European Parliament
2024-2029

TEXTS ADOPTED

P10_TA(2026)0305

Gender inequalities in health, specifically as regards gender-specific conditions

European Parliament resolution of 16 September 2026 on gender inequalities in health, specifically as regards gender-specific conditions (2025/2074(INI))

The European Parliament,

– having regard to Articles 2 and 3(3) of the Treaty on European Union,

– having regard to Articles 8, 9, 151, 153,157 and 168 of the Treaty on the Functioning of the European Union,

– having regard to the Charter of Fundamental Rights of the European Union, in particular Articles 21 and 35 thereof,

– having regard to the Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention),

– having regard to the UN Convention on the Rights of Persons with Disabilities, ratified by the EU in 2010,

– having regard to Regulation (EU) No 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC[1],

– having regard to Directive (EU) 2024/1385 of the European Parliament and of the Council of 14 May 2024 on combating violence against women and domestic violence[2],

– having regard to the Commission proposal of 16 July 2025 for a regulation of the European Parliament and of the Council on establishing the European Competitiveness Fund (‘ECF’), including the specific programme for defence research and innovation activities, repealing Regulations (EU) 2021/522, (EU) 2021/694, (EU) 2021/697, (EU) 2021/783 and amending Regulations (EU) 2021/696, (EU) 2023/588, (EU) [EDIP] (COM(2025)0555),

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1 OJ L 158, 27.5.2014, p. 1, ELI: http://data.europa.eu/eli/reg/2014/536/oj.
2 OJ L, 2024/1385, 24.5.2024, ELI: http://data.europa.eu/eli/dir/2024/1385/oj.

– having regard to its resolution of 17 December 2025 on the European citizens' initiative entitled 'My Voice, My Choice: For Safe and Accessible Abortion'[3],

– having regard to its resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health[4],

– having regard to its resolution of 12 February 2020 on an EU strategy to put an end to female genital mutilation around the world[5],

– having regard to its resolution of 29 April 2026 on the situation of fundamental rights in the European Union in 2024 and 2025[6],

– having regard to its question for written answer E-004697/2025 to the Commission regarding the recommendation on harmful practices,

– having regard to the Council Recommendation of 21 June 2024 on vaccine-preventable cancers[7],

– having regard to the Council Recommendation of 9 December 2022 on strengthening prevention through early detection: A new EU approach on cancer screening replacing Council Recommendation 2003/878/EC[8],

– having regard to the Council conclusions of 3 December 2024 on strengthening women's and girls' mental health by promoting gender equality,

– having regard to the Commission communication of 5 March 2026 entitled 'Gender Equality Strategy 2026-2030' (COM(2026)0113),

– having regard to its resolution of 13 November 2025 on the Gender Equality Strategy 2025[9],

– having regard to the Commission communication of 26 February 2026 on the European Citizens' Initiative (ECI) 'My Voice, My Choice: For Safe And Accessible Abortion' (C(2026)3225),

– having regard to the Commission communication of 16 December 2025 on an EU cardiovascular health plan: the Safe Hearts Plan (COM(2025)1024),

– having regard to the Commission communication of 7 March 2025 entitled 'A Roadmap for Women's Rights' (COM(2025)0097),

– having regard to the Commission communication of 3 February 2021 entitled 'Europe's Beating Cancer Plan' (COM(2021)0044),

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3 OJ C, C/2026/2155, 6.5.2026, ELI: http://data.europa.eu/eli/C/2026/2155/oj.
4 OJ C 81, 18.2.2022, p. 43.
5 OJ C 294, 23.7.2021, p. 8.
6 Texts adopted, P10_TA(2026)0146.
7 OJ C, C/2024/4259, 28.6.2024, ELI: http://data.europa.eu/eli/C/2024/4259/oj.
8 OJ C 473, 13.12.2022, p. 1.
9 Texts adopted, P10_TA(2025)0278.

– having regard to the Commission communication of 5 March 2020 entitled ‘A Union of Equality: Gender Equality Strategy 2020-2025’ (COM(2020)0152),

– having regard to the Commission publication of May 2024 entitled ‘Case studies on obstetric violence – Experience, analysis, and responses’[10],

– having regard to the express mandate entrusted to the College of Commissioners by the European Parliament to ‘lead the work on sexual and reproductive health issues’[11],

– having regard to the European Committee of the Regions Opinion of 15 October 2025 on strengthening women’s rights and gender equality in the EU: A local and regional perspective[12],

– having regard to the proposed guideline of the European Medicines Agency (EMA) issued for consultation on 4 June 2025 entitled ‘ICH E21 guideline on inclusion of pregnant and breastfeeding individuals in clinical trials – Scientific guideline’,

– having regard to the European Centre for Disease Prevention and Control (ECDC) surveillance and monitoring report entitled ‘Monitoring of the responses to sexually-transmitted infection epidemics in EU/EEA countries, 2024’, published in December 2025[13],

– having regard to the European Institute for Gender Equality’s (EIGE) Gender Equality Index 2025[14],

– having regard to the report of the Organisation for Economic Co-operation and Development (OECD) of January 2024 entitled ‘Beating Cancer Inequalities in the EU: Spotlight on Cancer Prevention and Early Detection’,

– having regard to the study published by its Directorate-General for Citizens’ Rights, Justice and Institutional Affairs in November 2025 ‘Gender Inequalities in Medical Research, Drug Development and Access to Care’ [15],

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10 European Commission: Directorate-General for Justice and Consumers, Fondazione Giacomo Brodolini (FGB) and Scientific Analysis and Advice on Gender Equality in the EU (SAAGE), ‘Case studies on obstetric violence – Experience, analysis, and responses’, Publications Office of the European Union, 2024.

11 European Commission, President von der Leyen’s mission letter to Hadja Lahbib, 2024.

12 OJ C, C/2025/6319, 3.12.2025, ELI: http://data.europa.eu/eli/C/2025/6319/oj.

13 European Centre for Disease Prevention and Control (ECDC), ‘Monitoring of the responses to sexually transmitted infection epidemics in EU/EEA countries, 2024’, Stockholm, 2025.

14 EIGE, Gender Equality Index 2025, Publications Office of the European Union, 2025.

15 Study requested by the European Parliament’s Committee on Women’s Rights and Gender Equality, ‘Gender Inequalities in Medical Research, Drug Development and Access to Care’, Policy Department for Citizens, Equality and Culture, Directorate-General for Citizens’ Rights, Justice and Institutional Affairs, European Parliament, 2025.

– having regard to the study published by its Directorate-General for Internal Policies in April 2024 ‘Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination’ [16],

– having regard to Rule 55 of its Rules of Procedure,

– having regard to the opinion of the Committee on Public Health,

– having regard to the report of the Committee on Women’s Rights and Gender Equality (A10-0200/2026),

A. whereas health is a fundamental right, and therefore everyone must have access to quality, affordable, timely and accessible healthcare services, irrespective of their socio-economic status, as enshrined in the European Pillar of Social Rights; whereas reducing inequalities presents an opportunity to address fragmentation and strengthen health outcomes across Member States, reinforcing the principles of equality and social cohesion enshrined in the Treaties through a stronger and more coordinated response at EU level;

B. whereas multiple and intersecting barriers to accessing healthcare services, as well as complex health needs, are encountered by refugee and ethnic minority women, women living in poverty, unhoused women, women in precarious employment or with unpaid care responsibilities, older women, women with disabilities, women residing in rural and socio-economically disadvantaged areas and individuals from LGBTIQ+ communities in particular; whereas an intersectional approach to women’s health is therefore essential;

C. whereas poverty and social exclusion have a significant impact on health outcomes and access to healthcare; whereas women face greater financial barriers than men in accessing health services; whereas these barriers are further exacerbated for vulnerable groups, who often face additional layers of discrimination and encounter multiple barriers to accessing inclusive, quality healthcare;

D. whereas unequal access to healthcare services across the EU, particularly in rural, remote and mountainous areas, islands and outermost regions, constitutes a significant barrier to timely diagnosis and treatment, including for pregnant women;

E. whereas access to safe, clean and affordable water and sanitation is a fundamental determinant of physical and mental health and a public good and plays a crucial role in disease prevention, chronic condition management and overall well-being across the course of a person’s life; whereas inequalities in access to water and sanitation mostly affect people living in poverty, inadequate housing and rural or remote areas and have a specific impact on women, children, older people and persons with disabilities;

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16 Study requested by the European Parliament’s Committee on Women’s Rights and Gender Equality, ‘Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination’, Policy Department for Citizens’ Rights and Constitutional Affairs, European Parliament, 2024.

F. whereas simplification and better coordination of cross-border healthcare would contribute to ensuring that women can access treatment across borders when needed, while reducing red tape for patients and providers;

G. whereas medical research has historically been male-centric, leading to insufficient understanding of women's health, physiology and sex-based differences; whereas this systemic inequality in medicine has an impact on the diagnosis, treatment, morbidity and mortality of under-represented sections of the population, including women and gender-diverse people;

H. whereas in 2020, only 5 % of global research and development funding was allocated to women's health research[17]; whereas research funding is often not proportional to the disease burden, and conditions that predominantly affect women, such as migraines or endometriosis[18], receive significantly less financial support and investment compared to conditions that primarily impact men; whereas addressing the persistent underinvestment in women's health requires stronger public action and targeted funding, which should drive developments that are in the interest of citizens; whereas adequate and sustained investment in health security, including gender-sensitive preparedness, prevention and response measures, is therefore necessary to ensure both societal resilience and equitable health outcomes;

I. whereas, although regulatory developments have improved inclusivity in clinical trials, the representation of women remains below that of men and the disparity is particularly acute for pregnant and breastfeeding women[19]; whereas this applies not only to clinical trials but also to pre-clinical, epidemiological, behavioural and health system research; whereas this undermines the safety and effectiveness of medicines and treatments for women; whereas, as a consequence of this lack of sufficiently balanced representation in the development stage of drugs, women experience adverse drug reactions 50 % to 75 % more often than men[20]; whereas more inclusive research, including on pregnant and breastfeeding women, is needed to reduce avoidable risks to maternal health; whereas studies have shown that women are subject to specific exposure patterns – including during pregnancy – that affect their health and that of the developing child;

J. whereas transgender, non-binary and intersex people and marginalised communities, such as ethnic minorities and women with disabilities, are often absent or disproportionally excluded from clinical trials[21] and medical research, resulting in significant gaps in evidence regarding the safety and effectiveness of treatments; whereas this lack of data contributes to unequal access to appropriate, timely and high-quality healthcare;

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17 Nature Reviews Bioengineering, 'Funding research on women's health', Vol. 2, 2024, pp. 797-798.

18 Nature, 'Women's health: end the disparity in funding', 2023.

19 Fewer than 0,4 % of trials in the EU include pregnant or breastfeeding women according to data from the Clinical Trials Information System cited by the European Medicines Agency on 4 June 2025; European Medicines Agency, 'New guideline on inclusion of pregnant and breastfeeding individuals in clinical trials', 2025.

20 Zucker, I. & Prendergast, B. J., 'Sex differences in pharmacokinetics predict adverse drug reactions in women', Biology of Sex Differences, June 2020.

21 Brotto, L.A. and Galea, L.A.M., 'Gender inclusivity in women's health research', BJOG, Vol. 129, No. 12, 2022.

K. whereas generic medicinal products are authorised on the basis of bioequivalence studies, which are still conducted predominantly on male participants and are not systematically analysed for sex differences; whereas reference medicinal products have historically been tested mainly on men; whereas differences in formulation between generic and reference medicinal products may affect bioavailability, raising uncertainties as to whether bioequivalence demonstrated in men can be equally assumed for women;

L. whereas 72 % of studies on drug trials fail to report and publish sex- and gender-disaggregated data[22], which significantly limits the understanding of sex-specific diseases, the factors contributing to their prevalence and the response to and safety of treatments;

M. whereas women and girls are disproportionately affected by a range of chronic and gender-specific conditions, which remain under-researched and under-diagnosed; whereas for common diseases, symptoms in women can present differently from 'textbook' symptoms, leading to significant misdiagnosis or delays in diagnosis compared to men[23]; whereas delayed diagnosis of gender-specific conditions leads to long-term pain, mental health consequences, loss of income and reduced participation of women in education and the labour market, reinforcing gender and social inequalities; whereas, for example, the total annual loss of production due to migraines, which disproportionately affect women, is estimated at EUR 111 billion in indirect costs in the EU[24]; whereas awareness, health literacy and prevention are essential components of women's health, as they enable early diagnosis and give women the opportunity to make informed decisions about their bodies and health throughout their lives;

N. whereas women are more likely to seek medical help than men, yet often face delayed or incorrect diagnoses, receive inappropriate treatment, or have their symptoms dismissed as psychosomatic, reflecting persistent gender bias in medical research, diagnostics and clinical practice[25]; whereas studies show that women wait 30 minutes longer in waiting rooms and are prescribed pain relief at lower rates than men with similar symptoms[26]; whereas women from ethnic minority backgrounds and patients facing racial discrimination are more likely to have their symptoms disregarded[27], which can lead to serious consequences, including undertreatment, misdiagnoses and loss of trust in medical institutions; whereas clinical practice guidelines often do not reflect best-practice clinical care for women;

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22 Care4Everybody study, 'Mind the Gap: Costs, consequences and correction of sex and gender inequality in medicine', 2023.

23 Jovani V, Blasco-Blasco M, Pascual E, et al., 'Challenges to conquer from the gender perspective in medicine: The case of spondyloarthritis', 2018.

24 European Migraine and Headache Alliance (EMHA), 'Towards a European Roadmap on Migraine: Strategic Conclusions and Policy Recommendations', 2025.

25 Prenuvo, 'The most common health misdiagnoses in women—and why they keep happening', 2025.

26 Mika Guzikevitsa, Tom Gordon-Heckerc, David Rekhtmand Shaden Salamehd, Salomon Israele, Moses Shayob, David Gozalh, Anat Perrye, Alex Gileles-Hillelj, and Shoham Choshen-Hillela, 'Sex bias in pain management decisions', August 2024.

27 MBRRACE-UK, 'Saving Lives, Improving Mothers' Care', October 2024.

O. whereas obstetric and gynaecological violence, including verbal abuse, discrimination and non-consensual procedures during pregnancy, childbirth and abortion care, constitutes a violation of women's rights and dignity, and remains a widespread yet under-recognised issue across the EU; whereas obstetric and gynaecological violence disproportionately affects women with disabilities and women from ethnic minorities, including Roma women, as well as intersex and transgender people[28]; whereas the Commission, in its Gender Equality Strategy 2020-2025, committed to issuing a recommendation on preventing harmful practices against women and girls, which should comprehensively include all forms of harmful practices, including the aforementioned forms of violence;

P. whereas women with disabilities continue to be subjected to unnecessary, harmful, irreversible or non-consensual medical treatments and interventions, including forced sterilisation, which remains a reality in some parts of the EU[29];

Q. whereas gender-based violence, in all its forms, constitutes a serious violation of fundamental rights and a major public health issue, with profound and long-lasting impacts on women's physical, mental, sexual and reproductive health; whereas certain socio-economic factors and inequalities increase women's exposure to gender-based violence; whereas fair and decent pay is essential for women's economic independence and enables women to leave situations of domestic violence;

R. whereas women are more exposed to economic vulnerability, and whereas highly female-dominated occupations disproportionately expose women to repeated physical and psychosocial strain, leading to premature deterioration in health and increased mental health risks; whereas women make up the majority (78 %) of healthcare workers in the EU[30]; whereas women's over-representation in precarious, fragmented or part-time employment limits their meaningful access to occupational health services; whereas occupational health and safety standards have historically been designed around male-dominated occupations and career patterns;

S. whereas harmful chemicals, including endocrine-disrupting chemicals, increase the risk of reproductive disorders by interfering with male and female hormonal systems[31], and contribute to significant consequences for health;

T. whereas gender inequalities, including the unequal allocation of informal and unpaid care responsibilities and disproportionate exposure to gender-based violence, the burden of chronic pain and gender-specific conditions, as well as socio-economic status, contribute to higher rates of anxiety, depression and stress-related conditions among women; whereas girls and women are exposed from an early age to persistent social,

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28 Study requested by the European Parliament's Committee on Women's Rights and Gender Equality, 'Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination', Policy Department for Citizens' Rights and Constitutional Affairs, European Parliament, 2024.

29 European Disability Forum report, September 2022, 'Forced sterilisation of persons with disabilities in the European Union'.

30 Eurostat, 'Majority of health jobs held by women', 2021.

31 Endocrine-disrupting chemicals and reproductive health: With focus on the developmental window of susceptibility, Terje Svingen National Food Institute, Technical University of Denmark, 2800 Kongens Lyngby.

cultural and commercial pressures related to beauty standards, which promote unrealistic body ideals and disproportionately affect their self-esteem, mental health and well-being; whereas eating disorders are among the most enfeebling psychiatric conditions that affect young women, with at least one person dying as a direct result of an eating disorder every 62 minutes[32]; whereas premenstrual dysphoric disorder affects at least 1,6 % of women[33];

U. whereas the digitalisation of healthcare and the increasing use of artificial intelligence (AI) risk reinforcing existing gender and racial biases; whereas these biases, stemming from non-representative datasets, can cause AI tools to downplay female medical symptoms; whereas sex- and gender-disaggregated data should be used to train AI in healthcare to enable it to recognise critical differences in disease progression, symptoms and drug metabolism between men and women;

V. whereas European health industries require innovation-friendly regulation, strong intellectual property protection and open but strategic trade in order to be resilient and competitive and to benefit women, both as patients and workers;

W. whereas according to the World Health Organization (WHO), global health challenges, including infectious diseases, antimicrobial resistance and climate-related health threats, have differentiated impacts on women and girls; whereas people in low- and middle-income countries face disproportionate gender inequalities in health compared to high-income countries in terms of mortality and serious morbidity, notably related to sexual and reproductive health and rights (SRHR);

X. whereas cardiovascular disease is the leading cause of death in the EU, with a higher mortality rate among women than men, despite prevailing societal misconceptions[34]; whereas these perceptions contribute to lower levels of risk awareness among women and healthcare professionals and lower rates of participation in cardiovascular screenings; whereas cardiovascular disease risk assessment models frequently overlook most gender-specific biological, social and psychosocial factors, such as hypertension, diabetes, gynaecological history, early menopause, intimate partner violence, socio-economic status and chronic stress, thereby contributing to women's vulnerability to ischemic heart disease and delayed diagnosis and treatment; whereas improving awareness, training and diagnosis of sex-specific cardiovascular symptoms is essential to ensure timely treatment, reduce avoidable health risks for women and strengthen the effectiveness of prevention and healthcare systems;

Y. whereas cancer is the second-greatest cause of death in the EU and has a higher mortality rate among men than women[35]; whereas approximately 12 million European

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32 European Institute of Women's Health (EIWH), response to the Commission's Green Paper: 'Improving the mental health of the population: Towards a strategy on mental health for the European Union'.

33 Thomas J. Reilly, Siya Patel, Ijeoma C. Unachukwu, Clare-Louise Knox, Claire A. Wilson, Michael C. Craig, Katja M. Schmalenberger, Tory A. Eisenlohr-Moul, Alexis E. Cullen, The prevalence of premenstrual dysphoric disorder: Systematic review and meta-analysis.

34 Eurostat, Statistics Explained, 'Cardiovascular diseases statistics', data extracted in July 2025.

35 Eurostat, Statistics Explained, 'Cancer statistics', data extracted in March 2024.

women are living with cancer, and more than 1,2 million women are diagnosed with cancer in the EU every year, with nearly 600 000 losing their lives; whereas the 2022 EU target to offer cancer screenings to at least 90 % of those eligible by 2025 has not been met universally across the EU;

Z. whereas full, effective and universal access to SRHR, including comprehensive, age-appropriate and science-based sexuality and relationship education, affordable and high-quality contraception, fertility care and safe and legal abortion services, is a fundamental pillar of gender equality, social justice, bodily integrity, privacy and personal autonomy, and is essential to countering disinformation and stigma and ensuring the dignity, health and equal participation of women and girls in all areas of life; whereas despite some progress, in practice, sexual and reproductive health services and access to related information remain partially unavailable in some Member States; whereas the lack of systematic data collection and insufficient disaggregated data on SRHR make it difficult to develop effective policies and address inequalities, particularly for women in vulnerable situations;

AA. whereas more than 20 million women[36] in the EU still do not have access to safe and legal abortion services, as several Member States maintain harmful and discriminatory regulatory and procedural barriers; whereas the European Citizen's Initiative entitled 'My Voice, My Choice' was a direct call from EU citizens for the EU to ensure access to safe and legal abortion services for all while respecting the division of competences under the Treaties; whereas the unmet need for contraception undermines bodily autonomy and global sustainable development, with unintended pregnancies accounting for approximately half of all pregnancies worldwide each year[37];

AB. whereas Parliament has voted on several occasions to strengthen and protect the right to abortion, including in texts on the European Citizens' Initiative entitled 'My Voice, My Choice', the Gender Equality Strategy 2026-2030, and its recommendation to the Council concerning the EU priorities for the 69th session of the UN Commission on the Status of Women;

AC. whereas 14 % of LGBTIQ+ people have reported experiencing discrimination in healthcare settings; whereas many Member States provide only limited and unaffordable access to transition-related healthcare;

AD. whereas sexually transmitted infections (STIs) disproportionately affect women[38] and continue to surge across the EU, while a lack of data and significant barriers to preventative measures and testing are hindering efforts to curb the epidemics of chlamydia, gonorrhoea and syphilis[39];

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36 This figure is based on the number of women living in Poland and Malta who do not have access to abortion because of restrictive laws in their countries of residence and restrictions and limitations in other EU Member States.

37 United Nations Population Fund (UNFPA), 'Nearly half of all pregnancies are unintended—a global crisis, says new UNFPA report', 2022.

38 Van Gerwen, O. T., Muzny, C. A., & Marrazzo, J. M. (2022), Sexually transmitted infections and female reproductive health, Nature microbiology, 7(8), 1116-1126.

39 European Centre for Disease Prevention and Control (ECDC), 'Monitoring of the responses to sexually transmitted infection epidemics in EU/EEA countries, 2024', Stockholm, 2025.

AE. whereas menstrual poverty – to be understood as insufficient access to menstrual hygiene products and facilities – affects an estimated 10 % of menstruating women, particularly women with low incomes, refugees, girls and women with disabilities[40];

AF. whereas inadequately funded and substandard maternity care can significantly impact the decision to have children; whereas postpartum depression is a mental health condition affecting 12 % of mothers in the EU after childbirth;

AG. whereas globally, one in six people face infertility[41], translating to approximately 25 million EU citizens, with women disproportionately affected by both the social stigma[42] and the physical burden of treatment; whereas polyendocrine metabolic ovarian syndrome is a common endocrine disorder affecting an estimated 11 % to 13 % of women worldwide[43], of which 70 % remain undiagnosed; whereas this disorder can cause severe pain, heavy bleeding and fatigue and has significant implications for fertility and long-term metabolic health; whereas no approved treatment currently exists that addresses the root causes of the condition due to limited understanding of its underlying mechanisms;

AH. whereas 85 % of women experience menopause symptoms; whereas by 2030, an estimated 1,2 billion women globally will be experiencing menopause[44]; whereas reproductive and hormonal shifts such as menstruation, pregnancy and menopause have a profound impact on women's physical, mental and social well-being throughout their lives; whereas menopause and perimenopause remain insufficiently recognised as major health and social issues, with associated symptoms widely disregarded, leading to unequal access to specialist and evidence-based care, unequal availability of hormone therapies and inadequate workplace accommodations; whereas the lack of adequate menopause care contributes to stigma, discrimination at work and a deterioration in quality of life, with direct consequences for economic independence and social participation;

AI. whereas endometriosis is a chronic condition affecting 10 % to 15 % of women of reproductive age[45] and can cause symptoms such as severe pain, fatigue and heavy

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40 European Parliament Briefing, 'Addressing menstrual poverty in the EU', Members' Research Service, European Parliamentary Research Service, 2025.

41 World Health Organisation, Infertility Fact Sheet, 2025.

42 Xie Y, Ren Y, Niu C, Zheng Y, Yu P, Li L., 'The impact of stigma on mental health and quality of life of infertile women: A systematic review', Front Psychol, 2023.

43 Gao, X., Zhao, S., Du, Y. et al., 'Data-driven subtypes of polycystic ovary syndrome and their association with clinical outcomes', Nat Med 31, 4214–4224 (2025).

44 Davaki, K., study requested by the European Parliament's Committee on Women's Rights and Gender Equality, 'Gender Inequalities in Medical Research, Drug Development and Access to Care', Policy Department for Citizens, Equality and Culture, Directorate-General for Citizens' Rights, Justice and Institutional Affairs, European Parliament, 2025, p. 86.

45 Becker, K., Heinemann, K., Imthurn, B. Marions, L. Moehner, S. et al. 'Real world data on symptomology and diagnostic approaches of 27,840 women living with endometriosis', Scientific Reports Vol. 11, No. 20404, 2021; Eder, C. and Roomaney R., 'Transgender and non-binary people's perception of their healthcare in relation to their endometriosis', International Journal of Transgender Health, Vol. 25, No. 4, 2024, 911-925.

bleeding; whereas this results in an estimated annual cost of sick leave of EUR 30 billion in the EU;

AJ. whereas, despite the prevalence of endometriosis, it takes on average 6 to 10 years to diagnose, resulting in prolonged suffering, reduced quality of life and increased socio-economic costs, including loss of productivity and increased pressure on healthcare systems; whereas early diagnosis and appropriate treatment can significantly improve health outcomes; whereas the diagnostic delay for endometriosis is structural and reflects gender inequalities and bias in healthcare;

AK. whereas metabolic diseases such as diabetes are diagnosed about 4,5 years later in women than in men and woman experience significantly worse long-term health outcomes than men, including a 30 % higher risk of mortality from cardiovascular disease; whereas women with type 1 diabetes are four times more likely to develop pre-eclampsia and women with gestational diabetes mellitus (GDM) have a high probability of developing type 2 diabetes within five years of giving birth; whereas children born to mothers with GDM are up to six times more likely to develop type 2 diabetes and childhood obesity than those born to mothers without GDM;

AL. whereas osteoporosis and autoimmune diseases as well as musculoskeletal disorders such as rheumatoid arthritis, lupus, osteoarthritis, gout and back pain, continue to be frequently minimised in clinical practice, underfunded and under-researched[46];

AM. whereas across the EU, women live longer than men but spend a greater proportion of those additional years in poor health – a disparity referred to as the 'healthy life years gap'; whereas older women represent the majority of residents in long-term care facilities, with many of them living with memory disorders, and often experiencing inadequate access to treatment of symptoms and chronic conditions, which disproportionately affects their overall health and well-being;

General considerations

1. Underlines that health policy, medical research and clinical practice must be grounded in robust scientific evidence, objective biological facts concerning women and men, and the highest standards of medical expertise;

2. Stresses that gender inequalities in health are multifaceted and a violation of fundamental rights, with inequalities resulting from decades of medical research based on and designed around the male anatomy, which in turn has shaped the entire cycle of care from diagnostics to treatment; underlines that the recognition of this imbalance presents an opportunity to redesign research frameworks, clinical guidelines and care delivery; highlights that these inequalities affect both life-threatening and non-fatal chronic conditions, and have a substantial impact on the physical, mental and social well-being of women and gender-diverse people in particular; underlines that gender equality in health policy is a prerequisite for equal opportunities, economic participation and social cohesion, and should be pursued in a way that empowers women while preserving individual responsibility and freedom of choice;

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46 Woolf, A.D., and Pfleger, B., 'Burden of major musculoskeletal conditions', Bulletin of the World Health Organization, vol. 81.9, 2003.

3. Stresses that health is a shared concern across the EU and that full respect for the principle of subsidiarity and Member States' responsibility for organising their health systems should not prevent coordinated action; highlights that coordinated EU action strengthens resilience, ensures continuity of care during crises, reduces inequalities between Member States and guarantees that citizens' health rights are effectively protected; underlines that women make up just over half of the population in the EU and the majority of the health and care workforce, and that EU-level cooperation is essential to ensure equitable access to gender-responsive health services, including sexual and reproductive health services, maternal care and prevention and treatment of female-prevalent conditions; calls for a more effective use of cross-border cooperation to deliver clear added value, such as access to specialised care and expertise on rare diseases;

4. Highlights that inequalities in healthcare are compounded by intersectional inequalities and discrimination, including those linked to gender, age, socio-economic status, disability, race or geographical location and those experienced by people from ethnic minorities, refugee, migrant and LGBTIQ+ communities, survivors of gender-based violence and women deprived of their liberty; stresses that employment, housing and income insecurities, as well as unpaid care responsibilities, deepen gender inequalities in health and limit access to timely, quality and affordable care; points out that inequalities are also evident in gender-specific conditions, as research into these conditions has been repeatedly undervalued and underfunded; notes that stigma, the visibility of symptoms and cultural perceptions of disease can further exacerbate barriers to timely diagnosis and care for women;

5. Deplores the fact that universal access to healthcare services across the EU has not yet been achieved; emphasises, in particular, the need for an intersectional approach to remove barriers to access faced by vulnerable women and girls, including women with disabilities, women from disadvantaged backgrounds and those living in institutional settings; calls on the Commission and the Member States to promote greater harmonisation of access to healthcare across the Member States, with full respect for their competencies, and to ensure affordable, high-quality healthcare for all; stresses that access to healthcare should never be impeded by ignorance, bias or stigma; calls for targeted measures to ensure accessible, inclusive and culturally and gender-sensitive healthcare and stresses the need to address these barriers to timely diagnosis and treatment;

6. Calls on the Commission and the Member States to address geographical disparities in accessing healthcare, which particularly affect women in rural and remote areas, islands and outermost regions, through coordination, funding and knowledge-sharing mechanisms at EU level; urges the Member States to tackle transport-related barriers to accessing healthcare by integrating a gender perspective into health infrastructure planning, including through the development of mobile healthcare units, telemedicine solutions and accessible public transport connections to healthcare facilities;

7. Calls on policymakers and healthcare professionals to address inequalities, in line with the principle of subsidiarity, and to correct discrepancies with measurable targets and accountability as innovative new treatments and procedures are developed; calls for the incorporation of a sex- and gender-informed perspective in all EU health legislation and initiatives; emphasises the importance of science-based, efficient and innovation-friendly health policies that take into account biological and social differences between

women and men and that address the disparities therein; reiterates that research and innovation models in the health sector should drive developments that are in the interest of citizens;

8. Encourages the Commission to include, as part of a comprehensive EU women's health strategy, clear, public, measurable targets with accountability to address health inequalities in EU policy and funding instruments, while ensuring that Member States retain sufficient discretion to tailor implementation to national contexts, and to implement a transparent monitoring system for these targets, notably for gender-specific conditions, with comparable indicators and follow-up actions where targets are not met, including a reassessment of funding priorities to ensure that inequalities in health are addressed in the most efficient way;

9. Stresses the importance of ensuring high-quality maternal healthcare for pregnant women;

10. Calls on the Commission and the Member States to strengthen health literacy by funding targeted, evidence-based, awareness-raising and communication campaigns to ensure that women and other vulnerable groups can make informed decisions about their health; stresses the importance of reliable, evidence-based and age-appropriate health information for women and girls as well as men and boys throughout the life course, and of education on SRHR, including fertility, pregnancy, contraception, maternal health and post-natal care, consent, bodily integrity, privacy, personal autonomy, respect and the prevention of gender-based violence; calls on the Commission to issue recommendations to the Member States on the provision of comprehensive sexuality education, in line with UNESCO standards;

11. Calls for strengthened collaboration with healthcare providers, civil society organisations and digital platforms to detect, investigate and prevent the spread of scams, fake 'miracle cures', misinformation and stigma regarding health and the growing influence of anti-gender movements in the EU, which are defined as movements seeking to undermine gender equality as a core value of democracy, as well as the rights of LGBTIQ+ people, and restrict access to SRHR services and space for civil society; stresses that algorithmic tools used to restrict 'inappropriate' content must be designed in such a way that they do not flag topics related to women's health, such as menstruation, menopause, fertility and reproductive health, as sexual or adult content, thus limiting their visibility;

Research, including clinical trials

12. Expresses concern that despite improvements to inclusivity in clinical trials, the representation of women and gender-diverse people remains below that of men and should be strengthened by introducing sex-disaggregated reporting; stresses that there are no inclusivity requirements in the pretrial phase and that the majority of animal testing is still conducted on males of the species only[47]; stresses the need for clinical trials to take into account differences in outcomes pertaining to hormonal fluctuations and life stages; recognises that pregnant women are often excluded from clinical trials; calls on the Commission to introduce requirements for sex-sensitive research design

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47 Galea, L.A. and Parekh, R.S., 'Ending the neglect of women's health in research', BMJ, Vol. 381.

throughout the full research cycle, including in the pretrial phase and animal testing, to address the ongoing imbalance in clinical trial participation;

13. Clarifies that, in the specific context of animal testing, research design should better take into account biological sex and the study of sex-based biological differences;

14. Welcomes the EMA's intention to adopt a new 'guideline on inclusion of pregnant and breastfeeding individuals in clinical trials' without compromising the safety of the expecting individual and child; urges the EMA to adopt similar guidelines to improve the inclusion of other vulnerable and under-represented communities, for example older women and gender-diverse and intersex people, as well as ethnic minorities and marginalised communities;

15. Urges the EMA to ensure that the evaluation and authorisation of generic medicinal products, as well as biopharmaceutical innovations, adequately consider sex- and gender-specific differences throughout the entire life cycle of a product from early-stage research to clinical validation, with a view to ensuring equal levels of safety and efficacy for all patients;

16. Stresses that the lack of understanding of sex- and gender-based differences in health is exacerbated by the fact that the data outcomes of research are rarely disaggregated by sex and gender; calls on the Commission to promote the collection and reporting of sex- and gender-disaggregated data in all EU-funded projects so as to ensure accountability and the effective use of public resources; notes that AI could be used to identify sex or gender biases in existing or historical research to prevent the need to repeat the research; warns, however, that the use of AI must be monitored closely to ensure that it does not impose biases;

17. Stresses that the lack of systematic collection of disaggregated data undermines the development of effective, evidence-based policies, including on sexual and reproductive health, and that an exposome approach to research is required; calls for improved collection, harmonisation and use of sex- and gender-disaggregated data, as well as intersectional data, in all areas of health policy, research and innovation, and pilot projects across the EU; calls on the Commission and the Member States to ensure that a strong gender perspective is incorporated into the implementation of the European Health Data Space;

18. Commends the work of the EIGE in strengthening the evidence base on women's health, including through the integration of health-related indicators into the Gender Equality Index; underlines that the EIGE's research provides clear European added value by improving data comparability, supporting evidence-based policymaking and enabling more targeted, effective and proportionate EU and national policies;

Diagnostics and treatment

19. Highlights the fact that as a result of systemic underfunding and a lack of research, diagnostic methods and treatments remain male-centric, which can lead to substandard and higher-risk treatment for women, transgender and gender-diverse people, including through a lack of necessary, evidence-, science-based and comprehensive healthcare and the dismissal of pain and symptoms, leading to delayed diagnoses for women and transgender and intersex individuals;

20. Urges the medical profession to apply a precision-medicine approach to treatment, in order to complement any measures taken to reduce inequality and increase investment in medical research; calls on the Member States to establish pilot programmes on gender-sensitive healthcare, notably in areas where programmes are non-existent or severely lacking, such as menstrual, perimenopausal, cardiovascular and mental health; points out that fears of misconceptions, misinterpretation of symptoms, judgement and stigmatisation can discourage women from seeking timely medical advice, resulting in avoidable complications and poorer long-term outcomes; calls for measures to be taken to change misperceptions among medical professionals and to address public misconceptions; calls for multidisciplinary collaboration in women's healthcare to gain a better understanding of gendered health conditions and corresponding gaps in treatment;

21. Underlines that medical professionals must act in a non-discriminatory manner; urges the Member States, in close cooperation with the medical profession and educational institutions, to integrate gender-sensitive, intersectional and patient-centred healthcare training into their medical, nursing and obstetrics curricula to ensure that medical professionals are equipped to recognise and respond to the specific needs of women and girls, including through training on gender prejudice, on pain management, on SRHR, on the prevention of discrimination, on conditions with a high prevalence in women, on how symptoms and treatment needs may change across hormonal life stages and on the wider recognition of gender-specific symptoms; stresses that such training should also include teaching on gender and cultural sensitivity; underlines that the development of measures to make diagnostic and treatment processes more gender-sensitive and responsive must take full account of real patient experiences;

22. Calls on the Commission to encourage the exchange of best practice and knowledge on how the healthcare workforce can be better trained and more attentive to sex- and gender-responsive healthcare; calls for the establishment of a European Reference Network (ERN) on women's health, building on the model of existing ERNs for rare diseases, to strengthen research collaboration, improve clinical practice and ensure that women's specific health needs are systematically addressed across the EU;

23. Calls on the Commission and the Member States to ensure that healthcare systems are equipped to prevent, identify and respond to gender-based violence and to the specific needs of women and girls in vulnerable situations, including through gender-sensitive, patient-centred, trauma-informed care and access to emergency contraception; calls on the Member States to establish clear pathways between health services, social services, and specialised support services for victims and survivors of gender-based violence, in line with Directive 2024/1385 on combating violence against women and domestic violence[48] and the revision of Directive 2012/29 establishing minimum standards on the rights, support and protection of victims of crime[49];

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48 Directive (EU) 2024/1385 of the European Parliament and of the Council of 14 May 2024 on combating violence against women and domestic violence (OJ L, 2024/1385, 24.5.2024, ELI: http://data.europa.eu/eli/dir/2024/1385/oj).

49 Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA (OJ L 315, 14.11.2012, p. 57, ELI: http://data.europa.eu/eli/dir/2012/29/oj).

24. Emphasises that harmful practices such as female genital mutilation, forced abortion, forced sterilisation, the denial of abortion care, intersex genital mutilation, obstetric and gynaecological violence, and malpractice in medical settings are forms of gender-based violence; expresses concern about medically unnecessary treatments, often carried out without informed consent, which particularly affect intersex women, as well as coercive medical interventions, such as forced sterilisation, which remain a reality for women with disabilities in the EU[50]; deplores the fact that, despite its commitment under the Gender Equality Strategy 2020-2025, the Commission has failed to publish its recommendation on the prevention of harmful practices against women and girls; urges the Commission to do so swiftly; stresses that this recommendation must complement Directive (EU) 2024/1385; calls for the establishment of independent complaint, reporting and accountability mechanisms and data collection systems in this regard;

25. Calls on the Commission and the Member States to recognise, prevent and address gynaecological and obstetric violence, including non-consensual, abusive or coercive medical procedures, verbal abuse, discrimination, dismissive treatment, such as delaying the treatment of or refusing to acknowledge women's reproductive health concerns, and violations of bodily autonomy in gynaecological and obstetric care, as a form of gender-based violence and denial of women's rights; notes that examples of gynaecological violence include the performance of perineal or episiotomy cuts during childbirth without explicit consent or informed agreement, and routine dismissal of women's reported pain or symptoms in the context of reproductive health; notes the severe impacts that such violence may have on women's and intersex people's physical, mental and social health; deplores the fact that, despite recent EU literature on the existence and reality of violence in gynaecological and obstetric settings, the Commission has not explicitly recognised obstetric and gynaecological violence as a form of gender-based violence; urges the Commission to establish clear legal definitions and prevention strategies, in this regard; calls on the Member States to explicitly recognise and combat all forms of obstetric and gynaecological violence;

26. Calls on the Commission and the Member States to promote respectful maternity care and to establish complaint mechanisms, data collection and training for healthcare professionals, regarding obstetric violence;

27. Calls for mandatory training for healthcare professionals, emergency responders and law enforcement authorities on identifying, responding to and documenting cases of gender-based violence, including female genital mutilation, in a sex- and gender-responsive and victim-centred manner;

28. Underlines that prevention-focused health policies particularly benefit women, reducing long-term healthcare costs and enabling higher labour-market participation; calls on the Commission and the Member States to introduce ambitious targets for the screening of cancer and other relevant diseases, such as osteoporosis and cardiovascular disease; urges the Member States to recognise and fully exploit the benefits of prophylactic medicinal products, but emphasises that further research into lactose-free prophylactics is required; draws particular attention to the need for early-detection and preventive

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50 European Disability Forum report of September 2022 entitled 'Forced Sterilisation of Persons with Disabilities in the EU'.

screening programmes for women with disabilities, with a view to preventing additional health complications;

29. Underscores the persistent gender care gap, namely the fact that women disproportionately perform both informal and formal care work, which increases their exposure to a range of health challenges, including mental health challenges; underlines the importance of promoting a fair and equal distribution of caregiving responsibilities; stresses that informal carers should be granted greater support, including financial, mental and peer support, as well as flexible work arrangements and care leave;

30. Warns that women's health medicines are not adequately prioritised in EU efforts to protect against shortages and supply disruptions, despite routine shortages of abortion medicine and contraception, among others, in Member States; calls on the Council to align with Parliament's proposal to recognise abortifacient and contraceptive medicinal products as medicinal products of common interest in the Critical Medicines Act; calls on the Council to consider these products for inclusion in the next revision of the EU list of critical medicines; calls for the forthcoming Critical Medicines Act to integrate a gender-sensitive approach, ensuring that the identification and prioritisation of critical medicines reflect the specific healthcare needs of women in all their diversity;

31. Calls on the Commission and the Member States to strengthen measures to protect women and girls from harmful chemical exposure, recognising that women are disproportionately affected due to biological, social and occupational factors; notes that chemicals in everyday products, including cosmetics, menstrual products and household items, can disrupt hormonal systems, increase risks of conditions such as breast cancer and endometriosis and the risks of fertility problems, and can affect foetal development during pregnancy;

Mental health

32. Urges the Commission to take mental health and its gender-related challenges into account in all relevant healthcare-related measures; stresses that, due to biological and social factors, including the gender pay, pension and care gaps, women are more likely to develop certain mental health conditions, such as depression, anxiety, post-traumatic stress disorder and eating disorders, and report higher rates of depression and psychological distress than men; highlights the strong interconnection between physical health conditions and mental health outcomes in women; notes that certain chronic, recurrent or visible health conditions are subject to stigma, and are frequently associated with anxiety, depression and social withdrawal;

33. Stresses the need for integrated care approaches that address both physical symptoms and mental well-being, and the need to integrate mental healthcare into the diagnosis and treatment of gender-specific conditions, including into maternal and post-partum health; stresses the need for research on the mental health outcomes of different parental leave models; calls for proportionate, evidence-based action to be taken at EU level to complement national strategies, including by ensuring access to appropriate psychological, psychiatric and nutritional care, as well as increasing access to mental health services for girls and young women; calls on the Commission to take the gender

dimension into account in the implementation of the initiatives outlined in its communication of 7 June 2023 on a comprehensive approach to mental health[51];

34. Highlights the need to address the gendered social and commercial pressures that negatively affect girls' and women's body image and health; expresses concern about the growing influence of social media on perceptions of women's health; calls on the Commission and the Member States to promote prevention strategies, including awareness-raising campaigns, including in schools, aimed at preventing eating disorders and fostering a healthy body image, self-esteem and informed health choices;

Digital health, medical devices, data and artificial intelligence

35. Highlights that medical devices play an increasingly central role in disease management and monitoring; underlines that insufficient consideration of physiological differences between sexes in the design, testing and validation of medical devices, including those used in sport, may result in differences in performance, accuracy and user experience; highlights that the development of medical devices in sport continues to be based on male anthropometric and biomechanical parameters, thereby undermining the efficacy and safety of such devices for women;

36. Calls for the systematic integration of sex- and gender-based analysis in the testing, authorisation, and monitoring of digital healthcare technologies, including AI-based diagnostic tools and machine learning systems, through the use of sex-disaggregated data and the meaningful involvement of women throughout the process; stresses that digital healthcare technologies must be developed and implemented in a manner that reflects gender-specific health needs, so as to prevent the replication or reinforcement of existing sex and gender biases;

Global health

37. Recognises the EU's commitment to advancing gender equality globally, including through the EU's Global Health Strategy; deplores the fact that the Union prevention, preparedness and response plan for health crises fails to adequately address the gendered aspects of preparedness and response; calls on the Commission and the Member States to integrate a sex- and gender-responsive and intersectional approach into all policies related to public health and to crisis preparedness and response;

38. Calls for the Commission and the Member States to prioritise access to gender-responsive and inclusive water, sanitation and hygiene (WASH) services as an essential component of women's health under the EU Global Health Strategy; stresses that improving WASH in healthcare facilities is key to reducing preventable maternal and neonatal mortality and to ensuring safe childbirth and menstrual hygiene management;

Gender-specific conditions

39. Expresses concern that, despite cardiovascular disease and heart diseases being the leading causes of death among women, women are twice as likely to be misdiagnosed, in part due to the fact that women's symptoms present differently to men's[52]; stresses that gender-specific biological, social and psychosocial risk factors play a role in the

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51 COM(2023)0298.

52 Roche Diagnostics, 'Heart failure: The hidden costs of late diagnosis', August 2020.

development of cardiovascular disease and heart disease in women; emphasises that late diagnosis delays access to timely and appropriate care, further increasing the risk of cardiovascular complications; underlines that women living with diabetes and other metabolic diseases are, on average, diagnosed up to 4,5 years later than men, and face an approximately 30 % higher risk of cardiovascular mortality; supports a strong EU framework for combating major diseases, including cardiovascular conditions, ensuring equal access for women to preventative care, early diagnosis, treatment and survivorship support;

40. Welcomes the Commission's commitment, made in its December 2025 communication on the Safe Hearts Plan, to invest in research to advance the understanding of sex- and/or gender-specific mechanisms of cardiovascular diseases; calls for the Safe Hearts Plan to integrate a holistic gender-sensitive approach to cardiovascular care, including with regard to screening, prevention campaigns, data collection, diagnostic criteria and clinical guidelines in order to improve early detection, ensure equitable care and reduce avoidable mortality among women; calls on the Commission and the Member States to engage in campaigns to raise awareness, dispel the misconception that cardiovascular disease primarily affects men, and promote preventative measures;

41. Highlights the fact that cancer is the second-greatest cause of death in the EU, affecting more men than women, on average; notes that some cancers present differently in men than in women, and some cancers are specific to, or more prevalent in, certain sexes; expresses concern that, on average, cancer in women is diagnosed 2,5 years later than it is in men[53]; underlines that more research is required into the impact of sex/gender factors on the occurrence of cancer, how it manifests and how it responds to existing treatments;

42. Highlights that lesbian women are statistically less likely to access routine screening, often due to misconceptions or previous negative experiences with healthcare providers[54]; underlines the need for tailored information to tackle misconceptions and ensure that lesbian women, transgender and gender-diverse people receive appropriate screening and preventive care, and, in the case of transgender people, gender-sensitive treatment; stresses that access to healthcare, including preventive care, should be based on health needs; calls on the Commission and the Member States to ensure that Europe's Beating Cancer Plan is implemented through a strong gender lens; welcomes the Commission's intention to issue guidance to financial undertakings on offering cancer patients fair access to financial services, but stresses the need for an EU-wide right to be forgotten for patients who have recovered from cancer, to prevent further discrimination in access to financial services, such as insurance and loans;

43. Highlights the fact that many cancer cases are preventable through behavioural and environmental changes, as well as early intervention measures to detect and prevent pre-cancerous changes; stresses that investing in preventive measures should be a priority for the EU; calls on the Commission and the Member States to strive towards ambitious targets of equal access to high-quality, publicly funded screening programmes for

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53 Westergaard, D., Moseley, P., Sørup, F.K.H., Baldi, P. and Brunak, S., 'Population-wide analysis of differences in disease progression patterns in men and women', *Nature Communications*, Vol. 10, February 2019.

54 Tracy, J.K., Lydecker, A.D., Ireland, L., 'Barriers to Cervical Cancer Screening Among Lesbians', *Journal of Women's Health*, Vol. 19, February 2010.

cancer across all EU countries, regardless of place of residence or socio-economic status; stresses the importance of comprehensive and gender-sensitive screening and/or vaccination programmes for breast cancer, cancers caused by the human papillomavirus (HPV), prostate cancer, colorectal cancer, skin cancer and lung cancer, which remain among the most common and preventable cancers in Europe, and for hepatitis B; calls for measures to target misinformation about the side effects of vaccines; encourages further investment in innovative diagnostic tools such as biomarker testing, and calls on the Commission to remove barriers to allow for the widespread use of these tools where appropriate, and to ensure equitable access to such tools;

44. Stresses that SRHR are fundamental human rights, which constitute a core component of women's health and public health policy, and that ensuring universal access to comprehensive sexual and reproductive healthcare is a necessity for gender equality; stresses that concrete measures on SRHR are necessary for progress towards achieving the vision outlined in the Commission's 2025 Roadmap for Women's Rights, and for alignment with international human rights and the public health standards issued by the WHO and UNESCO; calls on the Commission to take action to advance the full spectrum of SRHR through all relevant EU policy areas and funding instruments, including the proposed European Competitiveness Fund;

45. Welcomes the Gender Equality Strategy 2026-2030, put forward by the Commission, and its commitment to supporting Member States' healthcare actions regarding SRHR by mapping practices and international frameworks, by developing an EU framework and methodology for systematic data collection to improve the evidence base for SRHR, and by enhancing access to contraception; highlights the upcoming launch, in 2026, of the Sexual and Reproductive Health in Emergencies and Life in Dignity (SHIELD) initiative, which will aim to improve access to SRHR for victims of gender-based violence; calls on the Commission to include further policy and funding commitments, and data collection requirements, in the SHIELD initiative in order to support the Member States in advancing and safeguarding SRHR; is deeply concerned that women and girls with disabilities are far too often denied access to SRHR and stresses the need to safeguard physical integrity, freedom of choice and self-determination, with regard to the sexual and reproductive lives of persons with disabilities;

46. Stresses the need to improve the availability of, and access to, abortion throughout the EU; strongly supports the European Citizens' Initiative entitled 'My Voice, My Choice', which aimed to set up a voluntary, solidarity-based, opt-in EU financial mechanism to ensure safe and accessible abortion in Europe; reiterates its call on the Commission to make full use of its competence in health policy to provide support to the Member States in guaranteeing universal access to SRHR, and to enshrine SRHR and the right to safe, legal and accessible abortion in the Charter of Fundamental Rights of the European Union;

47. Welcomes the positive response from the Commission to the 'My Voice My Choice' European Citizens' Initiative in its February 2026 communication, acknowledging that unsafe abortion is a matter of public health, and enabling Member States, via appropriate funding within the European Social Fund Plus (ESF+) programme, to provide safe and legal abortion services, including by supporting travel and accommodation costs, to people who cannot access such services in their home country and, in general, for the most vulnerable persons, without interfering with national laws and regulations; recognises that this decision was aimed at reducing healthcare

disparities and ensure that people in vulnerable positions have access to essential healthcare services; urgently calls on the Member States to use the ESF+ for this purpose; calls on the Commission to ensure that the use of funds for equal access to sexual and reproductive healthcare is properly assessed in the programming and mid-term review of ESF+ operational programmes;

48. Calls on the Commission and the Member States to address the specific healthcare needs of LGBTIQ+ people, including by ensuring access to preventive care, treatment, and trans-specific healthcare, and to remove any coercive and unnecessary medical requirements, such as sterilisation, which hinder access to legal recognition and reproductive services, in line with the rulings of the European Court of Human Rights[55]; recognises the commitment from the Commission, in its LGBTIQ+ equality strategy 2026-2030, to facilitate exchanges of best practices between the Member States in this respect; encourages support for community-based healthcare initiatives and EU-funded research under EU4Health and the Horizon programme to ensure inclusive, equitable and safe healthcare for all LGBTIQ+ individuals; condemns conversion practices, such as practices aimed at changing, repressing or suppressing a person's sexual orientation, gender identity and/or gender expression, as violations of fundamental rights, and urges the Commission to tackle them through concrete actions; notes the Commission's response to the European Citizens' Initiative entitled 'Ban on conversion practices in the European Union', and urges the Commission to adopt a recommendation, without further delay, calling on the Member States to ban conversion practices;

49. Stresses the role of education, healthcare services and public institutions in preventing gender-based violence and promoting consent, bodily integrity, privacy, and personal autonomy and respect, and reducing gender inequalities; stresses that comprehensive, age-appropriate, science-based sexuality education, in line with UNESCO standards, is essential for promoting consent and SRHR, preventing gender-based violence, countering disinformation and stigma surrounding women's health, and empowering individuals to make informed, autonomous choices; calls on the Commission to issue clear guidelines to the Member States on the provision of comprehensive age-appropriate sexuality and relationship education, in line with international standards;

50. Calls on the Commission and the Member States to ensure universal access to affordable, safe and varied contraceptive methods; recognises that the contraceptive burden is – physically, financially and mentally – carried disproportionately by women; regrets the fact that, despite the unmet need for contraception globally, the EU has not funded the development of novel contraceptives since 2021; calls for increased investment in innovative research and development of globally applicable contraceptive technologies, including male contraceptives, with the aim of achieving greater gender equality and shared responsibility in family planning; stresses that women's self-determination in choosing contraception must be fully respected, including their right to receive complete and comprehensible information on the benefits and potential risks and side effects of different contraceptive methods, enabling informed consent; encourages the Member States to effectively curb epidemics of STIs, by integrating HIV and STI prevention, testing and care into broader gender-sensitive healthcare

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55 European Court of Human Rights judgment of 11 October 2018 in the case of *S.V.* v *Italy* (55216/08), and European Court of Human Rights judgment of 6 April 2017 in the case of *A.P., Garçon and Nicot* v *France*, (79885/12, 52471/13 and 52596/13).

strategies, as well as by removing barriers to testing and improving data collection on STIs;

51. Calls on the Commission and the Member States to ensure access for all to affordable, high-quality, toxin-free and environmentally sustainable – particularly reusable – menstrual products; encourages the Member States to use taxation as a tool to make menstrual products more available and affordable for everyone, and to combat menstrual poverty by providing free or affordable access to menstrual products, information and adequate sanitary facilities, particularly in public places such as educational institutions, workplaces, public buildings and reception centres or shelters; stresses that inadequate education about menstruation can lead to unsafe menstrual care and, in turn, serious illness, further highlighting the need for funded public awareness campaigns on menstrual health to address stigma and confront stereotypes linked to menstrual health, alongside increased research into menstrual health conditions; stresses that continence care is a significant, yet often overlooked, aspect of public health, which disproportionately affects women; calls on the Commission and the Member States to launch public awareness campaigns to destigmatise continence health and to ensure that symptoms are not dismissed by patients or providers, and that patients are aware of treatments to cure incontinence, as well as treatments that can manage or improve it;

52. Urges the Member States to ensure that pregnant women have access to high-quality maternity healthcare services, regardless of where they live; calls for the development of common EU standards in maternal healthcare, and for strengthened cooperation and exchange of best practice among healthcare professionals in this field, with the objective of improving quality and ensuring that preventable maternal mortality is eliminated; highlights the need for EU-level initiatives specifically addressing postpartum depression and maternal mental health and well-being;

53. Recognises that fertility is a critical aspect of health and emphasises the need to proactively address the multifaceted factors of, and challenges related to, fertility; calls on the Member States to ensure high-quality, timely and equitable access to fertility and miscarriage-related healthcare, including infertility diagnosis and treatment, regardless of a woman's economic situation or marital status, including for women with disabilities; stresses the need for evidence-based, reliable, public information on fertility that promotes a rights-based approach and supports reproductive autonomy; urges the Commission to provide support to the Member States through guidance, data collection and the exchange of best practice; stresses the importance of integrated mental health support and counselling to address the emotional and psychological impact of infertility and miscarriage;

54. Regrets the fact that, despite the prevalence of adverse, and serious, menopause and perimenopause symptoms among women, menopause is still not routinely integrated into primary healthcare, occupational health policies and workplace health strategies throughout all the Member States; calls on the Commission and the Member States to ensure that menopause is recognised as a significant public health issue and fully integrated into routine primary healthcare services, with a view to supporting women's long-term health and continued participation in the labour market; recalls that studies have shown that there is an estimated loss of EUR 9 billion to companies in Germany

alone every year[56] due to lack of treatment and support for women experiencing menopause symptoms; calls on the Member States to ensure timely access to menopause care, including through specialised services and clear clinical guidelines which give due consideration to hormonal life stages such as menstruation, pregnancy and menopause; recognises that the majority of available treatments are hormonal and, therefore, not suitable for all patients; highlights the need for the development of non-hormonal treatments alongside more effective and widely available hormonal treatments; notes that hormonal transitions can influence the onset, severity and management of other chronic conditions that disproportionately affect women, compared to men; highlights the fact that the majority of existing medical research focuses on the years of fertility, overlooking puberty, perimenopause and menopause, and that a more inclusive and representative approach to clinical trials is necessary;

55. Regrets that menopause remains shrouded in social stigma, and draws attention to the general lack of awareness of the symptoms of perimenopause; underlines the importance of training healthcare professionals on menopause management to provide consistent, evidence-based, and patient-centred support to women throughout the menopausal transition, as well as the need to empower women to recognise symptoms earlier and to seek appropriate care; calls on the Commission and the Member States to develop EU-level guidelines on menopause and perimenopause care and awareness;

56. Deplores the fact that since the inception of the EU's Community Research and Development Information Service almost 40 years ago, only 10 of the 145 983 EU-funded projects have focused specifically on endometriosis[57]; underlines that women's sexual and reproductive health can be adversely affected by untreated or late-diagnosed health conditions; stresses that timely access to prevention, diagnosis and treatment is essential to protect fertility, sexual health and overall well-being and to reduce avoidable long-term consequences; calls on the Commission and the Member States to recognise endometriosis as a chronic condition and to promote its earlier diagnosis through improved training of primary healthcare professionals, clearer referral pathways and increased awareness among healthcare providers, and calls on the Commission to develop an EU-wide action plan on endometriosis;

57. Calls on the Commission and the Member States to integrate a gender perspective into diabetes research, diagnosis, treatment and management, as diabetes can affect men and women differently and therefore requires a gender-sensitive approach; calls for EU support for gender-responsive technologies and mental health integration to ensure personalised care and outcomes for women living with diabetes;

58. Highlights the fact that chronic inflammatory skin diseases, including atopic eczema, present differently by gender and at different stages in life, and disproportionately affect women; recognises that these conditions entail severe and persistent symptoms, such as pain and an unbearable itch, which significantly impair an individual's quality of life, sleep and mental health; notes that hormonal changes make women more vulnerable to atopic dermatitis flares, especially during the premenstrual period and pregnancy, as

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56 FP Analytics & Bayer, 'The Health and Economic Impacts of Menopause', case study on Germany, May 2025.

57 Viganò, P., Casalechi, M. and Dolmans, M., 'European Union underinvestment in endometriosis research', *Journal of Endometriosis and Uterine Disorders*, Vol. 5, March 2024.

well as to psoriasis during puberty and menopause; emphasises the need for training for healthcare professionals on such skin diseases, including on how symptoms and treatment needs may change across hormonal life stages; underscores that indoor tanning is a likely factor in the steeper rise in melanoma rates among younger women compared with men; urges the Commission to introduce measures to restrict and reduce indoor tanning consistently across the EU in order to stop the melanoma epidemic[58]; stresses the need to strengthen consumer protection by regulating misleading or harmful beauty marketing practices and ensuring clear health warnings about risks to skin health linked to artificial UV exposure and certain cosmetic procedures;

59. Calls on the Commission and the Member States to address the gender-specific challenges of rheumatic and musculoskeletal diseases in women; stresses the need for increased EU research and innovation to better understand why women are disproportionately affected, experience more pain and respond differently to treatments; encourages the Member States to develop and adopt multidisciplinary care models, with progress indicators, tailored to the needs of women with musculoskeletal disorders, to ensure they have equal access to advanced medical and surgical treatments for rheumatic and musculoskeletal diseases;

60. Calls on the Commission and the Member States to strengthen gender-responsive policies in care for older persons, recognising that women represent the majority of older Europeans; calls for solutions that support accessible, affordable, high-quality and long-term care services that respect the dignity, autonomy and health of older women; encourages the sharing of best practices on gender-responsive treatment for older women, including preventive measures such as adequate nutrition and exercise, timely diagnosis and care for illnesses, and tailored approaches for women living in institutional settings and those with memory-disabling diseases who may struggle to express their needs, preferences and symptoms; stresses that there is a higher prevalence of memory-disabling diseases, such as Alzheimer's, among women than men, primarily due to women's longer average lifespans, but it is also evident among women and men of the same age;

61. Welcomes the publication of the Commission's Gender Equality Strategy 2026-2030 and the commitments therein to addressing the inequalities in women's healthcare and advancing SRHR; calls for the Commission to complement the Gender Equality Strategy in its forthcoming policy by prioritising and incentivising dedicated and targeted investment in women's health; stresses that investment in gender-specific conditions should reflect their severity and prevalence, while continuing to support research into rare diseases; points out that upcoming strategies must incorporate an integrated approach to care and the goal of improving physical and mental health;

Funding

62. Recognises that research and innovation are driven by a balance of incentives and obligations and that EU funding can play a significant role in encouraging greater investment in research into gender-specific issues and addressing the inequalities in access to treatment across the EU, including prevention, early diagnosis and long-term

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58 Lazovich, D., Vogel, R. I., Weinstock, M.A., Nelson, H.H., Ahmed, R.L. and Berwick, M., 'Association between indoor tanning and melanoma in younger men and women', *JAMA dermatology*, March 2016.

management of chronic conditions affecting women throughout their lives; stresses that there is little incentive for the private sector to invest in preventive care, and that it should therefore be a priority of the Commission and the Member States to invest in specific preventive care for women, focusing on conditions such as cardiovascular disease, diabetes, STIs and cancer;

63. Strongly supports gender mainstreaming across all EU policies and the EU budget, including the systematic consideration of the health needs of women across all stages of their lives; calls for the Commission to launch, without delay, dedicated and targeted funding calls for research and EU-related actions on gender-specific conditions and projects, in order to close the gap in sex- and gender-specific health data; recommends the establishment of an expert group on research and innovation in women's health to guide the development and collaborative implementation of the women's health research plan; stresses that such funding should prioritise public research and support access to healthcare systems for everyone, taking into account social and regional inequalities;

64. Underlines that a competitive, enterprise-driven economy is essential to sustaining high-quality healthcare and delivering better health outcomes for women; calls for policies that reward medical innovation, attract private investment and support economic growth, while removing unnecessary regulatory burdens that hold back European health businesses, researchers and the development of new treatments for women;

65. Stresses that closing gender health gaps is first and foremost a matter of fundamental rights; considers, however, the improvement of gender equality overall, but notably in the area of health research, to be a competitive opportunity for the EU and a driver of productivity and long-term fiscal sustainability; highlights that the World Economic Forum estimates that closing investment gaps in women's healthcare could boost the global economy by USD 1 trillion annually by 2040; points out that the gap in sex-specific health data constitutes a scarcity in the underlying basic science on gender-specific conditions, which constrains private-sector actors willing to invest in applied and development research; stresses that dedicating EU funding to addressing gender inequalities in health through the current and future Horizon Europe programmes, the European Competitiveness Fund and the current and future EU4Health programmes, coupled with measures to close the data gaps, could incentivise investment and boost innovation in the EU;

66. Calls for the Commission to develop and implement a specific women's health strategy, embedded in the European Pillar of Social Rights at EU level, to be implemented across the Member States, with the aim of reducing gender health gaps, boosting public research into gender-specific conditions and guaranteeing equal access to healthcare across the EU; stresses that the strategy should include specific indicators and reporting requirements regarding progress; calls on the Commission to prioritise earmarked funding under the new European Competitiveness Fund and Horizon Europe 2028-2034 (FP10) for research into women's health; calls for dedicated, ring-fenced and traceable EU funding for women's health, gender-specific conditions and sexual and reproductive healthcare, as well as for projects aiming to close sex- and gender-based data gaps; underscores the need for adequate funding because, on average, women face greater socio-economic constraints and are therefore more dependent on public healthcare and social services; highlights that the underfunding of care for gender-specific conditions can have negative impacts on Member States' economies and workforce;

67. Emphasises the critical role of civil society organisations in providing needs-based, community-level and peer-to-peer healthcare services, particularly for women facing poverty, discrimination or social exclusion; stresses that these organisations act as a bridge between patients and public institutions, and also work to advance gender equality and SRHR, collect data on women's health experiences and needs, prevent online health scams, and contribute to ensuring more gender-inclusive laws and policies in the field of healthcare; calls for their role to be explicitly acknowledged, in the upcoming European Competitiveness Fund and AgoraEU programme, through the earmarking of sufficient levels of funding for civil society organisations working on gender equality and SRHR in both programmes; expresses concern about the shrinking civic space and the decrease in funding available for civil society organisations working on women's health and rights across the EU; strongly condemns the Commission's decision to unexpectedly cut funding, including operating grants for health civil society organisations, in the EU4Health programme, and urges the Commission to immediately reinstate adequate funding for these health non-governmental organisations;

68. Calls on the Commission and the Member States to promote greater participation of women in all aspects of scientific research, both as researchers and as participants in research; recommends that measures be adopted to remove barriers to women's career progression in science and to ensure equal opportunities in access to research funding and management positions; stresses that a more gender-balanced composition of research teams and greater participation of women in clinical trials will contribute to improving the quality and reliability of health outcomes;

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69. Instructs its President to forward this resolution to the Council and the Commission.