

Policy Dialogue on Women's Health with Special focus on Polycystic Ovary Syndrome (PCOs)

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Introduction

Polycystic Ovary Syndrome (PCOS) is widely recognized as one of the most common endocrine disorders affecting women of reproductive age and represents a significant yet frequently under recognized public health challenge. The policy dialogue organized by the Institute of Public Health (IPH) on 30 January 2026 appropriately highlights the multidimensional burden of PCOS and underscores the urgent need for coordinated clinical, public health, and policy responses. From an expert perspective, the report effectively identifies several critical domains including the pathophysiology of PCOS, diagnostic challenges, psychosocial implications, and the importance of integrating PCOS management into broader health systems. However, translating these insights into sustainable health policies requires further emphasis on evidence-based frameworks, population-level strategies, and long-term surveillance mechanisms. PCOS affects approximately 6–20% of women globally depending on the diagnostic criteria used, making it one of the most prevalent

endocrine conditions in women of reproductive age.¹ Despite its high prevalence, the syndrome remains underdiagnosed in many low- and middle-income countries due to limited awareness, fragmented healthcare services, and sociocultural barriers affecting women's access to reproductive health care.² The policy dialogue therefore addresses a highly relevant and timely issue, particularly in contexts where women's health is often overlooked within broader public health planning.

PCOS as a Multisystem Disorder

One of the strongest aspects of the policy dialogue is the recognition of PCOS as a multisystem disorder rather than merely a reproductive condition. Contemporary scientific evidence demonstrates that PCOS involves complex interactions between endocrine dysfunction, metabolic disturbances, genetic predisposition, and environmental influences.³ Hyperandrogenism, insulin resistance, and chronic low-grade inflammation are key biological mechanisms contributing to the development and persistence of the syndrome.⁴ Insulin resistance is particularly central to PCOS pathogenesis and affects a substantial proportion of women with the disorder, including many who are not

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overweight. This metabolic dysfunction increases the risk of type 2 diabetes mellitus, metabolic syndrome, and cardiovascular disease later in life.⁵ Consequently, PCOS should be viewed as a lifelong health condition requiring continuous monitoring rather than a disorder limited to fertility or menstrual irregularities. By emphasizing the multisystem nature of PCOS, the policy dialogue appropriately broadens the scope of intervention beyond gynaecological care. Effective management must involve endocrinologists, nutritionists, psychologists, and primary healthcare providers working collaboratively within a multidisciplinary framework.

Phenotypic Variability and Diagnostic Challenge

The discussion on different phenotypes of PCOS highlights another critical dimension of the disorder. Clinical presentation varies widely, ranging from classic hyper androgenic and ovulatory dysfunction to milder phenotypes characterized primarily by metabolic disturbances. Recognition of phenotypic heterogeneity is essential because it influences both diagnostic strategies and treatment approaches.⁶ The report's emphasis on the Rotterdam diagnostic criteria is consistent with international consensus. According to these criteria, PCOS can be diagnosed when at least two of the following features are present: oligo- or anovulation, clinical or biochemical hyperandrogenism, and polycystic ovarian morphology on ultrasound.⁷ However, reliance solely on diagnostic imaging or laboratory investigations may lead to over- or under-diagnosis. Clinical evaluation, menstrual

history, and exclusion of other endocrine disorders remain essential components of accurate diagnosis. In many healthcare systems, diagnostic delays are common. Studies have shown that women with PCOS often consult multiple healthcare providers before receiving a definitive diagnosis, leading to frustration, psychological distress, and delayed treatment.⁸ Strengthening provider education and integrating standardized diagnostic protocols within primary healthcare settings could significantly reduce these delays.

Psychological and Social Dimensions of PCOS

An important contribution of the policy dialogue is the recognition of psychological well-being as an integral component of PCOS management. Women with PCOS frequently experience anxiety, depression, body image dissatisfaction, and reduced quality of life. These psychological consequences may arise from symptoms such as infertility, acne, hirsutism, and weight gain, which can significantly affect self-esteem and social interactions.⁹ Evidence indicates that the prevalence of depressive symptoms among women with PCOS is substantially higher than in the general female population.¹⁰ Additionally, chronic stress may exacerbate hormonal dysregulation, creating a vicious cycle that worsens clinical outcomes. Therefore, mental health screening and counselling should be incorporated into routine PCOS care pathways. The policy dialogue correctly identifies lifestyle support, motivation, and continuous counselling as essential components of treatment. Behavioural

interventions including structured lifestyle programs, nutritional guidance, and stress management have demonstrated measurable improvements in metabolic parameters and reproductive outcomes among women with PCOS.¹¹

Lifestyle Modification and Clinical Management

Lifestyle modification remains the cornerstone of PCOS management. Weight reduction through balanced nutrition and regular physical activity can significantly improve insulin sensitivity, menstrual regularity, and fertility outcomes.¹² Even modest weight loss of 5–10% has been associated with meaningful metabolic and reproductive benefits.¹³

However, clinical management of PCOS must be individualized according to the patient's symptoms and reproductive goals. Treatment options may include hormonal contraceptives to regulate menstrual cycles, anti-androgen therapy to address hyper androgenic symptoms, insulin-sensitizing agents such as metformin, and fertility treatments for women seeking pregnancy.¹⁴ The policy dialogue appropriately advocates for personalized care rather than uniform treatment protocols. Such individualized management aligns with international clinical guidelines that recommend symptom-based therapeutic approaches supported by multidisciplinary care teams.¹⁵

Public Health Significance of PCOS

The guest speaker's emphasis on the public health burden of PCOS is particularly

noteworthy. Historically, PCOS has been viewed primarily as a clinical endocrinological disorder, but growing evidence indicates that it has substantial population-level implications. These include increased risks of metabolic diseases, pregnancy complications, infertility, and long-term cardiovascular morbidity.¹⁶ In addition, PCOS imposes considerable economic costs due to repeated clinical consultations, diagnostic investigations, infertility treatments, and long-term management of metabolic complications. In several countries, the healthcare costs associated with PCOS are estimated to be comparable to those of other chronic conditions such as diabetes and cardiovascular disease.¹⁷ Therefore, addressing PCOS requires a shift from fragmented clinical care toward integrated public health strategies that prioritize prevention, early detection, and community awareness.

Policy and Health System Implications

The policy recommendations presented in the report represent a constructive starting point for integrating PCOS into national women's health agendas. Incorporating PCOS screening into primary healthcare services is particularly important, as primary care providers often represent the first point of contact for adolescent girls and young women experiencing menstrual irregularities. Development of standardized national guidelines could further ensure consistency in diagnosis and management across healthcare facilities. Many countries have adopted evidence-based clinical practice guidelines for PCOS, which help clinicians

deliver comprehensive and standardized care.¹⁵ Training healthcare professionals in gender-sensitive care is also essential. Cultural stigma surrounding reproductive health issues often prevents women from seeking timely medical attention. Healthcare providers must therefore create supportive environments that encourage open discussion of menstrual, metabolic, and psychological concerns.

Another important policy initiative is the establishment of multidisciplinary clinics dedicated to women's endocrine and reproductive health. Such clinics enable coordinated management by gynaecologists, endocrinologists, nutritionists, and mental health professionals, thereby improving patient outcomes and reducing healthcare fragmentation.

Community Awareness and Preventive Strategies

Community awareness programs targeting adolescents and young women represent a crucial preventive strategy. Early recognition of symptoms such as irregular menstruation, excessive hair growth, or persistent acne can facilitate timely diagnosis and intervention.

Educational programs in schools, universities, and community canters could help reduce stigma and improve understanding of PCOS. Public health campaigns emphasizing healthy lifestyles, balanced diets, and physical activity may also reduce the metabolic risk factors associated with the disorder.

Digital health platforms and telemedicine services could further enhance access to counselling and lifestyle guidance, particularly in underserved areas. Such innovations may play a significant role in improving continuity of care and long-term patient engagement.

Strengthening Research and Data Systems

While the policy dialogue provides valuable insights, future initiatives should also prioritize research and surveillance. Reliable epidemiological data on PCOS prevalence, risk factors, and health outcomes remain limited in many regions. Establishing national registries and population-based studies could provide the evidence necessary for informed policy decisions.

Research should also explore sociocultural determinants of PCOS awareness, healthcare access, and treatment adherence. Understanding these contextual factors is essential for designing culturally appropriate interventions and improving healthcare utilization among affected women.

Conclusion

The policy dialogue organized by the Institute of Public Health represents a significant step toward recognizing PCOS as a major women's health priority. The report successfully highlights the complex biological, psychological, and social dimensions of the disorder and calls for a comprehensive, multidisciplinary approach to its management. From an expert perspective, the key strength of the dialogue lies in its recognition of PCOS as a lifelong

multisystem condition with substantial public health implications. Integrating PCOS screening into primary healthcare services, developing national management guidelines, strengthening healthcare provider training, and establishing multidisciplinary clinics are critical steps toward improving patient outcomes. Equally important is the promotion of community awareness, early diagnosis, and lifestyle interventions that address the metabolic and psychological dimensions of the disorder. By adopting evidence-based policies and fostering collaboration between clinicians, public health professionals, and policymakers, health systems can significantly improve the quality of life of women affected by PCOS.

Ultimately, addressing PCOS effectively requires a paradigm shift—from isolated clinical treatment to coordinated public health action. Such an approach will not only enhance reproductive and metabolic health outcomes but also contribute to broader goals of gender equity and women's health empowerment.

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