



Executive Summary

On April 13, 2026, the Chronic Pain Centre of Excellence for Canadian Veterans (CPCoE) and the Canadian Pain Society (CPS) convened a national roundtable focused on advancing women's and women Veterans' health, with a particular focus on chronic pain. The event brought together researchers, clinicians, policymakers, funders, Veterans, people with lived experience, and additional national partners to begin shaping a coordinated Canadian strategy for research, health systems, policy, and implementation.

Women are a growing demographic within the Canadian Armed Forces (CAF) and Veteran community yet remain significantly under-researched and underserved.

Chronic pain affects approximately 22% of women in the general Canadian population, while emerging evidence suggests that upwards of half of women Veterans experience chronic pain alongside complex physical, psychological, and social comorbidities. Participants emphasized that women's pain is frequently dismissed and poorly understood, can be compounded by military sexual trauma (MST), and lacks coordinated, trauma-informed and culturally competent health services.

The roundtable identified major evidence and system gaps. Canada currently lacks national women-focused datasets, standardized definitions, longitudinal cohort studies, women-specific patient outcome measures, and integrated care pathways for chronic pain. Participants stressed that these challenges are shared by both Veteran and civilian women, highlighting the need for scalable and inclusive national solutions.

Participants identified several priority actions for a national strategy, including:

- Developing a pan-Canadian women and women Veterans chronic pain data strategy with standardized definitions and interoperable datasets.
- Investing in implementation science to translate research into accessible, high-quality care.
- Supporting lifespan and gender-specific research that incorporates reproductive health, menopause, trauma, and military service experiences.
- Expanding education and awareness for clinicians, policymakers, and the public.
- Ensuring women and women Veterans have representation within national women's health policy frameworks, including Bill S-243.

Three flagship initiatives were proposed:

- A Pan-Canadian Women and Women Veterans Pain Data Collaborative.
- Coordinating national research priorities.
- Women and Women Veterans Interdisciplinary Pain and Wellness Hubs.

The roundtable concluded that Canada has a critical opportunity to build a coordinated, trauma-informed, women-centered strategy that improves chronic pain outcomes, reduces disability and workforce loss, and strengthens health equity for women Veterans and civilian women alike. Achieving this vision will require sustained collaboration, harmonized data systems, interdisciplinary care models, and multi-agency investment across federal, provincial, academic, philanthropic, and industry partners.

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On April 13, 2026, an invitation-only event was hosted by the Chronic Pain Centre of Excellence for Canadian Veterans (CPCoE) and the Canadian Pain Society (CPS) to bring together key players who focus on women and women Veterans' health, and more specifically, chronic pain. **The overarching objectives were to discuss the beginnings of a national strategy, identify key areas of focus for specific research and impact projects, and identify key players to support such projects.**

Purpose



- 1** To engage leaders, researchers, clinicians, potential funders, national partners, Veterans, those with lived experience, and policymakers to understand the current state of evidence on women and women Veterans' chronic pain and related health burdens.
- 2** Define critical national gaps in research, data systems, care pathways, and lived-experience representation.
- 3** Clarify what datasets exist, who holds them, and what can be leveraged for data linkage and coordinated research projects.
- 4** Align CPCoE, Veterans Affairs Canada (VAC), Canadian Armed Forces (CAF), Department of National Defence (DND), Canadian Institutes of Health Research (CIHR), Health Canada, Statistics Canada, Canadian Institute of Military and Veteran Health Research (CIMVHR), Atlas Institute for Veterans and Families, and CPS priorities with respect to chronic pain.
- 5** Form the foundation for a co-developed National Research and Implementation Strategy on women and women Veterans with chronic pain.
- 6** Develop shared priorities for multi-agency investment, including implementation projects, data linkage, policy change, and a coordinated research agenda.
- 7** Identify possible sources of multi-agency, philanthropic, provincial, and federal investments.
- 8** Identify 2–3 flagship projects for immediate implementation.

Context



Women are a growing demographic in the Canadian Armed Forces and Veteran populations, and are amongst the most under-researched and underserved. Released in 2024, the Standing Committee on Veterans Affairs' (ACVA) *Invisible No More: The Experiences of Canadian Women Veterans*¹ report highlights:



Systemic invisibility of women across CAF, VAC, research systems, and public perception.



High rates of chronic pain, military sexual trauma (MST)-related trauma, multimorbidity, and social vulnerability among women Veterans.



No Canadian women-centered pain pathways, cohorts, Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs), or trauma-integrated models of care.



Fragmented care, repeated re-traumatization, and limited access to trauma-informed, culturally competent clinicians.

Chronic pain is defined as pain that has lasted longer than 3 months.

Chronic pain impacts approximately 22%² of women in the general Canadian population, yet emerging evidence suggests that as high as 50%³ of women Veterans live with chronic pain and associated multimorbidity.

Women's pain is often dismissed and psychologized and often overlaps with other physical or mental health disorders. This disproportionate burden highlights an urgent need for coordinated national action in research, clinical care, education, and policy. This has been recognized as a key priority to be advanced within the current Federal government's mandate⁴. Participants emphasized that women Veterans represent both a military and women's health priority, and that current systems fail to adequately capture the complexity of women's pain experiences across the lifespan.

¹ Canada. Parliament. House of Commons. Standing Committee on Veterans Affairs. (2024). *Invisible No More: The Experiences of Canadian Women Veterans*. <https://www.ourcommons.ca/Content/Committee/441/ACVA/Reports/RP13177333/acvarp15/acvarp15-e.pdf>

² Canada. Health Canada. Canadian Pain Task Force. (2021). *Canadian Pain Task Force Report: March 2021: An action plan for pain in Canada*. Government of Canada. <https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2021.html>

³ Talukdar, J. R., Zeraatkar, D., Thomas, A., & Busse, J. W. (2025). An exploration of the increasing prevalence of chronic pain among Canadian veterans: Life After Service Studies 2016 and 2019. *Canadian Journal of Pain*, 9(1). <https://doi.org/10.1080/24740527.2024.2443631>

⁴ Liberal Party of Canada. (2025). *Canada Strong*. <https://liberal.ca/cstrong/secure/#veterans>

Current State

Key Gaps and Drivers of Inequity

Participants highlighted that while women Veterans experience unique occupational and military-related exposures, many gaps mirror those experienced by civilian women with chronic pain. These include delayed diagnosis, dismissal of symptoms, fragmented care, underfunding of women's health research, and lack of integrated health service delivery models. The roundtable emphasized the importance of creating strategies that can improve care for both women Veterans and civilian women through shared data, scalable clinical care models, and policy initiatives.



Research

Participants identified several gaps which can have an impact on research focused on Canadian women and women Veterans living with pain:

- A dearth of population-level data regarding pain, reproductive health, trauma exposures, MST, or aging trajectories of women and women Veterans.
- Women Veterans are often grouped with spouses/widows, erasing women Veteran identity.
- Almost no data for Indigenous, Black, racialized, 2SLGBTQ+ women Veterans.
- Health questionnaires are not adapted to capture women's issues while serving in the Canadian Armed Forces.
- Lack of available data for different types of pain in women and impact on daily life.
- Clinical trials lack disaggregation of outcomes by sex and/or gender despite widespread guidance for doing so.

Participants also identified **research design limitations**:

- Women have often been excluded from pharmacological trials for pain therapeutics, so there is a dearth of evidence for their safety and efficacy in women.
- Predominance of cross-sectional studies.
- Little longitudinal or implementation science work.
- No women- or women Veteran-specific patient reported outcome measures (PROMs) or Patient reported experience measures (PREMs).
- Urgent need for real-world trials, community-based models, and trauma-integrated interventions.

Clinical Care



Participants identified the high burden of chronic pain and comorbidity which can impact clinical care:

- Women Veterans show disproportionately high rates of:
 - Chronic pain (20% civilian, 30-50% Veteran)
 - PTSD (10% civilian⁵, 13% Veteran⁶), depression (14% civilian⁷, 17% Veteran⁶), anxiety (10% civilian⁸, 11% Veteran⁶)
 - Migraines (8% civilian⁶, 14% Veteran⁶), GI disorders (5% civilian⁶, 9% Veteran⁶)
 - Complex multimorbidity in mid-life
- Military Sexual Trauma (MST) strongly predicts pain, sleep disturbance, cardiometabolic disease, and mental health complexity. MST is the strongest predictor of chronic pain complexity in women Veterans.
- Women civilians are also disproportionately affected by chronic pain and mental health issues compared to their male civilian counterparts.

Systems and Policy



Participants identified issues such as barriers to access to care, and structural drivers of inequity, which could be addressed by policy:

- Many women do *not* self-identify as Veterans.
- Veterans Affairs Canada processes often require repetitive recounting of trauma, unintentionally retraumatizing women.
- No accredited or harmonized trauma-informed approaches for the various service providers or healthcare professionals.
- Civilian clinicians lack adequate training to treat Veteran women and lack military cultural competence.
- Fragmented care during reproductive and menopausal transitions results in lifelong burden for women and women Veterans.
- Structural invisibility – a gender-neutral policy leads to men being the default. Women regularly experience and need to navigate gender taboos and stigma related to health.
- Women’s pain, physiology, and MST experiences were excluded from decades of policy.
- Equipment and physical standards in the workplace or military have historically been male-oriented leading to occupational strain. Additionally, lack of maternity, postpartum, and menopause accommodation can lead to occupational strain.
- Women Veterans experience a 21% decrease in income in the first 3 years post-release compared to men (1%)⁹, and higher rates of homelessness and housing insecurity.

⁵ Public Health Agency of Canada. (2024). *Posttraumatic stress disorder among adults in Canada: Key findings*. Government of Canada. <https://health-infobase.canada.ca/ptsd-survey/>

⁶ Canada. Veterans Affairs Canada. (2026). *Veteran physical & mental health*. Government of Canada. <https://www.veterans.gc.ca/en/about-vac/research/info-briefs/veteran-physical-mental-health>

⁷ Roberts, K. C., Rao, D. P., Bennett, T. L., Loukine, L., & Jayaraman, G. C. (2015). Prevalence and patterns of chronic disease multimorbidity and associated determinants in Canada. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice*, 35(6), 87–94. <https://doi.org/10.24095/hpcdp.35.6.01>

⁸ Public Health Agency of Canada. (2016). *Report from the Canadian Chronic Disease Surveillance System: Mood and anxiety disorders in Canada, 2016*. Government of Canada. <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/report-canadian-chronic-disease-surveillance-system-mood-anxiety-disorders-canada-2016.html>

⁹ Statistics Canada. (2019). *Examining the incomes of veterans using tax data: Now and in the future* (Catalogue no. 75F0002M2019008). Government of Canada. <https://www150.statcan.gc.ca/n1/pub/75f0002m/75f0002m2019008-eng.htm>

Setting the Stage

We asked our participants:

“In one sentence, what’s the most important problem we should solve?”

With responses provided to this question, we discerned that the strategy ahead of us would need to align with these 4 objectives:

1. Make it visible
2. Make it credible
3. Make it coordinated
4. Make it actionable

Research Strategy

We asked our participants to develop key strategies that could form a basis of a coordinated, multi-agency research strategy to address chronic pain in women and women Veterans in Canada. We also asked them to identify barriers, facilitators and key partners for these strategies. People then voted on what they perceived as the most important strategies. The key strategies, in order of most popular by number of votes are:

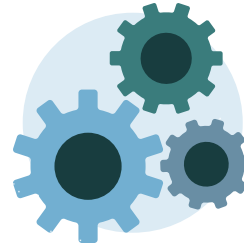




Make it visible



Make it credible



Make it coordinated



Make it actionable

OBJECTIVES

KEY STRATEGIES

1. Improve Data Accessibility and Transferability.

Improving data transparency and data sharing with standard definitions, influencing national & provincial data sharing legislation Bill S-5.

Participants strongly endorsed the development of a national women Veteran chronic pain data strategy that enhances and coordinates existing provincial, federal, military, and civilian datasets.

This includes creating standardized definitions for chronic pain and Veteran identity. This would also link administrative and clinical datasets, integrate patient-reported outcomes, and ensure the inclusion of reproductive, hormonal, trauma, and lifespan variables. The group emphasized that better data integration is foundational to future implementation science, precision care models, and policy reform.

2. Invest in an Implementation Science Program.

Including development of a strategy to mobilize research to clinical adoption, improving access to interdisciplinary/equitable care for women and women Veterans, and influencing provincial/territorial buy-in to allow for connected care for Canadians, sharing best practices, education, and having a coordinated approach.

3. Funding for a Lifespan, Gender-specific Approach to Research.

Including studying women across their lifespan. Special emphasis on the lifecycle of being a service member, requiring synchronized, coherent, trauma, gender, equity-informed research, and capacity building to ensure research strategy success.

4. Establish a seat and voice at the table for Bill S-243.

National Women's Health Framework.

5. Improve Education of Clinicians and of Women themselves.

Including developing an awareness-building advocacy campaign.

6. Ensure coordination of all initiatives.

Across centres/jurisdictions including Provincial Ministries of Health, VAC and CAF.

For more information on the barriers, enablers, and partners outlined for the research strategies identified, please see [Appendix A](#).

Flagship Projects

To address the identified gaps, needs and opportunities, we asked participants in small groups to plan a flagship project that could allow us to get started immediately on next steps. The flagship project plans needed to include the following components:

- Problem & Population
- Proposed intervention
- Evidence Gaps
- Partnerships
- Feasibility (12 – 24 months)
- Outcomes
- Funding targets

Several groups proposed similar ideas focused on women and women Veterans, chronic pain, longitudinal data collection, and harmonized national datasets. Rather than treating these as separate projects, they have been combined into a multi-phased, national strategy.

The proposed approach starts with foundational work such as environmental scanning, data mapping, and standardized definitions. From there, the initiative could expand into longitudinal cohort development, implementation science, policy change, and women-centered models of care. Overall, the suggested projects could be summarized into main themes outlined on the right:





1. Pan-Canadian Women and Women Veterans Health Data and Definitions Collaborative

A national collaborative initiative focused on developing common definitions, identifying data gaps, mapping existing datasets to strengthen future research, policy, and health interventions.

2. Coordinating National Research Priorities

A national approach to addressing research priorities identified by civilian and Veteran women living with chronic pain, such as the priorities developed by the CPCoE¹⁰, priorities identified in the Invisible No More Report¹¹ and priorities developed as part of the VAC women's health strategy.

3. Women and Women Veterans Interdisciplinary Pain and Wellness Hub

A province-based interdisciplinary care model integrating chronic pain care, women's health, trauma-informed practice, provider education, and coordinated support for women and women Veterans.

Current examples exist in Nova Scotia, and at Women's Hospital in Toronto.

For a capture of each group's flagship project plan of each group, see [Appendix B: Flagship Projects Plans](#).

¹⁰ Chronic Pain Centre of Excellence for Canadian Veterans. Research Priorities for Canadian Veterans Living with Pain. Hamilton, ON: Chronic Pain Centre of Excellence for Canadian Veterans; 2026. Available from: <https://www.veteranschronicpain.ca/documents/priority-setting-report-2025>

¹¹ House of Commons Standing Committee on Veterans Affairs. (2023). Invisible no more: The experiences of Canadian women veterans (Report No. 15). Parliament of Canada. <https://www.ourcommons.ca/Content/Committee/441/ACVA/Reports/RP13177333/acvarp15/acvarp15-e.pdf>

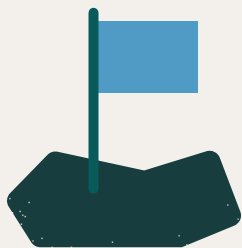
Funding and Partnership Pathways

We asked our participants to identify possible funders for the flagship projects beyond those that were identified in the strategic questions. The following organizations were identified:



Federal

1. National Defence
2. Canadian Armed Forces (CAF)
3. Veterans Affairs Canada (VAC)
4. Canadian Institutes for Health Research (CIHR)
5. Defence Research and Development Canada (DRDC)
6. Health Canada
7. Mitacs
8. CPCoE
9. Canadian Centre on Substance Use and Addiction (CCSA)
10. Digital Research Alliance Canada (DRAC)
11. Canadian Institute for Military and Veteran Health Research (CIMVHR)
12. Canadian Institute for Health Information (CIHI)
13. National Research Council (NRC)
14. Atlas Institute for Veterans and Families



Provincial

1. Quebec Pain Research Network (QPRN) -1-year project
2. Provincial/territorial pain related programs to pain strategies (e.g., Centre of Excellence for Women's Health in BC)
3. National Association of Provincial Health Research Organizations (NAPHRO) – no funding, but they can help coordinating provinces
4. Toll Roads (Veteran Highways)
5. Provincial Research Organizations (e.g., FRSQ, Alberta Innovates, Research Nova Scotia, Research New Brunswick, Michael Smith Foundation BC, etc.)



Philanthropic

1. Women and Gender Equality Canada (Women's capacity fund)
2. True Patriot Love
3. Other philanthropic organizations



Industry

1. BMO, other banks
2. Big Data Companies (e.g., Google)
3. Loblaws (e.g., Shoppers Drug Mart is funding a lot of women's health initiatives)
4. Defence-related companies, particularly those with Industrial and Technological Benefits (ITBs) to spend, can get up to an 8:1 multiplier for funding research.



Conclusions

The roundtable concluded that meaningful progress will require simultaneous changes across research, clinical care, and policy.



In research

Canada must invest in longitudinal women-centered and women Veteran-focused cohorts, harmonized national datasets, implementation science, and trauma-informed methodologies that recognize the interaction between chronic pain, hormonal health, reproductive transitions, mental health, and military service.

In clinical care

Participants identified an urgent need for interdisciplinary, lifespan-oriented, trauma-informed models that integrate pain medicine, gynecology, mental health, physiotherapy, rehabilitation, and peer support, with scalable hub-and-spoke models capable of serving both urban and rural populations.

In policy

Participants emphasized the need for women and women Veterans to have formal representation within national health frameworks, including Bill S-243, and for governments to recognize chronic pain in women as a major driver of disability, workforce loss, and inequity. The group agreed that Canada now has a critical opportunity to build a coordinated national strategy that improves outcomes not only for women Veterans, but for all women living with chronic pain.

Proposed Phased Approach

National Strategy on Women and Women Veterans Chronic Pain

This phased approach allows for achievable early milestones, coordinated multi-agency collaboration, and scalable growth toward a national women and women Veterans chronic pain research and implementation framework.

Phase 1

National Environmental Scan and Data Asset Mapping

- Conduct a pan-Canadian environmental scan of existing datasets, surveys, registries, and administrative databases relevant to women Veterans and chronic pain.
- Identify current definitions, data gaps, and inconsistencies across organizations.
- Map what variables already exist and determine where harmonization is possible.

Phase 2

Development of a National Core Dataset

- Develop standardized national definitions and variables for:
 - Chronic pain
 - Veteran identity
- Once established, furthering the initiative would benefit from interfacing with initiatives to develop definitions and variables for the following:
 - Trauma exposure and MST
 - Hormonal and reproductive health
 - Menopause and aging
 - Mental health comorbidity
 - Disability and function
 - Social determinants of health
 - Patient-reported outcomes and experiences (PROMs/PREMs)
- Ensure to the greatest extent possible data interoperability between provincial, federal, military, and civilian systems.

Phase 4

Knowledge Translation and Implementation

- Create a national data-sharing and implementation framework.
- Develop clinician education and policy briefs.
- Build pain evaluation and management pathways.
- Establish peer-support and patient engagement strategies.
- Use findings to guide future interdisciplinary clinical hubs and women-centered models of care.

Phase 3

Longitudinal Women Cohort that we pilot in Active military and Veterans

- Develop a prospective longitudinal cohort that:
 - Enrolls women early in military service or transition phases
 - Follows participants across the lifespan
 - Integrates quantitative and qualitative data collection
 - Evaluates chronic pain trajectories, resilience factors, functional outcomes, and barriers to care
 - Includes real-world and pragmatic data collection methods to minimize burden and survey fatigue



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Appendix A

Research Strategy (Barriers, Enablers, Partners)

Research Strategy	Barrier	Enabler	Partner
1. Improve Data Accessibility and Transferability.	<ol style="list-style-type: none"> 1. Lack of Funding available/ high cost of data 2. Lack of understanding about women's health 3. Different data holders not sharing their results 	<ol style="list-style-type: none"> 1. Funding to enable women-specific research data collection, using available data sets, chronic pain identifiers now available 2. Investing in knowledge sharing and knowledge mobilization when research is done 3. Broad data sharing 4. Establishing a coordinated coalition 	<ol style="list-style-type: none"> 1. VAC 2. CIHR 3. Statistics Canada 4. Health Canada 5. DND 6. CIMVHR
2. Invest in Implementation Science Program.	<ol style="list-style-type: none"> 1. People working in Silos and not sharing research results 2. Implementation practice falls short when research is done 3. Socioeconomic status, race, gender, sex, sexual orientation 4. Raising awareness of early intervention to minimize chronic pain with organizations like DND/ CAF 5. Cross-provincial challenges 	<ol style="list-style-type: none"> 1. Ensure research goes back to Veterans, civilians and decision makers 2. Dedicate funds and resources to implement research results 3. Related reports and data sets that could feed into the legislation (e.g., Invisible No More) 4. Cross-coordination between different organizations within a same goal 5. Bridging the populations (women and women Veterans) 	<ol style="list-style-type: none"> 1. CIHR 2. Social Sciences and Humanities Research Council (SSHRC) 3. VAC, DND, CAF 4. SKIP – Solutions for Kids in Pain 5. Establishment of Research Translation Enterprise for each project
3. Funding for a Lifespan, Gender-Specific Approach to Research.	<ol style="list-style-type: none"> 1. Lack of collaboration across different sectors that are involved in women's healthcare 2. Questions are not targeted and clear enough to identify issues affecting women. 3. Stigma: women may not feel comfortable disclosing their concerns 4. No data that captures lifespan and after service 	<ol style="list-style-type: none"> 1. Coming up with tailored questions and data sets that can help create effective interventions 2. Improving education strategies about women's issues, even during service to women and others, can care for them (e.g. how training for women during service can affect menopausal experience down the line) 3. Show DND that Veteran health contributes to force readiness 	<ol style="list-style-type: none"> 1. Transition organizations (CAF Transition / VAC Research) 2. Research funders

Research Strategy	Barrier	Enabler	Partner
4. Establish a seat and voice at the table for Bill S-243 National Women’s Health.	<ol style="list-style-type: none"> 1. Raising awareness of early intervention to minimize chronic pain with organizations like DND (historically, they have not shown interest) 2. A lot of minority/ marginalized groups at the table. 	<ol style="list-style-type: none"> 1. Related reports and data sets that could feed into the legislation (e.g., Invisible No More) 2. Scale and spread with what exists already 3. Pelvic pain – in McKinsey report 	<ol style="list-style-type: none"> 1. Provinces 2. International 3. Federal Government
5. Improve Education of Clinicians and Women.	<ol style="list-style-type: none"> 1. Unfair treatment to women healthcare 2. Misinformation that have become societal norms (you should be in pain as a woman) 3. Identify key opportunities and events for awareness building (VAC Women’s Forum, CPS, CIMVHR, Discipline-specific Forums). Have it recurring every year 	<ol style="list-style-type: none"> 1. Young people (Gen Z) are willing to learn and question social biases 2. The stories of education on the patient are very impactful – learning your diagnosis of chronic pain can be healing 	
6. Ensure coordination of all initiatives across centres including VAC, CAF and provincial and territorial health systems.	<ol style="list-style-type: none"> 1. Silos: Research is often conducted in isolation 2. Structures are usually set up to be operational and don’t allow for a feedback loop 	<ol style="list-style-type: none"> 1. Share the research back with Veterans, civilians and decision makers 2. Better communication strategies between centers conducting similar research about women’s health 	<ol style="list-style-type: none"> 1. VAC, DND (national level) 2. ATLAS, CIMVHR, CPCoE (organizational level) 3. Provincial MOHs

Appendix B

Pilot Projects Canvases

First Proposal: Clinical Hub for interdisciplinary care

1. Problem & population

- Civilian Women and Women Veterans
- Lack of coordinated care, central data, military competent health care providers, lack of gender, equity and trauma informed providers within the health care system

2. Proposed intervention

- Clinical hub for interdisciplinary care (NPs, Physicians, gynecologist, physio, full team etc.)
- Education for providers
- Care for women military members and women Veterans (starts in service and extends to after service without any barriers to accessing care)
- A cohort of 50 women are chosen and all care needs are met by this hub
- Pilot would start in one province

3. Evidence Gap

4. Partnerships

5. Feasibility (12-14 months)

- Looking at the women's lifespan, this would be a generational project expanded in all provinces. But for a pilot possibly 2 years

6. Outcomes

- Focus on a plan for Knowledge Mobilization, how to get MPs involved, and scalability. Measure impact. Needs to continue beyond seed funding
- Reduced pain, improved QoL, education awareness for providers
- Reduce disability and time off duty
- Recruitment retention

7. Funding targets

- Need multiple funders, government, philanthropy etc.

Second Proposal: Understand the Life Cycle of Women Veterans through Data Collection

1. Problem & population

- Lack of data that shows the life cycle and trajectory of women Veteran health to understand the in-service and post- service health experiences of women Veterans
- Data is collected, but not specifically to understand the trajectory of health with women Veterans, and it does not follow a longitudinal approach
- There are barriers with CAF sharing information about the health experiences of in-service personnel, and this information is essential for understanding the life cycle of women Veterans (collecting evidence at different data points is crucial)

2. Proposed intervention

- Understanding key milestones and mapping out which time points data should be collected (from recruitment to retirement/ discharge)
- Addressing the barriers at every point of data collection, e.g., how can CAF share information from surveys to understand in-service services of women Veterans
- Understanding the questions we need to ask, who will be responsible for data collection?
- Do an environmental mapping of what questions are available and what needs to be adjusted

3. Evidence Gap

4. Partnerships

- CAF
- High-level people in the government to help with breaking down the barriers
- CIHR
- VAC to help with policies
- ATLAS, CIMVHR, CPCoE can help with funding and engaging with the data

5. Feasibility (12-14 months)

- Barriers
 - Lack of participation from Veterans because of survey fatigue
 - Issues with bureaucracy
 - Lack of coordination between organizations that have stakes in women Veteran health

6. Outcomes

- Understand the questions that are already available and adjust as needed
- Establish a roadmap for data collection
- Better collaboration in data collection and data sharing for Veteran (women) health
- Timely data sharing from CAF, which will help with timely action regarding Women Veteran health and better interventions

7. Funding targets

- CAF
- ATLAS, CPCoE, CIMVHR

Appendix B

Pilot Projects Canvases (*continued*)

Third Proposal: untitled

1. Problem & population

- Women & women Veteran, compare against male civilians and male Veterans
- Longitudinal cohort that could include women Veterans, enroll people in basic training and follow throughout service – using pragmatic data collection
- Hormonal health and chronic pain
- Is qualitative data an avenue to explore – a step in the right direction

2. Proposed intervention

- Peer support
- Pain evaluation algorithm

3. Evidence Gap

- No data set for women Veterans

4. Partnerships

- RCMP – they have a large dataset on all their officers when they enroll

5. Feasibility (12-14 months)

- Ideally find one province or two to be the leaders

6. Outcomes

7. Funding targets

- Government Funded – CIHR exploring longitudinal study on cannabis right now
- Big Pharma?
- SSHRC

Fourth Proposal: untitled

1. Problem & population

- Inconsistency with standardized definitions (of Veteran, of chronic pain) across provincial and federal datasets, preventing dataset comparisons and future research. (Note: this is a more short/medium term problem to address, as the table agreed trying to tackle the transparency and other issues around data is likely too big of an animal and will take too long)
- Audience is provincial, federal

2. Proposed intervention

- Consistent definitions, and application of those definitions, for ‘who is a Veteran’ and ‘what is chronic pain’
- Remove any mention of federal penitentiary
- Get everyone using versions of these definitions to note down what they are/how they use them, and asset map those definitions and how everyone would change

3. Evidence Gap

4. Partnerships

- CIHR
- CIHI (Canadian Institute for Health Information)
- Primary care data networks in Canada
- Regional, provincial, federal, pan-Canadian

5. Feasibility (12-14 months)

- 12 to 18 months (just getting people to agree to come to the table with the politics and bureaucracy might take e.g. 6 months)

6. Outcomes

7. Funding targets

- \$250,000-\$500,000

Fifth Proposal: untitled

1. Problem & population

- Problem: Segregated data with inconsistent definitions of chronic pain in data representations
- Population: Civilian Women & Women Veterans

2. Proposed intervention

- Develop consistent definitions of chronic pain in data collection for Women, with a specific identifier for Women Veterans
- Begin provincial and build up to federal (identification and asset mapping exercise)
- Quebec and Ontario could be used as best practice comparisons to other provinces

3. Evidence Gap

- Lack of consistent data on chronic pain for Women and Women Veterans
- Representation is poor or unreliable

4. Partnerships

- Provincial Health Systems
- Provinces
- Statistics Canada
- Other Federal data collectors: DND, VAC

5. Feasibility (12-14 months)

- Leveraging what has occurred in provinces to use their best practices
- Leveraging Bill S-5

6. Outcomes

- Common definition of chronic pain
- Increased rigor, reliability, and efficiency of chronic pain data
- Reduce duplication and burden on Women/Women Veterans

7. Funding targets

- Federal: CIHR, WAGE, CPN, SSHRC, CPCoE, DND, VAC
- Provincial: Toll Roads, QPRN,
- Corporations: BMO, Canadian Tire, Rogers S+M, PWHL (fundraisers)

