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The World Health Organization

Addressing Global Disparities in Health Research and Development, with Focus on the Lacking Research on Women Regarding Medication Testing and Medical Technologies

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I. Introduction

a. Introduction to the Committee

The World Health Organisation (WHO) is the United Nations' leading health authority. It was founded in 1948 and aims to achieve the highest possible level of health for all peoples worldwide. As a specialised UN agency, the WHO coordinates international health initiatives, sets norms and standards, supports research and knowledge exchange. In addition, the WHO advises governments on health matters (World Health Organization, 2022). As part of its work, the WHO develops evidence-based guidelines and promotes global research collaboration with the aim of reducing health inequalities. Its key tasks include monitoring global health risks, coordinating vaccination campaigns and emergency responses (for example, during pandemics), and developing international health regulations. Furthermore, the WHO supports member states in strengthening their health systems and advancing research for more equitable healthcare.

In the area of health research and development (Health R&D), the WHO promotes collaboration and the equitable distribution of scientific knowledge and innovations by identifying global research needs. The WHO plays a pivotal role in the UN system by ensuring that scientific progress in the health sector benefits all countries and population groups, and by promoting global health equity (World Health Organization, 2022).

b. Introduction to the Topic

The chosen topic highlights the fundamental global problem of inequality in health research and development (R&D). The fact that women have historically been under-represented in drug trials and medical technologies is a particular focus. There are significant disparities in health R&D worldwide: On the one hand, there are differences between the Global North and South. The majority of medical research is conducted in industrialised nations, whilst diseases that occur primarily in low-income countries often remain under-researched. On the other hand, gender-specific inequalities exist in medical research. For decades, the male body was regarded as the 'norm' in medicine, resulting in female needs being systematically overlooked. Women – particularly pregnant women and those of childbearing age – were deliberately excluded from clinical trials for a long time, mostly out of an excess of caution or fears of legal liability (Singh & Swarup, 2025). This has led to a "gender data gap": There is a lack of important data and insights into women's health, such as on the gender-specific efficacy and safety of medicines. This historical under-representation of women in research and development has serious consequences for global health: It undermines the quality of medical care for women worldwide and raises questions of equality and human rights.

Universal access to the best possible healthcare is a fundamental right. However, if half the world's population is overlooked in research, there will be a and there is an already existing gap in evidence-based care. This places a significant strain on healthcare systems and health equity as a whole (World Economic Forum, 2025). Addressing these inequalities is of the highest importance, as they affect patient safety, global health goals and equality. This makes the issue a central topic of discussion at the WHO Forum.

II. Background and Key Data

a. The historical development of medical research

Medical research has made significant progress over the last few centuries – from the first vaccines in the 18th century to modern molecular medicine. However, this development was not immune to societal prejudices: Androcentrism – the practice of using the male body as the standard – shaped medicine for a long time. Consequently, clinical trials were historically often conducted exclusively on men. A well-known example is the Mr FIT study in the 1970s, in which around 325,000 exclusively male participants were examined for cardiovascular risks, whilst women were entirely excluded (Abbasi, 2023). Such practices assumed that findings from male study groups could simply be applied to women – a fallacy, as we now know. A key moment in the 1960s was the thalidomide disaster, where severe birth defects affected children, whose mothers took this sedative during pregnancy. In response, the US Food and Drug Administration (FDA) imposed a general prohibition on including women of childbearing age in early-stage clinical trials in 1977. This measure was originally intended to protect women. However, this rule has ironically resulted in the continued exclusion of women from research (Singh & Swarup, 2025).

It was not until the 1990s that a shift in thinking began: In 1993, the US government passed the NIH Revitalization Act, which stipulated that women (and minorities) must be adequately represented in government-funded studies (Taylor Wessing, 2024). In Europe, the regulatory framework was also adapted. For example, EU Regulation No. 536/2014 requires justification for gender representation in clinical trials (Taylor Wessing, 2024). These reforms marked a turning point: women were formally included in research. Nevertheless, a look back reveals that the history of medical research is characterised by phases of systematic exclusion, the repercussions of which are still felt today.

b. Gender data gaps

The gender data gap stems from the under-representation of women in medical research, where male bodies have historically been treated as the "standard." This bias starts in preclinical research with male cell lines and continues into clinical practice, often leading to suboptimal or harmful treatments for women.

Key consequences include:

- Dosing errors: For example, the FDA only halved the recommended dose of *Zolpidem* for women in 2013 after realizing they metabolize it more slowly.
- Misdiagnosis: Heart attack symptoms in women (like nausea or back pain) were long overlooked because they differ from "typical" male symptoms.
- Underfunding: Conditions primarily affecting women, such as endometriosis or autoimmune diseases, receive significantly less research funding.

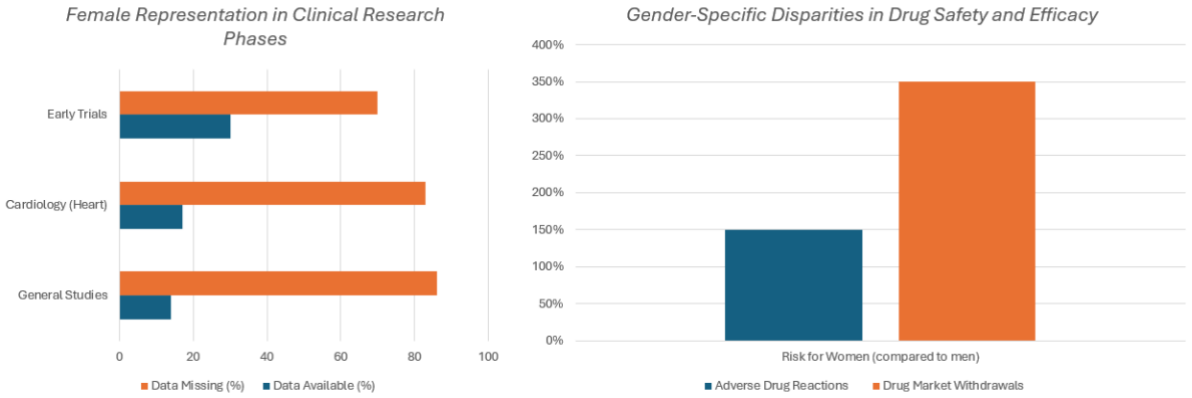
While international regulations now increasingly demand gender-specific data, closing this gap remains a major challenge for ensuring safe and effective healthcare for everyone.

c. Key statistical data (clinical trials, drug approvals, medtech)

Current data reveal significant gender disparities in health research:

- Clinical Trials: While women make up half the population, they account for less than 30% of participants in early-phase industry trials (Singh & Swarup, 2025). The representation is even lower for specific groups; for instance, only 4% of trials between 2011 and 2021 included pregnant women (WHO, 2025).
- Medicine Approval: Despite regulations, gender-specific results are rarely reported, with only 5–14% of studies providing sex-disaggregated data (Abbasi, 2023). In cardiology, specifically for blocked arteries, only 17% of studies analyze gender-specific outcomes despite clear biological differences (World Economic Forum, 2025).
- MedTech & AI: Many medical devices and AI tools are biased due to reliance on male anthropometric data. For example, female surgeons more frequently report difficulties with instruments designed for larger, male hand sizes (Penumudi et al., 2025).
- Patient Safety: Since 2000, women have reported side effects 50% more often than men, and medications are withdrawn 3.5 times more frequently due to risks specific to women (World Economic Forum, 2025).

In summary, despite some progress, the gender gap in health research remains a significant challenge for modern medicine (World Economic Forum, 2025; WHO, 2025).



Sources: Singh & Swarup (2025); World Economic Forum (2025); Abbasi (2023).

III. Current Global Situation

a. Current state of research on women and regional differences

Over the past decade, gender equity in health research has improved, particularly in Phase III trials. However, women remain under-represented in early-phase clinical trials, meaning differences in pharmacology and toxicity are often identified too late (Singh & Swarup, 2025). Significant gaps also persist in cardiovascular medicine and AI-supported healthcare (World Economic Forum, 2025).

Global disparities further complicate the issue: The Global North dominates R&D spending, often neglecting health problems specific to women in the Global South, such as tropical diseases during pregnancy. Furthermore, while the EU and North America enforce strict gender-equitable standards, weaker regulations in developing countries risk non-representative study populations or unethical testing practices. This is exacerbated by a “brain

drain," where top researchers from the Global South migrate to Northern institutions, further depleting local research capacities.

a. Impact on healthcare systems and patient safety

The unequal distribution of research means that medical guidelines are often not optimally tailored to all population groups. Medicines developed in the Global North may be less effective in the Global South because genetic backgrounds or specific effects on women were insufficiently tested. A lack of local research forces a reliance on Western studies that ignore contextual factors like diet or comorbidities, compromising patient safety.

Even in the Global North, data for groups such as pregnant women is lacking; currently, only about 5% of all medicines provide sufficient safety information for pregnancy and breastfeeding (World Economic Forum, 2025). This often forces doctors into uncertain off-label decisions or treatment discontinuations, straining the healthcare system (WHO, 2025). Furthermore, medical devices tested primarily on men can lead to misdiagnoses and harm in women.

Overall, the global situation shows both progress and shortcomings. These manifest as unequal health outcomes. Women globally spend around 25% more years of their lives in ill health or with a disability than men, despite having a higher life expectancy (World Economic Forum, 2025). Experts therefore see a need for action to reduce such inequalities (World Economic Forum, 2025).

IV. Medical and Technological Implications

a. Medicine trials: dosage, side effects, efficacy

The underrepresentation of women in clinical trials results in gaps in our knowledge of dosage recommendations and side-effect profiles. Biological differences, such as hormonal cycles, body fat percentage and enzyme activity, can significantly impact the absorption and metabolism of drugs (WHO, 2025). Without gender-specific testing, there is a risk of overdose. For example, the sleeping pill Zolpidem was found to cause more frequent morning impairment in women only after it was approved (FDA, 2013). Similarly, side effects often manifest differently or more frequently in women, a fact that only becomes apparent through gender-disaggregated data analysis (World Economic Forum, 2025). Since efficacy can also vary due to receptor density or immune responses, doctors lack precise guidelines without this research. Ultimately, gender-blind trials pose a higher risk of ineffectiveness or toxicity for female patients.

b. Medical technologies (diagnostics, AI, medtech)

The gender gap in medical technology compromises female patient safety, as hardware and digital solutions often rely on male standards. Physical products like implants, pacemakers, and protective gear frequently lack an inclusive design, leading to poor fit and reduced protection for women. In digital health, biased AI algorithms risk systematic misclassification because they are trained primarily on male data, often failing to recognize female-specific symptoms or pain reports.

These disparities result in misdiagnoses, user errors, and inadequate treatments. While the growing Femtech industry and new regulatory requirements (e.g., FDA/EU) are positive steps, systematically integrating gender-sensitive criteria remains essential to ensure medical technology is safe and effective for all genders.

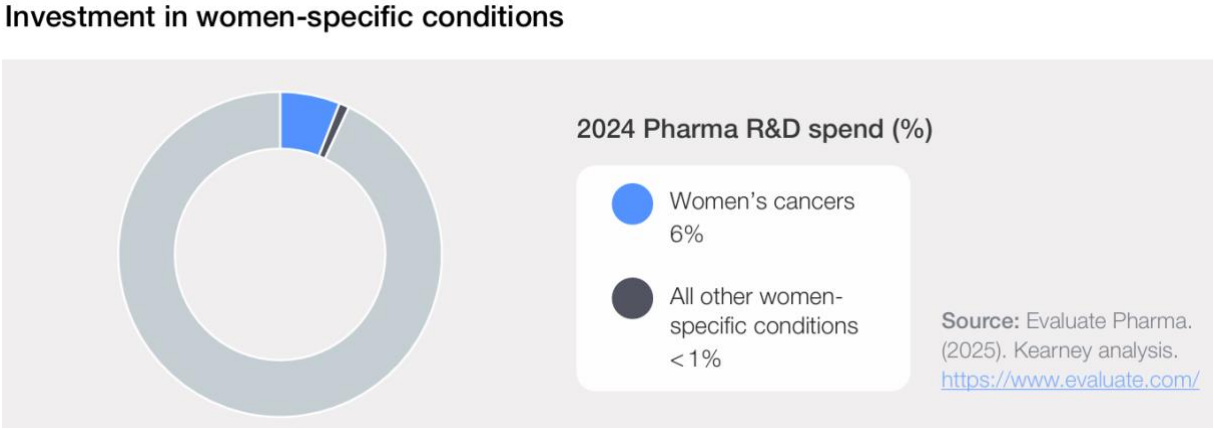
c. Consequences of the lack of representation of women

The implications outlined in this chapter have a common theme: If women are not properly taken into account in research and development, the negative consequences ultimately affect the healthcare system. As patients, women run the risk of being treated with diagnostic or therapeutic procedures that are not optimally tailored to them – which can damage their health. This also represents an economic loss: Inaccurate diagnoses and increased side effects mean higher treatment costs and productivity losses (World Economic Forum, 2025). From a global perspective, the gender gap in R&D also hinders progress in medicine. Furthermore, potential insights into disease mechanisms or innovative solutions remain undiscovered if female perspectives are excluded. This means that the full representation of both genders is not only a matter of fairness, but also of scientific excellence. More inclusive research leads to a more comprehensive understanding and better health outcomes for everyone.

V. Socioeconomic and Ethical Dimensions

a. Social, economic and cultural causes

The causes of global gender inequality in research are multifaceted. Historically, sexism within male-dominated leadership structures has led to women being given a lower research priority or being excluded due to perceived "complexity" (Comen, 2024). Women's participation in trials is further hindered by cultural norms, especially when fertility might be affected. From an economic perspective, pharmaceutical companies have traditionally prioritised markets with high profit potential, consequently neglecting female-specific conditions such as endometriosis as niche sectors (World Economic Forum, 2025). Furthermore, the underrepresentation of women in scientific leadership positions means that women's health issues are less likely to be recognised as urgent. In poorer regions, a lack of access to education and limited resources further prevent participation in research projects. These structural barriers require targeted political interventions.



b. Ethics in medical research

Research ethics is based on the principle of equity, requiring a fair distribution of benefits and risks across all population groups. Excluding women is ethically problematic because it denies them access to medical progress and exposes them to higher risks. A particular dilemma exists regarding pregnant women, who have historically been excluded protect the foetus. However, organisations such as the WHO now advocate for their inclusion in order to enable evidence-based treatment (WHO, 2025). Paternalistic approaches that exclude women "for their own protection" violate their autonomy. A balanced ethical framework must weigh up the risks and benefits without any unjustified exclusions (WHO, 2025). Ultimately, inclusive research is a human rights issue (Art. 12 UN Covenant); research gaps in women's health can be interpreted as violations of the right to health.

c. Relationship with the Sustainable Development Goals

Gender-related disparities in research impact several of the UN's Sustainable Development Goals (SDGs). SDG 3 (Good Health and Well-being), for example, calls for universal access to high-quality healthcare, which cannot be achieved for women without gender-sensitive research. SDG 5 (Gender Equality) is also impacted, as failing to address women's issues in research is a form of implicit discrimination (World Economic Forum, 2025). SDG 9 (Industry, Innovation and Infrastructure) also demands inclusive innovation for all. Human rights conventions such as CEDAW also require equal treatment in healthcare, which includes research. From a socio-economic perspective, increased research into women's health offers significant benefits: women remain in the workforce for longer and the costs associated with misdiagnosis are reduced (World Economic Forum, 2025). Closing these research gaps is essential to ending health disparities based on gender or origin.

VI. Relevant Actors and Stakeholders

- **WHO**
  As the global health authority, the WHO establishes policy frameworks and coordinates efforts to promote gender-equitable research. It develops guidelines and initiatives, for example to promote the inclusion of under-represented groups in clinical trials (see WHA Resolution 75.8 of 2022). Through working groups and research bodies (e.g. the Global Clinical Trials Forum), the WHO promotes dialogue between stakeholders and collects data on global R&D gaps. The WHO also acts as an advocate for health equity

by urging Member States to incorporate gender considerations into their research policies (WHO, 2025).

- **Governments and national health authorities**
  Governments play a key role by shaping regulatory frameworks and research funding programmes. Some countries have already introduced regulations stipulating that public research funding may only be awarded if women are adequately involved (e.g. the US, the EU – see NIH policy, EU regulation) (Taylor Wessing, 2024). National medicines regulatory authorities (such as the FDA, EMA, BfArM) can define requirements for clinical trials (e.g. gender-specific analyses as a licensing criterion) and analyse pharmacovigilance data by gender. Governments can also provide specific funding for women's health research. Politically, states are responsible for implementing their SDG commitments (SDG 3 and 5), which requires a commitment to closing the gender data gap.

- **Pharmaceutical industry**
  As the developer of most new medicines, it has a significant influence on who is included in clinical trials and which therapeutic areas receive investment. Pharmaceutical companies have a responsibility to design gender-diverse trials and to develop products that address women's specific health needs (e.g. contraception, the menopause, gynaecological conditions). In recent years, some companies have launched internal programmes to specifically promote the inclusion of women in trials or to enter partnerships with initiatives such as Global Health 50/50, which promote gender equality in healthcare. Nevertheless, the industry is also accused of conflicts of interest when market considerations take precedence over gender equality goals. Through public-private partnerships (PPPs), the industry can collaborate with the WHO or foundations to contribute to innovative solutions – e.g. new approaches to medication during pregnancy.

- **Research institutions and universities**
  Academic institutions and researchers can ensure that study protocols are designed to be inclusive (e.g. by including a representative number of women and formulating gender-specific hypotheses). Furthermore, universities train future scientists: Through curricula and mentoring, they can ensure that gender medicine and diversity awareness become integral parts of medical training. Research institutions also serve as a source of ideas for innovation in medical technology. Experience shows that inclusive teams develop more inclusive solutions.

- **Non-governmental organisations (NGOs) and civil society**
  Numerous NGOs are committed to women's health and gender equality in healthcare. Examples include Women in Global Health, Global Health 50/50, and organisations such as DNDi (Drugs for Neglected Diseases Initiative), which draw attention to overlooked areas of research. Patient organisations are also important: They share personal accounts of gaps in care and call for change, such as endometriosis associations or women's heart health networks. These groups engage in activism and can exert pressure on governments and companies to prioritise gender-specific research. Civil society, including the media and women's rights movements, has helped in recent years to bring the issue into the public and political spotlight (e.g. debates on International Women's Day, Lancet commissions on women's health).

VII. Past International Actions

- **WHO initiatives and resolutions**
  The WHO has increasingly focused on strengthening clinical trials and inclusive research. A notable outcome was Resolution WHA 75.8 of the World Health Assembly (2022), entitled 'Strengthening Clinical Trials to Provide High-Quality Evidence'. This resolution, adopted in May 2022, emphasises that under-represented groups – particularly women (including pregnant women), children and older people – must be increasingly included in clinical research. It calls on Member States and the WHO to remove barriers to such participation and to strengthen research capacity globally. To implement this, the WHO has established a Global Advisory Board and developed guidelines for best practices in clinical trials (2024). Furthermore, in 2023 the WHO founded a Global Clinical Trials Alliance to connect stakeholders and exchange experiences, for example regarding the inclusion of women. A specific initiative concerns pregnancy and breastfeeding. In 2025, the WHO established a task group with the aim of achieving the ethical and safe inclusion of pregnant women in trials by 2030 (WHO, 2025). This builds on earlier programmes, for example in the areas of malaria and HIV, which promote the participation of pregnant women in pharmaceutical trials.

- **UN programmes and resolutions**
  The United Nations itself addresses the issue indirectly in the context of women's rights and health. For example, the United Nations Commission on the Status of Women (UN CSW) has repeatedly emphasised the importance of gender-specific health data in its final declarations. Another globally significant soft-law document is the Beijing Declaration and Platform for Action (1995), which, although older, sets out key principles: It calls on governments to ensure gender equality for women in science and medicine at all levels – which implicitly also covers research content. The right to health has been discussed on several occasions in the Human Rights Council, with NGO reports also drawing attention to the gaps in women's health research (e.g. report of the Special Rapporteur on Health, 2019). More specifically, UN Women, in collaboration with the WHO, has launched programmes in recent years to improve health data in developing countries, for example to better collect mortality and morbidity statistics by gender (this is important for identifying research priorities).

- **international agreements, guidelines and strategies**
  There are also important initiatives outside the UN framework. In 2016, CIOMS (Council for International Organizations of Medical Sciences) published international ethical guidelines for health research, which highlight the need to avoid unjustified exclusion of pregnant women. Equally relevant are the ICH guidelines (International Council for Harmonisation of Technical Requirements for Pharmaceuticals), which are recognised globally by regulatory authorities. Recent revisions such as ICH E8(R1) emphasise representative patient populations in studies. Regional bodies have also responded: In 2021, the European Union reaffirmed the Gender Equality Strategy 2020–2025, which also enshrines health equality. In November 2025, the European Parliament published a detailed study with recommendations to close the 'gender health gap' in the fields of research, drug development and healthcare (Davaki, 2025). This recommends, for example, better funding for women's health research, regulatory adjustments and the strengthening of female participation in decision-making bodies.

In addition to official measures, there are networks and alliances: the Global Alliance for Women's Health, in collaboration with the World Economic Forum (WEF), published a white

paper in May 2025 entitled 'Prescription for Change: Policy Recommendations for Women's Health Research', which proposes coordinated action in five areas (World Economic Forum, 2025). The recommendations include, for example: financial incentives for women's health innovation, mandatory inclusion plans for women in studies, comprehensive analysis of gender data, etc. Although such proposals are non-binding yet, they demonstrate the growing need for global action. In recent years, there has been a significant increase in attention. Now concrete successes in implementation must follow**.**

VIII. Current Challenges

- **Scientific challenges**
  incorporating gender considerations into research requires adapted study designs and methodological work. For example, larger sample sizes are often required to identify gender-specific differences (men vs. women), increasing workload and costs. Variables like the menstrual cycle or hormonal contraceptives must be taken into account, further increasing the workload and costs. There is also a lack of trained staff (e.g. biostatisticians) capable of carrying out such analyses. For some women-specific conditions (e.g. endometriosis), there is a lack of fundamental knowledge of the pathophysiology, making it difficult to formulate research questions. This results in a vicious circle of limited knowledge leading to low priority and insufficient research.

- **Political and regulatory barriers**
  Although many guidelines exist, they are not always implemented or followed. Not all countries have binding regulations on women's representation in research, and even where such regulations exist, the strictness of their enforcement varies. Regulatory authorities primarily focus on overall efficacy and safety, leaving specific assessments for women to the discretion of the sponsors. Another obstacle is the fragmented global regulatory landscape: while the EU and the US have clear frameworks, comparable efforts are lacking in many low- and middle-income countries (LMICs). International harmonisation (e.g. through the International Conference on Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH)) is progressing slowly, meaning that global pharmaceutical companies may exploit loopholes. Moreover, politically, this issue is not at the top of every country's agenda. It competes with many other health priorities. This can result in a lack of political will to specifically embed gender issues in national research funding, particularly where social equality issues are controversial.

- **Financial barriers**
  Research costs money, and gender-specific research projects must compete for limited funding. Public funding is scarce in many countries, particularly in the Global South, where there is a lack of domestic programmes and countries depend on donors who often prioritise other areas. In the private sector, companies may be unwilling to undertake the additional effort of conducting separate analyses or development programmes specifically tailored to women if they do not see an immediate commercial benefit. This is also referred to as 'market failure' in women's health research. While the benefits to society as a whole are high, they are not always immediately profitable for the individual investor, particularly when it comes to maternity or rare women's conditions. Furthermore, patent durations, the high cost of clinical trials, and ineffective public–private partnerships are hindering the development of innovations such as

pregnancy-specific medicines, causing many promising projects to slow down or even stall.

- **Lack of data and knowledge gaps**
  A contradictory challenge is that, in order to eliminate inequality, we need data on inequality itself. For example, many countries do not collect health data divided by gender, particularly when it comes to databases on side effects or health expenditure. Without this data, it is difficult to quantify the problem and address it in a targeted way. Furthermore, in the Global South, there is a lack of research infrastructure in some cases to generate the necessary data – for example, a smaller number of clinical trial centres, insufficient laboratory capacity for women-specific trials, etc.

- **Regulatory issues in inclusive research (e.g. research involving pregnant women)**
  In particular, the inclusion of pregnant women remains a complex legal issue. Many ethics committees are unwilling to approve such protocols unless specific safeguards exist. Current regulations are sometimes inconsistent. While there are normative requirements for inclusion in the US, for example, companies may be deterred by liability provisions. Clearer international guidelines are needed on when and how pregnancy studies can be conducted.

- **Conflicts of interest**
  There are also conflicts of interest that slow down change processes. For example, the pharmaceutical industry seeks to delay regulations like quota systems for women in clinical trials, which impose stricter requirements. There's also resistance to change in the scientific system, where established patterns are followed and some researchers may find additional levels of analysis, like gender and diversity, burdensome.

These current challenges make it clear that eliminating global R&D disparities affecting women is not a foregone conclusion. It requires targeted strategies, coordination and perseverance. Whilst awareness of the problem now exists, the international community must tackle these obstacles. It is precisely these obstacles that provide the basis for discussion in this topic: Delegates can discuss how to set the course differently politically and financially, and how to integrate women into research safely and fairly using scientific and ethical solutions.

IX. Definition of Key Terms

- **Global Disparities in Health R&D**
  Differences in the distribution of resources, attention and outcomes in health research between countries/regions and population groups. Examples: Massive investment in R&D in the Global North versus limited resource allocation in the Global South; or research focusing on specific populations (e.g. men), potentially at the expense of others (e.g. women).

- **Health Research and Development**
  A collective term for systematic scientific investigation (research) and subsequent implementation (development, e.g. of medicines or technologies) in the field of health. This includes basic and clinical research (e.g. trials for medicines or vaccines), as well as the development of new products or processes until they are ready for market.

- **Gender Data Gap**
  There is a significant gender data gap, as in many areas (particularly within the healthcare system) data on women is collected or utilised to a lesser extent than data on men. In medical research, the gender data gap specifically refers to the gap that arises when women are under-represented in studies and, as a result, findings specific to them are lacking. The consequence is that a lack of data on female-specific aspects leads to gaps in knowledge and potentially suboptimal care.

- **The Global North & the Global South (disparities)**
  A division of the world that is not strictly geographical, but is based on levels of development and economic prosperity. The Global North generally refers to economically powerful, industrialised countries (North America, Europe, Japan, Australia, etc.). On the contrary the Global South refers more likely towards developing and emerging economies (large parts of Africa, Asia, and Latin America). In the context of health and R&D: the Global North has the most research infrastructure and funding, compared to the Global South, which often struggles with under-resourcing and research deficits.

- **Medical technologies and female technologies**
  MedTech is short for medical technologies – these can include diagnostic equipment, medical devices, digital health applications or AI systems in the healthcare sector. FemTech (female technology) is a relatively new term for technologies specifically designed for women's health (e.g. period apps, fertility trackers, digital services for pregnancy or the menopause). FemTech seeks to tackle previously ignored women's needs through new approaches to reduce the gender data gap.

- **Clinical Trial**
  Research involving human participants to test the efficacy and safety of medical interventions (e.g. new medicines, vaccines, medical devices).
- **Underrepresented Groups**
  Population groups that are under-represented or under-considered in the context of research. In the field of medicine, this often includes women, but depending on the context, it may also include, for example, ethnic minorities, children, older people or people from the Global South. Being under-represented means that a group appears in study populations or as the focus of research to a lesser extent than would be expected given its proportion of the total population or its share of the disease burden.

XI. Useful Links

1) WHO – Global Health R&D Observatory
   https://www.who.int/initiatives/global-observatory-on-health-research-and-development
2) WHO News 18 June 2025: Inclusion of Pregnant Women in Clinical Trials
3) World Economic Forum (2025)
   WEF Article May 2025: Women's Health Research Gap – Why More Must Be Done
   Politische Empfehlungen für die Forschung zur Frauengesundheit | Weltwirtschaftsforum
4) Nature India Viewpoint
   DNDi Viewpoint Mar 2025: Women are poorly represented in clinical trials
5) European Parliament Study (2025)
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