Migraine in Women

Overlooked and sub optimally managed: a call to action

The European Migraine & Headache Alliance (EMHA), in collaboration with a Migraine in Women Scientific Committee (see "who was involved" section below) and Prescient Healthcare Group, launched the Migraine in Women survey across 13 European countries. The results obtained from 5,410 screened-positive respondents point to three clear significant issues requiring action:

- underdiagnosis: around 42% of screened-positive respondents reported no formal migraine diagnosis
- limited awareness of menstrually-related migraine: around 2 in 3 migraine sufferers reported a pattern between attacks and their menstrual cycle/bleeding pattern, yet only ~59% had ever discussed hormonal triggers with a healthcare professional, and
- suboptimal therapeutic management: only 16% rated current treatments "very effective", and 68% reported never being offered tailored options for menstrual or menopausal attacks

These findings describe a pattern of avoidable burden that requires urgent action from European and country-level policy makers, clinicians, and patients.

Migraine is a common and disabling neurological condition: global prevalence is estimated at ~14-15%, and it is a leading cause of years lived with disability (YLDs) (1). It disproportionately affects women, with one-year prevalence around ~1 in 5 women vs ~1 in 17 men (1). A major contributor to women's burden is hormonally influenced migraine: 50–60% of women with migraine report increased attack frequency around the perimenstrual period, and these attacks are often more severe, longer lasting, and in some cases more treatment-resistant than non-menstrual episodes (2,3).

Migraine significantly affects how people work, parent, study, and participate in society. In Europe, the EMHA Migraine & Stigma survey (2023; 4,210 responses) found that 57% of responders reported experiencing >8 migraine days per month and 80% reported difficulties completing work tasks or that their career had been negatively affected (4,5). The same survey found that 93% of respondents believe migraine is not well understood by the public, underscoring that it remains too often normalised, under-recognised, and undertreated across Europe (4).

The EMHA, together with the Migraine in Women Scientific Committee and Prescient Healthcare Group, believes that acting on the Migraine in Women survey findings can deliver fairer, more effective care. This manifesto translates the EMHA Migraine in Women survey findings into practical actions for policymakers and health system leaders, clinicians (general practitioners (GP), gynaecologists, headache specialists and neurologists), and patient advocacy groups.

The evidence base

The survey analysed responses from 5,410 women across 13 European countries; respondents were positively identified using the validated 3-item ID Migraine™ screener (5).

Underdiagnosis

- ~42% of screened-in respondents have not received a formal migraine diagnosis (country range 31-55% undiagnosed)
- 35% say their burden has not driven them to visit a doctor, despite >80% reporting pain at or above 6/10, with 10 being the "worst possible pain"
- Seeing a doctor is associated with a ~4× higher likelihood of formal diagnosis (75% vs 17%)
- Among those who sought care, diagnosis is highest when a neurologist is involved (~90%), vs ~75% with gynaecologist and ~70% with GP

Lack of awareness of menstrually-related migraine

- ~2 in 3 report a potential pattern between attacks and their menstrual cycle
- Among those commenting on severity/duration, ~9 in 10 perceive their menstrual migraine attacks to be more painful and/or longer lasting
- While 76% have discussed headaches with a healthcare professional, only ~59% have discussed hormonal triggers
- 72% want more education on hormone–headache links

Suboptimal therapeutic management

- Burden remains high: 82% rate current pain ≥6/10
- Only 16% rate current treatments as "very effective"
- 68% were never offered tailored treatment for menstrual or menopausal attacks, even though, when tailored options are offered, ratings of "very effective" treatment responses were 2x higher (31% vs 17%)
- Menopause is not an "automatic cure" for migraine: although ~1/3 reported less frequent attacks, only ~1% reported headaches disappeared after periods stopped

Three pillars for action

1) Recognise

Increase awareness of healthcare professionals about migraine linked to hormonal changes

Hormonal patterns are common; many women report that attack timing, severity, or treatment response predictability changes with the menstrual cycle, bleeding pattern, hormonal therapies (contraception/HRT), and life-stage transitions such as postpartum and perimenopause. However, these links are not consistently discussed. Recognition is the gateway to timely diagnosis, appropriate escalation, and tailored care.

Calls to action

Policy makers / health system leaders

- Position migraine related to hormonal changes as a women's health awareness priority within national headache and women's health agendas
- Support low burden prompts and tools inside routine women's health touchpoints, including contraception consults, heavy menstrual bleeding/endometriosis pathways, preconception care, pregnancy/postpartum follow-up, perimenopause/menopause reviews
- Support targeted education on hormone-headache links for GPs and gynaecologists, including what specific questions can be helpful and how answers should influence management or referral e.g., around migraine severity / frequency / duration / current treatment, hormonal history, available treatment options and eligibility to prescribe, etc

Clinicians (GPs, gynaecologists, headache specialists, neurologists)

- Use a brief check-in for hormonal patterns when migraine is raised:
    - Timing (cycle timing *and/or bleeding pattern*), severity/duration, associated symptoms (nausea, photosensitivity, phono-sensitivity, and/or aura i.e., visual changes, tingling, speech disturbance), medication response
    - Perimenopause transition changes, postpartum changes
    - Contraception/hormone replacement therapy (HRT) changes and whether bleeding is suppressed or irregular
- Set expectations and route appropriately: if migraine related to hormonal changes isn't something you manage often, let the patient know what you can address today, and be clear about who you would refer them to (e.g., neurology/headache clinic, gynaecology, women's health service) and when (using the referral triggers below)

Patient advocacy groups

- Run simple education campaigns on:
    - What migraine related to hormonal changes can look like (including perimenopause and with hormonal therapies / contraception)
    - What to track (timing, severity/duration, disability, response)
    - Self-tracking and how to ask for escalation when needed
- Offer a one-page "appointment prep" tracker: a simple diary that captures 4 items:
    - Timing (cycle day and/or bleeding window)

        - Bleeding: none / spotting / light / moderate / heavy (optional, if relating to menstruation)
        - Cramps: none / mild / moderate / severe (optional, if relating to menstruation)
        - Hormone exposure: contraception or hormone therapy taken / change that day e.g., combined pill, progestin-only pill, patch/ring/injection/implant, hormone-releasing intrauterine system (IUS), HRT; dose change / missed dose)
    - Headache intensity (none, mild, moderate, severe), duration of attack (hours / days), and associated symptoms (nausea, photophobia, phono-phobia, and/or aura i.e., visual changes, tingling, speech disturbance)
    - Disability (missed work/school, bed days)
    - Medication used and response:
    - Acute medication used (name, dose, when taken after headache starts)
    - If relevant, preventive treatment used (name, dose, and/or past preventive(s) tried and whether they worked / had associated side effects)
    - Pain response i.e., whether pain is mild or gone within ~2 hours, and/or whether pain returns within 24–48 hours
    - Whether the most bothersome symptom (nausea, photophobia, phonophobia, aura) is mild or gone within ~2 hours
    - Need for additional medication (and when)
    - Any side effects that limited use or made them avoid repeating the medication

2) Diagnose

Improve timely diagnosis when migraine is suspected

With around 42% of respondents reporting no formal diagnosis, there is a pressing need in Europe to improve awareness for identifying women with potential migraine, ensure timely confirmatory diagnosis, and establish clear referral pathways to facilitate access to optimal therapy when required

Calls to action

Policy makers / health system leaders

- Promote awareness of migraine as a diagnosable and treatable neurological condition and support simple assessment tools that can be used when patients present with recurrent headache or suspected migraine
- Support practical “first contact” tools that help clinicians progress efficiently, such as brief screeners, red-flag checklists, and short diary templates to bring to follow-up or referral

- Clarify referral pathways and responsibilities (what can be managed in primary care vs what should be escalated), so patients don't cycle through multiple clinicians without a plan
- Reduce inequity by ensuring:
    - Greater access to migraine-trained clinicians e.g., through tele-neurology where shortages exist
    - Monitor / audit equity around diagnosis rates by region / population group, referral wait times, and follow-up completion

Clinicians (GPs, gynaecologists, neurologists)

- When migraine is suspected, consider using a brief, validated screener (e.g., the 3-item ID Migraine™) to support timely recognition and reduce avoidable misclassification
    - Consider using the EMHA Migraine Scoring System (EMHA-MSS) (7-9) as a quick way to capture migraine severity/burden, support patient-clinician conversations, and help flag higher-burden patients who may warrant review/escalation alongside clinical judgement
    - Before referral (where feasible), invite patients to complete a short headache diary (at least 4 weeks; and if the aim is to assess hormonal influences, a minimum of ~3 months / three menstrual cycles) before referral or review, capturing daily headache/migraine frequency, severity, duration, and acute medication response, alongside a simple hormonal context, including bleeding days and daily hormone use (type/dose where possible), and any interruptions/missed doses or changes (cycle/bleeding pattern where relevant, perimenopause changes, contraception/HRT changes, hormone-releasing intrauterine system where applicable).
    - This helps specialist appointments focus quickly on diagnosis and tailored management
- Where local guidance and prescribing rules allow, and where the patient meets migraine criteria, GPs and women's health clinicians can often start appropriate migraine-specific acute treatment rather than waiting for a neurology appointment (11), while still referring or escalating if attacks remain frequent, severe, or hard to control
    - *Practical scope will vary by country and pathway*

Patient advocacy groups

- Use data-backed messaging to encourage appropriate care-seeking:
    - In the survey, those who saw a clinician were ~4× more likely to have a formal diagnosis
- Raise awareness / education around "knowing your triggers + when to seek care", including:

- When attacks are severe/disabling
- Changing rapidly (e.g., perimenopause or during pregnancy/postpartum)
- Current treatment is not working

3) Treat

Improve therapeutic management and ensure tailored options are considered across life stages

Only 16% of survey respondents rate treatments "very effective", and 68% were never offered tailored options for menstrual/menopausal attacks.

Calls to action

Policy makers / health system leaders

- Ensure equitable access to evidence-based acute and preventive options and clinician time to tailor plans
- Commission and disseminate concise, primary-care-ready tools so GPs can manage suspected migraine related to hormonal changes confidently within scope, and refer efficiently when specialist input is needed:
  - Menstrually-related migraine management protocols
  - Perimenopause migraine management protocols
  - Menopause migraine management protocols (including guidance on what to do if patient is on HRT, including initiation/changes and escalation triggers)
  - Pregnancy/postpartum migraine risk and escalation protocols
- Review prescribing limitations that may delay access to evidence-based migraine treatments in some countries, and ensure clinicians have the practical education and referral pathways needed to route patients efficiently to headache specialists when escalation is required
  - Focus on reducing avoidable delays for patients who could be managed in primary care within existing rules, while prioritising specialist capacity for complex cases

Clinicians (GPs, gynaecologists, neurologists)

- Treat ongoing migraine burden responsibly across the life course, including after menopause, rather than assuming symptoms will resolve
  - *While some sufferers report fewer attacks over time during menopause, many continue to experience significant burden*
- Be aware that menstrual-related and perimenopausal patterns may require tailored management approaches and proactive follow-up to assess response

- Use local prescribing guidance confidently where migraine criteria are met, starting appropriate migraine-specific acute treatment when within scope rather than waiting for neurology referral. Ensure patients receive clear, practical instructions on how and when to take prescribed acute medication (including early use, dosing, maximum use limits, and what to do if the first dose is ineffective). Escalate if attacks remain frequent, severe, or hard to control (as per the below outlined referral guidance).
- Acknowledge evidence gaps and support further research and better real-world data on migraine across perimenopause/menopause (and pregnancy/postpartum), so future guidance and care pathways can be better informed
- When considering hormonal contraception or hormone therapies, routinely document whether migraine occurs with aura, as this may influence risk-benefit discussions and the choice of regimen

Patient advocacy groups

- Encourage patients to ask for a personalised plan when attacks concentrate around menstrual or menopausal windows:
    - "What (if anything) should I do differently for these attacks?"
    - "What would be the sign that it's time to speak to a physician about my treatment (e.g., add a rescue option, adjust dosing, etc)?"
- Provide patient-facing explainers that reduce stigma around hormonally triggered migraine and support shared decision-making

European Union (EU)-level actions to drive equity

1. Increase the level of awareness and clinical relevance given to migraine in women, supported by simple assessment tools that help clinicians act efficiently when migraine is suspected
2. Draft easy-to-use awareness prompts and materials at key touchpoints so hormonal patterns are more likely to be recognised when headache or migraine is already being discussed e.g., at contraception consultations, heavy menstrual bleeding/endometriosis pathways, perimenopause/menopause reviews, and pregnancy/postpartum follow-up
3. Establish a multidisciplinary working group (GPs, gynaecologists, neurologists, pharmacists, and where relevant nurse specialists) to agree and socialise a shared patient pathway (who does what, where, and when), supported by practical, clinician-friendly education on recognition, first-line management within scope, and clear review/escalation thresholds
4. Use a clear referral trigger framework to support consistent escalation

5. Use proportionate monitoring using existing data (where available): time to diagnosis, access to appropriate care, and follow-up/response-to-treatment checks to support learning and improvement of care

Country-level calls to action

Underdiagnosis

- Priority action: improve consistency when migraine is suspected using brief tools (e.g., short screeners), confirm diagnosis where appropriate, and agree clear escalation routes
- System lever: Define and implement a standardised patient pathway with clear responsibilities (who manages what at each step) and explicit escalation/referral triggers (when to step up treatment, when to refer). Use existing data (where available) to identify and address variation across regions/settings.

Care-seeking gaps

- Priority action: public awareness that encourages appropriate care-seeking and helps people recognise when symptoms warrant a clinical conversation

Access/engagement variation

- Priority action: share practical learnings on what supports earlier recognition, referral, and more effective first-line management
- System lever: act as informal "learning sites" for piloting EU-facing tools (e.g., patient diary templates, referral triggers) and sharing outcomes

Practical "referral trigger" guidance (for clinicians and patients)

A GP or gynaecologist should consider referral (or collaboration in the case of gynaecologist) when any of the following are present:

- Diagnostic uncertainty or neurological red flags, guided by the SNNOOP10 list of red and orange flags for secondary headaches in clinical practice (7)
- Severe disability, frequent attacks, or poor response to initial acute therapy, aligned with EMHA-MSS Level 4 (scores 10-15), often characterised by frequent headache days and/or severe attacks and/or unreliable acute response (7-9)
- Suspected menstrually-related migraine with predictable high-burden windows needing tailored planning
- Perimenopause with rapidly changing pattern or worsening burden
- Pregnancy/postpartum high pain or functional impairment
- Repeated healthcare visits ≥2 healthcare contacts for the same headache problem within 3 months (GP/urgent care/ED) without a clear management or review / check-in plan

What success looks like (measurable within 12–24 months)

- Higher formal diagnosis rates (reduce the 42% diagnosis gap)
- Fewer people staying outside care despite burden (reduce the 35% non-care seeking share of sufferers)
- More people discuss hormonal triggers with clinicians (reduce the 41% gap)
- More tailored hormonal treatment offered, where relevant (reduce the 68% "never offered")
- Improved perceived treatment effectiveness (grow the 16% "very effective" treatment response)

Closing statement

Migraine in women, including migraine related to hormonal changes, can be recognised earlier, diagnosed more consistently when suspected, and managed more effectively. Lasting change comes from raising awareness of the condition's relevance, equipping clinicians and patients with practical tools that fit into current workflows / systems to support timely decisions, using clear referral triggers, and building in routine check-ins so treatment can be adjusted early and consistently across countries.

Who was involved?

About the European Migraine & Headache Alliance (EMHA)

The EMHA is a non-profit umbrella organisation representing patient associations across Europe, working to improve recognition, care, and quality of life for people living with migraine and other headache disorders. EMHA brings together national patient groups to elevate lived experience into evidence, advocacy, and policy action at European level.

Executive Director Elena Ruiz de la Torre is the key EMHA representative and leader for this Migraine in Women project.

Migraine in Women Scientific Committee

The Migraine in Women Scientific Committee provided independent clinical and scientific oversight for the survey development, interpretation, and translation of findings into practical, Europe-relevant calls to action. It includes:

- Prof. Patricia Pozo-Rosich
  Neurologist and Head of Section of the Neurology Department, Director of Headache and Craniofacial Pain Clinical Unit and the Migraine Adaptive Brain Center at the Vall d'Hebron University Hospital in Barcelona. She is also coordinator of the Brain, Mind &

Behaviour eCORE and Group Leader and Principal Investigator of the Headache Research Laboratory at the Vall d'Hebron Institute of Research (VHIR).

- Prof. Peter J. Goadsby
  Neurologist and internationally recognised headache specialist with academic leadership roles spanning the UK and US. He is Dean, Division of Biomedical Sciences, King Abdullah University of Science and Technology, Saudi Araba, and director at the National Institute for Health and Care Research (NIHR)-King's Clinical Research Facility, King's College London, UK.

- Prof. em. Dr. med. Gabriele S. Merki-Feld
  Gynaecologist specialised in reproductive endocrinology, contraception, and menopause at the University of Zurich; University Hospital Zurich. She has worked extensively on migraine related to hormonal changes in both clinical practice and research, with a particular focus on how hormonal changes and hormonal treatments (e.g., contraception and menopausal hormone therapy) interact with migraine patterns and management.

- Prof. Rossella E. Nappi
  Full Professor of Obstetrics & Gynaecology, Chief of the Research Center for Reproductive Medicine and Gynecological Endocrinology-Menopause Unit, IRCCS San Matteo Foundation, University of Pavia (Italy). Prof. Nappi has clinical and research leadership in reproductive endocrinology and menopause, with a long-standing focus on women's health across the life course.

- Prof. Anne MacGregor
  Specialist in headache and women's health at Barts Health NHS Trust. Her extensive research has led to over 200 publications She has authored several books on the subject and has been instrumental in developing diagnostic criteria for menstrually-related migraine, adopted by the International Headache Society in 2004. Her contributions have been recognized with awards such as the Elizabeth Garrett Anderson Award in 2002 and the Special Recognition Award with Honorary Life Membership from the International Headache Society in 2011.

- Dr. Emile G. M. Couturier
  Neurologist and headache clinician at the Neurologie Centrum Amsterdam, where he balances clinical practice with innovative research. His work focuses primarily on migraine and cluster headache. Beyond the clinic, he serves as Chair of the Dutch Headache Centers and Secretary of the Dutch Headache Alliance, leading efforts to improve headache care nationwide.

- Dr. David P. B. Watson (NHS Grampian)
  GP with an extended role in headache care at Hamilton Medical Group in Aberdeen (Scotland). He has over 20 years' experience as a GP with an extended role in headache at Aberdeen Royal Infirmary. He has made several guideline and education contributions to improve migraine management pathways in collaboration with The Migraine Trust,

National Health Service (NHS) Grampian, and the British Association for the Study of Headache.

About Prescient Healthcare Group

Prescient Healthcare Group is a specialist partner to global biopharma, providing evidence-informed strategic support across the drug life cycle (from early development to later lifecycle stages)

Prescient contributors to this project

- Dr. Olga Fidalgo González (Vice President of Medical, Prescient)
  Medical doctor with >20 years of senior advisory leadership experience in biopharma strategy
- David Hurtado Niubò (Associate Director of Medical, Prescient)
  Advisory lead supporting evidence synthesis and translation into practical tools and implications
- Carmen Fairley Gil-Alberdi (Associate Consultant of Medical, Prescient)
  Project team supporting survey development, launch, analysis, synthesis of findings, and drafting of the manifesto and calls to action

References (Vancouver style):

1. Steiner TJ, Stovner LJ. Global epidemiology of migraine and its implications for public health and health policy. Nat Rev Neurol. 2023;19(2):109-117. doi:10.1038/s41582-022-00763-1
2. Allais G, Chiarle G, Sinigaglia S, Benedetto C. Menstrual migraine: a review of current and developing pharmacotherapies for women. Expert Opin Pharmacother. 2018;19(2):123-136. doi:10.1080/14656566.2017.1414182
3. Loder EW. Menstrual migraine: pathophysiology, diagnosis, and impact. Headache. 2006;46 Suppl 2:S55-S60. doi:10.1111/j.1526-4610.2006.00555.x
4. European Migraine & Headache Alliance (EMHA). EMHA Migraine & Stigma survey: Final analysis. Brussels: EMHA; 2023 Nov 30.
5. Goadsby PJ, Ruiz de la Torre E, Maassen van den Brink A, Irimia P, Mitsikostas DD, Ashina M, et al. Migraine stigma and general knowledge of migraine: A cross-sectional European survey. Cephalalgia. 2025;45(9):3331024251368251
6. Lipton RB, Dodick D, Sadovsky R, Kolodner K, Endicott J, Hettiarachchi J, Harrison W; ID Migraine validation study. A self-administered screener for migraine in primary care: the ID Migraine validation study. Neurology. 2003;61(3):375-382. doi:10.1212/01.WNL.0000078940.53438.83

7. Pozo-Roisch P, Caronna E, Ruiz de la Torre E, Goadsby PJ, Ashina M, Irimia P, et al. Evaluating a new migraine scoring system against established metrics. Cephalalgia. 2024;44(12):50-1.
8. Goadsby PJ, Irimia P, Terwindt G, Mitsikostas D, Ashina M, Maassen Van Den Brink A, et al. Development of the EMHA Migraine Scoring System. Cephalalgia. 2025;45(1S):198-9.
9. European Migraine & Headache Alliance (EMHA). EMHA Migraine Scoring System (EMHA-MSS) [Internet]. Brussels: EMHA; 2025 [cited 2026 Jan 29]. Available from: https://scoring.emhalliance.org/
10. Do TP, Remmers A, Schytz HW, Schankin C, Nelson SE, Obermann M, et al. Red and orange flags for secondary headaches in clinical practice: SNNOOP10 list. Neurology. 2019;92(3):134-144. doi:10.1212/WNL.0000000000006697
11. Tepper SJ, Dahlof CG, Dowson A, Newman L, Mansbach H, Jones M, et al. Prevalence and diagnosis of migraine in patients consulting their physician with a complaint of headache: data from the landmark study. Headache. 2004;44:856-64