



# Gender Gaps: A Structural Challenge in Global Health

## What Role Can Spain Play?

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## EXECUTIVE SUMMARY

Gender gaps constitute a structural problem that permeates global health. Although women have a higher life expectancy, this does not translate into a better quality of life, precisely because of historical inequalities that limit their access to resources, recognition, and healthcare. These gaps are reinforced by persistent biases in scientific research, marked by an androcentric approach, a lack of gender-disaggregated data, and the underrepresentation of women in leadership positions in the health sector. This has a detrimental effect on the health of all people whose genders are not represented in the masculine ideal.

To properly understand these dynamics, an intersectional and decolonial approach is essential to analyze how factors such as race, social class and colonial legacies exacerbate and complicate these disparities.

In this context, technological advances—and in particular the growing integration of artificial intelligence into health systems—pose new challenges, as there is a risk of reproducing and amplifying existing gender inequalities. Added to this is an international landscape marked by a funding crisis, shifts in the global health ecosystem, and reactionary political trends that threaten previous gains in equality. An example of this is the rollback of sexual and reproductive rights.

In light of this situation, Spain is positioning itself as an international leader through its Feminist Cooperation Strategy, which represents a model aimed at transforming global health governance and advancing toward social justice in health.

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# Introduction

**“Gender health gaps are the result of structural mechanisms that span from knowledge generation to healthcare delivery and the global health governance ecosystem.”**

Health disparities between women and men constitute one of the persistent pillars of inequality at the global level. Women have a higher life expectancy than men; however, this quantitative advantage does not translate into a better life. On the contrary, a greater proportion of women’s life years are spent with illness, disability, or functional limitations that have a major impact on their quality of life, a result of structural health inequality at the global level.<sup>1,2</sup> This inequality permeates every step of the process, from decision-making to healthcare delivery, including scientific research and the design of technologies. It is also present in the living conditions that have a direct impact on health, as women are subject to economic, social, and political vulnerabilities.

**According to data from the European Union (EU):**

Men spend a greater proportion of their lives in good health compared to women (79.8% versus 75.4%), despite having a shorter life expectancy.<sup>3</sup>

Women live approximately 25% of their lives with some form of disability, while for men the figure is 20%.

This gap is consistently replicated across multiple contexts and is linked to both biological factors and historically entrenched social determinants. Women have a higher prevalence of chronic, and disabling diseases (arthritis, osteoporosis, autoimmune diseases, depression, and dementia), as well as specific diseases that have traditionally been neglected in biomedical research and underprioritized in health planning. These knowledge gaps lead to diagnostic delays, less effective treatments, and a systematically underestimated burden of disease among women.

Gender, understood as a social and power structure, has historically been configured as binary and exclusionary. The binary understanding of gender—male-female—has subordinated women, but also all non-cisgender identities, that is, trans and non-binary people. This has given rise, through interaction with other social structures, to a **form of social order** that entails power relations and hierarchies determining the distribution of resources, roles, opportunities, and social recognition. Gender operates as a key determinant of health.

The World Health Organization (WHO) defines gender roles as social constructs that shape the behaviors, activities, expectations, and opportunities considered appropriate in a given sociocultural context for all people.<sup>4</sup> These dynamics influence differential exposure to risks, access to resources—including health care systems—and the ability to make decisions about one’s own health.<sup>5</sup>

As stated in a United Nations report,<sup>4</sup> **gender justice** is defined as the elimination of inequalities between women and men within the family, the community, the marketplace, and the state. This also involves recognising all genders—including transgender and non-binary people—and their inequalities, realities, and health status. In the realm of health policy, this would translate into identifying these differences and creating robust strategies to prevent their perpetuation.

To structure the analysis, the document draws on **four priority areas of intervention** proposed by the World Economic Forum to close the gender gap in health. This framework was chosen because it has the capacity to influence the global agenda and facilitates the identification of priorities for action:

- **Science:** biomedical research has historically been shaped from an androcentric perspective, that is, one in which **the male body has served as the reference standard**. This orientation has been reinforced by the **low representation of women on research teams and committees**, a factor that has determined which questions have been considered relevant and which lines of study have been prioritized. As a result, throughout history, fewer medical treatments have been specifically validated or designed for women.<sup>6</sup> As an example, medications in general are 3.5 times more likely to be withdrawn from the market due to safety risks specific to women, while biomedical inventions patented by women are 35% more likely to specifically benefit women's health.<sup>7</sup>
- **Data:** The **gender data gap** significantly limits our understanding of diseases that affect women differently. Although various international commitments, such as the Sustainable Development Goals (SDGs), require the disaggregation of data, such data is rarely reported or is reported only superficially. The lack of conceptual clarity and inconsistency in data collection have led to gender being incorporated in a fragmented manner, hindering the generation of robust and comparative knowledge in global health.
- **Care delivery:** Women are more likely to face barriers to accessing healthcare, as well as to experience **diagnostic delays**<sup>8</sup> or receive **inadequate treatments**. Furthermore, the burden of disease among women is systematically underestimated, largely determined by the interaction of gender with other vulnerabilities.
- **Chronic underfunding:** gender inequalities in health are also reflected in international funding patterns. Despite growing institutional concern for gender equity, a significant portion of global Official Development Assistance (ODA) continues to lack objectives that actively address gender inequality, including in health cooperation.

This document is based on the premise that gender gaps in health are the result of structural mechanisms that span from knowledge generation to healthcare delivery and the global health governance ecosystem. The objective is to provide a framework that allows for contextualizing these mechanisms within the current landscape and posing relevant and necessary questions.

Therefore, we will first explain the current context and ecosystem of global health, followed by a clarification of key concepts regarding the distinction between gender and sex, and their interaction with other categories of vulnerability. We will then outline three major biases—leadership, the digital divide, and evidence bias—that contribute to inequality, among other factors. Finally, we will highlight the remaining gaps and key questions that will chart a path for further reflection on gender inequality in global health.

# Current International Context, Goals, and Budget Cuts

**“Ending gender-based health inequalities globally is among the goals of the 2030 Agenda and comes at a critical moment for the global health ecosystem, with a funding crisis that particularly jeopardizes initiatives developed to address these inequalities.”**

Ending gender-based health inequalities globally is one of the goals of the 2030 Agenda and comes at a critical moment for the global health ecosystem, with a funding crisis that particularly jeopardizes initiatives designed to address these inequalities. The disappearance of these initiatives, at a time when women’s rights are being eroded in countries where they were once considered consolidated, would mean losing a shield against this reactionary drift. Initiatives such as Spain’s recently approved Feminist Cooperation Strategy provide a good example of how to direct cooperation efforts toward ending this global inequality and will be discussed later in this document.

## Relevance to the 2030 Agenda and the Current Context

Gender equality is a **cross-cutting theme of the 2030 Agenda** and a prerequisite for progress on several key SDGs.<sup>9</sup> As of today, only **15.4% of the indicators** for SDG 5 (Gender Equality) **are on track**,<sup>10</sup> although only 57% of the data needed to adequately monitor progress is available.<sup>11</sup>

At this rate, it would take centuries to end child marriage, eliminate gender-discriminatory laws, and achieve equality in leadership and political representation. These gaps reflect **deeply entrenched systemic** barriers: nearly 2.4 billion women still lack equal rights and economic opportunities. In fact, 178 countries maintain legal barriers that restrict women’s autonomy; a particularly telling example is child marriage: in 2019, one in five women aged 20 to 24 was married before the age of 18.

Although SDG 5 directly addresses gender equality, it is necessary **to integrate this perspective into all public policies**. All stakeholders must ensure parity in decision-making, promote equitable access to resources, and foster women’s full participation in all spheres.

## The Importance of the Global Dimension: Partnerships and Multilateralism Under Scrutiny

The global health system currently faces significant structural challenges, including a funding crisis, the rise of nationalism, and the absence of clear and sustained leadership in multilateral organizations. These factors have weakened mechanisms for international cooperation and led to increasingly fragmented and less effective responses.

Foreign policy dynamics indirectly reflect domestic political dynamics. Ultra-conservative state and non-state actors have promoted active opposition to what they call “gender ideology.” These narratives seek to reverse decades of progress on women’s rights, delegitimizing political and social rights based on gender equality. In countries such as the United States, Hungary, Poland, Brazil, and Argentina, there have been regulatory setbacks regarding sexual and reproductive rights, including the right to abortion.<sup>12</sup> This has spilled over into cooperation initiatives beyond their borders. A notable example is the case of the United States, which based much of its initial ODA cuts on defunding programs that “promoted abortions,” effectively ending funding for its global family planning initiatives.<sup>13</sup>

Until now, the U.S. allocated 607.5 million euros annually to global family planning and reproductive health programs; according to estimates, the loss of these funds will result in 17.1 million unintended pregnancies and, consequently, the deaths of 34,000 women and girls from childbirth-related complications.<sup>14</sup>

These tensions result in deadlocks over the adoption of resolutions, which end up being drafted in watered-down language, avoiding explicit references to gender and/or sex.<sup>15</sup> The negotiation process for the Pandemic Agreement has been criticized for failing to incorporate a sufficiently robust gender perspective.<sup>16</sup> These dynamics are not limited to the health sector; similar debates have taken place in international forums such as COP30.<sup>17</sup>

The funding crisis exacerbates this situation. In a sector that has historically been underfunded, cuts will result in the loss of programs that served as the last line of defense for the most vulnerable groups.

In this context, building strong alliances takes on strategic importance. Initiatives such as the Feminist Cooperation Strategy place crucial emphasis on identifying with whom alliances are formed and how they are built. The goal is to actively move beyond traditional models of cooperation—which are often vertical and paternalistic—to foster genuinely collaborative, equitable relationships grounded in a decolonial perspective.<sup>18</sup>

TABLE 1.  
The Case of Spain:  
Feminist Cooperation  
and Global Health

Spain's **Feminist Cooperation Strategy** represents an evolution toward transformative foreign policy that seeks to eradicate structural gender inequalities through an **intersectional** approach and the fair redistribution of power. This policy is based on four fundamental pillars: **rights, representation, resources, and alliances**.

Within the framework of **global health**, this strategy is closely aligned with the **Spanish Global Health Strategy 2025–2030**, highlighting the following points of connection:

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— **Guarantee of Sexual and Reproductive Health and Rights (SRHR):** This is the strongest point of connection. It is considered a pillar of universal public health and a fundamental human right. This includes universal access to contraception, voluntary termination of pregnancy, comprehensive sex education, and the fight against female genital mutilation.
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— **Equity and Social Determinants Approach:** It recognizes that gender is a critical social determinant that generates avoidable and unjust health inequalities. Therefore, it promotes the strengthening of **public and resilient health systems** based on primary and community care.
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— **Economics and Ethics of Care:** aims to transition toward a “care society” that places the **sustainability of life** at the center. This involves recognizing the value of care, redistributing the burden of unpaid work borne by women, and strengthening public systems that guarantee the right to care for others and to be cared for.
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— **Leadership in Specific Initiatives:** Spain projects its feminist approach through leadership in the global elimination of **cervical cancer** and the humanization of maternal health, integrating this vision into scientific diplomacy and innovation.
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— At least **60% of new cooperation interventions** must have a clear positive impact on gender equality, ensuring that global health is a space for empowerment and social justice.

## SECTION 2.

# Conceptual Clarifications and Intersectionality

**“Although gender is a central axis of inequality, gender justice in health requires analyzing its interaction with other social, political, economic, and legal determinants that collectively influence the health and well-being of populations.”**

To address this topic in depth, it is necessary to make some notes on the historical meaning of gender and its relationship to colonialism and the effect it has had on everyone’s health, as well as to discuss the concepts of sex and gender to understand how they are being used in this context. It is also necessary to keep in mind the concept of intersectionality to understand that many factors interact with one another to give rise to inequalities.

## Colonialism, Traditional Gender Hierarchies, and the Historical Evolution of Sexual and Reproductive Health

The United Nations Secretary-General’s report,<sup>19</sup> published in July 2023, emphasizes that the gender health gap should not be understood as a contemporary phenomenon, but rather as the **result of a historical trajectory** in which colonialism has played an essential role. Colonial systems, underpinned by patriarchal, binary, and hierarchical frameworks, imposed legal, religious, and scientific structures that institutionalized inequalities of gender, sex, and race. These asymmetries persist in postcolonial contexts. Estas asimetrías perduran en los contextos poscoloniales.

Colonial powers reinforced **gender binarism** through laws and practices rooted in an androcentric model dominated by the male gender. This approach had several effects: on the one hand, it intensified violence and discrimination against people of non-hegemonic genders and identities for the colonial powers. On the other hand, it imposed colonial medical systems, displacing traditional birth attendants and midwives, and favoring the formalization of healthcare systems controlled primarily by men.<sup>20</sup> Furthermore, colonialism constitutes one of the main historical roots of restrictive abortion legislation, which was in force in most countries by the late 19th century.<sup>21</sup>

Ignoring the colonial legacy in the analysis of the gender gap in health limits our understanding of its structural determinants and reduces our ability to effectively design global health policies.

## Conceptual Distinction: Sex versus Gender

Sex and gender interact in complex and close ways in shaping health outcomes and are not interchangeable concepts.

According to a report by the *Lancet* Commission on Gender and Global Health (2025), **sex** primarily refers to **biological characteristics** linked to sexual reproduction, including chromosomal genetics, hormonal profiles, and secondary sexual characteristics, such as the reproductive system. These characteristics have traditionally been grouped into two sexes, but there are combinations of these characteristics that do not correspond to the binary categorization into two categories, making such a classification exclusionary. In quantitative research, sex is typically classified dichotomously as male and female, a simplification that, while operational in certain analytical contexts, has limitations in capturing the existing biological diversity.

**Gender** must be understood as a **social structure** interwoven with power relations that determine the distribution of resources, roles, opportunities, and social recognition. Gender constitutes a way of organizing society that begins by assigning social mandates to bodies and is naturalized based on factors such as religion or biology.<sup>22</sup> There is a symbolism of the masculine and the feminine that extends beyond the individual biological characteristics of men, women, and transgender and non-binary people, and shifts according to its political and social context. This normative system establishes hierarchies of legitimacy for bodies, identities, and behaviors, privileging those categories that conform to the binary and heteronormative norm, while those who do not fit these standards face exclusion and social delegitimization. Within this hierarchy, the categories that conform to heteronormative binarism are not homogeneous in terms of power: although women are legible and normative, they are subordinated to masculinity due to the historical and social structuring of power, which positions masculinity as the dominant category.<sup>23</sup>

Gender norms also affect **men's health**, encouraging risky behaviors such as increased alcohol and tobacco use and a higher incidence of accidents—factors largely responsible for their premature mortality.

According to an analysis by *Global Health 50/50* (2022), only 3% of global health organizations explicitly recognize men and boys as beneficiaries of gender equality efforts.

## Intersectionality: How Gaps Are Amplified by Race, Class, Sexual Orientation, and Disability

Although gender is a central axis of inequality, gender justice in health requires analyzing its interaction with other social, political, economic, and legal determinants that collectively influence the health and well-being of populations. The *Lancet* Commission on Gender and Global Health underscores the need to examine how “multiple exclusions and oppressions intersect and interact” to produce unequal health outcomes.

Career opportunities and barriers do not affect all groups of women uniformly; factors such as **race, ethnicity, sexual orientation, and socioeconomic status** significantly shape access to employment, career advancement, and participation in decision-making.<sup>24</sup> For example, in South Africa, it has been observed that the intersection of race and gender substantially limits the career advancement of Black women in leadership positions, and in low-income contexts, the lack of access to education restricts women’s entry into and advancement within the healthcare sector.<sup>25</sup>

TABLE 2.  
According to the State  
of World Population  
2024 report

- Access to basic sexual and reproductive health services is deeply shaped by structural inequalities related to gender, socioeconomic status, ethnicity, sexual orientation, and disability.
- Women of African descent are more vulnerable to obstetric violence and experience poorer maternal health outcomes.
- Indigenous women also face a lack of maternal care and the criminalization of traditional childbirth practices, which significantly increases the risk of maternal death.
- Women and girls with **disabilities are up to ten times more likely to experience gender-based violence** and, at the same time, face greater barriers to accessing sexual and reproductive health services and information.
- The stigma and discrimination affecting LGBTQIA+ people are not only a violation of rights but also act as direct determinants of profound health inequalities.

## Biases and Vulnerabilities

**“The underrepresentation of women in decision-making, evidence generated from androcentric frameworks, and the reproduction of biases in digital and data tools contribute to the consolidation of priorities, investments, and policies that do not equitably address the needs of the entire population.”**

In global health, gender biases present in public policies and funding flows must be understood as an expression of deeper imbalances that permeate the system. The underrepresentation of women in decision-making, evidence generated from androcentric frameworks, and the reproduction of biases in digital and data tools contribute to the consolidation of priorities, investments, and policies that do not equitably address the needs of the entire population.

### Leadership, the wage gap, and underrepresentation in the global health sector

Women are the backbone of the healthcare workforce. Paradoxically, as one moves up the salary and hierarchical ladder, their representation diminishes.

Globally, women account for approximately **70% of the global workforce in the health and social care sectors**. However, they hold only a minority of leadership positions in health ministries, private sector companies, and medical schools, and are underrepresented in decision-making spaces. Current estimates suggest that it would take approximately 176 years to achieve parity in management and leadership positions globally.

In terms of wages, the gender pay gap per hour worked is wider in the health and care sector than in other sectors: **women earn, on average, 19.2% less** than men, compared to 11.5% less in other economic sectors.<sup>26</sup> Furthermore, 76% of unpaid care work is performed by women, which limits their availability for paid employment and career advancement.<sup>27</sup>

A 2019 WHO report already showed that the **gender pay gap in the health sector exceeds that of other sectors**: on average, female health workers earn 28% less than their male counterparts, and the wage gap between men and women working in nursing and midwifery stood at 11% even after accounting for occupational segregation.<sup>28</sup> A 2024 report showed that this gap persisted even after controlling for variables such as working hours or educational level.

### Biases in the Evidence: Problems in Data Collection and Lack of Standardization

Statistical data constitute one of the fundamental pillars of public policy and decision-making processes in the health sector. They enable the identification of population priorities, the evaluation of the effectiveness of implemented interventions, and ensure that policies reach the target population equitably.

Having disaggregated data to highlight inequities and inequalities is essential. When public agencies collect health data, although progress has been made in gathering information on sexual and gender minorities, these efforts remain sporadic, fragmented, and unsystematic. Furthermore, they are sometimes hindered by social stigmatization or the criminalization of certain communities and identities.<sup>29</sup>

An analysis conducted in 2022 by *Global Health 50/50* showed that during the COVID-19 pandemic, only five countries reported data disaggregated by ethnicity or disability, and only four reported on COVID-19 in pregnant women. This is not an isolated phenomenon but reflects their systematic exclusion, as is also the case in clinical trials. There is a lack of robust information to guide therapeutic decisions, leaving significant gaps in maternal and child health care and research.

This situation is further compounded by inequalities in national research policies and investment in knowledge generation, which positions the Global North as the primary producer of health evidence. We must take into account power asymmetries in the definition of research agendas, data production, and the interpretation of results, as well as their implications for the applicability of evidence in diverse contexts.<sup>30</sup>

Finally, it is necessary to question the limited integration of the sex-gender approach into medical education, as biases are introduced from the earliest stages of learning.<sup>31</sup> Medical education continues to focus primarily on **male biology as the standard**.

We must not lose sight of the fact that scientific evidence generates a hegemonic narrative on health permeated by patriarchy, which renders a portion of the population invisible. This leads to the design of technologies, protocols, and strategies that result in incomplete or delayed diagnoses, poorly targeted treatments, and outcomes that are difficult to evaluate and compare.

### Gender Digital Divide: The Threat of Bias in AI

Digitalization has substantially transformed global development and has been key to increasing access to education and healthcare, but in many cases it acts as an amplifier of inequalities.<sup>32</sup> On average, women have **less access** to digital technologies. In 2023, 70% of men had internet access, compared to 65% of women<sup>33</sup>—a disparity that is more pronounced in countries of the Global South.

The growing use of Artificial Intelligence (AI) presents both opportunities and risks. Although the use of these tools can facilitate research and healthcare, we cannot overlook how they work. In many cases, opaque algorithms and their use of pre-existing data—already biased by the aforementioned issues—cause **AI tools to replicate biases**. With one caveat: rather than being a process mediated by “human intelligence,” they do so through a process that is unknown. Consequently, there is a danger that the information returned by AI will reproduce and even amplify existing biases.

In the healthcare sector, one example is how AI systems applied to diagnosis can **reproduce and amplify gender and ethnic inequalities**. A very clear example lies in the misinterpretation of cardiovascular symptoms, where algorithms—developed primarily using data from men—tend to misinterpret the clinical manifestations most common in women. Similarly, in mammogram analysis systems trained on ethnically homogeneous populations, there are limitations in extrapolating results to the general population.

Thus, AI can become a factor that **mitigates or exacerbates** gender inequalities. The ultimate impact will depend on who designs these technologies, the data used to train them, and the extent to which biases are prevented or reproduced.

# Spain's Transformative Leadership as We Look Ahead

**“Spain’s determination in defending women’s equality constitutes a distinguishing value in the current global health architecture.”**

As detailed throughout this report, gender gaps in global health are not mere statistical disparities but the result of **structural mechanisms** and historical biases that permeate science, data collection, and governance. At a historic moment marked by a **reactionary offensive** that threatens to roll back established rights, the response cannot be merely technical, but must be deeply political. In this context, **Spain positions itself as an international leader** capable of spearheading the response to the fundamental questions that will shape the future agenda.

**Spain’s Feminist Cooperation Strategy** and its **Global Health Strategy 2025–2030** provide a solid framework for spearheading the necessary transformation in the following areas:

- **Challenging patriarchal structures in science and technology:** Faced with the question of how to overcome androcentric conceptions in research, Spain can lead through its **scientific diplomacy and innovation**. By promoting the abandonment of the male body as a universal norm, ensuring that the knowledge generated is representative of human diversity.
- **AI governance and data sovereignty:** Faced with the risk that Artificial Intelligence will act as an “echo chamber” for misogynistic biases, Spain has the opportunity to promote international regulatory frameworks that require **transparent algorithms and data disaggregated** by sex and gender.
- **From representation to the transformation of power:** The Spanish model, based on the **redistribution of power and resources**, addresses the need for the increase in women in decision-making positions to be more than merely quantitative. Spain can advocate for a transformation of global health spaces—currently “intrinsically masculine”—toward **feminist governance** models that recognize and adequately compensate the work of women, who constitute the backbone of the system.
- **Practical intersectionality and rights advocacy:** Spain’s commitment to an **intersectional and decolonial** approach is key to addressing inequalities comprehensively. Spain’s leadership must ensure that health policies recognize how race, class, and disability amplify barriers to access.
- **Protection of Sexual and Reproductive Health Rights (SRHR):** In the face of the rollback of rights driven by ultra-conservative coalitions, Spain must act as an **international shield**. Through cooperation that prioritizes SRHR as a pillar of universal public health, Spain’s role is fundamental in securing the funding and political will necessary to protect women’s autonomy in forums such as the WHO.

In conclusion, Spain’s determination to **defend women’s equality** constitutes a distinguishing value in the current global health architecture. Spain’s firm stance against reactionary trends and its commitment to **feminist governance** position the country as a key actor in ensuring that health is a space for real empowerment and the full exercise of human rights for all women and girls worldwide.

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