Resources

All figures cited in this paper are drawn from independent research published in 2025 or 2026 unless otherwise noted. Numbered references correspond to citations throughout the body of the document.

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