

Review

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Policy Blind-Spots: A Systematic Review of Midlife Health in Global Women's Care (KATHERINE Project)

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Review

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Nimesha Wijamuni ^{1,†} Neha Raghuraman ^{2,†}, Mohammad Haddadi ^{3,†}, Elizabeth Liles ^{2,†}, Abirame Sivakumar ¹, Vindya Pathiraja ⁴, Peter Phiri ³, George Eleje ⁵, Nihal Al-Riyami ⁶, Sohier Elneil ^{7,*}, Sam Halabi ⁸ and Gayathri Delanerolle ^{2,3}

¹ University of Colombo, Sri Lanka

² University of Birmingham, Birmingham, United Kingdom

³ Hampshire and Isle of Wight Healthcare NHS Foundation Trust, Southampton, United Kingdom

⁴ University of Ruhuna, Matara, Sri Lanka

⁵ Nnamdi Azikiwe University, Awka, Nigeria

⁶ Sultan Qaboos University, Muscat, Sultanate of Oman

⁷ University College London, London, United Kingdom

⁸ Georgetown University, Washington DC, United States of America

* Correspondence: sohier.elneil@ucl.ac.uk

† Shared first author.

Abstract

Background: Women in perimenopause, menopause, and post-menopause experience significant biological, psychological, and social changes, including vasomotor symptoms, urogenital atrophy, sleep disturbances, and cognitive shifts. Despite the impact on quality of life, productivity, and social participation, these life stages are underrepresented in national and international health policies compared to reproductive years. **Methods:** A systematic review following PRISMA guidelines was conducted. English-language national and international policy documents published up to March 2025 were retrieved from PubMed, Science Direct, Google Scholar, WHO, UNFPA, and national health ministry websites. Policies were included if they addressed women's health during perimenopause, menopause, or post-menopause. Data extraction captured policy focus, target populations, chronic disease management, cancer screening, menopause care, equity considerations, and alignment with global standards. Thematic and conceptual analyses synthesized findings into key domains and gaps. **Results:** Thirty policies from 13 jurisdictions were reviewed, addressing women's health across the reproductive life course, including peri-menopause, menopause, and post-menopause. Common priorities included chronic disease management, menopause symptom management, cancer prevention and screening, mental health support, and management of reproductive disorders such as PCOS, endometriosis, and infertility. Equity considerations focused on underserved populations, including rural women, socioeconomically disadvantaged groups, Indigenous and ethnic minorities, and other high-risk populations such as sex workers and adolescents. **Conclusion:** Policies addressing later reproductive years remain heterogeneous, with inconsistent integration of chronic disease management, cancer screening, and reproductive health care. Strengthening equitable, evidence-based policy frameworks is crucial to support women's health, reduce disparities, and improve quality of life during perimenopause, menopause, and post-menopause.

Keywords: perimenopause; menopause; post-menopause; women's health; policy; chronic disease; PCOS; endometriosis; cancer screening; health equity

Introduction

Through women's life course, perimenopause, menopause, and the post-menopausal periods are critical transitions for women because most women spend approximately more than 30% of their lives in this stage, especially in elderly ages [1]. Through these years, there are significant biological, psychological, and social changes, including vasomotor symptoms, sleep disturbances, cognitive shifts, and urogenital atrophy [2]. In addition to physical changes for women through these years, there are significant changes in the women's quality of life, productivity, social participation, and health equity [3]. Regardless of mentioned challenges and issues, international and national health agendas mostly neglect appropriate actions and policies for perimenopause, menopause, and the post-menopausal periods compared to reproductive years such as maternity health [4].

Women's health can be considered as a foundation of public health, with important implications for population health, economic growth, and social developments [5]. Policies for women's health are important to addressing and shaping the inequities that challenges affect women throughout their lives [6]. However, appropriate policies for women in their perimenopause, menopause, and the post-menopausal years are poorly integrated into health systems, or inadequately implemented [4]. For example, hormone replacement therapy (HRT) is an appropriate treatment for menopausal women to alleviate many related symptoms such as hot flashes, sleep problems, mood swings, and vaginal dryness, which affecting significantly the women's quality of life and their social participation [7]. However, in low- and lower-middle-income countries (LMICs), multiple factors such as high costs, absence of supportive policies, and inadequate regulation significantly limit access to this medication for many women who need it [8,9]. Furthermore, although some policies and actions address the medical challenges of these years, psychosocial needs, workplace equity, and cultural contexts are often neglected, limiting access to essential services and exacerbating disparities in health outcomes [10,11].

Rationale

The KATHERINE Project addresses a critical policy blind spot: the needs of young-to-middle-aged women navigating the menopausal transition including premature, early, surgical and medically induced menopause who are often overlooked in frameworks geared to older populations. A systematic evaluation of perimenopause, menopause and post-menopause policies is required to map strengths, expose gaps in prevention, diagnosis, treatment access, workplace protections and social protection, and to identify inequities experienced by women at the intersection of gender, age, race/ethnicity, disability, migration status and socioeconomic position. By interrogating policy content, implementation fidelity and real-world impact against global equity-focused standards, KATHERINE will generate a rigorous, comparative assessment that surfaces where policies fail younger cohorts such as fragmented care pathways, fertility and contraception considerations, mental health, violence and safeguarding, and return-to-work supports. Focusing this paper on young-to-middle-aged groups is therefore strategic: it captures the period of highest role intensity such as employment, caregiving, parenting, when poorly designed policies magnify health and economic harms and widen lifetime inequalities. The project's ultimate aim is to deliver evidence-based, actionable recommendations that strengthen policy design and implementation so that women experiencing perimenopause through post-menopause particularly in younger and midlife stages can realise their health, rights and participation in society.

Methods and Materials

Study Design

This review was conducted in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Figure 1). The methodological approach was established in advance to ensure transparency and reproducibility. Although the review was not formally registered, the structure adhered closely to PRISMA requirements, and each stage of the process was prospectively defined.

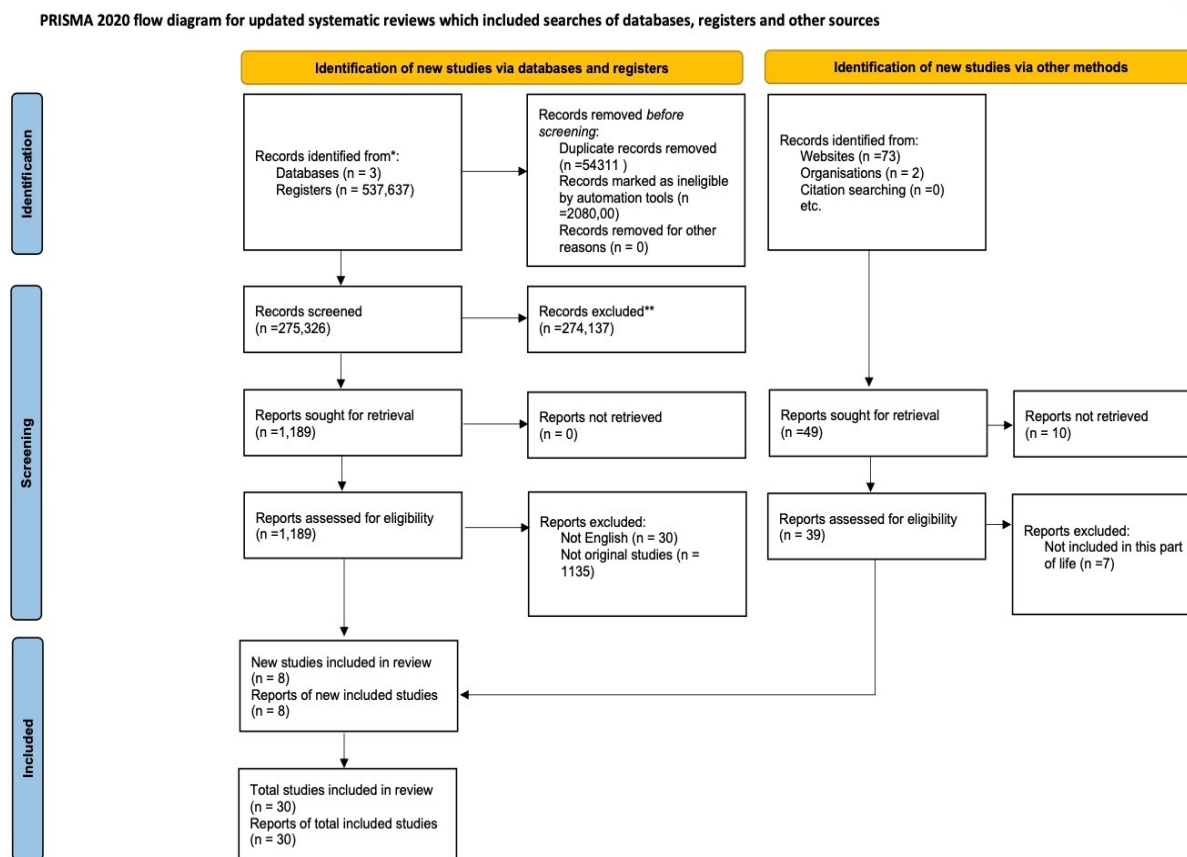


Figure 1. The study selection process is detailed in the PRISMA flow diagram.

Search Strategy

A comprehensive search was conducted on MEDLINE/PubMed, Science Direct, and Google scholar until March 30, 2025. The search utilized keywords such as “women’s Health”, “maternal health”, “reproductive health”, and “policy”. Additional studies were identified by national and International Websites such as WHO (World Health Organization), UNFDP (United Nations Financial Disclosure Programme), and the ministry of health of countries.

Study Selection and Data Extraction

Three reviewers screened the collected articles to identify studies that met the following inclusion criteria: (1) Population: women; (2) Intervention: health policy interventions; (3) Comparison: absence of such interventions; (4) Outcome: health policy related outcomes; (5) Setting/Time: all settings and time periods; and (6) Study design: observational, interventional, or qualitative studies. Discrepancies among reviewers were resolved through discussion and consensus. The selection process was documented in detail and summarized in a PRISMA flow diagram (Figure 1) [12]. Studies or policies without an available English version were excluded.

Quality Assessment

Two reviewers independently assessed the quality of the included studies using the AACODS (Authority, Accuracy, Coverage, Objectivity, Date, Significance) checklist, a critical appraisal tool designed specifically for grey literature sources. The overall quality ranged from low to high. Studies scoring ≥ 25 were considered high quality, those scoring ≥ 19 but < 25 were classified as moderate quality, and those scoring < 19 were rated as low quality. Full details of the quality assessment are provided in the Supplementary Data.

Data Analysis

The synthesis followed a dual approach. Thematic and contextual analysis was used to identify recurring patterns in governance, eligibility, inclusivity, financing, and ethical framing. Descriptive statistics were generated to summarise numerical variables such as age limits, Body Mass Index (BMI) thresholds, inclusivity provisions, and financing arrangements across jurisdictions. Comparative matrices were constructed to contrast commonalities and differences between national and subnational contexts, and findings were mapped against underpinning legal instruments. The results were consolidated into a master thematic table that captured themes, sub-themes, indicators, exposures, determinants, intersections, and policy strengths and weaknesses

Results

Overview of Included Policies

A total of thirty national and international policies, strategies, and guidelines published between 1980 and 2025 were reviewed [13–22]. These policies spanned diverse geographic and socio-economic contexts, including high income countries (HIC) such as Australia, Sweden, the United Kingdom, and Israel, as well as low - middle income countries (LMIC) countries including Ghana, Tanzania, South Africa, Rwanda, India, Nepal, Bhutan, Sudan, Botswana, Mauritius, and Mongolia [15,16,18–20,22–24]. The policy types encompassed national women's health strategies, reproductive health policies, cervical cancer and human papilloma virus (HPV) screening guidelines, maternal health frameworks, sexual and reproductive health rights initiatives, and action plans targeting chronic conditions and menopause management. Collectively, these documents reflected a broad spectrum of health priorities, ranging from clinical and preventive care to rights-based and equity-oriented approaches, demonstrating both the influence of international frameworks such as CEDAW, ICPD, and SDGs, and national socio-cultural and political contexts [25,26].

Among these policies, HICs consistently embedded equity, intersectionality, and life-course approaches into health planning. For example, Australia's National Women's Health Strategy 2020–2030, the chronic conditions policy brief (2017), and Scotland's Women's Health Plan (2021–2024) integrated menopause care, reproductive health, and mental health considerations with attention to marginalized groups, including Indigenous women, rural populations, and migrants. In contrast, low- and middle-income countries often prioritized maternal survival, family planning, and reproductive service accessibility, frequently shaped by donor-supported initiatives, as evident in Ghana's Free Delivery Care Policy (2007), Tanzania's Population Policy (2006), and Rwanda's RMNCAH policy [15]. Across all settings, adolescents and younger women remained inconsistently addressed, with policies tending to focus on reproductive prevention rather than the broader spectrum of sexual, mental, and chronic health needs.

Study Characteristics

The 30 policies represented a wide geographical distribution, including sub-Saharan Africa (Ghana, Tanzania, Rwanda, Botswana, South Africa, Swaziland), South Asia (India, Nepal, Bhutan), Southeast Asia (Myanmar), East Asia (Mongolia), the Middle East (Israel), and high-income settings such as Australia, New Zealand, Sweden, Scotland, Wales, and England [16,17,20–23,27,28]. The policies varied in scope, with some focused narrowly on reproductive health, family planning, or cancer screening (e.g., Ghana's National Reproductive Health Service Policy, South Africa's Cervical Cancer Guidelines), while others adopted a more comprehensive life-course approach integrating chronic disease, menopause, and equity dimensions (e.g., Australia's National Women's Health Strategy 2020–2030, NHS Wales Women's Health Plan 2024 [29]). Policy formats ranged from national strategies and legislative acts to technical guidelines and policy briefs, reflecting diverse approaches to addressing women's health needs across reproductive, perimenopausal, and postmenopausal stages.

Table 1. Characteristics of the studies included in the systematic review.

Study ID	Policy/articles name	Year	Policy Level	Country/Region	Policy Focus Area	Targeted Population	Policy Status	Objective	Outcomes	Equity Consideration	Global Alignment
1	Ghana's Free Delivery Care Policy [29]	2020	National	Ghana	Maternal Health Policy	Women of reproductive age who had recent live births	Implemented	Evaluate the impact of the free delivery policy on utilization and quality of delivery services, delivery outcomes, and the economic consequences for households.	The policy covered the following maternal health services: 1. Normal deliveries, <i>Assisted deliveries, including Caesarean sections</i> 2. Services were provided across: Public health	Universal Health Coverage	- Millennium Development Goals

									facilities		
									Private		
									health		
									facilities		
									Faith-		
									based		
									health		
									facilities		
2	National	2	Nati	Austra	Wome	All	Implem	To improve	1.	All	SDG3;
	Women'	0	onal	lia	n's	Australi	ented,	women's	Reproducti	wome	SDG5;
	s Health	2			health	an	Active	health	ve health	n and	SDG10
	Strategy	0			across	women,		across	and	girls	
	2020–				the life	with		Australia	sexuality	in	
	2030				course:	emphasi		and reduce	2. Health	Austra	
					reprod	s on		inequities	of ageing	lia,	
					uctive,	those			women	with	
					sexual,	most at			3.	additi	
					matern	risk			Emotional	onal	
					al,	(e.g.,			and mental	focus	
					mental	rural,			health	on	
					health,	socially			4. Violence	priorit	
					chroni	disadva			against	y	
					c	ntaged,			women	popul	
					illness,	Aborigi			5.	ations	
					ageing	nal and			Occupatio	(e.g.	
					,	Torres			nal health	Abori	
					violenc	Strait			and safety	ginal	
					e	Islander			6. Health	and	
						women)			needs of	Torres	
									carers	Strait	
									7. Health	Island	
									effects of	er	
									sex role	wome	
									stereotypin	n,	
									g	rural/r	
										emote,	
										low	
										socioe	
										conom	
										ic	
										status,	
										those	

										with disabil ity, LBTI comm unities , wome n affecte d by violen ce or justice syste m, vetera ns)	
3	Israel: Reprodu ction and Abortion : Law and Policy [27]	2 0 1 2	Nati onal	Israel	Fundi ng of Repro ductiv e care; Univer sal health covera ge; equita ble access to healthc are service s	All Israeli resident s	Implem ented, Active	To analyse Israel's specific policies and law on reproducti ve technologie s and abortions and discusses their social, religious, and political context.	1. Access to essential medical services 2. Prevention and treatment of diseases 3. Maternal and child health (Access to prenatal care, Safe delivery services) 4. Mental health 5. Chronic disease manageme nt 6.	Vulne rable Popul ations (such as low- incom e indivi duals, elderl y, those with chroni c condit ions)	Not mentio ned (Indirect ly associat ed with Univers al Health access)

									Prevention of genetic disorders 7. Reproducti ve autonomy and family planning		
4	National Populati on Policy	2 0 0 6	Nati onal	Tanza nia	"Popul ation and develo pment integra tion Repro ductiv e health Gende r equalit y Nutriti on Enviro nment al conser vation Educat ion Resear ch Advoc acy and comm unicati on (IEC)"	Entire Tanzani an populati on, with special focus on women, youth, and vulnera ble groups	Revised and Active	To evaluate progress in implem ting reproducti ve health policies and programs after the 1994 ICPD (Internatio nal Conference on Population and Developme nt).	"Reproduc tive Health Services Addressed Antenatal Care (ANC) Childbirth care Obstetric emergency care Newborn care Postpartu m care Post- abortion care Family planning Prevention and manageme nt of STIs and HIV/AIDS Cancer care Childhood illnesses and	Yes, Adher ence to gende r equalit y and equity , childr en's rights and rights for other vulner able group s	Nation al Develo pment Vision 2025 Millenn ium Develo pment Goals

									immunisa- ble diseases Nutrition Prevention and manageme- nt of fistulae and pregnancy- related morbidity s"		
5	Reproductive Health Policy Brief	2019	National	Australia	Reproductive Health	Australian women	Advisory/Researcher-informed (not direct implementation, support National Women's Health Policy 2010)	Highlight findings from ALSWH (2010–2018) to inform policy on reproductive health	Identified prevalence of PCOS (10%), endometriosis (10%), infertility (18.6%); menopause age data; hysterectomy impact; links to chronic diseases	Recognizes disparities in reproductive health outcomes (e.g., obesity, mental health, fertility problems)	Linked to National Women's Health Policy 2010; indirectly aligned with global reproductive health frameworks (ICPD, WHO women's health agenda)
6	National Reproductive Health	2014	National	Ghana	Reproductive health,	Women, children, adolescents	Implemented	aimed at making explicit the direction of	Cancer screening Family planning	Yes – includes vulnerable	ICPD 1994 and WHO

	Service			matern	nts,	reproducti	Infertility	able	standar		
	Policy			al and	couples,	ve health in	care	group	ds on		
	and			child	general	the context	unsafe	s and	reprod		
	Standard			health,	populati	of	abortion	promo	uctive		
	s (3rd			family	on	universal	and post-	tes	and		
	Edition)			planni		access to	abortion	access	matern		
				ng,		care	care	for all	al		
				safe			menopaus		health		
				mothe			e				
				rhood			Gender				
							based				
							violence				
7	HPV	2	Nati	Austra	Cervic	Women	Implem	To estimate	Reduce	Focus	WHO/I
	Screenin	0	onal	lia	al	aged	ented	the likely	incidence	d on	ARC-
	g,	1			cancer	25–69		impact of	of	age	aligned
	Invasive	7			screeni	eligible		Australia’s	oncogenic	group	in
	Cervical				ng	for		new 5-	HPV	30–69;	purpos
	Cancer					cervical		yearly	infections	didn’t	e; raises
	and					screenin		primary	(by 20% by	assess	concern
	Screenin					g		HPV	2030) in	stratifi	re: SDG
	g Policy							screening	women	ed	3.4
	in							policy	and	outco	(prema
	Australia							(Renewal	adolescent	mes	ture
								Policy) on	girls;	for	mortali
								the	decrease	First	ty
								incidence	age-	Natio	reducti
								of cervical	standardis	ns or	on);
								cancer	ed	migra	aligns
								compared	mortality	nt	with
								with the	rate from	wome	UN’s
								previous 2-	cervical	n	caution
								yearly	cancer (to		on
								cytology	20% by		overdia
								screening	2030).		gnosis
								policy.	Improve		
									quality of		
									life of		
									women		
									with		
									terminal		
									cancer.		
									Reduce		

Policy(30)	al Cancer Preven tion	years old); Women living with HIV and women with other immuno suppres sive conditio ns; sex workers ; adolesce nts; migrant s	and control programm e comprising three interlinked strategies: (1) reducing oncogenic HPV infections; (2) detecting and treating cervical precancer; and (3) ensuring timely treatment and palliative care for invasive cancer.	(by 20% by 2030) in women and adolescent girls; decrease age- standardis ed mortality rate from cervical cancer (to 20% by 2030). Improve quality of life of women with terminal cancer. Reduce incidence of invasive cancer (to 20% by 2030)	aged 9–12 via streng thened school health servic es, expan ding access to and prima ry preve ntion. 2030), Global Strateg y for Women 's, Childre n's and Adoles cents' Health, and targets such as univers al health coverag e and NCD mortali ty reducti on	orks, notably Sustain able Develo pment Goal 3 (univer sal access to sexual and reprod uctive health, by 2030), Global Strateg y for Women 's, Childre n's and Adoles cents' Health, and targets such as univers al health coverag e and NCD mortali ty reducti on
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10	Sweden's international policy on Sexual and Reproductive Health and Rights [22]	2021	International	Sweden	Safe abortions; maternal care; neonatal care; access to contraceptive services; HIV/AIDS and sexually transmitted infections	Women; newborn babies; infants; men	Implemented	to increase access to SRHR interventions, enhance knowledge, shift social norms, and strengthen accountability, with special focus on deprived areas and vulnerable groups, including LGBTQI population	Reduce maternal mortality rates; reduce infant mortality; prevention of transmission of HIV to newborn babies and infants; reducing spread of HIV and AIDS	Focus on inclusion of women and minorities as subjects in clinical research. Planning, conducting, reporting of analyses for sex/gender and racial/ethnic differences.	-
11	Women's Health Plan: A plan for 2021-2024	2024	National	Scotland	Women's Health and Gender Equality	Women (see considerations)	Implemented	to reduce avoidable health inequalities experienced by women and girls across their lifespans—from puberty	"• ensure women who need it have access to specialist menopause services for advice and support on the	Consider gender inequalities as a factor influencing SRHR	Yes. bilaterally, multilateral, operational and nominative work that

through diagnosis Define Sweden
 later and s in
 years—by manageme sexual differen
 focusing on nt of rights t ways
 areas menopaus as carries
 commonly e; meani out in
 stigmatized • improve ng all internat
 , access for people ional
 overlooked women to irresp context
 , or appropriat ective s.
 dismissed e support, of sex,
 as speedy age,
 “women’s diagnosis ethnici
 issues,” and best ty,
 including treatment disabil
 heart for ity,
 health, endometri gende
 menopause osis; r
 , menstrual • improve identit
 health, access to y, or
 endometriio informatio sexual
 sis, n for girls orient
 contracepti and ation
 on, women on have a
 abortion menstrual right
 services, health and to
 and access manageme their
 to nt options; own
 informatio • improve body
 n access to and
 abortion sexual
 and ity.
 contracepti
 on
 services;
 • ensure
 rapid and
 easily
 accessible
 postnatal
 contracepti
 on;

									<ul style="list-style-type: none"> • reduce inequalities in health outcomes for women's general health, including work on cardiac disease." 		
12	The NHS Wales Women's Health Plan	2024	National	Wales	Women's Health and Gender Equality	Women (see equity considerations)	Implemented	To close the gender health gap in Wales by transforming the way healthcare services are designed and delivered for women and those assigned female at birth—ensuring they are listened to, their health needs are understood, and care is equitable across the lifespan	"Menstrual Health (Including: Heavy Menstrual Bleeding (HMB), Endometriosis, Fibroids, Adenomyosis, Polycystic Ovary Syndrome (PCOS), Pre-menstrual Syndromes (PMS), Pre-menstrual Dysphoric Disorder (PMDD)); Endometriosis and Adenomyosis;	"Inclusive transgender men, non-binary people, and intersex people or people with variations in sex characteristics."	e NHS Wales Women's Health Plan is globally aligned through its commitment to the SDGs, WHO's life-course approach, and international frameworks on gender equality and health equity



Contraception, Post-Natal
Contraception and Abortion Care;
Preconception Health; Pelvic Health and Incontinence;
Menopause;
Violence Against Women, Domestic Abuse and Sexual Violence;
Aging Well and Long-term Conditions Across the Life Course
(Including: Adolescent Health and Wellbeing; Sexual Health, HIV and Blood Borne Viruses;



									Mental Health and Wellbeing; Alzheimer' s and Dementia; Diabetes; Myalgic Encephalo myelitis/C hronic Fatigue Syndrome; Cardiovasc ular Disease; Cancer Recovery; Musculosk eletal Conditions ; Palliative and End of Life Care)"		
13	Women's Health Strategy for England	2 0 2 2	Nati onal	Engla nd	Impro vemen t of wome n's health	Women	Implem entation	-	"Tackling disparities in access to services and experience s of services and outcomes. Women with additional risk factors or barriers to have	Includ es trans men and non- binary people record ed female at birth. Addre sses wider deter minan	Though not explicit ly named in the strateg y, its focus on equitab le access, improv ed health system s, and

equitable access. Menstrual health and gynaecological conditions (heavy menstrual bleeding, premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD), endometriosis, adenomyosis, fibrosis, polycystic ovary syndrome (PCOS) (and also urogynaecological conditions including urinary incontinence, vaginal prolapse, recurrent urinary tract infections),

ts of health (ranging across social, economic, and environmental factors).

rights-based care support s SDG 3 (Good Health & Well-Being) and SDG 5 (Gender Equality). The fiscal framings also resonates with global economic rationalisation for investment in women's health

worse health disparities. Intersectionality and vulnerability is

and address
gynaecological
cancers.

Fertility,
pregnancy,
pregnancy
loss, and
postnatal
support
(contraception,
preconception
health,
fertility
and
infertility,
pregnancy
loss and
stillbirth,
birth
trauma,
support for
expectant
and new
mothers
and their
partners.

Personalised
care.

Menopause.

Mental
Health and
Wellbeing.

Cancers
(uterus,

									ovarian, cervical, vulval, vaginal)."		
14	Chronic conditio ns policy brief	2 0 1 9	Nati onal	Austra lia	Chroni c diseas e conditi ons of wome n	Women (ages ranging from 30s to 90s), specifica lly from Australi an Longitu dinal Study on Women' s Health (ALSW H)	Implem ented	The brief synthesizes key findings from ALSWH data (since around 2010) on chronic conditions among Australian women, aiming to inform and guide the developme nt of national health policies—	Multimorb idity, frailty, mental health, urinary incontinen ce, injury from falls, obesity, diabetes, stroke, arthritis, cancer, cardiovasc ular disease	Addre ssed transg ender men and non- binary people with female reprod uctive organs wrt cancer screen ing. Addre sses dispar ities experi enced by "wom en from under- served and seldo m- heard group s". Consi ders	While primari ly nationa l in scope, the brief aligns with internat ional framew orks by recogni zing chronic conditi ons as life- course, non- commu nicable disease s, advocat ing evidenc e- based, equity- focused strategi es— parallel ing WHO

group priorities with barriers to health, such as women's experiential health and homeliness, reduction, refugees, asylum seekers, women in prison; also: disabled women, lesbian and bisexual women, and black and Asian women.

15	Pregnan	2	Nati	Austra	Pregna	Women	Ongoin	highlight	Gestational	Emph	Alignm
	cy and	0	onal	lia	ncy	in	g	maternal	diabetes,	asis	ent



maternal	1	and	reprodu	mortality	hypertensi	typical	with
health	9	matern	ctive	and	on, low	ly on	SDG 3,
policy		al	age	morbidity	birth	reduci	especia
brief		health		trends,	weight,	ng	lly
				underscore	maternal	dispar	Target
				gaps in	depression	ities—	3.1
				prenatal/po	and	adres	(matern
				stnatal	anxiety,	sing	al
				care, and	childhood	racial/	mortali
				recommen	obesity,	ethnic,	ty
				d strategic	antenatal	socioe	reducti
				interventio	health	conom	on) and
				ns—like	behavior	ic, and	3.8
				improved		geogra	(univer
				access to		phic	sal
				quality		inequi	health
				services,		ties in	coverag
				care		mater	e);
				continuum		nal	adhere
				strengtheni		outco	nce to
				ng, and		mes;	WHO's
				workforce		promo	human-
				capacity		ting	rights
				building		cultur	based,
						ally	life-
						respon	course
						sive	matern
						care,	al
						includi	health
						ve	framew
						data	orks;
						collect	often
						ion,	reflects
						and	the
						comm	reprod
						unity-	uctive
						based	justice
						suppo	approa
						rt.	ch,
							which
							centers
							intersec

										tional, rights- based access to care	
16	Sexual and health policy brief [28]	2 0 1 9	Nati onal	2017	Sexual health policy brief	Australi an women	Ongo in	To present key research findings on sexually transmitted infections (STIs) and contra cepti ve use among Australian women, with the goal of informing national health policy and improving sexual health outcomes	STIs (e.g., chlamydia , thrush, contra cepti ve behavior, reproducti ve heal ing	highli ghts dispar ities in sexual health outco mes across region s (urban vs rural), socio- econo mic status, and cultur al or identit y group s	Aligns implicit ly with global health efforts such as the Sustain able Develo pment Goals (SDG 3) related to sexual and reprod uctive health and the WHO's STI prevent ion framew orks
17	Women' s Health: Best Practices in Sex Educat ion Impleme nted by	2 0 1 7	Nati onal	Japan	Sexual and reprod uctive health educat ion; HIV/A IDS	Student s (elemen tary to high school), school teachers , and	Ongo in	to contribute to the promotion of sex education within educational institutions	Knowledg e of STDs, contra cepti on, reproducti ve health, sexual behaviors,	Emph asizes clear policy, long- term imple menta tion,	WHO health prioriti es on reprod uctive health access, STI s

	Local Governments [20]			and STD prevention; youth sex education	education stakeholders			throughout Japan through the wide sharing of these practices	HIV/AIDS prevention	evaluation, and multi- stakeholder collaboration— ensuring culturally and regionally responsive inclusion	
18	National action plan for endometriosis [31]	2 0 1 7	National	Australia	Endometriosis awareness, early diagnosis, treatment, and support	Public population	Active and Ongoing	improved quality of life for women living with endometriosis and reduced burden of disease for individuals and for the nation	Chronic pelvic pain, infertility, fatigue, mental health impacts, delayed diagnosis	Not mentioned	Aligned with WHO/ UNESCO Recommendations on Comprehensive Sexuality Education (CSE)
19	RANZOG Submission to the National Women'	2 0 2 3	National	Australia and New Zealand	Women's health equity, reproductive	Women and girls	Implemented	aims to evaluate strategies for advancing women's	Improved maternal care, abortion access, reproductive	Not mentioned	Australian Health Ministers' Advisory

s Health Strategy [21]	health, matern al health, gynaec ologica l care	health by (1) placing wāhine/wo men+ at the centre of care through addressing knowledge gaps, inequities, and social determinan ts of health; (2) ensuring integrated, accessible, and fully funded multidiscip linary services spanning community , hospital, and maternity care; (3) strengtheni ng leadership, governance , and data systems to enhance accountabil ity and quality; and (4) developing sustainable	ve choice, chronic disease manageme nt, menopaus e support, culturally safe care	ry Council (AHM AC)
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								workforce planning and support mechanism s			
20	Sexual and Reproductive Health Rights under the Reproductive and Child Health Policy – Compro mising Women's Dignity [17]	2 0 1 0	Nati onal	India	matern al health, child mortal ity, gender equalit y and HIV/A IDS	women' s and children 's	Implem ented	To bring women's and children's health to the attention of Parliament arians, with detailed policy recommen dations and actions for MPs.	women in the interventio n districts reported an increase in their discussion s about family planning with spouses, from 42.3% to 90%; an increase in the use of family planning methods, from 7% to 35%; more women reported being involved in decision- making at home, up from 49% to 71%; more women reported that they felt they	Yes, Inner Spaces Outer Faces Initiati ve (ISOFI): A Gende r and Sexual ity Project in Uttar Prades h	Yes, achievi ng the Millenn ium Develo pment Goals

had a right to refuse sex if they wished, from 37% to 95%; and more women reported expressing sexual needs to her spouse, from 25.4% to 67.5%

21	National Sexual and Reproductive Health and Rights Policy [17]	2022	National	Myanmar	Sexual and Reproductive Health	General population	Implemented	1. To inform decision makers, development/implementation partners, health providers, and beneficiaries about the policy and ensure that they are supported by the policy in their work and/or lives.	1. To comprehensive, high-quality health information and services will be provided to all women throughout pregnancy, childbirth, and the postpartum period. All individual reproductive age will have equitable access to	Assuring gender equality in health through gender-sensitive approaches to be mainstreamed through all levels of the health system,	1. Beijing Platform for Action 2. Every Woman, Every Child 3. Family Planning 2020 & 2030 4. Millennium Development Goals 5. Sustainable Development
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, and quality and Goals definitions and indivi (SDGs) that restrict inclusive duals 6. access to FP affecte Interna essential informatio d by tional SRHR n, gende Confer informatio commoditi r- ence on n and es, and based Populat services, services violen ion and especially and will ce will Develo among have the have pment adolescents freedom to ready (ICPD), youth, decide on access Progra and the desired to mme of marginaliz number of qualit Action ed and children y, 7. vulnerable and compr Conven groups. determine ehensi tion on the healthy ve the timing and sexual Elimina spacing of and tion of pregnancie reprod All s. utive Forms The health of highest servic Discri achievable es minatio standard n of sexual against and Women reproducti 8. ve health Conven for all tion on adolescent the s will be Rights pursued of the by Child protecting and fulfilling adolescent s' right to informatio

n, quality
and
inclusive
services, in
addition to
promoting
enabling
environme
nts and
opportunit
ies to
develop
life skills.
All
individual
s will have
their
dignity
and rights
upheld,
including
their right
to health.
Gender-
sensitive
approache
s will be
mainstrea
med
throughou
t all levels
of the
health
system,
and
individual
s affected
by GBV
will have
timely
access to
quality,

									comprehen sive sexual and reproducti ve health services. All women, men, and young people will have access to informatio n, prevention , early diagnosis, and care for reproducti vze health morbidity s.		
22	National Reproductive Health Policy [18]	2 0 1 0	Nati onal	Sudan	reprod uctive health	General populati on	Implem ented	To assure quality reproducti ve and sexual health care that women survive pregnancy and childbirth and enjoy a good family life; adolescent and young children	Provision of post- abortion care, antenatal care including PMTCT, skilled assistance during childbirth, essential obstetric care, postnatal care, and appropriat	Yes, unity and empowerme nt in accessi ng and availin g reprod uctive health care is seen in the policy	Yes , o achievi ng MDG 5, thus contrib uting to the Millenn ium Declara tion for Achievi ng MDGs, particul arly 3,



have e in the 4, 5 and
 optimal manageme contex 6
 physical nt of fistula t of
 and sexual cases. social
 developme Provision deter
 nt; the of minan
 sexually “continuu ts of
 transmitted m of care” health.
 infections/ model by
 HIV, addressing
 reproducti the three
 ve tract delays:
 infections, delay in
 cervical decision-
 cancer and making to
 other RH seek
 morbidities medical
 , including care
 fistula, are during
 combated; obstetric
 traditional emergenci
 practices es; delay in
 harmful for transportin
 reproducti g woman
 ve and to an
 sexual appropriat
 health are e referral
 prevented; hospital;
 and family and delay
 planning in
 services are receiving
 made adequate
 available care at the
 hospital.
 Provision
 of neonatal
 care with
 special
 emphasis
 on
 improving
 the

antitetanus
coverage
to both
mothers
and the
neonates.
Services
regarding
reproducti
ve choices
and birth
spacing
methods
provided
free of
charge.
General
practitione
rs and
specialist
physicians
shall
provide
the whole
range of
family
planning
services. At
primary
health care
level,
health
visitors
and
medical
assistants
shall
provide
family
planning
informatio
n and

services for
child
spacing
and
welfare of
women. In
remote
villages
and
nomadic
settings,
village
midwives
and
communit
y health
workers
shall act as
change
agent and
in addition
to
providing
hormonal
contracepti
ves and
condoms,
refer
clients to
health
facilities.
The
induction
of
abortion,
except
under
medical
advice, is
pronounce
d illegal by
this policy.

Emphasize
s
promoting
adolescent
reproducti
ve and
sexual
health,
including
combating
sexually
transmitte
d
infections,
and
reproducti
ve tract
infections.
Measures
shall be
taken for
ensuring
early
diagnosis
of cervical
cancer and
that other
RH
morbidity
s including
complicati
ons of
unsafe
abortion
and vesico-
vaginal
fistula are
combated.
Pre-marital
care for the
health and
life of the

family and
future
generation
s; this shall
be
incorporat
ed within
the
provided
services.
Premarital
counseling
, to include
counseling
on
nutrition,
HIV
testing,
genetically
transmitte
d diseases,
harmful
behaviors
and
misconcept
ions
regarding
sexual and
reproducti
ve health/
Traditional
practices
that are
harmful
for
reproducti
ve and
sexual
health
particularl
y female
genital

									<p>mutilation, early marriage, and GBVs are prevented. Procedures like cloning and semen donation are prohibited and not allowed under law; therefore are not supported by this policy.</p>		
23	NatioNal Medical StaNdard d For reproduc tive Health [20]	2 0 2 0	Nati onal	Nepal	reprod uctive Healt H	General populati on	Implem ented	to provide policymake rs, health officers, hospital directors or health facility in- charges, clinical supervisors and service providers of all level of governmen ts in federal context with accessible,	Informatio n: right to accurate, appropriat e, understan dable, and unambigu ous informatio n related to reproducti ve health and sexuality, and to overall health. Informatio n and materials	Yes, attenti on to equity for ELEM ENTS Of Care	Interna tional Referen ce Texts/ Materia ls e.g. FP Global Handb ook 2018, Medica l Eligibili ty Criteria , 2015 (WHO) Scientif ic

clinically-oriented information to guide the provision of reproductive health services in Nepal

for clients need to be available in all parts of the healthcare facility. **Access to services:** right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, gender, age, marital status, fertility, nationality

or
ethnicity,
social
class,
religion, or
sexual
orientation

**Informed
choice:**

right to
make a
voluntary,
well-
considered
decision
that is
based on
options,
comprehen-
sible
informatio-
n, and
understan-
ding. The
informed
choice
process is a
continuum
that begins
in the
communit-
y, where
people get
informatio-
n even
before they
come to a
facility for
services. It
is the
service

provider's
responsibil
ity either
to confirm
that a
client has
made an
informed
choice or
to help the
client
reach an
informed
choice.
**Safe
services:**
Clients
have a
right to
safe
services,
which
require
skilled
providers,
attention
to infection
prevention
, and
appropriat
e and
effective
medical
practices.
Safe
services
also mean
proper use
of service-
delivery
guidelines,
quality

assurance
mechanisms within
the facility,
counseling and
instruction
for
clients, and
recognition
and
management of
complications related
to medical
and
surgical
procedures

**Privacy
and
confidentiality:**
Clients
have a
right to
privacy
and
confidentiality during
the
delivery of
services.
This
includes
privacy
and
confidentiality during
counseling,
physical



examinatio
ns, and
clinical
procedures
, as well as
in the
staff's
handling
of clients'
medical
records
and other
personal
informatio
n.
**Dignity,
comfort,
and
expression
of
opinion:**
right to be
treated
with
respect
and
considerati
on. Service
providers
need to
ensure that
clients are
as
comfortabl
e as
possible
during the
procedures
. Clients
should be
encourage
d to

									express their views freely, even when their views differ from those of service providers.		
									Continuity of care: right to continuity of services, supplies, referrals, and follow-up necessary to maintainin g their health.		
24	Reprodu ctive, Maternal , Newbor n Child and Adolesce nt + Health of Ageing(RMNCA H+A) Strategy	2 0 2 5	Nati onal	Bhuta n	RMNC AH+ Health y ageing strateg y	women, children , and adolesce nts	implem ented	provide strategic guidance to the national and district level managers to implement the life course approach and continuum of evidence- based interventio	There are four strategic outcomes that are inter- related and mutually reinforcing and contribute to 13th FYP health outcome of “improved health and wellbeing for all Bhutanese	Yes, Enhan ce the capabi lity of at nation al and subnat ional levels to carry out stewar dship functi ons with	Yes. Aligne d with SGD and WHO and UNFD P indicat ors

								ns along the life course in achieving the human capital to its fullest potential	". The strategic outcomes are linked to several outputs identified by the MOH in the health sector section of the 13th FYP	special focus on PHC. PHC orient ed health syste ms are critical for better health outco mes, equity and efficie ncy	
25	National Health Policy [19]	2 0 1 1	Nati onal	Botsw ana	Compr ehensi ve nation al health system policy	All people living in Botswa na	Implem ented	Strengthen health system to ensure universal access, address disease burden	Expanded facilities; improved ART access; progress on malaria reduction; persistent inequities in maternal/c hild mortality & HRH shortages	Explici t focus on reduci ng inequi ties across social group s, region s, gende r, disadv antage d; incorp orates social deter	Anchor ed in WHO health system "six buildin g blocks, " MDGs, Ouaga dougou Declara tion, Paris Declara tion on Aid Effectiv eness



										minan	
										ts of	
										health	
26	National Sexual and Reprodu ctive Health Policy	2 0 2	Nati onal	Maurit ius	Sexual and Repro ductiv e Health	General populati on	Implem ented	to provide guidance to the Ministry of Health and Wellness and all stakeholder s on the coordinatio n and implement ation of relevant programm es in response to the country's Sexual and Reproducti ve Health and Rights and needs.	have their bodily integrity, privacy, and personal autonomy respected; • freely define their own sexuality, including sexual orientation and gender identity and expression; • decide whether and when to be sexually active; • choose their sexual partners; • have safe and pleasurabl e sexual experience s; • decide whether, when, and	Mains tream SRHR issues of equity and empowerme nt	UNDP' s Sustain able Develo pments Goals WHO's Reprod uctive Health strateg y 2004 Interna tional Confer ence on Populat ion and Develo pment (ICPD) 1994 4th World Confer ence on Women (Beijing) 1995

whom to
 marry;
 • decide
 whether,
 when, and
 by what
 means to
 have a
 child or
 children,
 and how
 many
 children
 to have;
 and
 • have
 access over
 their
 lifetimes to
 the
 informatio
 n,
 resources,
 services,
 and
 support
 necessary
 to achieve
 all the
 above, free
 from
 discrimina
 tion,
 coercion,
 exploitatio
 n, and
 violence.

27	National	2	Nati	The	Sexual	Women,	Implem	Provide	Increased	Emph	Explicit
	Policy on	0	onal	kingd	and	men,	ented	coordinate	ANC	asis on	ly



	Sexual and Reproductive Health [14]	13	om of Swaziland and Health	Reproductive Health	adolescents, youth, ageing population		d, integrated SRH services; improve maternal and child health; reduce HIV/STI burden; promote gender equity and rights	coverage (94%); facility deliveries (74%); integration of HIV/SRH; policy guidelines for FP, PMTCT, cervical cancer	gender equality, community participation, rights-based approach	aligned with ICPD PoA, FWCW, MDGs, AU SRHR framework, Maputo Plan of Action, SADC protocols
28	National Reproductive Maternal Newborn, Child And Adolescent Health (RMNCAH) Policy [15]	2018	National Rwanda	Reproductive Health	women, new born, children and adolescents	Implemented	The continuum of care throughout the life cycle and health system which has been proved to have a high impact on reducing maternal, neonatal and child mortality and morbidity.	Strengthen inter-sectoral collaboration and coordination and harmonize existing policies to address the social determinants of poor RMNCAH outcomes, and conduct research to identify major obstacles	Yes, All women, new born babies, children and adolescents - witho ut distinction of age, gender, marital status, ability (mental or physical	Millennium Development Goals

and the al),
 most race,
 effective religio
 coordinati n,
 on sexual
 mechanis ity,
 ms. politic
 Implement al
 and beliefs
 monitor a ,
 harmonize geogra
 d, phical
 integrated situati
 and on, or
 sustainable socio-
 package econo
 of quality mic
 client and status
 youth- - have
 friendly a right
 essential to
 RMNCAH equal
 promotion, and
 prevention univer
 and sal
 treatment access
 interventio to
 ns, RMN
 commoditi CAH
 es and interv
 innovative ention
 technologi s
 es at
 hospital,
 health
 centre and
 communit
 y levels
 and
 conduct
 research
 on the



cost-
effectivene
ss of
interventio
ns.
Build
capacity of
training
institutions
,
managers
and health
care
providers
in
integrated
RMNCAH
care so that
health staff
at all levels
from
communit
y upwards
are
able to
deliver
quality,
integrated,
client and
youth-
friendly
RMNCAH
services.
Strengthen
health
systems
and
research
towards
universal
coverage
of

RMNCAH
services
paying
attention
to the
deployment
t and
retention
of health
staff,
financial
and
geographic
al access to
services
by under-
served and
vulnerable
groups/
beneficiari
es and use
the HMIS
to monitor
equity.
Intensify
health
promotion
efforts
to increase
communit
y
knowledge
and skills
on
RMNCAH
interventio
ns and
promote
health
seeking
behaviour.



Strengthen
governanc
e systems
and
accountabi
lity (joint
planning,
budget
allocation,
implement
ation,
monitoring
and
evaluation)
of
integrated
RMNCAH
interventio
ns
at central,
decentralis
ed and
communit
y
levels,
including
with
public-
private
partnershi
ps
and
through
Imihigo
and
performan
ce-
based
contracts.

29	Populati on and Reprodu	1 9	Nati onal	Sri Lanka	"Popul ation	Women of reprodu	Implem ented	to review existing data and	Safe motherhoo d	Yes,E mphas is on	Not mentio ned,
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ctive	9	stabiliz	ctive	discover		gende	Aligns
Health	8	ation	age, the	emerging	Maternal	r	with
Policy			elderly,	issues of	morbidity	equity	ICPD
		Repro	urban	population	and	,	1994,
		ductiv	migrant	in Sri	mortality	under	MDG 5,
		e	s,	Lanka in		served	SDGs
		health	general	order to	Subfertility	areas,	(esp.
			populati	propose	and	rural/	SDG 3,
		Family	on,	appropriat	infertility	urban	5)
		planni	national	e policy		balanc	
		ng	policym	interventio	Anemia in	e	
			akers	ns which	reproducti		
		Gende	and	will	ve-aged		
		r	instituti	facilitate	women		
		equalit	ons.	the	and		
		y		promotion	pregnant		
				of overall	mothers		
		Youth/		developme			
		adoles		nt in the	Unwanted		
		cent		country	pregnancie		
		health			s		
		Elderl			Reproducti		
		y care			ve tract		
					infections		
		Migrat			(RTIs)		
		ion					
		and			Sexually		
		urbani			transmitte		
		zation			d		
					infections		
		Public			(STIs) and		
		aware			HIV/AIDS		
		ness					
		Data			Reproducti		
		system			ve cancers		
		s"			(e.g.,		
					cervical,		
					ovarian,		
					breast,		
					prostate)		

30	Reproductive Health, Gender & Rights in Mongolia a [16]	2020	National	Mangilao	Reproductive Health, Gender & Rights	General population	Implemented	Aims at creating a favorable environment for positive support and actions in the field of reproductive health, through advocacy with law and policy-makers and programme managers at all levels	This report provides a critical analysis of the legal environment related to reproductive health, gender, and as such provides the necessary background to identify gaps which need to be addressed in the current laws. The workshop mentioned above provides us with a series of recommendations for such changes to be advocated for and these are presented	It was relatively straightforward for government to implement strong legal guarantees for equality in employment under a central planne d system.	Yes
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in
Appendix
1. It is
hoped that
this report
will be a
useful
reference
tool for
Members
of
Parliament
, for
policy-
makers,
decision-
makers
and
programm
e-
managers,
for NGOs,
for
internation
al donors
for a better
understan
ding of the
legal
environme
nt in
Mongolia
for
reproducti
ve health
and for
gender.

Table 2. AACODS Scoring Table of Included studies.

Study ID	Policy/article name	Year	Country	Authority (5)	Accuracy (5)	Coverage (5)	Objectivity (5)	Date (5)	Significance (5)	Total score (30)	Total Quality
1	Ghana's Free Delivery Care Policy [29]	2003	Ghana	5	3	3	3	3	5	22	Medium
2	National Women's Health Strategy 2020–2030	2020	Australia	5	4	4	3	5	5	26	High
3	Israel: Reproduction and Abortion: Law and Policy [27]	2012	Israel	5	4	4	3	4	5	25	High
4	National Population Policy	2006	Tanzania	5	4	4	3	4	5	25	High
5	Reproductive Health Policy Brief	2019	Australia	4	3	3	3	5	4	22	Medium
6	National Reproductive Health Service Policy and Standards (3rd Edition)	2014	Ghana	5	4	4	3	4	5	25	High
7	HPV Screening, Invasive Cervical Cancer and Screening	2017	Australia	5	4	3	3	4	5	24	Medium

	Policy in Australia											
8	National Guidelines for Cervical Cancer Screening Programme	201 2	South Africa	5	4	3	3	4	5	24	Mediu m	
9	Cervical Cancer Prevention and Control Policy [30]	201 7	South Africa	5	4	4	3	4	5	25	High	
10	Sweden's international policy on Sexual and Reproducti ve Health and Rights [22]	202 1	Sweden	5	4	4	4	5	5	27	High	
11	Women's Health Plan: A plan for 2021-2024	202 4	Scotlan d	5	4	4	4	5	5	27	High	
12	The NHS Wales Women's Health Plan	202 4	Wales	5	4	4	4	5	5	27	High	
13	Women's Health Strategy for England	202 2	Englan d	5	4	4	4	5	5	27	High	
14	Chronic conditions policy brief	201 9	Australi a	4	4	4	3	5	4	24	Mediu m	
15	Pregnancy and maternal health policy brief	201 9	Australi a	4	4	4	3	5	4	24	Mediu m	

16	Sexual and health policy brief [28]	2019	Australia	4	3	3	3	5	4	22	Medium
17	Women's Health: Best Practices in Sex Education Implemented by Local Governments [20]	2017	Japan	4	3	3	3	4	4	21	Medium
18	National action plan for endometriosis [13]	2017	Australia	5	4	3	3	4	4	23	Medium
19	RANZCOG Submission to the National Women's Health Strategy [21]	2023	Australia & New Zealand	5	4	4	4	5	4	26	High
20	Sexual and Reproductive Health Rights under the Reproductive and Child Health Policy – Compromising Women's Dignity [17]	2020	India	5	4	4	3	3	4	23	Medium
21	National Sexual and	2022	Myanmar	5	4	4	3	5	5	26	High

	Reproducti ve Health and Rights Policy [17]											
22	National Reproducti ve Health Policy [18]	201 0	Sudan	5	4	4	3	3	4	23	Mediu m	
23	NatioNal Medical StaNdard For reproductiv e Health [20]	202 0	Nepal	5	4	4	3	5	4	25	High	
24	Reproducti ve, Maternal, Newborn, Child and Adolescent + Health of Ageing (RMNCAH +A) Strategy [23]	202 5	Bhutan	5	4	4	3	5	5	26	High	
25	National Health Policy [19]	201 1	Botswa na	5	4	4	3	4	5	25	High	
26	National Sexual and Reproducti ve Health Policy	202 2	Mauriti us	5	4	4	3	5	5	26	High	
27	National Policy on Sexual and Reproducti ve Health [14]	201 3	The kingdo m of Swazila nd	5	4	4	3	4	5	25	High	

28	National Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) Policy [15]	2018	Rwanda	5	3	3	3	4	4	22	Medium
29	Population and Reproductive Health Policy	1998	Sri Lanka	5	4	4	3	2	4	22	Medium
30	Reproductive Health, Gender & Rights in Mongolia [16]	2000	Mongolia	4	3	3	3	2	4	19	Medium-Low

Table 3. Combined Thematic and Contextual Analysis.

Theme	Contextual Evidence	Findings/ Patterns	Implications for IVF & Geriatric Mothers
Legal & Policy Frameworks	Policies such as Israel's Reproduction and Abortion Law (2012), Sweden's Sexual and Reproductive Health and Rights policy (2006), and Australia's National Women's Health Strategy (2020–2030) provide frameworks for reproductive rights, access to assisted reproductive technologies, and menopause care(22).	Rights-based approaches have increasingly replaced purely maternal/child-focused policies, yet implementation is inconsistent. Many LMIC policies reference reproductive health broadly but lack explicit provisions for IVF or age-related fertility interventions.	IVF access for older women is often constrained by age limits, religious or cultural norms, and coverage gaps. Legal clarity and supportive regulation are needed to ensure older women have equitable access to reproductive technologies and fertility counseling.

Financing & Coverage	Ghana's Free Delivery Care Policy (2007) and Nigeria's Saving One Million Lives illustrate targeted financing models; Australia's strategy includes dedicated funding for chronic conditions and reproductive health [29].	Fee removal, insurance coverage, and government subsidies can improve service uptake, but LMICs face sustainability challenges and hidden costs that reduce access for older or IVF-seeking women.	Older women seeking IVF or geriatric maternal care may face high out-of-pocket costs in LMICs, while HICs provide better coverage through insurance and public health financing. Dedicated funding streams for assisted reproductive technologies are essential.
Service Delivery & Workforce	Decentralization in Argentina (abortion care), Scotland and Wales (menopause services), and Sri Lanka's integrated MCH services demonstrate workforce adaptation to population needs.	Nurse- and midwife-led services expand access; integration of reproductive, chronic, and menopause care improves continuity. Gaps persist in provider training, age-specific care, and adolescent-sensitive approaches.	Geriatric mothers and older IVF patients require specialized clinical expertise, including high-risk pregnancy management and menopausal support. Workforce training in these areas ensures safer outcomes and patient-centered care.
Equity & Structural Determinants	Australia's equity focus on Indigenous, rural, and LGBTI women; South Africa's cervical cancer screening policy for high-risk groups; Ghana's reproductive health policies highlighting rural and poor populations.	Policies increasingly recognize social, economic, and cultural barriers, but targeted interventions for marginalized older women or IVF patients are limited.	Older women and IVF patients often face compounded inequities, including rural residence, low income, and cultural barriers. Equity-oriented policies should prioritize access, counseling, and support services for these groups.
Perimenopause, Menopause, Post-Menopause	Australian Reproductive Health Policy, NHS Wales Women's Health Plan, Scotland's Women's Health Plan, and Ghana's reproductive health policies address menopause	Recognition of menopausal symptoms and chronic disease management is increasing. Integration into primary care remains limited	Older women pursuing IVF or experiencing late pregnancies need tailored menopause management, HRT counseling, and screening for chronic conditions. Policies must

care, HRT, and chronic condition management. in many LMICs; guidance is inconsistent regarding fertility, late pregnancies, and hormonal support. integrate reproductive planning and geriatric maternal care for optimal health outcomes.

Combined Thematic and Contextual Analysis

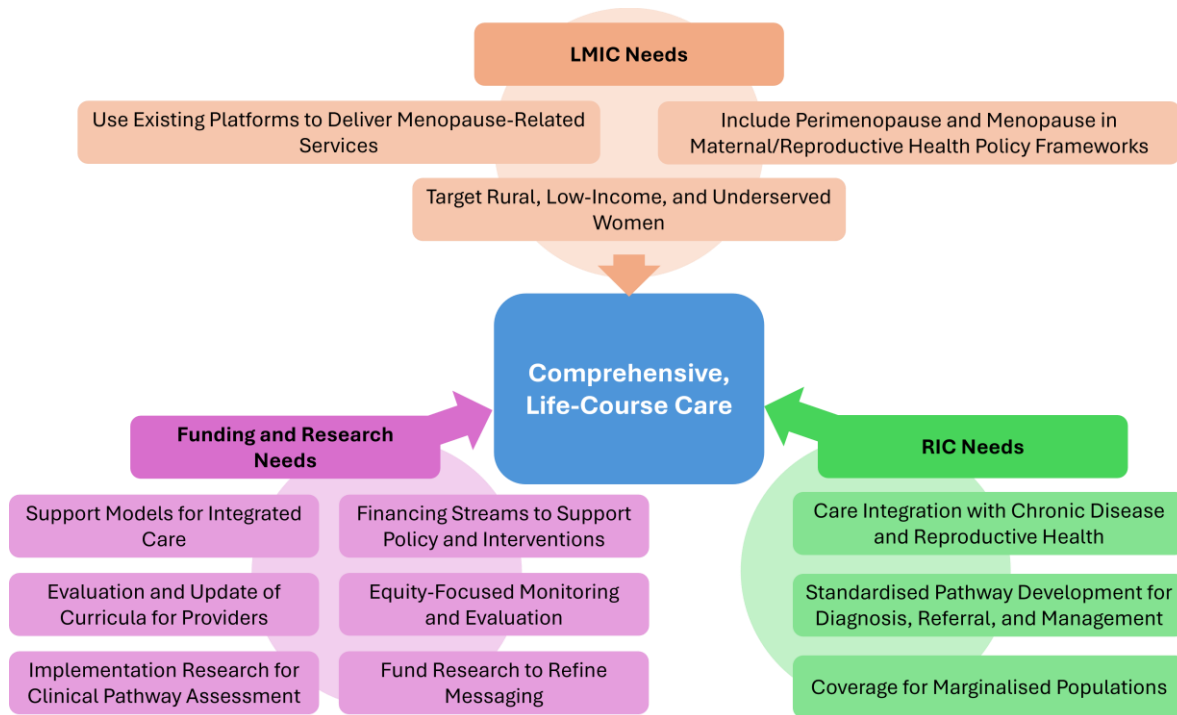


Figure 2. Key international actions required to ensure comprehensive, life-course care for menopause.

Peri-Menopause, Menopause, and Post-Menopause Health

Menopause-specific considerations were addressed in only a subset of policies, primarily in HICs. Australia, Scotland, England, and the NHS Wales strategies explicitly incorporated menopause and peri-menopause care, including vasomotor symptom management, chronic disease prevention, mental health support, and hormone therapy. Data from these policies highlighted that the average age of natural menopause ranged from 51 to 52 years, with 2–8% of women experiencing early or late menopause, and vasomotor, genitourinary, and psychosocial symptoms were common. Awareness, diagnostic services, and culturally appropriate education were identified as critical gaps, as noted in Australia’s national action plan for endometriosis and chronic conditions briefs [13]. The FDA’s recent approval of Veozah (fezolinetant) underscores the potential for novel non-hormonal therapies to broaden treatment choices and help destigmatize menopause care. However, whether HIC governments will integrate fezolinetant into national strategies and public funding mechanisms remains uncertain, highlighting a policy gap between therapeutic innovation and equitable access [32].

LMIC policies appeared to generally marginalize menopause care, focusing instead on maternal health and reproductive capacity. Ghana’s National Reproductive Health Policy (2014) and Tanzania’s Population Policy (2006) acknowledged midlife women indirectly through chronic disease or family planning initiatives but lacked actionable guidelines for menopause management [24,29]. This gap illustrates the broader trend in global health policy where midlife women are under-

prioritised, despite evidence of significant morbidity associated with menopause transition and postmenopausal conditions.

Financing and Health System Capacity

Financial accessibility and health system capacity emerged as critical determinants of policy effectiveness. In Ghana, the removal of delivery fees increased service utilization but disproportionately benefited wealthier populations due to indirect costs and variable facility-level implementation. Similarly, Australia and the UK invested in comprehensive health service coverage, including cervical cancer screening, chronic disease prevention, and menopause care. South Africa's cervical cancer screening programs demonstrated partial financial accessibility through free lifetime smears, though high-risk populations such as women living with HIV and adolescents remained vulnerable due to structural inequities [30].

Across these contexts, financial reforms improved theoretical access but did not fully eliminate structural barriers. Adolescents and women in midlife were particularly sensitive to hidden costs, transport barriers, and service gaps, which could delay preventive care, including HPV vaccination, cancer screening, and menopause management [30].

Service Delivery Models and Health Workforce

Service delivery models evolved from a narrow focus on maternal–child health to integrated reproductive and midlife health approaches. In Australia, clinical guidelines addressed perimenopause and chronic conditions through preventive and individualized care, while Scotland and England emphasised menopause awareness, workplace health, and mental well-being. Nurses and midwives remained central to delivering reproductive health and screening services in both high- and low-income countries, but limited training on age- and context-specific needs hindered effective service provision. Confidentiality, provider bias, and insufficient youth-friendly or midlife-focused care were consistent barriers across several policies, including Ghana, South Africa, and Rwanda [15,29,30].

Policy Drivers and Global Influences

The review revealed a strong influence of global frameworks in shaping national agendas. High-income countries were able to align policy goals with the Sustainable Development Goals, WHO recommendations, and international rights conventions, translating these into integrated strategies that addressed both reproductive and chronic health, including menopause. For instance, Sweden's international policy on Sexual and Reproductive Health and Rights (2006) and Australia's multiple health briefs emphasized equitable access to care, preventive health, and chronic disease management, while also recognizing the social determinants of health and age-specific needs of women in midlife [22].

Low- and middle-income countries demonstrated more selective adoption of global frameworks, often focusing on immediate maternal health needs and fertility regulation. Ghana's Free Delivery Care Policy, Tanzania's reproductive health initiatives, and Rwanda's RMNCAH policy illustrate donor-driven priorities, where adolescents and women's midlife health were frequently integrated into broader maternal health strategies but rarely operationalized as targeted interventions [15,29]. This reflects a tension between aspirational commitments to equity and reproductive rights, and the practical limitations imposed by resource constraints, institutional capacity, and competing priorities [15,29].

Equity and Structural Determinants

Equity was a prominent theme in high-income countries, which explicitly addressed intersectional vulnerabilities in their national strategies. For example, Australia's Women's Health Strategy, Scotland's Women's Health Plan, and the NHS Wales plan highlighted disparities affecting

rural women, Indigenous populations, migrants, and those with disabilities. In contrast, low- and middle-income countries often focused equity discussions on poverty reduction and geographic access, with limited attention to age, chronic disease, or social determinants such as education and employment.

Legal and rights-based policies further underscored the importance of structural determinants. Sweden's SRHR policy, South Africa's cervical cancer prevention policy, and Australia's reproductive health strategy demonstrated how recognition of rights could enhance women's agency in health decision-making, yet operationalization remained uneven, particularly for marginalized or younger populations [22,30].

Narrative Synthesis

Overall, the 30 policies demonstrate that while women's health policies have progressively incorporated life-course, rights-based, and equity-oriented approaches, peri-menopause and post-menopause care remain inconsistently addressed. High-income countries provide models of integrated care that combine preventive, chronic, and menopause-focused services, often with attention to marginalized populations. Low- and middle-income countries, constrained by financial and systemic limitations, continue to prioritize maternal survival and fertility management, leaving older women underserved. Adolescents and young women remain inconsistently addressed across both contexts, highlighting the need for age-specific, life-course-responsive, and equity-driven health policy frameworks.

Discussion

This systematic evaluation shows most policies focusing on later reproductive years are scarce, particularly in the LMIC settings. Although there are policies aligned to chronic disease management, menopause symptom management, reproductive disorders including PCOS, endometriosis, and adenomyosis, and cancer prevention, their implementation and comprehensiveness vary considerably. HICs such as Australia have integrated structured approaches with dedicated services and inclusive equity considerations, while LMICs like Sri Lanka, Ghana, and South Africa often demonstrate fragmented policy frameworks, limited access to menopause management, and underdeveloped psychosocial support [28,29]. The UK demonstrates policy variability across England, Wales and Scotland, which could attribute to health inequalities and limitations to health service infrastructure development. Cancer screening programs are generally more established in high-income settings, with LMICs showing considerable gaps in accessibility and coverage. Across all settings, policies frequently recognize equity as a principle but often fail to operationalise it fully, particularly for marginalized populations including rural, low-SES, ethnic minority, and transgender or non-binary individuals.

Over the past two decades, there has been a shift from narrowly framed maternal and reproductive health priorities toward a broader, life-course, and rights-based perspective. Equity considerations are often limited, leaving rural, socioeconomically disadvantaged, and marginalized populations at a disadvantage. These gaps underscore the continued need for comprehensive, age- and stage-specific health strategies that bridge policy rhetoric with clinical practice.

The findings highlight a global disparity in the prioritization and operationalization of women's health policies beyond reproductive years. Despite the growing life expectancy and the significant portion of women's lives spent in perimenopause, menopause, and post-menopause, policies continue to emphasize maternity and reproductive-age health. Chronic diseases, which disproportionately affect women during these later life stages, are variably addressed, and targeted management strategies for conditions such as cardiovascular disease, diabetes, and osteoporosis remain inconsistent. Reproductive disorders such as PCOS and endometriosis conditions with substantial impacts on quality of life and productivity receive limited attention outside high-income settings [13]. Psychosocial needs, workplace equity, and cultural considerations are particularly underrepresented, reflecting broader systemic gaps in addressing social determinants of health.

Comparison with Prior Policy Trajectories

The trajectory of women's health policy, as reflected in these 30 policies, aligns with three broad phases: the maternal survival era, the reproductive health and rights era, and the life-course and equity-based era. In the **maternal survival era**, early policies emphasized safe childbirth, skilled attendance, and fertility control. For example, Ghana's Free Delivery Care Policy (2007) focused on access to facility-based deliveries, benefiting maternal mortality outcomes but failing to address later life stages, including menopause [29]. During the **reproductive health and rights era**, policies incorporated family planning, fertility management, and safe abortion, as seen in Tanzania's Population and Reproductive Health Policy (2006) and Israel's reproductive care legislation (2012) [27]. Although these policies recognized women's reproductive agency, the focus remained primarily on fertility and early maternal outcomes, leaving midlife health largely unaddressed. The **life-course and equity-based phase** is exemplified by policies from Australia, Scotland, and England, which included chronic disease management, menopause care, sexual health, and palliative care. These policies reflect a broader recognition of the diversity of women's needs throughout life. Yet, despite these advances, age- and stage-specific interventions remain insufficient, particularly for women experiencing perimenopause or early menopause, highlighting persistent gaps between policy rhetoric and clinical reality.

Implications for Perimenopause, Menopause, and Post-Menopause

Among these policies, only a subset explicitly addressed menopause. Key gaps include insufficient guidance on symptom management (e.g., vasomotor symptoms, sleep disturbances, mood changes), limited access to hormonal and non-hormonal therapies, and a lack of structured screening or preventive programs targeting midlife women.

Policies that successfully integrated menopause into broader women's health strategies, such as Australia's Reproductive Health Policy and Scotland's Women's Health Plan, demonstrate the importance of combining preventive care, chronic disease management, and mental health support. Conversely, policies from LMICs like Ghana and Tanzania acknowledged menopause largely in descriptive terms, without operational guidance, resulting in inconsistent service provision [24,28,29].

The absence of early-perimenopause-specific interventions also suggests that women entering the menopausal transition are underrepresented in policy frameworks. This omission risks delayed identification of symptoms, reduced access to hormonal therapies, and underdiagnosis of associated chronic conditions, such as osteoporosis or cardiovascular disease.

Clinical Implications

The findings highlight the need for healthcare systems to integrate menopause and perimenopause care into routine primary and reproductive health services. Clinicians should adopt a **life-course perspective**, screening for common menopausal symptoms, providing guidance on hormone replacement therapy where appropriate, and addressing comorbid chronic conditions.

Training for healthcare providers should include menopause-specific care, mental health support, and patient-centered communication to reduce stigma and improve adherence. Policies should also promote preventive interventions such as cervical cancer screening, HPV vaccination, and management of endometriosis and PCOS, which have implications for midlife health [31].

Additionally, equity-focused implementation is essential. Rural, socioeconomically disadvantaged, and minority women often face barriers to accessing menopause care, and clinical services must be adapted to reach these groups. Integrating adolescent, perimenopausal, and post-menopausal care under the same life-course framework can enhance continuity and improve long-term health outcomes.

Strengths and Limitations

This is the first systematic evaluation of global women's healthcare policies focusing on the later reproductive years. The lack of access to hard-copy policies and those in languages other than English is a limitation. Furthermore, heterogeneity in policy scope and format limited the ability to perform quantitative comparisons.

Policy Recommendations

The review of 30 policies reveals a gradual but uneven global transition towards a life-course approach in women's health, with significant disparities between HICs and low- and LMICs. While some HICs have begun to integrate perimenopause and menopause into national health strategies through clear clinical pathways, provider training, and service standards, LMICs remain primarily focused on maternal and reproductive health, with limited attention to midlife health. Across all settings, adolescents and midlife women are underrepresented, resulting in fragmented care and restricted access to targeted interventions. To close these gaps, policies must explicitly address perimenopause and menopause, backed by dedicated financing and robust monitoring systems with age- and menopause-stage disaggregated data. Public education campaigns are essential to reduce stigma and promote uptake of services, while integration with chronic disease and reproductive health care will enable holistic, continuous support. Real-time research and evaluation particularly in LMICs are critical to generate evidence on prevalence, symptom burden, and intervention effectiveness. Without enforceable policy entitlements, secure funding, and integrated service delivery, efforts will remain aspirational and fail to produce meaningful improvements in the health and rights of women throughout the life course.

Table 4. Evidence-Based Policy Considerations for Perimenopause and Menopause.

Domain	High-Income Countries (HICs)	Low- and Middle-Income Countries (LMICs)	Funding & Research Needs
Policy Integration	Embed menopause in national women's health strategies with enforceable entitlements and service standards.	Expand beyond maternal/reproductive health to explicitly include perimenopause and menopause in policy frameworks.	Multi-donor and domestic financing streams to support real-time policy development and pilot interventions.
Clinical Pathways	Develop clear, standardized pathways for diagnosis, referral, and management, linked to workforce training.	Create simplified, scalable clinical guidelines adaptable for rural and resource-limited settings.	Fund implementation research to assess clinical pathway effectiveness.
Provider Training	Incorporate menopause-specific education into medical, nursing, and allied health curricula.	Strengthen training for primary care and community health workers to identify and manage midlife health needs.	Continuous evaluation and updating of curricula based on emerging evidence.

Service Delivery	Integrate menopause care with chronic disease and reproductive health services for seamless care.	Use existing maternal and reproductive health platforms to deliver menopause-related services where new services are not yet feasible.	Support pilot models for integrated care, with funding for scale-up.
Equity and Access	Ensure coverage for marginalized populations, including migrants, LGBTQ+ individuals, and low-income groups.	Target rural, low-income, and underserved women, reducing financial and geographic barriers to care.	Establish equity-focused monitoring and evaluation frameworks with disaggregated data.
Public Awareness	Implement campaigns to normalize menopause and reduce stigma, engaging workplaces and communities.	Address cultural barriers and misinformation through locally adapted education and outreach.	Fund qualitative and participatory research to refine messaging.
Monitoring & Evaluation	Establish robust systems with age- and menopause-stage disaggregated data for quality and outcome tracking.	Build basic data collection capacity within health information systems to track service uptake and outcomes.	Support real-time digital tools for data collection and policy feedback loops.
Research & Evidence Base	Support longitudinal studies on menopause trends, interventions, and workforce impacts [28].	Prioritize baseline epidemiological studies to map prevalence, symptom burden, and access gaps.	Allocate funding for cross-country comparative studies and policy evaluations.

Conclusions

Effective policy for perimenopause and menopause requires enforceable entitlements, secure financing, and integrated service delivery that address women's diverse and evolving needs. Without dedicated investment in data, research, and monitoring, policies risk remaining aspirational rather than achieving tangible improvements in women's health and rights. Bridging the gap between HICs and LMICs through equitable, evidence-based strategies is essential to ensure all women can access comprehensive, life-course care.

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