An Evidence Map of the Women Veterans' Health Literature (2016–2023)

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PREFACE

The VA Evidence Synthesis Program (ESP) was established in 2007 to conduct timely, rigorous, and independent systematic reviews to support VA clinicians, program leadership, and policymakers to improve the health of Veterans. ESP reviews have been used to develop evidence-informed clinical policies, practice guidelines, and performance measures; to guide implementation of programs and services that improve Veterans' health and wellbeing; and to set the direction of research to close important evidence gaps. Four ESP Centers are located across the US. Centers are led by recognized experts in evidence synthesis, often with roles as practicing VA clinicians. The Coordinating Center, located in Portland, Oregon, manages program operations, ensures methodological consistency and quality of products, engages with stakeholders, and addresses urgent evidence synthesis needs.

Nominations of review topics are solicited several times each year and submitted via the ESP website. Topics are selected based on the availability of relevant evidence and the likelihood that a review on the topic would be feasible and have broad utility across the VA system. If selected, topics are refined with input from Operational Partners (below), ESP staff, and additional subject matter experts. Draft ESP reviews undergo external peer review to ensure they are methodologically sound, unbiased, and include all important evidence on the topic. Peer reviewers must disclose any relevant financial or non-financial conflicts of interest. In seeking broad expertise and perspectives during review development, conflicting viewpoints are common and often result in productive scientific discourse that improves the relevance and rigor of the review. The ESP works to balance divergent views and to manage or mitigate potential conflicts of interest.

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The authors are also grateful for the contributions of the following individuals:

Operational Partners

Operational partners are system-level stakeholders who help ensure relevance of the review topic to the VA, contribute to the development of and approve final project scope and timeframe for completion, provide feedback on the draft report, and provide consultation on strategies for dissemination of the report to the field and relevant groups.

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Technical Expert Panel

To ensure robust, scientifically relevant work, the technical expert panel (TEP) guides topic refinement; provides input on key questions and eligibility criteria, advising on substantive issues or possibly overlooked areas of research; assures VA relevance; and provides feedback on work in progress. TEP members included:

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Disclosures

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The findings and conclusions in this document are those of the author(s) who are responsible for its contents and do not necessarily represent the views of the Department of Veterans Affairs or the United States government. Therefore, no statement in this article should be construed as an official position of the Department of Veterans Affairs. The final research questions, methodology, and/or conclusions may not necessarily represent the views of contributing operational and content experts. No investigators have affiliations or financial involvement (*eg*, employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties) that conflict with material presented in the report.

Main Report

Evidence Synthesis Program

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ABBREVIATIONS TABLE

Abbreviation	Definition
ABC-I	Acceptance and commitment therapy for insomnia
ACC	American College of Cardiology
ACEs	Adverse childhood experiences
ADL	Activities of daily life
AHA	American Heart Association
ASCVD	Atherosclerotic cardiovascular disease
AUB	Abnormal uterine bleeding
BMI	Body mass index
BSO	Bilateral salpingo-oophorectomy
CBT-I	Cognitive behavioral therapy for insomnia
CKD	Chronic kidney disease
COMFORT	Center for Maternal and Infant Outcomes and Research in Translation Study
COPD	Chronic obstructive pulmonary disease
DESTRESS	Delivery of Self Training and Education for Stressful Situations
DOD	Department of Defense
ECUUN	Examining Contraceptive Use and Unmet Need
EMPOWER	Enhancing Mental and Physical Health of Women through Engagement and Retention
EPOC	Effective Practice and Organization
ESP	Evidence Synthesis Program
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
MCC	Maternity care coordination
MST	Military sexual trauma
MVP	Million Veteran Program
NESARC-III	National epidemiologic survey on alcohol and related conditions
NIH	National Health Institute
NSSI	Non-suicidal self-harm
OEF/OIF/OND	Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn
PACT	Patient aligned care team
PCP	Primary care provider
PE	Prolonged exposure
PRESS	Peer review of electronic search strategies
QI	Quality improvement
RCT	Randomized controlled trial
SDOH	Social determinants of health
SERV	Survey of experiences of returning veterans
SUD	Substance use disorder
TBI	Traumatic brain injury

Abbreviation	Definition
TVMI	The Veterans Metris Initiative
VA	Veterans Affairs
VHA	Veterans Health Administration
VALOR	The Veterans After-discharge Longitudinal Registry
WH-PACT	Women's Health Patient Aligned Care Team
WH-PBRN	Women's Health Practice-Based Research Network
WHRN	Women's Health Research Network
WVCS	Women Veterans Cohort Study
WV	Women Veteran

BACKGROUND

Since its inception, the VA has aimed to provide high-quality care that recognizes and addresses the unique health care needs of all Veterans. For much of the history of the VA, however, women have made up a small proportion of the US armed forces and the scope of VA services has been largely tied to the health needs of Veteran men. Only in recent decades has the number of women Veterans (WVs) seeking care at the VA begun to steadily grow, and with that there is an increased demand for programs and services that meet the health and well-being needs of women.

WVs now comprise approximately 10% of the Veteran population and are expected to make up 18% of the Veteran population by 2040.[1,2] The number of women using the VA for health care continues to increase every year and has seen a 1.8-fold increase since 2010, with WVs utilizing outpatient care at a higher frequency than Veteran men.[3,4] WVs tend to be younger, more racially and ethnically diverse, and more likely to be service-connected than Veteran men.[3] In fact, younger women VA users are more likely to be service-connected and have high service-connected disability ratings than older women VA users, making them eligible for lifelong VA care for service-connected conditions.[4] It is thus critical that the VA utilize available research to understand best practices for providing evidence-based care to WVs across their lifespan—from reproductive years to perimenopause, geriatric years, and end of life.

In response to the unique health care needs and changing population demographics of WVs, the VA has prioritized initiatives to address knowledge gaps, improve care, and eliminate barriers to care for WVs as well as transgender and/or non-binary Veterans who may utilize VA women's health services. In 2004, the first national VA Women's Health Research Agenda[5] was developed and provided a framework to drive new research addressing the specific health needs of WVs. In 2010, the VA funded the Women's Health Research Network (WHRN) with 2 initial objectives: (1) build research capacity by supporting VA women's health researchers and (2) support multisite studies and quality improvement projects that emphasize the recruitment of women, through the establishment of a Women's Health Practice-based Research Network (WH-PBRN). The WHRN has been pivotal to the exponential amplification of women's health research through the VA and has led to multiple trials and journal supplements focused on WVs health as well as expansion of the WH-PBRN to 76 VA medical centers across the country.[6] Additionally, in 2010, the VA Women's Health Services Research Conference, sponsored by the VA HSR&D Service and the VA Women Veterans Health Strategic Health Care Group, brought together researchers and leadership and resulted in the development of the VA Women's Health Services Research Agenda. This new agenda outlined 6 research priority areas: access to care and rural health, primary care and prevention, mental health, post-deployment health, complex chronic conditions/aging and long-term care, and reproductive health.[5]

To date, there have been 3 articles[7-9] which broadly summarize the field of WVs health research. The evidence map, developed in 2017 by the VA ESP, included 440 articles published between 2008-2015.[9] More than 90% of identified studies were observational and nearly half were related to mental health. The 2017 ESP map showed dramatic growth in several critical research areas: access to care and rural health, post-deployment health, reproductive health, and mental health. Recommendations for improving WVs health research made by the map authors included reporting outcomes disaggregated for WVs, engaging WVs in research, conducting focused systematic reviews of evidence in certain research areas, expanding research to address vulnerable populations, and addressing the expanding role of women in combat.

In the 8 years since the 2008-2015 evidence map was published, there has been considerable growth in WVs health research. The present evidence map includes studies published from 2016 to the present. In addition to describing this new evidence and identifying research areas that have significantly grown from the 2008-2015 period, we revisited the future research recommendations of the earlier evidence map to clarify what questions about WVs health and health care have since been addressed, and what questions remain unanswered.

METHODS

REGISTRATION AND REVIEW

A preregistered protocol for this review can be found on OSF. A draft version of this report was reviewed by external peer reviewers; their comments and author responses are located in the Appendix.

KEY QUESTIONS AND ELIGIBILITY CRITERIA

The following key question was the focus of this evidence map: *What is the scope and breadth of the literature on WVs health published since 2015?* Study eligibility criteria are shown in Table 1.

Table 1. Study Eligibility Criteria

	Eligibility Criteria

Population	Included:
	• Individuals who have served in the armed forces (including national guard and reserves) and who identify as women or who are transgender and/or non-binary and were assigned female at birth
	• More than 75% of the study population comprised WVs or the study reported results separately for WVs as subgroup analysis or otherwise reported results separately for women. Included studies could:
	  ○ Stratify or disaggregate results by sex and/or gender (*eg*, report the effect separately for women only)
	  ○ Report subgroup analysis by sex and/or gender by modeling results separately for men and women
	  ○ Include mediation modeling or interaction terms to evaluate the contribution of individual sex and/or gender factors to differences between men and women
	• Health care team members who provided care to WVs if the focus of article was on provision of care to the WVs population
	
	Excluded:
	• Studies that did not include US WVs
	• Studies that included only active-duty members of the military
	• Animal studies

Intervention	Any or none
Comparator	Any or none
Outcomes	Any
Setting	Health care settings in the US (or US Veteran expats if outside the US)
Study design	Included: • Trials, observational (prospective and retrospective) studies, systematic reviews (*eg*, scoping, mapping, umbrella, qualitative), protocols, qualitative studies, secondary analyses of trials, implementation studies, multisite or national program evaluations, measurement or methods studies if specifically used for WVs • Designs other than qualitative or methods development, for which the total number of WVs was over 50 • Qualitative studies of only WVs or those with a qualifying subgroup analysis, which included either a specific plan outline to compare men and women or at least 1 theme broken out that was specific to WVs

	Eligibility Criteria
	Excluded: • Letters, case reports and case series, meeting abstracts, dissertations not published in a peer reviewed journal, editorials, narrative review, comprehensive or narrative reviews, measurement development studies not specific to WVs, single-site QI projects, commentaries, opinion papers, feasibility studies, pilots • Studies that used sex and/or gender as a component of the regression or propensity model • Studies that treated sex and/or gender as a covariate only
Years	Published January 2016 to present
Language	English only

SEARCHING AND SCREENING

We conducted a primary search from January 1, 2016, to October 2023 of MEDLINE (via Ovid), Embase (via Elsevier), and CINAHL (via EBSCO) (see Appendix for complete search strategies). We used terms for Veterans (*eg*, *post-deployment*) and women (*eg*, *women's health*). To ensure completeness, search strategies were developed in consultation with an expert medical librarian and peer reviewed by a second librarian in accordance with PRESS guidance.[10] After an initial pilot process with the whole team for calibration, we screened all identified citations with 2 reviewers at the title and abstract level. Although we identified a large number of mixed-sample studies that included both Veteran men and WVs, or WVs and non-Veteran civilian women, we were often unable to verify, based on title and abstract alone, whether studies reported results among WVs. While infeasible to review all mixed-sample studies at full text, we prioritized mixed-sample studies with at least 10,000 participants for a further full-text review. Our rationale for this choice was that, as WVs comprise ~10% of the Veteran populations, such studies would likely include ~1,000 WVs depending on the condition of study, would be more likely to report results separately for WVs, and would thus be more generalizable to the larger WVs population. We also reviewed an additional 20% of studies in duplicate that had been excluded at the title and abstract level for not disaggregating results for WVs. We conducted 3 pilot full-text review rounds of 10 studies each for team calibration, prior to independent full-text review. Full-text review was then conducted by a single reviewer. Twenty percent of studies excluded at full-text review by 1 reviewer were then reviewed in duplicate by a second reviewer [AAT]. We did not include individual studies from the 2008-2015 map within the current map, though we reference findings from that map throughout.

DATA EXTRACTION

Citations meeting eligibility criteria at full-text review were included for extraction. Extraction was completed by an individual reviewer. Given the large volume of literature, we quality checked data extractions for up to 20% of each extracting reviewer. If significant accuracy concerns were identified, we reviewed further for correction as needed. In addition, we quality checked all included studies for focus areas and target populations. Primary focus area was assigned based on an assessment of the framing and emphasis of the article by drawing from the title, introduction, stated aim or objective, and analytic approach. When an article had multiple potential primary focus areas, we classified it based on relevant medical condition (*eg*, hypertension) rather than care delivery characteristic (*eg*, utilization). Each article was assigned to only 1 primary focus area (*eg*, reproductive mental health and reproductive health are mutually exclusive). We also assigned up to 2 secondary focus areas. We extracted key study characteristics such as the study population (*eg*, military service era, age), study

focus areas, study design, population, and funding source. The internal validity (risk of bias) of each included study was not rated, in keeping with evidence map methodology.

SYNTHESIS

We described key study characteristics of the included articles and investigated patterns across these characteristics to identify data-rich areas that warranted further investigation. In particular, we mapped the included articles across key categories considered of interest and a priority to the WVs research community. Articles were mainly grouped according to the primary focus area. We used visualizations to present important research and publication patterns for the overall evidence base and within primary focus areas.

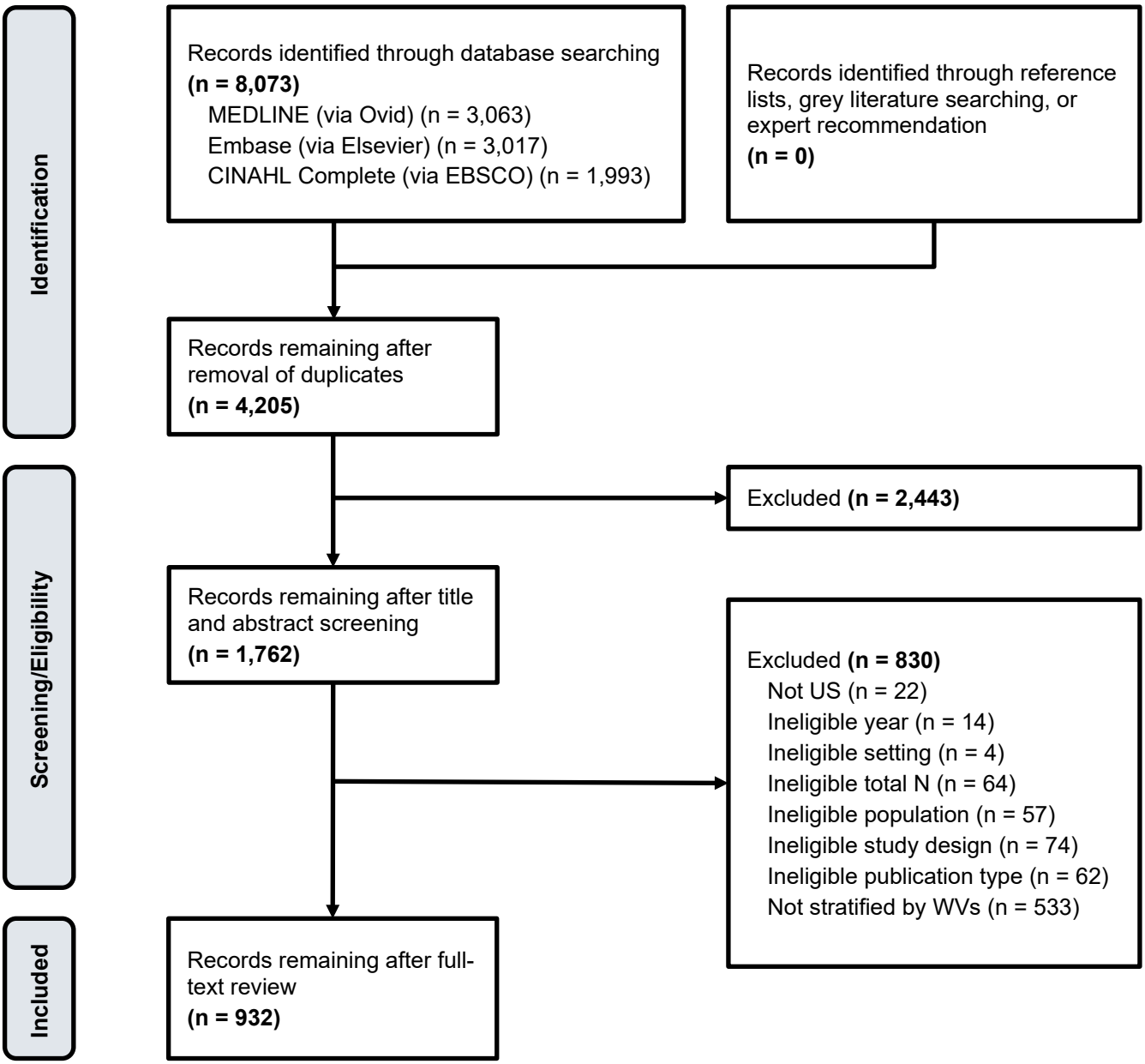
Study designs and stages were classified, where possible, using the design declared by the study authors. The Cochrane Effective Practice and Organisation of Care (EPOC) suggests that 4 study designs should be considered for systematic review with multiple sites and data collection points: randomized trials with 2 intervention and 2 control sites, non-randomized trials with 2 intervention and 2 control sites, controlled before-after trials with 2 intervention and 2 control cites, and interrupted time series and repeated measure studies with 3 data collections before and 3 data collections after the intervention.[11] In this report, however, experimental studies were not held to the full (EPOC) study design criteria requiring multiple sites or data collection time points, as the category was intended to capture interventional studies that did not employ a randomization process. Secondary analyses of RCT data that did not preserve random allocation (*eg*, comparisons of intervention-group participants by level of intervention adherence) were considered observational studies.

RESULTS

LITERATURE FLOW DIAGRAM

The literature flow diagram summarizes the results of the study selection process (Figure 1). A full list of excluded studies is provided in the Appendix.

Figure 1. Literature Flow Diagram



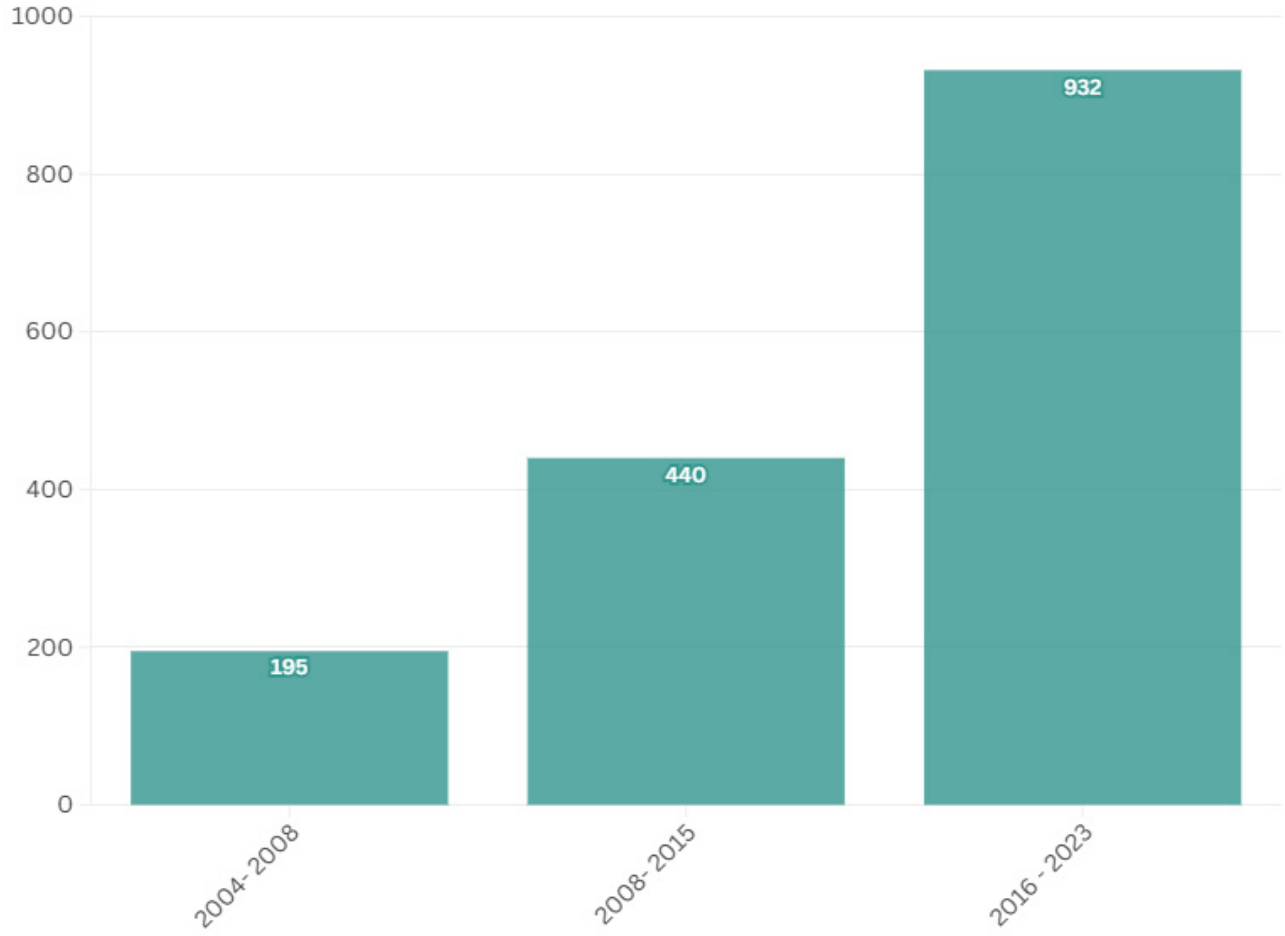
OVERVIEW OF INCLUDED STUDIES

We identified 8,073 publications through database searching. After deduplication and title and abstract screening, 1,762 articles remained for full-text review. We subsequently excluded 533 articles that reported on samples that included both Veteran men and WVs, or WVs and non-Veteran civilian women, but that did not report outcomes specifically for WVs (it is possible that more studies shared this limitation but were excluded for another reason). A total of 933 publications met eligibility criteria and were included for extraction. Overall, we found that more than double the number of articles had been published per year between 2016-2023 (932 articles [117 per year]) compared with the 2008-2015 map (440 articles [55 per year]), and an earlier 2004-2008 map (195 articles [39 per year]) (Figure 2). (Note: the comparison across maps is not exact due to some overlap.) The literature described in this map represents the work of 598 unique first authors.

Primary Focus Areas

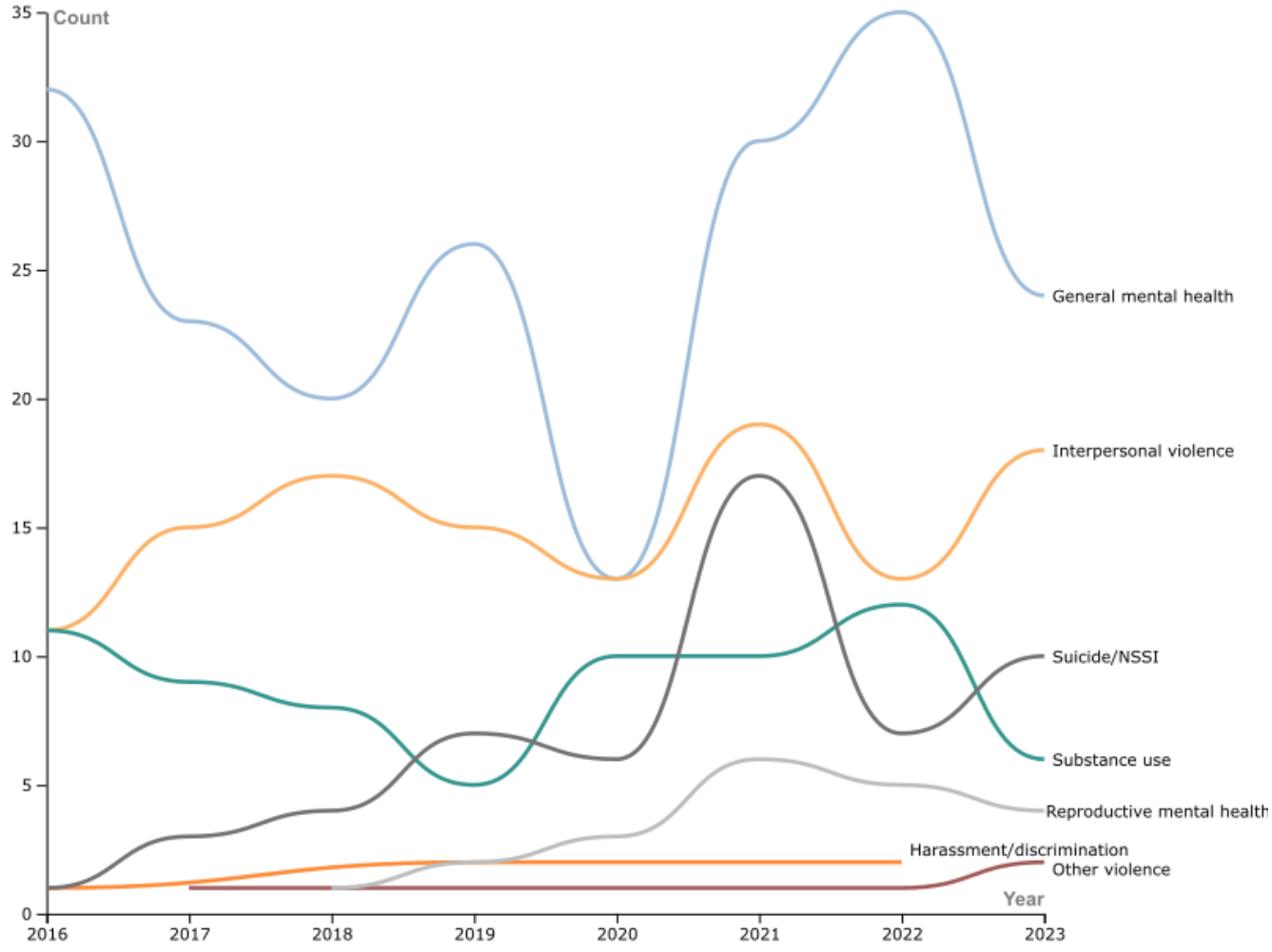
We categorized each article by primary focus area, the largest of which was general mental health (k = 203 [22%]) (see Appendix). Importantly, the current evidence map separately addressed several categories as individual focus areas that were previously included under the general mental health category in the 2008-2015 map: interpersonal violence, substance use, suicide/NSSI, other violence, and reproductive mental health. For a more direct comparison, we found that the number of mental health articles in the current map (k = 471 [50%]) had more than doubled compared with the 2008-2015 map (k = 208 [47%]). Despite this marked growth, mental health-focused studies comprised a similar overall proportion of published research as in the earlier map. The second largest focus area in the current map was chronic medical conditions (k = 137 [15%]). When combined with the current map categories of cancer and chronic pain/opioids, 179 (19%) studies were published between 2016-2023. This amounted to over twice the number of studies that were included in the comparable medical conditions category of the 2008-2015 map (k = 78 [18%]).

Figure 2. Change in Publication Volume from 2008 to 2023



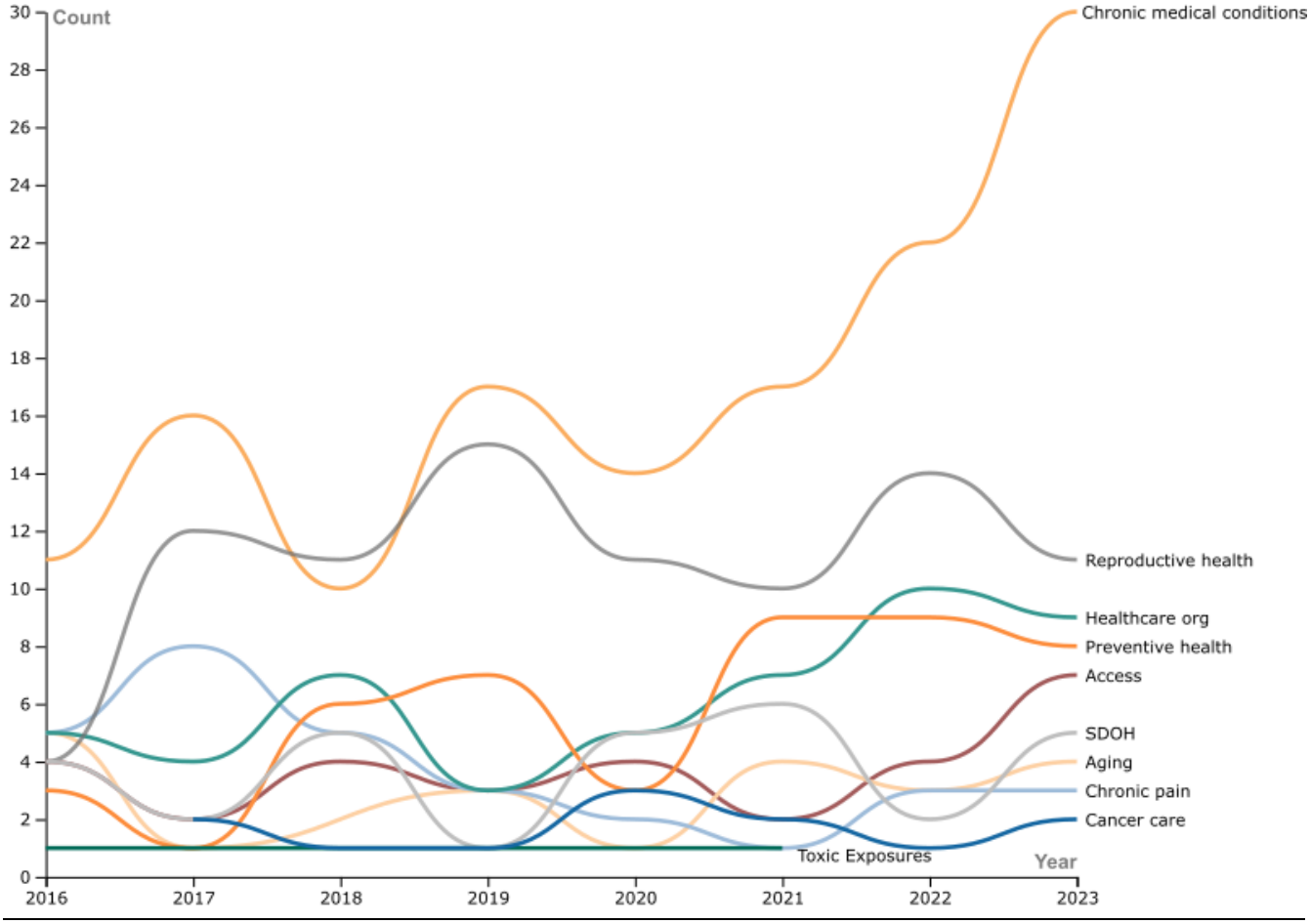
Focus areas with the largest proportional change since the 2008-2015 map were reproductive mental health (4 to 21 articles; 5.25-fold increase), chronic pain/opioid use (7 to 30 articles; 4.3-fold increase), and suicide/NSSI (13 to 55 articles; 4.2-fold increase). Focus areas with relatively limited increase included long-term care/aging (13 to 21 articles) and cancer (6 to 12 articles). Health care organization/delivery of care for WVs was also relatively flat (31 to 50 articles) as was access/utilization of care (24 to 30 articles) (Figure 3 and Figure 4). (Note: these comparisons are inexact by nature of the subjectivity of assignment to focus areas and the slightly differing categorization approaches used in this report.)

Figure 3. Change Over Time Across Mental Health and Trauma, Violence, and Stress Focus Areas



Notes. Reproductive mental health is mutually exclusive from reproductive health.
Abbreviations. NSSI=non-suicidal self-injury.

Figure 4. Change Over Time Across Medical Conditions, Structures of Care, and Other Focus Areas

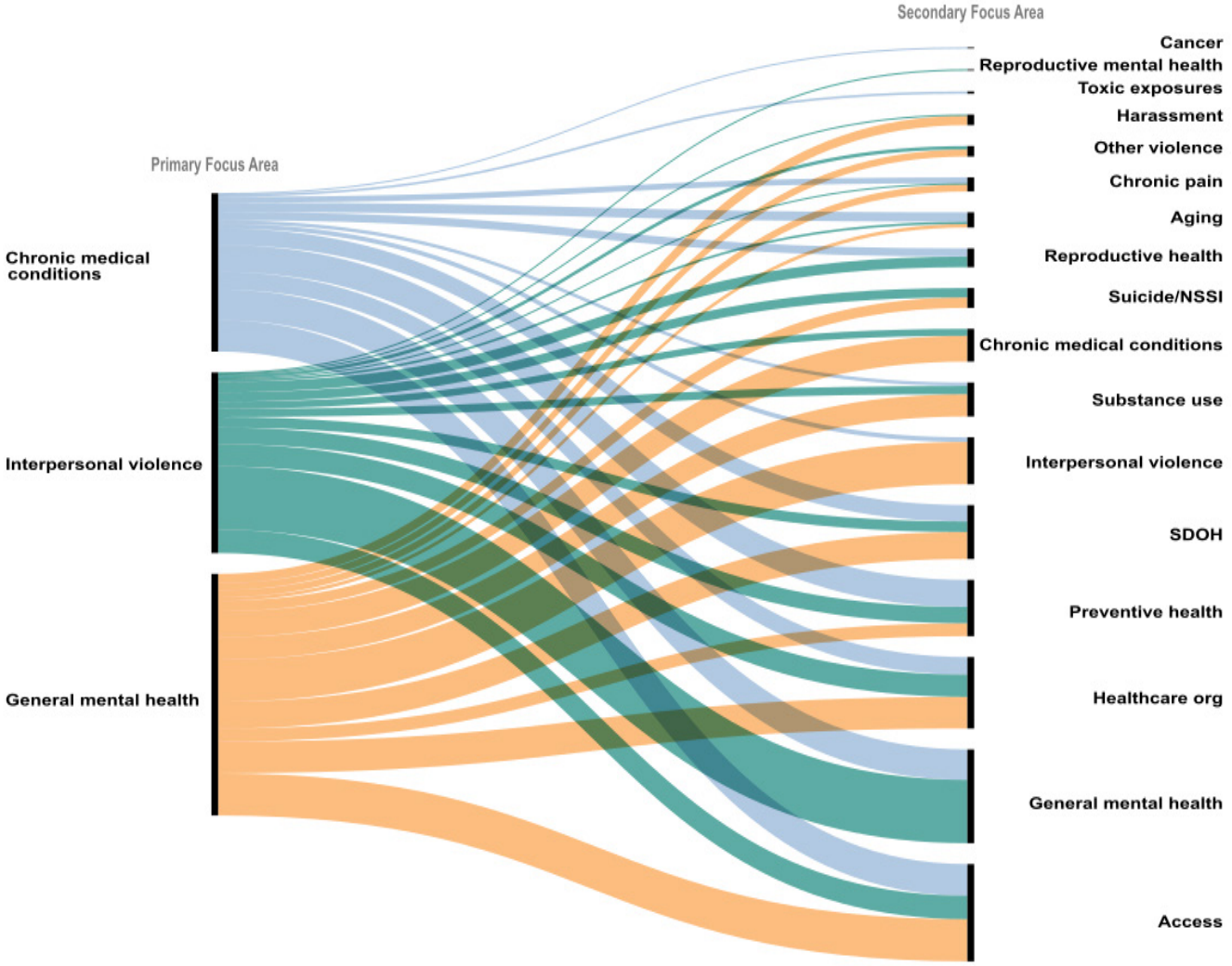


Abbreviations. SDOH=social determinants of health.

Secondary Focus Areas

Mapping the connections between primary and secondary focus areas demonstrated additional breadth and depth to the field. To illustrate these connections, we explored the secondary focus areas assigned to articles in the largest 3 primary focus areas: chronic medical conditions, interpersonal violence, and general mental health (Figure 5). We found that the most common secondary focus areas identified were access/utilization of care, general mental health, health care organization/delivery of care for WVs, and preventive health. This likely accounted for the apparent limited growth in the primary focus area groupings of access/utilization of care and health care organization/delivery of care for WVs. Conversely, the least common secondary focus areas were cancer, reproductive mental health, other violence, chronic pain/opioids, and long-term care/aging. This highlights those topics with overall limited volume of literature as either primary and secondary focus areas, such as cancer and long-term care/aging. For example, no articles primarily focused on general mental health or interpersonal violence that identified cancer as a secondary focus area.

Figure 5. Secondary Focus Areas for Largest Primary Categories: Chronic Medical Conditions, Interpersonal Violence, and General Mental Health



Study Designs

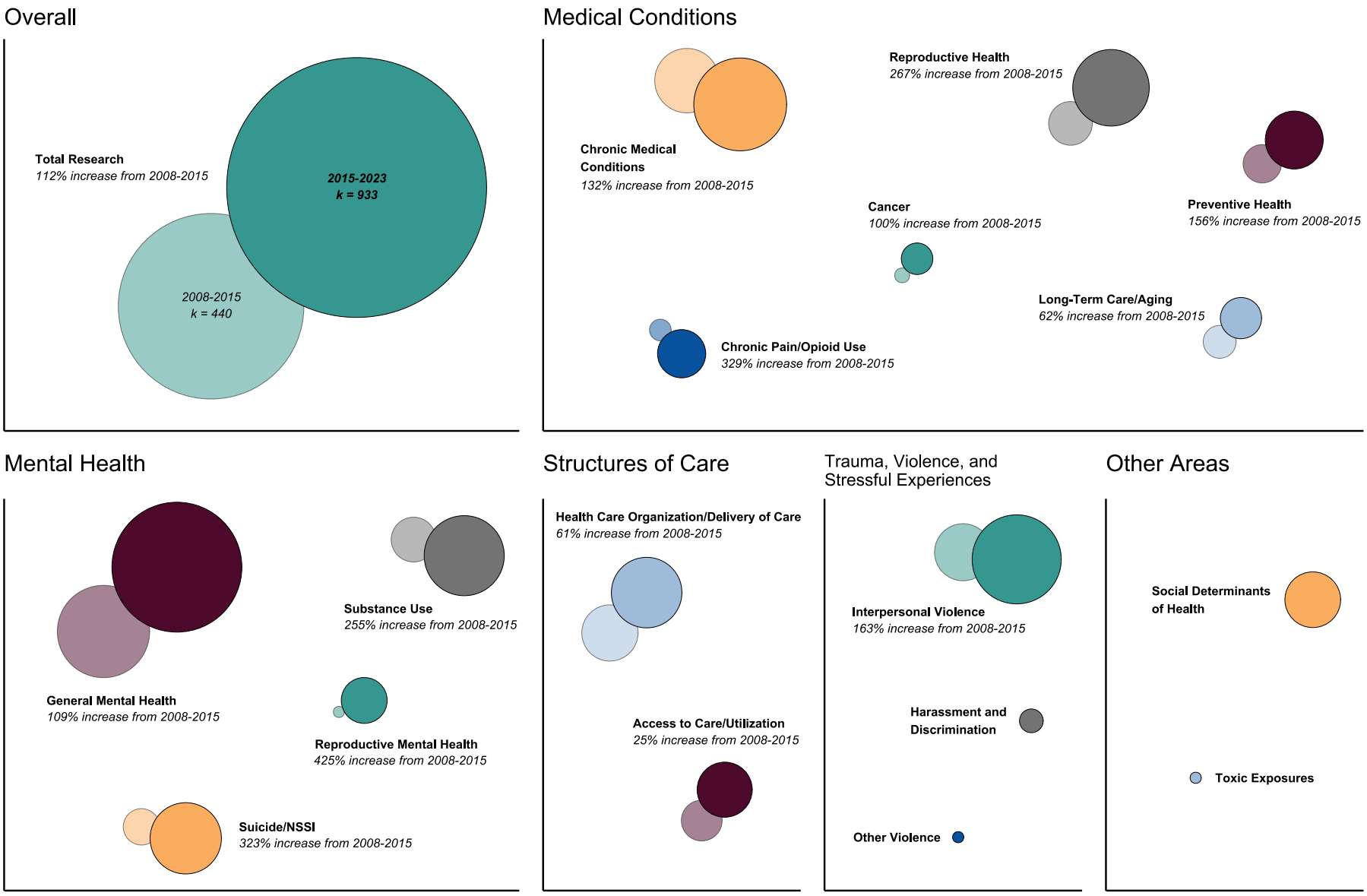
Across this collection of articles, we found the majority used an observational design (k = 760 [81%]), similar to the 2008-2015 map (k = 375 [85%]), which was also the most common design within each focus area (Figure 6). Of the 759 observational studies, 303 included WVs only, 398 included both women and men with sex- or gender-stratified analyses, and 57 included WVs and non-Veteran women with Veteran-stratified analyses. Across WVs-only observational studies, the median size was 744. The largest WVs-only study (N = 790,726) addressed the prevalence of sexual desire and arousal difficulties.[12] The largest mixed-sex and mixed-gender observational study (N = 46,112,675 clinical encounters [8.2% women]) evaluated rates of chiropractic care utilization by sex.[13] We found 107 articles (12%) reporting qualitative evaluations, most of which (k = 80 [74%]) represented Veterans, 21 represented providers and staff, and 6 represented both Veterans and providers and staff. In comparison, the 2008-2015 map included 22 (5%) qualitative studies. The area with the most qualitative studies was interpersonal violence (k = 24).

We identified 32 articles reporting experimental studies, which included 26 trials compared to 8 RCTs or controlled clinic trials in the 2008-2015 map. Most trials (13 [50%]) were categorized in the general mental health focus area. We also identified 43 articles that described VA QI or program evaluation studies. General mental health and the health care organization/delivery of care for WVs focus area had the largest number of experimental and program evaluation and QI studies. Twenty-four articles reported mixed-methods studies, none of which included a randomized efficacy or effectiveness design. Six of the included studies were protocols, 3 of which were for RCTs, 1 was for an EPOC or other experimental design, 1 was for a mixed-methods study, and 1 was for an observational study. These protocols were identified across chronic medical conditions ($k = 2$), interpersonal violence ($k = 1$), preventative health ($k = 1$), reproductive health ($k = 1$) and suicide/NSSI ($k = 1$). We also identified 1 evidence map, 6 scoping reviews, and 10 systematic reviews published since 2016. Eight reviews were found in mental health-related focus areas including general mental health, substance use, and interpersonal violence. Reviews were also found related to long-term care/aging, chronic medical conditions, and social determinants of health (SDOH). One prior ESP evidence map on SDOH included a subsection of articles specific to health issues among WVs (see Appendix).

We identified 26 RCTs, 3 of which were protocol papers, 1 was an implementation trial, 1 was a program evaluation, 1 was a methods development paper, and 1 was a secondary analysis of an RCT study. These studies were concentrated within the general mental health ($k = 13$) and substance use focus areas ($k = 4$). Nineteen of these studies recruited only WVs, while 6 recruited both men and women. One study recruited WVs and non-Veteran women. Ten of the RCTs specifically enrolled Veterans with a history of trauma. Funding sources were varied, though the majority of RCTs were VA funded ($k = 9$). (See Appendix for additional details about the articles describing trials).

Forty-three articles described program evaluations of VA-specific initiatives, including regional and national clinical and staff education programs for improving the care of WVs and/or exploring the effects of crucial clinical innovations (see Appendix). These articles used various study designs including mixed-methods evaluations of observational cohorts, pre-post evaluations in the setting of natural program rollouts, and cross-sectional evaluations. Some evaluated the adaptation of existing evidence-based programs for the needs of WVs, for example, a Diabetes Prevention Program and MomMoodBooster (a cognitive behavioral therapy program for postpartum depression). Others looked at aspects of the national rollout of new programming such as IPV screening, including early response and the use of evidence-based implementation strategies. These articles were most often categorized to the health care organization/delivery of care for WVs and general mental health primary focus areas.

Figure 6. Growth in Women Veterans' Health Research from 2008–Present by Focus Areas



Note. Lighter-shaded circles indicate volume of literature in the 2008–2015 period.

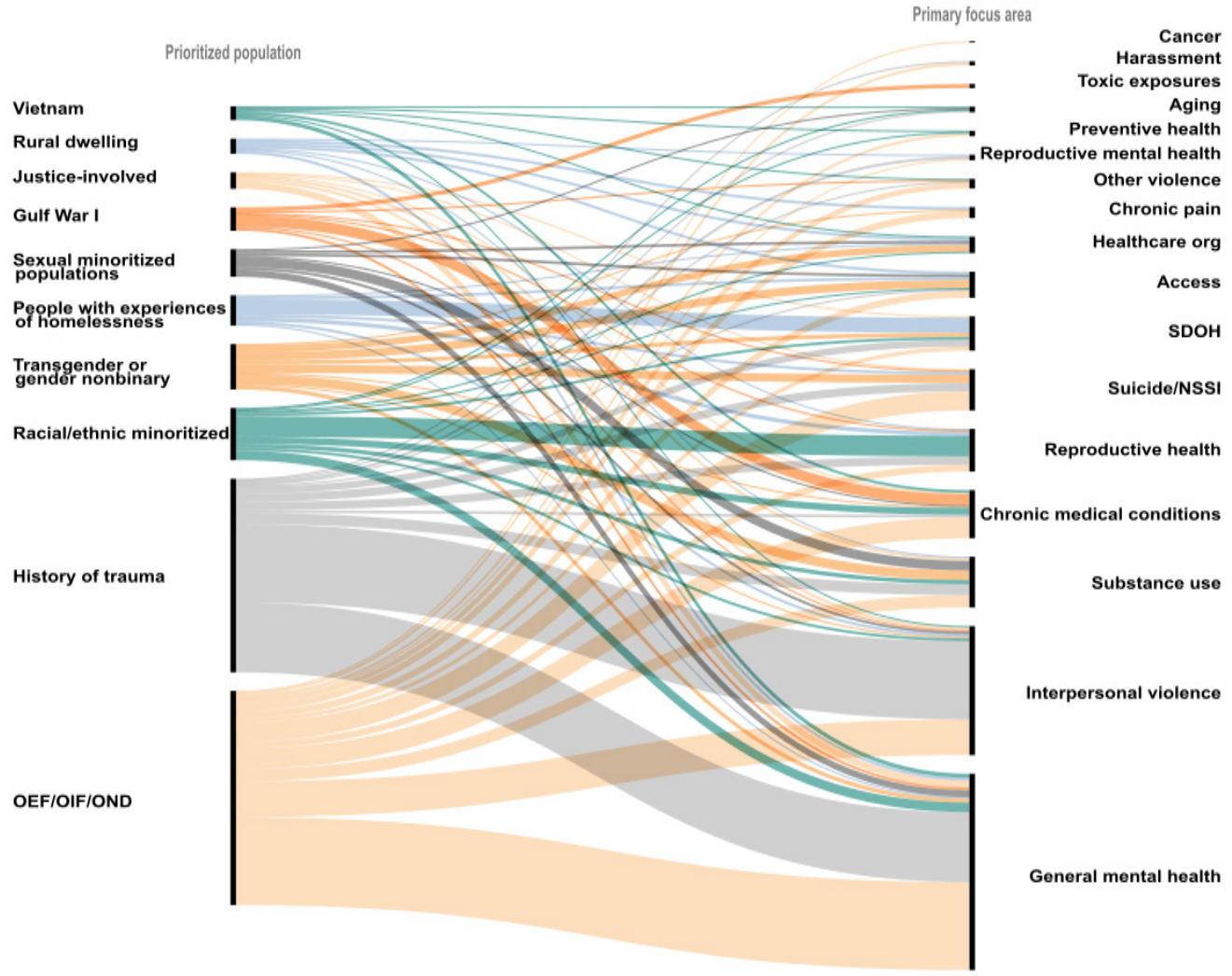
Participant Composition

Of the included articles, we found that 405 (43.5%) included WVs only, similar to the 2008-2015 map (k = 187 [42.5%]). Sixty-seven used qualitative methodology (median number of participants: 23 [range: 4 to 1,255]) and 303 used observational (median number of participants: 744 [range: 20 to 790,726]). There were 19 trials that included only WVs. Focus areas with the largest number of WVs-only studies were general mental health (k = 80), reproductive health (k = 75), and interpersonal violence (k = 69). Thirty-six articles reported studies assessing a mix of WVs and non-Veteran women, for which the median number of participants across was 8,590 (qualitative study population range: 10 to 59; observational study population range: 106 to 6,196,432). Both WVs and Veteran men were included in 411 articles which reported a sex- or gender-stratified analysis. The median number of participants across the 411 studies was 9,720 (qualitative study range: 24 to 119; observational study range: 90 to 46,112,675). These were most often found in the general mental health (k = 111) and chronic medical conditions (k = 90) focus areas. We identified 25 articles which evaluated WVs, non-Veteran women, and Veteran men, for which the median number of participants was 28,823 (range: 373 to 831,302). There were 34 studies that reported provider or staff data only, 21 of which were from qualitative studies (qualitative study median: 32 [range: 8 to 127]; observational study median: 288 [range: 94 to 2664]). Eleven studies combined provider and staff data and patient-level data (qualitative study median: 52 [range: 52 to 119]; observational study median: 7,346 [range: 956 to 130,765]).

Prioritized Populations

We identified many studies which specifically sought to include prioritized Veteran populations (Note: individual articles could report studies targeting multiple prioritized populations). The prioritized population most commonly sought for study participation was OIF/OEF/OND Veterans (k = 156), Veterans with a history of trauma (k = 141), racial and ethnic minoritized Veterans (k = 38), transgender and/or nonbinary Veterans (k = 32), Veterans with experiences of homelessness (k = 22), sexual minoritized Veterans (k = 20), Gulf War I Veterans (k = 17), justice-involved Veterans (k = 11), rural-dwelling Veterans (k = 11), and Vietnam Veterans (k = 10). One article targeted the inclusion of World War II Veterans. Only 61 articles reported sex and gender separately. We illustrated the distribution of articles across primary focus areas per population in Figure 7. While the 2008-2015 map did not capture prioritized populations identically, we noted a 1.6-fold increase in articles focused on OEF/OIF/OND Veterans, an 11-fold increase in those focused on justice-involved Veterans, and a 3.8-fold increase in articles focused on LGBTQ+ populations. Of note, articles that sought to include, or solely focus on, OEF/OIF/OND Veterans covered topics from combat exposure and re-integration but also a wide array of health conditions and symptoms impacting this population. For the current map, the latter was separated into transgender and/or nonbinary and sexual minoritized Veterans. We found a similar overall number of articles targeting populations with experiences of homelessness in the current (k = 22) and 2008-2015 map (k = 19). Figure 6 demonstrates the mapping of articles for each prioritized population to primary focus areas. As observed with the overall distribution of articles, all prioritized populations had some overlap with the general mental health focus area. Other common focus areas for articles with VA prioritized populations were interpersonal violence, substance use, and chronic medical conditions.

Figure 7. Prioritized Population Across Primary Focus Areas



Notes. This figure demonstrates the volume of literature across the studies enrolling prioritized populations and the primary focus area reported in those studies.

Funding Source and Engagement

We identified 850 articles (91%) which reported the presence or absence of funding and a specific source when relevant. Fifty articles (5%) were unfunded. Multiple sources of funding were reported by 210 articles (23%). VA funding was cited by 684 articles (73%), similar to the 2008-2015 map which found 69%. One hundred and eighty-three cited the National Institute of Health (NIH) or other government funding, 46 Department of Defense (DOD), 40 university, 31 foundation, 28 industry, and 20 other assorted sources. Of note, 28 articles clearly documented Veteran engagement during the study development, conduct, or dissemination. General mental health was the most funded focus area for the VA ($k = 136$) and DOD ($k = 26$). General mental health ($k = 32$) and chronic conditions ($k = 39$) were the top 2 focus areas funded by NIH or other government sources. Studies reporting no funding or university support were mostly focused on interpersonal violence ($k = 10$, $k = 10$, respectively).

INCLUDED ARTICLES BY PRIMARY FOCUS AREA

Here we described the mapping of each article to a primary focus area based on previously established categories from prior evidence maps and current VA women's health research priorities. (See Appendix for full list of included studies).

Mental Health

Within the 2008-2015 map, mental health was considered a primary focus area and included 208 articles. For the current evidence map, we used a similar overall category entitled general mental health which included common mental health conditions such as PTSD and mood disorders. In addition, we created 3 new mental health-related focus areas: substance use, reproductive mental health, and suicide/NSSI. When we combined these 6 focus areas, a total of 472 articles were included, representing a 127% increase from the 2008-2015 map.

General Mental Health (k = 203)

Table 2. Overview of General Mental Health Focus Area

Highlights	
Participant composition	• WVs-only (*k* = 80) • WVs versus Veteran men (*k* = 114) • WVs versus non-Veteran women (*k* = 9) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = 3) • Other (*k* = 3)
Key study designs	• Observational (*k* = 161) • Qualitative (*k* = 17) • RCT (*k* = 13) • EPOC or quasi-experimental (*k* = 6) • Mixed methods (*k* = 6)
Key study stages	• Program evaluation and/or QI (*k* = 10) • Efficacy and/or effectiveness (*k* = 11) • Implementation (*k* = 0) • Systematic reviews (*k* = 4) • Methods development (*k* = 4)
Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 57) • History of trauma (*k* = 51) • Racial and ethnic minoritized (*k* = 6)
Top 3 subcategories	• PTSD (*k* = 95) • Multiple diagnoses (*k* = 28) • Disordered eating (*k* = 18)
Top 3 secondary focus areas	• Access to care/utilization (*k* = 36) • Interpersonal violence (*k* = 36) • Health care organization/delivery of care for WVs (*k* = 27)

General mental health was the largest primary focus area in this map (k = 203) and examined common mental health conditions impacting WVs including PTSD and depression. We identified articles in this focus area addressing psychological well-being and resilience assessment, symptoms screening for many disorder types, and in-depth examination of specific diagnoses. The most frequent secondary focus areas were access to care/utilization, interpersonal violence, and health care organization/delivery of care for WVs. We identified an additional 171 articles which had general mental health as a secondary focus, most often in those with interpersonal violence, chronic medical conditions, and suicide/NSSI primary focus areas.

Prioritized populations included in this area were most commonly OEF/OIF/OND Veterans (k = 57), though a significant subset focused on Veterans with a history of trauma (k = 51). Few focused on other prioritized subpopulations such as racial and ethnic minoritized (k = 6), sexual minoritized (k = 4), or transgender and/or nonbinary (k = 3) Veterans.

We determined that the unit of observation was predominantly at the Veteran level (95%). Most studies (k = 114) examined WVs in comparison to Veteran men or examined Veteran women only (k = 80). Over 75% of studies in this focus area were observational (k = 161). The next most common study designs were qualitative (k = 17) and mixed methods (k = 6). There were 13 RCTs which focused on patient-level treatment approaches for screening or treatment of mental health conditions, of which 9 tested PTSD-related interventions. The other RCTs focused on mental health symptoms, mental health care, and psychological well-being. One RCT focused on a sleep intervention. Sample sizes ranged from 32 to 284, and 8 of the 13 RCTs included only women. There were 10 program evaluations, 3 with WVs only. These evaluations used observational (k = 5), mixed-methods (k = 1), and other experimental designs (k = 4). Four of the 10 program evaluations were focused on PTSD treatment, although interventions ranged widely (*eg,* inpatient trauma-focused treatments, virtual care, and social functioning). There were 4 reviews (2 systematic and 2 scoping reviews) which covered 4 topics: barriers and facilitators to receiving and providing mental health care, interventions for WVs with mental health care needs, post-deployment psychological health of WVs, and the quality and content of literature regarding WVs mental and physical health. Regardless of study design, most studies considered risk factors and prevalence of mental health conditions.

PTSD (k = 95)

We found that 95 articles addressed PTSD diagnosis, care delivery, or related topics, representing a modest increase from the 71 identified in the 2008-2015 map. Within this section, the most common secondary focus was interpersonal violence (k = 31), access to care/utilization (k = 11), and health care organization/delivery of care for WVs (k = 11). Among these studies, we identified 57 which looked at differential effects between men and women, while 38 exclusively focused on WVs. Populations of interest addressed in this area were those with a history of trauma (k = 40), racial and ethnic minoritized (k = 6), sexual minoritized (k = 4), rural-dwelling (k = 2), or transgender and/or nonbinary (k = 3) populations. Most studies utilized observational designs or qualitative data collection and mixed methods. The observational studies primarily explored prevalence, epidemiology, and risk factors for PTSD. The most frequent secondary focus areas within the observational studies included access to care/utilization and interpersonal violence. PTSD, depressive disorders, and symptomatology were often studied as comorbid outcomes of traumatic experiences.

Qualitative and mixed-methods research investigated health care delivery (*eg*, therapy marketing messages, telehealth, privacy preferences) and PTSD intervention development. RCTs (k = 9),

including 3 that conducted secondary or interim analyses of trial data, described testing treatments such as yoga (telehealth yoga or trauma center trauma-sensitive yoga) and cognitive behavioral therapies (*eg*, acceptance and commitment therapy, a transdiagnostic approach; prolonged exposure [PE], for PTSD) or delivery features of existing interventions (*eg*, waitlists, telehealth, group therapy, self-administered treatments). RCT analyses sample sizes ranged from 32 to 284, and 7 included only women. The volume of RCTs identified is similar to the 9 articles with primary or secondary trial analyses in the 2008-2015 map.

Multiple Mental Health Symptoms and Diagnosis (k = 28)

We found this category included studies that examined either general mental health symptoms or at least 3 different mental health diagnoses (*eg,* anxiety disorders, PTSD, depressive disorders, substance use). Three qualitative studies explored post-deployment mental health experiences. The remaining studies were observational and examined risk factors or the epidemiology of various mental health symptom types, often using survey-based methods or existing data sources. Observational study sizes ranged from 134 to 4,867,049 participants and 4 included only women. One RCT (*N* = 172 [31.4% women]) assessed the efficacy of a video intervention on treatment-seeking intentions among Veterans.[14] In addition, 5 articles assessed general mental health symptoms or diagnoses related to specific physical health conditions (*eg*, temporomandibular disorders[15]) or general (*eg*, physical function[16]). A single 2021 systematic review utilized results of the last women's health evidence map to review 21 articles about clinical complexity in WVs, particularly mental and physical health comorbidities.[17]

Disordered Eating (k = 18)

We identified 15 observational studies addressing disordered eating, which examined clinical correlates, physical and psychological comorbidities, health care utilization, and prior traumatic exposures related to eating disorder diagnoses or symptoms. Three studies used a large sample of post-9/11 Veterans to examine gender differences in weight concerns, prior trauma, and eating disorder symptoms. We also identified 3 qualitative studies on disordered eating, of which 2 focused on disordered eating treatment preferences and 1 focused on understanding Veteran experiences. One of these studies was conducted within a single VA site[18] and 1 was conducted with Veterans recruited from VA facilities and the community.[19] Fifty-five percent of studies in this focus area used WVs-only samples. The 2008-2015 map included only 5 studies on disordered eating, all of which were observational.

Sleep-Related Conditions and Symptoms (k = 17)

Studies in this section included those related to sleep-related symptoms or disorders, primarily focused on insomnia. Although there were no sleep-related studies reported in the 2008-2015 map, this topic constituted 8.8% of articles in the general mental health primary focus area of the current map. Additionally, there were 12 observational studies examining the prevalence of insomnia, medication use, and other treatments. Seven studies explored the relationship between trauma and insomnia symptoms. The largest observational study (*N* = 500,332 [1.7% women]) focused on gender differences in prescribing of zolpidem (a sleep-aid medication). One RCT (N = 149 [100% women]) compared acceptance and commitment therapy with cognitive behavioral therapy for insomnia among Veterans. (Note: 5 observational studies on sleep disorders were also categorized under the chronic medical conditions focus area).

Mental Health Care Delivery (k = 17)

We identified 17 articles in this category which focused on the nature and quality of mental health care delivery. Most focused on VA users ($k = 11$). Twelve were observational and examined practice patterns and patient-level predictors of mental health care utilization. Of these observational studies, 7 were WVs only. The largest observational study ($N > 1.5$ million [$N = 236,268$; 15.2% women]) examined gender differences in the use of video telehealth mental health care visits conducted from home among Veterans. Three qualitative or mixed-method studies were conducted to understand barriers, preferences, and decision-making related to mental or behavioral health care within the VA. This section also included a 2022 scoping review exploring interventions for WVs with mental health concerns ($k = 8$)[20] and a 2023 scoping review summarizing barriers and facilitators of engaging in mental health care for women ($k = 24$).[21] We identified 1 RCT ($N = 153$) that tested a primary care computerized intervention aimed at increasing use of mental health treatment among WVs. None of these studies examined pharmacological treatment.

Depression (k = 8)

Of the 8 observational studies we identified that examined depression, 1 examined prevalence and 4 examined predictors for depressive disorder diagnosis or symptoms (*eg*, social-, work -, or family-related factors). Care needs and preferences of WVs with depression in primary care were examined in 1 observational study.[22] Two observational studies examined aspects of treatments for depressive disorders (*eg*, biological measures of treatment, differences in depression care by comorbidities). Two of the 8 studies included only women, while the others ranged from 2% to 23% WVs. The largest observational study ($N = 110,603$ [9.1% WVs]) examined gender differences in lowest dose depression treatment and follow-up in VA primary care.[23]

Well-Being (k = 5)

Five of the studies we identified examined mental health with a wider lens, incorporating measures of well-being alone or alongside concepts such as overall or psychological health. A 2017 systematic review synthesized 8 qualitative studies regarding the psychological health and well-being of WVs post-deployment (*eg*, adjustment, post-traumatic growth, loss, and belongingness).[24] An RCT examined the effect of mindfulness on psychological well-being among 136 WVs.[25] The 3 remaining studies examined the changes in health and well-being of Veterans after leaving military service,[26] the impact of civic service on psychological health and well-being,[27] and the comparison of post-9/11 Veterans with non-Veterans in terms of health, work, financial, or social well-being.[28]

Moral Injury (k = 3)

After stressful events in which people behave contrary to important personal values or observe behavior that conflicts with these values, moral injury symptoms (*eg,* guilt, shame, anger) can develop distinctly from PTSD.[29] We identified 3 observational studies which examined moral injury related to sexual harassment, substance use and mental health, and chronic pain, including gender differences in prevalence and outcomes.

Additional Mental Health Topics (k = 12)

We found that 12 studies did not fit into the above categories. Two examined groups with a single diagnosis (*eg*, personality disorder, schizophrenia). The remaining 10 studies focused on a wide variety of topics related to mental health conditions, such as allostatic load,[30,31] stress-related biobehavioral

responses,[32] cognitive impairment,[33] deployment and other stressors,[34] neuropsychiatric assessments,[35] peer support,[36] and relationship characteristics.[37,38]

Substance Use (k = 71)

Table 3. Overview of Substance Use Focus Area

Highlights	
Participant composition	• WVs0only sample (*k* = 19) • WVs versus Veteran men (*k* = 34) • WVs versus non-Veteran women (*k* = 4) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = *1)* • Other (*k* = 14)
Key study designs	• Observational (*k* = 57) • Qualitative (*k* = 7) • RCT (*k* = 4) • EPOC and/or quasi-experimental (*k* = 3) • Mixed methods (*k* = 0)
Key study stages	• Program evaluation and/or QI (*k* = 5) • Efficacy and/or effectiveness (*k* = 4) • Implementation (*k* = 0) • Systematic review (*k* = 1) • Scoping review (*k* = 1) • Methods development (*k* = 1)
Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 10) • History of trauma (*k* = 8) • Transgender and/or nonbinary (*k* = 7) • Sexual minoritized (*k* = 7)
Top 3 subcategories	• Treatment access, utilization, and outcomes (*k* = 19) • Prevalence, risk factors, and mortality (*k* = 17) • Stress and substance use (*k* = 15)
Top 3 secondary focus areas	• General mental health (*k* = 16) • Access to care/utilization (*k* = 12) • Preventative health (*k* = 9)

We identified 71 articles that primarily focused on substance use in WVs. The most common substances addressed were alcohol or tobacco, with relatively fewer articles addressing opioid use disorder, general substance misuse, and none related to intravenous drug use. The most common secondary focus areas included general mental health (*k* = 16), access/utilization of care (*k* = 12), preventive health (*k* = 9), SDOH (*k* = 8), and health care organization/delivery of care for WVs (*k* = 8). Forty-three articles with other primary focus areas also touched on aspects of substance use in WVs, most commonly those evaluating general mental health, interpersonal violence, or sexual violence. Three articles collected data from VA staff (including providers), 65 from patients, and 1 from VA clinics or facilities. The remaining 2 articles were review papers, 1 of which was a systematic review.[39,40] Studies in this group were primarily observational (*k* = 57) or qualitative (*k* = 7). An additional 7 studies addressed the effects of health system interventions, 4 of which were RCTs. The

RCTs included an evaluation of a gender-focused recovery model, a proactive outreach intervention, a personalized normative feedback intervention, and a cognitive reappraisal coping strategy.

Of the 7 qualitative articles we identified, the total *N* ranged from 14 to 30. The largest observational study of Veteran men and WVs in this focus area included 11,492,586 Veterans, of whom 1,202,949 were women (10.5%).[41] We found 19 articles focused only on WVs, and 41 examined the differences between men and women. The largest observational WVs-only study included 2,784 individuals. Since publication of the 2008-2015 map, there has been a 7-fold increase in studies of substance abuse that focus on historically marginalized populations such as gender minority (*eg*, transgender and/or nonbinary), sexual minority, and racial and ethnic minority groups of WVs. Seven articles used large VA or national databases such as Enhancing Mental and Physical Health of Women through Engagement and Retention (EMPOWER) QUERI, Survey of Experiences of Returning Veterans (SERV), The Veterans After-Discharge Longitudinal Registry (Project VALOR), National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III), National Patient Care Database, and Women's Health Initiative.

Treatment Access, Utilization, and Outcomes (k = 19)

Among the 19 studies focused on substance use-related treatment, we found 12 which aimed to identify and understand gender disparities in access, utilization, and outcomes of related services. Most were observational ($k = 9$) or qualitative ($k = 4$), and 1 was a systematic review published in 2022. This review included 44 studies evaluating trends in online alcohol treatment utilization.[39] Two additional articles examined treatment outcomes using a quasi-experimental design; 1 was a 2021 study using data from an implementation study to evaluate alcohol use in Veteran men and WVs following VetChange, an online alcohol intervention.[42] The other was a 2020 program evaluation study that assessed alcohol use outcomes after PTSD treatment in Veteran men and WV.[43] In addition, we found 3 RCTs in this category. One was a 2019 post hoc analysis of gender differences in smoking cessation using data from a pragmatic multisite trial comparing proactive outreach to usual care ($N =$ 2,654 [5.2% women]).[44] The second was a 2018 RCT evaluating the effect of a 12-session, gender-focused substance use disorder recovery model compared to a 12-step facilitation non gender-focused model ($N = 66$) on substance use. The third was a 2017 trial which tested a very brief online alcohol intervention compared to a video game control on drinking behavior among young OIF/OEF Veterans ($N = 784$ [17% WV]).[45] This study was not limited to VA users and included a gender-based moderator analysis. Finally, 2 articles with a qualitative design focused on identifying methods of reducing disparities in women's substance use care by evaluating smoking cessation experiences and preferences.

Prevalence, Associations, and Risk Factors (k = 17)

Three of the articles we identified addressed mortality rates for either drug overdose ($k = 2$) or chronic alcohol consumption ($k = 1$).[46] Of those remaining, 10 focused on prevalence of cannabis use disorder, alcohol use disorder, opioid use disorder, or overall substance disorder and misuse. Additionally, 3 articles focused on comorbid substance use (tobacco or alcohol) and medical conditions such as heart disease, lung cancer, and traumatic brain injury (TBI). One article focused on insomnia as a risk factor for alcohol misuse in a sample of only WVs.[47] All of these studies were observational, and the majority included only 1%-18% WVs.

Stress and Substance Use (k = 15)

We identified 15 articles related to stress and substance use that addressed the relationship between stressful event exposure or PTSD and substance use. For example, 7 studies focused on the relationship between sexual trauma, MST, or IPV and substance use. Five studies focused on the association between PTSD and substance use and 3 focused on other stressors such as COVID-specific anxiety and childhood adversity. Finally, most of these 15 articles used observational designs, although 1 was a 2021 RCT. This RCT examined the effect of cognitive reappraisal compared to non-therapeutic psychoeducation on alcohol craving and inhibitory control among 50 WVs with unhealthy alcohol use.[48]

Substance Use in Marginalized Groups (k = 13)

Seven articles addressed transgender and/or nonbinary Veteran substance use or substance use–related health care. Six articles focused predominantly on sexual orientation–related differences in substance use. We identified one 2016 literature review that included 25 studies evaluating rates of smoking behaviors in both racial and ethnic minoritized and sexual minoritized groups.[40] Most articles were observational, although 1 quasi-experimental design was used to investigate the influence of a transgender health care directive on alcohol-related service utilization in VA.[49]

Screening and Detection (k = 7)

Among articles addressing screening, detection, or assessment of substance use, 5 focused on alcohol use screening or detection, 1 on tobacco screening,[50] and 1 on hazardous substance use more broadly.[51] Three of these articles were qualitative inquiries of either WVs or provider perceptions of barriers to and facilitators of disclosure[52,53] or detection.[51] One of these articles also described methods development of a gender-tailored alcohol use screener.[54]

Suicide and Non-Suicidal Self-Injury (k = 55)

Table 4. Overview of Suicide/NSSI Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 15) • WVs versus Veteran men (*k* = 36) • WVs versus non-Veteran women (*k* = 4) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = 2) • Other (*k* = 2)
Key study designs	• Observational (*k* = 47) • Qualitative (*k* = 4) • RCT (*k* = 0) • EPOC and/or quasi-experimental (*k* = 2) • Mixed methods (*k* = 2)
Key study stages	• Program evaluation and/or QI (*k* = 1) • Efficacy and/or effectiveness (*k* = 0) • Implementation (*k* = 0) • Systematic reviews (*k* = 0) • Methods development (*k* = 2)

Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 14) • History of trauma (*k* = 6) • Transgender and/or nonbinary (*k* = 6)
Top 3 subcategories	• Prevalence, risk factor, and formative evaluations (*k* = 43) • VA practices and programs (*k* = 8) • Research methods (*k* = 3)
Top 3 secondary focus areas	• General mental health (*k* = 24) • SDOH (*k* = 10) • Interpersonal violence (*k* = 9)

We identified a 4-fold growth in the volume of literature related to suicide/NSSI compared to the 2008-2015 map, which identified 13 articles. In addition to the 55 articles assigned to this primary focus area, we located an additional 20 articles with suicide/NSSI as a secondary focus. The 2008-2015 map noted a lack of focus on suicide among prioritized subpopulations, while we found 1 study addressing Gulf War Veterans,[55]1 addressing justice-involved Veterans,[56] 2 addressing those with experiences of homelessness,[56,57] 6 addressing Veterans with a history of trauma, 6 conducted among transgender and/or nonbinary individuals, and 14 addressing OIF/OEF/OND Veterans (Note: some articles focused on more than 1 subpopulation). We did not identify any experimental study designs for this focus area.

Prevalence Studies, Risk Factor Analyses, and Formative Evaluation (k = 44)

Most studies (74%) in this primary focus area described the risk factors or prevalence of suicide or other evaluations intended to better describe the phenomenon of suicidal ideation, suicidal behaviors, or NSSI behaviors. Eighteen studies in this category included data from at least 1,000 WVs, and 5 studies from more than 100,000 WVs. Fifteen focused on WVs only, 4 compared findings between WVs and non-Veteran civilian women, and 37 compared WVs to Veteran men (2 overlapped with the Veteran and non-Veteran civilian comparison). Ten articles described prevalence of suicidal ideation and behavior across the general Veteran population or subpopulations such as transgender and/or nonbinary Veterans,[58-60] midlife and older women,[61] and OIF/OEF/OND Veterans.[62-64] Three articles described qualitative investigations of aspects of suicide risk and suicidal ideation or behavior including women's experiences with their partners' role in firearm access and storage,[65] gender differences in suicidal behavior development,[66] and gender differences in recovery needs.[67] The remaining articles in this category explored the risk of suicide associated with factors such as moral injury,[68] sexual violence,[69] housing,[56] and dementia.[70] In particular, a 2023 meta-analysis of data from 22 identified studies (*N* = 10,898,875; [% women not reported]) evaluated the association of MST and suicide outcomes (*eg*, ideation, attempt) and included an analysis of the moderation effect of gender with data from 10 studies.[71]

VA Practices and Programs to Address Suicide (k = 8)

We found 8 articles which evaluated aspects of existing VA programs and services designed to address suicide including the Veteran crisis line, suicide prevention coordinators, and electronic health record flag use for suicide risk. Most articles included a comparison between men and WVs using VA administrative data; 1 focused on WVs only and described interviews with suicide prevention coordinators about the experience of women who access Veterans Health Administration (VHA) for enhanced suicide-related care.[72] One notable article (*N* = 458,092 [4.6% women]) explored the effect

of intersecting identities including gender, race and ethnicity, disability status, and housing on receipt of a suicide risk flag in the VA electronic health record among Veterans.[73]

Research Methods (k = 3)

Two articles[74,75] examined specific measures or approaches used in research on women and gender-based differences in suicide risk and 1 described methods to increase recruitment of women to suicide prevention trials.[76]

Reproductive Mental Health (k = 21)

Table 5. Overview of Reproductive Mental Health Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 17) • WVs versus Veteran men (*k* = 1) • WVs versus non-Veteran women (*k* = 2) • Other (*k* = 1)
Key study designs	• Observational (*k* = 15) • Qualitative (*k* = 3) • RCT (*k* = 0) • EPOC and/or quasi-experimental (*k* = 1) • Mixed methods (*k* = 2)
Key study stages	• Program evaluation and/or QI (*k* = 2) • Efficacy and/or effectiveness (*k* = 0) • Implementation (*k* = 0) • Systematic reviews (*k* = 0) • Methods development (*k* = 0)
Top 3 prioritized populations	• History of trauma (*k* = 2) • OEF/OIF/OND Veterans (*k* = 1) • Rural dwelling (*k* = 1)
Top 3 subcategories	• Peripartum mental health care (*k* = 9) • Prevalence and risk factors of peripartum mental health (*k* = 7) • Sexual functioning (*k* = 3)
Top 3 secondary focus areas	• Access to care/utilization (*k* = 7) • Health care organization/delivery of care for WVs (*k* = 7) • Reproductive health (*k* = 5) • General mental health (*k* = 4)

We identified 21 articles that primarily focused on reproductive mental health in WVs, indicating a 4-fold increase in publications on reproductive mental health since the 2008-2015 map, including a greater variety of study designs. Note that this focus area is mutually exclusive from the reproductive health focus area. The most common secondary focus areas of these articles included access to care/utilization and health care organization/delivery of care for WVs. Ten articles that identified reproductive mental health as a secondary focus had primary focus areas of reproductive health and chronic pain/opioids. The majority of articles which focused on reproductive mental health addressed pre-, peri-, or postnatal mental health (*k* = 16), half of which used data from the Center for Maternal

and Infant Outcomes and Research in Translation Study (COMFORT). An additional 2 articles addressed mental health in relation to other aspects of the reproductive cycle (premenstrual and perimenopausal phases) and other reproductive health topics such as hysterectomy. Finally, 3 studies addressed sexual functioning in WVs. One article collected data from VA staff and providers and 20 from Veterans. Articles were primarily observational (k = 15) or qualitative and/or mixed methods (k = 5). Among the 15 observational studies, the total N ranged from 70 to 790,726. There were no RCTs, although 1 quasi-experimental study evaluated an internet-delivered cognitive behavioral therapy for postpartum depression.[77]

Peripartum Mental Health Care (k = 9)

Two articles evaluated perinatal depression screening, 1 article evaluated a mental health intervention (internet-delivered cognitive behavioral therapy[77]), and the remainder focused on access to care/utilization. The 2021 quasi-experimental investigation of an internet-delivered cognitive behavioral therapy, MomMoodBooster, evaluated depression outcomes in rural-dwelling Veterans. Most articles included only WVs, however, 1 study that evaluated a perinatal depression screener included a mix of military service members and Veterans (N = 110 [2.5% WVs]). A 2019 qualitative study of VA mental health providers explored their experiences of delivery care for WVs during the peripartum period.[78]

Prevalence and Risk Factors of Peripartum Mental Health (k = 7)

We identified 3 articles which evaluated risk factors for peripartum depression, 1 using a longitudinal design.[79] Two articles focused on the prevalence of health risk behaviors such as prenatal smoking.[80] The remaining 2 explored trauma and stress exposure as risk factors for peripartum mental health concerns. Three articles used data from the COMFORT study, and 1 used data from the Women Veterans Cohort Study (WVCS).

Reproductive Lifecycle (k = 2)

Two cross-sectional studies of data from VA users examined mental health associated with reproductive health outside of pregnancy. Only 1 article (N = 186 WVs) with a primary focus area of reproductive mental health addressed the full reproductive lifecycle, including mental health in the premenstrual and postmenopausal phases.[81] An additional article (N = 770) evaluated the relationship between mental health and likelihood of choosing minimally invasive hysterectomy to treat uterine fibroids in women.[82]

Sexual Functioning (k = 3)

We found 2 articles focusing on assessing the prevalence of sexual dysfunction, and 1 examining the association between mental health, specifically PTSD, and sexual dysfunction.[83] All 3 articles were observational, with sample sizes ranging from 151 to 790,726. Only 1 included only WVs (N = 790,726); the other 2 included samples comprising 60.9%-80.2% WVs.

MEDICAL CONDITIONS

Chronic Medical Conditions (k = 137)

Table 6. Overview of Chronic Medical Conditions Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 36) • WVs versus Veteran men (*k* = 95) • WVs versus non-Veteran women (*k* = 9) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = *4)* • Other (*k* = 1)
Key study designs	• Observational (*k* = 129) • Qualitative (*k* = 5) • RCT (*k* = 2) • EPOC and/or quasi-experimental (*k* = 0) • Mixed methods (*k* = 1)
Key study stages	• Program evaluation and/or QI (*k* = 2) • Efficacy and/or effectiveness (*k* = 1) • Implementation (*k* = 1) • Systematic reviews (*k* = 1) • Methods development (*k* = 5)
Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 13) • Gulf War I (*k* = 8) • Racial and ethnic minoritized (*k* = 5)
Top 3 subcategories	• Cardiovascular disorders (*k* = 32) • Endocrine disorders (*k* = 22) • Nervous system disorders (*k* = 21)
Top 3 secondary focus areas	• Access to care/utilization (*k* = 26) • General mental health (*k* = 26) • Preventative health (*k* = 23)

We identified 137 articles with a primary focus on chronic medical conditions. Sixty-six additional articles with chronic medical conditions as a secondary focus area were identified, mostly under the primary focus areas of general mental health, preventative health, and long-term care/aging. Overall, we identified nearly double the number of articles categorized under medical conditions in the 2008-2015 map. A majority of the articles under "medical conditions" in the last map were chronic conditions (*eg*, diabetes, hypertension) though also included topics that we have separated out in this report, including chronic pain and cancer. Additionally, articles in the current map represent a much broader range of medical conditions, including a 3-fold increase in articles related to the cardiovascular system. Although the total number of articles remains low, we also identified an 8-fold increase in those addressing amputation, the majority of which were focused on prostheses, and an increase in articles on diabetes and TBI. The number of articles with a focus on obesity, HIV, and spinal cord injuries remained stable. Unlike the 2008-2015 map, we did not identify any articles with a focus on multiple sclerosis. New areas in which we identified multiple articles included interstitial cystitis, musculoskeletal and rheumatologic disease, chronic kidney disease (CKD), COVID-19, and chronic

medical conditions within military generations. Notably, there were few to no articles specifically related to certain conditions common among WVs, such as hypertension, anemia, lumbosacral disorders, eye disorders, asthma, esophageal disorders, and irritable bowel syndrome. As in the 2008-2015 map, a large majority (k = 129 [94.2%]) were observational and mainly investigated prevalence and epidemiology or risk and prognostic factor or association. There were 2 RCTs, compared to none in the 2008-2015 map. Notably, a majority of articles (k = 95) provided a sex-based analysis in studies comprised of both men and WVs (range: 0.7% to 62% women). Thirty-six articles had a WVs-only sample (N = 10 to 570,049) and 9 were comparisons between WVs and non-Veterans. Twenty-nine articles included prioritized populations, primarily OEF/OIF/OND (k = 13) and Gulf War Era (k = 8) Veterans. The main secondary focus areas of articles in this section were access to care/utilization (k = 26), general mental health (k = 26), and preventative health (k = 23).

Cardiovascular Disorders (k = 32)

Thirty-two articles were identified with a focus on diseases of the cardiovascular system, most commonly atherosclerotic cardiovascular disease (ASCVD; k = 26) and resultant complications, such as myocardial infarction, ischemic heart disease, or cerebrovascular accidents. All were observational and 6 articles included only WVs. The WVs-only studies looked at either cardiovascular risk assessment or associations with other chronic medical conditions, mental health conditions, or health behaviors. Two WVs-only articles (N > 69,000, each) addressed ASCVD risk, 1 using the same construct as the American College of Cardiology/American Heart Association (ACC/AHA) and 1 an internally validated risk score.[84,85] Another study (N = 157,195) aimed to determine which mental health conditions have the strongest association with established coronary artery disease among WVs.[86] One WVs-only study (N = 171) focused on a racial and ethnic minority population, looking at the prevalence of calcified carotid artery atheromas on digital panoramic images in African American WVs.[87] Ten of the mixed-sex and mixed-gender studies focused on the prevalence of ASCVD risk factors, gender differences in medication prescription and adherence rates, outcomes after myocardial infarction or percutaneous coronary intervention, and cardiovascular risk related to diabetes and PTSD. One notable study (N = 1,145 [51.2%] WVs) examined barriers to preventative behaviors in OEF/OIF/OND Veterans with a focus on barriers unique to women.[88] The remaining studies focused on heart failure (k = 4) and pulmonary hypertension (k = 1), primarily evaluating sex differences on long-term outcomes or mortality risks.

Endocrine Disorders (k = 22)

We found 22 articles which focused on endocrine disorders, primarily obesity (k = 9) and diabetes (k = 8). Studies addressing obesity were primarily observational with a focus on weight reduction initiatives such as the MOVE! program and health associations related to body mass index (BMI). One qualitative study (N = 24 [50% women]) looked at patient perspectives on weight management treatment among VA users.[89] One 2016 RCT (N = 481 [15% women]) related to obesity among Veterans evaluated weight loss in those who completed the Aspiring for Lifelong Health weight loss program.[90] Note that 14 articles on obesity prevention were placed in the preventative health primary focus area.

Studies addressing diabetes were mainly observational, but included 1 qualitative study examining gender differences in social support for diabetes self-management,[91] and 1 mixed-methods QI study evaluating the impact of gender-tailoring on a diabetes prevention program for WVs.[92] Two articles, both with less than 10% women, examined prescription patterns and adherence for antidiabetic medications.[93,94] Lastly, 1 study used Women's Health Initiative data to determine the impact of

diabetes plus additional chronic conditions on physical functioning in WVs compared with non-Veteran women.[95] The remaining studies looked at prevalence, disease progression, and risk factors for developing diabetes.

Three observational articles addressed osteoporosis, mainly focusing on prevalence and risk factors. One large study (N = 344,488 [100% women]) aimed to characterize racial, ethnic, and age-specific prevalence of site-specific fractures and the association to health care utilization.[96] Another mixed-sex and mixed-gender study looked at risks for osteoporotic fractures in Veterans with spinal cord injuries.[97] Three observational articles from 1 author looked at thyroid disorders and evaluated the association between iodine-induced thyroid dysfunction and cardiac pathology.

Nervous System Disorders (k = 20)

We identified 20 articles which focused on nervous system disorders; the largest subgrouping was TBI (k = 7). All were observational, except for 1 qualitative study which aimed to understand the experience of female service members and WVs after a TBI.[98] Among the observational articles focused on TBI, 1 women-only study addressed the prevalence and effects of IPV-related TBI and the remainder focused on the effects of TBI on functioning and chronic medical conditions. One notable study (N = 491,604 [8.3% women]) examined the impact of interactions between TBI and gender on medical comorbidities.[99]

We identified 5 observational studies on sleep disorders. Two used a WVs-only sample to investigate diagnosis and treatment patterns of sleep apnea, and 1 evaluated the impact of caregiving on sleep in a population of WVs. The 2 remaining articles were mixed-sex and mixed-gender studies and used large data sets to investigate genetic determinants and associations with sleep disorders and cardiovascular disease (CVD).

The remaining articles looked at seizure disorders (k = 5), headache (k = 2), cerebrovascular accident (k = 1) and amyotrophic lateral sclerosis (k = 1). Many of these studies focused on gender differences or WV-specific topics, such as prescribing trends of antiseizure medication for women of reproductive age.[100] One study (N = 1,524,960 [17.2% women]) examined gender differences in headache types, military service and exposures, and health care utilization among Veterans.[101]

Musculoskeletal and Rheumatologic Disorders (k = 15)

We identified 15 primarily observational studies focused on musculoskeletal and rheumatologic disorders. Thirteen were mixed-sex and mixed-gender and 2 were WVs only. Eight articles focused on amputations and primarily reported on aspects of prosthesis prescribing or use (k = 6), marking a significant increase from the 2008-2015 map, which included just 1 article on amputations. No articles on amputations included a prioritized population. Two notable articles included WVs only. The first (N = 100) was an observational study that looked at footwear limitations in WVs prosthesis users.[102] The second was a qualitative study (N = 30) that aimed to describe experiences with VA prosthetic care and devices.[103]

Of the remaining musculoskeletal disorder articles, 3 focused on the prevalence of Veterans with a musculoskeletal disorder. One notable article focused on OEF/OIF/OND Veterans (N = 765,465 [13% women]) and examined the prevalence of musculoskeletal conditions at their initial VA visit and the incidence rates of new musculoskeletal conditions.[104] Another focused on racial and ethnic minoritized Veterans (N = 517 [27% women]) and evaluated race and gender variation in the use of

complementary and alternative medicine for knee osteoarthritis.[105] Three articles focused on rheumatologic disorders; 2 looked at rheumatoid arthritis prevalence and treatment risks, and the third looked at the association between neurologic dysfunction, PTSD, and autoimmune disease in OEF/OIF/OND Veterans.[106]

Military Era Associated Chronic Conditions (k = 12)

We identified 12, mostly observational, studies that evaluated chronic medical conditions among cohorts of Veterans who served during different military time periods. Eight articles focused on Gulf War Veterans. One specifically looked at the prevalence of Gulf War Illness between men and WVs, while the rest primarily addressed the longitudinal effects of serving during the Gulf War Era upon health. Notably, the only systematic review within chronic medical conditions addressed epidemiologic studies on the health of WVs who served during the Gulf War.[107] We found 1 qualitative study in this category, which aimed to understand the military experiences and subsequent health of 10 Gulf War WVs to better inform and improve their clinical care.[108] Additional studies evaluated chronic medical conditions in Vietnam era and post 9/11 era Veterans.

Infectious Diseases (k = 10)

We identified 10 articles on infectious diseases, all observational in design. Five articles focused on HIV; 2 evaluated the impact of the COVID-19 pandemic on HIV care, and 1 evaluated the impact of gender upon the association between alcohol use and HIV care outcomes. There were 2 HIV studies with an all-WVs sample; the first aimed to determine whether the incidence of female genital tract cancers in the antiretroviral era had decreased,[109] and the second evaluated predictors of hospitalization among HIV-infected and at-risk HIV-uninfected women.[110]

Three articles focused on COVID-19 and notably included a WVs-only sample or a prioritized Veteran population. The first (N = 77,364 [100% WVs]) examined COVID-19-associated mortality and CVD outcomes in a racially diverse population.[111] The second (N = 355,603 [11% women]) investigated gender-specific racial and ethnic differences in COVID-19 infection among VA patients.[112] The third (N = 6,620,099 [7.3% women]) assessed the association between sexual orientation and any physical health conditions that might elevate the risk of COVID-19 severity among Veterans.[113] Two mixed-sex and mixed-gender studies, both with fewer than 5% WVs, looked at prevalence and direct-acting antiviral use in Veterans with hepatitis C virus.

Urinary System Disorders (k = 10)

We found 10 articles focused on urinary system diseases and almost all were observational. We identified 1 RCT protocol comparing the effectiveness of 2 virtual care delivery modalities for urinary incontinence among WVs (N = 286).[114] The most common condition addressed was interstitial cystitis and bladder pain syndrome (k = 5). Articles addressing this syndrome looked at prevalence or risk factor association. One notable study investigated whether prescription patterns for WVs with interstitial cystitis aligned with treatment guidelines.[115] The remaining studies assessed prevalence and risk factor association for overactive bladder, bladder cancer, and the efficacy of nitrofurantoin for the treatment of cystitis.

Renal Disorders (k = 6)

We identified 6 articles focusing on the renal system which addressed CKD, utilized an observational study design, and included a mixed-sex and mixed-gender sample (all had less than 7% WVs). Five of

these articles looked at medication prescribing practices or medication interactions with CKD and end-stage renal disease. One study (N = 174,443 [1.9% women]) of racial and ethnic minoritized Veterans evaluated disparities in prescription patterns for sodium-glucose cotransporter-2 inhibitors.[116]

Pulmonary Disorders (k = 3)

Three observational studies focused on pulmonary diseases. Two investigated gender-based differences and disparities for prescribing patterns and hospitalizations in chronic obstructive pulmonary disease (COPD)[117,118] and 1 examined the use of antifibrotic medication in idiopathic pulmonary fibrosis.[119]

Gastrointestinal Disorders (k = 2)

We identified 2 observational articles with a focus on a gastrointestinal disorders. One evaluated the association between healthy eating indices and metabolic associated fatty liver disease,[120] and investigated the rates of recommended vaccine administration in patients with inflammatory bowel disease.[121]

Other (k = 5)

We located 5 articles which described conditions that did not fit into any of the above categories. Three observational articles focused on disability, of which 2 were notable. The first (N = 2,950 [100% WVs]) evaluated the impact of combat-related injury on post-deployment health profiles of OEF/OIF/OND Veterans,[122] and the second (N = 4,029,672 [10% women]) compared military service and disability ratings between men and WVs under 50 years of age.[123] One mixed-sex and mixed-gender observational study focused on the auditory system using data from the Million Veteran Program (MVP) to analyze hearing loss and tinnitus within the context of military exposures.[124] The last article examined gender differences in health conditions within the MVP cohort.[122]

Reproductive Health (k = 88)

Table 7. Overview of Reproductive Health Focus Area

Highlights	
Participant composition	• WVs-only sample (k = 75) • WVs versus Veteran men (k = 4) • WVs versus non-Veteran women (k = 6) • Other (k = 7)
Key study designs	• Observational (k = 79) • Qualitative (k = 5) • RCT (k = 0) • EPOC and/or quasi-experimental (k = 1) • Mixed methods (k = 3)
Key study stages	• Program evaluation and/or QI (k = 5) • Efficacy and/or effectiveness (k = 0) • Implementation (k = 2) • Systematic reviews (k = 1) • Methods development (k = 2)
Top 3 prioritized populations	• Racial and ethnic minoritized (k = 15)

	• History of trauma (*k* = 5) • OEF/OIF/OND Veterans (*k* = 5)
Top 3 subcategories	• Maternal health (*k* = 30) • Family planning (*k* = 29) • Uterine diagnoses and surgeries (*k* = 11)
Top 3 secondary focus areas	• Health care organization/delivery of care for WVs (*k* = 27) • Access to care/utilization (*k* = 27) • SDOH (*k* = 14)

We identified 89 articles which primarily focused on reproductive health of WVs, indicating an increase from the 24 included in the 2008-2015 map. In addition, 35 articles with other primary focus areas had reproductive health as a secondary focus area. While most of these articles focused on Veteran-level data, 5 included VA staff alone or combined with WVs. Observational studies (*k* = 80) comprised a large majority of this focus area. The remaining articles were qualitative (*k* = 5), mixed methods (*k* = 3), and 1 QI study protocol. Notably, we found no RCTs in this section. The largest observational study (*N* = 6,196,432 [*N* = 17,495; 0.28% WVs]) addressed timeliness and adequacy of prenatal care by Veteran status and payer.[125] The largest sample size of WVs in a study (*N* = 407,482) assessed gynecologist supply deserts.[126] The 1 EPOC study design article in this section presented a patient portal-based educational intervention protocol compared to usual care and planned assessment of its impact on knowledge and shared decision-making.[127]

The objectives of the articles in this section were largely risk factor identification (*k* = 46) and prevalence description (*k* = 24). Prioritized populations which we identified within this section largely included racial and ethnic minorized populations (*k* = 15), those with a history of trauma (*k* = 6), and OEF/OIF/OND Veterans (*k* = 5). Within this subsection, the predominant focus was upon maternal health (*k* = 30) and family planning (*k* = 29). Most work published in this section was supported by VA funding (*k* = 71), and NIH, DOD, or other governmental funding (*k* = 22). The articles primarily focused on WVs-only populations (*k* = 75). A minority of the articles studied WVs and men (*k* = 4) or non-Veteran women (*k* = 5) though all reported data separately for WVs. One study jointly studied active service members and WVs.[128] Thirteen papers from this section arose from a single larger study: Examining Contraceptive Use and Unmet Need among WVs (ECUUN).[129]

Maternal Health (k = 30)

The largest subsection of this focus area was maternal health with 30 articles, of which 28 were observational and 2 were qualitative.[130,131] The observational studies covered topics ranging from risk factors associated with pregnancy outcomes (*eg*, payer status and war exposure), the relationship between mental health and pregnancy outcomes, racial disparities (*eg*, transitions of care, cardiovascular risk, substance use, c-section rates), pregnancy counseling, and medications with teratogenic potential. Three of these studies[132-134] assessed development and evaluation of the Maternity Care Coordination program. One article described development and implementation of an electronic health reminder to improve teratogenic medication counseling.[135] The 2 qualitative studies[130,131] focused on patient perceptions on VA maternity care and VA staff perceptions on post-partum care.

Family Planning (k = 29)

We found 29 articles which focused on aspects of family planning including contraception (*k* = 20), infertility (*k* = 4), preconception counseling (*k* = 3), and unintended pregnancies (*k* = 2). Twenty-five studies were observational. Contraception-focused articles covered concepts ranging from usage rates, variables impacting use, and contraception counseling, to long-acting reversible contraception and oral emergency contraception provision. Six articles explored contraception issues among prioritized populations including women with experiences of homelessness (*k* = 3),[136-138] and racial and ethnic disparities (*k* = 3).[139-141] One of the 25 observational studies assessed financial and health implications of 12-month oral contraceptive dispensing options through VA compared to the standard 3-month maximum.[142] Two studies[143,144] were qualitative with a particular focus on patient preferences for family planning counseling and provider- or facility-level factors influencing contraception use. Two studies[145,146] were mixed methods with 1 focused on the relationship between race and infertility and the second reporting agreement between ideal and current usage of contraceptive methods.

Uterine Diagnoses and Surgeries (k = 11)

We found 11 articles which addressed uterine diagnoses and surgeries, specifically related to hysterectomy, salpingo-oophorectomy, and the management of abnormal uterine bleeding (AUB). Five observational studies assessed hysterectomy trends in VA, 3 of which focused on racial disparities in hysterectomy routes and rates. Two observational studies[147,148] assessed rates of concomitant bilateral salpingo-oophorectomy (BSO) with hysterectomy related to military status, race, and menopausal status. Two observational studies[149,150] addressed racial disparities in uterine fibroid treatment. Two studies[151,152] focused on AUB; 1 mixed-methods study for developing quality indicators for care of women with AUB in primary care, and 1 observational study focused on assessment of adherence to treatment guidelines in VA primary care.

Menopause (k = 7)

Seven articles focused on menopause care. Four observational studies[153-156] focused on menopausal hormone therapy varying from assessment of adherence to prescribing guidelines, risk of venous thromboembolism with varying routes, association with suicide, and racial and ethnic disparities in diagnosis and management. One observational study assessed the association between vasomotor symptoms and Veteran status. One article was a QI study protocol for a patient portal-based educational intervention compared to usual care and its impact on menopause knowledge and shared decision-making.[127] One qualitative study assessed 30 WVs perceptions of menopause and its management in VA.[157]

Sexual Health (k = 5)

We found 5 observational studies which addressed sexual health. Three[158-160] focused on women with a history of trauma (*eg*, MST, non-sexual trauma). The remaining study focused on the impact of sexual health on the relationship between eating-disordered behavior and relationship satisfaction.[128] Only 1 of these studies focused on WVs alone.[160] Two studied WVs with men though reported data separately for WV.[158,159] One studied WVs with service members.[128]

Other Reproductive Health Services (k = 7)

Two observational studies[126,161] focused on geographical access to reproductive health services across the VA and in the community. Two observational studies [162,163] focused on abortion rates and

experiences among WVs receiving VA health care. Only 1 observational study assessed sexually transmitted infections.[164] The remaining study addressed breast reduction surgery and complications.[165] The 1 systematic review we identified in this section included 52 studies and synthesized the existing literature on reproductive health of WVs from 2008 to 2017.[166]

Preventive Health (k = 45)

Table 8. Overview of Preventative Health Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 17) • WVs versus Veteran men (*k* = 25) • WVs versus non-Veteran women (*k* = 1) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = *1)* • Other (*k* = 3)
Key study designs	• Observational (*k* = 35) • Qualitative (*k* = 7) • RCT (*k* = 2) • EPOC and/or quasi-experimental (*k* = 0) • Mixed methods (*k* = 1)
Key study stages	• Program evaluation and/or QI (*k* = 3) • Efficacy and/or effectiveness (*k* = 1) • Implementation (*k* = 2) • Systematic reviews (*k* = 0) • Methods development (*k* = 3)
Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 2) • Vietnam era (*k* = 1) • Rural dwelling (*k* = 0) • Racial and ethnic minoritized (*k* = 1)
Top 3 subcategories	• Screening (*k* = 21) • Health behaviors (*k* = 21) • Vaccinations (*k* = 2)
Top 3 secondary focus areas	• Health care organization/delivery of care for WVs (*k* = 11) • General mental health (*k* = 8) • Access to care/utilization (*k* = 8) • Chronic medical conditions (*k* = 8)

We identified 45 articles on preventive health, which were included if focusing on proactive measures to maintain well-being or prevent illness. This encompassed measures such as screening for risk factors and/or disease presence, health behaviors, and vaccinations. Most were observational (*k* = 35) or qualitative (*k* = 7), with the remaining studies including 1 RCT, 1 randomized implementation intervention protocol, and 1 mixed-methods study. The largest observational study evaluated data from 5,993,010 Veterans, of which 496,034 (8.3%) were women.[167] Among exclusively WVs observational studies, the largest sample was 585,818.[168] Twenty-five articles compared data between men and women, and with the proportion of women ranging from 0.7% to 50%. Several articles in this section leveraged data from large VA cohort studies and programs, including the MVP, WVCS, VA MOVE!, Weight and Veterans' Environments Study (WAVES), and EMPOWER QUERI. The most common

secondary focus area among preventive health studies included health care organization/delivery of care for WVs, general mental health, chronic medical conditions, and access to care/utilization. Additionally, we identified 79 articles that addressed aspects of preventive health as a secondary focus, most of which primarily focused on chronic medical conditions and general mental health.

Screening (k = 21)

We identified 21 articles which described aspects of health screening or risk assessment, representing the largest sub-category of preventive health. Among these studies, 8 focused on cancer screening, half of which ($k = 4$) highlighted breast cancer screening or mammography services. The only RCT noted in preventive health[169] examined the effect of mammography referral methods on completed mammograms among WVs. Five articles addressed mental health screening, including a OEF/OIF/OND WVs study which examined the association between screening for MST and HIV screening.[170] Four studies evaluated sexual and reproductive health screening, including 1 study that reported on transgender and/or nonbinary persons.[171] Three studies highlighted cardiovascular screening, and the remaining 2 reported general health screening. Six observational studies[172-177] ($N =$ 167 to $N =$ 8,759,079) described the efficacy and prevalence of screening in both WVs-only and mixed-sex and mixed-gender Veteran samples. Three articles[178-180] addressed factors related to patient and/or provider preferences, barriers, and facilitators to screening, including 1 qualitative study that used provider and patient interviews to inform the development of a cardiovascular risk identification toolkit.[179] Three studies[181-183] assessed the performance of risk assessment tools in WVs to inform research methods. One notable example was a 2021 article ($N =$ 17,264) that tested the performance of a WV-specific cardiovascular risk score calculator.[181]

Health Behaviors (k = 21)

We identified 21 articles that addressed aspects of health behavior. Most ($k =$ 14) focused on body weight, BMI, weight management programs, or obesity (Note: 9 articles on obesity as a chronic condition were placed in the chronic medical condition focus area). Alternative topics within this section included cardiovascular risk behaviors, sexual behavior, and nutrition. Several articles used data from large VA cohort studies and programs. Four studies[184-187] assessed health behaviors using the VA MOVE! program data, and 4 studies[186-189] used WAVES. Two of these articles[186,187] examined the effects of the WAVES on VA MOVE! program outcomes. Two studies[190,191] described health behaviors and BMI using data from the MVP, and 1 study assessed physical activity among the Women's Health Initiative cohort.[192] Three qualitative studies[184,193,194] evaluated WVs health behavior preferences and experiences ($N =$ 25 to $N =$ 30). We also identified a protocol paper for a mixed-methods hybrid type 3 effectiveness-implementation trial comparing implementation strategies across interventions related to the promotion of prevention and mental health telehealth service use by WVs, the EMPOWER QUERI 2.0.[195]

Vaccinations (k = 2)

Two observational studies addressed the prevalence and acceptance of vaccination against COVID-19. The larger of the 2 ($N =$ 5,871,438 [9.4% women]) assessed racial, ethnic, and rural disparities in COVID-19 vaccination rates.[196] The second described acceptance and beliefs of the COVID-19 vaccine among pregnant Veterans.[197]

Chronic Pain/Opioids (k = 30)

Table 9. Overview of Chronic Pain/Opioids Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 10) • WVs versus Veteran men (*k* = 18) • WVs versus non-Veteran women (*k* = 3) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = 1) • Other (*k* = 0)
Key study designs	• Observational (*k* = 27) • Qualitative (*k* = 3) • RCT (*k* = 0) • EPOC and/or quasi-experimental (*k* = 0) • Mixed methods (*k* = 0)
Key study stages	• Program evaluation and/or QI (*k* = 1) • Efficacy and/or effectiveness (*k* = 0) • Implementation (*k* = 1) • Systematic reviews (*k* = 0) • Methods development (*k* = 0)
Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 6) • Rural dwelling (*k* = 2) • Transgender and/or nonbinary (*k* = 1)
Top 3 subcategories	• Risk factors for chronic pain (*k* = 10) • Opioid use among VA users (*k* = 8) • Pain assessment and management (*k* = 5)
Top 3 secondary focus areas	• Access to care/utilization (*k* = 8) • Health care organization/delivery of care for WVs (*k* = 5) • General mental health (*k* = 4)

We identified 30 articles that primarily focused on chronic pain/opioids for the treatment of pain within the WVs population. We also identified 16 additional articles with chronic pain/opioids as a secondary focus area, mostly within articles with the primary focus areas of chronic medical conditions and general mental health, specifically addressing the relationship between mental health disorders (PTSD, insomnia) and pain. A majority (*k* = 27) of the articles were observational, of which 16 addressed risk and prognostic factors or associations, 9 focused on prevalence or epidemiology, 1 was an implementation study, and 1 was a program evaluation of mindfulness-based training for WVs. We identified 3 qualitative articles; all obtained data from Veterans and 2 from WVs only. There were no interventional studies.

Overall, 10 articles had a WVs-only sample, the largest with a sample of *N* = 516,950. Within mixed-sex and mixed-gender articles, the proportion of WVs ranged from 0.8% to 53.8%. Nine articles included prioritized populations, mostly OEF/OIF/OND Veterans (*k* = 6). The single WVs-only study which included a prioritized population investigated health care priorities and utilization of rural-dwelling WVs with chronic pain.[198] This was also the only article to report Veteran engagement during study conduct for the chronic pain/opioid focus area.

Risk Factors for Chronic Pain (k = 10)

The articles we identified in this area primarily evaluated associations between pain and other medical or mental health disorders. Two articles compared pain prevalence and effects of pain between Veterans and non-Veterans. The remaining 6 articles evaluated aspects of associations between pain and other medical or psychiatric risk factors. One article aimed to determine the association between combat experience in Veterans and pain intensity, examining PTSD, depressive symptoms, and resilience as parallel mediators of this association.[199] Another article, the largest all-WVs study (N = 516,950), compared the prevalence of chronic pain conditions among WVs with and without a history of MST.[200] A third examined differences between men and women with fibromyalgia.[201] The remaining articles looked at other associations with pain, such as menopause, cigarette smoking, and obesity.

Opioid Use Among VA Users (k = 8)

We found that most articles which focused on opioids investigated prescribing patterns within certain Veteran subpopulations, such as pregnant or menopausal individuals. One notable article examined the receipt of outpatient opioids, high-risk opioid prescribing, and opioid poisoning between transgender and/or nonbinary and cisgender Veterans (N = 46,320).[202] Three articles examined gender-based differences or other predictors of involvement in complementary and integrative health services or opioid monitoring programs in populations prescribed opioids for chronic pain treatment. The remaining articles evaluated the prevalence of opioid prescribing and potential adverse events of long-term opioid prescribing. We did not identify any studies examining differences in opioid prescribing between men and WVs nor any studies on harm reduction strategies for WVs.

Pain Assessment and Management (k = 7)

Articles which we categorized in this section primarily evaluated the impact of nonpharmacologic interventions in addition to opioids. Three articles specifically evaluated the impact and benefit of complementary pain interventions in the WVs population, including chiropractic care, mindfulness, interdisciplinary team-based approach to fibromyalgia care, and an integrated pain team. One article (N = 130,765 [9% WVs]) assessed pain intensity measurements in emergency department patients to determine if pain intensity measurements differed between male and female nurses and whether this information led to differences in patient triage.[203]

Health Care Utilization Among Patients with Chronic Pain (k = 5)

Two of the articles that focused on health care utilization were qualitative; 1 examined the challenges of using an integrated health system to manage pain[204] and the other, an WVs-only study, examined the experiences and priorities of rural-dwelling WVs seeking health care for chronic pain.[198] Another rural-focused article examined gender-based differences and the impact of rurality on pain care.[205] The remaining 2 articles addressed utilization patterns for patients with musculoskeletal pain.

Long-Term Care/Aging (k = 21)

Table 10. Overview of Long-Term Care/Aging Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 9) • WVs versus Veteran men (*k* = 9) • WVs versus non-Veteran women (*k* = 5) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = 2) • Other (*k* = 0)
Key study designs	• Observational (*k* = 21) • Qualitative (*k* = 0) • RCT (*k* = 0) • EPOC and/or quasi-experimental (*k* = 0) • Mixed methods (*k* = 0)
Key study stages	• Program evaluation and/or QI (*k* = 0) • Efficacy and/or effectiveness (*k* = 0) • Implementation (*k* = 0) • Systematic reviews (*k* = 2) • Methods development (*k* = 0)
Top 3 prioritized populations	• History of trauma (*k* = 1) • Racial and ethnic minoritized (*k* = 1) • Sexual minoritized populations (*k* = 1) • Vietnam (*k* = 1)
Top 3 subcategories	• Morbidity and mortality (*k* = 9) • Cognitive function (*k* = 7) • End of life care (*k* = 3)
Top 3 secondary focus areas	• Chronic medical conditions (*k* = 6) • Access to care/utilization (*k* = 3) • Preventative health (*k* = 3)

We identified 21 observational studies primarily focused on long-term care/aging of WVs, a modest increase compared to the 13 articles included in the 2008-2015 map. In addition, 20 articles identified long-term care/aging as a secondary focus area, most commonly within articles with the primary focus area of chronic medical conditions (*k* = 7). Twelve articles described prevalence or epidemiology of aging-related topics, 7 addressed risk factors or associations, and 2 were scoping reviews. All articles included in this focus area used patient-level data and 9 included WVs only (*N* = 152 to *N* = 188,094). Among articles with a WVs subpopulation, the proportion of WVs ranged from 0.9% to 5.7% with 1 outlier at 56.9%. Four articles targeted prioritized populations including those with a history of trauma (*k* = 1), racial and ethnic minoritized populations (*k* = 1), sexual minoritized populations (*k* = 1), and Vietnam Veterans (*k* = 1).

Morbidity and Mortality (k = 9)

We found 5 articles which described mortality in association to sexual orientation,[206] gender and race and ethnicity intersectionality,[207] hip fracture,[208] frailty,[209] military generation,[210] and other physical

and mental health conditions.[211] The article addressing mortality and hip fracture was the only study conducted solely among WVs (N = 3,719) and addressed the relationship between military status and mortality analyzed data in the Women's Health Initiative study.[210] One article described common multimorbid clusters of health issues among 38,597 older WVs[212], and another described the relationship between telomere shortening, gender, and Veteran status.[213] We also identified a 2023 scoping review of 6 studies which sought to describe the scope of the literature on mortality among Vietnam era WVs.[214]

Cognitive Function (k = 7)

We identified 7 studies focused on cognitive function ranging from mild cognitive impairment to Alzheimer's disease. One 2023 study reported the epidemiology of mild cognitive impairment, Alzheimer's disease, and other dementia types among Veterans including 6,824 WVs (2.4%).[215] The other articles included in this category described associations between the risk of cognitive dysfunction and various conditions including alcohol use disorder,[216] TBI,[217,218] and cardiorespiratory fitness.[219] One article explored the intersectionality of sex and race in the relationship between TBI and dementia.[217] Another article reported analyses from the Women's Health Initiative[220] exploring longitudinal global cognitive functioning. The largest number of WVs in an analysis in this category (N = 109,140) explored the relationship between TBI, PTSD, depression, and dementia.

End-of-Life Care (k = 3)

We found 3 articles related to end-of-life care. One described the prevalence of palliative care knowledge and symptoms burden among 152 WVs[221] and a second the prevalence of wanting advanced care directives among 484 WVs.[222] The third article was a 2021 scoping review that included 19 studies exploring literature on palliative and hospice care of WVs.[223]

Functioning (k = 2)

We identified 1 prospective cohort which explored the relationship between prior TBI and activities of daily living (ADL) in late life, including 2,887 WVs (56.9%).[224] A second study explored indicators of aging well among WVs and non-Veteran women using data from the Women's Health initiative.[225]

Cancer (k = 12)

Table 11. Overview of Cancer Focus Area

Highlights	
Participant composition	• WVs-only sample (k = 3) • WVs versus Veteran men (k = 7) • WVs versus non-Veteran women (k = 2) • Both WVs versus Veteran men and WVs versus non-Veterans (k = 1) • Other (k = 1)
Key study designs	• Observational (k = 11) • Qualitative (k = 1) • RCT (k = 0) • EPOC and/or quasi-experimental (k = 0) • Mixed methods (k = 0)

Key study stages	• Program evaluation and/or QI (*k* = 0) • Efficacy and/or effectiveness (*k* = 0) • Implementation (*k* = 0) • Systematic reviews (*k* = 0) • Methods development (*k* = 1)
Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 1) • N/A • N/A
Top 3 subcategories	• sex-specific cancer (*k* = 6) • non-sex-specific cancer (*k* = 6) • N/A
Top 3 secondary focus areas	• Preventative health (*k* = 3) • Chronic medical conditions (*k* = 2) • General mental health (*k* = 1)
Identified gaps	• No articles on sex specific cancers other than breast, such as cervical, ovarian, or uterine • No WVs only articles on non-sex-specific cancers that commonly affect women (*ie,* lung) • No articles including transgender and/or nonbinary Veterans

We identified 12 articles that primarily focused on aspects of cancer care for WVs. Eight articles on cancer screening were included under preventative health. Three articles with cancer as a secondary focus were identified, with 2 categorized under preventive health and 1 under chronic medical conditions. A majority (*k* = 11) of articles on cancer care were observational, 6 of which focused on prevalence and epidemiology, 4 investigated risk and prognostic factors or association, and 1 was a methods development article (prediction models for development of pancreatic cancer in patients with uncontrolled diabetes).[226] We identified 1 qualitative article which included data from VA providers and staff and no interventional studies. The largest observational study (*N* = 892,740 [*N* = 209,220; 23.4% WVs]) evaluated young-onset colorectal cancer among Veterans.[227] The only study which focused on a prioritized population, OEF/OIF Veterans, was also the largest WVs-only observational study (*N* = 576,601) and determined if WVs deployed during the OEF/OIF era had a greater likelihood of breast cancer compared with other WVs. Three articles collected data from WVs only, and 7 collected data from a mixed-sex and mixed-gender sample of Veterans. Within the 7 mixed-gender articles, 3 focused on breast cancer and the rest on a variety of non-sex- and gender-specific cancers. The proportion of WVs in these articles varied from 3% to 82.8%. Since the 2008-2015 map,[9] which identified 6 observational studies related to breast cancer, there was a slight increase in the total number of published articles and a broader focus across cancer types. We identified no articles which addressed sex-specific cancers other than breast cancer that commonly affect women such as cervical, ovarian, or uterine, nor any which specifically sought to include transgender and/or nonbinary WVs.

Sex-Specific Cancers (k = 6)

The 6 articles we identified which addressed sex-specific cancers primarily included breast cancer (*k* = 5) with 1 addressing gynecologic cancer care coordination. One article examined an all-women sample of OEF/OIF WVs (*N* = 576,601) to determine the likelihood of breast cancer compared with other WVs.[228] Breast-cancer-related articles addressed differences in cancer characteristics between men and WVs, evaluated different breast cancer excisional procedures, and assessed breast cancer prediction

and risk evaluation.[229,230] We identified no other studies of sex-specific cancers (*eg*, cervical, ovarian, or uterine) or studies on sex-specific cancers within the transgender and/or nonbinary population.

Non-Sex-Specific Cancers (k = 6)

Articles regarding non-sex-specific cancers addressed a mix of individual cancers and unspecified cancer types. Two related articles[231,232] used the same data to investigate cancer incidence in Veterans: 1 in a mixed-sex and mixed-gender sample and 1 in a sub-analysis of women only. One article surveyed coping strategies among Veterans while undergoing chemotherapy.[233] The remaining 3 articles were mixed-sex and mixed-gender and looked at brain, colon, and pancreatic cancer. We did not identify any all-women studies on non-sex-specific cancers other than the single paper on cancer incidence.

TRAUMA, VIOLENCE, AND STRESSFUL EXPERIENCES

Interpersonal Violence (k = 121)

Table 12. Overview of Interpersonal Violence Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 69) • WVs versus Veteran men (*k* = 43) • WVs versus non-Veteran women (*k* = 2) • Both WVs versus Veteran men and WVs versus non-Veterans (*k* = *1)* • Other (*k* = 8)
Key study designs	• Observational (*k* = 89) • Qualitative (*k* = 24) • RCT (*k* = 4) • EPOC and/or quasi-experimental (*k* = 2) • Mixed methods (*k* = 2)
Key study stages	• Program evaluation and/or QI (*k* = 3) • Efficacy and/or effectiveness (*k* = 3) • Implementation (*k* = 4) • Systematic reviews (*k* = 3) • Methods development (*k* = 5)
Top 3 prioritized populations	• History of trauma (*k* = 58) • OEF/OIF/OND Veterans (*k* = 26) • Racial and ethnic minoritized (*k* = 2) • Justice involved (*k* = 2) • Sexual minoritized (*k* = 2) • Persons with experiences of homelessness (*k* = 2)
Top 3 subcategories	• MST (*k* = 69) • IPV (*k* = 41) • Other interpersonal trauma (*k* = 6)
Top 3 secondary focus areas	• General mental health (*k* = 54) • Access to care/utilization (*k* = 20)

- Health care organization/delivery of care for WVs (*k* = 19)

We identified 121 studies with a primary focus on interpersonal violence. Additionally, 78 studies were identified with interpersonal violence as a secondary focus, most commonly those with a primary focus on general mental health. The most common prioritized population represented was Veterans with a history of trauma (*k* = 58), though a notable subset focused on OEF/OIF/OND Veterans (*k* = 26). Very few studies focused on other prioritized subpopulations. Most studies in this focus area used samples consisting exclusively of WVs (*k*=60*)*, though a substantial minority (35.2%) used mixed samples to compare data from WVs and Veteran men. The latter frequently focused on gender differences in rates of exposure to interpersonal violence or mental health outcomes related to these trauma types.

We determined that these studies were overwhelmingly observational in nature, though a subset used qualitative methods (*k* = 24) or mixed designs (*k* = 2) to investigate Veterans' experiences of these trauma types and experiences with VA care. Most studies examined the prevalence of MST and IPV, risk factors for MST and IPV, or mental and physical health sequalae of these experiences. Only 6 studies were classified as RCTs or other experimental designs, which largely focused on testing intervention efficacy for MST and IPV survivors. While a significant number of non-experimental studies examined MST and IPV screenings within VA, only 1 RCT addressed this issue.[234] Overall, implementation studies were rare, accounting for 4 of the 122 studies identified.

Military Sexual Trauma (k = 69)

We identified 69 studies with a focus on MST, nearly double the number identified in the 2008-2015 map (*k* = 37). Thirty-five were conducted in samples consisting exclusively of WVs, 34 with mixed WVs and Veteran men samples, and 1 with primary care providers. These studies relied almost exclusively on observational (*k* = 50) or qualitative and/or mixed-methods (*k* = 17) designs. Most observational studies focused on understanding prevalence of MST or associations between MST and various physical or mental health outcomes (*eg*, PTSD, sexual functioning, hypertension). Qualitative studies generally focused on understanding Veterans' experiences of MST, related outcomes, and/or VA care for those with MST. Findings from 68 studies addressing the prevalence of MST were summarized in a 2018 meta-analysis.[235] We also identified 1 2019 systematic review that addressed findings from 6 MST-related studies and sexual health among WVs.[236]

We identified 1 study using an experimental design to test a telehealth-based intervention for MST survivors.[237] No identified studies reported the results of a finished RCT; however, 1 consisted of an RCT protocol testing a telehealth version of PE among WVs receiving MST-related PTSD treatment.[238] An additional study used secondary data from this ongoing RCT to examine dropout predictors.[239]

We found very few studies in this topic which focused on high-priority subpopulations. The few noted were among Veterans with experiences of homelessness (*k* = 2), racial and ethnic and/or sexual minoritized Veterans (*k* = 2), and transgender and/or nonbinary Veterans (*k* = 1).

Intimate Partner Violence (k = 41)

We identified 41 articles which focused on IPV, marking a significant increase from the 9 IPV-based studies reported in the 2008-2015 evidence map. Most studies used observational designs to understand the prevalence of IPV among WVs and associations between IPV and various mental and

physical health conditions. Findings related to IPV and mental health were summarized in a 2017 systematic review of 13 studies.[240] Notably, in the current map, there was a significant emphasis on IPV screening among identified studies. We identified 1 RCT that tested facilitated implementation of IPV screening in primary care across 9 VA facilities, which resulted in increased rates of both screening and disclosure among WVs.[234] Screening was also a key focus for qualitative, implementation, and QI studies in this category. We identified only 1 RCT ($N = 60$) that tested an intervention designed to facilitate recovery from IPV among WVs (*ie*, Recovering from Intimate Partner Violence through Strengths and Empowerment [RISE]) relative to enhanced usual care (*ie*, psychoeducation, safety planning, resources).[241] Most IPV studies used samples consisting entirely of WVs. Regarding high-priority subpopulations, the experiences of OEF/OIF/OND Veterans were considered in 4 studies, while only 1 study focused on the experiences of a minoritized group, sexual minoritized Veterans.

Sexual Violence (k = 5)

We identified 5 studies which considered sexual violence more broadly. One tested prior experiences of sexual abuse and assault as a predictor of revictimization among men and WVs. Four studies used observational ($k = 3$) or qualitative ($k = 1$) designs to explore links between sexual assault history and health care utilization and outcomes, including cancer screening,[242] emergency department visits,[243] and family planning and reproductive health services among WVs.[244,245]

Other Interpersonal Trauma (k = 6)

We identified 6 observational studies (4.9%) that considered exposure to multiple interpersonal trauma types. Four studies used mixed samples to compare men and WVs. Three studies focused on co-occurring MST and IPV, while others considered lifetime exposure to interpersonal trauma types. Most studies focused on the impact of exposure to these traumatic experiences on mental health.

Other Violence (k = 6)

Table 13. Overview of Other Violence Focus Area

Highlights	
Participant composition	• WVs-only sample ($k = 3$) • WVs versus Veteran men ($k = 3$) • WVs versus non-Veteran women ($k = 0$)
Key study designs	• Observational ($k = 4$) • Qualitative ($k = 1$) • RCT ($k = 0$) • EPOC and/or quasi-experimental ($k = 0$) • Mixed methods ($k = 1$)
Key study stages	• Program evaluation and/or QI ($k = 0$) • Efficacy and/or effectiveness ($k = 0$) • Implementation ($k = 0$) • Systematic reviews ($k = 0$) • Methods development ($k = 0$)
Top 3 prioritized populations	• OEF/OIF/OND Veterans ($k = 4$) • History of trauma ($k = 1$)

	• Gulf war I and/or Vietnam (*k* = 1)
Top 3 subcategories	• Firearm ownership (*k* = 4) • Exposure to violence (*k* = 2) • N/A
Top 3 secondary focus areas	• General mental health (*k* = 3) • Suicide/NSSI (*k* = 2) • Interpersonal violence (*k* = 2)

We identified 6 studies with other violence as a primary focus. Other violence was the secondary focus for 13 additional studies, most often those with a primary focus on general mental health or interpersonal violence. Studies were observational (*k* = 4), mixed methods (*k* = 1), or qualitative (*k* = 1) in design, and focused on either prevalence and epidemiology, description, or risk factors and associations. The studies were conducted primarily among OEF/OIF/OND Veterans (*k* = 4) and VA users (*k* = 4).

Firearms (k = 4)

Of the 6 studies within the other violence primary focus area, 4 focused on firearm ownership (Note: there was 1 additional study on firearm access with a primary focus of suicide/NSSI). Among the firearm ownership studies, 3 focused exclusively on WVs and examined firearm-related attitudes, experiences, and behaviors among WVs. The fourth used a mixed sample to compare documentation of firearm access screening for men and WVs.[246] Notably, the included studies did not address firearm beliefs and behaviors among potentially high-risk or high-priority groups, such as transgender and/or nonbinary Veterans and sexual minoritized Veterans.

Exposure to Violence (k = 2)

We found 2 studies which considered exposure to various forms of violence. One used data from The Veterans Metrics Initiative (TVMI) study to assess adverse childhood experiences (ACEs) and combat exposure[247] and the remaining study assessed Veterans' reactions to completing surveys asking about trauma exposure with the trauma type unspecified.[248]

Harassment and Discrimination (k = 9)

Table 14. Overview of Harassment and Discrimination Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 5) • WVs versus Veteran men (*k* = 3) • WVs versus non-Veteran women (*k* = 0) • Other (*k* = 1)
Key study designs	• Observational (*k* = 5) • Qualitative (*k* = 4) • RCT (*k* = 0) • EPOC and/or quasi-experimental (*k* = 0) • Mixed methods (*k* = 0)
Key study stages	• Program evaluation and/or QI (*k* = 0) • Efficacy and/or effectiveness (*k* = 1)

	• Implementation (*k* = 0) • Systematic reviews (*k* = 0) • Methods development (*k* = 0)
Top 3 prioritized populations	• OEF/OIF/OND Veterans (*k* = 2) • History of trauma (*k* = 1) • N/A
Top 3 subcategories	• Harassment in the VA (*k* = 7) • Other harassment (*k* = 2) • N/A
Top 3 secondary focus areas	• Health care organization/delivery of care for WVs (*k* = 6) • Access to care/utilization (*k* = 2) • General mental health (*k* = 1) • SDOH (*k* = 1)

We created this new primary focus area due to the recent attention to stranger harassment reported on VA grounds (*k* = 9). There were also an additional 12 articles identified with harassment and discrimination as a secondary focus area, most often regarding the influence of harassment and/or discrimination among factors or related outcomes of a specific condition, rather than the experience of harassment or discrimination itself (*eg*, weight discrimination and the development of disordered eating).[249] Only 2 articles focused on prioritized subpopulations; 1 targeted OIF/OEF/OND Veterans and those with a history of trauma[250] and the second OIF/OEF/OND Veterans generally.[251] We did not identify any experimental study designs in this area.

Harassment in VA (k = 7)

Seven articles described aspects of harassment experienced while in VA. Two observational studies reported data from WVs regarding the prevalence of stranger harassment (*N* = 1,387)[252] and gender-based discrimination in VA (*N* = 2,294).[253] Four qualitative studies explored perspectives on harassment and/or how to address it from both patient[251,254] and provider and staff perspectives.[255,256] One article (*N* = 3,011) described an evaluation before and after the launch of a national campaign to reduce stranger harassment in VA among WVs.[257]

Other Harassment (k = 2)

We identified 2 additional articles for this focus area, 1 observational study that explored non-sexual harassment during deployment and its effect on mental health functioning[250] and 1 study that evaluated gender differences in the validation of a measure of sexual harassment.[258]

STRUCTURES OF CARE FOR WOMEN VETERANS

Health Care Organization/Delivery of Care for WVs (k = 50)

Table 15. Overview of Health Care Organization/Delivery of Care for WVs Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 19) • WVs versus Veteran men (*k* = 11) • WVs versus non-Veteran women (*k* = 2)

	• Both WVs versus Veteran men and WVs versus non-Veterans (*k* = *1)* • Other (*k* = 19)
Key study designs	• Observational (*k* = 31) • Qualitative (*k* = 15 • RCT (*k* = 1) • EPOC and/or quasi-experimental (*k* = 1) • Mixed methods (*k* = 2)
Key study stages	• Program evaluation and/or QI (*k* = 9) • Efficacy and/or effectiveness (*k* =0) • Implementation (*k* =0) • Systematic reviews (*k* = 1) • Methods development (*k* = 6)
Top 3 prioritized populations	• Transgender and/or nonbinary (*k* = 5) • Rural dwelling (*k* = 2) • Vietnam era (*k* = 1) • Veterans with experiences of homelessness (*k* = 1) • Sexual minoritized (*k* = 1)
Top 3 subcategories	• Service delivery (*k* = 27) • Research methods (*k* = 10) • Staffing and training of VA women's health providers (*k* = 7)
Top 3 secondary focus areas	• Access to care/utilization (*k* = 11) • Health care organization/delivery of care for WVs (*k* = 9) • SDOH (*k* = 6)

We identified 50 articles that focused on aspects of models, strategies, staffing, or experiences related to health care organization/delivery of care for WVs. We found 153 articles with other primary focus areas that also touched on aspects of health care delivery for WVs, most commonly in articles assigned to reproductive health and general mental health. Fourteen articles collected data from VA staff and providers, 29 from patients, 3 from both patients and staff, and 4 from VA clinics or facilities. Of the 15 articles describing qualitative studies, the total *N* ranged from 10 to 148. The largest observational study in this focus area included data from 111,911 Veterans (*N* = 36,456 [31.5%] women).[259] The largest observational study of WVs included 7,620 participants.[260] Articles in this group were primarily observational or qualitative, with 2 mixed-methods studies and a single 12-site cluster-randomized trial evaluating an approach to tailoring a primary care model for WVs. Of the 5 articles in this group that evaluated transgender and/or nonbinary Veterans as a prioritized population, 4 addressed methods for research and 1 described provider training on topics related to this population. The 11 articles that compared data between Veteran men and WVs did not concentrate on any 1 subtopic, and the proportion of women ranged from 0.96% to 51%.

Service Delivery (k = 26)

Articles related to health care service delivery addressed aspects of the structure and experience of care delivery for WVs. Five studies assessed aspects of the organization and model of staffing for WVs care within the VA, including patient-centered medical home models of care and patient-aligned care teams (PACTs),[261,262] and reproductive health services.[263] Three of these 6 articles were linked to a cluster-randomized trial of an evidence-based QI approach to tailoring PACTs for WVs. Nine studies used

qualitative or observational methodology to explore WVs experiences related to various aspects of receiving care, including trust of the VA health care system or providers,[264-266] VA care including inpatient care, [267] and the Veterans Choice Program.[268] Four studies used qualitative interviews or survey methodology to explore aspects of WVs care provision from the perspective of VA staff and providers, and included topics such as experiences of patient aggression[269] and PACT participation.[270,271] Other articles in this category addressed the provision of certain care types, such as equine-facilitated therapy[272] and provider documentation of sexual orientation during care delivery.[259]

Population-Specific Care Needs and Preferences (k = 6)

We identified 4 articles which described the health care needs and preferences of WVs. Two focused on WVs generally and 2 on specific subpopulations (*ie*, rural-dwelling women and those with experiences of homelessness). Two articles assessed the needs of women using specific care types: telehealth and community-based services. These articles were all qualitative or observational.

Staffing and Training of VA Women's Health Care Providers (k = 7)

Five articles addressed approaches to training VA staff and providers on care delivery for WVs in general or specific subpopulations, such as transgender and/or nonbinary Veterans[273] or rural-dwelling Veterans.[274] Two articles[275,276] assessed retention of VA women's health primary care providers.

Cost of Care (k = 1)

We identified only 1 study which evaluated cost and described medical expenditures in the context of service-connected disability for Vietnam-era Veterans.[277]

Research Methods (k = 10)

Articles related to research methodologies were included in this section as opportunities to participate in VA research are viewed as a critical component of the VA's efforts to enhance care delivery for WV. Four methods articles[278-281] examined strategies for identifying gender using administrative data, 5 articles[282-286] explored the participation of women in VA research studies, and 1 described a specific approach to data collection from WVs.[287]

Access/Utilization of Care (k = 30)

Table 16. Overview of Access/Utilization of Care Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 15) • WVs versus Veteran men (*k* = 9) • WVs versus non-Veteran women (*k* = 1) • Other (*k* = 5)
Key study designs	• Observational (*k* = 21) • Qualitative (*k* = 7) • RCT (*k* = 0) • EPOC and/or quasi-experimental (*k* =0) • Mixed methods (*k* = 2)
Key study stages	• Program evaluation and/or QI (*k* = 1) • Efficacy and/or effectiveness (*k* = 0)

	• Implementation (*k* = 1) • Systematic reviews (*k* = 1) • Methods development (*k* = 0)
Top 3 prioritized populations	• Transgender and/or nonbinary (*k* = 6) • OEF/OIF/OND Veterans (*k* = 5) • Sexual minoritized (*k* = 2) • Rural dwelling (*k* = 2) • Veterans with experiences of homelessness (*k* = 2)
Top 3 subcategories	• General access/utilization of care (*k* = 13) • Access by prioritized population (*k* = 12) • Service specific access/utilization of care (*k* = 4)
Top 3 secondary focus areas	• Health care organization/delivery of care for WVs (*k* = 11) • SDOH (*k* = 7) • Chronic medical conditions (*k* = 3)

We identified 30 articles that addressed aspects of access/utilization of care for WVs without focusing on a specific condition or diagnosis. Importantly, 166 articles identified access/utilization of care as a secondary focus, commonly those with the general mental health primary focus area. Twelve articles explored access to care for VA prioritized populations, mostly commonly LGBTQ+ Veterans (*k* = 8). There was a mix of studies focusing on data from WVs only and those reporting analyses stratified by sex or gender, while 4 studies included data from VA providers. Most studies in this focus area were observational (*k* = 21) or qualitative (*k* = 7). We also included 1 mixed-methods systematic review of barriers and facilitators to access to health care and social services for WVs experiencing homelessness[288] and a mixed-methods program evaluation of the transgender e-consult program.[289]

General Access to Care/Utilization (k = 13)

Articles included in this category focused on access/utilization of care for WVs generally, without a specific focus on a subpopulation or type of clinical service delivery. Topics ranged from VA care attrition,[290] barriers to receiving VA care (*eg*, cost and care fragmentation), relationship of food insecurity and utilization,[291] and impact of distance on receipt of recommended care[292] to how to improve overall access to care for WVs. Seven articles described cross-sectional surveys. Eight of the 11 observational studies included only WVs (*N* = 186 to *N* =118,113) and 2 large studies compared men versus women (*N* = 555,183 [8.5% women[293]]; *N* = 49,865 [16% women][294]). The largest observational study of WVs only compared patterns of health profiles and utilization of OIF/OEF/OND Veterans in Puerto Rico-based VAs to those in the mainland.[295] The larger of the 2 that included both men and women evaluated no-show rates by age, gender, and appointment type across VA service lines[293]; the other examined gender differences in VA and non-VA use by 49,865 (16% women) OIF/OEF/OND Veterans after separation from active duty.[294] One qualitative article included VA provider and staff perspectives from 127 semi-structured interviews and 81 focus groups across 21 VA sites on issues related to access to care for women. The second qualitative article explored women's perspectives on decisions around attrition from the VA.[290] Six articles in this category addressed care received both inside and outside the VA, and 4 addressed access to care specifically for OIF/OEF/OND Veterans.

Specific Service Access and Utilization (k = 4)

Three observational studies described patterns of care and related outcomes and predictors for specific clinical services including chiropractic care,[13] primary care,[296] and vocational rehabilitation.[297] One qualitative study explored experiences and identities of WVs that led to use of mental health services.[298]

Prioritized Population-Specific Utilization and Access (k = 12)

We identified 12 articles which described aspects of access/utilization of care for prioritized populations within the VA, specific Veterans with housing insecurity or experiences of homelessness ($k = 2$), rural-dwelling Veterans ($k = 2$), and Veterans who identify as LGBTQ+ ($k = 8$). This included 6 observational studies, 4 qualitative investigations, 1 mixed-methods program evaluation, and 1 systematic review. The systematic review included 35 studies that evaluated access to care and social services among WVs experiencing homelessness.[288]

Disability Claims (k = 1)

We found 1 observational study ($N = 663$ [72.3%] WVs) which examined gender differences in the reversal of PTSD benefits claims after strengthening MST claims processes.[299]

OTHER FOCUS AREAS

SDOH (k = 30)

Table 17. Overview of SDOH Focus Area

Highlights	
Participant composition	• WVs-only sample ($k = 12$) • WVs versus Veteran men ($k = 16$) • WVs versus non-Veteran women ($k = 3$) • Both WVs versus Veteran men and WVs versus non-Veterans ($k = 2$) • Other ($k = 1$)
Key study designs	• Observational ($k = 24$) • Qualitative ($k = 4$) • RCT ($k = 0$) • EPOC and/or quasi-experimental ($k = 0$) • Mixed methods ($k = 2$)
Key study stages	• Program evaluation and/or QI ($k = 1$) • Efficacy and/or effectiveness ($k = 0$) • Implementation ($k = 0$) • Systematic reviews ($k = 2$) • Methods development ($k = 0$)
Top 3 prioritized populations	• Veterans with experiences of homelessness ($k = 11$) • History of trauma ($k = 5$) • Transgender and/or nonbinary ($k = 3$)
Top 3 subcategories	• Housing instability ($k = 15$) • General and overlapping SDOH ($k = 6$)

	• Other SDOH (*k* = 6)
Top 3 secondary focus areas	• Access to care/utilization (*k* = 9) • Interpersonal violence (*k* = 7) • General mental health (*k* = 6)

The articles we identified under this category addressed the influence of nonmedical factors (*eg*, housing) on health outcomes, reflecting forces and systems with a daily influence on WVs. This category was not included as a distinct category in the 2008-2015 map.[9] In the current map, we also included articles that reported key social outcomes not otherwise linked to a specific health condition (*eg*, employment). Reflecting the breadth of literature in which considerations of SDOH were integrated, we note that an additional 69 articles listed SDOH as a secondary focus area. Most of the articles in this primary focus area employed observational methodologies (*k* = 24), 4 were qualitative, 2 used mixed methods, and 2 were systematic reviews. Of the studies that reported individual patient data, 16 provided comparisons between WVs and Veteran men based on observational data, with the proportion of WVs ranging from 10% to 45.7%.

Housing Instability (k = 15)

Fifteen articles were focused on aspects of housing instability or Veterans who had experiences of homelessness, including 11 observational, 2 qualitative, and 2 mixed-methods studies. An additional 11 articles across 6 other primary focus areas included targeted inclusion criteria for Veterans with experiences of homelessness. In comparison, the 2008-2015 map identified 12 articles related to homelessness among WVs. Two articles provided information on the breadth of this issue among Veterans in the VA and the services provided. Specifically, a large analysis of administrative data (*N* = 6,857,884) provided updated prevalence of experiences of homelessness among Veterans including comparisons by gender.[300] A second article described the predictors of receipt of VA housing service support after screening positive by gender (*N* = 27,403 [10% women]).[301] Four articles explored risk factors for housing instability, including a scoping review funded by the Veterans Affairs Canadian project that included 15 US-based studies which explored risk factors for housing instability across the lifespan.[302] Two of the studies exploring risk factors included comparisons between men and women, 1 of which was a large observational study of Veterans (*N* = 601,892 [12.3% women]).[303] Four articles explored aspects of the relationship between IPV and housing, including a multisite QI pilot project that explored IPV screening of Veterans in VA homeless Veterans programs and compared outcomes between men and women (*N* = 577 [10.9% women]).[304] Two observational studies characterized experiences of housing instability among transgender and/or nonbinary Veterans. Other articles in this category addressed general aspects of the experience of, and providing services to, Veterans having insecure housing.

General or Overlapping SDOH (k = 6)

Six articles reported findings from medium to large observational studies of broad categories of SDOH or multiple overlapping types of SDOH. We identified a prior VA ESP evidence map which examined health disparities in Veterans and included 109 studies relevant to WVs health.[305] One study examined perceived everyday discrimination as mediators of the association between race and ethnicity and mental health conditions among 3,060 Veterans (50% women).[306] Three articles described analyses of the association between adverse social experiences and health outcomes; 2 focused on broadly occurring adverse social experiences (*N* = 6212 [100% women][307]; *N* = 293,407, [8.2% women][308]) and 1 on adverse childhood experiences (*N* = 36,309 [1% women]).[309] Of note, there were 5 additional

articles[247,310-313] assigned to other primary focus areas which also addressed adverse childhood experiences.

Other SDOH (k = 6)

Six additional articles did not fall within the above categories of SDOH. Two studies examined patterns of social support, of which 1 was large observational study which compared social support among Veterans and non-Veteran civilians (*N* = 34,520 [358 WVs]), and the other examined gender differences in social support in OIF/OEF/OND Veterans with a history of trauma (N = 672 [45.7% WVs]).[314] Other articles examined health impacts of justice involvement,[315] food insecurity,[316] and transgender identity.[317] Finally, this category included a systematic review of 9 studies examining racial and ethnic disparities in the health of WVs.[318] Of note, we identified an additional 38 articles that explored the influence of race and ethnicity and specific health outcomes, or purposefully sought to include Veterans from racially and ethnically minoritized populations but were placed into other primary focus areas.

Social Outcomes (k = 3)

We identified 3 articles that addressed social outcomes not otherwise captured in another category, including community reintegration and work-related outcomes. One study interviewed 13 WVs with physical and/or psychological injuries to explore barriers and facilitators to community reintegration after separation from the military.[319]

Toxic Exposures (k = 3)

Table 18. Overview of Toxic Exposures Focus Area

Highlights	
Participant composition	• WVs-only sample (*k* = 1) • WVs versus Veteran men (*k* = 2) • WVs versus non-Veteran women (*k* = 0) • Other (*k* = 1)
Key study designs	• Observational (*k* = 3) • Qualitative (*k* = 0) • RCT (*k* = 0) • EPOC and/or quasi-experimental (*k* = 0) • Mixed methods (*k* = 0)
Key study stages	• Program evaluation and/or QI (*k* = 0) • Efficacy and/or effectiveness (*k* = 0) • Implementation (*k* = 0) • Systematic reviews (*k* = 0) • Methods development (*k* = 0)
Top 3 prioritized populations	• Gulf War I (*k* = 3) • N/A
Top 3 subcategories	• N/A
Top 3 secondary focus areas	• Chronic medical conditions (*k* = 2) • Reproductive health (*k* = 1) • Long-term care/aging (*k* = 1)

We identified 3 observational studies[320-322] that focused on toxic exposures among Gulf War Veterans, all VA funded. One study analyzed risk factors for chronic illnesses associated with deployed WVs during the Gulf War Era related to exposure of pesticides, oil well fires, and pyridostigmine bromide pills.[320] The other 2 included both men and women. The largest study examined all-cause mortality among Gulf War Veterans with toxic exposures (N = 1,368,148 [10.4% WVs]).[322] The other examined the risk of birth defects among Gulf War Veterans (N = 2,189 [22% WVs]).[321] Topics covered in the 3 articles with toxic exposures as a secondary focus include health patterns and symptoms after Gulf War deployment,[323] associations between toxic exposure and infertility,[324] and self-reported prevalence of chronic medical conditions and positive screens for mental health conditions in Gulf War Era Veterans.[325] Three other observational studies examined toxic exposures as a secondary focus area.[323-325] While no study focused on a prioritized population beyond Gulf War I Veterans, we found 1 study of toxic exposure as a secondary focus that reported outcomes for transgender and/or nonbinary Veterans.[324]

DISCUSSION

This evidence map identified 933 articles on WVs health published between 2016 and 2023, which was double the number published in the preceding 8 years. Similar to the 2008-2015 evidence map, most studies were observational and focused on mental health. Areas with the greatest growth were suicide/NSSI, reproductive mental health, reproductive health, chronic pain/opioids, and interpersonal violence. Within prioritized populations, there was an 8-fold increase in papers focusing on transgender and/or nonbinary Veterans; however, overall this remained an infrequent target population (k = 32). More commonly prioritized populations were OEF/OIF/OND Veterans and Veterans with a history of trauma. Emerging areas included harassment and discrimination experienced within the context of VA care, sleep disorders, disordered eating, and military-related toxic exposures. Literature areas with modest growth include long-term care/aging and access to care/utilization. Additional gaps in this literature included conditions common among women Veterans including hypertension, anxiety, and depression. As observed in the 2008-2015 map, we found that this overall body of literature remains primarily observational, though we identified 26 trials in the areas of general mental health and substance use, in addition to 11 implementation trials. Overall, there was also a similar portion of articles that exclusively included WVs (~44%) compared with articles with mixed samples of WVs and Veteran men or WVs and non-Veteran civilian women.

The areas of greatest growth for the WVs health literature are largely consistent with recent priority areas for VA research and major shifts in the overall population demographics. For example, pain, opioid use, and suicide prevention are all stated areas of emphasis in VA research. In addition, new areas of this literature map to previously underrecognized areas of importance, such as stranger harassment in VA facilities, or to areas of growing focus, such as military toxic exposures following the 2022 PACT Act.[326] We also identified a growth in research regarding health issues of women in their reproductive years (*eg*, maternal health, family planning), perhaps reflecting the increase in reproductive-age WVs receiving care in the VA.[327] This growth has been supported by multiple strategic actions from the WHRN[6] including the organization and hosting of relevant national collaborative research workgroups (*eg*, reproductive mental health, suicide prevention, LGBTQ+ Veterans, SUD), sponsoring of multiple women Veteran's health-focused journal supplements, and the direct involvement of congressionally mandated IPV work.[328-330] In addition, new workgroups have been recently launched to address the information need around menopause, women, aging, and women's military exposures which will support the needed growth in these areas.

In developing this map, we also explored the representation of prioritized populations within the field of WVs research by identifying both the area of focus for each article as well as the patient populations included. We observed an increase in the number of articles related to the health of transgender and/or nonbinary Veterans (4 to 32 articles), as well 156 articles focused on OEF/OIF/OND Veterans and 141 focused on Veterans with a history of trauma. We also identified 38 articles that specifically sought to include or focus on Veterans from racially and ethnically minoritized populations. We were unable to directly compare this finding to the 2008-2015 WVs health evidence map due to differences in categorization. Increases in research that investigates or accounts for the role of race, ethnicity, and gender identity in WVs health and VA health care align with the VA Office of Research and Development (ORD) strategic priority to *actively promote diversity, equity, and inclusion*.

Significant opportunities exist to leverage existing data sets to expand the impact of VA research and generate valuable information to inform patient-centered, personalized care for WVs.[328] Similar to the 2008-2015 map, we excluded over 500 articles that did not report findings for WVs subsamples,

representing an important missed opportunity since in many of these studies, it would likely have been feasible to disaggregate outcomes for WVs. These observations suggest that, in line with the VA ORD strategic priority to *put VA data to work for Veterans*, future research could better utilize VA data to explore differences in outcomes among Veteran women and Veteran men. Moreover, even when lacking statistical power to support subgroup analyses, investigators can still make retrospective or prospective data on WVs available for hypothesis generation or for contribution to future individual participant meta-analyses. A related strategy is to harmonize eligibility criteria, outcomes, and data collection strategies of prospective VA studies within the same research area to better enable pooling of findings across studies. These strategies could be useful, in particular, for building the limited literature on common but still understudied conditions impacting WVs, such as hypertension, anemia, lumbosacral disorders, and irritable bowel syndrome.[3]

Although there were relatively few randomized trials, we identified a notable number of program evaluations. This finding highlights the growth of VA clinical offerings and innovations designed to improve the health of WVs, as well as greater use of program evaluation resources available within VA's Learning Health Care System model. Although resource-intensive and methodologically sophisticated trials are often warranted for higher-risk innovations, lower-risk innovations can likely advance more rapidly to clinical practice, along a pathway that includes pragmatic research studies and well-designed program evaluations. This is especially true when evidence on safety and benefits exists in other clinical settings and populations. As such, ongoing evaluation of the field of WVs health research should involve tracking the progress and outcomes of program evaluation efforts alongside findings from rigorous efficacy and implementation trials.

This evidence map is focused on WVs, but findings have implications beyond the VA setting.[330] First, more WVs receive care outside of the VA than within the VA. While there are known differences in health status and demographics between VA users and non-users,[331] many of the findings from this work can inform the care provided to WVs outside the VA. Second, a growing number of WVs receive dual care (simultaneous care from inside and outside the VA) due to the need to seek clinical expertise in women's health from outside of the VA and in response to the expansion of VA-purchased care in the community. Clinicians in both settings could benefit from a richer understanding of the dynamics and prevalence of health issues and health care challenges experienced by this population. Finally, many of the health issues and complexities of health care for WVs are not unique to the Veteran population. Comorbid mental and physical health conditions, amputations, care barriers due to SDOH, and long-term effects of sexual trauma are also experienced by many men and women in the non-Veteran civilian population. The extensive expertise built in the VA research community has long supported clinical practice and professional guidelines used by non-Veteran civilian populations (*eg*, shingles vaccine) and WVs research offers similar benefits.[332]

Limitations

These findings should be considered within the context of the limitations of our approach. First, the categorization of identified articles could have been conducted in multiple ways—both overall and with each individual article. We aimed to align our categorization with the existing structure and approach to WVs health research by the VA ORD and Women's Health Research Network while expanding the opportunities to look for overlap and connections across areas of research. A different approach may have revealed different patterns in the literature. Although we made efforts to maintain comparability with earlier evidence maps and reviews, we acknowledge that some of our categorization and literature mapping approaches were not identical to those used in past mapping

efforts. For example, we identified articles focused on OEF/OIF/OND Veterans as a population targeted for inclusion; however, this is not the same as being focused specifically on post-deployment issues (less than 10 of the 156 articles seeking to include this group of Veterans were framed around re-integration and fewer than 10 focused explicitly on ramifications of combat exposure). Second, we excluded articles that described single-site quality improvement projects to focus on recent and generalizable scientific literature designed to translate broadly. However, reports of these projects likely describe important efforts to improve the health and well-being of WVs and may merit future synthesis. Third, due to the volume of literature, we were unable to screen each citation in duplicate, which may have led to the incorrect exclusion or misclassification of articles. We quality checked 20% of each investigator's citations (and up to 100% if needed). Lastly, given the volume of literature, we did not contact authors for clarification when aspects of study reporting or analyses were unclear; we described the study characteristics to the best of our abilities based on information in the primary literature.

Future Research

The current map demonstrates advances on research recommendations made in the 2008-2015 evidence map. Specifically, there has been a greater intersectional focus on certain minoritized populations, research on emerging topic areas, and increased reporting of funding sources. In addition to identifying areas of WVs literature that have grown and are ready for a focused synthesis, another key value of an evidence map is its ability to identify areas warranting further investigation. We have thus highlighted gaps in the literature that could be areas for future scientific exploration (Table 19).

First, the largest portion of WVs who received care in the VA are middle aged or younger. There is a time-sensitive need to understand conditions affecting this subpopulation now and in coming years, including chronic conditions such as heart disease, cancer, menopause, caregiving, cognitive decline, and mental health conditions such as PTSD, depression, and anxiety. Additionally, the intersectional and cumulative toll, and long-term management of these conditions needs to be explored. Particularly for chronic diseases, military exposures, and cancer, there is a great opportunity to leverage VA data to explore how and when care should be tailored for women. Although we observed an increased number of articles related to CVD in this map compared to the 2008-2015 map, the volume of long-term care and aging-related articles saw nominal growth. The 2024 White House Initiative for Women's Health Research underscores the importance of growing women's health research, especially related to mid- and late-life health issues for women.[333] Similarly, other conditions commonly affecting aging women such as menopausal symptoms, cancer, and dementia have been explored minimally in the WVs population and are identified as a priority for VA women's health research. Evolving VA research activities, such as the newly established WHRN workgroups mentioned above, the Women's Operational Military Exposure Network Center of Excellence (WOMEN CoE) and the recently established VA Center for Oncology oUtcomes Review And Gender Equity (COURAGE), are women's health-focused research groups well positioned to address these existing gaps in a timely manner.

Second, this body of literature grew rapidly since the 2008-2015 map, and now presents a robust picture of many topics important to the health of WVs. Despite continued growth, it will be important for research efforts to continue to respond to evolving patterns of care, access, and utilization and to the emerging health care needs of an aging and changing WVs population. We noted gaps in areas that might inform how care is provided in the VA including the use of dual sources of care, comparisons to non-VA care received by WVs, and care coordination across sites. In addition, while research on many

prioritized VA populations has increased, there will be a continued need to ensure representation of minoritized populations and intersectional identities in study samples and findings. In addition, we note that many articles[163,334-338] identified in this map leveraged data from a collection of larger survey and cohort studies, which demonstrates a path for growth in the field and may suggest the benefits of more funding for similarly designed studies.

Third, we also highlighted several important study design and reporting considerations. Crucially, participant sex and gender identity were reported separately in only 61 included articles. Because patient sex and gender identity have been captured separately in VA medical records for only the last few years, studies based on administrative data have not had sufficient time to use this additional information. It will be critical to approach the thoughtful incorporation of these variables into future analyses. The relevance and importance of these variables will vary by topic, as will the ability to conduct meaningful sex- or gender identity-based analyses built on data availability. However, reporting of stratified outcomes for WVs as a standard practice would support future hypothesis generation and potential inclusion in meta-analyses. In addition, the prior 2008-2015 evidence map noted the importance of considering Veteran engagement to strengthen and advance the field of WVs health literature.[9] While we sought to identify which articles noted the practice of WVs engagement during study conduct, this was rarely reported (only 28 articles). Aside from increasing engagement efforts, future research should articulate if, how, and when engagement with WVs was sought and implemented over the course of the research (*eg*, topic ideation, study implementation, interpretation of findings, dissemination). Engagement advances scientific rigor, feasibility, and acceptability[339,340]; however, there are still many unanswered questions in the field of engagement science. Thorough and appropriate documentation of patient partners and engagement activities could assist in advancing the field of engagement science, a strategic focus area of the VA Office of Research Development. The many existing resources in the VA through the WHRN[6] and groups such as Growing Rural Outreach through Veteran Engagement (GROVE)[341] may be leveraged to support WVs research moving forward.

Fourth, the vast majority of the existing WVs literature continues to be observational in nature. While there was a 3-fold increase in clinical trials since the 2008-2015 map, the percentage of articles with a RCT study design remains low (3%) and we identified only 11 implementation studies. One example of current VA efforts to increase clinical trials participation among WVs is the Women's Enhanced Recruitment Process (WERP) which is funded through the Cooperative Studies Program. While not all innovations will require sophisticated trials prior to application in clinical practice, there may be other ways to improve inclusion of women in trials (*eg,* aligning recruitment activities with locations where women receive clinical care, tailoring study recruitment messaging and images to be inclusive of WVs) to assist with meeting the VA ORD strategic priority of *increasing Veterans' access to high-quality clinical trials.*

Finally, we found 17 systematic reviews, scoping reviews, and evidence maps across areas of general mental health, interpersonal violence, and SDOH. Focus areas that could have sufficient evidence to support a future focused synthesis include MST, PTSD, substance use, and suicide/NSSI.

Table 19. Gap Analysis of Recent WVs Health Literature

Population	• Women with health issues common during midlife, peri-, and post-menopausal age • Older WVs and their caregivers • Rural-dwelling women

	• Women from racially and ethnically minoritized populations • Mixed-sex and mixed-gender populations
Intervention or phenomena	• Common chronic conditions impacting women including hypertension, anemia, lumbosacral disorders, asthma, and irritable bowel syndrome • Gender-based differences in pain management including opioid prescribing and/or harm reduction strategies • Toxic exposures • Care received via dual site (*eg*, VA and non-VA) • Women's health provider and staff retention • SDOH impact • Combat exposure impacts
Comparator	• Non-VA care • Non-sex-based or gender-informed care
Outcomes	• Implementation outcomes
Setting	• Community-delivered care for Veterans
Other design and reporting considerations	• Collect and report self-identified gender and sex assigned at birth • Explore experimental, interventional, and implementation studies • Conduct sex and/or gender-based analyses appropriate to condition under study; when impacted by statistical limitations, stratify by sex and gender for hypothesis generation and future meta-analyses • Report nature of any Veteran and partner engagement that occurs during a study

CONCLUSIONS

A robust evidence base is critical to promote the overall health of WVs and improve their quality of life and well-being. The pace of growth of WVs health research has doubled and has expanded in important areas that align with VA research priorities. Further advancement of this field should include research on health issues pertinent to an aging WVs population and greater utilization of rigorous but pragmatic research and program evaluation approaches.

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