Pathways to impact

Advancing gender equality, health equity and the right to health through WHO's Special Programming Initiatives

Contents

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Introduction

The Fourteenth General Programme of Work (GPW 14) of the World Health Organization (WHO) represents a global health strategy for 2025–2028, with the vision to save 40 million lives over its four-year span *(1)*. The GPW 14 pursues a threefold mission: to promote health by addressing the root causes of disease; to provide health by strengthening health systems; and to protect health by preventing, preparing for, mitigating, detecting and responding to health emergencies. WHO's mission to achieve health for all is grounded in a steadfast commitment to gender equality, human rights and health equity, captured within the guiding principles of GPW 14 and reflected in its strategic objectives.

According to the United Nations 2024 report on the Sustainable Development Goals (SDGs), only 15% of the health-related SDG targets are currently on track *(2)*. Gaps in access to services are widening, health inequities are growing, and challenges related to gender, human rights and the digital divide are intensifying. These shortfalls are particularly acute among populations facing marginalization, including women and girls, Indigenous Peoples, rural communities and those affected by poverty or conflict. Structural and systemic barriers – such as weak data systems and discriminatory health practices – continue to limit the realization of the right to health for all. Achieving the SDGs, particularly SDG 3 (good health and well-being), SDG 5 (gender equality) and SDG 10 (reduced inequalities), requires urgent and focused action.

The WHO Department of Gender, Rights, Equity and Sexual Misconduct Prevention (GEM) plays a pivotal role in aligning WHO's work with Member State commitments and ensuring that programming reflects the values of gender equality, equity and human rights. GEM supports system-wide accountability and drives the integration – or "mainstreaming" – of gender-responsive, rights-based and equity-centred approaches across WHO's work. While notable progress has been made in mainstreaming, integration alone is not sufficient. The scale and complexity of today's health challenges require a dual strategy: combining mainstreaming with targeted programmes that address specific challenges. This ensures institutional efforts are reinforced by concrete initiatives capable of driving real and measurable change. Balancing long-term impact with immediate needs calls for a coordinated, strategic approach that delivers on-the-ground results, while strengthening health systems for lasting transformation.

In this context, GEM has developed six Special Programming Initiatives (SPIs) to support the implementation of GPW 14 (see Fig. 1). The primary aim is to drive meaningful, measurable and transformative health outcomes through initiatives at the country level, supported by regional efforts and guided by normative leadership from WHO headquarters. These initiatives complement and enhance WHO's broader programming by offering comprehensive theories of change and clear causal pathways between the outputs, activities and outcomes necessary for achieving meaningful health transformation. The development of the SPIs reflects the collaborative and partnership-driven ethos of the GEM Department. Extensive consultations and joint planning across all three levels of WHO helped to shape the SPIs, ensuring broad alignment and cross-programmatic support.

Special Programming Initiatives (SPIs)

SPI 1: Decision-making and investments for gender-responsive PHC-orientated health systems

SPI 2: Systematic generation and use of sex, gender and health data and evidence

SPI 3: Integration of gender equality, human rights and equity considerations in digital health strategies, services and tools

SPI 4: Advancing Indigenous Peoples' health and well-being through rights-based approaches

SPI 5: Health equity and resilience in the world's rural and remote areas

SPI 6: Measurement of unmet health care needs and barriers to effective coverage with health services

Designed to be scalable and adaptable, the SPIs can be tailored to different regions and contexts, enabling response to diverse health systems and evolving challenges. They offer flexible pathways to impact, whether implemented as comprehensive initiatives or through focused actions on selected priority areas. Their ultimate purpose is to create clear, measurable links between actions and results, helping WHO to remain responsive and relevant in a changing world, while advancing gender equality, equity and rights.

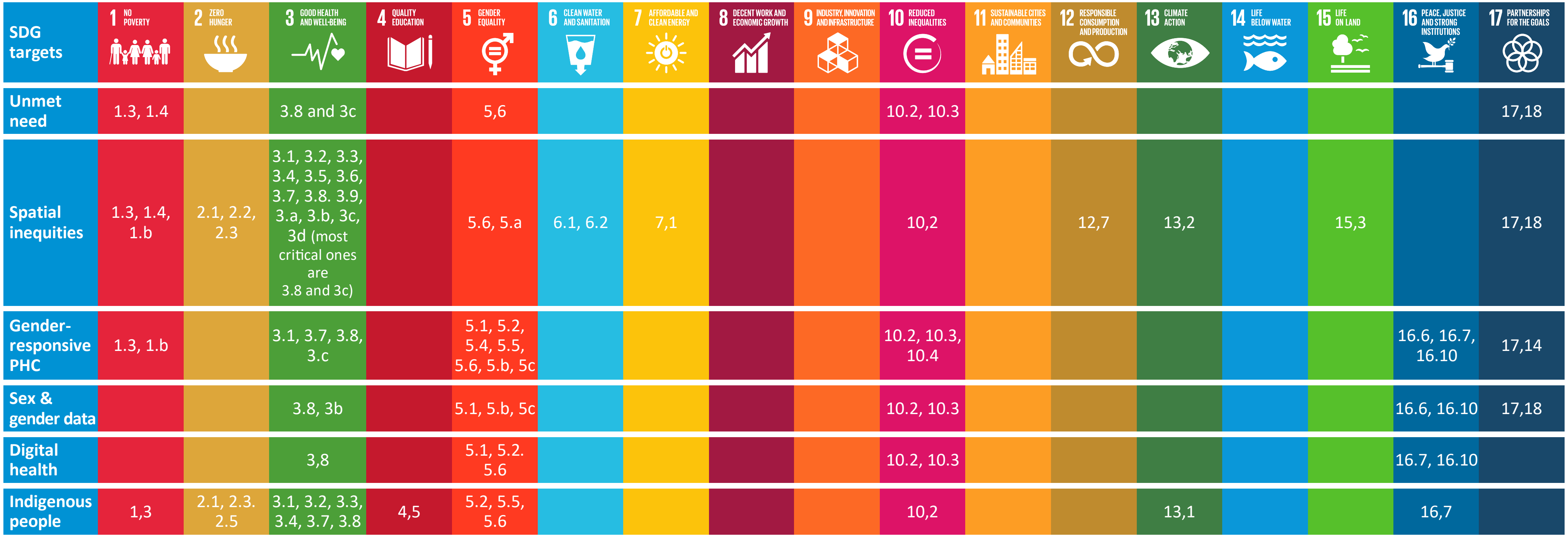
The SPIs can guide countries in strengthening legal and policy frameworks, expanding inclusive service delivery and building equitable, rights-based health systems. Modular by design and tailored to country contexts, they allow partners to invest in individual components or full packages aligned with national priorities. They foster dialogue while providing the technical framing needed for effective implementation. Transparent monitoring and reporting are integral to the SPI model to promote accountability, learning and continuous improvement. Delivered through a portfolio of country- and/or region-specific projects, the SPIs are supported by a global technical framework that ensures consistency and quality across all initiatives. They align with global health priorities and are designed to respond to emerging health challenges, providing a model for international health initiatives and setting a benchmark for effective programming.

By leveraging high-quality non-core resources, the SPIs aim to build on and enhance the impact of WHO's core funding, ensuring efficient and strategic use of resources. Anchored in the 2030 Agenda for Sustainable Development (see Fig. 2), the SPIs also anticipate a post-SDG future, ensuring that health efforts remain adaptive, sustainable and forward-looking. Crucially, the SPIs create opportunities for partnership by building on the efforts of other organizations and stakeholders, fostering collaboration and maximizing collective impact.

Fig. 1. Contributions of the SPIs to GPW 14 outputs

Output cluster	Output		Unmet Need	Spatial inequities	Gender-responsive PHC	Sex & gender data	Digital Health	Indigenous People
1	**1.1.1**	WHO supports countries in developing health vulnerability and adaptation assessments and national adaptation plans, and provides guidance, capacity-building and piloting of interventions to enhance the climate resilience of health systems through a One Health approach		X				X
	1.2.1	WHO develops norms, standards, policy guidance and strengthens capacity in countries to reduce greenhouse gases and other pollutants from the health sector, and to engage other sectors (such as food, transport, energy, education) to reduce their emissions		X				
2	**2.2.1**	WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations		X				X
	2.3.1	WHO develops guidance and supports countries to strengthen their capacity to engage with and empower individuals and communities and all levels of government across sectors to increase health literacy, enable healthier behaviours, advance co-benefits and improve the governance and implementation of settings-based approaches and health promotion policies			X		X	
3	**3.1.1**	WHO strengthens country capacity and provides guidance on the design, delivery, quality and measurement of integrated services	X	X	X	X		X
	3.1.3	WHO strengthens countries’ national capacity to develop implementable national strategies for universal health coverage	X		X		X	X
	3.2.2	WHO generates evidence, guides design and supports health-related macroeconomic policies and practices for sustainable health financing	X		X			
	3.3.1	WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact				X		
4	**4.3.1**	WHO provides guidance and technical assistance and strengthens capacity to track and analyse health expenditures at the system level to monitor financial hardship and financial barriers to access and inform decision-making for financial and social health protection	X		X			
6	**6.2.2**	WHO ensures the provision of life-saving care and maintains essential health services and systems in emergencies and vulnerable settings, addressing barriers to access and inequity	X					
7	**7.1.1**	Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities			X	X	X	X
	7.2.3	WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards Sustainable Development Goals indicators and targets, including inequality monitoring	X			X		

Fig. 2. Contributions of the SPIs to SDG targets



SDG targets	1 NO POVERTY	2 ZERO HUNGER	3 GOOD HEALTH AND WELL-BEING	4 QUALITY EDUCATION	5 GENDER EQUALITY	6 CLEAN WATER AND SANITATION	7 AFFORDABLE AND CLEAN ENERGY	8 DECENT WORK AND ECONOMIC GROWTH	9 INDUSTRY, INNOVATION AND INFRASTRUCTURE	10 REDUCED INEQUALITIES	11 SUSTAINABLE CITIES AND COMMUNITIES	12 RESPONSIBLE CONSUMPTION AND PRODUCTION	13 CLIMATE ACTION	14 LIFE BELOW WATER	15 LIFE ON LAND	16 PEACE, JUSTICE AND STRONG INSTITUTIONS	17 PARTNERSHIPS FOR THE GOALS
Unmet need	1.3, 1.4		3.8 and 3c		5,6					10.2, 10.3							17,18
Spatial inequities	1.3, 1.4, 1.b	2.1, 2.2, 2.3	3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8. 3.9, 3.a, 3.b, 3c, 3d (most critical ones are 3.8 and 3c)		5.6, 5.a	6.1, 6.2	7,1			10,2		12,7	13,2		15,3		17,18
Gender-responsive PHC	1.3, 1.b		3.1, 3.7, 3.8, 3.c		5.1, 5.2, 5.4, 5.5, 5.6, 5.b, 5c					10.2, 10.3, 10.4						16.6, 16.7, 16.10	17,14
Sex & gender data			3.8, 3b		5.1, 5.b, 5c					10.2, 10.3						16.6, 16.10	17,18
Digital health			3,8		5.1, 5.2. 5.6					10.2, 10.3						16.7, 16.10	
Indigenous people	1,3	2.1, 2.3. 2.5	3.1, 3.2, 3.3, 3.4, 3.7, 3.8	4,5	5.2, 5.5, 5.6					10,2			13,1			16,7	

SDG targets

1,3 Implement social protection systems
1,4 Equal rights to ownership, basic services, technology & economic resources
1.b Pro-poor and gender sensitive policy frameworks
2,1 Universal access to safe & nutritious food
2,2 end all forms of malnutrition
2,3 double the productivity & incomes of small-scale food producers
2,5 maintain genetic diversity in food production
3,1 reduce maternal mortality
3,2 end all preventable deaths under 5 years of age
3,3 fight communicable diseases
3,4 reduce mortality from non-communicable diseases & promote mental heath
3,5 prevent & treat substance abuse
3,6 reduce road injuries & deaths
3,7 universal access to sexual & reproductive care, family planning & education
3,8 achieve universal health coverage
3,9 reduce illnesses & death from hazardous chemicals and pollution
3.a implement WHO Framework Convention on Tobacco Control
3.b Support research, development & universal access to affordable vaccines & medicines
3.c Increase health financing & support health workforce in developing countries
4,5 eliminate all discrimination in education
5,1 end discrimination against women & girls
5,2 end violence against & exploitation of women & girls
5,4 value unpaid care & promote shared domestic responsibilities
5,5 ensure full participation in leadership & decision-making
5,6 universal access to reproductive health & rights
5.a equal rights of women to economic resources
5.b use technology to promote women's empowerment
5.c sound policies & legislation to promote gender equality
6,1 safe & affordable drinking water
6,2 access to sanitation & hygiene
7,1 universal access to modern energy
10,2 promote universal social, economic & political inclusion
10,3 ensure equal opportunities & end discrimination
10,4 adopt fiscal & social policies that promote equality
12,7 promote sustainable public procurement practices
13,1 strengthen resilience & adaptive capacity to climate related disasters
13,2 integrate climate change measure into policies & planning
15,3 end desertification & restore degraded land
16,6 develop effective, accountable & transparent institutions
16,7 ensure responsive, inclusive & representative decision-making
16.a ensure public access to information & protect fundamental freedoms
17,9 enhance SDG capacity in developing countries
17.e enhance policy coherence

How to read the SPIs

Each SPI includes a thematic overview that identifies existing inequalities, highlights key entry points, and outlines a clear approach and methodology for achieving impact. Grounded in results-based management principles, each SPI presents a high-level “theory of change” – starting with the desired long-term impact and then mapping the necessary outcomes and outputs at the country level and, where relevant, at regional and global levels. Key assumptions, risks and barriers to progress are clearly articulated. Specific indicators are provided to monitor outcome-level results.

While each SPI offers a comprehensive pathway toward its intended impact, the individual outputs and outcomes are designed to make distinct, measurable contributions. The theory of change framework for each SPI is intended to guide programme design and planning, with flexibility to adapt based on context and intended scope.

Addressing gender inequality in health

SPI 1: Decision-making and investments for gender-responsive PHC-orientated health systems

SPI 2: Systematic generation and use of sex, gender and health data and evidence

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Addressing gender inequality in health

Gender inequalities are rooted in deeply entrenched harmful social norms, discriminatory practices and unequal power relations within society and social institutions. These inequalities intersect with health in multiple ways, shaping individual risk and outcomes, influencing social and environmental determinants of health, and affecting people's agency to access services. They also shape the responsiveness of health systems, with health policies, programmes and services either perpetuating these inequalities or actively contributing to redressing them. At the same time, health is a critical driver of equal opportunities and capabilities across the life course.

The commitment to gender equality and the elimination of discrimination in health is enshrined in the foundational principles of the United Nations System. The WHO Constitution affirms health as a fundamental human right and calls for "the highest attainable standard of health" for all people without distinction. International frameworks – including the Convention on the Elimination of All Forms of Discrimination Against Women, the Beijing Platform for Action (BPfA) and the SDGs (particularly SDG 3 on health and well-being and SDG 5 on gender equality) – reinforce the imperative to address gender inequality in and through health.

Effective, gender-responsive health systems are foundational to realizing global, regional and national commitments to both health and gender equality. Meeting these goals requires more than isolated or vertical programmatic efforts: it demands a systems-based approach to policy-making and implementation. This includes tackling structural barriers that perpetuate gender inequality within health systems and ensuring that services are accessible, inclusive and free from gender-based discrimination. Importantly, such systems must be supported by adequate, realistic budget allocations and informed by the voices and experiences of those most affected.

Evidence must underpin decision-making. According to UN Women, only 42% of countries currently produce sufficient sex-disaggregated health data, limiting the ability to understand and address the gendered dimensions of health. Longstanding biases in clinical and public health research further compound the issue. Historically, women have been underrepresented in – or entirely excluded from – clinical trials and biomedical research, resulting in knowledge gaps around how diseases present and affect people differently based on sex and gender. As a result, diagnostics, treatments and interventions are often based on male physiology and experiences, which can compromise their effectiveness and safety for women and gender-diverse populations.

Without targeted investment in gender equality, especially investments that address structural drivers and deliver scalable impact, efforts to build inclusive and resilient societies risk falling short. The SPIs offer structured, results-based pathways for countries and partners to make real progress towards gender equality in and through health, leaving no one behind. By choosing to fund all outputs, or only a few aligned with country-specific needs, partners can make meaningful contributions to broader health outcomes.

Two of WHO's SPIs specifically advance gender equality in and through health:

- SPI 1: Decision-making and investments for gender-responsive PHC-orientated health systems
- SPI 2: Systematic generation and use of sex, gender and health data and evidence

SPI 1:

Decision-making and investments for gender-responsive PHC-orientated health systems

Overview

Primary health care (PHC) is central to Member State commitments to achieving universal health coverage, as it offers the most inclusive, equitable and cost-effective way of bringing integrated health services as close as possible to people, where they live. PHC aims to bring integrated health services close to people where they live not only by addressing geographical and/or financial barriers, but also by making services responsive to the realities of people's lives. This means that health systems are able to promote individual health and well-being, as well as their broader rights, capacities and opportunities in society.

Harmful gender norms within the health system undermine both PHC and universal health coverage, as well as the health system`s potential – as a major social institution – to contribute to advancing gender equality. Gender inequalities can be perpetuated in all aspects of decision-making, priority setting and investments.

Gender-responsive health systems are ones that take proactive coherent measures to address harmful norms and gender inequalities throughout the entirety of the system. Gender mainstreaming has its "premise [...] that policymaking is not a gender-neutral process but relies on underlying gender-biased assumptions about how society is structured and organized." Its objective is to ensure all actions, legislation, policies and programmes are gender-responsive *(3)*. To date, such efforts have commonly been led by mechanisms that are "not strategically integrated into the institutional apparatus" and are "ill-resourced" *(3)*. Efforts have focused on shifting policy and legislation, integrating gender considerations into vertical programmes, shifting harmful gender norms in interpersonal interactions between the provider and user, and/or addressing specific issues (for example, sex-disaggregated data). All of these are essential. However, actions have been scattered or incomplete, lacking an overall strategic vision, and structural barriers within health systems are consistently reported. There are few monitoring tools to measure progress towards gender equality and limited mechanisms to track budgetary allocations *(3)*.

Systems thinking enables consideration of complexities and interactions between individual beliefs/behaviours and structural-level components, such as clinical facilities, financing, governance and workforce *(4)*. Health system-level approaches permit an analysis of how each component of PHC delivery interrelates, helping country-level decision-makers to strategically target their actions and investments. However, although commonly used models map the components and recognize the dynamic and complex nature of health systems, they do not provide a framework for understanding how systems interact with the social environment nor how health systems themselves are affected by gender bias and restrictive gender norms. This invisibility undermines the ability of national policy-makers to ensure that their PHC efforts are transparent, cost-efficient, effective and equitable, and are contributing to gender equality aims.


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Analysis of entry points for action

Resolution WHA64.8 on Strengthening national policy dialogue to build more robust health policies, strategies and plans emphasizes the importance that countries give to PHC to achieve universal health coverage and to the need for "effective leadership and ownership of the process". WHO is unique in the United Nations System in providing technical assistance to countries for the health systems strengthening required for effective PHC, with well-established Member State-agreed frameworks to shape these efforts. WHO's Special Programme on Primary Health Care generates evidence and provides guidance for building people-centred, resilient and sustainable PHC-based health systems. The WHO Department of Health Financing and Economics supports the development of health system financing policies and reforms within the context of national health plans/strategies and progress on universal health coverage, and 150 WHO country offices are on hand to provide countries with contextually relevant support.

Significant national- and local-level health system reforms have resulted from these efforts, such as in Kazakhstan, Greece, Liberia and Bangladesh, among others.

At the same time, Member States have long emphasised their commitment to advancing gender equality. In 2007, through resolution WHA60.25 on Integrating gender analysis and actions into the work of WHO mandates, countries agreed to "include gender analysis and planning in joint strategic, and operational planning, and budget planning as appropriate" and to "formulate national strategies for addressing gender issues in health policies, programmes and research". Countries recently reiterated this commitment through the GPW 14, which includes an outcome indicator on advancing gender equality in and through health, and an output-level indicator that tracks countries with new/revised national health laws, policies, strategies and plans that incorporate gender equality, human rights and equity considerations in line with WHO guidance and tools. The WHO-hosted UHC Partnership, as part of the Special Programme on Primary Health Care, advocates for gender-responsive health systems. The Department of Gender, Rights, Equity and Sexual Misconduct Prevention (GEM) supports countries to advance gender equality in health through, for example, the 2011 gender mainstreaming manual, which is widely used by country-level health practitioners and policy-makers. Current updating of the manual offers an opportunity to provide further practical tools to support countries to design, implement and invest in gender-responsive health systems, building on their experiences over the last decade.

Implementing these commitments and reaching the goals is a tall order for many countries, especially those with fragile health systems and complex contexts of gender norms and inequalities. Systemic approaches and unified frameworks benefit countries by being cost- and resource-effective, eliminating duplication and identifying catalytic levers for investment. Use of the innovative tools and tailored capacity-strengthening offered by the WHO Academy, in conjunction with support for adaptation and implementation from WHO's network of regional and country offices, provide the organizational infrastructure to support countries and enable meaningful implementation of gender-responsive PHC-orientated health systems.

Proposed approach

Translation from the theory of systems thinking and overall frameworks requires multiple, aligned and systematic actionable measures across different components of the health system. This SPI will support national health policy-makers in prioritizing strategic actions and investments for gender-responsive PHC-orientated health systems relevant to their own context, enabling them to assess how each of their current health system levers enable or obstruct gender-responsive transformation, whether that be service delivery modalities, coverage and capacity of health workers, infrastructure, information systems, essential medicines or procurement processes, among others. It will also ensure that appropriate budgetary assessment tools and financing mechanisms are available for national policy-makers to effectively allocate resources to policy and programmes in ways that facilitate gender-responsive actions and systems.

To accomplish this, the initiative will review published peer reviewed and grey literature, and consult with country-level stakeholders, to draw together evidence and identify consistent structural/system-level barriers faced by gender mainstreaming in health programmatic initiatives. It will also review how existing frameworks for gender-responsive health systems include and propose solutions for these challenges. The initiative will then bring partners together to develop a global, action-orientated framework that advances a systems approach to gender responsiveness in the delivery of PHC. This framework will demonstrate the need for aligned gender-responsive actions across health system levers for transformative change.

Based on an understanding that no action can be meaningfully implemented without adequate financing, a complementary line of work will seek to better understand how current resource allocations facilitate or hinder the gender responsiveness of different levers within the health system. It will establish budgetary assessment and financing mechanisms for allocating resources across the health system, in alignment with country-level decisions and priorities, and for regular monitoring of their effectiveness in meeting specific gender equality objectives. Tools will be developed to support policy-makers in allocations and monitoring.

Both the overall action framework and the budgetary assessment and financing mechanisms will stress the importance of inclusive governance through meaningful engagement of civil society, representing diverse voices and health worker perspectives at all stages. They will identify key entry points for such engagement, the means of identifying organizations that represent diverse intersectional perspectives, and the systematic ways in which evidence and feedback from civil society and health workers can be used as part of the process of identifying barriers and solutions and of the overall decision-making process.

The framework and tools will subsequently be used as the basis for a user-friendly decision-making and financing modelling tool. This will be based on simulation techniques and scenario planning methodologies that include context-specific qualitative and quantitative data, and will involve stakeholder engagement *(5)*. National decision-makers from 12 pilot countries will be facilitated to use the tool for localized future analysis and context-specific and feasible actions that effectively harness the power of health systems to transform gender inequalities at the same time as achieving health outcomes. Gender parity of participating policy-makers will ensure that gender equality aims and principles are reflected both in the process and results.

Tools and knowledge products, as well as advocacy and communications materials, will also be adapted to regional needs, and specific technical assistance will be provided to the pilot countries to enable them to fully implement their acquired capacity and knowledge in the design of national policies and programmes for gender-responsive health systems, including effective financing. Implementation experiences will be shared among countries in regional communities of practice to promote further context-specific initiatives. The experiences of pilot countries, including those representing fragile and/or conflict-affected settings and contexts where intersectional inequalities (e.g. refugee status, ethnicity, disability) have been at the forefront of considerations will be documented, and the lessons learned will feed into revised iterations of global and regional frameworks, tools and related products in ways that respond to continually evolving gender equality and public health environments.

Desired impact	SPI 1 theory of change	Indicators
More people have access to gender-responsive PHC-oriented health systems that meet all their health needs and advance positive gender norms	• **If** all levers within health systems act in synergy to proactively redress harmful gender norms/inequalities and meet diverse health needs • **If** national decision-makers are equipped with tools to make evidence-based, contextually relevant decisions within a systems framework • **If** sufficient financial resources are allocated to ensure effective implementation of gender-responsive actions across health systems • **Then** structural, systems-level barriers to gender-responsive actions will be eliminated • **Then** health systems will optimize their potential to advance gender equality • **Then** the goal of universal health coverage, especially through effective PHC, will be advanced	• Country plans and strategies exist to implement gender-responsive health systems, including effective resource allocation • Country uses societal dialogue as a mechanism for prioritizing and co-shaping the health agenda (GPW 14 indicator) • WHO global framework used for country-level decision-making and financing of gender-responsive health systems • Increased number of people with effective coverage of gender-responsive PHC

	Outcome 1	Outcome 2	Outcome 3
	Decision-makers are equipped with an actionable evidence-based framework and tools for design and delivery of gender-responsive PHC-oriented health services	**Decision-makers are equipped with participatory budgetary and financing mechanisms to allocate and monitor sufficient resources for gender-responsive PHC-orientated health systems**	**National policy-makers have strengthened capacity to design, finance and monitor effective gender-responsive PHC-orientated health systems**
Theory of change	• **If** knowledge is gathered, systematized and disseminated on structural barriers faced by programmatic gender mainstreaming efforts at country level and system levers/barriers are identified • **If** gender-related interlinkages between the levers of a PHC-orientated health system are translated into a global action framework that can be adapted to regional and country contexts and diverse health systems • **If** capacity-building and user-friendly tools are available to support decision-making by national policy-makers that promotes use of contextually relevant data and representative civil society and health worker engagement • **Then** enabling conditions will be in place to support country-level decision-making for the design and delivery of gender-responsive PHC-orientated health systems	• **If** knowledge is systematized on how current resource allocations facilitate or hinder the gender responsiveness of different levers within the health system • **If** participatory gender-responsive financing mechanisms are established for allocating resources across the health system, in alignment with country-level decisions and priorities • **If** tools exist for national policy-makers to regularly monitor the adequacy and effectiveness of resource allocations for ensuring gender-responsive actions across the health system • **If** civil society representing diverse women's voices and health workers are meaningfully engaged in resource allocations and monitoring of resource allocation effectiveness • **Then** knowledge and tools will be in place for national policy-makers to allocate adequate, well-targeted funding for the implementation of feasible strategies and plans aimed at achieving gender-responsive PHC-orientated health systems	• **If** capacity of national policy-makers is strengthened to use decision-making and financing tools for gender-responsive health systems • **If** knowledge of national policy-makers is increased on the interlinkages between different gender-responsive levers of PHC-orientated health systems and gender-responsive financing • **If** tools are adapted and applied using regional- and country-level knowledge and data • **If** national policy-makers are supported to design policies and programmes for gender-responsive health systems, including financing • **If** gender parity in gender-responsive policy-making skills is promoted • **Then** policies and programmes for gender-responsive PHC-orientated health systems, including financing, will be designed, delivered and monitored with equal inclusion of diverse women's voices in decision-making • **Because** national policy-makers will have the localized tools, knowledge and skills to identify structural barriers, understand gender-responsive interlinkages between health system levers, and design, deliver and monitor effective gender-responsive PHC-orientated health systems
Outputs	1.1 Evidence gathered and systematized on structural barriers experienced by programmatic gender mainstreaming efforts in health across countries and in diverse settings (including crisis settings and health systems undergoing digital transformation) and on how barriers are addressed in current frameworks on gender-responsive PHC-orientated health systems, through systematic review of peer reviewed and grey literature and consultation with country stakeholders	2.1 A systematic review conducted of gender-responsive budgetary tools and financing mechanisms in health (especially for PHC) and mapping of existing mechanisms across countries	3.1 Global tools, policy briefs and advocacy materials for gender-responsive health system decision-making and financing adapted at regional level
	1.2 A global working group, including WHO technical leads and external experts, established to identify key elements of a gender-responsive PHC-orientated health system (using the findings of output 1.1)	2.2 Experts and national stakeholders meeting(s) organized to share findings and success stories on effective sustainable financing mechanisms that have advanced gender equality in health and other related fields	3.2 National policy-makers' capacity strengthened in 12 pilot countries to use decision-making modelling and financing tools, including at least 50% women policy-makers, through global and regional training workshops

	Outcome 1	Outcome 2	Outcome 3
	1.3 An actionable systems-level framework developed for gender-responsive PHC-orientated health systems, through consultation with national leaders of different components of the health system (especially those representing fragile health systems, crisis contexts and health systems undergoing digital transformation), global experts, multilateral partners, civil society and health worker representatives	2.3 Experts within and beyond WHO collaborated to develop tools for gender-responsive assessments of government spending on PHC at central, regional and local levels and for institutionalization of gender-responsive financing mechanisms, considering findings from gender-responsive assessments	3.3 Technical assistance from regional and global experts provided in 12 pilot countries (including fragile and conflict-affected settings) representing diverse health systems, sociocultural contexts and intersectional inequalities (e.g. refugee status, ethnicity, disability) to design policies and programmes for gender-responsive health systems, including financing
	1.4 Technical and communication products developed to advocate for gender-responsive health systems and disseminate knowledge (gender mainstreaming toolkit module, report and derivative products on evidence and framework) and a user-friendly decision-making modelling tool developed based on simulation techniques and scenario planning, including qualitative and quantitative data as well as representative civil society, health worker and stakeholder engagement	2.4 Advocacy materials, policy briefs, evidence and tools for gender-responsive assessments of public spending on PHC and on gender-responsive financing mechanisms disseminated and incorporated into decision-making modelling tool	3.4 Regional communities of practice established to share experiences of developing and implementing gender-responsive health systems in diverse contexts, and pilot/case-study experiences, impacts and lessons learnt systematized, documented and disseminated to be used for revisions of global framework/tools and for integration into WHO planning instruments
Key assumptions	Political will and commitment of countries; availability and accessibility of relevant data to identify structural barriers and effective approaches; capacity to absorb and apply new knowledge; stakeholder collaboration in systematizing barriers; diverse stakeholders actively engaging in developing a shared framework	Ministries of health and finance are receptive to conducting gender-responsive budgetary assessment and adopting gender-responsive financing mechanism; political will to adjust resource allocations based on gender-responsive analyses; collective understanding that gender-responsive transformation in financing is a complex, long-term process; reliable, disaggregated data are available and utilized systematically for evidence-based decision-making, particularly financial planning; civil society organizations have capacity and mandate to engage in participatory budgeting processes; sufficient and stable funding for PHC	National policy-makers are enabled by their authorities to participate in training; women policy-makers are in relevant positions at country level for meaningful participation and subsequent implementation; sufficient country- and regional-level data are available to support implementation of tools at national level; mechanisms for engagement with civil society exist in countries; sufficient resources exist at national level to adequately finance policies and programmes for gender-responsive PHC systems; platforms exist to facilitate virtual communities of practice
Risks/barriers	Limited political will in countries; lack of comprehensive/comparable data across different contexts; resistance to adopting new frameworks/tools; insufficient resources for capacity-building or for adoption of new frameworks and tools; inability to secure necessary engagement for inclusive and meaningful participation in working group and framework development	Resistance of government bodies to conduct assessments and/or adopt new financing mechanisms; political resistance to challenging existing financial norms and power structures, and to transparency and accountability; assessments may be perceived as unnecessary if not clearly leading to tangible changes in health outcomes; economic instability, insufficient funding and/or diverted funding; limited civil society capacity or engagement	Insufficient interest from authorities to enable participation of national policy-makers; lack of gender parity among policy-makers; limited sex-disaggregated and gender-related data to meaningfully apply to tools at national level; weak/non-existent mechanisms for civil society engagement and/or limited capacity to input into processes and decision-making; limited time of stakeholders to participate in communities of practice

SPI 2:

Systematic generation and use of sex, gender and health data and evidence


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Overview

Gender inequality remains one of the key drivers of health inequities at a structural level. As the world's leading authority on public health, WHO has a unique role in tackling gender inequality both within and beyond health, given the significance of health and well-being to individuals' opportunities and capacities to participate fully in society. Scientific rigour and evidence underpin WHO's role in setting and implementing norms and guidance to ensure that health policies, programmes and interventions meet everyone's needs. To date, there has been insufficient focus on sex and gender norms, stereotypes and roles affecting health across health information systems, health research and data ecosystems *(6)*. In addition, inconsistencies in the use of related categories and variables in data sets have created obstacles to monitoring and analysing the effects of sex, gender identity and gender-related dynamics on health *(7)*.

Although national guidance aimed at health equity has increased in many contexts, women – and, by extension, considerations of sex differences and gender inequalities more broadly – are often still excluded from clinical trials and health research (frequently for "safety" reasons associated with pregnancy and lactation), meaning that there is inadequate consideration of how women experience health in specific, disproportionate and different ways to men *(8)*. There is a lack of understanding about how sex characteristics, as well as gender roles, norms and inequalities, relate to all aspects of health across the life course. Often, current understanding and differentiation of sex and gender identity are not reflected in the variables used in data collection and data sets, which have conflated the terms sex, gender and gender identity.[1] Such conflation has particularly negative impacts on the health of women, girls and gender-diverse people as it allows little space for analysis of how overlapping identities, discrimination and dimensions of inequality influence systemic disadvantage and disempowerment, and thus experiences of illness and health outcomes. This translates to persistent, structural gender inequality within the health system, meaning that health policies, programmes and services are ill equipped to meaningfully apply a person-centred, equitable, gender-responsive and inclusive approach.

This situation is likely to be exacerbated by the current global crisis in the collection and availability of data on sex and gender-related inequalities in the context of health. Up to now, one of the most reliable sources of data for health-related indicators from which gender inequalities can be extrapolated has been the Demographic and Health Surveys (DHS), which are currently on pause. However, this significant moment of disruption is also an opportunity to examine other sources of data at country level. This opportunity creates entry points to address challenges in the accurate and consistent collection of data, ensure coherence with global standards and reflect current understandings of sex, gender and gender identity, while also strengthening country capacities to produce their own data in ways that reflect distinct contextual realities of gender norms and inequalities.

Analysis of entry points for action

The BPfA and its chapter on women and health provide an important reference for Member States to advance better data and research on sex, gender and health. WHO plays a unique role in supporting countries to strengthen their health information systems and research capacity as part of broader health systems

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[1] Definitions for sex, gender and gender identity applied in this document follow those found on WHO's website *(9)*. Accordingly, gender-related factors can be measured using a variety of different variables in quantitative data, as well as analysed using qualitative data. For example, at individual level, variables such as control over assets and resources for health, decision-making autonomy, experiences of violence and/or discrimination may be relevant.

strengthening. WHO's Health Inequality Monitor and its related tools, resources and capacity-strengthening initiatives provide entry points to advance these efforts, as do mechanisms such as SCORE. Data from global, regional and national research complement routine administrative data and data sources such as household surveys, censuses and civil registration and vital statistics (CRVS) to ensure that national policies are grounded in sound evidence. WHO's network of collaborating centres – more than 800 institutions in over 80 countries – are important producers of clinical and public health research. WHO's Science Division is responsible for overseeing the setting of global standards and guidelines for research produced at all levels across all health topics, as well as setting standards for scientific research and convening partners for alignment (for example, hosting the Global Clinical Trials Forum and the International Clinical Trials Registry Platform (ICTRP)). WHO has recently adopted the Sex and Gender Equity in Research (SAGER) guidelines, which provide a framework to ensure that sex and gender are adequately considered in research, data collection, analysis and reporting. As part of the process of developing a Guideline on the Health of Trans and Gender Diverse Adults, WHO commissioned systematic reviews of evidence on how stigma and discrimination faced by trans and gender-diverse people can be tackled through inclusive health policy, including in health information systems.

Within the United Nations System, WHO is the global lead in institutionalizing approaches to advancing gender equality in and through health. Its gender mainstreaming manual has been widely used by health managers in countries since 2011 and is now being updated to include modules on the SAGER guidelines, gender-responsive health systems and accountability. WHO's implementation of the Gender Equality Acceleration Plan and annual reporting against the updated United Nations action plan on gender mainstreaming (UN-SWAP 3.0) provide key impetus for this work, given their focus on data and accountability. With respect to data on gender identity, WHO has committed to the 2024 United Nations LGBTIQ+ strategy, which includes internal and external programming commitments.

These initiatives fully align the GPW 14, which includes an outcome indicator on advancing gender equality in and through health, as well as an output-level indicator to measure the proportion of national health policies, strategies or plans that incorporate gender equality, human rights and equity considerations.

Beyond WHO, significant recent initiatives promoting attention to sex and gender in health research, policy and programmes can provide useful frameworks for action and partnership opportunities. Examples include the Innovation Equity Forum (IEF), co-convened by the Bill & Melinda Gates Foundation, the World Economic Forum's Global Alliance for Women's Health and its report on women's health gaps, and G-FINDER's reports on funding for neglected women's health issues.

Proposed approach

WHO aims to advance gender equality in and through health with a priority focus on enhancing knowledge on sex, gender and health, including women's health across the life course. SPI 2 seeks to address gender bias in administrative health data, clinical and public health research, and other mechanisms such as household surveys, censuses and CRVS. This will strengthen understanding of how sex and gender influence health risks, disease manifestation and outcomes, and experiences of ill health and health systems, across all areas of health.

This initiative will build on WHO's existing normative guidance, technical tools and country support to national health information systems and other data collection platforms. Standards will be established for monitoring and reporting on women's health across the life course and on broader aspects of gender inequalities in and through health. The SPI will also provide guidance on means of collecting consistent data on sex and gender identity variables and on intersectional gender-related factors. To ensure the inclusion of diverse clinical, gender equality and human rights perspectives, WHO will convene key global actors and include perspectives from national decision-makers representing diverse health system contexts. Monitoring will be strengthened through existing mechanisms, such as the Global Health Inequality Monitor. WHO will then support regions and countries to adapt and implement these standards and tools so that national health information systems, and other routine data collection platforms, capture globally comparative data in ways that are relevant to contextual realities and needs. Country experts/representatives will be facilitated to share knowledge on national-level initiatives and strategies to overcome the challenges for systematic inclusion of sex-disaggregated and gender-related data in health information systems and other routine data collection platforms. Support will also be provided to enable national mechanisms for reporting on advances towards gender equality in and through health, including on women's health.

In addition to the focus on administrative and routine survey data, WHO will seek to advance the production of evidence on sex, gender and health through clinical and public health research. Building on existing tools such as the Sex and Gender Equity in Research (SAGER) guidelines, WHO will establish global standards, guidance and tools for research that equitably considers sex, gender and women's health across the life course and for coherent approaches to sex and gender identity variables. Drawing upon other efforts, such as the IEF initiative and the Women's Health Alliance report, and by convening key partners and stakeholders, WHO will agree on shared research priorities to fill evidence gaps on women's health and to generate evidence for establishing tracer indicators on gender equality in and through health. National research institutions, especially WHO collaborating centres, will be supported to enhance the focus on sex and gender across all clinical and public health research, including by institutionalization of WHO standards, coherent approaches to sex and gender identity, and access to knowledge-sharing opportunities. Collaborating centres that lead in institutionalizing such approaches, or pioneer research agendas to address knowledge gaps on women's health or on sex, gender and health more broadly, will be championed.

Desired impact	SPI 2 theory of change	Indicators
All people's rights to health, well-being and dignity are advanced through gender-responsive health systems informed by stronger evidence on sex, gender and health	• **If** sex-disaggregated and gender-related data are included in national health information systems and other routine data collection (e.g. household surveys, censuses and CRVS) and national reporting mechanisms • **If** evidence on sex, gender and health (with a priority focus on women's health across the life course) is strengthened • **If** all health data take a consistent and coherent approach to variables on sex and gender identity • **If** research bias in relation to sex, gender and health is identified and eliminated • **If** there is routine monitoring of gender equality and women's health gaps, using global and national-level tracer and programmatic indicators • **Then** health systems will be enabled to implement evidence-based policy, programmes and services that advance gender equality in health and improve health outcomes for women, girls and gender-diverse people, and to leverage their unique role to champion gender equality and positive gender norms	• Number of countries implementing WHO global standards on sex, gender and health in national health information systems • Number of countries that establish and produce specific reporting mechanism(s) on gender equality in and through health, including women's health across the life course • Number of WHO collaborating centres that adopt SAGER and/or other tools to coherently address sex and gender bias in health research

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
	Decision-makers have coherent and expanded data and evidence available on sex, gender and health to inform gender-responsive health policies and systems	**Health ministries and national statistical agencies have strengthened capacity for systematic inclusion of sex-disaggregated and gender-related data in national health information systems and other routine data collection and reporting mechanisms**	**Global stakeholders prioritize clinical and public health research that generates better evidence on the relationship between sex, gender norms and inequalities, and health across the life course to inform gender-responsive interventions and policies**	**National research institutions produce and champion sex, gender and health evidence**
Theory of change	• **If** routine administrative data and other data collection mechanisms, as well as regular reporting mechanisms, monitor all aspects of women's health across the life course and intersectional gender factors related to health outcomes and access to services • **If** sex and gender identity variables are consistently, coherently and appropriately collected by national health information systems and routine data collection mechanisms • **If** consensus on data-related priorities of diverse stakeholders is established to address gaps and inconsistencies with respect to women's health across the life course, gender factors related to health outcomes and access, and variables on sex and gender identity • **If** global standards, guidance and tools are available to drive and support gender-responsive/inclusive health information systems, routine data collection and regular reporting mechanisms • **Then** the availability of comparable, coherent and consistent administrative and routine health data on sex, gender, gender identity and women's health issues, at global level, will be improved	• **If** national health information systems are gender-responsive and gender-inclusive in capturing globally comparative data in ways that are relevant to contextual realities and needs • **If** there is regular national reporting of gender equality in and through health, including all aspects of women's health across the life course • **If** cross-country learning and transparency are advanced and maintained • **Then** there will be systematic inclusion of and reporting on sex-disaggregated, gender and gender-identity data, and on all aspects of women's health across the life course, in national health information systems and other routine data collection mechanisms (e.g. household surveys, censuses, CRVS)	• **If** global standards, guidance and tools exist for clinical and public health research that equitably considers sex, gender and women's health across the life course • **If** global partners agree on coherent approaches to variables on sex and gender identity, based upon WHO technical guidance • **If** shared research priorities on women's health across the life course are established • **If** criteria, data and evidence are identified for the establishment of tracer indicators for monitoring gender equality in and through health • **Then** there will be a complete and coherent global evidence base on how sex and gender relate to different aspects of health and for monitoring advances towards gender equality in and through health	• **If** gaps on priority areas of research on sex, gender and health are filled • **If** evidence on sex, gender and health is generated in ways that are specific and relevant to country and regional contexts • **If** capacity of national research institutions is strengthened to enhance the focus on sex and gender across all clinical and public health research • **If** standards in gender and health research are championed among national research institutions • **If** one (or more) dedicated institutional lead is established for sex, gender and health and research • **Then** there will be better country and regionally relevant evidence and analysis on the ways in which sex, gender and health intersect for evidence-based policy-making to advance gender equality in and through health, with a priority focus on women's health across the life course
Outputs	1.1 An evidence base for expert-led priority setting established through a review of inconsistencies and gaps across existing administrative data, other health data and regular reporting mechanisms (including women's health across the life course, intersectional gender factors related to health, and variables on sex and gender identity)	2.1 Technical assistance from national, regional and/or global gender and data experts provided on regional adaptation of guidance and tools, and workshops held in 12 pilot countries on systematic inclusion of sex-disaggregated and gender-related data in national health information systems, household surveys, censuses, CRVS and reporting mechanisms	3.1 Global standards, guidance and tools developed (drawing upon existing tools such as SAGER) to drive gender-responsive and gender-inclusive clinical and public health research that considers women's health across the life course and coherent approaches to variables on sex and gender identity	4.1 A desk review (mapping) conducted of current research on sex, gender and health across national research institutions in 12 pilot countries and identification of evidence gaps according to priorities (related to, among others, relevant GPW 14 indicators, BPfA priority areas on women's health, IEF initiative, Women's Health Alliance report) and regional/country-level evidence

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
	1.2 Global multistakeholder consultation(s) held to agree priorities and opportunities for strengthening the systematic inclusion of sex-disaggregated, gender and gender-identity data in health information systems, household surveys, censuses, CRVS and reporting mechanisms, which meet diverse clinical and social needs across the life course and are rights-aligned (including UN DESA, UNFPA, the UN Statistical Commission, UN Women, civil society organizations, academia, global health experts, national decision-makers representing diverse country/health system contexts, and others)	2.2 Twelve pilot-country report cards produced on gender equality in and through health, including women's health across the life course	3.2 Innovative tools, including artificial intelligence (AI), developed to identify sex and gender bias in research study design and findings , including systematic reviews, reports, guidelines and so on	4.2 Expert meeting held for national research institutions from 12 pilot countries to develop a road map for addressing priority evidence gaps according to country and regional context
	1.3 Global guidance and tools developed for health information systems and other routine data collection platforms (e.g. household surveys, censuses, CRVS), with a priority focus on monitoring advances in women's health across the life course and closing health outcome and/or access gaps underpinned by harmful gender norms and inequalities, as well as on consistent collection of variables on sex and, where possible, gender identity	2.3 Peer study visits organized between at least two countries in each WHO region to ensure knowledge exchange on national-level initiatives/strategies by health ministries, national statistical agencies and academia to overcome challenges in systematic inclusion of sex-disaggregated and gender-related data in health information systems, household surveys, censuses, CVRS and reporting mechanisms	3.3 Systematic review(s) conducted of the gender equality and health indicators used by global institutions and at programmatic levels, and identification of research gaps, needs and opportunities to establish "gold standard" global tracer indicators on gender equality in and through health	4.3 Capacity of at least three national research institutions strengthened in each of the 12 pilot countries to enhance the focus on sex and gender across all clinical and public health research, including by institutionalization of the SAGER guidelines, coherent approaches to sex, gender, and gender identity through global/regional workshops, access to knowledge sharing opportunities such as communities of practice/digital platform for sharing tools and initiatives in priority knowledge gap areas
	1.4 Monitoring system in place for closing gender equality and women's health gaps through enhanced focus in the global Health Inequality Data Repository, and standards developed for country report cards on gender equality in and through health (including women's health across the life course)	2.4 Interactive data platform integrated into existing WHO data hub(s) to disseminate and analyse country reports/initiatives on strengthening gender-responsive and inclusive health information systems and other routine health data collection	3.4 Meeting held for global stakeholders (research funders, research consortiums/networks, journals, United Nations partners including UNDESA, UNFPA, UNRISD, UN Women and others, civil society) to agree on adoption of WHO standards on systematic inclusion of sex and gender considerations in clinical and public health research (including SAGER) and future research priorities on women's health across the life course (drawing on efforts such as the IEF initiative and the Women's Health Alliance report), and to generate required evidence on tracer indicators on gender equality in and through health	4.4 WHO gender and health research champion seal developed for national research institutions, and one or more collaborating centres on sex, gender and health established in each WHO region
Key assumptions	Inconsistencies and gaps exist in health information systems and other routine data collection platforms; willingness of global stakeholders to prioritize resolving data inconsistencies and closing gaps; openness of stakeholders to adapt to needs of each perspective and be clinically sound, rights-based/gender-responsive and inclusive	Capacity exists in WHO regional and country offices for adaptation of global guidance and tools; countries are open to disseminating information on initiatives to advance gender equality in health and women's health; resources and political will exists to permit study visits to countries	Interest and availability of funders and stakeholders in the global public health research ecosystem; interest of major AI players (e.g. Google, Open AI); data availability/data collection sources (e.g. DHS) for tracer indicators	Interest of national research institutions in engaging; national-level resources for research institutions to implement a research agenda on sex, gender and health; capacity of research institutions to translate evidence in ways that will influence policy
Risks/barriers	Gender bias regarding priority women's health issues; lack of willingness to engage on issues related to the distinction between sex, gender and gender identity; disciplinary gaps (e.g. between statisticians, health practitioners, social sciences); different perspectives and interests between distinct groups of stakeholders	Lack of capacity for technical support at regional/country levels; gender bias/lack of openness to women's health issues beyond sexual and reproductive health and to gender responsiveness/inclusivity	Gender bias regarding priority women's health issues; lack of buy-in from global funders and stakeholders; AI gender biases; lack of willingness to engage on issues related to distinction between sex, gender and gender identity; disruptions to global data environment (beyond current pause to DHS); limited data availability/collection sources for tracer indicators; lack of willingness to change existing data collection practices (e.g. data collection forms)	Lack of engagement by collaborating centres in more restrictive contexts; lack of national resources to pursue research agendas; lack of funding by global stakeholders of research produced by institutions beyond high-income countries; lack of willingness by global peer reviewed journals to publish research by national research institutions from lower- and middle-income countries and/or in languages beyond English

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Advancing human rights in health

SPI 3: Integration of gender equality, human rights and equity considerations in digital health strategies, services and tools

SPI 4: Advancing Indigenous Peoples' health and well-being through rights-based approaches

Advancing human rights in health

Health is a human right that underpins dignity, well-being, social justice and sustainable development. Recognized in the WHO Constitution and reaffirmed in international instruments (such as the International Covenant on Economic, Social and Cultural Rights and the United Nations Declaration on the Rights of Indigenous Peoples), the right to the highest attainable standard of physical and mental health must be realized without discrimination. Yet, despite widespread recognition, this right is often not translated into policy and practice.

In many countries, human rights commitments are not systematically considered in health policy, planning or service delivery, especially in fast-evolving areas such as digital health – where innovation often outpaces governance. Digital transformation is reshaping health systems globally, offering powerful tools and technologies – from telemedicine to AI – that can expand access and improve health outcomes. However, without deliberate attention to human rights, gender equality and equity, these technologies risk reinforcing exclusion and inequities. As emphasized in WHO's Global strategy on digital health 2020–2025 and the GPW 14, digital health must be people-centred and rights-based to fulfil its promise.

The need for rights-based approaches to health is also central to Indigenous Peoples' health. Indigenous Peoples face persistent health inequities stemming from systemic discrimination, loss of land and culture, and exclusion from mainstream health systems. Resolution WHA76.16 calls for action on the health of Indigenous Peoples through intercultural approaches, integration of traditional knowledge and ethical data practices.

The SPIs offer structured, results-based pathways for countries and partners to strengthen legal and policy frameworks, expand inclusive service delivery and build equitable, rights-based health systems. By choosing to fund all outputs, or only a few aligned with country-specific needs, partners can make meaningful contributions to broader outcomes.

Two of WHO's SPIs specifically advance a human rights-based approach to health:

- SPI 3: Integration of gender equality, human rights and equity considerations in digital health strategies, services and tools
- SPI 4: Advancing Indigenous Peoples' health and well-being through rights-based approaches

SPI 3:

Integration of gender equality, human rights and equity considerations in digital health strategies, services and tools

Overview

Digital transformation is reshaping every aspect of people's lives, from how they communicate with each other to how they access services. The rapid advancement of digital technologies has the potential to revolutionize health service delivery worldwide. Technologies such as telemedicine, electronic health records, mobile health applications and solutions supported by AI offer unprecedented opportunities to increase equitable access to health services and improve health outcomes by enhancing reach, efficiency and personalization of care. However, digital transformation and digital health innovations are currently not benefiting everyone equally and may even present risks to marginalized and disadvantaged groups if effective safeguards are not in place. Additionally, unless gender, rights and equity issues are adequately considered in the design and roll-out of AI and other digital technologies and tools, these tools may inadvertently replicate or exacerbate existing inequalities and bias and/or perpetuate exclusion, disadvantage and health inequities *(10)*.

One of the strategic objectives of WHO's Global strategy on digital health 2020-2025[2] focuses on people-centred health systems that are enabled by digital health *(11)*. Strengthening gender equality and health equity approaches, addressing social and commercial determinants and facilitating community engagement in digital health initiatives are essential elements of the strategy. The GPW 14 includes a focus on addressing inequities and systemic and structural barriers in the context of digital health and ensuring a people-centred approach in the development of national digital health strategies, digital public infrastructure and digital public goods.

In September 2024, United Nations Member States adopted the Pact for the Future, which includes a Global Digital Compact *(12)*. The Compact includes several strong commitments on human rights and gender equality, including commitments to: close all digital divides; mainstream a gender perspective to digital connectivity strategies; address all forms of violence, discrimination and mis- and disinformation; ensure safe and secure data collection and processing practices; and uphold human rights throughout the life-cycle of digital and emerging technologies.

The GPW 14 and the Digital Compact provide a strong foundation for WHO's efforts to integrate gender equality, human rights and equity perspectives into digital health strategies, technologies and tools.


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Analysis of entry points for action

Digital transformation is unfolding in a highly unequal world. There is a persistent digital gender divide, with women less likely than men to use the internet *(13)*, adolescent girls and young women less likely to own a mobile phone compared to their male counterparts *(14)*, and only 65 young women with digital skills for every 100 young men who possess such skills globally. There is also a significant digital divide between low- and high-income countries, reflecting broader economic inequalities *(15,16)*. Additionally, a significant urban-rural divide exists *(17)*, affecting access to digital technologies and their benefits.

Human rights protections are needed in the context of digital health. For example, inappropriately protected data may lead to infringement of privacy rights, and inadequate regulation may pose risks to patient safety.

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[2] Note that the strategy has been extended for two years by the World Health Assembly. A new strategy will be developed during that time.

The use of technology is also facilitating new forms of gender-based violence against women and girls, as well as violence towards marginalized populations. Another critical issue is algorithmic bias, where AI tools and systems, trained on biased data sets, produce diagnostic and other tools that fail to accurately identify health risks, symptoms and treatments for marginalized groups, particularly those experiencing intersecting forms of discrimination. If left unaddressed, this has the potential to exacerbate health inequities and discrimination towards specific population groups.

These issues remain largely unaddressed in current digital health policies. A recent review of 20 national digital health strategies *(18)* revealed that while most strategies address privacy and confidentiality concerns, none recognize the digital gender gap or broader equity or human rights issues. They overlook critical factors such as linguistic and cultural diversity, geographic disparities, and inequalities in digital literacy among different populations, as well as the specific needs of different age groups, ethnicities or persons with disabilities.

These findings underscore a pressing need for action to integrate gender equality, human rights and equity considerations into digital health initiatives. The role of regulation is crucial to ensure that the advancements in technologies foster an inclusive and equitable society. Increased awareness, enhanced collection of disaggregated data and better community engagement are also needed to address the current gaps and challenges.

Proposed approach

This SPI seeks to ensure that digital health services, technologies and tools reach all population groups equally and advance gender equality, human rights and equity in the context of health.

At the upstream level, the initiative will focus on ensuring that national digital health strategies, broader health strategies and national development strategies, as well as relevant regulations, fully integrate gender, rights and equity considerations. WHO will provide guidance, tools and technical assistance to Member States to develop digital health strategies, policies and regulations in a participatory manner and with a human rights-based, gender-responsive and disability-inclusive approach.

The work will also focus on intentional use of digital health technologies, services and solutions to reduce inequities, bridge digital divides and promote safe access to health services. Emphasis will be given to equity in health literacy in the digital context, to preventing and responding to technology-facilitated violence against women, girls and marginalized populations, and to involvement of communities and civil society in the design, implementation and monitoring of digital health strategies, tools and services. The work will include the collection of disaggregated data and generation of evidence on rights-based, gender-responsive and equity-oriented approaches to digital health.

The work will contribute towards the following GPW 14 outcome indicators: 3.3 “Existence of national digital health strategy, costed implementation plan, legal frameworks to support safe, secure and responsible use of digital technologies for health” and 3.1 “% population reporting perceived barriers to care (geographic, sociocultural, financial) and gender equality advanced in and through health”. The work also contributes towards the following 3.1.3 output indicators: “the proportion of tracer countries with new or revised national health laws, policies, strategies and plans that incorporate gender equality, human rights and equity considerations, in line with WHO guidance and tools” and “number of countries that have advanced social participation, with WHO support”.

Desired impact	SPI 3 theory of change	Indicators
Health equity is enhanced through rights-based and gender-responsive digital health strategies, services and tools	• **If** national digital health strategies and other relevant strategies are developed through inclusive and participatory processes • **If** gender equality, human rights and equity considerations are integrated into the strategies • **If** digital technology innovations are intentionally used to increase equity, promote gender equality and uphold human rights in the context of health • **If** health literacy is equitably increased in the digital context • **If** progress and impact are monitored and evidence is generated to inform future adjustments • **Then** digital health services, technologies and tools will be equitably accessible and responsive to the needs and rights of everyone, including those in vulnerable or marginalized situations	• Existence of national digital health strategy or other relevant strategy that integrates gender equality, human rights and equity considerations in line with WHO guidance and tools • National digital health strategy developed through community participation (including youth) • Rate of utilization of digital health services by different populations groups

	Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5
	Policy-makers systematically integrate gender equality, human rights and equity considerations in national digital health strategies with the help of globally available guidance, tools and capacity-building resources	**States and regulatory authorities adopt or revise national laws and regulations to strengthen the legal foundation for inclusive and equitable digital health services, ensuring the protection of human rights and advancement of gender equality and health equity**	**People benefit more from digital health technologies and digital service delivery models that are intentionally designed and used to increase equity, promote gender equality and uphold human rights in the context of health**	**Women, men, adolescent girls and boys, and populations in vulnerable or marginalized situations can make informed decisions about their health and can safely access health services in a digital context**	**Women, girls and marginalized populations are able to exercise their rights to safety and bodily autonomy in digital spaces through strengthened policies, digital health strategies and multisectoral responses**[3]
Theory of change	• **If** WHO works in collaboration with relevant actors to develop practical and accessible guidance and tools, and provides technical support on the integration of gender, rights and equity into national digital health strategies • **If** the strategies are developed through participatory processes that involve civil society, communities and youth • **If** the strategies are informed by gender equality, human rights and equity analysis • **If** the work is informed by country experiences and good practices to ensure relevance and real-world applicability • **Then** countries will be better equipped to embed gender equality, human rights and equity principles in the design, implementation and governance of digital health strategies	• **If** WHO provides technical advice to countries on applying human rights standards and gender and equity principles to digital health regulation • **If** WHO provides technical assistance to countries to conduct gender equality, human rights and equity impact assessments and to apply findings to the development or revision of relevant legislation and digital health regulatory frameworks • **If** WHO facilitates inclusive stakeholder engagement (e.g. national human rights institutes, national statistical committees, civil society) in the development and implementation of such regulations • **Then** countries will be better equipped to adopt digital health-related laws and regulations that uphold human rights, gender equality, and equity, and provide a foundation for inclusive digital health services, technologies and tools	• **If** WHO identifies and disseminates, in collaboration with health service providers and affected communities, evidence-informed digital health tools and digital service delivery models that have been shown to increase safe and equitable access to services, improve health outcomes and respond to the different needs of women, men, girls and boys, and populations in vulnerable or marginalized situations • **If** WHO strengthens stakeholder capacity and provides technical support to adapt and implement the tools and service models at national and local levels • **If** WHO supports capacity-building efforts at the national level for a digitally skilled health workforce • **If** WHO supports the monitoring of progress and generation of evidence on how digitalization in health can be used to reduce inequities in the context of health and to bridge digital divides • **Then** countries will be better equipped to use digital health tools and service delivery models to address health inequities and to promote gender equality and human rights through health systems	• **If** WHO supports countries to integrate gender-responsive, rights-based and equity-oriented health and digital literacy approaches into digital health strategies, education systems and service delivery models • **If** WHO promotes the active engagement of communities, civil society and young people in the design and implementation of digital and health literacy initiatives • **Then** all people, including those in vulnerable or marginalized situations, will be better equipped to make informed decisions about their health and can safely access health services in a digital context	• **If** WHO raises awareness and builds understanding among policy-makers, digital health actors and service providers about the public health and human rights impacts of technology-facilitated gender-based violence and digital violence targeting marginalized populations • **If** WHO supports countries to integrate prevention and response to such violence into digital health strategies, legal frameworks and public health responses • **If** WHO facilitates the health sector response within a multisectoral approach (including civil society, digital platforms and national institutions) to strengthen detection, reporting and support mechanisms • **Then** countries will be better equipped to prevent, detect and respond to technology-facilitated gender-based violence and digital violence in a manner that upholds gender equality, human rights and health equity

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[3] This builds on existing WHO work on technology-facilitated violence, including collaboration with UN Women and UNFPA on the measurement of technology-facilitated gender-based violence as part of the Global Partnership for Action on Gender-Based Online Harassment and Abuse. WHO also participates at the United Nations Global Forum on Gender Statistics and is contributing to development of a statistical measurement framework on technology-facilitated violence, working with the UN Statistical Commission.

	Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5
Outputs	1.1 National policy-makers’ and relevant stakeholders’ capacity strengthened to adopt and implement rights-based, gender-responsive and equity-oriented digital health strategies	2.1 National legal and regulatory frameworks aligned with international human rights commitments and the Digital Health Compact, informed by WHO guidance and tools	3.1 Access of all people, including marginalized populations, to safe and equitable digital health services increased	4.1 Policy-makers equipped through participatory processes to ensure that health literacy efforts in the context of digitalization are informed by the needs of different populations	5.1 Capacity of health policy-makers and service providers increased to address technology-facilitated gender-based violence and digital violence targeting marginalized populations
	1.2 New/revised national digital health strategies and other relevant strategies developed, informed by inclusive multistakeholder processes involving communities, youth and civil society, including those working on gender equality issues	2.2 Health policy-makers’ capacity strengthened in gender, rights and equity impact assessments	3.2 Countries’ and stakeholders’ capacity strengthened to implement inclusive digital health technologies, tools and service delivery models and to adapt them to the needs of diverse populations	4.2 Health professionals, especially at PHC level, equipped with digital literacy and capacity to promote digital inclusion	5.2 Health professionals, especially at PHC level, equipped to respond to technology-facilitated violence as part of a multisectoral response and referral systems
	1.3 Health policy-makers benefitted by practical tools (such as checklists, implementation briefs, and model monitoring and evaluation frameworks, including gender, rights and equity-focused indicators) to track progress and drive implementation of inclusive digital health strategies	2.3 Policy-makers equipped through participatory processes to ensure that national laws and regulations related to digital health reflect inputs from key stakeholders, including civil society and communities	3.3 Health professionals and health service users benefitted by digital health technologies that reduce health inequities, bridge digital divides and promote safety and human rights at all levels of the health system	4.3 All people, including marginalized populations, increased their health literary in the digital context	5.3 Effective collaboration of health authorities, civil society, digital technology providers, national human rights institutions and other relevant actors to respond to technology-facilitated violence
	1.4 Health professionals’ capacity strengthened across all health system levels to support the integration of gender equality, human rights and equity in digital health			4.4 National stakeholders’ developed and disseminated communications materials (such as infographics, videos and social media explainers) to improve awareness and understanding among health professionals and health service users of their rights and responsibilities in the context of digital health	
Key assumptions	Sustained support for a gender, rights and equity approach to digital health within WHO; countries recognize value of gender, rights and equity and actively seek guidance and tools on their integration in digital health; several countries develop/revise their digital health strategies during timeframe of the initiative and seek WHO support; new WHO digital health strategy incorporates a strong gender, rights and equity component and enables country-level alignment; country experiences and good practices can be identified and documented; collaboration across WHO departments and regional/country offices, and with other relevant United Nations entities, enables broad outreach and uptake	Government will update legal and regulatory frameworks to address human rights risks and equity gaps in digital health; collaboration with other relevant United Nations agencies (e.g. ITU, OHCHR, UNDP, UNFPA, UNICEF, UN Women) to facilitate the work (the focus must be multisectoral); WHO is able to influence national laws and regulations that may go beyond health, but which have implications for digital health; national human rights bodies, regulators and civil society actors are willing and able to engage in legal and policy reform processes	Demand exists in countries to address health inequities through the use of digital technology; evidence is available on digital health technologies, tools and service models shown to increase equity; political commitment exists to address digital divides and structural inequalities and to embed gender, rights and equity principles in digital health initiatives	Governments recognize health literacy in the context of digitalization as a priority; WHO can leverage partnerships with relevant United Nations entities, ministries (health, education, information and communications technology) and civil society to support equitable health literacy initiatives; marginalized populations are willing and adequately supported to participate in initiatives	Governments and health authorities recognize technology-facilitated violence as a public health and human rights concern requiring multisectoral action; digital platform providers, app developers and data governing bodies are open to collaborating to increase user safety; individuals/communities affected by technology-facilitated violence are willing and able to engage in the co-design of responses; WHO has convening power across health and other relevant sectors

	Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5
Risks/barriers	Development of global guidance and tools is out of sync with digital health strategy development at country level; rapid technology development outpaces WHO guidance development; without dissemination and capacity-building support, guidance and tools may be underutilized at country level; resistance to gender equality or human rights language in some contexts may hinder political acceptance or implementation of principles; national strategies are not being developed or revised during the project timeframe	Rapid economic or technological advancement may be prioritized over human rights and equity in some contexts; technology industry may oppose regulatory measures around data privacy, consent and equity; rapid technological advancements may outpace governments' ability to regulate effectively; inadequate coordination between ministries (health, information and communications technology, justice, trade, etc.) may hinder comprehensive regulatory reform for digital health; possible resistance to addressing commercial determinants of health through regulation of technology companies	Digital health solutions may prioritize efficiency over equity, with pressure to scale up technologies without assessing differential impacts; limited availability of data and evidence on gender equality, rights and equity-related outcomes of use of digital health tools and services; lack of overall strategy on reducing inequities and advancing gender equality and rights through health may hinder progress	Mis- or disinformation competes with evidence-based information in online spaces; insufficient coordination and collaboration across sectors may hinder development of effective approaches to increase equity in health literacy in the digital context; digital infrastructure gaps may hinder access to digital tools	Addressing technology-facilitated violence not seen as a priority; fragmentation of responsibility across health, technology, legal and social sectors may hinder coordinated response; lack of data on technology-facilitated violence may make programme design difficult; resistance from digital platforms to adopt protective measures

SPI 4:

Advancing Indigenous Peoples' health and well-being through rights-based approaches


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Overview

Indigenous Peoples represent over 6% of the world's population, which is equivalent to 476.6 million people in around 90 countries.[4] Indigenous Peoples' concept of health is holistic and encompasses spiritual, environmental and social dimensions, in addition to physical and mental health. Indigenous Peoples view health as an individual and collective right, strongly linked to community, land and the environment. Many Indigenous communities have traditional knowledge and healing practices as well as community and spiritual practices that enhance health and well-being *(19,20)*. However, Indigenous Peoples' worldviews and traditional healing practices have frequently been overlooked or marginalized. In addition, they often experience discrimination in mainstream health services and face inequities in social determinants of health such as income, education, employment and housing *(21)*. Consequently, life expectancy for Indigenous Peoples is estimated to be up to 20 years lower and they are more likely to experience disability and reduced quality of life than non-Indigenous people. Indigenous mothers and children also experience higher levels of mortality and morbidity *(22,23)*.

Many countries have taken measures to address inequities and inequalities experienced by Indigenous Peoples in the context of health. For example, countries in the Region of the Americas have recognized the need to adopt differentiated approaches to the health and well-being of Indigenous Peoples and, in 2017, adopted a policy on ethnicity and health, followed by a strategy and action plan in 2019 *(24,25)*.

In May 2023, the World Health Assembly adopted resolution WHA76.16 on the health of Indigenous Peoples. The resolution urged Member States, inter alia, to: develop knowledge about the health situation of Indigenous Peoples through ethical data collection; develop and implement national health plans to reduce gender inequality as well as social, cultural and geographic barriers faced by Indigenous Peoples to equitable access to quality health services; take an intercultural and intersectoral approach in the development of policies on the health of Indigenous Peoples; and explore ways to integrate traditional medicine within national health systems. The resolution calls on all relevant actors to: ensure social participation; foster research and development while ensuring that Indigenous Peoples' rights to cultural heritage, traditional knowledge and cultural expressions are respected; and use culturally appropriate approaches in research and development, respecting Indigenous Peoples' rights over lands, territories, resources and traditional knowledge. The resolution also requested the WHO Secretariat to develop a global plan of action for the health of Indigenous Peoples and to provide technical support to Member States upon request.

Analysis of entry points for action

Health inequities among Indigenous Peoples are due to several interconnected factors *(26)*. Lack of recognition of Indigenous identities, historical and ongoing colonization, including displacement, loss of ancestral lands, cultural assimilation policies and discrimination on the basis of race or ethnicity continue to affect the health and well-being of Indigenous Peoples in many countries and regions. Biodiversity loss, climate change and environmental degradation also impact Indigenous Peoples' well-being and disrupt community cohesion, traditional lifestyles and diet, further exacerbating health disparities. Loss of language, culture and identity can also have profound impacts on both physical and mental health and on community well-being. Furthermore, limited political power and representation

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[4] Accurately estimating the Indigenous population remains a challenge due to the limited recognition of Indigenous Peoples in some countries and lack of disaggregated data.

affects Indigenous Peoples' ability to influence health policy, and unequal power relations between men and women impact on the health outcomes of Indigenous Peoples, especially for Indigenous women and girls.

Disvaluing and marginalization of Indigenous knowledge and healing practices also impacts on the health of Indigenous Peoples. Indigenous knowledges and practices are deeply intertwined with cultural identity *(27)*. When these practices are disregarded or marginalized, it can lead to a distrust of mainstream health systems and to culturally inappropriate care. Many Indigenous healing practices have proven effective and could benefit broader health systems if provided alongside national or local health services in a manner that respects Indigenous Peoples rights to self-determination and to their knowledge, resources and cultural heritage. This would benefit both Indigenous Peoples and the society as a whole *(19)*. By not valuing Indigenous knowledge, health systems miss opportunities for cross-cultural learning and collaboration that could lead to more innovative, effective and culturally appropriate care practices, especially at the PHC level.

Proposed approach

To address the existing health inequities and to improve health outcomes for Indigenous Peoples, WHO proposes an approach that respects, values and recognizes Indigenous knowledges and practices. This approach emphasizes mutual respect, self-determination of Indigenous communities and the importance of ensuring that health interventions are culturally safe. The proposed approach also recognizes the importance of addressing the underlying determinants that impact on Indigenous Peoples' health, including those related to the natural environment and to systematic racism, and highlights the value of intercultural dialogue, meaningful participation and shared decision-making. This approach not only aims to improve health outcomes for Indigenous Peoples but also advances the PHC approach and universal health coverage. The approach is grounded in WHO's GPW 14, outcome 3.1: "The primary health care approach renewed and strengthened to accelerate universal health coverage". The work will help countries to reduce barriers in access to care and advance gender equality in and through health, and to implement the health-related aspects of the United Nations Declaration on the Rights of Indigenous Peoples.

Actions are proposed at global, regional and country levels. At the global and regional levels, WHO will facilitate the sharing of knowledge and good practices on rights-based, gender-responsive, intercultural approaches to improving the health and well-being of Indigenous Peoples. This will include facilitating knowledge sharing on Indigenous-led data collection and research methods, as well as examples of intercultural and Indigenous approaches to health. At the country level, WHO will support inclusive national or local dialogues between health and other relevant authorities and Indigenous communities to jointly set priorities and to co-develop policies and programmes tailored to the needs and preferences of Indigenous Peoples. WHO will also support the engagement and leadership of Indigenous Peoples in health decision-making. The focus will be on strengthening the PHC approach and on ensuring that health services are available, accessible, culturally safe and of good quality for Indigenous populations. Interregional collaboration will be promoted, leveraging good practices and lessons learned from different contexts, including the application of the knowledge dialogue methodology developed by the Pan American Health Organization *(28)*, as well as adaptation of good practices of working with traditional healers and midwifes.

Desired impact	SPI 4 theory of change	Indicators
Indigenous Peoples' health outcomes and overall well-being are improved	• **If** Indigenous Peoples' health situation, determinants, needs and priorities are collaboratively identified • **If** Indigenous Peoples and their representative organizations have the capacity and resources to lead and advocate on their needs and priorities, claim their rights and participate on an equal footing in health policy-making and programme implementation • **If** national policy-makers have capacity to address the barriers Indigenous Peoples face in access to health services and to increase equitable availability, accessibility, acceptability and quality of health services for Indigenous Peoples • **If** multistakeholder partnerships are working to address the effects of colonization, racism and discrimination, and to promote intercultural approaches • **If** Indigenous cultures, identities and traditional knowledge are recognized and valued, shared and used to inform and complement national or local health services, policies, data collection and research, while respecting Indigenous Peoples' self-determination • **If** effective norms, policies and accountability mechanisms exist to promote and monitor health related rights for Indigenous Peoples • **Then** the health-related rights of Indigenous Peoples will be enhanced and health outcomes for Indigenous Peoples will be improved	• Existence of national health plans or other relevant strategies that integrate Indigenous Peoples' health and intercultural approaches in line with WHO guidance and tools • National or subnational health strategies developed through effective participation of Indigenous Peoples (including youth, women and elders) • Rate of utilization of essential health services by Indigenous Peoples compared to national averages, disaggregated where possible In the Region of the Americas (indicators approved by Member States of the Pan American Health Organization, in the Strategy and action plan on ethnicity and health) • Number of countries and territories that have laws, policies and/or strategies to recognize, respect, protect and incorporate traditional, knowledge-based ancestral and complementary medicine in national health systems • Number of countries and territories that ensure social participation by different groups (Indigenous Peoples) in national mechanisms for health-related policies and action

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
	National policy-makers and Indigenous Peoples apply a shared understanding of Indigenous Peoples' health situation, determinants, needs and priorities to co-develop inclusive health policies, plans and programmes	**Indigenous Peoples' have equitable access to culturally safe and good quality health services**	**Indigenous Peoples and health authorities collaborate to bridge Indigenous knowledges and traditional medicine and healing practices with national health systems, strengthening culturally safe, holistic and inclusive PHC**	**Policy-makers use good practices and lessons learned on Indigenous Peoples' health to co-develop health policies, programmes and intercultural approaches with Indigenous Peoples**
Theory of change	• **If** national health systems meaningfully engage with Indigenous Peoples to collaboratively document and understand their health situation, determinants, needs, priorities, and traditional health knowledge and practices • **If** ethical data collection strategies are used, ensuring Indigenous data sovereignty and involvement of Indigenous Peoples in data collection and analysis • **If** national health systems collect and use data appropriately disaggregated by ethnicity, gender, age and other relevant characteristics • **If** Indigenous-led health research is supported • **Then** national health systems will have an enhanced understanding of Indigenous Peoples' health situation, determinants, needs and priorities as a basis for inclusive health policies and programmes •	• **If** national health authorities, in collaboration with Indigenous Peoples, identify and address systemic barriers (e.g. discrimination, gender inequality, geographic and linguistic exclusion, lack of recognition of Indigenous identities) that hinder Indigenous Peoples' access to health and care services • **If** culturally safe, gender-responsive and rights-based service delivery is supported through capacity-building and institutional reform • **If** Indigenous Peoples are meaningfully involved in the planning, delivery and evaluation of health services, and appropriately represented across the health and care workforce • **Then** health services will become more available, accessible, acceptable and of quality for Indigenous Peoples	• **If** Indigenous Peoples' traditional medicine systems and knowledges are recognized, integrated and protected in national legal and policy frameworks • **If** Indigenous communities are enabled to exercise stewardship over biodiversity protection and transmit healing practices across generations • **If** national health systems engage in respectful dialogue and collaboration with Indigenous healers and health practitioners • **If** the recruitment, training and retention of the Indigenous health and care workforce is valued and supported • **Then** holistic, culturally safe health care will be enhanced through the respectful co-existence and complementarity of Indigenous and mainstream health systems	• **If** good practices, innovations and lessons learned on Indigenous Peoples' health are documented through participatory and culturally respectful methodologies, led or co-led by Indigenous Peoples • **If** Indigenous-led and intercultural models are systematically shared through global and regional platforms, networks and learning exchanges • **If** national and global actors use this knowledge to inform their policies and programming • **Then** evidence-based, culturally grounded approaches to Indigenous Peoples' health will be strengthened and replicated
Outputs	1.1 National/local health authorities and Indigenous Peoples conducted joint participatory assessments and dialogues on Indigenous Peoples' health situation, needs, priorities and traditional health knowledge	2.1 Health authorities, in collaboration with Indigenous communities, systematically assessed and documented barriers to health service access, leading to design and implementation of targeted measures to address inequities and improve accessibility and cultural safety of health services	3.1 Indigenous-led initiatives supported to safeguard biodiversity and intergenerational transmission of traditional healing knowledge	4.1 Research institutes and Indigenous communities collaborated to facilitate knowledge exchange and support health research projects that use Indigenous methodologies
	1.2 Health data enhanced through ethical data collection and research protocols, respecting Indigenous data sovereignty and ensuring free, prior, informed consent and leadership of Indigenous Peoples	2.2 Indigenous Peoples benefitted from culturally safe, rights-based and gender-responsive service delivery models	3.2 Indigenous healers/traditional health practitioners and national health authorities engaged in dialogue and utilized collaboration mechanisms	4.2 Policy-makers and health authorities informed on recent research, tools, case-studies and good practices related to Indigenous Peoples' health

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
	1.3 Health information systems strengthened to collect, analyse and use data disaggregated by ethnicity, gender, age and other relevant characteristics to enhance availability of data on the health status of Indigenous Peoples	2.3 Health and care workers' capacity increased in intercultural competence, cultural safety, anti-racism and the rights of Indigenous Peoples in health service delivery	3.3 Indigenous Peoples' knowledges protected from misappropriation via relevant protocols and safeguards	4.3 Regional and global peer-learning exchanges, dialogues or communities of practice facilitated to support knowledge sharing
	1.4 Health authorities' and Indigenous Peoples' established and utilized national and subnational mechanisms to enable inclusive, rights-based dialogue and mutual knowledge sharing, and to strengthen participatory data governance and decision-making in health systems	2.4 National and subnational mechanisms established/utilized to ensure co-design with Indigenous Peoples of health policies, services and programmes		
Key assumptions	Political will and institutional openness of national/subnational health authorities to engage meaningfully with Indigenous Peoples and integrate their knowledge and perspectives into data collection and evidence generation; Indigenous Peoples and representative organizations are willing and able to engage in assessments, dialogues and processes	National and subnational health authorities recognize the need to reform systems to address discrimination and inequity in service provision; health authorities and health and care workers are willing to engage in self-reflection and training to improve cultural safety and address implicit bias	Openness/interest of health policy-makers, health professionals and Indigenous communities in collaborating to bridge Indigenous approaches with conventional health care practices; existing health sector policies and regulations facilitate knowledge exchange and Indigenous self-determination over their lands, territories and medicinal plants	Willingness of Indigenous communities to document/share health practices, with ethical safeguards and consent in place; global and national health actors recognize value of Indigenous-led and intercultural innovations and are open to learning from them; mechanisms exist/can be developed to ensure knowledge is shared ethically and in ways that prevent misappropriation; interest and capacity exist to adapt good practices to diverse legal, cultural and health system contexts
Risks/barriers	Mistrust of health policy-makers, researchers and organizations such as WHO may limit willingness of Indigenous Peoples to engage/share data and knowledge; lack of interest of other stakeholders may undermine inclusive collaboration; inadequate protections for Indigenous data sovereignty may lead to unethical collection/use of data and misappropriation of knowledge; failure to identify/ensure participation of representatives chosen by Indigenous Peoples may compromise legitimacy; weak institutional capacity may pose barriers to collection, analysis and use of disaggregated data; lack of recognition of Indigenous identities in national data systems and policies may contribute to exclusion and invisibility of Indigenous health information	Failure to address structural discrimination and colonial legacies may result in superficial rather than meaningful change; resource constraints (infrastructure, staffing, budgets) may limit reach and sustainability of quality service delivery in remote areas; power imbalances in co-design processes may sideline Indigenous voices/preferences unless safeguards are in place	Risk of cultural appropriation/token engagement of Indigenous Peoples; resistance from health care workers and/or policy-makers due to bias against Indigenous knowledges and approaches; environmental degradation, land dispossession or extractive industries may threaten biodiversity essential to traditional healing; resistance to reviewing legal and policy frameworks; differing views and approaches regarding the methods for scientific validation of health practices	Documentation without Indigenous leadership or free, prior and informed consent could result in exploitation/erasure of cultural meaning; misapplication/decontextualization of practices could lead to poor outcomes or reinforce stereotypes; imbalance in representation may privilege certain regions/models over others, limiting diversity in shared knowledge

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Advancing health equity through strategic measurement and targeted service delivery

SPI 5: Health equity and resilience in the world's rural and remote areas

SPI 6: Measurement of unmet need and barriers to effective coverage with health services

Advancing health equity through strategic measurement and targeted service delivery

Persistent gaps in service coverage, access and health outcomes continue to affect millions of people, especially those in rural and remote areas, people living in poverty, women and girls, Indigenous communities and people living with disabilities. These inequities are magnified in fragile settings and low-resource environments, where health systems may lack the capacity to identify and respond to the needs of those left furthest behind. Moreover, current systems often fail to measure and act upon "unmet need" – populations who require care but remain invisible in standard coverage statistics. Barriers may be financial, legal, geographic, cultural or discriminatory, and their identification is central to fulfilling the right to health.

The imperative to act on health equity is embedded in the 2030 Agenda for Sustainable Development, most explicitly in SDG 3 (Ensure healthy lives and promote well-being for all at all ages) but also in SDG 5 (gender equality), SDG 10 (reduced inequalities) and SDG 17 (partnerships). The 2024 Pact for the Future emphasizes the importance of strengthening social protection, resilient health systems and data-driven decision-making to achieve universal health coverage and uphold human rights. WHO's GPW 14 and its flagship initiatives on PHC and universal health coverage further prioritize reaching underserved populations and addressing the structural drivers of health inequities.

The SPIs offer structured, results-based pathways for countries and partners to make real progress toward leaving no one behind. By choosing to fund all outputs, or only a few aligned with country-specific needs, partners can make meaningful contributions to broader outcomes on health equity and universal health coverage. Each output is designed to be both scalable and context-sensitive, with the understanding that every country and every health system starts from a different baseline. Together, these initiatives equip countries to better understand and act on health inequities, ensuring that efforts to improve coverage are grounded in the lived experiences of those most often excluded, and that health systems serve all people, not just those who are easiest to reach.

WHO has developed two SPIs focused on closing equity gaps through targeted action and measurable change:

- SPI 5: Health equity and resilience in the world's rural and remote areas
- SPI 6: Measurement of unmet need and barriers to effective coverage with health services

SPI 5:

Health equity and resilience in the world's rural and remote areas

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Overview

Globally, extreme and multidimensional poverty overwhelmingly occurs among rural populations, with the bulk of people experiencing poverty living in rural areas with low public service coverage, limited market opportunities, geographic remoteness and spatial isolation, higher levels of food insecurity, and economic production and labour systems with high levels of precarity and/or informality *(29)*. Health systems are also typically weaker in rural areas: people living in rural settings and the poorest households experience lower coverage of essential health services than national averages, and impoverishing health spending[5] is more common among households in rural areas compared to those in urban areas *(30)*. Estimates in the *WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas* suggest that 2 billion people living in rural and remote areas across the world do not have adequate access to the essential health services they need within their communities *(31)*. Environmental determinants, including environmental degradation (e.g. desertification, water contamination), biodiversity loss (e.g. pollinator and agrobiodiversity loss, deforestation) and climate change (e.g. extreme weather events) particularly shape the health of rural populations, while also influencing the health of urban populations that rely on the natural capital and ecosystem services stewarded by rural populations.

Analysis of entry points for action

Delivering on WHO's GPW 14 outcomes will require a scaled-up focus on tackling rural health inequities. This enhanced focus by WHO on "rurality" as part of a comprehensive approach to addressing health inequities complements the existing programmatic focus on "urban health" and "healthy cities". Particularly in relation to the environment, while there has been some focus on the specific needs of Small Island States from the perspective of health equity, it is timely to do more across rural settings.

Proposed approach

During 2025–2028, WHO will contribute to reducing rural health inequities through: targeted country support and multi-country exchange platforms; capacity-building for health and rural development stakeholders; providing leadership for rural health in select international platforms (e.g. Mountains Partnership, United Nations Decade for Ecosystem Restoration forum, Alliance for Transformative Action on Climate and Health); and driving research and normative guidance for rural health (including on rural proofing). This will be accompanied by ongoing monitoring of socio-spatial inequalities in health.

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[5] Defined as expenditures without which the household they live in would have been above the US$ 2.15 poverty line, but because of the expenditures is below the poverty line.

Desired impact	SPI 5 theory of change	Indicators
Health inequities experienced by rural populations are reduced	• **If** national health authorities integrate a focus on both spatial and social inequities into health sector planning • **If** national health authorities coordinate with other relevant sectors (e.g. agriculture, environment) for shared goals benefiting health • **If** national health authorities break silos and advance integrated, participatory and evidence-based programming • **Then** health inequities will be reduced and ecosystem services for health will be preserved or improved	• % of population reporting perceived barriers to care (GPW 14 indicator) • Coverage of essential health services (GPW 14 indicator) • Index of national climate change and health capacity (GPW 14 indicator) • Proportion of population aged 15+ with healthy dietary pattern (GPW 14 indicator)

	Outcome 1	Outcome 2	Outcome 3
	Country level: PHC-oriented health systems are strengthened in rural areas	**Country-level: Social and environmental determinants of health are addressed in rural areas**	**Global and regional level: Health and health equity of rural populations is increased through enhanced availability of evidence, know-how and connectivity of countries, the multilateral system and partners**
Theory of change	• **If** health authorities integrate a focus on both spatial and social inequities into PHC-oriented health systems strengthening across all strategic and operational levers • **If** this is backed by legislation and resources, and implemented nationally • **Then** inequities in service coverage and financial protection for health will be reduced in rural areas	• **If** national health authorities coordinate with other relevant sectors for shared goals benefiting health • **If** national authorities break silos and advance integrated, participatory and evidence-based programming • **Then** health inequities will be reduced and ecosystem services for health preserved/improved	• **If** WHO strategically aligns with key partners to optimize cross-sectoral reach • **If** WHO can resource and advance rural health-related research, normative products and training activities • **Then** the availability of evidence, know-how and connectivity of partners for health equity for rural populations will be enhanced
Outputs	1.1 Socio-spatial inequities for select health indicators mapped through use of WHO health inequality monitoring tools (e.g. HEAT) and with support of the WHO Geographic Information Systems Centre for Health	2.1 National rural development plans incorporate a focus on improving rural health	3.1 Health authorities' and partners' capacity enhanced through use of WHO's technical product on rural proofing national health policies, strategies, plans and programmes and related communities of practice
	1.2 Barriers to effective coverage with health services in rural and remote areas identified through use of the WHO approach for assessment of barriers to effective coverage with health services	2.2 Health sector climate-change mitigation/adaptation plans and national ecosystem restoration plans "rural proofed" and socio-spatial health inequities addressed	3.2 Multisectoral authorities' and partners' operational knowledge enriched through the WHO training on health equity in integrated rural development and access to a WHO network of universities working on rural health equity
	1.3 National PHC reforms benefited from WHO technical assistance to integrate evidence and know-how for tackling socio-spatial inequities in all PHC-operational levers	2.3 National public food procurement policy and practice incorporate measures to support healthy food produced in ecologically sound, equitable ways	3.3 Health authorities enabled to access tools supporting transition of public food procurement towards more healthy food produced in ecologically sound and equitable ways, through WHO and partner multi-country activities
	1.4 National health workforce policies and medical education standards revised to improve rural workforce development, attraction, recruitment and retention, in line with WHO guidelines	2.4 National nutrition plans and programming incorporate and uphold biodiversity protection and ecosystem restoration	3.4 WHO-led rural health working group enabled to facilitate country-to-country exchange under the Mountains Partnership, and a dedicated workplan linked to the UNGA Five Years of Action for the Development of Mountainous Areas Opportunities developed
	1.5 National health policies, strategies, plans and programmes updated using participatory "rural proofing" approaches	2.5 National social protection floors incorporate specific measures to close coverage gaps in rural areas	3.5 National authorities adopt forthcoming WHO guidance on mainstreaming biodiversity for nutrition, health and health equity, (with a focus on Small Island Developing States)
			3.6 Multisectoral authorities access emerging global evidence on the health equity impacts of environmental degradation (e.g. desertification, topsoil loss, glacier loss) and case-studies on improving health equity through biodiversity protection and ecosystem restoration

SPI 6:

Measurement of unmet health care needs and barriers to effective coverage with health services

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Overview

In a context of stagnated, slow and – in some cases – reversed progress towards universal health coverage in many countries, Member States requested WHO (through resolution WHA76.4) to strengthen its strategic focus on "unmet health care needs" and related barriers to effective coverage with health services *(32)*. This is echoed in WHO's GPW 14, with its explicit commitment to equity and action on barriers causing forgone care, and a dedicated indicator on perceived barriers for outcome 3/output 3.1 (The primary health care approach renewed and strengthened to accelerate universal health coverage).

In 2024, WHO launched an internal technical working group to respond to these calls, bringing together seven global programmatic areas (gender, rights and equity [coordinating]; health financing; data, analytics and delivery for impact; integrated health services; the WHO Centre for Health Development in Kobe; social determinants of health; and health emergencies) and regional colleagues, with the purpose of developing an official WHO position on advancing the quantitative measurement of unmet need. Additionally, the global WHO handbook for assessment of barriers to effective coverage with health services *(33)* and related regional work *(34)* on scaling up the use of mixed methods barrier assessment approaches are enabling this information to feed into country-level reforms towards universal health coverage.

Analysis of entry points for action

Based on a review of the existing global landscape for the measurement of unmet health care needs and barriers, the working group devised a workplan for 2025–2028. This SPI document describes related country-level and global- and regional-level activities.

Proposed approach

Working group members will lead on the different outputs. An external expert group of researchers (from academia, civil society organizations and national authorities) and partners is also being convened to feed into refinement of the deliverables. Project outputs will be amplified through the UHC Partnership *(35)*, the P4H Social Health Protection Network *(36)* and country office liaison with ministries. The working group will report back to the World Health Assembly on resolution WHA76.4. Learnings from this work will inform the post-2030 monitoring approach for universal health coverage.

Desired impact	SPI 6 theory of change	Indicators
More people, particularly the most disadvantaged, are reached in reforms towards universal health coverage	• **If** countries share experiences and have access to the latest global research and normative guidance on the measurement of unmet needs and barriers to effective coverage with health services • **If** countries allocate resources for the collective refinement and application of these measures • **Then** the evidence will fuel equity-oriented reforms towards universal health coverage, reduce inequities in service coverage and decrease health care-related financial hardship at the country level	• Coverage of essential health services (GPW 14 indicator) • % of population reporting perceived barriers to care (GPW 14 indicator) • Incidence of catastrophic out-of-pocket health spending/financial hardship (GPW 14 indicator) • Proportion (%) of vulnerable people in fragile settings provided with essential health services (GPW 14 indicator)

	Outcome 1	Outcome 2
	Country-level: National health authorities have improved approaches to the measurement of unmet needs and assessment of barriers to effective coverage with health services	**Global and regional levels:** National health authorities and partners have strengthened access to global WHO-led research, evidence and normative guidance on the measurement of unmet health care needs and the assessment of barriers to effective coverage with health services
Theory of change	• **If**, in at least 12 pilot countries,[6] national health authorities share experiences and receive WHO technical assistance and capacity-building for the measurement of unmet needs and assessment of barriers • **If** resources are allocated, and national and partner surveys and mixed methods assessments are advanced using enhanced approaches • **Then** improved evidence will be available for equity-oriented reforms towards universal health coverage	• **If** WHO reviews cutting-edge evidence on the measurement of unmet needs and assessment of barriers • **If** resources are in place to develop research and normative products and to convene national health authorities and partners for inputs and consensus-building • **Then** WHO will be able to support the strengthened and scaled-up measurement of unmet health care needs and related barriers, thus supporting equity-oriented reforms towards universal health coverage in countries while delivering on resolution WHA76.4 and informing the post-SDG agenda
Outputs	1.1 National health authorities and partners access enhanced data through incorporation of an updated questionnaire module on unmet health care in the WHO-supported World Health Survey plus (WHS+)	2.1 National health authorities and partners access a background paper that consolidates existing measurement approaches, identifies research needs and proposes a draft adaptable questionnaire for testing
	1.2 National health authorities and partners access enhanced data on unmet health care needs through WHS+ sample-frame adjustment (to oversample underrepresented subpopulations), and updated module tested	2.2 National health authorities and partners access the latest data on unmet health care needs, through the WHO Health Inequality Data Repository
	1.3 National health authorities and partners access enhanced data on unmet health care needs through incorporation of updated module in national and partner surveys, with technical assistance from WHO	2.3 National health authorities and partners access emerging research on measurement approaches, summarized in a scientific journal special edition on measurement of unmet needs
	1.4 National health authorities and partners produce evidence using mixed methods application of the WHO barriers assessment handbook, and national data-to-action stakeholder meeting convened	2.4 National health authorities and partners access an evidence brief on interlinkages between financial barriers to access and financial hardship that analyses the implications for quantitative measurement
	1.5 Humanitarian health clusters' evidence improved through use of unmet needs measurement and barriers assessment approaches, including through ongoing WHO work on attacks on health care	2.5 National health authorities, partners and WHO share case-studies/expertise and consensus on a measurement approach for unmet health care needs and barriers reached through a global consultation
	1.6 National health authorities and partners access country case-studies highlighting data use, from national to local levels, for closing coverage gaps (to be used for collective deliberation through output 2.5)	2.6 National health authorities and partners access a position paper on the measurement of unmet needs and barriers and a briefing on implications for the post-2030 monitoring approach
		2.7 National health authorities and partners access expanded, continuously refined WHO guidance for conducting assessments of barriers to effective coverage with health services
		2.8 Health cluster leads, health authorities and other humanitarian partners access a pocketbook on measurement of unmet needs and barriers in humanitarian contexts and related capacity-building opportunities

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[6] Number of countries engaged will depend on resource availability.

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