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# Menstrual Health **Manifesto**

**Recommendations for EU policymakers** to  
achieve menstrual health equity

Manifesto prepared by the **YWHG**





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## 1. What is Menstrual Health?

**Menstrual health** refers to “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle”, according to the definition proposed in 2021 by the Global Menstrual Collective (1). The WHO refers to menstrual health as a fundamental human right, which has to be recognised as a health issue concerning the well-being and dignity of people menstruating, “with physical, psychological, and social dimensions, and one that needs to be addressed in the perspective of a life course, from before menarche to after menopause” (2,3).

With this manifesto, we aim to, firstly, show that the persistent lack of knowledge, understanding, and research surrounding menstrual health deeply affects the well-being and daily lives of all young women and young people who menstruate (PWM). Secondly, we provide concrete and tailored recommendations for European Union (EU) policymakers and member states’ governments to urgently address these gaps.

### 1.1 Why is menstrual health important for young women and all young PWM?

Menstrual health is essential for the overall well-being, bodily autonomy, and full participation in society of all PWM. For young women and PWM aged 18–35, a life stage often marked by societal pressure, fewer economic resources, educational advancement, employment, reproductive decision-making, and civic engagement, ensuring menstrual health is particularly critical (4,5). The absence of adequate support structures for menstrual health directly affects multiple aspects of well-being: from health risks linked to unsafe alternatives to school absenteeism, salary loss, mental health challenges, and social exclusion (6–8). Yet, these impacts are almost entirely absent from EU-level monitoring. Key

statistical instruments, including the EU Statistics on Income and Living Conditions (EU-SILC), the European Health Interview Survey (EHIS), the Gender Equality Index, and the OECD Better Life Index, fail to track menstruation-specific indicators. They do not measure access to menstrual products, affordability, or how menstruation contributes to inequalities in education, health, and the labour market. Without systematic, intersectional data on menstruation, policies intended to promote gender equality, decent work, health, and well-being are fundamentally incomplete. We cannot address what remains invisible.

Menstruation is not a disease, but societal misunderstanding and structural neglect of menstrual health have created unnecessary burdens and suffering for PWM. In this manifesto we recognise that not all women menstruate and not all menstruators are women. This is why we also use the term “people who menstruate” and use the terms “women and girls” to refer to the specific biological characteristics. Menstrual health is essential for all PWM across their life course, from menarche (first period) to menopause, and encompasses girls and adolescents, young women (ages 18–35), women aged 35 to menopause, trans and non-binary PWM, people with disabilities, people who are unhoused, and people in humanitarian crisis settings. Furthermore, in this manifesto, we specifically focus on young women and PWM as it is often the age of majority globally, even though the legal age may differ from region to region.

## 2. An intersectional approach to menstruation

## **2.1 Introduction: Why do we need to approach menstruation through an intersectional lens?**

Menstruation is not experienced equally by all. The stigma, access to products, healthcare, and the ability to manage periods with dignity are all shaped by overlapping factors like gender identity, race, class, disability, and migration status (9,10). This means understanding that menstrual health is about biology but also about how different aspects of a person's identity, like gender, race, ethnicity, and socio-economic status, come together to shape their experiences. Applying an intersectional lens is crucial for:

1. Understanding how systems of power and discrimination, such as sexism, racism, and classism, interact and contribute to inequalities in menstrual health.
2. Identifying structural barriers to menstrual health (e.g., period poverty, stigma, access to products and care).
3. Capturing diverse lived experiences across socioeconomic and cultural backgrounds.
4. Developing targeted interventions and inclusive policies that address overlapping systems of disadvantage (11).

## **2.2 The numbers behind menstrual inequity: making the invisible visible**

- Based on 2024 data in the EU, 4 out of 10 PWM experience menstrual poverty with a lack of access to products, facilities, information, and dignity, with higher prevalence among low-income individuals, refugees, youth, and people with disabilities (12,13).
- For unhoused women, the lack of access to sanitary facilities makes menstruation particularly difficult to manage with dignity and in safety (14).
- Nearly 34% of trans men and 24% of non-binary people live in period poverty, twice as many as cisgender individuals (16%) (15).

## **3. Negative Impact of Menstrual Conditions**

Menstruation can be accompanied by a variety of physical symptoms – such as pelvic or abdominal pain (dysmenorrhoea), heavy bleeding, fatigue, nausea, headaches, bloating, and musculoskeletal discomfort (16). In this manifesto, we understand that menstruation itself is not a disease, yet it is often accompanied by burdensome symptoms that are further exacerbated by societal pressure, expectations, and stigma. At the same time, there are conditions directly related to menstrual health that are unequivocally pathological, such as endometriosis and polycystic ovary syndrome (PCOS) (17). While these fall outside the primary focus of this manifesto, we acknowledge that limited awareness, both among PWM and healthcare providers, as well as systemic shortcomings and lack of research, often contribute to delays in diagnosis. Too often, the symptoms of these conditions are dismissed as a ‘normal’ part of the menstrual experience.

Menstrual symptoms affect an estimated 16-91% of PWM, with 2–29% experiencing severe pain that interferes with daily life (18). Such pain is a leading cause of school and work absences across Europe. For instance, in European university settings, 78–80% of students report dysmenorrhea, with many noting fatigue, stress, headaches, and reduced energy during their period (Gambadauro et al., 2024). In addition to these cyclical physical symptoms, many individuals, about 48% globally, experience psychological symptoms of Premenstrual Syndrome (PMS), with some, about 3–8% experiencing severe cases of Premenstrual Dysphoric Disorder (PMDD), which includes pronounced mood disturbances, emotional lability, physical discomfort, and significant functional impairment (19,20).

Despite their prevalence and impact, menstrual symptoms are rarely recognised as burdensome, and conditions such as PMS and PMDD remain under-diagnosed and under-treated in clinical practice across the EU (21–23). Stigma, lack of awareness among healthcare providers, and absence of standardised care pathways often force individuals to suffer in silence and self-manage their symptoms.

Menstrual health disorders are also an under-recognised driver of socioeconomic burden, particularly for young women in academic and professional settings. In a study of nursing students in Spain, over 60% reported absenteeism from classes due to menstruation-related symptoms (18). The study also highlights presenteeism, meaning attending academic or clinical responsibilities while symptomatic, as a hidden but significant issue.

Similarly, a large-scale study conducted in the Netherlands found that productivity loss due to menstruation-related symptoms averaged 8.9 full working days per woman per year, primarily due to presenteeism rather than absenteeism (18). Only 13.8% of women reported missing work due to menstrual symptoms, but more than 80% reported reduced performance while working. Young women (under 21) were found to be three times more likely to miss work or school due to menstrual symptoms, highlighting an age-related vulnerability with long-term implications for workforce development. Chronic menstrual symptoms are often normalised, leading to under-reporting and under-treatment. The majority of women manage symptoms on their own, rarely seeking professional medical help. This contributes to a continuous neglect of menstrual health as a legitimate factor affecting education and labour productivity. Moreover, institutional structures, such as rigid schedules, lack of flexible accommodations,

and absence of supportive policy, further entrench these burdens.

#### **4. Women's Health: underresearched and underfunded**

Research on menstrual health has only recently started to gain attention. A simple search by title and abstract on PubMed reveals that, as of September 2025, the search for “premenstrual syndrome” produces 5,626 results, versus 31,316 results on “erectile dysfunction”, despite both being very common conditions across the life course, with a potential severe impact on the wellbeing of the person affected. This reflects a broader issue, namely that women’s health research lacks funding, and, where it is funded, the amount is not aligned with the burden of diseases. As noted in an analysis published by Smith (24), using the latest National Institutes of Health information on funding and burden of disease, migraines, headaches, endometriosis, and anxiety disorders, for example, which disproportionately affect women, all attract less funding in proportion to the burden they exert on the US population than other conditions do. A striking example remains endometriosis, which affects roughly 10% (190 million) of women and girls of reproductive age globally (25). It is a chronic disease associated with severe, life-impacting pain during periods, sexual intercourse, bowel movements and/or urination, chronic pelvic pain, abdominal bloating, nausea, fatigue, and sometimes depression, anxiety, and infertility. However, a recent study by Viganò (26), documented the significant underinvestment in endometriosis research projects across the EU’s framework programmes, where a staggeringly low 27 out of 145,983 projects funded in total (0.02%) were found to be related to endometriosis. This lack of financial support perpetuates a cycle of knowledge gaps and limited awareness, contributing to delayed diagnosis and inadequate treatment options for those affected.

## 5. Research on menstrual health

Clinical trials, central to medical innovation, have long overlooked menstrual health and PWM. A 2023 review found that of 94 tools developed to assess menstrual health, only 3 were robust enough for clinical trial use (27). Heavy menstrual bleeding, affecting up to 20% of PWM, still lacks consistent outcome measures across studies (28). This glaring disparity highlights a critical gap: conditions affecting a significant portion of the population remain vastly under-researched, limiting progress in diagnosis, treatment, and patient care across Europe.

Historically, women and PWM have been sidelined in research. In 1977, the U.S. FDA barred women of childbearing potential from participating in early-phase clinical trials due to fears of foetal harm after the thalidomide tragedy (29). Although never formally adopted in the EU, similar ethical caution discouraged inclusion, and the bias lingers today. Women remain under-represented in early-phase clinical trials, with a study finding that between 2013 and 2015, only 29–31% of Phase 1 participants were women (30,31). Another recent study found that, up until 2017, women were still inadequately represented in randomised clinical trials across several major medical fields, including cardiovascular diseases, neoplasms, endocrine disorders, respiratory diseases, bacterial and fungal infections, viral diseases, and digestive system diseases (32).

A review of the EU Clinical Trials Register starkly illustrates the under-representation of menstrual health in clinical research (33). Out of more than 44,000 registered trials, only 85 focus on endometriosis, 54 on PCOS, and a mere 16 on menorrhagia. Similarly, a review of the CORDIS database revealed 39 projects on menstrual health, of which only 4 were funded before 2020 (34). For endometriosis,

55 projects are recorded, of which 8 date from before 2020, which further underscores the persistent underinvestment in this field.

When women are included, menstrual status is rarely recorded, let alone analysed. The menstrual cycle and known hormonal fluctuations in women are often seen as confounding variables that complicate data interpretation, deterring inclusion, despite their direct impact on drug metabolism, immune response, and symptom variability (34, 35). As a result, critical safety and efficacy questions, such as how a drug interacts with hormonal shifts, are routinely left unanswered. The EMA's delayed response to reports of menstrual disturbances after the Pfizer-BioNTech COVID-19 vaccine, adding heavy menstrual bleeding as a side effect only in 2022, is a stark reminder of what happens when menstrual health is ignored in trial design (33).

While the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) guidelines reference sex and gender, for example, acknowledging menstrual status (E3) and requiring contraception for women of childbearing potential (E8, M3[R2]), they lack dedicated guidance for including perimenopausal and postmenopausal women or addressing menstrual health in trial design (37). Likewise, the EU Clinical Trials Regulation No. 536/2014 provides protections for pregnant and breastfeeding women but does not specifically consider (38). These gaps, combined with added procedural burdens like pregnancy testing and contraception verification, contribute to persistent recruitment biases (32).

## 6. Economic impact and period poverty

As defined in the European Parliament Think Tank Briefing, 'Addressing Menstrual Poverty

in the EU', menstrual poverty is the insufficient access to menstrual hygiene products and facilities (12). According to the report, menstrual poverty affects an estimated 10 % of the half of the EU population who menstruate, with a higher prevalence among migrants, refugees, people with a low income, young people, and people with disabilities.

Across the EU, menstrual products face high tax rates that treat necessities as luxury items. Current VAT rates range dramatically: Hungary imposes 27%, Denmark and Sweden 25%, and Greece 24% (39). This constitutes what scholars term "a tax on female bodies" that burdens individuals with biological characteristics, not choice (40).

The discriminatory nature becomes clear when compared to preferential tax treatment for other products. In Italy, menstrual products, like expensive truffles and collectible stamps, are taxed at 10%, while bread and books receive 4%, revealing a profound misunderstanding of why menstrual products should be considered as essential.

Recent reforms show progress in Germany, where VAT was reduced from 17% to 7% and in 2020, Spain, Poland, and Luxembourg, where VAT is 3-5%. Ireland, Cyprus, and Malta achieved zero VAT rates (39).

Research across 17 European countries reveals that VAT cuts lead to persistent price reductions: 3-5% in the short term, 6-8% long term. Approximately 41% of VAT reductions pass to consumers, with stronger benefits for low-income households (41).

Based on a 2025 survey by Opinionway Healthcare and Règles Élémentaires, 4 out of 10 PWM are affected by period poverty in 2024, with 34% of menstruating women opting out of purchasing menstrual products due to financial reasons and 13% having to forgo buying an essential item such as food to afford them (13). National studies confirm this severity: in Belgium, 12% of girls and women aged 12-25 cannot afford menstrual products, rising to 45% among those living in poverty; in Germany, 23% report monthly menstruation

expenses as a financial burden; in Spain, specifically Barcelona, over 15% of young women have experienced period poverty (12).

## 7. Period Product Safety

The safety of period products is an emerging concern, with a growing body of evidence detecting potentially harmful substances across product types, including toxic metals such as lead, for which there is no established "safe" exposure level (42,43). These findings are especially troubling given that vaginal and vulvar tissue is highly permeable and absorbs chemicals without first-pass metabolism, raising concerns about the potential of endocrine-disrupting chemicals (43).

In response to this, the Food and Drug Administration commissioned an independent literature review and an internal laboratory study in September 2024 specifically to measure metal leaching under conditions mimicking normal use, acknowledging that this foundational question had not yet been answered (44).

Nevertheless, significant evidence gaps remain. As of 2025, it has not been established whether or to what degree these substances leach out of products during use, are absorbed through the vaginal mucosa, or reach systemic circulation, the critical chain of evidence needed to confirm harm. Further evidence is urgently needed on the possible health implications of these findings, including the bioaccessibility of metals in tampons, and their absorption, both local and systemic, through vaginal tissue (45). This concern is compounded by a significant regulatory gap: the International Organization for Standardization has noted that menstrual products lack the harmonised global safety standards that apply to other body-contact products, such as condoms and wound dressings (46). Organisations such as Règles Élémentaires are already doing excellent work

in this space, and, while the issue falls outside the scope of this manifesto, we encourage readers to consult their website and social media channels for further information (47).

## **8. Recommendations for EU Policymakers**

Achieving menstrual health means that women, girls, and all PWM are supported throughout their life course to:

- Receive comprehensive, age-appropriate, and accessible education on the menstrual cycle and self-care for all, not only women, girls, and PWM.
- Manage menstruation in a way that respects their preferences and ensures hygiene, comfort, privacy, and safety.
- Have universal access to timely diagnosis, treatment, and care for menstrual-related discomforts and disorders, such as dysmenorrhea or endometriosis, including pain relief, tools for self-care, and support from healthcare providers.
- Live in a supportive and stigma-free environment that empowers people to make their own choices about their bodies and care for their needs as they see fit, in which menstruation is recognised as a normal and healthy biological process, not as something shameful or hidden.
- Exercise autonomy in deciding whether and how to engage in all aspects of life, including social, cultural, educational, economic, and political activities, throughout all phases of the menstrual cycle, free from menstrual-related exclusion, restrictions, discrimination, coercion, or violence.
- Experience menstrual health as a matter of equity and justice, with the elimination or reduction of taxes on menstrual products, and the provision of free or subsidised supplies to those facing economic hardship.

This is why we call on EU policymakers to:

1. Urgently integrate menstrual health indicators into all relevant EU and national monitoring systems – covering not only access to products but also the full spectrum of menstruation's impact on education, work, income, health, and social participation. This will be crucial in advancing meaningful, evidence-based policies that protect the rights and well-being of all PWM.
2. Encourage Member States to formally include psychological aspects of menstrual health such as PMS and PMDD within public health monitoring and women's health initiatives under the upcoming EU Strategy for Women's Health. Align with EU mental health and gender mainstreaming priorities, reinforcing ongoing efforts under EU4Health and EIGE initiatives.
3. Encourage Member States to integrate menstrual health into national workplace policies through protected leave and flexible work options, aligned with other chronic condition accommodations, especially in line with the new Action Plan on the implementation of the European Pillar of Social Rights.
4. Allocate dedicated funding in the next Multiannual Financial Framework 2028-2034 for research on menstrual health, prioritising interdisciplinary studies on menstrual disorders, the fair use of AI when it comes to menstrual cycle tracking apps and devices, and the intersection of menstruation with mental health, education, and workplace outcomes.
5. Support the creation of an EU-wide menstrual health research observatory, tasked with mapping existing gaps, funding priorities, and gender biases in biomedical research on menstruation and menstrual-related conditions.
6. Mandate the collection and reporting of sex- and gender-disaggregated data across all EU-funded research and real-world

evidence (RWE) studies, including menstrual status where relevant. Leverage the European Health Data Space (EHDS) to integrate and analyse these variables at scale, enabling more precise, inclusive insights into treatment outcomes and ensuring regulatory decisions reflect the full diversity of the population.

7. Leverage the review of the EU Clinical Trials Regulation, under the upcoming EU Biotech Act, to ensure systematic inclusion of women and PWM in early-stage clinical trials, as well as the adequate integration of menstrual phase, ovulatory status, and hormonal contraceptive use, in study design and implementation.
8. EU member states should eliminate VAT on menstrual products, recognising them

as essential health items. While some Member States like Ireland, Cyprus, and Malta have achieved zero VAT rates, others like Hungary (27%), Denmark and Sweden (25%) still apply standard rates (12). The EU's 2022 VAT Directive amendment allows Member States this flexibility and they must use it.

9. All schools, universities, and educational facilities should be legally required to provide free menstrual products in restrooms. Following successful models in Ireland, France, and parts of Spain (12), institutions should ensure consistent supply chains to prevent educational disruption due to menstruation.

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