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Divergence in diversity: why women's health matters

Introduction

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This year's International Women's Day unfolds amid geopolitical upheaval and democratic backsliding, as fundamental rights across Europe and beyond face renewed contestation. In this climate, equality is tested not only in rhetoric but even more so in policy - in decisions affecting healthcare, bodily autonomy, and access to services. As the European Commission enters the second half of its current mandate, discussions on the future of women's health have moved higher on the agenda, reflected in the Roadmap for Women's Rights and calls for a Gender Equality Strategy 2026–2030. While this is undoubtedly positive news, in an era of democratic decline and polarisation, recognition alone is insufficient. It is exactly for this reason that this year's compendium places women's health at its centre.

Across their lives, women face disparities rooted in underrepresentation in medical research, bias in data and diagnostics, and limited investment in gender-sensitive care, compounded by intersecting social, technological and economic factors. At the same time, gender-based violence remains a persistent health crisis. As debates over withdrawing from the Istanbul Convention on preventing violence against women intensify in some countries, nearly one in three women in the EU report having experienced physical or sexual violence.

The voices brought together in this publication reflect a broad range of expertise and lived experience, combining personal reflection, analysis and policy recommendations. Through their diverse approaches, a common insight emerges: women's health is both an expression of inequality and a barometer of broader societal resilience, impacting labour market participation, productivity, public trust and social stability. While the entries highlight meaningful progress, they also expose the significant gap between formal commitments and lived realities.

As human rights face mounting pressure, advancing women's health is inseparable from safeguarding democratic integrity. "Divergence in Diversity" alerts us to a looming wave of gender inequality and reminds us that diversity must not translate into unequal protection or uneven access to care. This year's compendium therefore serves as a call to action, to establish a dedicated EU Women's Health Strategy before the end of the second von der Leyen Commission's mandate in 2029.

Natasha Azzopardi Muscat
Director, Division of Health Systems, at the World Health Organization (WHO), Europe

International Women's Day 2026 calls on us to advance rights, justice and action for all women and girls. This means acknowledging a simple truth: women's health is shaped not only by biology, but by power, policy and opportunity. As a mother, a medical doctor and a public health professional, I have seen how gender norms, income, migration status, disability and digital access can profoundly influence whether a woman receives timely, respectful and high-quality care. Diversity among women should enrich our societies; not determine their health outcomes.

Under the European Programme of Work 2026–2030, and the leadership of our Regional Director Dr Hans Kluge, WHO/Europe is placing equity, gender and human rights at the heart of health system reform. One urgent priority is preventing and responding to violence against women and girls (VAWG), including technology-facilitated abuse. Digital tools have expanded the reach and permanence of violence, with severe physical, psychological and social consequences. Health systems must be equipped not only to treat the aftermath, but to identify risk, respond safely and prevent harm.

Through the WHO Special Initiative on Violence against Women and Girls, and in collaboration with UN Women and UNFPA, we are strengthening the evidence base, harmonising data and supporting countries to build survivor-centred services. WHO is the custodian agency for SDG indicator 5.2 on VAWG prevalence, and the normative lead for clinical and policy guidelines for the health sector. Our added value lies in a whole-of-health-system approach - integrating prevention and response into primary health care, hospitals, financing and governance frameworks.

Sadly, only 38% of countries in our Region currently meet WHO standards for comprehensive post-rape care. This must change. Investing in rights-based policies, workforce capacity, and multisectoral coordination is both a moral and economic imperative.

Our health systems mirror society. When we design systems that uphold the rights of women and girls, we strengthen trust, resilience and equity for everyone. Rights demand justice. Justice demands action.

Ana Berdzenishvili
Junior Policy Analyst, Sustainable Prosperity for Europe Programme, at the European Policy Centre

Climate change is increasingly recognised as a public health emergency. One reality, however, remains insufficiently acknowledged: climate change is not gender neutral, and the evidence is unambiguous.

The climate crisis is already harming health and threatening lives worldwide. More frequent and severe storms, heatwaves, floods, droughts and wildfires increase mortality, worsen noncommunicable diseases, and accelerate the spread of infectious illnesses. Climate change therefore acts as a "health threat multiplier" - and one with distinctly gendered consequences.

Entrenched social and economic inequalities concentrate women in agriculture, care work, and domestic environments, where exposure to environmental stress accumulates, elevating reproductive and maternal health risks. During recent heatwaves, mortality rates were higher among women, a disparity linked less to biology than to inequalities in housing, income and social isolation. In drought-affected regions, climate stress falls hardest on those responsible for harvesting, food preparation, and local distribution - labour overwhelmingly performed by women alongside limited land rights and decision-making power.

The consequences extend beyond differential exposure and risk. Studies show a 28% increase in femicide during heatwaves, while projections link climate change to one in every ten cases of intimate partner violence by century's end. These climate-driven pressures unfold alongside growing economic insecurity: 48 million more women experience hunger than men today, while up to 158 million women could be pushed into poverty as the climate crisis deepens.

Despite these disparities, sex- and gender-disaggregated health data remains underrepresented in climate research and policy planning. Unmeasured health risks cannot be addressed, nor can protections be designed for populations rendered statistically invisible. Strengthening gender-responsive health systems and closing data gaps on women's environmental exposures will enable EU and member states to account for inequalities long obscured by aggregated data.

Centring women's health within climate action means addressing not only the environmental risks but the inequalities that determine who bears its burden. For the European Union, recognising climate change as a women's health issue is not rhetoric, but a necessity for equitable and effective policy.

Imane Bouali
Events and Communication Assistant
at the European Policy Centre

The term 'Mediterranean syndrome' provides a compelling entry point into the discussion of divergence in diversity within women's health. It refers to a historically racialised clinical stereotype used in certain European healthcare contexts, particularly in emergency medicine, to describe patients perceived to be generally of North African origin as exaggerating or inventing their pain. Used as a shortcut in clinical reasoning, this stereotype serves to discredit patients' reports of suffering, justify reduced use of pain relief and normalise delayed or inadequate care.

It illustrates how medicine, when based on limited sampling and unverified preconceptions, can transform difference into deficit. Based primarily on data from Western, male and often mono-ethnic populations, medical knowledge establishes a partial and exclusive norm against which other bodies are compared. When racialised biases combine with gendered expectations that women are 'emotional' or 'dramatic,' the result is greater rejection. The body becomes legible not through biology, but through prejudice.

Maternal health outcomes illustrate this dynamic with devastating clarity. In many high-income countries, women of colour experience significantly higher rates of pregnancy-related mortality and preventable complications than their white counterparts. These disparities persist even after accounting for income and education levels, highlighting unequal treatment and structural discrimination within health systems.

To remedy these inequalities, it is not enough to provide training in cultural sensitivity. It is imperative to change how medical knowledge is produced. Studies must deliberately include diverse ethnic backgrounds and body types to identify meaningful differences in risk and treatment response. Without this, guidelines will continue to reflect a 'standard body,' while others will be evaluated against it and deemed inadequate.

Women's health will only improve when diversity is recognised and treated with fundamental scientific rigour rather than being discarded as inconvenient noise, and when discrimination is actively denounced, challenged and dismantled.

Georgia Mourad Brooks
Founder & CEO, The Nine and Senior Advisor
at the European Policy Centre

"And since we all came from a woman
Got our name from a woman and our game from a woman
I wonder why we take from our women
Why we rape our women, do we hate our women?
I think it's time to kill for our women
Time to heal our women, be real to our women
And if we don't we'll have a race of babies
That will hate the ladies that make the babies
… And since a man can't make one
He has no right to tell a woman when and where to create one"

– Tupac Shakur

Women's health and women's health *rights* sit at the core of public health and social stability. Yet the data reveals a persistent disparity: women live longer than men but spend more years in ill health. Cardiovascular disease - the leading cause of death among women - remains underdiagnosed because clinical models were built around male symptoms. Chronic pain, autoimmune disorders and mental health conditions disproportionately affect women, but have been historically under-researched or dismissed.

Endometriosis illustrates the problem starkly: in the EU, more people live with endometriosis than have a Netflix subscription. However, whereas setting up a Netflix account takes minutes, receiving an endometriosis diagnosis takes, on average, eight years.

Modern healthcare was largely designed around male bodies as the norm. Women's physiology was treated as variable, inconvenient and secondary. When symptoms do not align with male-centric diagnostic frameworks, the model is rarely challenged; the woman is.

The real issue, then, is not only research gaps but *belief*. Credibility in medicine has long been gendered, and women are still too often perceived as exaggerating, emotional or hysterical. A sustainable and healthy Europe requires confronting this bias and finally listening to and believing women.

Javier Carbonell

Policy Analyst, European Politics and Institutions Programme, at the European Policy Centre

Despite decades of progress toward gender equality, parts of today's cohort of young men appear increasingly drawn to far-right narratives that foster sexist attitudes and behaviours that directly and indirectly harm women.

The impact on women's health is not limited to explicit misogyny or violence. It also operates in subtler ways by deepening gender divisions among young people - already one of the most socially isolated generations. Youth mental-health services frequently report difficulties engaging young men in therapeutic spaces, while girls are more likely to seek support early. When boys and young men disengage from conversations about emotions, relationships and consent, the burden of relational and mental health work falls disproportionately on girls. A meaningful response to gender inequality must, therefore, actively involve boys and men from early adolescence.

Mental-health support should be strengthened in schools and universities. This includes integrating emotional literacy into curricula, expanding digital literacy programmes and considering social media bans for children under 16.

Moreover, increasing the number of male care workers, psychiatrists, and psychologists may help engage more young men in mental health services. While nursery and social work are more feminised and thus comparatively lower paid, the gender balance among medical professionals is also shifting rapidly: 76% of medical students in Spain are women, for example, and in some EU countries, men make up less than 30% of all doctors, a share that falls further in specialties such as psychiatry. In mental health, a health worker's gender can influence patients' willingness to engage with services. Just as we need more women in STEM, we should also encourage more men into HEAL (Health, Education, Arts and Literacy) because it can foster healthier models of masculinity, include adolescent boys in mental-health support earlier, and ultimately benefit health outcomes for all in the long term.

Sarah Collen

Senior Policy Manager at the European Association of Urology (EAU)

Women's health matters, because health connects us in a divided world.

In the last year, our newsfeeds have filled with awful scenes: conflicts, hatred, injustice, violence and the climate crisis. It feels like we're more divided than ever. Amid the perma-crisis, one may wonder: does women's right to health really matter?

The answer lies in the kind of world we imagine for ourselves, and those around us. What kind of Europe do we want to maintain and build, beyond the doom?

When I asked a friend what she thought I should write for this compendium, she encouraged me simply to consider what my health means to me and my family. As I realised, my health is central to my connection with others, my family and our economic stability. Good health connects and benefits us all, empowering us to live, learn, play and work. Equally, poor health isolates us, or conversely, if addressed well, can encourage scientific and cooperative creativity, care and collective efforts.

Working for urologists, I see this effect in the field of incontinence. This condition affects women in complex ways, particularly throughout and after pregnancy, and in menopause. Beyond physical implications, incontinence disrupts economic activity and patients' social life. When we commissioned a report on the costs of urinary incontinence, these were estimated at four times higher for women than men.

This isn't surprising, considering women not only share a higher physical burden, but also bear most caregiving responsibilities. Our lives are shaped not only by our own health, but by that of those around us, who require our care. An adequate response to urinary health requires collective thinking, involving patients' experience.

So, this year, reflecting on the European Charter of Fundamental Rights, and the EU's Roadmap for Women's Rights, I view health as a central element of women's connection with the world. In today's climate, as loud voices sow fear and division, fostering this connection seems even more relevant, and a value we should hold dearly.

Vanna Curin
Programme Assistant, Transnationalisation Programme,
at the European Policy Centre

There is a form of labour that leaves no visible trace, yet quietly organises the world. The mental load shapes women's health in ways our metrics still fail to capture. To carry it is to live in permanent anticipation: to remember the birthday and the deadline, to sense tension in a room and dissolve it before it erupts, and to constantly multitask.

Science shows that sustained hyper-awareness elevates cortisol, disrupts sleep, divides attention and increases vulnerability to anxiety, depression and cardiovascular disease. Yet society normalises this state, reframing the mental load as competence, reliability, and love.

These health consequences follow structural patterns. From early socialisation, girls are trained to monitor atmospheres, anticipate discomfort, and assume responsibility for relational stability. In adulthood, these expectations follow them into both the home and workplace. Employers rely on them for coordination, emotional regulation and "office housework" - essential yet seldom rewarded tasks. At home, even in formally egalitarian partnerships, women remain the default managers of everyday life.

Intersecting inequalities intensify this burden. Single mothers, trans women and women of colour, for example, often shoulder additional vigilance as they navigate bias, safety concerns and institutional gatekeeping. Class shapes cognitive labour as well: some women partially outsource care, though often to other women, while others absorb it entirely.

Across contexts the pattern is clear - institutions lean on women's attention to compensate for systemic gaps. If women's health matters, our policy imagination must widen.

Policy must curb mental load to protect attention as much as time. Employers should recognise coordination and relational labour as real contributions. Similarly, health data collection must account for stress exposure linked to unpaid responsibility. Until we treat cognitive labour as a shared societal responsibility rather than a gendered reflex, the mental load will remain a quiet extraction from minds rarely permitted to rest.

Samuel Goodger
Policy Analyst, Health and Societal Resilience Programme,
at the European Policy Centre

In 2026, the continually growing popularity of AI chatbots meant to assist humans with tasks spanning from drafting emails to providing medical advice, poses critical challenges for the road to gender equality. While language models' accuracy is rapidly improving, so is their ability to spew and spread convincing false narratives, gaining users' unbridled trust.

Rather than addressing these concerns, the world's most powerful tech CEOs, nearly all men, are aligning themselves with Trump and his campaign to dismantle any AI trust and safety guardrails altogether, disavowing "woke AI" governance campaigns. This risks undoing efforts to mainstream fair AI principles, which include reducing the impact of algorithmic bias, or the algorithms' tendency to reflect their source data, and the lenses they project, and tackling AI-facilitated gender bias, as in the recent X/Grok nudification scandal.

Perhaps most importantly, while progress has been made, today's medical literature remains steeped in centuries of scientific sexism and racism. Lack of information on many diseases' specific effects on women, and historic male-default assumptions, mean that women experience adverse effects from medication at nearly twice the rate of men. Just as a human doctor may fail to correctly diagnose women and people of colour, AI now risks scaling these gaps further.

At the same time, when responsibly developed and employed, AI can offer paths forward to identify and close gender gaps in healthcare.

Several initiatives are taking place at different governance levels to do just that. Recently, the Council has called for advancing gender equality in the AI age. At the same time, under the European Health Data Space and Life Sciences Strategy, research is set to benefit from harmonised access to large, high-quality datasets and intensify cross-border clinical trials.

These commitments now must be honoured through action. Beyond enforcing laws on gender-based violence online, as offline, policymakers should hold systems shaping how millions of women access health information accountable, promote AI literacy campaigns, insist on adequate gender equality safeguards and ultimately work on translating medical progress into the new information sphere.

Christine Heeger
Managing Partner at Phoenix

Various studies - including a recent analysis published in the Stanford Social Innovation Review - demonstrate that economies perform better when gender equality is stronger.

As executive search professionals, we are aware that companies across Europe have invested significantly in diversity initiatives over the last decade. However, we also observe that progress in gender equality has slowed in recent years. In November 2025, the Allbright Foundation reported that since 2014, the number of women in top executive positions in Germany has hardly changed.

It seems that implementing gender quotas alone is not sufficient. Senior female talent tends to leave at specific points in their careers, and relatively few women advance from mid-management to executive roles. To address this structural gap, policies must also take into account women's biology and health across different life stages: fertility journeys, pregnancy and the postpartum period, as well as perimenopause and menopause.

In our search mandates, we frequently observe that pregnancy and early motherhood coincide with the very years in which career progression typically accelerates. High-performing women may hesitate to take on more demanding roles or may step back from senior leadership positions due to health-related challenges or family circumstances.

This indicates that considering gender quotas during the hiring process is not sufficient and that retention measures must also be implemented. To improve retention, organisations can adopt health-aware policies, such as integrating women's health into their DEI strategies or introducing more flexible leadership models that take common women's health conditions into account.

Organisations that systematically address women's health may be seen as promoting a socially responsible image - an increasingly relevant factor, as companies with strong ESG practices are often perceived as more sustainable and better long-term investments. Above all, however, they protect their female leadership capital, enhance the long-term financial performance of their organisations, and at the end of the day support the broader economy.

Viktoria Henkemeier
Junior Policy Analyst, Health and Societal Resilience Programme, at the European Policy Centre

Access to reproductive healthcare diverges sharply across the EU, with more than 20 million individuals affected by abortion restrictions. *My Voice, My Choice* was the first European Citizens' Initiative on abortion care access at the EU level. It aims to introduce an EU-wide financial instrument facilitating equal access to safe abortion, recognising that limited access to reproductive health has not just severe physical, but also mental, economic and political consequences.

As a European Citizens' Initiative, it is a key instrument of participatory democracy. Its success is therefore no surprise: controlling reproduction is a matter of democratic self-determination. It is not just a health issue but a mechanism of power, determining economic independence, life conditions, and equal participation in democratic society. When people are forced to continue unwanted or dangerous pregnancies, their bodily autonomy is constrained, impacting their civic and political agency. In weakened democracies, reproductive rights are consistently among the first to be restricted - because controlling bodies means controlling people. Women's health is therefore an indicator of democratic stability and the rule of law.

This link between reproductive rights and crumbling democratic systems can be exemplarily observed in the US. What started with the Supreme Court overturning the constitutional right to abortion anchored in *Roe v. Wade* is now escalating further under Trump's Project 2025, systematically dismantling reproductive rights through abortion restrictions, funding cuts to global health, and broader attacks on human rights. These developments mark the result of a long-standing political strategy and a warning for the EU.

In March - International Women's Day month - the Commission must respond to what over one million citizens have demanded through democratic process. This is Europe's moment to demonstrate that fundamental rights are not subject to political will or ideological mood - and that we will not follow our transatlantic former allies down that path.

Leah Hoctor
Vice President for Europe at the Center for Reproductive Rights

Across Europe, the promise of sexual and reproductive health and rights remains unfulfilled for millions of women. Although there is significant progress to celebrate, these rights remain widely curtailed and restricted across the region. Too many people are denied the ability to live free and equal in dignity and rights due to harmful laws, policies and practices that constrain and violate their sexual and reproductive rights.

Contraception remains expensive and unsubsidised in much of Europe. Access to assisted reproduction for single women and lesbian couples is still inaccessible in several countries. Gender-based violence and violations of women's human rights in childbirth, remain a reality for far too many. Despite decades of ongoing legal reform on abortion, tens of thousands of women in Europe each year still have to travel across borders for abortion care or resort to illegal pathways, enduring the fear and anguish created by criminalisation. Meanwhile, intersectional discrimination and structural inequality compound the violations faced by certain groups of women.

Europe stands at a crossroads. It can address these types of protection gaps and dismantle discriminatory and coercive laws and practices. It can build on decades of progress and repeal measures that contravene international human rights standards and public health guidance. And it can embrace a vision of democratic legitimacy and human security that centres respect for sexual and reproductive rights.

Or it can stall, prevaricate and evade accountability.

This moment calls for courage and action. It demands collaboration and creativity. Decision makers, institutions, civil society and experts must work together to ensure that Europe's progress on SRHR and gender equality is not only preserved, but strengthened.

Shada Islam
Founder of New Horizons Project and Senior Advisor at the European Policy Centre

At a recent meeting in Brussels, I listened as women in and around the EU ecosystem bubble spoke openly about burnout, caused by long hours, emotional exhaustion and the relentless pressure to perform. It was an important conversation. And yet I left feeling uneasy.

That discussion ignored two central realities, which must be part of any serious feminist conversation on women's mental health. First, the impact of the daily experience of racism, which shapes the lives and bodies of Black and brown European women. Second, the deep yet largely ignored trauma, carried by women living through wars and violent conflicts across the Global South.

Studies – and lived experiences – teach us about the many ways in which European women of colour, especially Muslim women, are impacted by the structural racism embedded in European healthcare systems. The racism they encounter causes trauma - anger, frustration, hopelessness and depression. Discrimination leads to shortened consultations, delayed diagnoses and the racist assumption that some women are more "robust" and more tolerant of pain, requiring less urgency.

This same racist hierarchy of women's suffering is visible in how many governments and agencies deal with war-inflicted trauma in the Global South. Whether in Gaza, Sudan, or refugee camps across the Sahel, women's psychological suffering is too often treated as secondary, and an unfortunate but acceptable consequence of war.

And yet we know that in war, women and girls endure displacement, bombardment, sexual violence and economic loss. In camps and detention centres, they face more layers of distress, driven by racism, language barriers, legal precarity and social isolation.

So yes, let us talk about women's mental health, as such a discussion is long overdue. But let's not be blinded by our Eurocentric gaze. A feminist agenda worthy of the name must confront racism within health systems at home, and demand sustained support for women living through conflict abroad.

Madalina Iamandei
Executive Director at
All.Can International

Eduardo Pisani
Chief Executive Officer
at All.Can International

All too often, women's health is treated as a niche issue. In cancer care, this oversight carries systemic consequences. Across Europe and globally, women experience cancer not only through biology, but through gender roles, economic hardship and structural inequalities. They are more likely to act as carers, to face financial precarity following diagnosis, and to see their symptoms dismissed or misinterpreted. Health systems remain largely designed around institutional convenience, rather than lived experience.

All.Can International's global research reinforces this picture. In a survey of nearly 4,000 people affected by cancer, around 80 percent of respondents were women. Diagnosis experience was most frequently identified as inefficient, with respondents highlighting persistent gaps in information-sharing and clinical decision-making involvement. This points to a broader pattern, in which women shoulder responsibility for navigating complex systems, while not always being fully heard within them.

These insights reinforce a broader conclusion from All. Can's upcoming report, *Implementing person centred cancer care to improve outcomes, experiences and efficiency*: person-centred care is not a soft add-on, but a measurable driver of better outcomes and more efficient use of resources. This is particularly relevant for women, whose needs extend beyond biology to include fertility counselling, psychosocial support, survivorship planning and protection from financial stress.

When these dimensions are overlooked, inefficiencies follow. Delayed diagnoses, fragmented pathways and inadequate support contributes to avoidable inequities. Women with rarer, or less- understood cancers are too often insufficiently involved in care decisions, and may need to advocate for themselves, when they should focus singularly on treatment and recovery.

Recent European calls to action on gynaecological cancers similarly stress the urgency of timely diagnosis, equitable access to specialist care and political prioritisation of women's cancers. Investing in gender-responsive, person-centred cancer care is therefore not only a matter of equity. It is essential for the sustainability, and high performance of healthcare across Europe.

Ffion Storer Jones
Senior Policy and Advocacy Officer at the
Deutsche Stiftung Weltbevoelkerung (DSW)

Women's health is not a niche issue; it is a stress test for whether our societies truly value women. When women's bodies, needs and lives are treated as marginal, the result is a quiet divergence in diversity: we celebrate inclusion in rhetoric while tolerating exclusion in budgets, research, consultation rooms and beyond.

Women's health is systematically under-researched, under-funded and under-prioritised, especially for conditions that exclusively or predominantly affect women. EU investment in women's health R&D has risen on paper, but coherence, prioritisation and coordination remain limited. For conditions such as polycystic ovarian syndrome (PCOS), uterine fibroids and post-partum hemorrhage, funding is still vanishingly small or non-existent.

This persistent neglect of women's health raises concerns for many reasons. First, it is a question of justice: women are half the population, not a special interest group, and enduring pain or ill-health is not acceptable - particularly as women equally contribute to the public budgets that largely fund health research, as I argued in Eurohealth. Second, it is a question of quality in our science and systems: when trials, diagnostics and treatments are designed around a "default male", we generate biased evidence and unsafe care. Third, it is an economic and social imperative: untreated or poorly treated women's health conditions silently drain productivity, deepen poverty, strain social cohesion and entrench gender gaps across generations.

Divergence in diversity becomes visible when political speeches invoke gender equality, yet policymaking and budgets in particular fail to reflect women's realities. At the EU level, systematic integration of sex and gender considerations in biomedical research is urgently needed, alongside increased dedicated research funding - especially for issues that affect women exclusively. If we are serious about closing the gender health gap, this shift is non-negotiable.

Elizabeth Kuiper
Associate Director and Head of the Health and Societal Resilience Programme at the European Policy Centre

For too long, women's health has been ignored.

My own journey with women's health started around 2012, when I was negotiating the EU's Clinical Trials Regulation. I always assumed healthcare policy was based on gender-specific methods. I did not know that women are often excluded from clinical trials. I did not realise that although women tend to live longer, they frequently do so in poorer health, partly because historical bias in medical research has left gaps in women's healthcare. Nor was I aware that women have a higher risk of certain heart and brain conditions.

From my own experience with IVF treatments to witnessing female family members or friends suffer from the lack of specific approaches, I have seen that women's health often gets ignored. Stereotypes persist that dismiss women's struggles as exaggeration - simply because they are women. This is unacceptable.

It is unacceptable, not least because of the economic case for women's health. The World Economic Forum and the McKinsey Health Institute have underscored how closing the gender gap could add $400 billion to global GDP by 2040.

Alongside many others dedicated to improving women's health, I find it concerning that these issues remain so deeply rooted and widespread. After all, women's health in Europe is not lacking ideas - but it is lacking coherence, scale and political prioritisation.

What is needed is a dedicated EU Women's Health Strategy. This could provide the political anchor that's currently missing, aligning funding, research, healthcare delivery and data, because without comparable, interoperable data across member states, we are essentially policymaking in the dark. The tools are largely there; the challenge now is to connect them into a coherent and ambitious EU-level response.

Ultimately, improving women's health is not only a health issue - it is a question of democracy, equality, economic resilience and social justice.

Naina Madan
Founder & CEO at the NuSiaM Madn Tea and Co-host of the Podcast Off Script

Women's health is not nurtured in isolation. It is shaped by economics, caregiving responsibilities, access to care and cultural expectations.

During a period of separation and single motherhood, I entered perimenopause while managing financial pressure and professional responsibility. What followed was stress, brain fog, insomnia and a level of mental exhaustion that sleep could not repair. My body was asking to slow down, but life circumstances would not allow it.

What struck me most was how little information was available to help me manage this. Healthcare feedback was fragmented and, at times, dismissive. Hormones were treated separately from real life challenges. Mental health was discussed separately from economic strain. Yet in lived reality, they collided.

Women also carry a disproportionate financial burden for their own health - annual screenings, hormonal consultations, reproductive care and menopause support. Preventative care often comes at personal cost. For many women, seeking specialised support or simply slowing down is not financially neutral.

This is where divergence matters. A woman navigating divorce, entrepreneurship and perimenopause will experience health differently from someone with structural security, paid leave or shared economic responsibility. One roadmap cannot reflect these realities. Women's health policy must move beyond reactive treatment toward anticipatory support. It must reduce financial barriers, increase transparency around hormonal transitions and create educational spaces -including for men - to better understand women's health across life stages.

Women's health is not a niche concern. It is societal infrastructure.

Peggy Maguire
Director General at the European Institute of Women's Health (Ireland) (EIWH)

Women's health is not a "soft" issue. It is a political battleground - and a litmus test for whether equality is real or rhetorical.

For too long, women's bodies have been treated as secondary evidence in medicine and secondary priorities in policymaking. The consequences are clear: delayed diagnoses, dismissed pain and systems designed around a male default. From endometriosis to heart disease, from menopause to mental health, women are too often told to wait, cope or endure. This is not a medical accident. It is a policy choice.

Yet women's health is not one uniform experience - it is shaped by inequality. A woman in a capital city does not face the same barriers as a migrant woman navigating complex systems, a rural woman travelling long distances for care, or a woman with a disability encountering inaccessible services. Across Europe, access to essential and reproductive healthcare is increasingly determined by postcode and politics. Rights expand in one country while being rolled back in another. Such divergence is not diversity - it is injustice.

Women continue to carry societies through crisis - caring, working, birthing, ageing and sustaining communities - often without adequate healthcare support. When women's health is underfunded and under-researched, the costs are absorbed silently in lost productivity, chronic illness and preventable suffering.

Women's health must be treated as infrastructure - central to economic policy, research funding, labour rights and public health planning. Building on *Towards an EU Strategy for Women's Health*, supported by over 50 organisations, we must work together to turn evidence into action. Because when women's health is negotiable, so is equality.

Anastasiya Markvarde
Women's health innovation expert and Advisor at the Women's Health Hub Finland

My journey as a women's health advocate started with both personal and professional realisations. I recognised that every time I visit a doctor, there is a significant chance the treatments and therapies prescribed to me have not been tested on women or developed with women's physiology in mind. Furthermore, there is little awareness about the scarcity of care for half of the population, even among industry professionals - and therefore, not enough is being done to close the gap.

In my work to design women's health strategies and policies, and help organisations implement them, I am starting to see positive shifts. Country leaders are increasingly recognising that providing women with the care they deserve will result in reduced preventable deaths, improved quality of life and substantial economic gains (at least a 3:1 ROI). A few frontier countries are moving ahead with progressive models of women's health support, implementing national strategies and initiating policy change, setting up women's health research centres, expanding access to care and reimbursement, and investing in training and education. I am proud to be supporting strategy development for the Women's Health Hub Finland, which is on its way to becoming a national centre of women's health competence and innovation.

First movers in women's health will gain the biggest advantages and set examples and best practices for other countries. In my opinion, while investment in research is fundamental, innovation support should not be overlooked. It will take time for new research to emerge and be implemented into care. Meanwhile, evidence-based innovative solutions can offer support to women today. I'm convinced countries should foster spinouts and promote startup growth, as innovative companies can help patch the existing gaps in women's care and drive better health outcomes and sustainable economic returns.

Mariana Mesel-Lemoine
Vice President for Diversity, Equity and Inclusion
at the Institut Pasteur

In 2026, addressing women's health is not just a medical imperative – it is a matter of justice. My commitment to equity was forged early, shaped by my parents' resistance during Brazil's military dictatorship. From them, I learned that justice, equality and dignity must be enacted, not merely affirmed.

I chose the Institut Pasteur because its history, grounded in public health and scientific responsibility, resonates deeply with my own convictions. Here, science is accountable to society. That alignment matters to me.

Women's health reveals a foundational asymmetry in biomedical history: the male body has long been treated as the default, and the female, a deviation. Research protocols, diagnostic frameworks and therapeutic standards were built on male physiology and later generalised. What was presented as universal was, in reality, partial.

The effects persist and are damaging. Cardiovascular symptoms in women are under-recognised. Endometriosis, which affects approximately one in ten women of reproductive age, often still takes years to diagnose. Work addressing hormone-related conditions remains comparatively underfunded. These are blind spots, embedded in knowledge production.

The problem runs even deeper. Women's health is inseparable from the conditions under which women conduct science. When women leave research because of structural barriers or maternity-linked career penalties, we lose more than representation. We lose out on expertise, lived experience and research questions that may reshape our health and care priorities. Attrition narrows the scientific agenda.

There is no singular women's experience. Outcomes diverge across race, disability, socioeconomic status, migration history, and age. Addressing women's health requires intersectional data, funding and an institutional culture that recognise life-course realities.

Women's health matters, because science matters. And science, at its best, is a common good. Making science more inclusive strengthens its capacity to serve society as a whole, more accurately and more justly. Together, we can transform this agenda.

Tilly Metz
Member of Parliament, Group of the Greens/European Free Alliance,
European Parliament

Across the European Union, women live longer than men – yet, they spend longer living in ill health. This is a political issue. For decades, women have been underrepresented in clinical trials, and medical research has been built around male norms. The result is misdiagnosis, ineffective treatments, unsafe medical devices and health systems that systematically fail half the population.

These structural inequities weaken our societies and our economies. Women form the backbone of Europe's workforce, care systems and communities. When chronic conditions go untreated, when reproductive and mental health are sidelined, when older women in long-term care lack dignity and adequate support, we all pay the price. This means lost productivity, rising care costs and social instability.

Women's health must be viewed with an intersectional lens. A credible, European approach must address the specific barriers faced by women with disabilities, racialised and migrant women, and LGBTIQ+ people. Mental health, too often treated as secondary, must be recognised as a fundamental concern.

Europe needs action. We need a comprehensive approach to women's health - with dedicated funding, strong research mandates and compulsory sex- and gender-disaggregated data. Pursuing evidence-based policy would be impossible without this.

At a time when defence dominates the agenda, we must say clearly: health is security. A resilient, competitive Europe cannot be built on fragmented systems that fail women. Strengthening the EU's role in health is necessary, to overcome inequality and inefficiency.

If the Union is to deliver for all its citizens, women's health must be elevated to political priority. Because it matters for all us, and not only for half of the population.

Brooke Moore
Policy Analyst, Sustainable Prosperity for Europe Programme, at the European Policy Centre

Environmental degradation and the climate crisis are, in measurable ways, women's health issues. For example, women face disproportionate risks from air pollution and heat stress, particularly women of colour and those in lower-income groups. Each 1°C rise in average temperature increases the risk of premature birth by about 5% - up to 15% during heatwaves - leaving those affected 40% more likely to develop postpartum depression. Even these figures likely only scratch the surface, given the chronic underfunding and limited research into women's health.

Despite bearing this brunt, women have also been at the forefront of movements for change. Rachel Carson's 1962 *Silent Spring* was a pioneering exposé of the dangers of pesticides, though critics dismissed her as hysterical and uninformed - a reminder that sexism has long undermined scientific fields. In 1977, Wangari Maathai founded the Green Belt Movement, using nature conservation and gender-based advocacy as engines of community health and resilience. Women were also central to the Warren County protests against toxic waste dumping, which would become a catalyst for a national movement against environmental racism.

The pattern persists today. Indigenous women, such as the Yuturi Warmi in the Ecuadorian Amazon, defend rivers their communities rely on from extractive industries, while Greta Thunberg, who gained prominence for climate activism, has also been engaged against the assault on Gaza.

This handful of examples highlights not only women's central role in movements for change, but also how struggles over issues such as health, justice, land and climate are deeply intertwined. At a moment when the extreme right seeks to fracture Europe's liberal democracies, advances in women's health - and in the many movements intertwined with it - cannot rely on gender-responsive policies alone. They will depend on cross-community mobilisation around shared goals and a vision for system-change. What comes next will depend on whether that shared ground can be turned into shared action.

Dr Audrey-Flore Ngomsik
CEO, Trianon Scientific Communication; Vice Chair at the Brussels Climate Committee and Governing Board Member at the European Policy Centre

In chemistry, activation energy is the minimum energy a reaction needs for anything to happen. Two substances that should react can sit in the same flask indefinitely. Without the right conditions, temperature, pressure and mix of elements, nothing will happen.

Medicine decided the right mix was male, white, 70 kilograms and hormonally stable. Not a reference type. THE reference. Women were excluded from clinical trials because hormones made the data messy. Half the planet was excluded from medical research because half the planet has a menstrual cycle. The solution to messy data was to pretend it did not exist. They called that science. Someone got tenure for it. And it gets worse. Thalidomide - a sedative prescribed for morning sickness and never tested on pregnant women - caused malformations in thousands of newborns and killed 40% of affected infants. The industry's defense was that nobody tested drugs on pregnant animals back then, which is false. Another sedative from the same decade went through 15 months of studies, including on pregnant females. The science existed. They chose not to use it.

That was 1961. In 2020, 5% of global R&D went to women's health. One quarter of that addressed fertility. The rest covered everything else. Sixty years. Same choice. A 2024 European study found emergency clinicians rated female chest pain patients 13% less urgent than male patients. Black patients, 11% less urgent. A 2025 review confirmed this is not individual bias. It is systemic. Being a Black woman is an exponential risk.

Climate change just turns up the heat. Pesticide safety limits are calculated per kilogram of body weight, using THE reference patient. They ignore hormonal vulnerability during pregnancy and menopause. They ignore cocktail exposure to multiple chemicals at once. As climate-driven contamination grows, the women most exposed are the same women least studied, least treated and least protected by the standards that were never designed for them. Exposure increases. The standard stays the same. Safe for whom?

Women are not a subgroup. We are half the population. When the system fails us, it fails at scale. We have all the elements in the flask (data, science, proof). Women's health is the activation energy that the whole reaction has been waiting for.

Xavier Prats Monné
Associate at Dones Mentores and Former Director-general for Health at the European Commission

Women's health is not a specialist subchapter of medicine; it is where the health of our economies, democracies and societies is decided. When women's health is neglected, the losses expand far beyond individual consultations or hospital budgets. The bill comes twice: women pay in lost health, income and autonomy, and societies pay in stalled productivity, shrinking tax bases and fraying social cohesion. Closing the women's health gap could add at least 1 trillion dollars a year to the global economy by 2040, the equivalent of 140 million women moving into full-time work. Adverse drug events alone, many linked to trials designed around male bodies, kill 130.000 women each year and cost €52 billion.

In most areas of health, we can't do more because we don't yet know enough. In one area, women's health, we fail to do more not for lack of evidence, but for lack of political and professional will. Data gaps, androcentric research and stubborn stereotypes still cast the female body as a deviation from the male norm, with predictable, harmful results. Yet we know what would make a difference: mandating sex and gender disaggregated data in all trials, adopting dedicated European and national women's health strategies, overhauling medical education to remove bias, and introducing workplace policies that take menstruation, maternity and menopause seriously. When the remedies are so clear and feasible, choosing not to act is not a technical oversight; it is a deliberate political choice.

Every time a woman's symptoms are dismissed, her condition under-researched or her treatment misdesigned, the cost is not only to her health, but to the balance sheet of our shared future. Persisting in this model is not only unethical and unjust; it is an irrational economic choice - and an easy one to correct, if we only care to.

Samira Rafaela
Former Member of European Parliament and Visiting Fellow at Cornell University

Women's health is a significant and pressing issue, demanding our attention and action. As a former member of the European Parliament, I have seen firsthand the necessity for legislators to develop inclusive policies that genuinely promote women's health. Recognising this need, I launched the initiative "Let's Talk About Our Bodies," creating a manifesto in collaboration with European stakeholders.

This manifesto advocates for a more inclusive workforce, comprehensive research and a dedicated strategy on women's health in Europe. Currently, women's health remains underfunded and under-researched, creating numerous societal blind spots. These challenges persist everywhere - from general practitioners' to gynaecologists' offices, and from the workplace to education – as women's health concerns remain insufficiently addressed.

Effective solutions begin with leadership and diversity. Increasing leadership diversity, with more women as role models, will foster a deeper appreciation for women's health. The European Union, with its 27 member states, is uniquely positioned to address this issue, leveraging its resources and collective decision-making power. Women's health matters because women constitute half of the population and access to quality healthcare is a fundamental human right. Moreover, it directly impacts the economy. One ongoing challenge is the continued taboo surrounding the uterus, and hormone-related complaints – it is disheartening to witness women unable to participate fully in the workforce or advance in their organisations due to such conditions.

The stigma associated with these issues must be broken, fostering open dialogue so that women feel safe and empowered to discuss their concerns. So, Let's Talk About it!

Understanding women's life phases more thoroughly is essential, and this learning should shape policies, legislation and research agendas. This integration will not only better inform women and young girls, but prevent diseases and alleviate unnecessary burden. By prioritising these actions, we can strive toward a future where women's health is fully recognised and supported across all aspects of society.

Amira Salama
Communications Officer at the European Network Against Racism

Women make up nearly half of the world's population, yet our wellbeing is still treated as an afterthought. For generations, women's health has been misunderstood, under-researched and too often dismissed. When it comes to mental health, the neglect is even greater.

We still live in a society that recognises sickness only when it can be seen plainly. The flu warrants rest; a drained brain does not. Sick leave policies often revolve around physical illness, while anxiety, depression, chronic stress - often caused by working hours tailored to men's routines - or the psychological toll of invisible conditions or disabilities are quietly sidelined. Women are expected to carry on at work, at home, in their communities, regardless of the emotional cost they face.

And then there's burnout. It is frequently framed as something that affects a narrow, privileged slice of society - typically white, financially secure professionals. But for many women, especially those facing structural racism and discrimination, juggling low-paid work and financial hardship, and caregiving, exhaustion isn't a trend. It is structural, constant and defines their livelihood.

When we minimise women's mental health, we minimise women's lives. We normalise their suffering and call it "resilience". We label their distress as weakness, instead of asking how the systems fail them.

Prioritising women's mental wellbeing isn't indulgent or niche, it is mandatory. Because when half the population struggles in silence, that is a societal issue.

Prof. Dr. Bharati Shivalkar MD, PhD, FESC, Clin. Pharm/Pharm. Med
Women's Heart Health Advocate, Consultant Cardiologist at the Delta (CHIREC) Hospital and RIVA Medical, Board member at the Heart Health India Foundation and Past Pharma Executive

Ancient traditions such as Hinduism recognised feminine and masculine divine power as equally potent. Greek mythology represented male and female deities in positions of equal authority -demonstrating that gender equity is not a modern invention but a forgotten principle. True equality begins with health equity.

While contraception emancipated women in the 20th century, other sex-specific health issues were and continue to be overlooked. Women spend 25% more of their lives in poor health compared to men – amounting to human suffering and substantial economic burden. Healthcare consistently fails to address how the multiple societal roles of caregiving, workforce participation and household management impact women's physical and mental health across their lifespan.

The historical neglect of female physiology beyond "bikini medicine" has created critical knowledge gaps with serious public health implications. Cardiovascular disease exemplifies this failure: it is the leading cause of death for both sexes, with recent EU statistics showing that more women die from cardiovascular disease than men. Despite the equality in risk, public health campaigns and clinical research focus on male risk factors.

Today, evidence-based women's health policy is more urgent than ever. Health equity can correct historical imbalances that continue to undermine population health and economic productivity. Awareness precedes informed choice, and choice enables behavioural change. We need sustained commitment, adequate funding and cross-sectoral coordination to educate and empower women about their health needs throughout their life.

Healthy women contribute to healthy, productive societies and robust economies. The European Union's "Safe Hearts Plan" should seize the opportunity to prioritise sex-specific and predominantly cardiovascular risk factors. The recent policy framework developed by the European Institute of Women's Health, endorsed by over 50 organisations, provides an evidence-based roadmap for a comprehensive EU strategy on women's health. Implementing such strategies is not merely a matter of equity - it is sound public health policy and economic investment.

Paweł Świeboda
Senior Visiting Fellow at the European Policy Centre

In 2026, it is remarkable that a basic fact remains overlooked in brain health: women are not men. Physiological and hormonal differences shape women's brain health in distinct ways across their life stages. Sex-based differences are a fundamental biological variable.

There is ample evidence that brain health challenges are often more severe for women. They are more affected by migraines and account for nearly two-thirds of Alzheimer's disease cases. Diagnoses are often late because symptoms present differently than in men, with schizophrenia diagnosed, on average, three years later in women than in men. Treatments may be less effective as well.

Although women live longer than men on average, they spend more years in poor health, particularly between the ages of 20 and 60. Brain health conditions account for a significant share of that burden. The consequences are both medical and economic in nature, including through reduced workforce participation, increased caregiving responsibilities, and billions in lost productivity each year. Women are more likely to shoulder care work, including for relatives with dementia - efforts that should be reflected in social production accounts.

The problem is compounded by chronic underinvestment in women's health research. Women are also underrepresented in clinical trials while registries often fail to capture sex-specific data. If the persisting gap is not bridged, the consequences will accumulate across healthcare systems and labour markets.

The gap needs to be bridged holistically, from the recognition of gender-specific risk factors in early detection programmes, to the disaggregation of outcomes in data, and workplace policies addressing mental health across life stages, including menopause and caregiving pressures. Women-specific initiatives are needed as well, including targeted research networks and registries that enable women to contribute data and shape the research questions being asked.

Back to 2026: it is high time to make sure that women's brain health will no longer be under-researched, under-diagnosed and sub-optimally addressed.

Ilaria Todde
Advocacy & Research Director at the EL*C – Eurocentralasian Lesbian* Community

When we talk about diversity in women's health, we should start here: who is recognised without explanation, and who has to justify their body and life at the door?

Think of the first questions at a gynaecology visit. *Sexually active? Contraception? Any chance you might be pregnant? No?! How is that even possible?!* Routine questions. Shocked looks, follow-up interrogation and medically incorrect assumptions are what many lesbians meet when seeking care.

It happened to me at 18, during my first gynaecological appointment. After I came out, the doctor froze, unsure whether he could examine me "properly," and unable to offer medically sound advice. After 25 years of practice, he asked me – an 18-year-old girl – what he should say "in these cases," admitting I was the first patient to come out to him.

At the time, I could not name what was happening. Years of activism - and hearing dozens of similar stories - made it clear: our health system is built around heterosexuality, and honesty can carry consequences. Mine was small (awkward questions and no useful advice). For many, the cost is higher.

The FRA LGBTI survey (2024) shows that one in six lesbian women experienced inappropriate curiosity or comments in healthcare. As a result, many avoid disclosing their orientation or avoid care altogether. When they do disclose, they often receive unsound advice that discourages STI testing or cervical cancer screening. The research gap for lesbians is just as stark. EL*C examined over 230 health-related systematic reviews on sexual minority populations: only 8% focused on non-heterosexual women, while 51% focused exclusively on men.

Women's health will not become inclusive through perfunctory inclusion of LGBTQI+ individuals. It needs data that includes sexual orientation and gender identity, mandatory professional training and sustained funding for community-led, trust-building care - especially for those facing racism, migration barriers, transphobia or disability.

Divergence in diversity is not a slogan. It is a call to stop making lesbian health invisible.

Giulia Torchio
Former Policy Analyst, Europe's Political Economy Programme, at the European Policy Centre

While discussing the centrality of fostering women's wellbeing in today's society, we often overlook one of the most pervasive environments they inhabit: the digital sphere. Though the EU prides itself on having one of the world's most comprehensive digital rulebooks, a widening gap is emerging between its ambitions and the lived reality of thousands of women.

In today's world, health and wellbeing are no longer confined to clinical outcomes. They are inherently shaped by the quality of online spaces and information ecosystems. The ongoing platform decay, dubbed by some an "enshittification" process, has real-life consequences for women's health and wellbeing. The rise of AI-powered "nudification" apps also sheds light on the proliferation of unsafe tech features enabling a new frontier of gender-based violence through, for example, the manipulation of sexually explicit images.

Make no mistake, this is not a technical glitch. It is a byproduct of deliberate corporate choices and policy failures. Driven by greed, tech companies are forsaking platform utility in favour of extreme user engagement, often relying on extractive, unjust and safety-compromising features.

Sexual exploitation on social media is a rapidly evolving and deeply troubling issue, primarily affecting women and children. These abuses directly harm individuals' livelihoods. Victims face tangible consequences like chronic anxiety, social withdrawal and psychological trauma from digital violations.

The current pace of legislation, combined with the lack of political momentum for proper enforcement of files such as the Digital Services Act (DSA), is simply too slow to have a meaningful impact. While proceedings are a step forward, investigations and ex-post bans are merely reactive measures to a systemic problem. It is crucial that EU policymakers recognise that tackling tech-facilitated violence requires moving beyond the 'notice-and-action' approach to proactive algorithmic accountability. If the EU fails to enforce its own standards, the digital space will remain not a tool for empowerment, but a driver of ill-health.

Kata Tüttő
President at the European Committee of the Regions

As life expectancy rises across Europe, women spend over one third of their lives beyond their reproductive years. This fundamentally reshapes women's health needs. Yet health systems, research priorities, medical training and workplace policies overwhelmingly focus on women's reproductive capacity, as if biological sex differences were relevant only until menopause.

This assumption is scientifically flawed.

Menopause is not the end of an individual's biology, but a major endocrine transition, marked by profound hormonal, metabolic, neurological and musculoskeletal changes. It is preceded by perimenopause - a phase lasting seven to ten years and beginning as early as the late 30s. Menopause is not a rare condition nor a disease, and many women who live long enough will experience it. Yet, perimenopause and menopause remain critically under-researched and under-recognised despite their wide-ranging effects on health, work capacity and quality of life.

Most policy discussions focus on menopause as a single moment, while perimenopause, the long lead-up to that point, remains largely invisible. During perimenopause, fluctuating and declining levels of hormones affect multiple systems simultaneously, including the brain, cardiovascular system, bones, joints, skin, immune function and metabolic regulation. Symptoms are often episodic, non-linear and heterogeneous – from sleep disturbance, mood instability and brain fog to weight gain and muscle stiffness - making them difficult to recognise without specific training. Women therefore present with multiple complaints that are diagnosed and treated across separate care pathways, leading to delayed recognition, over-medication, unnecessary investigations and the trivialisation or psychologisation of symptoms. This gap will persist if medical education and research continue to overlook menopause and perimenopause. The costs of such a systemic failure are tangible: higher morbidity, increased healthcare use, reduced productivity and social participation and loss of functional independence.

What is not researched or measured remains politically invisible. Australia offers a relevant precedent, having explicitly treated menopause as a public health issue and acted accordingly. Europe must now follow suit and adopt such an approach.

Leo Varadkar

Former Taoiseach (Prime Minister) of Ireland; Distinguished Policy Fellow at the Keough Naughton Institute for Irish Studies, University of Notre Dame; Senior Fellow at the Carr-Ryan Centre for Human Rights Policy, Harvard Kennedy School; Board Member at the Institute of International and European Affairs (IIEA); Member of the Global Advisory Board at Global Citizen; Advisory Board Member at Care4everyBody; Honorary Fellow of the Royal College of Physicians of Ireland; Medical Doctor and qualified General Practitioner

Historically, medical research and clinical standards have been based primarily on male physiology, with women significantly underrepresented. This imbalance has contributed to persistent gaps in diagnosis and treatment and, ultimately, to inequalities in women's healthcare. Despite a longer life expectancy, women have a higher risk of illness and a lower quality of life.

"Men die quicker, women get sicker" (Gender Health Paradox).

The consequences of unequal healthcare for women extend beyond individual health, causing a direct economic impact. Poorer healthcare leads to absenteeism, reduced productivity, and earlier withdrawal from the workforce. This disrupts women's careers and contributes to lower pension entitlements while also driving economic losses for businesses and the wider economy.

Taken together, these patterns indicate that the inequalities in healthcare for women are structural. Women encounter risks and shortcomings in diagnosis and treatment that are largely preventable, arising from centuries of bias embedded in health research, clinical standards and healthcare systems themselves.

Care4everyBody, an NGO I am proud to represent, therefore advocates for the eradication of sex- based inequalities in medicine and healthcare. However, despite growing awareness, calling for improvement in the interest of women remains an uphill battle.

To overcome this resistance, Care4everyBody takes a different approach, emphasising the economic impact and potential of equal healthcare. By framing the underlying issue as an economic opportunity, rather than solely an act of social fairness and equality, we highlight the economic costs and growth potential linked to it. This becomes particularly clear at the organisational level: at Care4everyBody, we are now able to quantify the costs caused by absenteeism associated with specific female health conditions, demonstrating that neglecting women's health is not only a social but also a direct economic liability. Ultimately, this should incentivise businesses to actively support, and invest in, improving women's healthcare.

After all, the saying is *"it's the economy, stupid"* (James Carville, 1992).

Margrietha H. (Greet) Vink

Co-Founder of Netherlands Women's Health Research & Innovation Center at Erasmus MC, University Medical Center Rotterdam, and Board Member at the UN Women Netherlands

Women's health has been sidelined for far too long. For decades, the male body has been treated as the medical default, leaving women underdiagnosed, undertreated and under-researched. The result is a profound divergence, across scientific capability and political will, and between technological progress and lived reality. While women live longer than men, they spend longer in in poor health. Heart disease symptoms are missed. Chronic pain is dismissed. Conditions such as endometriosis take years to diagnose. This data gap is not an accident - it is a systemic failure.

Diversity among women further exposes these inequities. Ethnicity, income, age, migration background, and gender identity shape health risks and access to care. When research ignores these intersecting realities, inequality deepens. Women's health is not a niche topic. It affects half the population. It shapes economic productivity, family stability and societal resilience. The European Union holds the scientific excellence, technological capacity and moral responsibility needed to structurally transform women's health. Across Europe, several countries have established dedicated research clusters - and many more could follow, building on models such as the Netherlands Women's Health Research and Innovation Center at Erasmus MC. By establishing and connecting such centres, the EU can foster a powerful network that unites biomedical science, clinical expertise, artificial intelligence, entrepreneurship and policy. This is how knowledge becomes implementation, and innovation fosters impact.

Artificial Intelligence sits at a crossroads. If trained on biased datasets, it risks automating discrimination at scale. If built without gender awareness, it will reproduce the very blind spots we are trying to close. But if designed with intention - using representative data from centres across Europe, transparent algorithms, and sex- and gender-sensitive frameworks - AI can open doors for women's early diagnosis, personalised medicine and preventive care.

This is not about special treatment. It is about equal evidence, equal innovation and equal health. Closing the women's health gap is not optional - it's an urgent necessity.

Emma Woodford
Chief Operating Officer at the European Policy Centre

Can you imagine sitting in a doctor's appointment and being told that the pain, or other symptoms you have been experiencing are nothing? If this sounds familiar, then you are very likely to be a woman or intersex. I was even told that I could not be experiencing my monthly cycle because of the birth control I was using. Of course, I knew that I was, but the doctor did not believe me.

In 2017 I suffered a traumatic brain injury (TBI) in an accident which kept me from working for several months. Even after returning to work, the brain fog, headaches and decreased concentration resurfaced once a month. At that time, research on the differentiated effects of concussions on men and women, and the role that hormonal changes play in recovery, was in its infancy. My general practitioner was sympathetic but unable to know what to advise. Most TBI research then focused on military personnel and sports-related injuries, where observed differences between men and women were attributed to women having weaker necks. Since then, research has expanded, along with an understanding of sex and gender differences in TBI impact and recovery. Unfortunately, this progress is driven in part by the greater prevalence of women with concussions resulting from intimate partner violence.

I am fully aware that my healthcare experiences as a middle-class cis white woman, have been mainly positive even if sometimes deeply infuriating. If I was a black woman, or intersex, I know I would have faced even more problems. Racism and discrimination are significant barriers to equitable healthcare yet remain under-researched in Europe.

Recognising the differences in types of discrimination and structural barriers to health care in order to put measures in place to overcome them, combined with radical empathy for all in healthcare provision, should form the backbone of any new EU Strategy on Women's Health.

Elisabetta Zanon
Chief Executive Officer, European Cancer Organisation (ECO)

Across Europe, women's health remains marked by a persistent and unacceptable divergence between what we know is possible and what too many women continue to experience. Diversity should be a source of strength in our societies, yet when it comes to health, it too often translates into unequal access, delayed diagnosis and preventable suffering. Nowhere is this more evident than in cancer prevention and care.

Women face a unique and complex cancer burden. They are disproportionately affected by cancers linked to reproductive health, by gender-specific risk factors, and by social determinants that shape exposure, access and outcomes. At the same time, women continue to shoulder the majority of caregiving responsibilities, often placing their own health needs last. This double burden - being both patients and caregivers - creates a cycle of vulnerability that health systems have yet to fully address.

We know what works. Prevention strategies such as Human Papilloma Virus (HPV) vaccination, tobacco control, physical activity and equitable access to screening can dramatically reduce cancer incidence and mortality. Yet uptake remains uneven, and too many women - particularly those from disadvantaged communities - are left behind. Improving women's health is not simply a matter of expanding services; it requires redesigning systems to recognise gendered barriers, challenge stigma and ensure that every woman can benefit from timely, high-quality care.

Investing in women's health is not only a moral imperative; it is a strategic one. When women thrive, families, communities and economies thrive with them. Closing the gaps in cancer prevention and care is therefore a cornerstone of resilient and equitable health systems.

Stéphanie van de Werve
Co-founder of Thémis and Advisor at the Obama Foundation

Women's health was not central to the beginning of my career as a political scientist and researcher. I initially focused on the major radical problems of the world: Islamism and authoritarianism. I came to it gradually. First as an observer: colleagues for whom menstrual leave was not a luxury, friends with complicated fertility treatment journeys, mothers and aunts going through challenging menopause symptoms, and then my own experience as a woman with chronic iron deficit and a mother of three. How do other women manage these different stages of their lives, and how do they reconcile this with their careers? As I started digging and researching further, I met my co-founder Fatoumata Ly, who opened my eyes to what I believe is the last inequality affecting women left largely unaddressed. We created Thémis, a European foundation committed to closing the women's health gap.

Despite progress on gender equality, women's health remains underserved due to systemic gaps in research, data, investment and policy. There have been significant improvements in areas such as pay transparency, violence against women, and women's representation on boards. Nevertheless, disparities and inequalities related to sex and gender persist, particularly in areas such as health, where women face discrimination in access to diagnosis and treatment.

We need to unite science, policy, and philanthropy to make women's health a recognized infrastructure, as fundamental as climate or education. We also need to be ambitious to shape a 2035 vision where women's health is no longer invisible, but central to how societies and economies function.

I believe this is our shared responsibility: to redesign the systems that were not built for us, and to create the future we want for the next generation of women, and ultimately men and societies as a whole. The EU should position itself as a global leader in promoting women's health, delivering benefits not only for women but for society as a whole, both within Europe and beyond.

The **European Policy Centre** is an independent, not-for-profit think tank dedicated to fostering European integration through analysis and debate, supporting and challenging European decison-makers at all levels to make informed decisions based on sound evidence and analysis, and providing a platform for engaging partners, stakeholders and citizens in EU policymaking and in the debate about the future of Europe.

The **Health and Societal Resilience** Programme (HSR) focus is on society's ability to recover from crises and economic shocks. In recent years, the European Union has come under increasing pressure as a result of permanent and overlapping crises, and the societal and political repercussions these have generated. The economic and social disparities among EU member states, coupled with rising nationalism and populism, all point to a need to focus on areas where citizens experience a loss of trust in governments – such as in housing or healthcare.

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