

FEMTECH
SPAIN

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FEMTECH SPAIN

Industry Report 2026

IN PARTNERSHIP WITH





AUTHOR AND EDITOR NOTE

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Founder FemTech Spain · The FemTech Ecosystem · One year later

When I set out to write the FemTech Spain report last year, I had one priority: to finally map the reality of women's health innovation in the country. A year later, a lot has moved, locally and internationally.

At the beginning of this year, the industry published multiple reports putting more numbers and evidence behind its value: the successful exits in women's health companies, the business case for countries and employers, the actions needed to bridge the gap. This report does the same work for Spain: showing the business case for women's health within the ecosystem, highlighting local innovation and connecting it with what is happening elsewhere.

It has been a very interesting, yet contradictory year for women's health in Spain. The buzz around it has only grown, new companies have been launched, and the Government is starting

to look at it as a source of R&D and country competitiveness, taking the lead at European policy level. In Brussels, the European Commission finally named women's health in its new Gender Equality Strategy 2026–2030.

And yet, we are still seeing founders deeply struggling with fundraising or with closing B2B partnerships, women who are still not able to reach the standard of care they need, or research still being conducted without disaggregation by sex.

Things are moving, but a bigger shift is needed to close a gap that has been open for decades. Only through the collaboration of every actor in the ecosystem — researchers, founders, policymakers, investors, clinicians, pharmaceutical companies, patients —, we will be able to create the critical mass needed to change women's health. And that is what we built FemTech Spain for.

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7 things we learned

These findings carry the rest of the report. Each is documented in full in the sections that follow.

01 **64** **Spain's FemTech map has expanded**

64 active FemTech companies with a base in Spain, up 14 on 2025. Growth was spread across the map rather than clustering behind a single vertical.

02 **a third** **Spain's advantage is deep science**

A third of the map is regulated technology — medical devices, diagnostics and therapeutics. For an ecosystem mostly founded after 2019, that is a heavy concentration of CE-marked, clinically validated work.

03 **€18M** **Women's health is now a Spanish state mission**

Somos. Contamos. triples state R&D dedicated to women's health to around €18M a year, delivered through CDTI, ISCIII and AEI. €15M of it is already reserved and published. The first call closed in June. The next opens in October.

04 **17** **One way to evaluate, seventeen roads to adoption**

RD 415/2026 creates a single national framework for evaluating digital health products. The evaluations are non-binding, and reimbursement and procurement still sit with the regions.

05

\$2B

The money got harder, and the middle is missing

Roughly \$2 billion was invested in women's health globally in 2025, down from the 2024 peak, and half of all investment in women's-health-specific companies still sits at the earliest stages. The gap is the Series A and B cheques that carry a validated seed company to scale.

06

20–30%

Being filed under women's health carries a discount

European Series A valuations for FemTech run 20–30% below comparable digital-health companies. A structural penalty for founders; for investors, the entry argument.

07

The gap this year is no longer awareness, but infrastructure.

Spain has the companies, the institutions and now the public money. What it is missing is the route from a funded product to a reimbursed one.

01 · THE CONTEXT

Introduction & context

The women's health gap, refreshed — and why 2026
reads differently

“**Women live longer than men**, but spend more of the years in worse health”. This is the sentence that has anchored most of the women's health reports of the last three years, including our own 2025

FemTech Spain Report. As time passes and new reports come out, we have started to gain more understanding of what that gap is made of, and to see more funding behind closing it.

World Economic Forum · McKinsey Health Institute, 2024–2025

25% more time women spend in poor health than men	\$1T annual global GDP unlocked by closing the gap, by 2040	7 days additional healthy days per woman, per year	9 conditions driving a third of the entire gap
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The World Economic Forum and the McKinsey Health Institute established the headline economics in 2024: women spend roughly 25% more of their lives in poor health than men, and closing that gap could add at least \$1 trillion to annual global GDP by 2040, along with seven additional healthy days per woman each year, which translates into more than 500 days across a lifetime.¹ Any country that decides to invest in this industry should expect an exponential return on productivity gain and economic growth.

Their 2025 follow-up, the Blueprint to Close the Women's Health Gap, did something more useful for anyone building in this sector: it named the conditions. Nine of them — ischemic heart

disease, cervical cancer, breast cancer, maternal hypertensive disorders, post-partum haemorrhage, menopause, premenstrual syndrome, migraine and endometriosis — account for a third of the entire women's health gap between them. Closing the gap on those nine alone would unlock an estimated \$400 billion in annual global GDP by 2040.²

That shift, from a headline number to a named list of conditions, matters, as it helps turn a statistic into a research agenda and an investment thesis. It is also, not coincidentally, the logic underneath the mission that the Spanish Government has just opened in 2026 — biomedical research into the pathologies with the greatest impact on women (see Section 3).

The gender health gap is no longer an abstraction. We now have a list of conditions that we need to act on.

Why the gap persists

The causes are structural, and they have compounded over time. Evidence is thin: a review of more than 650 studies found that only half differentiated their findings by sex, and where sex-disaggregated data did exist, outcomes were worse for women roughly two-thirds of the time.¹ Investment follows evidence, so under-researched conditions attract less capital, which produces less data, which in turn makes them be less

visible. Care given to women patients ends up being built on that same incomplete evidence base.

The result is that the years of poorer health are not concentrated at the end of the woman's life, like one would come to expect as it is the case for men. Instead, they fall in the middle of it — during working, caregiving and earning years — which is precisely why the economic argument is as large as it is.

Only half of more than 650 reviewed studies differentiated their findings by sex.

An economy that runs on women in poor health is an economy running under capacity.

Women's health in Spain

In Spain, the status of women's health reveals urgent gaps that FemTech solutions can address. According to the most recent Encuesta de Salud de España, over 60% of women report chronic conditions like back pain and arthrosis, mental health challenges affect 1 in 3, and preventive screenings like mammograms and cervical tests are declining.³

Older women face high rates of functional limitations, with two-thirds of those 85 years old or older struggling with daily activities. Notably, the broader survey shows chronic illness

prevalence rising sharply nationally — 57.7% of the population now reports a chronic condition, up roughly 10% versus 2020 — a trend that disproportionately affects women given their longer lifespan in poorer health. These figures highlight a clear opportunity: digital health solutions tailored to women's needs are more relevant than ever, and the 2025 Encuesta de Salud survey wave will be the first real test of whether the gap is narrowing.

60%

of women report chronic conditions like back pain and arthrosis

1 in 3

affected by mental health challenges

57.7%

of the population now reports a chronic condition

The Spanish position: deep science, not only consumer apps

While consumer wellness applications dominate much of the global FemTech landscape, Spain's competitive advantage sits in hardware, regulated technology and deep science. As we will see later in our FemTech Spain 2026 map, Spanish ventures over-index on medical devices, diagnostics and clinically validated tools relative to the size and age of the ecosystem.

This is not an exclusive orientation: the other big European FemTech markets tilt in the same direction. France now reimburses medical-device companies through its national health system, Germany fields the continent's deepest bench of regulated diagnostics. What sets Spain apart is not the deep-

science bet, but that it is making that bet without resources these countries have: no dedicated national FemTech fund, no reimbursement pathway, thin growth-stage capital.

Spain is making the harder bets without the support behind it. The focus on the harder-science is a genuine differentiator that will prove an exponential competitive advantage for Spain, but it is also a harder path to finance: regulated deep-science companies need more capital and longer runways than app businesses, a reality Spain's funding environment has not been built for, resulting in some FemTech companies having to close this year.

The tension between what Spain is good at building and what Spain is able to fund is the central story of this year's report.

■ THE FEMTECH SPAIN READ

Spanish FemTech is challenged with having the weakest scale-up capital and with being the only major market with no national reimbursement route.

02 · MARKET

The FemTech market in Spain

Size, growth, and the Market Map 2026

Since our previous report, the estimate on how big the FemTech market is has only grown, and has become one of the hotter topics within the industry: how to measure this market, when the impact affects the whole economy?

Global Market Insights sized the worldwide FemTech market at \$66.2 billion in 2025, projecting \$255.5 billion by 2035 at a 14.9% compound annual growth rate,⁴ a materially larger and later-

dated projection than the "\$100 billion by 2030" figure we cited in 2025. Still, only about 6% of private healthcare capital goes to conditions affecting women, who are close to half the population.⁵ Growth projections and capital allocation seem to still be moving in opposite directions, in a market still without all the means to fund its ambition.

\$66.2B global FemTech market, 2025	14.9% projected global CAGR to 2035	6% of private health capital to women's conditions	1 in 7 investors with women's health in their strategy ³⁶
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As of 2024, Spain's FemTech market was valued at approximately \$900 million, up from \$773 million in 2023 — roughly 2% of the global market.⁶ It is projected to reach \$2.31 billion by 2030, a CAGR of 16.9%, outpacing forecast growth in

Spanish digital health (10%) and smart healthcare (13%) over the same period,⁷ and broadly in line with the global FemTech CAGR of 16.4%.⁸

FemTech Spain Market Map 2026

64

As of August 2026, we have identified 64 active FemTech companies with HQ (or subsidiary) in Spain, an uplift of 14 versus 2025.

+14

versus 2025

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Market Map 2026

Reproductive Health (9)



Oncology (9)



Maternal Health (8)



Mental Health (6)



Endometriosis (3)



Perimenopause & Menopause (8)



Menstrual Health & Contraception (6)



Pelvic Health (4)



General Health & Wellness (11)



A partnership between:

CO·SALUD



Image 1: FemTech Spain Market Map 2026

Category distribution

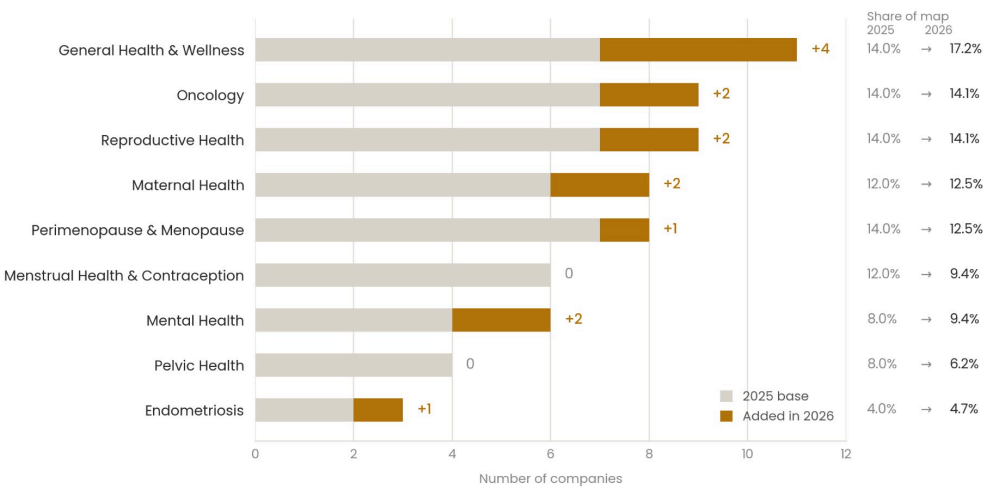
Year over year growth in the number of companies is broadly spread across the map, with General Health & Wellness being the biggest one (mainly from new companies identified, despite having launched before this year). The smaller categories of Mental Health and Endometriosis also grew, with innovation focusing on condition-specific solutions instead of getting absorbed into broader wellness or reproductive plays.

The ecosystem is thickening across the board rather than clustering behind a single vertical, and the largest share of the year's growth went to the broadest, lowest-barrier category.

The map is widening at the base as the market is maturing.

Category counts and share, 2025 to 2026

Bars show company counts; percentages show each category's share of the map.



FemTech Spain Industry Report 2026 · femtechspain.es

Image 2: Category Shift for FemTech companies in Spain (2026 vs 2025)

Geographic distribution

Barcelona continues to hold the majority of the companies (58%, in line with 2025), a concentration that supports Barcelona's standing as one of Europe's largest FemTech clusters and a leading hub for digital health

venture capital. Madrid represents 25% of the map (vs 24% in 2025), with the remaining companies distributed across the territory (Bilbao, San Sebastian, Valencia, Sevilla, Jaen).

58%

Barcelona, in line with 2025

25%

Madrid, vs 24% in 2025

Technology profile

Software and digital platforms remain the backbone of Spanish FemTech, at 42% of all solutions in 2026 (27 of 64), with an unchanged share year over year. This is not Spain specific, as Software is the default entry point in every FemTech market, since it is the fastest and cheapest thing to build. In absolute terms, this was the largest single gainer, adding six solutions, followed by Consumer Health and D2C products (+3, now 16). Together, these two lower-barrier categories accounted for two-thirds of the year's net growth — solutions that are faster and cheaper to bring to market.

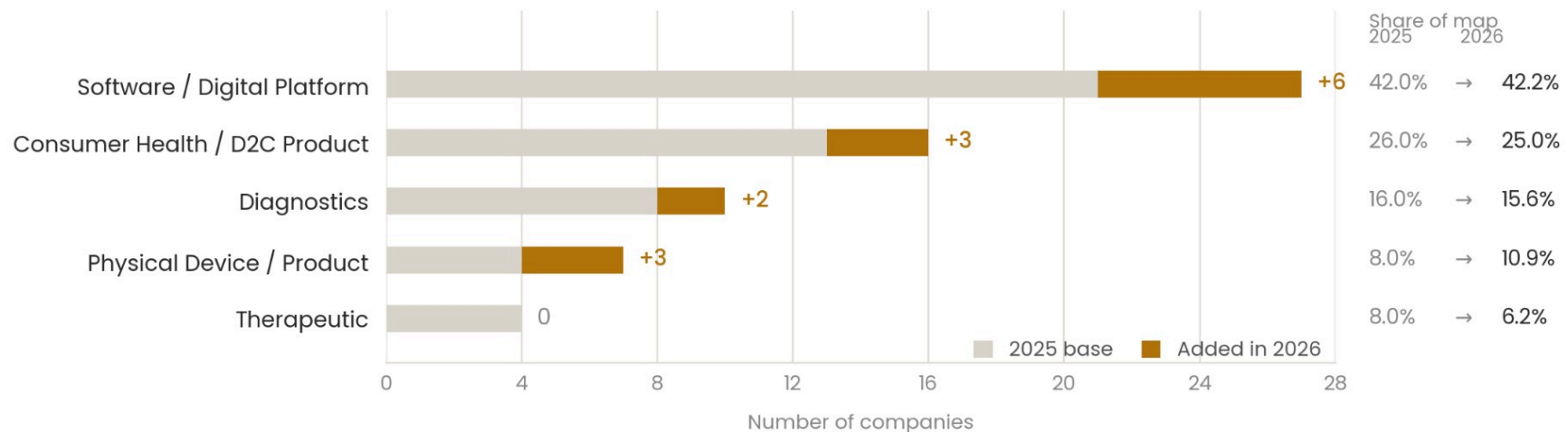
What differentiates Spain is that a third of the map is regulated technology: physical/medical devices (+3, now 7), diagnostics (+2, now at 10) and therapeutics (flat at four, from a company closing but a new one launching). For an ecosystem this young, most of it founded after 2019, that is a heavy concentration of CE-marked, clinically validated work. Even with the steady growth this year, the share of this harder-science has remained mostly flat.

■ THE FEMTECH SPAIN READ

Deep science is not the majority of Spanish FemTech, but it is the part Spain does disproportionately well for its size and age, and the part that is hardest to copy. Five of this year's fourteen new solutions come from these categories, but the fact that the other solutions (Software and Consumer) grew more is basically the funding gap showing up in the map. If we want the competitive advantage of deep science to remain, capital needs to follow these solutions too.

Technology profile counts and share, 2025 to 2026

Bars show company counts; percentages show each product type's share of the map.



FemTech Spain Industry Report 2026 · femtechspain.es

Image 3: Technology Profile Shift for FemTech companies in Spain (2026 vs 2025)

03 · POLICY

Regulatory & policy environment

Somos. Contamos. · the calls now open · the standing framework

2026 is the first year in which Spain has attached specific public money to women's health research as a named national priority. This is pointing to a shift in the public agenda that we hope will trickle down to all levels of

government, and will help build the critical mass of research, capital and clinical evidence needed to fully close the gender health gap in Spain.

From invisibility to evidence: the *Somos. Contamos.* program

On 15 June 2026, the Government of Spain presented *Somos. Contamos* — a national program that triples state R&D investment specifically dedicated to women's health, with the aim to end the discrimination on women in health research.⁹ The initiative is driven by the Ministry for Science, Innovation and Universities. That Diana Morant announced it beside President Pedro Sánchez, with the Health and Equality ministers present, signals a level of attention women's health R&D in Spain had not previously received.

The program's ambition is to close the gap at its root, exactly where it starts. As stated by the Government, they want to go *from invisibility to evidence, from evidence to innovation, and from innovation to better diagnosis and treatment for women.* The program names its target pathologies explicitly — chronic pain, autoimmune and thyroid disease, cardiovascular and mental health, menopause and hormonal health — and anchors itself in a familiar but still-underfunded reality: conditions like endometriosis can take seven to ten years to diagnose.

€18M/yr announced total state R&D for women's health under the program	3x increase over prior investment	3 agencies delivering it: CDTI · ISCIII · AEI	1st time women's health is a named Spanish state mission
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Three institutional actors, three distinct instruments

What makes *Somos. Contamos.* more than a headline is that it works through three agencies, each operating on a different part of the innovation pipeline:

CDTI

The industry mission

The *Centro para el Desarrollo Tecnológico y la Innovación* carries the business-facing instrument: a dedicated women's health mission inside the *Misiones Ciencia e Innovación 2026* call, mobilizing companies and research centres to run collaborative R&D projects. A second call, *ININTERCONECTA STEP* is to be open in October 2026 with 10M€ specifically reserved for women's health. This is the piece FemTech companies can actually contract against.

ISCIII

The research networks

The *Instituto de Salud Carlos III* opens a new financing line to get networked research centres working collaboratively on women's health areas. This is the public-research and clinical backbone, oriented to collaboration and data-sharing across institutions rather than to companies. This research effort is expected to be developed through the CIBER network and the IMPaCT infrastructure. Women's health is included as a strategic priority in the 2027 *Acción Estratégica en Salud* (AES)

AEI

The talent pipeline

The *Agencia Estatal de Investigación* adds specific predoctoral contracts tied to women's health projects within its main call, aimed at building the critical mass of researchers in a field that has traditionally lacked it.

The design is coherent across the initiatives: CDTI funds the companies, ISCIII funds the collaborative research base, and AEI funds the people who will still be doing this work in ten years. This is a full-pipeline commitment, more than a single grant.

The FemTech Spain read: what changed, and what comes next

What changed this year.

For the first time, women's health is a named strategic mission within the Spanish Government, not as a sub-line, but as a country challenge and opportunity, with a dedicated budget and three agencies behind it.

It now sits alongside energy resilience, antimicrobial resistance, strategic defence, food sovereignty and industrialised housing as a named national priority — a framing that would have been difficult to imagine in the last edition of this report.

This framing has value beyond the euros: it gives founders, investors and institutional partners a shared reference point. It gives our ecosystem a mandate to point to.

What is live now.

The announced figure is €18M/yr. What has been published since gives it shape, and the first calls are already live:

INSTRUMENT	RESERVED	STATUS
CDTI · Misiones 2026 ¹⁰	€5M minimum	Closed 12 Jun 2026 · resolution due 2026
CDTI · Innterconecta STEP 2026 ¹¹	€10M	Opens Oct 2026 · resolution H1 2027
ISCIII · inter-CIBER	Pending	Pending
ISCIII · IMPaCT 2026, AES 2027 ¹²	Line of interest	IMPaCT open · AES 2027 pending
AEI · predoctoral contracts	Set by evaluation	Second semester 2026

€15M of the €18M is already reserved, published and traceable, all of it through CDTI. The Misiones reserve is a floor rather than a ceiling, and the ISCIII and AEI figures are still to come — so the 2026 total may land above the announcement.

What we are asking for next.

The money has arrived ahead of the strategy. Two things are still to come, and both would make this programme easier to build against. The first is the full picture: the remaining breakdown — what ISCIII and AEI will each contribute — the baseline the "triple" is measured from, and the metrics the programme will be evaluated on. The second is bigger: Spain still has no unified national women's

health strategy. Ireland has run Women's Health Action Plans since 2022 with a dedicated recurring fund.¹³ England renewed its ten-year Women's Health Strategy in April 2026.¹⁴ Australia anchored its research investment directly to the priorities of a published national strategy.¹⁵ In each case, the money hangs off a framework. Spain has moved in the opposite order — funding first — and the

call for the framework is already being made from inside the sector: by the EsMujer initiative in Congress,¹⁶ by the Observatorio de Salud at the Ministry itself, and now in the update of the Estrategia de Salud Sexual y Reproductiva. We add our voice to it. *Somos. Contamos.* is the strongest signal this field has had from the Spanish state.

WHERE THE MONEY HANGS OFF A FRAMEWORK

Ireland

Since 2022

Women's Health Action Plans, with a dedicated recurring fund

England

April 2026

Ten-year Women's Health Strategy, renewed

Australia

Published strategy

Research investment anchored to national strategy priorities

Spain

2026

€18M/yr reserved by name. No national strategy behind it

A national strategy is what would turn a signal into a system.

What we are asking for next.

Little of it is built for the companies on our map. Both CDTI instruments fund through consortia, and both carry filters that fall hard on this ecosystem. Misiones requires total project budgets of €3.5M to €10M — few Spanish FemTech companies can anchor a grouping that size alone. Innterconecta STEP is the more reachable of the two at €1M to €4M

per project, with a €175,000 floor per company and consortia of two to six. It is co-financed through FEDER, which means the eligible territories are set by European cohesion rules rather than by CDTI. Projects must run across at least two of the nine eligible communities, and all the work has to happen inside them, with staff registered at work centres in those

regions. Catalonia, Madrid and the Basque Country are not on the list. Barcelona and Madrid alone account for 83% of our map. This is a limit to the ecosystem, even if a company in those regions can still take part through a work centre in an eligible one, or by joining a consortium anchored elsewhere.

ININTERCONECTA STEP · WHERE THE WORK MUST HAPPEN

- Andalucía
- Canarias
- Castilla–La Mancha
- Castilla y León
- Comunitat Valenciana
- Extremadura
- Galicia
- Illes Balears
- Región de Murcia

83%

of our map sits in Barcelona and Madrid alone, before counting the Basque Country — outside the territories this call can pay for.

Not eligible in 2026: Catalonia · Madrid · Basque Country

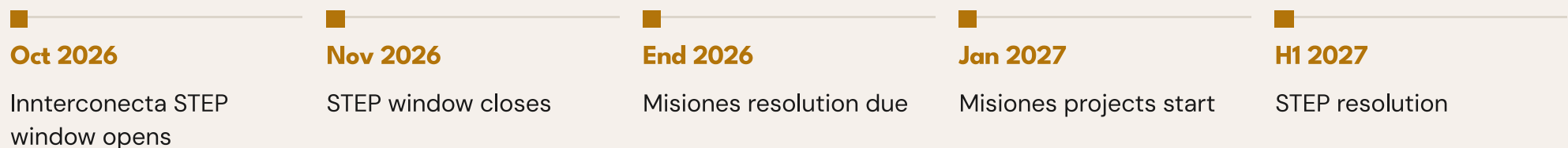
That is the route in, and building those consortia is work this ecosystem can do for itself.

What we can do about it.

Women's health research has been funded in Spain for years, through general competitive calls, and continues to be. What is new is money reserved specifically for it by name in the Misiones calls. We will report which FemTech companies appear in that cohort.

Women's health having a specific line in the Misiones call deserves attention. If there are not enough fundable proposals in the women's health mission, the reserve can be reassigned to others.

WHAT HAPPENS NEXT, AND WHEN



The money is there, and it will stay there if the sector shows up for it.

Connecting the two sides of this is our job. FemTech Spain sits between the companies building in women's health and the institutions now funding it, and our work is to make sure what the ecosystem needs and what the state offers actually meet. That runs both ways: bringing the calls to

founders early enough to act on them, and bringing back to the agencies what founders run into when they try. We expect the support to keep coming, and we intend to help shape where it goes.

"Somos. Contamos." moves women's health from invisible to named. The next report will tell us whether it also moved from named to funded.

The standing framework

Menstrual leave, three years on

Spain became the first European country to legislate paid menstrual leave in 2023, offering up to five days per month for workers with debilitating symptoms, but three years on, the significance remains symbolic rather than operational. The Ministry of Equality estimated that around 1% of the roughly six million women aged 16–50 in Spain (60,000 workers)¹⁷ would qualify. Actual uptake has run far below that: according to the Ministry's own figures, only 2,688 women used the leave between June 2023 and February 2025,¹⁸ with an average duration of about three days.

The most-cited explanations for the low uptake are structural, rather than an evidence of disinterest from the women: the requirement for a medical diagnosis effectively limits the leave to workers with an established condition such as endometriosis or severe dysmenorrhea, and low awareness among both doctors and workers has made it harder to access than expected. There is also a concern from the demand side: some employees fear being perceived as a liability by the company.

2,688

women used the leave between June 2023 and February 2025

60,000

workers estimated eligible by the Ministry of Equality

What the law has achieved sits apart from how little it has been used. By naming incapacitating menstruation in legislation, it moved menstrual health into the workplace conversation and gave companies a legitimate basis to engage with women's health services. But the more useful read for the FemTech industry is in the gap between the two numbers: 2,688 workers reached out of 60,000 workers estimated eligible. That distance

measures a broken access pathway — undiagnosed conditions, low awareness, a diagnosis requirement most never clear. Diagnosis and awareness are precisely the gaps FemTech tools are built to close, and this leave is less a symbolic policy and more a state-generated evidence that the demand exists, but the system is not able to meet it yet.

■ THE FEMTECH SPAIN READ

That distance measures a broken access pathway — undiagnosed conditions, low awareness, a diagnosis requirement most never clear.

Data protection and medical devices

Spain remains aligned to the European framework when it comes to data and devices. Any application handling health data must comply with GDPR and Spain's *Ley Orgánica de Protección de Datos y Garantía de Derechos Digitales*, under which health data is a specially protected category. On devices, Royal Decree 192/2023 aligns national regulation with EU MDR 2017/745: any solution functioning as a diagnostic or therapeutic device

requires CE marking and must meet quality-system and clinical-validation obligations. These requirements are a burden on early-stage companies and simultaneously the reason Spanish ventures arrive at European market entry with clinical evidence already in hand, becoming also a clear advantage.

The regulatory ground is currently visibly shifting on three fronts for FemTech founders:

26 March 2025
March 2027
March 2029
March 2031

The European Health Data Space (EHDS) entered into force on 26 March 2025 (Regulation (EU) 2025/327)¹⁹ creates a long term obligation and concern for founders, with implementing acts due by March 2027 and the first primary-use and most secondary-use rules applying from March 2029, extending to imaging, lab results and genomic data by March 2031. EHDS creates a structured, EU-wide pathway to access health data for research and innovation ("secondary use"), which over this horizon could materially lower the data-access barrier that early-stage FemTech companies currently face, provided they build interoperability, capturing data in the EU's common exchange format (FHIR-based) from the start rather than retrofitting it later.

2 August 2028
2 December
2027
August 2026

The EU AI Act (Regulation (EU) 2024/1689) treats any AI system that is itself a medical device, or a safety component of one, as automatically high-risk. In practice, most AI-enabled FemTech tools regulated under MDR fall into this category and inherit conformity-assessment, data-governance, technical-documentation and human-oversight obligations on

top of MDR. The timeline has just shifted: the Commission's "Digital Omnibus," adopted in June 2026, pushed the high-risk deadline for AI embedded in regulated medical devices to 2 August 2028 (and 2 December 2027 for standalone high-risk systems).²⁰ The AI-literacy obligation, however, applies from August 2026 regardless.

16 December
2025

MDR reform is now on the table. On 16 December 2025, the Commission published a proposal (COM(2025) 1023) to simplify the MDR and IVDR — explicitly targeting the certification bottlenecks, Notified Body capacity constraints and disproportionate SME compliance costs that make the "burden" side of the equation above so heavy.²¹ It aims

at roughly a 30% reduction in administrative burden and, for the first time, legally fixed assessment timelines. It is only a proposal (realistically not adopted before 2027, and likely to change substantially in negotiation), but it is the first serious signal that the EU recognises the SME burden as a problem to fix.

The current framework Spanish FemTech companies are building against today is mid-transition: EHDS may ease data access, MDR reform may ease certification, and the AI Act adds a new

layer to look after. Building for the current rules while tracking where they're headed is now part of the operating reality of founders.

Regional fragmentation

The 2021 National Digital Health Strategy established regional innovation hubs across Catalonia, Madrid and Andalusia, but health competence remains devolved to the 17 autonomous communities, each responsible for planning, organising and delivering services. For a FemTech company, this has meant up to 17 procurement processes and, until this year, no national framework for how a digital health product should even be assessed.

Last year, we said that establishing a unified validation and market-access pathway was a critical opportunity; this year, the validation side has progressed. Royal Decree 415/2026, in force from 18 June, creates for the first time a complete national framework for evaluating health technologies, and notably names digital

health products explicitly alongside medicines and medical devices.²² It builds a single national evaluation system with fixed assessment timelines, a right for developers to respond to draft reports, an early scientific-consultation mechanism, and a hook into the *Espacio Nacional de Datos de Salud* for real-world data.

That is the largest step yet toward the pathway we called for, but only on assessment, and only on paper so far. The system still has to be built: the decree gives the Ministry a year to publish the methodological instructions that make it run, and until then the old regime applies. And it fixes validation, but not market access: the evaluations are explicitly non-binding, and reimbursement and procurement still sit with the regions.

17

autonomous communities, each responsible for planning, organising and delivering services

■ THE FEMTECH SPAIN READ

So the tension is narrower but not resolved: *Somos. Contamos.* pours public money into discovery, EHDS may open the data, MDR reform may ease certification, RD 415/2026 now gives Spain one way to judge a digital product

rather than seventeen. Even a company that clears all that, still faces 17 separate roads to actual adoption. The missing piece is a national reimbursement route — without it, public money for R&D funds discovery, but stops at adoption.

04 · VOICES FROM THE ECOSYSTEM

Voices from the ecosystem



Four contributed perspectives



CO-AUTHOR NOTE

Laia Pascual
Carmen
Izuzkiza

Co-authors · Ship2B Ventures

Beyond Reproductive Health: The Case for a Gender Lens in Every Investment

Women's health is usually framed as a category: reproductive health, menstrual health, menopause, but that framing is too narrow. Sex shapes how nearly every disease shows up in the body, not just the ones labelled "women's health," and treating it as niche is costing lives and money.

Start with the money. Women's health gets only 6% of private healthcare investment, 90% of it concentrated in three areas: women's cancers, reproductive and maternal health.⁵ Just 1% of global health research funding targets female-specific conditions beyond oncology.¹ Yet the McKinsey Health Institute found the real shortfall isn't in women-specific conditions: it's in how every other disease is studied, diagnosed and treated in women's bodies. Closing that gap could add close to \$1 trillion a year to the global economy by 2040 — roughly \$3 per \$1 invested.

The clinical picture confirms it. Four in five autoimmune-disease patients are women.²³ Heart attacks — the leading cause of death for

both sexes — are 50% more likely to be misdiagnosed in women, raising their 30-day death risk by 70%.²⁴ These are two of the most common causes of death and disability, and medicine still doesn't fully account for how differently they present by sex.

Why? Start with who gets studied. Women were just 41% of US clinical-trial participants (2016–2019).²⁵ Seventy-six of the 86 most-prescribed drugs show sex-based differences in how the body processes them, yet dosing rarely reflects it, and women suffer adverse drug reactions at nearly twice the male rate.²⁶ The effect compounds downstream: across 6.9 million patients and 770 diseases, women are diagnosed four years later than men — 2.5 years for cancer, 4.5 for diabetes — because early symptoms are misread or downplayed, not because disease appears later.²⁷ Test a product on a population that's 60% male, and it underperforms for the other half — by design, not accident.

The fix has to start upstream — in the research question, the trial protocol, the consumer panel — not at the pharmacy counter. This goes well beyond drugs: diagnostics, devices, workplace health benefits and consumer products are all built and tested on male-skewed data, then assumed to work for everyone. AI is now repeating the pattern at scale: a 2024 study of cardiac-disease prediction algorithms found that even when trained on data balanced by sex, models stayed consistently less accurate for women, missing disease more often across sixteen independent experiments.²⁸

Which is why a gender lens belongs in every investment decision, not just "FemTech." A cardiac diagnostics company that improves atrial-fibrillation detection — diagnosed less often and later in women — is a gender-lens investment even without marketing itself as women's health. The test: does a product meet the needs of women and men, or was it built for one and assumed to work for both?

The fastest lever isn't product design — it's who sits at the table when capital is allocated. Only 11% of VC decision-makers globally are women, yet firms with a female partner back female founders 2.3 times more often, and firms with 30%+ female partners invest 4.7 times more in them. Women already control roughly 32% of global wealth, projected to reach 45% by 2030²⁹ — capital not yet matched by influence. Communities like Anima close that gap by bringing women from family offices, corporate leadership and entrepreneurship into the investment process as allocators, not just beneficiaries.

The performance case is already there. AOA Dx's Follow the Exits report documented 272 women's health exits (2000–2024) worth over \$91B in disclosed value; 2025's billion-dollar deals pushed realized value past \$100B, nearly half of it in the last five years alone.³⁰ FemTech looked like an emerging category mainly because it was never measured as one — legacy misclassification filed these exits under other labels, understating the sector's real scale.

This isn't a reproductive health story. It's a data quality, product design and capital allocation story — overdue by the numbers.

Women's health can no longer be a category: it's the horizontal that has to cross every level of innovation and investment.



CONTRIBUTOR NOTE

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Designing Trials for the Women They Are Meant To Serve

Getting to a clinical trial site can look a lot like getting to a university campus. Travel. Childcare. Parental care. Time away from work. Appointments during working hours. One more schedule to somehow fit into an already full calendar.

Here's what happened in education when those barriers fell. From 2007 to 2016, female graduate students adopted online education at rates averaging 20% higher than those of men. By 2016, women represented 59% of all graduate students, and 64% of online graduate students.³¹ When earning a graduate degree no longer required being physically present on campus, women captured a disproportionate share of the expanded access. Women were already the majority of U.S. graduate students when online education began its rapid expansion — but the degree to which it amplified their participation is remarkable.

For FemTech sponsors, a decentralized clinical trial (DCT) may be the single most effective tool for accelerating recruitment and improving participant retention. Having helped design and execute DCTs since the pandemic, this claim does not feel controversial. Education and clinical research involve very different motivations, risks and eligibility requirements, and the parallel does not prove DCTs will produce the same effect. But the barriers to participation are strikingly alike.

European regulators have already issued recommendations on the use of DCT elements in the EU/EEA. EMA describes their potential to reduce participant and caregiver burden and improve accessibility.^{25,26} DCT elements include remote visits, home nursing, local testing, electronic consent, digital data collection, and direct-to-patient delivery of study medicines and supplies.

The graduate-education comparator lets us put a number against the claim. A study of 1,433 U.S. drug and device trials conducted between 2016 and 2019 found that women represented 41% of participants across adult cardiovascular, psychiatric and cancer trials.²⁵ That is roughly 70 women for every 100 men. If clinical trial participation produced the same 20% relative increase as seen in graduate education, female representation could rise from 41% to approximately 46%.

This is a scenario, not a proven DCT effect. The scientifically appropriate target is not always 50:50 either. Representation should reflect the sex distribution of the affected and eligible patient population. But for FemTech, the entire point is to develop better products for women. If the product is designed for women, the trial should be designed for women too.

Doing this well requires a coordinated approach across three stages.

First, map the entire participant journey, from discovery through follow-up. How will women find your trial? Bring patient representatives into feasibility discussions. Understand what their day-to-day lives look like. Are they balancing work, childcare and

aging parents? Do they need caregiver support themselves? Are they living with reduced mobility or chronic pain? Do this before designing the protocol — DCT elements are difficult and expensive to retrofit once the protocol is finalized.

Next, challenge protocol requirements. Is each exclusion criterion necessary, or simply inherited from previous protocols? For every visit, ask: What must happen? Who must perform it? Does it genuinely require a physical clinical trial site?

Finally, remove the practical barriers. Offer remote follow-up and televisits where feasible. Use home nursing, local laboratories and direct-to-patient delivery of study products and supplies. Enable eConsent, ePRO and remote patient monitoring. Allow evening appointments. Reimburse childcare, dependent care and travel promptly. Give participants a genuine choice between remote and site-based pathways.

Online graduate education provides a powerful precedent. If clinical trials reproduce even a similar effect, the opportunity is significant: reach eligible women faster, improve retention, reduce trial costs and delays, and build stronger evidence for patients, regulators and investors.

If the product is designed for women, the trial should be designed for women too.



CONTRIBUTOR NOTE

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The Gap Within the Gaps: Rethinking Women's Health in Midlife

Spain has made significant and, in many areas, particularly progressive advances in Europe in sexual, reproductive and women's health. Over recent decades, policies have addressed abortion rights, equal maternity and paternity leave, menstrual health and period poverty, breast cancer screening and early detection, prenatal and childbirth care, access to contraception and emergency contraception, sex and emotional education, the prevention of sexual and reproductive violence, and measures to reduce gender inequalities in health.

I believe these advances matter. They demonstrate that women's health can become a genuine public health priority when policy, healthcare systems and society recognise an existing gap and decide to act on it.

But I also believe there is another gap that now deserves much greater attention: the Gender Health Gap in midlife, and particularly around menopause. Menopause is a stage of life where several inequalities can converge.

For me, this last point is particularly important. When gaps are filled primarily through out-of-pocket spending, the socioeconomic gap expands a gap within the gap. Women with greater purchasing power may be able to access specialist consultations, shorter waiting times, more personalised care and a broader range of treatment and lifestyle options. Meanwhile, women with fewer resources may have to navigate longer waits, fragmented care or, in some cases, simply go without the support they need. The risk is therefore not only unequal access to menopause care today. It is the potential accumulation of health inequalities throughout the decades that follow midlife.

In other words, innovation and quality of care should not become privileges determined by income, but improvements that benefit all women equally.

[RESEARCH, MEDICINE]

The gender gap

Women's health has historically been under-researched and underrepresented in clinical research, particularly when it comes to female-specific conditions and life stages

[HEALTHCARE]

The gender health gap

Symptoms and diseases affecting women can be under-recognised, misdiagnosed, potentially delaying appropriate prevention, diagnosis and treatment

[HEALTHCARE MIDDLE-LIFE]

The menopause gap

Care is often fragmented, with significant differences in awareness, diagnosis, treatment and long-term follow-up

[INCOMES]

The socioeconomic gap

Access to specialist consultations, treatments, lifestyle interventions and preventive care can increasingly depend on disposable income

[HEALTHCARE SYSTEM]

The public-private gap

In Spain, a woman's experience of menopause care can vary considerably depending on whether she relies exclusively on the public health system or has the financial means to complement it with private healthcare

This is precisely why the recent announcement by the Spanish Government is such an important opportunity. In June 2026, it was announced that they will triple investment in research and development specifically dedicated to women's health, reaching €18 million per year.⁹ The initiative explicitly includes areas that have historically received insufficient attention, including chronic pain, autoimmune and thyroid diseases, cardiovascular and mental health, menopause and hormonal health.

What I find particularly significant is not only the increase in funding, but the recognition of the structural nature of the problem. The Government framed this initiative as an effort to

reduce inequalities across the entire biomedical research and innovation pathway. Menopause is therefore being acknowledged not as an isolated issue, but as part of a broader challenge in women's health research, diagnosis and care.

The next challenge, in my view, is to bring that same ambition to midlife women's health and menopause: improving professional and public education, developing integrated models of care, prioritising prevention and ensuring equitable access regardless of socioeconomic status. In other words, innovation and quality of care should not become privileges determined by income, but improvements that benefit all women equally.



CONTRIBUTOR NOTE

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The FemTech Founder's Journey

Looking back, building OXOLIFE remains one of the most rewarding and transformative experiences of my professional life. Founding a deep-science company in women's fertility was never going to be easy. Over more than a decade, we navigated scientific, regulatory, and financing hurdles — and every obstacle reinforced our belief that we were addressing a critical, long-overlooked medical need.

Over fourteen years, we completed several financing rounds, secured around €15 million in funding, and advanced genuinely innovative science in an area of enormous unmet need. What it took was conviction, resilience, and a relentless focus on the science — combined with treating fundraising not as a one-off event, but as a continuous activity. Every investor, grant

agency, pharmaceutical company and advisor views an opportunity through a different lens, and success depends on understanding those perspectives and building trust over time.

As we progress to the clinical stage, a new challenge emerged on top of the scientific and operational demands: it was no longer about proving scientific potential, but about accessing the scale of capital that clinical-stage development demands. We often encountered a gap between interest and commitment — many investors recognised the importance of women's health, but few had the mandate or expertise to back therapeutic innovation in the sector long-term. This isn't unique to OXOLIFE; it reflects a broader reality in which women's health remains significantly underfunded relative to the scale of the need.

My advice to other founders: stay close to the mission, build exceptional science, surround yourself with people who share the long-term vision, and be ready for a journey that may take longer than expected.

Receiving the EU Women Innovators Prize in 2025 was an incredible honour. The award recognises the breakthrough innovation, impact and inspiration behind our work and it validated the dedication of the entire team. But recognition and financing do not always go hand in hand: awards create much-needed visibility and momentum, while clinical development requires sufficient long-term capital. I see this less as a contradiction than as a snapshot of where the ecosystem stood at that moment — society increasingly recognises the importance of women's health innovation and is slowly beginning to catch up.

If I could change three things: more specialised investors with deep expertise in women's health therapeutics; public funding mechanisms that better reflect clinical-stage timelines; and greater continuity of support. One of the most important lessons I learned is how critical timing can be. Closing a significant financing round depends not only on the quality of the science and the strength of the company, but also on whether investors, pharmaceutical partners, financial institutions and public funding bodies are ready to commit at that particular point of time. This is something founders cannot fully control. More continuous funding mechanisms for validated technologies would help ease capital constraints and provide greater financial visibility. While raising capital will always be part of building a company, reducing funding gaps would help companies move faster through development and bring solutions to patients sooner. This is the core of what I take from the OXOLIFE experience: OXOLIFE proved that the science

was solid. The real challenge was a financing ecosystem still immature for women's health. Even so, the sector is moving in the right direction — women's health is attracting more attention, talent and investment than a decade ago, and that momentum is accelerating.

That conviction is exactly why I'm so energised about this new chapter as CEO of ORIVA Therapeutics. We're building the company with the lessons of the past decade fully in mind: a clear therapeutic focus, robust science, an experienced leadership team, a clear development strategy, and investors who understand what long-term clinical-stage innovation requires. Our mission is to develop transformative therapies for chronic gynaecological diseases, starting with endometriosis — and what excites me most isn't only the science itself, but the combination of science, team, commitment and aligned capital behind it.

ORIVA was born with precisely what that journey taught us: the right lessons, the right team, the right science, and the right investors to take this vision further.

My advice to other founders: stay close to the mission, build exceptional science, surround yourself with people who share the long-term vision, and be ready for a journey that may take longer than expected. Progress in women's health has never been linear — but it is accelerating, and I've never felt more confident that ORIVA is positioned to lead this next chapter.

05 · CAPITAL

Funding & investment trends



A harder year, honestly told

Proven market, marginal allocation

The case for women's health has never been better evidenced. The market size is measured, the disease burden is quantified, the exits are on the record, but what is still missing is capital that matches the evidence. The global picture is by now familiar: 6% of private healthcare capital to women's health, 90% of it concentrated in just three areas (maternity, reproduction, and

oncology).⁵ What this means is that proven demand and demonstrated returns are receiving marginal allocation. Closing the gap on four conditions alone — menopause, osteoporosis, Alzheimer's, and cardiovascular disease — could unlock more than \$100 billion in market value by 2030 if all women received the standard of care.³⁴

6% of private healthcare capital to women's health	<1% to purely women's-health- specific companies	\$100B+ in market value by closing the gap on just four conditions	\$2B invested in women's health, 2025
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Women’s health is a market inefficiency.

A harder year, and the missing middle

In the same window, the money got harder to raise. Silicon Valley Bank recorded roughly \$2 billion invested in women's health in 2025, down from the 2024 peak, with a \$1.2 billion pullback in US venture capital specifically — a dip SVB attributes to the sector's therapeutics weighting leaving it outside 2024's AI surge, and

expects to reverse in 2026.³⁵ Where large money did land, it went to companies already at scale; two of them, Midi Health and Pomelo Care, reached unicorn status by March 2026 and between them raised over half of the year's women's health total.³⁵

The top of the FemTech market has set records, but the floor has gotten harder.

The gap is not attention: the equity market is broadening, with W Group recording \$1.55 billion across 85 rounds in 2025 and ten institutional-scale deals over \$50 million, double the prior year.³⁶ Only about one investor in seven has women's health in their

strategy as a named vertical,³⁶ whilst half of all investment in women's-health-specific companies globally still sits at the earliest stages, against a third for healthcare overall.⁵ This is the shape of the global market Spain is raising into.

■ THE FEMTECH SPAIN READ

The gap is the missing middle — the Series A and B cheques that carry a validated seed company to scale, and the generalist conviction to treat women's health as a standard portfolio line rather than a thematic bet.

Spain: what this year showed

Spain's FemTech sector is still in the early stages. Barcelona's FemTech ecosystem raised only €8.3 million in 2023 (still an eightfold increase on 2019),³⁷ and most rounds in Spain have sat at a seed stage below €2 million. Deal flow through 2024–2026 has been steady but modest: mid-sized, early-stage rounds rather than breakout raises. European Series A valuations for FemTech run 20–30% below comparable digital-health companies,³⁸ the double-edged fact of the industry. For a founder, it is a structural penalty for being filed under "women's health". For an investor, it is the entry argument: priced below the broader digital-health market while addressing demonstrably underserved demand.

This discount is explained by the missing investor base. With no Spanish venture fund dedicated exclusively to women's health, nor a defined women's health vertical in a broader fund, generalist and

pan-European funds dominate. Specialist investor depth remains thin internationally too: as of June 2026, only seven investors appeared in more than one disclosed FemTech round globally.³⁹ The constraint is not conviction among a small group of specialists, but the fact that the category has not entered generalist investment theses yet.

20–30%

below comparable digital-health companies: European Series A valuations for FemTech³⁸

A second problem is that there are two investor types looking at Spanish FemTech, and each is waiting for something the other does not require. The clinical investor wants de-risked science, and much of Spain's pipeline still needs basic research to get there, so the money that

understands the technology often arrives late. The generalist investor, on the other hand, wants revenue proof, when health has a willingness-to-pay problem in a public-system market where women are the least likely to spend on their own care. Companies die between the two walls, and Spain is exposed on both given its maturity and the FemTech solutions mix we saw before.

This is also the year the first public money arrives with women's health written on it. €15M through CDTI is not growth capital, but it changes what a seed round has to carry. Interest in Spanish FemTech is real and rising, helped this year by that reserve and, in RD 415/2026, a single national route to evaluation. But the capital arriving is early-stage, small, and discounted relative to adjacent sectors. This missing middle is where public money and private capital ideally would meet.

Who is pushing forward women's health, from local to international actors



Image 4: Broader FemTech Ecosystem mapping in Spain, including Capital, Health Adoption, Knowledge, Advocates, Enablers and Visibility institutions.

06 · OUTLOOK

Strategic landscape: looking ahead

What has to happen next

THE FEMTECH SPAIN READ

The gap this year is no longer awareness, but infrastructure.

Spain now has the two things it lacked when we published the first edition of this report: a mapped ecosystem and a named national priority with money attached. What it does not have is a road from funded research to reimbursed care, or the capital to carry a clinical company down it. The gap this year is no longer awareness, but infrastructure.

A national reimbursement route

RD 415/2026 gave Spain, for the first time, one way to *evaluate* a digital health product instead of seventeen. That is the furthest we have come toward the pathway we called for last year. But this just fixes assessment, not access. The evaluations are non-binding; reimbursement and procurement still sit with the regions. So the picture sharpens rather than resolves: *Somos*.

Contamos. funds discovery nationally, RD 415/2026 now evaluates health technologies under a unified national system, and a company that clears both still faces seventeen roads to adoption. France reimburses through PECAN, Germany through DiGA. Public research funding without a reimbursement pathway subsidises discovery and stops before deployment.

The CDTI mission makes this gap more visible, not less: we are funding women's health research at national scale into a system with no national route to market.

Growth-stage capital for clinical companies

Spain has a solid seed capital ecosystem, both domestic and European. However, there remains a significant funding gap — in Spain and internationally — for clinical-stage women's health companies seeking growth capital to advance into later stages of development.

Closing this gap will require mobilising strategic corporate capital, impact investors and family offices with longer investment horizons, alongside strengthening public co-

investment mechanisms.⁴⁰

We are nevertheless optimistic that this is beginning to change. We are seeing early signs of a shift in the market, with growing interest from pharmaceutical companies that have historically been largely absent from investment in women's health. This emerging strategic interest could play an important role in unlocking the growth capital needed to build and scale the next generation of women's health companies.

The ecosystem needs coordination

Much of the opportunity this year is only reachable through coordination. Both CDTI instruments fund consortia. Ininterconecta opens in October and closes in November. FemTech companies need to partner with hospital networks or insurers to run pilots to show their product works in real settings, with real patients. Public money now flowing into women's health

research will only pay off if the studies it funds disaggregate by sex from the start, otherwise we fund a new generation of research on the old blind spot.

The consortia, the pilots, and the research standards have one thing in common: none of them assemble themselves.

Spain has the companies, the institutions and now the public money. What it is missing is the connective capacity to bring them together, and that is the gap the FemTech ecosystem has to close.

Conclusion

The case for women's health has never been better evidenced: nine conditions account for a third of the gap, broader women's health research yields a highly competitive 3:1 return on investment,⁴¹ and two and a half decades of exits total more than \$100 billion.³⁰ **Spain has, for the first time, named women's health as a national research mission and reserved public money against it.**

And yet, in the same year, one of the country's most decorated FemTech companies ran out of road, global funding contracted, and early-stage founders started lowering valuations to get institutional money through the door. **Six percent of private healthcare capital reaches women's health; under one percent reaches the companies built specifically for it.**

Both of those realities define the women's health sector. The economic potential of FemTech companies is huge, and yet they are among the hardest companies to finance. **Closing this gap is not a question of awareness anymore — we are finally seeing the awareness, but are missing the infrastructure to enable the change:** a national route from

evidence to reimbursement, capital that can hold a clinical company through the years when it is expensive and unfinished, and the coordination to put consortia together when public money appears. **If Spain builds these, it will become a European (and International) leader.**

When health systems are designed for women, they are better designed for everyone. Spain is now close enough to that to be judged on execution rather than intent.

07 · APPENDICES

Appendices & Sources

Methodology, references, sources

Appendix 1 • Market Map methodology

Inclusion. A company must meet the following criteria to be included in the map:

Working website: proof the company is still active.

Active Spanish operation in the reporting year: Spain as a primary hub, not just a served market. For example: Natural Cycles is available here, but it is not a Spanish FemTech company.

Core FemTech service, or a validated women's-health use case: the map includes generalist companies with a specific line validated in women's health, alongside dedicated ones.

Clinical categories. Nine verticals: General Health & Wellness, Reproductive Health, Perimenopause & Menopause, Oncology, Maternal Health, Menstrual Health & Contraception, Mental Health, Pelvic Health, Endometriosis.

One category per company, assigned by the main solution's primary condition or life stage, not by everything the product touches.

Benchmarked against the schemes used by the main international FemTech maps, so Spain can be read against other markets.

Single assignment costs nuance and buys comparability. Double-counting would inflate the smaller categories.

Product type. A second, independent axis: what the company builds, regardless of clinical category. Five types in 2026, refining the 2025 scheme by resolving an ambiguity in how diagnostics were labelled.

Software / Digital Platform — apps, SaaS, telemedicine, digitally-delivered programmes.

Consumer Health / D2C — physical consumer goods sold direct, including supplements, menstrual products, health textiles.

Physical Device / Product — regulated hardware and medical devices whose core value is the device itself.

Therapeutics — therapeutic interventions or the underlying biology, including drug and treatment R&D.

Diagnostics — tests, biomarker platforms, liquid biopsy and lab-based diagnostics producing a diagnostic result.

Limits. Stealth companies are absent by definition, and foreign companies without a Spanish base are excluded, however large their user numbers here. The snapshot this year is as of August 2026.

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