

ADVANCING WOMEN'S HEALTH

The 2026 Women's 20 (W20) calls on G20 governments to close the women's health gap and deliver measurable, gender-responsive health outcomes across the life-course.

WHY THIS MATTERS

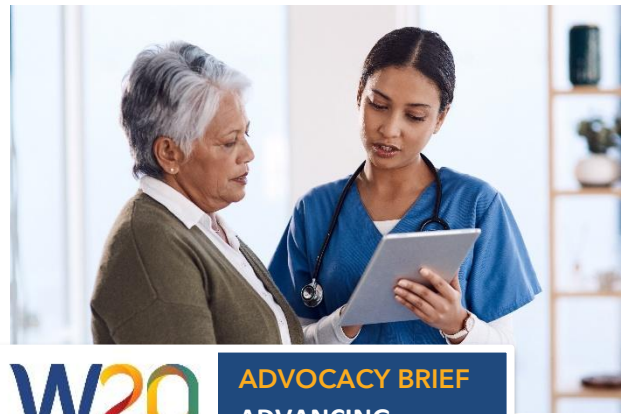
Women's health is a human right and a strategic economic asset, yet it remains systemically under-prioritized. Medical research, diagnostics, and treatment protocols have historically used male physiology as the default, leaving women at greater risk of delayed diagnosis, misdiagnosis, and adverse drug reactions. Health must be understood across the entire life-course, not reduced to maternal and reproductive health alone.

Closing the global women's health gap represents a **US\$1 trillion annual opportunity** (McKinsey, 2024). Poor mental health compounds this loss: depression and anxiety cost the global economy roughly **12 billion working days a year** (WHO, 2024), with women disproportionately affected by paid work, unpaid care, and workplace discrimination combined. Around **1 in 10 women** also leave the workforce due to menopausal symptoms that are, in most cases, treatable.

The burden falls hardest on women in low-income, rural, migrant, and marginalized communities, where health outcomes are driven not only by clinical gaps but by structural determinants, including unequal unpaid care responsibilities, economic insecurity, and restrictive gender norms. As G20 economies face ageing populations and labor shortages, retaining women already in the workforce is among the fastest, most cost-effective policy responses available.

The mandate already exists. The 2025 G20 Johannesburg Leaders' Declaration affirmed the importance of investing in women's health, continuing a line running through the Italy (2021), Indonesia (2022), and Brazil (2024) declarations.

What is missing is **implementation, financing, and measurement**.



W20
Women20 for the G20

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The numbers at a glance:

- **US\$1 trillion** – potential annual gain from closing the women's health gap (McKinsey, 2024)
- **12 billion** working days lost each year to depression and anxiety (WHO, 2024)
- **1 in 10 women** leave the workforce due to menopausal symptoms (Riach et al., 2023)

THE CHALLENGE

Persistent, structural barriers to equitable care.

Health outcomes are inextricably linked to broader gender inequalities; financial, legal, geographic, and social barriers limit access to primary care, sexual and reproductive health and rights (SRHR) services, and treatment for conditions like cardiovascular disease and cervical cancer, hitting hardest women in low-income, rural, migrant, and marginalized communities.

Mental health systems and workplaces not built for women's realities.

Women face higher rates of anxiety, depression, and burnout, driven by the systemic burden of caregiving loads, workplace discrimination, and insecure work, reflecting a societal failure to address the structural roots of gender inequality. Yet few G20 countries have national workplace mental health standards.

Menopause remains clinically and organizationally invisible.

Research is globally underfunded, few clinicians receive structured training, and few employers have supportive policies, driving preventable workforce exit at peak career stage.

Data gaps and unmet accountability.

Only a minority of national health datasets are sex-disaggregated, and most G20 countries lack baselines, targets, or public reporting to track whether commitments, including the 2025 Johannesburg Declaration translate into results.



THE RECOMMENDATIONS



1. STRENGTHEN GENDER-RESPONSIVE UNIVERSAL HEALTH COVERAGE.

By 2031, raise women's access to affordable primary care toward 90% coverage (2024 baseline, WHO Universal Health Coverage (UHC) Service Coverage Index). Remove barriers to comprehensive SRHR services, prioritizing underserved populations. Cut preventable maternal mortality by 30% from 2023 levels, and scale up human papillomavirus (HPV) vaccination and cervical cancer screening.

Why it matters: Coverage gaps drive avoidable death and illness and undercut the economic benefit of a healthy workforce.

2. INTEGRATE WOMEN'S MENTAL HEALTH INTO WORKPLACE AND HEALTH POLICY.

Establish national workplace mental health standards by 2031, increase employer adoption of evidence-based programs by 50% (2025 baseline), and integrate women's mental health into workforce monitoring.

Why it matters: Investment returns up to US\$4 per US\$1 spent; inaction costs 12 billion working days a year.

3. MAKE MENOPAUSE A HEALTH AND WORKFORCE PRIORITY.

By 2031, adopt national clinical guidelines and training for healthcare professionals and managers (from a 2026 baseline), promote menopause-inclusive workplace policies, and expand menopause-specific research.

Why it matters: Symptoms are largely treatable, yet many women leave the workforce over them; low-cost adjustments have proven effective at retaining experienced staff.

4. MANDATE SEX-DISAGGREGATED DATA AND GENDER-SENSITIVE RESEARCH.

Require collection and public reporting of sex-disaggregated health data, increase investment in sex- and gender-sensitive medical research, and ensure responsible, privacy-protective use of digital health and AI tools.

Why it matters: This is the foundation on which every other target's credibility depends.

GLOBAL SNAPSHOT

Indicator	What it shows
UHC Service Coverage Index	Even high-income G20 members show measurable coverage gaps, particularly in SRHR and mental health services.
Maternal mortality ratio	Varies roughly fifty-fold across G20 members; most deaths are clinically avoidable.
Cervical cancer screening coverage	No G20 member is on track across all three WHO elimination targets (90% vaccinated, 70% screened, 90% treated); coverage varies more than tenfold between members.
Clinicians trained in menopause management	Not systematically measured in any G20 member; where studied, knowledge levels are very low.
National health datasets disaggregated by sex	Only a minority are disaggregated, leaving gaps in outcomes invisible to policymakers.

