ALLIANCE FOR HEADACHE DISORDERS ADVOCACY

November 16, 2026

President Donald J. Trump
First Lady Melania Trump
The Honorable Robert F. Kennedy, Jr., Secretary of Health and Human Services
The Honorable Stephen Miller, White House Chief of Staff
The Honorable Susie Wiles, Assistant to the President and Director of Political Strategy and Outreach
Dr. Jay Bhattacharya, Director of the National Institutes of Health
Members of the White House Women's Health Task Force
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear President Trump, First Lady Trump, Secretary Kennedy, Mr. Miller, Ms. Wiles, Dr. Bhattacharya, and members of the White House Women's Health Task Force:

We write on behalf of the Alliance for Headache Disorders Advocacy (AHDA) and the undersigned organizations to welcome President Trump's October 19 Executive Order, "Advancing Women's Health to Improve Outcomes in All Phases of Life." We appreciate the President's action and First Lady Melania Trump's leadership in bringing attention to women's health. The order creates a timely opportunity to strengthen research, improve prevention and early diagnosis, and move evidence into care for women and girls. Specifically, we respectfully ask that migraine and headache disorders be a central part of the Women's Health Division and Task Force.[1]

The Executive Order recognizes that women's health needs change from childhood through pregnancy, midlife, menopause, and aging. It directs federal agencies to coordinate research and care, address conditions that disproportionately affect women, and move evidence into clinical practice. Migraine and headache disorders sit at the center of those priorities; they are common, disabling, and costly, and their effects often correspond to the stages of a woman's life. We urge the Women's Health Division and Task Force to give these diseases a visible place in their agenda and to work with the organizations and patients who know this burden firsthand. We also urge support for the bipartisan HEADACHE Act, H.R. 5536, which offers a ready framework for sustained federal coordination, a core function of the Task Force.

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[1]Executive Order, "Advancing Women's Health to Improve Outcomes in All Phases of Life," October 19, 2026, especially sections 1–4; The White House, "First Lady Melania Trump Champions New U.S. Women's Health Initiative," October 19, 2026.
https://www.whitehouse.gov/presidential-actions/2026/10/advancing-womens-health-to-improve-outcomes-in-all-phases-of-life/ ;
https://www.whitehouse.gov/briefings-statements/2026/10/first-lady-melania-trump-champions-new-u-s-womens-health-initiative/

Migraine and headache disorders disproportionately affect women's health, work, and disability

Migraine and other headache disorders are complex neurological diseases, not simply head pain. Migraine attacks can bring severe pain, nausea, sensitivity to light and sound, visual or cognitive symptoms, and days of reduced function. They interrupt a student's attendance, a parent's caregiving, a worker's shift, an employee's income, and time with family. More than 40 million Americans live with migraine alone; many more are affected by other headache and facial pain disorders. These are not occasional inconveniences. For people with frequent or severe attacks, migraine can shape daily life and limit participation at school, at work, and at home.[2]

The burden falls disproportionately on women, particularly during the years when many are building careers and raising families. A systematic review of U.S. population studies found that migraine prevalence ranged from 17.1% to 19.2% among women and 5.6% to 7.2% among men.[3] The 2023 Global Burden of Disease analysis found that disability from headache disorders was more than twice as high among females as males, with burden especially high among young adults and females.[4]

Migraine can begin in childhood and change over time. For some people, episodic migraine becomes chronic and more disabling. A U.S. longitudinal study found that ineffective acute treatment was associated with greater risk of new-onset chronic migraine. Early recognition and access to effective care matter: women and girls should not have to wait until attacks become more frequent or disabling before migraine is taken seriously.[5]

Migraine can take a serious toll on mental health, particularly when attacks remain uncontrolled. A systematic review and meta-analysis found an association between migraine and suicidal ideation that remained after adjustment for other factors. This underscores the importance of timely, effective care and attention to mental health for people living with migraine.[6]

The consequences extend well beyond attacks themselves. Migraine contributes to missed work and school, reduced productivity, disability, and healthcare use. The American Headache Society estimates the annual U.S. economic burden of migraine at $78 billion in direct and indirect costs. When women lose workdays, productivity, or the ability to participate fully in family life, the effects reach employers, households, and communities as well as the healthcare system and overall economy.[7]

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[2]Schwedt TJ, Starling AJ, Ailani J, et al. "Routine migraine screening as a standard of care for Women's health: A position statement from the American Headache Society." Headache. 2026;66(2):511–516. https://doi.org/10.1111/head.70023

[3]Cohen F, Brooks CV, Sun D, et al. "Prevalence and burden of migraine in the United States: A systematic review." Headache. 2024;64(5):516–532. https://doi.org/10.1111/head.14709

[4]GBD 2023 Headache Collaborators. "Global, regional, and national burden of headache disorders, 1990–2023: a systematic analysis for the Global Burden of Disease Study 2023." The Lancet Neurology. 2025;24(12):1005–1015. https://doi.org/10.1016/S1474-4422(25)00402-8

[5]Lipton RB, Fanning KM, Serrano D, Reed ML, Cady R, Buse DC. "Ineffective acute treatment of episodic migraine is associated with new-onset chronic migraine." *Neurology.* 2015;84(7):688–695. https://doi.org/10.1212/WNL.0000000000001256

[6]Friedman LE, Gelaye B, Bain PA, Williams MA. "A systematic review and meta-analysis of migraine and suicidal ideation." Clinical Journal of Pain. 2017;33(7):659–665. https://doi.org/10.1097/AJP.0000000000000440

[7]Schwedt TJ, Starling AJ, Ailani J, et al. "Routine migraine screening as a standard of care for Women's health: A position statement from the American Headache Society." Headache. 2026;66(2):511–516. https://doi.org/10.1111/head.70023

NIH's own funding-versus-burden analysis compares research spending with U.S. and global disability-adjusted life years and shows that both "Headaches" and "Migraines" receive low research funding relative to their burden. The underfunding of a disease that affects millions of women belongs in the Women's Health Division's priority-setting; conditions that disproportionately affect women should not remain marginal in federal research while their disability and economic costs accumulate.[8] NIH's FY 2025 Research, Condition, and Disease Categorization estimates list $43 million for "Migraine" and $54 million for the separate "Headache" category. These estimates show how little federal research funding is directed to conditions with an enormous burden on women's health, disability, families, and the economy.[9]

Migraine must be at the table wherever women's health is discussed, particularly given its co-morbidity with other diseases such as cardiovascular disease, depression, and anxiety. We were pleased to see chronic pain explicitly mentioned in the executive order as women's reports of pain are viewed as less severe and often undertreated compared to men's pain. As a neurological disease that often involves chronic pain, this is especially relevant to migraine and headache disorders and consequently can lead to a reluctance to seek proper treatment. In headache medicine, that reluctance can have lasting consequences in conversion to chronic disease.[10] The Women's Health Division and Task Force can make a concrete commitment to the women living with migraine disease by naming migraine and headache disorders in their priorities, building research across women's lives, and tracking how investment improves diagnosis, care, and outcomes.

Make migraine screening an early priority

The American Headache Society has recommended yearly diagnostic screening for migraine as part of women's preventive healthcare, particularly for girls and women from adolescence through menopause. The need is clear. Migraine is common, but underdiagnosis and undertreatment leave many women without a diagnosis or effective treatment. In a U.S. study of people with episodic migraine and at least mild migraine-related disability, only 26.3% had consulted a healthcare professional for headache, received a migraine diagnosis, and were using a migraine-specific acute treatment in the preceding year. Screening can help bring this treatable neurological disease into routine care sooner.[11]

An annual well-woman visit is a practical place to screen for this disease. The AHS recommends the three-question ID Migraine screener, which a patient can complete in less than two minutes, including on a pre-visit form. A routine question about migraine can reach women who may otherwise regard severe attacks as something they must endure, and it gives clinicians a clear opening to discuss diagnosis and care. Primary care, pediatric, and obstetric and gynecologic

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[8]National Institutes of Health. "Report on NIH Funding vs. Global Burden of Disease," analysis comparing categorized NIH research spending with U.S. and global disability-adjusted life years using Global Burden of Disease 2017 data. https://report.nih.gov/report-nih-funding-vs-global-burden-disease

[9]National Institutes of Health. Research, Condition, and Disease Categorization (RCDC), Categorical Spending, FY 2025 estimates, separate categories "Headache" and "Migraine." https://report.nih.gov/funding/categorical-spending

[10] M. Guzikevits, T. Gordon-Hecker, D. Rekhtman, S. Salameh, S. Israel, M. Shayo, D. Gozal, A. Perry, A. Gileles-Hillel, & S. Choshen-Hillel, Sex bias in pain management decisions, Proc. Natl. Acad. Sci. U.S.A. 121 (33) e2401331121, https://doi.org/10.1073/pnas.2401331121 (2024).

[11]Schwedt TJ, Starling AJ, Ailani J, et al. "Routine migraine screening as a standard of care for Women's health: A position statement from the American Headache Society." Headache. 2026;66(2):511–516. https://doi.org/10.1111/head.70023

settings are all important points of contact, especially as symptoms change around menstruation, pregnancy, and menopause.[12]

Screening is also a sound investment. The AHS position statement reports that accurate diagnosis is associated with lower healthcare use and costs. Workplace programs that combine screening with education and treatment have reduced missed workdays and improved productivity. We urge the Task Force to work with HHS and HRSA to add annual migraine screening to preventive care, including the Women's Preventive Services Guidelines, and to pair it with clinician education and a clear route to evaluation and treatment.[13]

Research should follow women's lives, beginning in childhood

Women's health research on migraine must begin before adulthood. Migraine often starts in childhood, and its prevalence rises among girls at puberty. A girl whose symptoms are missed or dismissed may lose school days, struggle to participate in activities, and reach adulthood without a diagnosis or a plan for care. Research on children and adolescents remains thinner than the evidence available for adults. NIH should support studies that follow migraine from childhood through adolescence, examine how symptoms affect education and development, and improve the transition from pediatric to adult care.[14]

Migraine also runs in families. Mothers, daughters, sisters, and other relatives may experience the disease across generations, yet researchers still need to understand how inherited susceptibility interacts with hormonal change and other biological and environmental factors. Studies that follow families and patients over time can help explain why migraine develops, why its course changes, and why women may be affected differently at different stages of life. That knowledge may ultimately point toward preventing migraine before repeated attacks and disability take hold.[15]

Research must continue through menstruation, pregnancy, postpartum, lactation, perimenopause, menopause, and aging. During pregnancy and breastfeeding, women and clinicians must weigh the need to treat disabling attacks against incomplete safety and effectiveness evidence. A systematic review prepared for AHRQ found that evidence on how to prevent primary headache during pregnancy, postpartum, and breastfeeding was sparse, with major questions still unanswered. NIH should build this evidence through well-designed studies, registries, and clinical research that report outcomes by life stage and give women and their clinicians information they can use.[16]

The executive order calls for stronger data collection, inclusion of women and girls in clinical trials, research methods that clarify sex-specific outcomes, and accountability for NIH's policy on sex as a biological variable. The Women's Health Division can apply these commitments to migraine and headache disorders by coordinating across institutes, tracking research investment against disease

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[12]Schwedt TJ, Starling AJ, Ailani J, et al. "Routine migraine screening as a standard of care for Women's health: A position statement from the American Headache Society." Headache. 2026;66(2):511–516. https://doi.org/10.1111/head.70023

[13]Schwedt TJ, Starling AJ, Ailani J, et al. "Routine migraine screening as a standard of care for Women's health: A position statement from the American Headache Society." Headache. 2026;66(2):511–516. https://doi.org/10.1111/head.70023

[14]Schwedt TJ, Starling AJ, Ailani J, et al. "Routine migraine screening as a standard of care for Women's health: A position statement from the American Headache Society." Headache. 2026;66(2):511–516. https://doi.org/10.1111/head.70023

[15]Stewart WF, Staffa J, Lipton RB, Ottman R. "Familial risk of migraine: a population-based study." Annals of Neurology. 1997;41(2):166–172. https://doi.org/10.1002/ana.410410207

[16]Saldanha IJ, Cao W, Bhuma MR, et al. "Management of primary headaches during pregnancy, postpartum, and breastfeeding: A systematic review." Headache. 2021;61(1):11–43. https://doi.org/10.1111/head.14041

burden, and moving findings into clinical education and practice. Research should measure disability and quality of life as well as symptoms, and should reflect the ages and life stages in which women experience the disease.[17]

Study menstrual and menstrually related migraine

Menstrual migraine and menstrually related migraine deserve focused attention. A U.S. population-based study of 1,697 women with migraine found that nearly 60% reported that their attacks were associated with menstruation. Women reporting both menstrual and menstrually related migraine experienced greater headache impact and migraine-related disability than women whose attacks were not associated with menses. These patterns can mean missed school or work, disrupted caregiving, and a greater need for effective treatment.[18]

NIH should support studies that follow menstrual and headache patterns over time and measure attack frequency, severity, disability, and treatment response. Research should include adolescents as well as adult women and consider how menstrual migraine and menstrually related migraine change across the reproductive years. These experiences strengthen the case for asking about migraine during well-woman visits and for making screening part of routine preventive care. It also aligns with the research priorities jointly agreed upon by the American Headache Society and NINDS which explicitly mentions menstrual migraine and menstrually related migraine as a research priority.[19]

The HEADACHE Act offers a practical federal framework

The bipartisan HEADACHE Act (H.R. 5536), introduced by Representatives Lori Trahan and Brian Fitzpatrick, would direct HHS to establish a National Headache Disorders Initiative and an Advisory Council on Headache Disorders Research, Care, and Services. The Initiative would coordinate federal research, clinical care, workforce development, and data collection; improve diagnosis and care coordination; and support public awareness. The bill also calls for shared federal data, an annually updated national plan, and regular reporting to Congress. The Advisory Council would bring federal agencies together with patients, clinicians, researchers, and other experts.[20]

The executive order calls for coordinated federal leadership, stronger research, earlier diagnosis, and moving evidence into clinical practice. The HEADACHE Act gives those goals a focused structure for a group of conditions that affects more than 40 million Americans and disproportionately burdens women. Its national initiative and advisory council can connect the women's health agenda

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[17]Executive Order, "Advancing Women's Health to Improve Outcomes in All Phases of Life," October 19, 2026, sections 2 and 4. https://www.whitehouse.gov/presidential-actions/2026/10/advancing-womens-health-to-improve-outcomes-in-all-phases-of-life/

[18]Pavlovic JM, Stewart WF, Bruce CA, et al. "Burden of migraine related to menses: results from the AMPP study." *The Journal of Headache and Pain.* 2015;16:24. https://doi.org/10.1186/s10194-015-0503-y

[19] Schwedt TJ, Pradhan AA, Oshinsky ML, et al. *The headache research priorities: Research goals from the American Headache Society and an international multistakeholder expert group*. *Headache*. 2024; 64: 912-930. doi:10.1111/head.14797

[20]Congress.gov, H.R. 5536, 119th Congress, HEADACHE Act, introduced September 19, 2025, bill text. https://www.congress.gov/119/bills/hr5536/BILLS-119hr5536ih.pdf

to the broader work needed on headache research, clinical training, data, and care. We urge the Administration to support the goals of the Act and Congress to advance this bipartisan legislation.[21]

Include headache and facial pain disorders beyond migraine

Migraine is not the only headache disorder affecting women. Federal research should also address cluster headache, tension-type headache, post-traumatic headache, new daily persistent headache, headache related to spinal cerebrospinal fluid leak or idiopathic intracranial hypertension, and other primary and secondary headache disorders. Facial pain conditions, including trigeminal neuralgia and other orofacial pain disorders, also belong in this work. The HEADACHE Act recognizes this wider landscape, including orofacial pain and conditions affecting children, pregnant women, and older adults.[22]

These disorders may first appear in primary care, pediatrics, obstetrics and gynecology, emergency medicine, neurology, pain medicine, or dentistry. Women need clinicians who can recognize them, make timely diagnoses, and coordinate appropriate care. Medical school education in headache medicine remains inconsistent. In a survey of U.S. and Canadian curriculum leaders, only 44.9% said their institutions coordinated headache education across preclinical and clinical training.[23] The Task Force should include headache education for medical students and frontline clinicians in its early diagnosis and workforce efforts. The executive order's emphasis on chronic pain, neurological conditions, early diagnosis, specialty services, and a strong provider workforce is directly relevant. We ask the Task Force to name headache and facial pain disorders in its work and to include specialists, patients, and caregivers in its consultations.

Migraine Is Primed for Super Intelligence Innovation: Connecting a Lifetime of Symptoms, Hormonal Changes, and Treatment Experiences to Improve Care

Migraine is particularly well-suited for SI tools that can map a woman's lifetime journey, uncover patterns around hormonal transitions, clarify treatment experiences, identify warning signs of worsening disease, capture its full personal and economic burden, and reveal inequities and missed opportunities in care. The strongest opportunity would be to connect information that currently sits in separate places: headache diaries, medical records, pharmacy claims, reproductive health history, and women's own accounts of living with migraine. Such a lifetime perspective matters because migraine can change around menstruation, pregnancy, and menopause, and hormones are only one part of a complex neurological disease. Overall, SI resources could help build a connected picture of a woman's migraine journey over decades - showing how symptoms, treatment, hormonal transitions, and access to care interact.

Our requests

As the Women's Health Division and Task Force begin their work, we ask that they:

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[21]Executive Order, "Advancing Women's Health to Improve Outcomes in All Phases of Life," October 19, 2026, sections 1, 3, and 4. https://www.whitehouse.gov/presidential-actions/2026/10/advancing-womens-health-to-improve-outcomes-in-all-phases-of-life/

[22]Congress.gov, H.R. 5536, 119th Congress, section 2, definition of "headache disorder." https://www.congress.gov/119/bills/hr5536/BILLS-119hr5536ih.pdf

[23]Pace A, et al. "The current state of headache medicine education in the United States and Canada: An observational, survey-based study of neurology clerkship directors and curriculum deans." Headache. 2021;61(6):854–862. https://doi.org/10.1111/head.14134

- Name migraine, headache disorders, and facial pain disorders in the Division's research priorities and the Task Force's clinical initiatives.
- Support research from childhood through aging, including puberty, menstruation, pregnancy, postpartum, lactation, menopause, and the transition between life stages.
- Apply the order's research, clinical trial, sex-specific data, and research-to-practice priorities to migraine and headache disorders.
- Implement the American Headache Society's recommendation for yearly migraine screening in women's preventive care, with clinician education and timely follow-up.
- Invite AHDA, patients, clinicians, researchers, and caregivers to contribute through Task Force meetings, roundtables, and other opportunities.
- Support the HEADACHE Act as a complementary federal framework for sustained coordination, data collection, research, and care.

Migraine and headache disorders affect 40 million Americans and carry $78 billion in annual costs. By including our diseases in the important work of the Women's Health Division, we can help millions of women living with these often disabling conditions. We thank President Trump and First Lady Melania Trump for elevating women's health and welcome the opportunity to help advance this work.

Sincerely,

Julienne Verdi, JD
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Alliance for Headache Disorders Advocacy
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On behalf of the undersigned organizations:

Alliance for Patient Access
Alliance for Women's Health and Prevention
American Academy of Neurology
American Brain Coalition
American Headache Foundation
American Migraine Foundation
Chronic Migraine Awareness
Clusterbusters
Cyclic Vomiting Syndrome Association
Danielle Byron Henry Migraine Foundation
Facial Pain Association
Family Voices National
Fibromyalgia National Health Organization
Florida Alliance for Healthcare Value
Floridians for Accountability in Health Care, Inc
Great Lakes Regional Headache Society
Headache Cooperative of the Northeast
Headache Cooperative of the Pacific
Migraine World Summit

Miles for Migraine
National Headache Foundation
National Pain Advocacy Center
Neurotech Network (a DBA of The Society to Increase Mobility Inc.)
New England Regional Headache Center
Southern Headache Society
Spinal CSF Leak Foundation
The Coalition for Headache and Migraine Patients (CHAMP)
The Headache and Migraine Policy Forum
US Pain Foundation
World Health Education Foundation