In collaboration with the Global Alliance for Women's Health, the Kearney Health Institute, the Gates Foundation and Wellcome Leap

The Women's Health Innovation Radar: Revealing Gaps and Opportunities Across the Science-to-Patient Journey

INSIGHT REPORT

MAY 2026

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Foreword

Shyam Bishen
Head, Centre for Health and Healthcare; Member of the Executive Committee, World Economic Forum

Paula Bellostas Muguerza
Senior Partner, Global Lead, Healthcare and Life Sciences, Kearney

Anita Zaidi
President of the Gender Equality Division, Gates Foundation

Regina E. Dugan
President and Chief Executive Officer, Wellcome Leap

Advancing women's health requires progress in scientific discovery and an innovation ecosystem capable of translating this into evidence, technologies and scalable solutions that improve health outcomes for women around the world. Yet, despite growing attention to women's health, the innovation landscape remains poorly understood. Research activity, clinical development and product innovation are often examined in isolation, making it difficult to see where progress is advancing and where critical gaps persist. Consequently, many high-impact conditions that exclusively, disproportionately and differently affect women continue to receive insufficient targeted innovation.

Recognizing both the urgency and the opportunity to address these gaps, the World Economic Forum's Global Alliance for Women's Health has convened leaders from across the healthcare ecosystem to accelerate progress in women's health science and innovation. In collaboration with partners, including the Kearney Health Institute, the Gates Foundation and Wellcome Leap, the initiative aims to strengthen the global ecosystem for women's health innovation and help translate scientific advances into meaningful impact for patients.

This report introduces the Women's Health Innovation Radar, an initiative designed to create greater transparency on women's health innovation across the research and development landscape. By mapping activity across research funding, scientific publications, clinical trials, product pipelines and marketed products, the Radar provides a clearer picture of where innovation is advancing and where important gaps remain across 10 high-impact conditions.

Creating this transparency is a critical step towards accelerating progress. A clearer understanding of where innovation is concentrated and where gaps persist can help guide research priorities, inform policy decisions and mobilize investment to areas of unmet need. Women's health innovation should not be constrained by fragmented evidence or limited transparency. By building a shared understanding of the innovation landscape, stakeholders across the global health ecosystem can work together to accelerate the next generation of innovation in women's health.

Executive summary

Women's health innovation remains limited and constrained by a system that does not consistently translate scientific progress into scalable impact for women.

Women's health represents one of the largest untapped opportunities in global health innovation.[1] Despite significant progress in biomedical research, innovation across the women's health ecosystem remains structurally misaligned with the conditions that most affect women.[2] As a result, many high-burden conditions continue to receive limited targeted research, clinical validation and product development.[3]

The Innovation Radar analyses women's health innovation across 10 high-impact conditions, selected based on their economic impact (GDP)[4] over a 10-year period (2016–2025).[5] It examines activity across the full science-to-patient journey: research funding, scientific publications, clinical trials and product development. The analysis reveals three structural gaps that collectively constrain progress in women's health innovation.[6]

The allocation gap: Innovation funding is limited, especially for high-burden conditions. Across the 10 conditions analysed, only 20% of programme research funding is women-focused, and more than half of that funding is concentrated in just two conditions: ovarian cancer and menopause. Meanwhile, several high-burden conditions affecting women disproportionately and differently (including ischaemic heart disease, migraine and mental health disorders) receive comparatively limited women-focused investment relative to their disease burden.

The evidence gap: Women-focused clinical validation remains underdeveloped. Across conditions affecting women disproportionately and differently, relatively little research explicitly examines sex-specific differences. Outside women-specific conditions, only 16% of scientific publications and fewer than 3% of clinical trials are women-focused, limiting the generation of robust evidence on how diseases manifest and respond to treatment in women.

The translation gap: Innovation does not consistently convert science into scalable solutions. Product development activity remains highly concentrated. Within the women-specific conditions analysed, approximately 96% of development programmes focus on ovarian cancer, while other areas show minimal pipeline depth and limited late-stage development. Across several conditions affecting women disproportionately and differently, large research portfolios do not translate into proportional market impact.

These gaps reinforce one another across the innovation life cycle. Concentrated funding shapes the scientific evidence base, which in turn influences downstream investment and product development. This dynamic amplifies existing research momentum while other high-burden conditions remain underdeveloped. Closing the women's health innovation gap therefore requires strengthening the entire innovation pathway from funding allocation and clinical evidence generation to late-stage development and commercialization to ensure that scientific advances translate into scalable health solutions for women.[7]

Introduction

Mapping innovation across 10 high-impact conditions reveals structural gaps in funding, evidence generation and translation.

Women's health is increasingly recognized as one of the most significant opportunities to improve global health outcomes and strengthen economic productivity.[8] Women experience a wide range of conditions that affect them exclusively, disproportionately and differently compared with men. These differences influence disease risk, clinical presentation and treatment response across many therapeutic areas.[9] Despite this reality, women's health has historically been treated as a relatively narrow field of biomedical innovation, often focused primarily on reproductive health.[10] Many conditions that represent major drivers of disease burden for women, including ischaemic heart disease, mental health disorders and migraine, have received limited targeted attention in research, clinical development and healthcare innovation.[11]

In recent years, awareness of these gaps has grown significantly.[12] Governments, research institutions and industry leaders increasingly recognize that improving women's health outcomes requires a deeper understanding of sex-specific biology, stronger representation of women in clinical research and more robust innovation pipelines addressing conditions that affect women across the life course. However, greater awareness alone does not automatically translate into innovation progress. Understanding where innovation is advancing and where important gaps remain requires a systematic view across the research and development ecosystem.

Mapping the women's health innovation landscape

This report introduces the Women's Health Innovation Radar, a framework designed to map innovation activity across the science-to-patient journey.[13] The framework builds on the Women's Health Impact Tracking (WHIT) Platform, originally developed by the World Economic Forum in collaboration with McKinsey Health Institute and now transitioning to its new host, Global Centre for Asian Women's Health (GloW), NUS Medicine. The analysis expands the understanding of the innovation landscape by including additional high-burden conditions that affect women uniquely, disproportionately or differently, alongside women-focused research and selected medical devices analysed over 10-year time periods.[14] The analysis examines four key stages of innovation: research funding; scientific publications; clinical trials; and product development, including market launches. By examining these stages together, the Innovation Radar provides a comprehensive view of scientific discovery and how it translates, or fails to translate, into clinical evidence, technological development and ultimately patient impact.

The analysis focuses on the 10 conditions that drive the greatest GDP impact on the women's health gap.[15] These top 10 conditions were previously identified in the *Closing the women's health gap: A $1 trillion opportunity to improve lives and economies* report as driving the greatest economic benefits if addressed; for example, through fewer health issues, fewer early deaths, expanded participation and increased productivity.[16] The conditions include both women-specific conditions and conditions that affect women disproportionately and differently. Together, they capture a broad cross-section of the women's health landscape, spanning the cardiovascular, neurological, mental health and gynaecological domains.

Across these 10 conditions, the report analyses innovation activity over a 10-year period from 2016 to 2025[17] using global datasets covering research funding, scientific publications, clinical trials and product development (see Appendix for a detailed methodology). In the earlier stages of innovation, such as research funding, scientific publications and clinical trials, the analysis specifically looks at the comparison between women-focused activity and overall activity. This comparison is intended to show not only where innovation activity is occurring in absolute terms but also the extent to which that activity is meaningfully focused on women's health.

This cross-stage perspective reveals a consistent pattern. While the scientific ecosystem generates research activity, it is still limited and does not consistently progress through the later stages of development needed to create scalable health solutions. Additionally, innovation activity remains concentrated in a small number of conditions and geographies.

The analysis identifies three structural gaps that shape the current women's health innovation landscape:

1. **The allocation gap**, where funding is limited and does not consistently reflect women's disease burden
2. **The evidence gap**, where women-focused clinical validation remains underdeveloped
3. **The translation gap**, where scientific advances do not reliably convert into scalable products and solutions

Together, these gaps highlight systemic challenges throughout the innovation pathway. Addressing them requires coordinated action across research funding, clinical trial design, regulatory frameworks and commercialization incentives. The following sections examine each of these gaps in detail, providing a data-driven assessment of where women's health innovation is advancing and where critical opportunities for acceleration remain.

BOX 1

Terminology

Definition of women's health and women-focused research	Focus of this insight report
Women's health – which includes conditions that affect women exclusively, disproportionately and differently to men – is often simplified to include only sexual and reproductive health. This report defines women's health as covering conditions that affect women exclusively, such as ovarian cancer and menopause, but also conditions that affect women disproportionately, for instance, bone health, brain health and autoimmune diseases, or differently, including cardiometabolic conditions. **Women-focused research** – as part of the Innovation Radar analysis, innovation stages such as programme research funding, scientific publications and clinical trials are analysed by contrasting women-focused research activity against overall activity. For the analysis, women-focused research is defined as research that is women-specific or has a sex/gender comparative focus. See Appendix for the detailed methodology and research definitions.	The focus of this insight report is on sex-associated biological variables as an initial step, even though its authors recognize the importance of gender as a cross-cutting issue. Throughout this report, the term "sex" is used to mean sex-associated biological variables. Furthermore, the terms "women" and "men" are used to mean individuals with female- and male-typical biological variables, respectively. It is important to acknowledge the complexity of sex and gender and the need for more research into the challenges facing transgender, genderfluid and non-binary communities.

BOX 2

Data limitations

This report draws on multiple data sources with intended global coverage across funding, research, clinical development and product launches. However, several limitations should be considered.

First, data availability and reporting standards vary across regions. Coverage is more comprehensive for North America and Europe, while other regions – particularly low- and middle-income countries (LMICs) – remain less well represented.

Second, differences in data coverage across the innovation life cycle may affect comparability. Pipeline data is more consistently captured than early-stage research or real-world adoption, and product launch data may vary by market and timing. Clinical trial data uses high-quality, curated global data sources, but may not be exhaustive of all global clinical trials. Small, private, local trials or trials without a clinical product focus may be excluded.

Third, variation in definitions and classification across sources – including by condition, innovation type and development stage – as well as gaps in sex-disaggregated data may introduce some inconsistencies across analyses.

These factors may lead to the under-representation of certain geographies, conditions and innovation activities. The findings should therefore be interpreted with these considerations in mind, while still providing a robust directional view of innovation patterns in women's health.

1 The allocation gap: Innovation funding is limited, especially for high-burden conditions

Funding for women's health innovation remains limited and highly concentrated, with significant gaps in high-burden disease areas.

Research funding is a critical foundation of innovation. It determines which conditions are studied, which hypotheses are tested and, ultimately, which solutions reach patients. However, the current funding landscape in women's health reveals significant gaps. Across the 10 high-impact conditions analysed, women-focused research remains limited in scope and highly concentrated across a small number of conditions and geographies. This creates a system in which scientific progress is uneven and many high-burden conditions that affect women disproportionately and differently remain underfunded and under-researched.

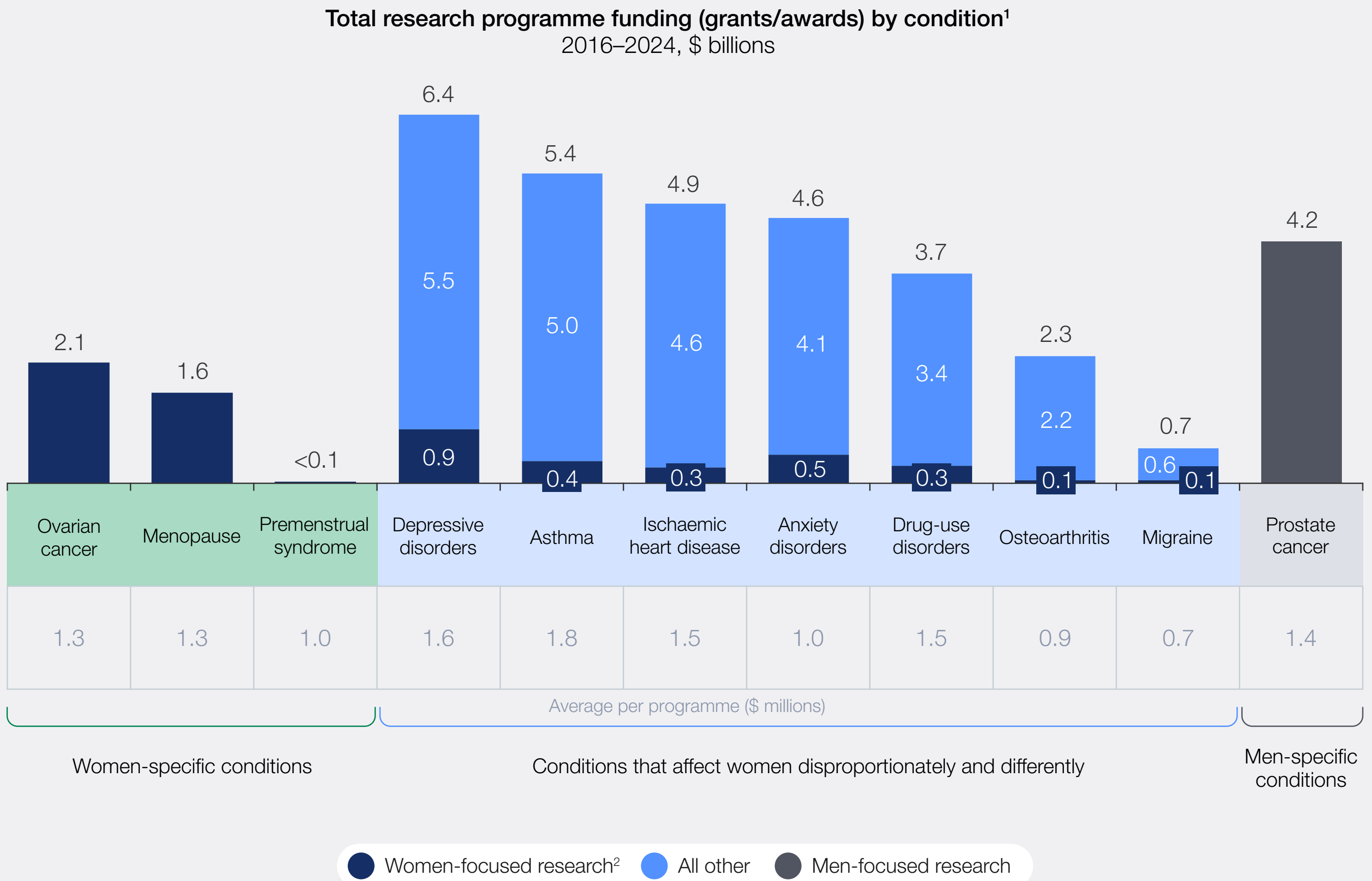
1.1 Funding remains limited and highly concentrated

Across the conditions analysed, only 20% of programme research funding is women-focused, indicating that most research investment does not explicitly address women-specific needs or sex-specific differences (Figure 1). This imbalance is even more pronounced in conditions that affect women disproportionately and differently. Across these conditions, only 9% of total research funding is women-focused, highlighting how rarely sex-specific perspectives are embedded in broader research agendas. In practical terms, this results in a substantial funding gap. Across the 10 conditions analysed, research without a specific focus on women receives approximately four times more funding than women-focused programmes, reinforcing the structural under-representation of women's health within the overall research landscape.

At the same time, women-focused funding is highly concentrated. Across the 10 conditions, more than 59% of women-focused research funding is allocated to just two conditions, ovarian cancer and menopause. This concentration reflects a narrow prioritization of certain women-specific conditions, while others remain comparatively underfunded. The imbalance becomes even more visible when compared with men-specific conditions, which receive higher levels of research funding. Even in conditions with substantial overall funding, women-focused targeting remains limited. Depressive disorders receive the largest overall research funding across the conditions analysed, yet only 15% of funding is directed towards women-focused programmes. Similarly, osteoarthritis and ischaemic heart disease have the lowest proportions of women-focused funding, at approximately 2% and 6% respectively.

Taken together, these patterns indicate that while awareness of the women's health gap is increasing, programme funding is still limited and highly concentrated, further reinforcing existing research priorities and historical investment patterns.

FIGURE 1 | **Research programme funding by condition**



1. Funding includes awards/grants provided by international research organizations. Funding includes direct funding and indirectly funded collaborations; see Methodology for details and data limitations.

2. Women-focused is defined as research that is women-specific or has a sex/gender comparative focus; see Methodology for full details.

Sources: NIH World RePORT, Kearney, World Economic Forum

1.2 Funding gaps persist across high-burden conditions

To further understand how funding is being allocated, the analysis compares women-focused research funding with female disease burden measured in disability-adjusted life years (DALYs)[18] (Figure 2). DALYs capture both years of life lost and years lived with disability, providing a comprehensive measure of disease impact. The analysis highlights a clear funding gap – the lack of funding for women's health research across all conditions and, in particular, for conditions that affect women disproportionately and differently.

This pattern reflects a legacy of research approaches that have implicitly treated women as scaled versions of men, rather than recognizing women as a distinct population with important sex-specific health conditions. It is increasingly clear that research is required to diagnose and treat the sex-specific aspects of these conditions and, furthermore, that the conditions with the highest burden for women are often those receiving the least women-focused funding.[19]

As an example, cardiovascular diseases, including ischaemic heart disease, account for around one in three deaths in women.[20] Yet ischaemic heart disease, which has the highest female disease burden across the conditions analysed, receives limited women-focused funding. Similarly, mental health disorders such as depressive disorders and anxiety disorders, which are up to twice as common in women than in men,[21] combine high disease burden with relatively low levels of research on sex-specific biology.

Even menopause and ovarian cancer, which receive comparatively greater investment, still receive substantially less funding than men-specific prostate cancer – approximately 2 to 3 times less. As such, this relatively stronger alignment between disease burden and funding should not be interpreted as funding being sufficient in these areas, nor does it offset the broader lack of investment across other high-impact conditions.

Of course, while female disease burden is not the sole determinant of research funding priorities, it is an important lens for understanding how future investments might address it. Funding decisions should also be shaped by a broader set of considerations, including the maturity of the evidence base, the feasibility of the research and the potential for innovation and translation. Accelerating progress will require maintaining support for conditions where momentum is already building, while directing additional funding towards under-represented areas to expand the overall scale of women's health innovation.

FIGURE 2 **Women-focused research funding as a function of disease burden (DALYs)**

1. DALYs: disability-adjusted life years, a measure of years of life lost (YLL) and years lived in disability (YLD). Metric represents total years aggregated across a population.

2. Women-focused is defined as research that is women-specific or has a sex/gender comparative focus; see Methodology for full details.

3. Funding includes awards/grants provided by international research organizations. Funding includes direct funding and indirectly funded collaborations; see Methodology for details and data limitations.

4. Menopause is included under "other gynaecological diseases" in the GDB data and not broken out separately, so "other gynaecological disease burden" was used as a proxy.

Sources: IMHE Global Disease Burden 2023 Data, NIH World RePORT, Kearney, World Economic Forum

1.3 Structural and geographic drivers reinforce the gap

The allocation gap is further reinforced by strong geographic concentration in research funding, which shapes both who funds women's health research and where it is conducted.[22] Across the 10 conditions analysed, over 80% of women-focused programme research funding reported in NIH's World RePORT database is awarded to North American institutions, with the United States as the dominant contributor (Figure 3). Within this system, the role of the National Institutes of Health (NIH) is particularly pronounced. Approximately 97% of North American women-focused grant funding across the 10 conditions is provided by the NIH, making it the single most influential funding body in this landscape.

Although North American grants are primarily issued by a few major funders, the recipients span a wide range of research organizations. Institutions such as the Mayo Clinic, University of Pittsburgh and Johns Hopkins University are among the largest recipients of women-focused research funding across the 10 conditions, but hundreds of institutions have received grants for women-focused research since 2016.

In comparison, Europe represents a secondary but significantly smaller funding hub. European funding for the 10 conditions is primarily driven by the Medical Research Council (UK), which accounts for approximately 41% of European funding, and the European Commission, contributing around 40%. While Europe has strong academic institutions, including King's College London, the University of Oxford and the University of Edinburgh, the overall scale of funding remains substantially lower. As a result, North American institutions receive more than six times as much women-focused research funding as European institutions, reinforcing disparities in research capacity and influence.

Outside North America and Europe, funding is more fragmented and difficult to track. In Africa, organizations such as the Kenyatta National Hospital (Kenya) and the Council for Scientific and Industrial Research (South Africa) are examples of institutions conducting women-focused research on conditions ranging from perinatal depression and anxiety to ovarian cancer. However, programme-level funding data in regions such as Africa, Latin America and Asia is very limited, and these regions receive only a marginal share of women-focused research funding. This limits not only the scale of research activity, but also the visibility and diversity of research priorities and perspectives, particularly for conditions that may vary across populations and geographies.

1.4 Implications for women's health innovation

The allocation gap has direct consequences for how innovation evolves across women's health. Funding determines which conditions generate scientific evidence and attract sustained research attention. As a result, current funding patterns shape not only what is studied, but also which conditions progress through clinical validation and product development. While funding for women's health continues to increase, progress is slow, with funding growing at an average compound annual growth rate of ~3% across the 10 conditions between 2016 and 2024.

For conditions that affect women disproportionately and differently, limited women-focused funding constrains the development of sex-specific evidence. This reduces the ability to identify differences in disease manifestation, establish appropriate diagnostic thresholds and develop targeted treatment approaches.

In contrast, conditions with concentrated funding benefit from stronger research ecosystems, deeper evidence generation and more advanced development pathways. This creates a self-reinforcing dynamic in which well-funded areas continue to attract further investment, while underfunded conditions remain structurally disadvantaged. Without a more deliberate alignment between funding and metrics such as female disease burden, innovation will continue to reflect existing priorities rather than the areas of greatest need for women.

We cannot expect innovation to align with women's health needs if investment continues to follow historical priorities rather than disease burden.

Lovisa Afzelius, General Partner, Flagship Pioneering

FIGURE 3 | **Women-focused programme research funding by region**[1]

$5,120M
North America

$1M
South America

$813M
Europe

$19M
Africa

$4M
Middle East and Asia

$297M
Australia and New Zealand

North America

Top funders: National Institutes of Health (US), Canadian Institutes of Health Research

Top researchers: Mayo Clinic, University of Pittsburgh, Johns Hopkins University

Top conditions: Ovarian cancer, menopause

Europe

Top funders: Medical Research Council (UK), European Commission

Top researchers: King's College London, University of Edinburgh, University of Oxford

Top conditions: Ovarian cancer, depressive disorders

Australia and New Zealand

Top funders: National Health and Medical Research Council, Health Research Council of New Zealand, QIMR Berghofer Medical Research Institute

Top researchers: University of Melbourne, University of Queensland, QIMR Berghofer Medical Research Institute

Top conditions: Ovarian cancer, menopause

1. Women-focused is defined as research that is women-specific or has a sex/gender comparative focus. Funding includes awards/grants provided by international research organizations. Funding includes direct funding and indirectly funded collaborations; see Methodology for details and data limitations.

Sources: NIH World RePORT, Kearney, World Economic Forum

2 The evidence gap: Women-focused validation remains underdeveloped

Women-focused research remains limited across scientific publications and clinical trials, constraining the development of robust evidence for women's health.

The evidence gap reflects a fundamental limitation in women's health innovation. Across many conditions, the evidence base remains incomplete, limiting the ability to understand how diseases manifest and respond to treatment in women. While overall research activity is substantial for some conditions, relatively little of it is explicitly focused on women or designed to capture sex-specific differences in disease manifestation, diagnosis and treatment response, and growth in women-focused research remains modest and uneven across conditions.

As a result, the evidence required to guide clinical decision-making and support effective, tailored healthcare solutions for women remains limited. This gap is visible both in the overall volume of women-focused research and in its progression into clinical validation.

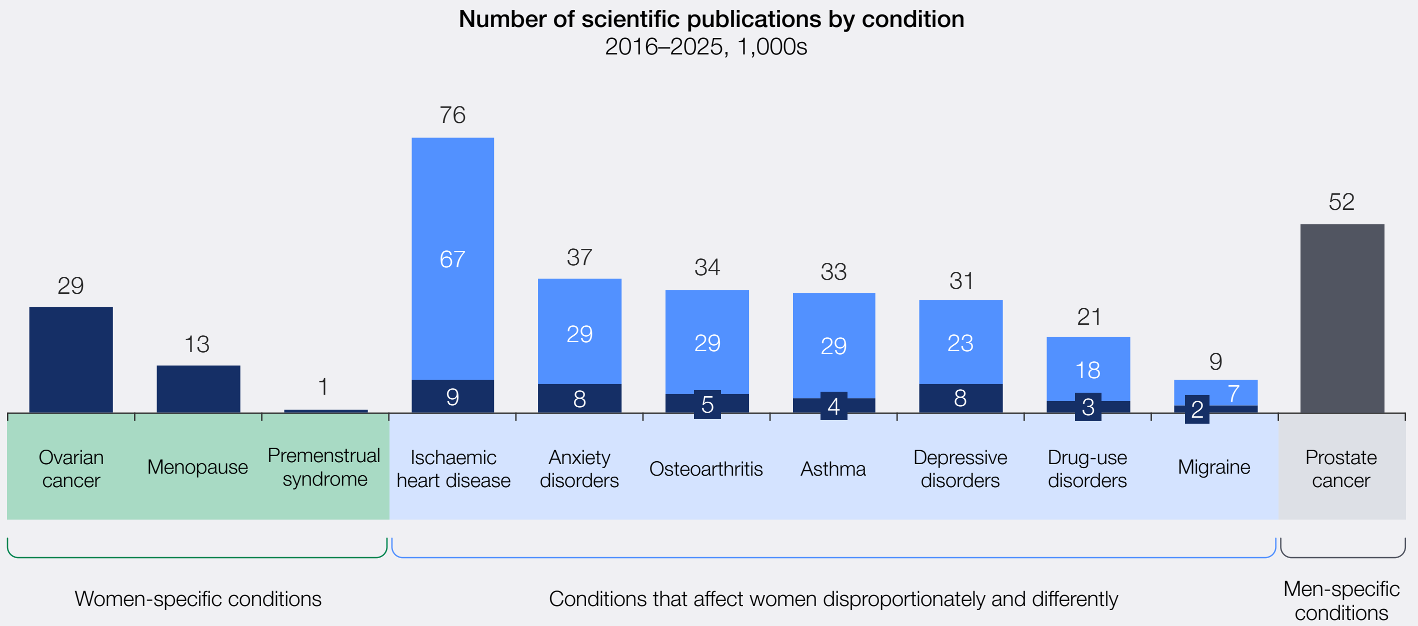
2.1 Women-focused evidence is limited and does not consistently progress into clinical validation

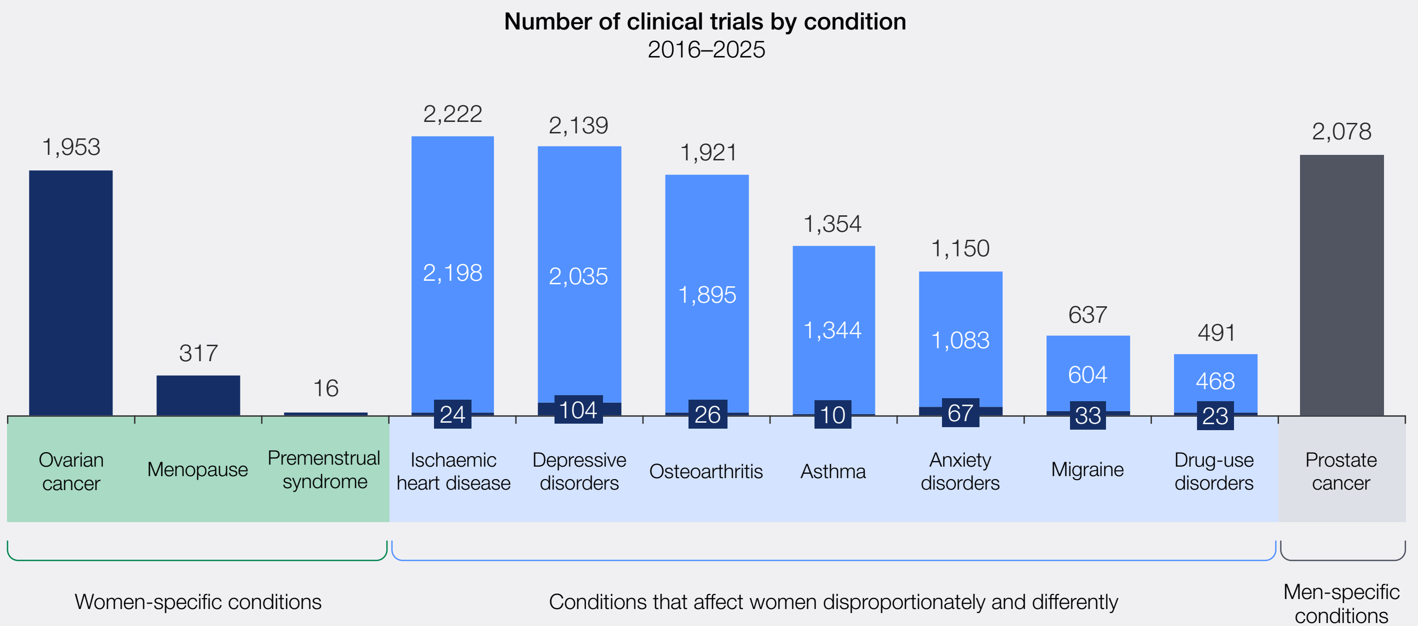
Across the conditions analysed, women-focused research represents only a small share of overall scientific activity. In addition, even when evidence is generated, it does not consistently translate into clinical validation in human trials. In scientific publications for conditions that affect women disproportionately and differently, only 16% of articles are women-focused, indicating that most research does not explicitly examine sex-specific differences (Figure 4). This gap becomes even more pronounced in clinical validation, where fewer than 3% of clinical trials are women-focused. This pattern suggests that early-stage insights into sex-specific differences are not consistently translated into clinical validation. As a result, the evidence required to guide treatment decisions, optimize dosing and ensure safety in women remains limited.

The implications are particularly significant for some conditions. In depressive disorders, for example, overall clinical trial activity is high in proportion to the volume of scientific publications relative to other conditions. However, when looking at women-focused evidence specifically, research on sex-specific differences has not translated into a proportional increase in clinical trials designed to validate these differences. This limits the ability to establish standardized diagnostic thresholds and treatment pathways tailored to women.

At the same time, the distribution of evidence is uneven. Women-focused research is concentrated in a limited number of conditions, particularly ovarian cancer, which dominates both publications and clinical trials. In contrast, other women-specific conditions, such as premenstrual syndrome, remain near-marginal in both research output and clinical validation.

FIGURE 4 | **Scientific publications and clinical trials by condition**





Women-focused[1] All other Men-focused research

1. Women-focused is defined as research that is women-specific or has a sex/gender comparative focus; see Methodology for full details.

Sources: PubMed, Citeline, Kearney, World Economic Forum

2.2 Evidence generation is insufficient across high-burden areas

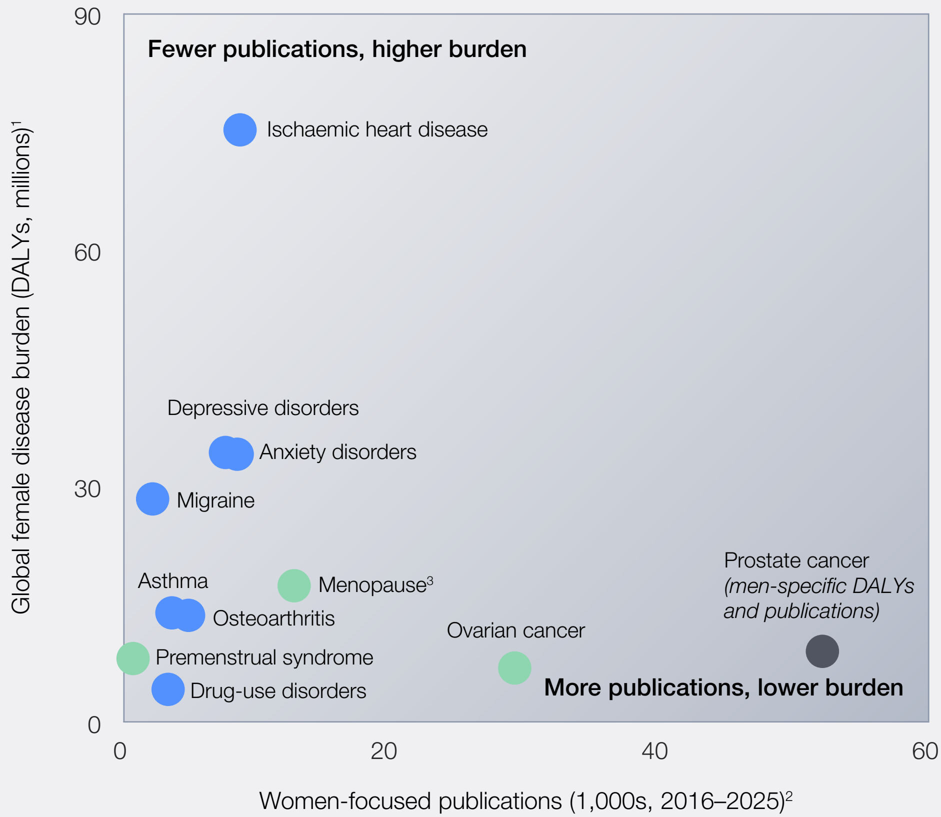
While the evidence landscape is limited in volume, it also lacks focus in the areas of greatest need. When comparing scientific publication volume and clinical trial activity across the 10 conditions to female disease burden, measured in disability-adjusted life years (DALYs), the imbalance is clear (Figure 5). Conditions that impose the greatest burden on women often have the least women-focused evidence, with clinical trials showing an even wider gap than publications.

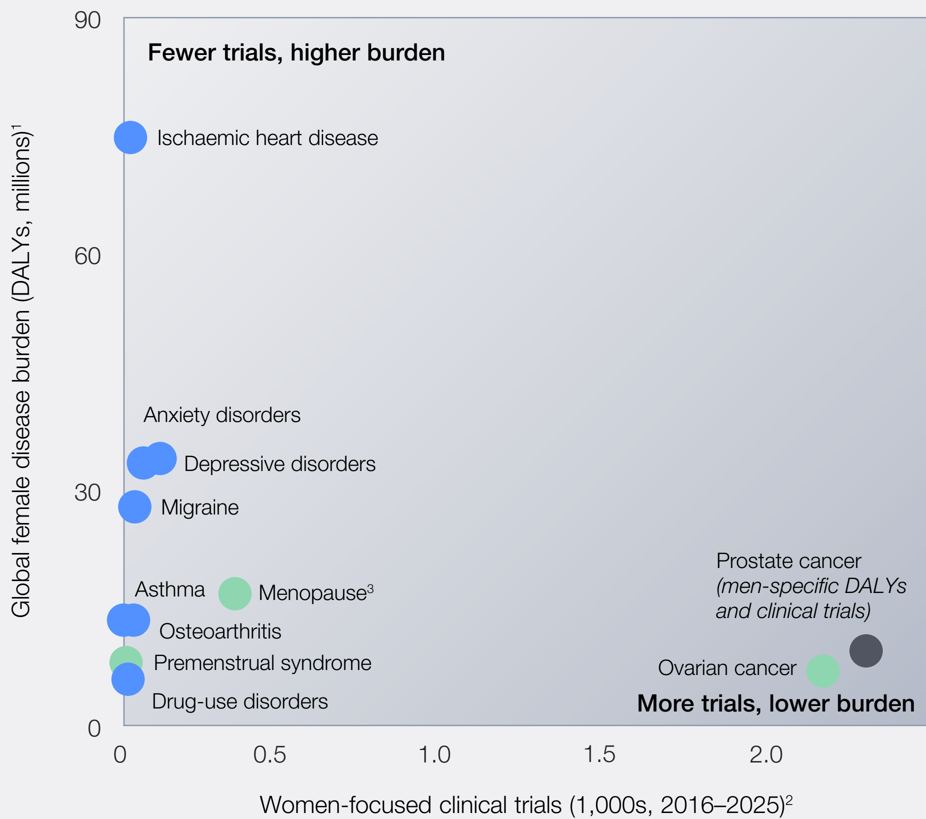
This pattern is particularly visible in conditions that affect women disproportionately and differently. For example, ischaemic heart disease represents one of the largest contributors to female disease burden globally,[23] yet remains one of the most under-represented areas in women-focused publications and clinical trials, reflecting an area of potential significant opportunity for increased research.

Additional gaps can be observed when drawing comparisons across disease areas. Ovarian cancer and prostate cancer pose similar levels of disease burden, yet prostate cancer has nearly twice the volume of scientific publications. While ovarian cancer shows a comparable number of clinical trials, this likely reflects its frequent inclusion in multi-cancer "basket" trials rather than a specific research focus.

The overall misalignment between research activity for men and women is even more pronounced in other conditions. Premenstrual syndrome and prostate cancer, for example, show comparable levels of disease burden, yet premenstrual syndrome receives only minimal research attention across both publications and clinical trials. This highlights that research prioritization does not consistently align with total disease burden and continues to be influenced by factors such as mortality risk, visibility and historical investment patterns. More broadly, the analysis shows that the women's health gap is becoming more pronounced at later stages of research. As research moves closer to patient application, the evidence base becomes narrower rather than stronger and the misalignment with patient need only grows.

FIGURE 5 | **Women-focused scientific publications and clinical trials as a function of disease burden (DALYs)**





Women-specific conditions | Conditions that affect women disproportionately and differently | Men-specific conditions

1. DALYs: disability-adjusted life years, a measure of years of life lost (YLL) and years lived in disability (YLD). Metric represents total years aggregated across a population.

2. Women-focused is defined as research that is women-specific or has a sex/gender comparative focus; see Methodology for full details.

3. Menopause is included under "other gynaecological diseases" in the GDB data and not broken out separately, so "other gynaecological disease burden" was used as a proxy.

Sources: IMHE Global Disease Burden 2023 Data, PubMed, Citeline, Kearney, World Economic Forum

2.3 Research themes reveal gaps across the patient journey

Beyond the limitations in both the volume of evidence and its progression to clinical validation, significant gaps remain in the content focus of scientific publications. Across conditions, scientific research is beginning to look at sex-specific risks, barriers to care and considerations for treatment. However, this research is only just emerging and further barriers exist in translating these insights into actionable and scalable solutions. Across the care pathway, such gaps are visible from prevention through to long-term monitoring. Evidence on prevention remains limited, with few validated and scalable programmes tailored to women and a lack of usable risk assessment tools across diverse populations. In diagnosis, inconsistent thresholds and limited validation of sex-specific biomarkers continue to constrain accurate identification of disease.

Further downstream, evidence on care pathways remains fragmented, with limited understanding of which models can be scaled effectively across healthcare systems to reduce disparities. In treatment, gaps persist in long-term safety and effectiveness data in women, particularly for specific populations such as pregnant, lactating and post-menopausal women. Similarly, monitoring remains underdeveloped, with limited use of women-relevant outcomes and a lack of standardized follow-up protocols. As a result, even when evidence is emerging it is often not structured in a way that supports consistent clinical decision-making or scalable implementation.

2.4 Implications for women's health innovation

The evidence gap has direct consequences for the broader innovation pathway. Clinical evidence is a critical bridge between scientific discovery and product development. Where this evidence is limited, misaligned or incomplete, the translation of research into scalable solutions becomes significantly more difficult.

For those conditions that affect women disproportionately and differently, this results in persistent gaps in diagnosis, treatment and care delivery. Limited and misaligned evidence creates uncertainty for product developers, constrains regulatory decision-making and results in fewer effective, evidence-based options for diagnosing and treating women. Without a stronger and more targeted evidence base, scientific advances are unlikely to translate into meaningful improvements in women's health outcomes.

Generating more research is necessary, but insufficient. Without sex-specific evidence, we cannot deliver the regulatory confidence needed to translate innovation into safe, effective care for women.

Delese Mimi Darko, Director General, African Medicines Agency (AMA)

3 The translation gap: Innovation does not consistently convert into scalable solutions

Product development in women's health remains highly concentrated and does not consistently convert into scalable solutions.

Even where funding and scientific evidence exist, innovation does not consistently translate into products and scalable health solutions. The transition from research and clinical validation to product development and market adoption represents a critical stage in the innovation pathway.

However, across women's health, this stage remains uneven and structurally constrained. The analysis reveals a clear translation gap. Product development is concentrated in a small number of conditions, while many high-burden areas show limited pipeline depth and weak commercialization outcomes.

3.1 Product development remains highly concentrated

Across the women's health conditions analysed, product development activity is heavily concentrated in a limited set of conditions. Within women-specific conditions, 96% of pipeline activity is concentrated in ovarian cancer, with very limited development activity in other areas (Figure 6). This concentration is mirrored in commercialization outcomes. Some 81% of women-specific product launches originate from ovarian cancer, indicating that innovation is not broadly distributed across conditions.

In contrast, other women-specific conditions such as menopause and premenstrual syndrome show minimal pipeline activity and very limited representation in late-stage development, mirroring findings from the WHIT analysis.[24] This pattern closely reflects the concentration observed in funding and evidence generation. Conditions that receive greater investment and research attention are more likely to progress into product development, while underfunded areas struggle to build viable pipelines.

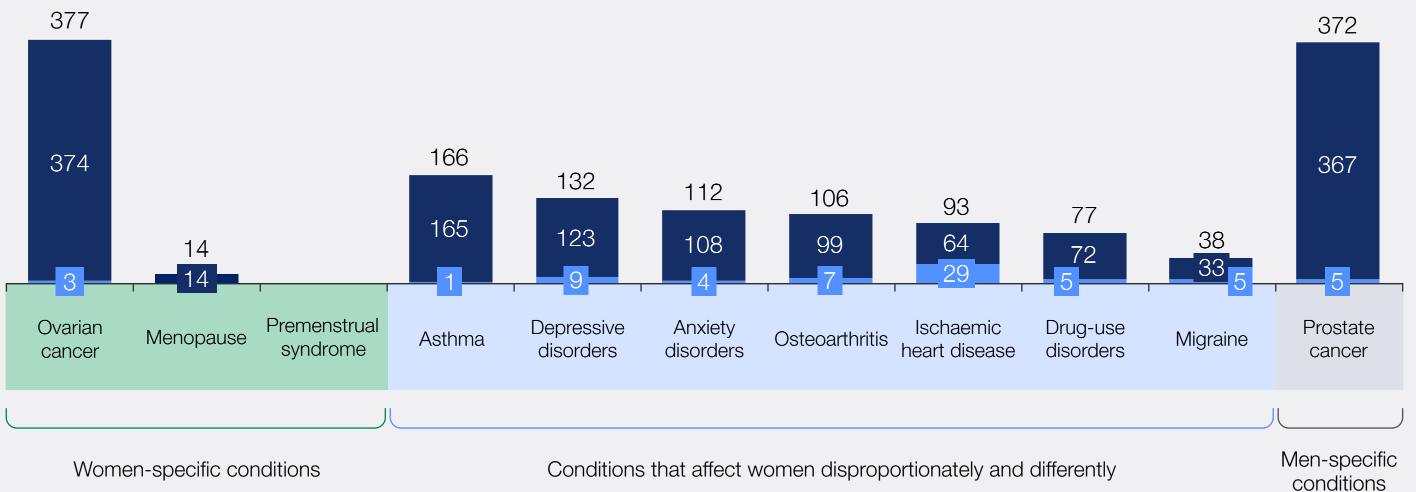
3.2 Development activity does not consistently translate into market impact

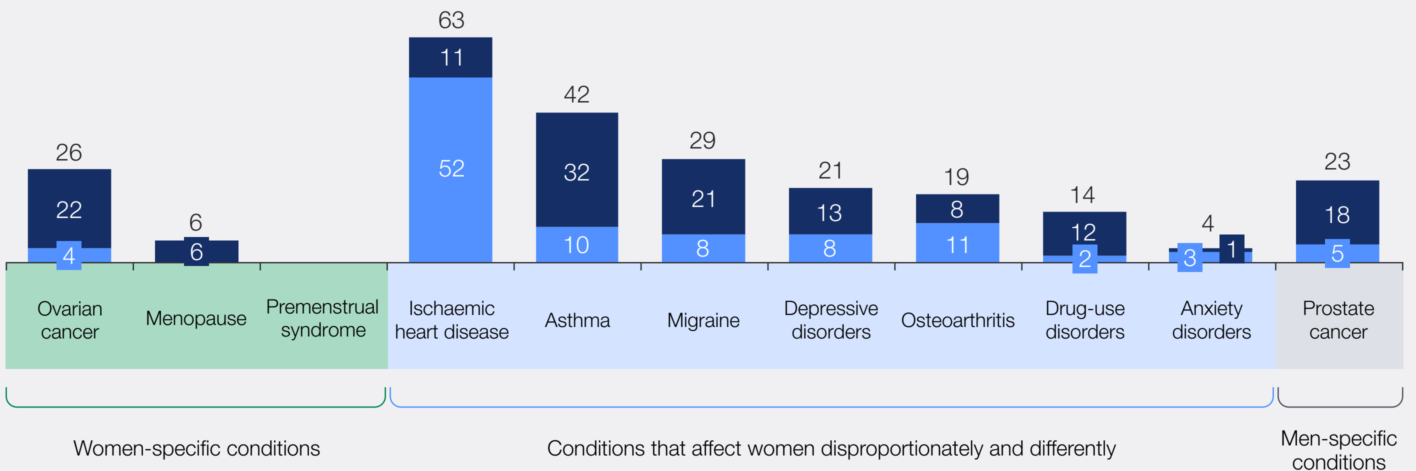
Even in conditions with significant pipeline activity, development does not consistently translate into proportional market outcomes. While attrition between development and commercialization is a common feature of healthcare innovation, the gap is particularly pronounced in women's health, where structural limitations further constrain late-stage progression and market realization.

This is particularly visible in conditions that affect women disproportionately and differently. For example, anxiety disorders show substantial development activity, with 112 pipeline programmes identified, yet only four products were launched between 2016 and 2025 (Figure 6).

This gap between pipeline volume and market output highlights a broader structural issue. High levels of research and development activity do not necessarily result in successful commercialization or widespread patient impact. Several factors may contribute to this dynamic, including challenges in clinical validation, regulatory complexity and difficulties in demonstrating differentiated value for women-specific populations. As a result, even in areas with strong development activity, innovation does not consistently reach patients at scale.

FIGURE 6 | **New products pipeline and launches across conditions**





1. Counts reflect programmes currently active in development based on the latest available status (scope: 2016–2025; see Methodology for full details.

2. Counts reflect distinct products launched between 2016 and 2025; only first recorded global launches are included; see Methodology for full details.

Sources: Citeline, Kearney, World Economic Forum

3.3 Limited diversification of innovation across technologies and conditions

The translation gap is further reinforced by limited diversification in the types of innovation being developed. Across the pipeline, development activity is predominantly driven by pharmaceutical products, which account for most programmes across the conditions analysed. In several areas, pharmaceutical approaches represent more than 90% of pipeline activity, with medical technology (MedTech) contributing only a small share (Figure 6).

This imbalance is particularly pronounced in women-specific conditions. In ovarian cancer, for example, more than 99% of pipeline programmes are pharmaceutical, with only minimal MedTech representation. A similar pattern is observed across other conditions, such as asthma and depressive disorders, where pharmaceutical approaches consistently dominate development activity. Even in areas where MedTech plays a more visible role, such as ischaemic heart disease, pharmaceutical products still account for most of the pipeline, representing 69% of programmes.

This lack of diversification limits the range of solutions available to address women's health needs. In many conditions, particularly those that affect women disproportionately and differently, innovation may depend not only on new therapies but also on improved diagnostic tools, care pathways and digital health solutions. Without broader diversification, the innovation ecosystem risks overlooking important opportunities to improve outcomes through non-pharmaceutical interventions.

3.4 Implications for women's health innovation

The translation gap represents the final bottleneck in the women's health innovation pathway. Even where funding is available and evidence is generated, limited pipeline depth and weak commercialization outcomes prevent innovation from translating into meaningful patient impact. For many conditions that affect women disproportionately and differently, this results in persistent gaps in available treatments, diagnostics and care solutions. High disease burden is not matched by a corresponding level of innovation reaching the market.

At the same time, concentration of development activity in a small number of conditions reinforces existing imbalances across the system. Innovation continues to build on areas of established momentum, while other conditions remain structurally underdeveloped. Without stronger translation from research and evidence into scalable solutions, the benefits of scientific progress will remain uneven and many unmet needs in women's health will persist.

Innovation only matters when it reaches patients. Today, too many advances in women's health stop before they deliver real-world impact.

Stephanie Ledesma, Senior Vice-President, National Health Plan Enablement and Integration, Kaiser Permanente

4 System-level dynamics: How the gaps reinforce each other

The allocation, evidence and translation gaps form a self-reinforcing system that perpetuates imbalances in women's health innovation.

The allocation gap, evidence gap and translation gap do not operate independently. Instead, they form a connected system that shapes how innovation progresses across women's health. Each stage of the innovation pathway influences the next. Funding determines where research is conducted, research shapes the evidence base and evidence drives product development and market outcomes.

When imbalances exist at one stage, they are amplified as innovation moves through the system. As a result, the gaps identified in this report are not isolated challenges, but part of a self-reinforcing cycle that perpetuates structural imbalances in women's health innovation.

4.1 A reinforcing cycle across the innovation pathway

Across the science-to-patient journey, the three gaps interact in a consistent and cumulative pattern. The allocation gap shapes where resources are directed. Funding remains concentrated in a limited set of conditions, often reflecting historical research priorities rather than female disease burden.

This concentration directly influences the evidence gap. Conditions that receive more funding generate more scientific publications and clinical trials, while underfunded conditions struggle to build a robust evidence base. As demonstrated, women-focused evidence remains limited and misaligned with disease burden, particularly in conditions that affect women disproportionately and differently.

These imbalances then carry forward into the translation gap. Conditions with stronger evidence bases are more likely to attract development activity and achieve commercialization, while others remain under-represented in pipelines and market launches. This creates a reinforcing dynamic across the innovation pathway (Figure 7). Rather than correcting the imbalances, the system amplifies them over time.

FIGURE 7 | **Self-reinforcing cycle in women's health innovation**

Sources: Kearney, World Economic Forum

4.2 Why the system does not self-correct

A vital challenge in women's health innovation is that the system does not naturally shift towards the areas of greatest need. First, path dependency in funding systems plays a central role. Established research topics and historically prioritized conditions benefit from existing expertise, infrastructure and funding networks, making them more likely to attract continued research and grant funding.

Second, the evidence requirements for development and regulation reinforce existing patterns. Product development depends on the initial identification of scientific opportunity, followed by robust clinical evidence. Where women-focused evidence is limited, particularly in conditions that affect women disproportionately and differently, development becomes more difficult and riskier.

Third, commercial incentives influence investment decisions to bring an innovation to market. Conditions with clearer development pathways or larger established markets are more likely to attract investment, even when their relative disease burden is lower. This dynamic increases the perceived risk of more novel innovations or those addressing less-studied disease states. Even where solutions exist, insufficient commercial support may prevent them from reaching patients at scale. This challenge is further shaped by reimbursement and adoption dynamics. In many healthcare systems, and particularly in the US, payers act as key validators of value and gatekeepers of scale, assessing whether innovations demonstrate not only clinical benefit, but also economic and operational relevance. Where innovation is not aligned with these expectations, even strong evidence may fail to translate into broad uptake, reinforcing the cycle of underinvestment, persistent evidence gaps and limited product development.

Finally, the limited integration of sex-specific perspectives across the innovation pathway further constrains progress. Where sex-specific differences are not systematically incorporated into research design, clinical validation and product development, opportunities for innovation remain underexplored.

Together, these dynamics create a system that favours continuity over change. The result is a persistent structural imbalance. High-burden conditions that affect women disproportionately and differently remain under-represented across funding, evidence generation and product development. Breaking this cycle will require deliberate, coordinated intervention across the entire innovation pathway. Without such intervention, innovation will continue to reflect existing priorities rather than addressing the areas of greatest unmet need.

These gaps are not isolated challenges. They are part of a system where funding, evidence and development reinforce existing priorities rather than shift toward unmet need.

Verena Schoen, Head of Business Line X-Ray Products, Siemens Healthineers Plan Enablement and Integration, Kaiser Permanente

5 Strategic priorities to close the women's health innovation gap

Addressing the women's health innovation gap requires coordinated action across funding, evidence generation and translation, supported by a clear investment case for innovation.

The analysis presented in this report shows that the women's health innovation gap is driven by a system in which funding, evidence generation and product development reinforce one another. As outlined, these dynamics do not correct themselves. Instead, they create a reinforcing cycle that sustains existing priorities and limits progress in high-burden conditions.

Breaking this cycle will require coordinated action across stakeholders, and efforts to address these challenges are already underway. In 2025, the Global Alliance for Women's Health, in collaboration with Kearney and the Gates Foundation, published the white paper *Prescription for Change*,[25] which outlines policy recommendations to advance women's health research.

In addition, the *Women's Health Innovation Opportunity Map*,[26] developed by the Innovation Equity Forum through a partnership between the Gates Foundation and the NIH Office of Research on Women's Health, has identified 50 high-return opportunities across the research and development continuum, providing a concrete roadmap for advancing women's health innovation. Wellcome Leap offers a complementary model focused on addressing urgent unmet needs through bold, milestone-driven programmes designed to accelerate breakthroughs in years rather than decades. By bringing together multidisciplinary teams around clearly defined outcomes and tight timelines, this approach helps translate high-priority women's health challenges into targeted innovation agendas across research, development and implementation. Aligning investment and innovation strategies with these opportunity areas and delivery models can accelerate progress and ensure that resources are directed towards high-impact interventions. Building on this existing work, the following priorities outline the key system-level shifts required to close the women's health innovation gap.

5.1 Improve and accelerate translation of innovation

A central finding of this report is that closing the women's health innovation gap requires not only increasing research but also ensuring that it progresses into clinical validation and scalable solutions. Expanding research is essential, but greater volume alone will not be sufficient unless it advances through late-stage development, regulatory approval and payer coverage and reimbursement. Strengthening translation will therefore be critical to improving outcomes for women.

Key areas for action include:

- Embedding sex-specific considerations into trial design, end-points and analysis
- Strengthening late-stage clinical validation in high-burden conditions
- Bridging the gap between early-stage research and commercialization through cross-sector partnerships and targeted financial and regulatory incentives
- Aligning innovation with payer requirements to support progression into late-stage development and enable more predictable and efficient pathways to approval and reimbursement

Implementing these actions will require stakeholders to work in parallel rather than sequentially. Researchers and entrepreneurs can translate emerging science into viable product concepts, while public and philanthropic funders can help de-risk late-stage validation. Pharmaceutical companies can look at new partnership models, helping to bridge the funding gap between preclinical and clinical validation, while regulators in turn can provide clearer, faster, more predictable routes to approval, reducing the risk for industry. Investors and payers also have a critical role in signalling what evidence is needed for scale, reimbursement and uptake, helping ensure that promising innovations are designed from the outset for both clinical impact and practical use.

5.2 Increase capital for high-burden conditions

The allocation gap highlights the need to better prioritize female disease burden in investment decisions. Current funding patterns reflect historical priorities rather than the areas of greatest need. Directing future capital towards underfunded, high-burden conditions will be essential to enabling more impactful innovation. To do this, strengthening the business case for women's health innovation will be critical. Investment decisions are influenced by expected returns, regulatory clarity and market potential. Improving the visibility of unmet need, economic impact and commercial opportunities can help mobilize private-sector investment alongside public funding.

Key areas for action include:

- Incorporating standardized female disease burden metrics (e.g. DALYs) into innovation prioritization frameworks
- Introducing funding criteria and incentives that prioritize under-represented, high-impact conditions
- Establishing dedicated funding mechanisms for structurally underfunded areas
- Strengthening the investment case for women's health by improving the visibility of unmet need and economic impact

To implement these actions, NGOs, medical societies, patient advocacy groups and providers should help surface the conditions and symptoms that remain most overlooked, while researchers and innovators build the evidence base (and business case) on where the unmet need and opportunities lie. Public funders, private equity and pharma/MedTech can then use these identified opportunities to guide future investments towards under-researched but high-impact conditions, rather than continuing to follow historical funding patterns. Working together through translational partnerships will be essential to turn insight into a stronger pipeline of diagnostics, therapeutics and care models.

5.3 Institutionalize women-focused clinical evidence

The evidence gap highlights the need to make women-focused research a standard requirement across the innovation pathway. Currently, sex-specific evidence remains limited and inconsistently generated. Institutionalizing women-focused clinical validation will be essential to improving both research quality and downstream innovation outcomes.

Key areas for action include:

- Embedding sex as a biological variable across research design and clinical development
- Mandating and encouraging the inclusion of women, including under-represented populations, in clinical trials
- Standardizing the collection, analysis and reporting of sex-disaggregated data
- Strengthening the integration of sex-specific evidence into clinical guidelines, regulatory submissions and product information

Embedding sex-specific evidence into research and development requires coordination across the full evidence pathway. Funders, regulators and scientific journals can set new expectations on sex and gender inclusion, analysis and reporting, while academia and industry can operationalize those standards through trial design, recruitment strategies and sex-disaggregated end-points to ensure representation across different populations of women. Health systems and clinicians can then support implementation by contributing real-world data and incorporating new evidence into practice and guideline development, while payers can reinforce the value of this evidence by linking coverage decisions to more robust demonstration of outcomes by sex and gender.

5.4 Diversify beyond oncology-led momentum

Innovation in women's health remains concentrated in a limited set of conditions, particularly within oncology and other established areas of innovation. Expanding innovation into a broader range of conditions will be essential to addressing unmet needs, particularly in areas such as ischaemic heart disease, asthma, migraine, mental health disorders (including depression and anxiety), osteoarthritis and drug-use disorders that affect women disproportionately and differently.

Key areas for action include:

- Expanding funding and innovation efforts into non-oncology, high-burden conditions
- Supporting the development of diagnostics, digital health solutions and care delivery models tailored to women
- Increasing transparency on innovation concentration to guide research and investment priorities
- Strengthening ecosystem development in under-represented therapeutic areas, as well as in under-represented countries and regions

Increasing momentum beyond oncology will require stakeholders to deliberately expand the areas where attention, capability and capital are directed.

Funders and investors can signal demand by backing under-researched conditions with strong unmet need, while researchers and industry build the solutions and commercial case needed to make those areas investable. Providers, health systems and patient communities also have an important role in identifying where current innovation is lacking and partnering with developers to demonstrate the need, shape the solutions and support adoption across a wider range of conditions.

At the same time, driving influence across a broader set of women's health needs will require a more globally representative innovation ecosystem, where regional perspectives that reflect differing health systems realities, disease patterns and implementation needs can help shape more inclusive innovation priorities and pathways to scale.

Across all four priorities, a common enabler is the need for greater transparency, coordination and alignment across stakeholders. No single actor can close the women's health innovation gap in isolation. Progress will depend on coordinated action across public, private and research ecosystems. Translating these priorities into impact requires clear ownership and action across stakeholder groups.

Closing the women's health innovation gap requires more than awareness. It requires aligned incentives, a clear investment case and coordinated action across the innovation ecosystem.

Fiona Marshall, President of Biomedical Research, Novartis

Conclusion

Closing the women's health innovation gap requires system-level change to align funding, evidence and development with women's needs. Women's health innovation is at a critical juncture. Advances in science, growing awareness of sex-specific differences and increasing attention from policy-makers and industry leaders have created a strong foundation for progress, yet the findings of this report show that significant structural gaps remain.

Across the 10 high-impact conditions analysed, innovation does not consistently align with female disease burden. Instead, funding, evidence generation and product development remain concentrated in a limited number of areas, while many conditions that affect women disproportionately and differently continue to receive limited attention. These gaps are not independent. They form a reinforcing system in which early-stage imbalances in funding shape the generation of evidence, which in turn influences development activity and market outcomes. As a result, innovation ecosystems tend to amplify existing priorities rather than respond dynamically to unmet need.

This has important implications. High-burden conditions remain under-represented across the innovation pathway, limiting the development of diagnostic tools, treatment options and care models tailored to women. At the same time, the lack of women-focused clinical evidence constrains both scientific understanding and the ability to translate research into practice. Addressing these challenges requires a shift from fragmented efforts to coordinated, system-level action.

As outlined in this report, four priorities will be central to enabling this transition: strengthening translation; increasing funding in areas of high disease burden; institutionalizing women-focused evidence; and diversifying innovation beyond established areas.

However, implementing these priorities will depend on more than policy change alone. A stronger and more clearly articulated business case for women's health innovation will be critical to mobilizing investment and sustaining long-term progress. This includes demonstrating the economic impact of women's health, the potential for innovation within key therapeutic areas and the opportunities for value creation across the healthcare ecosystem. Equally important is the need for greater transparency. Without a clear understanding of the areas where innovation is progressing and where gaps remain, it is difficult to direct resources effectively or align stakeholders around shared priorities. The Women's Health Innovation Radar provides a foundation for such transparency, enabling a more informed and coordinated approach to advancing women's health innovation.

Ultimately, improving women's health innovation is not only a scientific and medical imperative. It is also an opportunity to strengthen health systems, drive more inclusive innovation and improve health outcomes for everyone. Realizing this opportunity will require sustained commitment from all stakeholders. By accelerating funding, strengthening evidence and improving translation into scalable solutions, it is possible to build a more balanced and effective innovation ecosystem – one that better reflects the needs of women and delivers meaningful impact at scale.

Appendix: Methodology

Methodology	Programme funding (grants/awards)	Scientific publications	Clinical trials	Pipeline and marketed products
Data source(s)	NIH World RePORT	PubMed	Citeline Trialtrove	Citeline Pharmaprojects and Meddevicetracker
Geography	← Global →			
Conditions covered	Ovarian cancer, menopause, premenstrual syndrome, drug-use disorders, depressive disorders, anxiety disorders, osteoarthritis, migraine, ischaemic heart disease, asthma, prostate cancer (as reference)			
Unit of analysis	Direct and indirect research investments in biomedical programmes	Journal articles	Phase I–III trials	Product–condition combinations for drugs and medical technologies
Type/scope/filters	Funding organizations: leading governmental/ NGO/philanthropic (non-exhaustive); research organizations: academic, governmental and private (non-exhaustive)	Regular journal articles, classical articles, reviews; excludes clinical trials to reduce overlap with clinical trial analysis	Phase I–III; active and completed trials; device and drug trials, focus on industry-led trials	Pharmaceutical products and medical technologies; class II and III medical devices only; excludes class I and "research use only" devices
Time period	2016-2024; 2025 data not available at time of analysis	Publications between 2016 and 2025	Trial initiation between 2016 and 2025 Note: Some 2025 trials may not yet be included due to reporting lag of research organizations	2016–2025 entrants based on first appearance in global development or launch records
Condition identification logic	Condition included in programme title/abstract	Condition included in article title or Medical Subject Headings (MeSH) tagged terms	Condition listed as indication for trial; in cases where condition is not an available indication, MeSH tagged terms and/ or trial title were searched	Condition listed as indication for product
Women-focused definition and analysis methodology	Women-focused research was defined as programmes/articles/trials that had one or more of the following: 1. Condition is women-specific (e.g. menopause or ovarian cancer) 2. Patient gender is female-only (if disclosed) 3. Title and/or abstract and/or objective includes reference to sex/gender comparative terms such as, but not limited to: "between men and women", "male vs. female", "sex-specific", "stratified by sex", "gender differences", etc. 4. Title and/or abstract and/or objective includes reference to "female", "females", "women", "woman", "women's", but does not include reference to "male", "men", "males", "man" to avoid including every mixed-sex research that references "men and women" or "females and males"			None – data does not allow identification of women-focused products
Other definitions/ notes	Data on research programme funding outside North America, Europe and Australia is very limited; some funding organizations do not report to NIH World RePORT database (e.g. Fondation Inserm, France) and are therefore not included in the analysis	N/A	N/A	New product/entrant = first entry into global development/ commercialization during observation period Pipeline products = in clinical/regulatory development and not marketed anywhere globally Marketed products = approved and commercially launched in at least one market globally

Contributors

World Economic Forum

Emily Fitzgerald
Initiatives Lead, Women's Health

Annabell Klais
Project Fellow, Women's Health

Emily Rowe
Project Fellow, Women's Health

Gates Foundation

Ru Cheng
Director, Women's Health Innovations

Kaitlin Christenson
Senior Program Officer, Program Advocacy and Communications

Wellcome Leap

Regina Dugan
President and Chief Executive Officer

Ramiz Khan
Chief of Staff, Director of Strategic Partnerships

Kearney

Paula Bellostas Muguerza
Senior Partner, Global Lead, Healthcare and Life Sciences

Anna Bode
Global Head, Kearney Health Institute

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Lovisa Afzelius
General Partner, Flagship Pioneering

Pablo Arriagada
Vice-President, Head Clinical Development Women's Healthcare, Bayer

Alison Cave
Chief Safety Officer, Medicines and Healthcare products Regulatory Agency (MHRA)

Alysha Croker
Director, Strategic and Horizontal Policy, Health Canada

Delese Mimi Darko
Director General, African Medicines Agency (AMA)

Victoria DiBiaso
Vice-President, Global Head Patient Informed Development & Health Value Translation, Sanofi

Axel Haupt
Senior Vice-President, Clinical Investigation Diabetes, Obesity and Complications, Eli Lilly and Company

Martin Hund
Director, Clinical Development Lead and Indication Lead Women's Health, Roche Diagnostics

Amy Kao
Senior Vice-President, Head of Research Unit in Neuroscience and Immunology, Merck

Elizabeth Kuiper
Associate Director and Head of the Health and Societal Resilience Programme, European Policy Centre (EPC)

Stephanie Ledesma
Senior Vice-President, National Health Plan Enablement and Integration, Kaiser Permanente

Rita Lobo
Senior Medical Director, Global Research and Medical Reproductive Medicine, Ferring Pharmaceuticals

Rita Mangione-Smith
Vice-President, Research and Healthcare Innovation, Kaiser Foundation Health Plan of Washington

Sue Mann
National Clinical Director in Women's Health, NHS England

Fiona Marshall
President, Biomedical Research, Novartis

Bilikis Oladimeji
Senior Vice-President, Clinical Programs, Progyny

Andrea Renda
Director of Research, Centre for European Policy Studies (CEPS)

Verena Schoen
Head of Business Line X-Ray Products, Siemens Healthineers

Ishita Shively
Senior Vice-President, Apollo Research & Innovation

Michelle Snowden
Senior Director Global Program Management, Genentech

Marie Teil
Global Head, Special Patient Population – Women of Childbearing Age Program/Pediatric/Elderly, UCB

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Production

Bianca Gay-Fulconis
Designer, 1-Pact Edition

Tanya Korniichuk
Illustrator, 1-Pact Edition

Alison Moore
Editor, Astra Content

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Endnotes

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World Economic Forum
91–93 route de la Capite
CH-1223 Cologny/Geneva
Switzerland

Tel.: +41 (0) 22 869 1212
Fax: +41 (0) 22 786 2744
contact@weforum.org
www.weforum.org