OGMUN - SHSID

Model United Nations Conference

牛津大学-上海中学国际部国际模拟联合国大会

2026

Commission on the Status of Women (CSW)

#BACKGROUND GUIDE

Contents

Letter to Delegates 2
Introduction to the Committee 3
Gender Bias in Medical Research 4
Background of the Problem 4
Current Situation 8
Historical Solutions 14
Relevant UN Actions 16
Questions A Resolution Must Answer 18
Proposed Solutions 20
Bloc Positions 22
Suggestions for Further Research 26
Bibliography 27

Letter to Delegates

Dear Delegates,

Welcome to the Commission on the Status of Women - we are very much looking forward to meeting you all at the conference! Throughout this Background Guide, you will understand the barriers to fair medical experiences that girls and women around the world face. This is a pressing issue that the world faces today; the elimination of gender bias in medical research is critical to achieving gender equality globally.

The Commission on the Status of Women under the United Nations Economic and Social Council (ECOSOC) is central to monitoring issues related to women's political, civil, economic, and educational rights. It serves as a platform for nations to collaborate on strategies to promote gender equality and the empowerment of women globally. Central to its discussions is the elimination of gender bias on many levels, such as in education and medical research.

It is important to recognise the dangers prevalent in gender biased medical trials and work towards their future elimination. It is vital that, as the Commission on the Status of Women, we raise awareness of such issues and attempt to address them with a thoughtful and effective resolution.

We are very much looking forward to hearing your ideas and discussion on this topic, and hope that in doing so, we will be able to contribute constructively to the global discussion. Most importantly, you will gain insights into the transformative potential of gender equality. We hope you will build upon the progress while proposing your own solutions that centre women's needs and voices.

Above all, we hope you will walk away from this MUN feeling more confident in your leadership, the unique ideas you bring to the table, and your capacity to drive meaningful change!

Sincerely,

SHSID OGMUN team

Introduction to the Committee

The Commission on the Status of Women (CSW) is a functional commission of the United Nations Economic and Social Council (ECOSOC), established in 1946.1It was created to promote gender equality and the empowerment of women globally. Initially composed of 15 member states, CSW now includes 45 member states elected for four-year terms with equitable geographical distribution: 13 from Africa, 11 from Asia-Pacific, 9 from Latin America and the Caribbean, 8 from Western Europe, and 4 from Eastern Europe.2

The CSW is now the leading intergovernmental body monitoring issues related to women's political, civil, economic, and educational rights.3 The committee's primary role is to develop policies, assess progress, and recommend actions to further the status of women in the political, economic, civil, social, and educational realms. Its key achievements include drafting the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979 and contributing to the Beijing Declaration and Platform for Action (1995), a landmark global agenda for women's empowerment. It was also responsible for guiding the integration of gender equality goals into the 2030 Agenda for Sustainable Development, particularly SDG 4 (Quality Education) and SDG 5 (Gender Equality).1

CSW hosts an annual session at the UN Headquarters in New York, drawing thousands of participants from governments, NGOs, and civil society. It uniquely integrates grassroots voices through parallel NGO forums, known as the NGO-CSW.4 Functioning as both a policy-shaping and advocacy platform, the CSW's structure pushes governments to report progress and share best practices for gender equality in an environment that encourages dialogue among a variety of stakeholders and elevates women's advocacy.

Part of the CSW's mission is to "contribute gender perspectives" to other UN bodies, such as the UN Peacebuilding Commission and the UN Security Council.2 Through these recommendations, the CSW can influence the agendas and operation of the UN more broadly and advise comprehensive strategies for

dismantling barriers to women. At this conference, CSW will examine how medical bias affects women's access to health care more broadly.

Gender Bias in Medical Research

Background of the Problem

Gender bias in medical research is a topic that is gaining more recognition in healthcare and medical fields. Often, medical literature fails to find clarity and agreement on the definition and characteristics of gender bias in medicine. [1] Gender bias in medical research can be defined as the systematic underrepresentation, misrepresentation, or neglect of sex and gender differences in the design, conduct, and analysis of biomedical studies. This bias can be seen in multiple ways during medical research, such as the exclusion of women from clinical trials, failure to analyse results by sex, and the use of male-centric models in preclinical research. The consequences of bias in research can be profound, including the fact that diagnostic criteria, treatment, and medicine dosages are often optimised for males. This can subsequently lead to higher rates of misdiagnosis, ineffective treatment, and preventable harm to women. As there is a widespread appearance of sex differences in diseases experienced by humans, it is required that detailed experiments be performed on both sexes, unless the studies have the intention of specifically addressing reproduction or sex-related behaviours. [2] The consequences of this practice of gender bias undermine the achievement of Sustainable Development Goal (SDG) 3 (Good Health and Well-being) and SDG 5 (Gender Equality) and contravenes obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Male-Centric Paradigms in Medicine

From the late 19th century onwards, biomedical research largely treated the male body as the "default" human model. Women's health was often reduced to reproductive concerns, with systemic conditions studied primarily in men.

The Thalidomide and DES Legacies

The thalidomide tragedy (1950s–60s), in which a drug prescribed for morning sickness caused severe birth defects, [3] and the diethylstilbestrol (DES) case, where a synthetic oestrogen led to cancer in daughters of women who took it, prompted overprotective policies. [4] In the United States, the Food and Drug Administration (FDA) in 1977 recommended excluding women of childbearing potential from early-phase drug trials, [5] and this policy persisted for over a decade and had long-lasting impacts on the recognition of women in medical research.

The "Yentl Syndrome"

The term "Yentl Syndrome" describes how women with heart disease were less likely to receive appropriate treatment unless their symptoms mirrored those of men. [6][17] This concept encapsulates the broader issue that women's health needs are often addressed only when they conform to male norms.

Underrepresentation in Research

- Women constitute only 41% of participants in drug and device trials globally (2016– 2019). [7]
- In Phase I trials, women make up just 22% of participants. [8]
- Preclinical studies overwhelmingly use male animals and cell lines, even for conditions more prevalent in women.

Lack of Sex-Disaggregated Analysis

Only 5–14% of studies across medical disciplines examine outcomes by sex. [9] Even when women are included, results are often pooled without sex-based analysis.

Consequences for Health Outcomes

- Cardiovascular disease: Women are 50% more likely than men to be misdiagnosed after a heart attack. [10]
- Pharmacology: Women are 50–75% more likely to experience adverse drug

reactions [11]

- Mental health: Depression is nearly twice as prevalent in women, yet many studies fail to explore sex-specific risk factors.

Institutional Bias

Medical curricula and research funding priorities have historically centred on male health models. Women's health is often siloed into obstetrics and gynaecology, neglecting systemic conditions.

Economic and Industry Factors

Pharmaceutical companies may avoid including women in early trials to reduce perceived risks and costs, perpetuating data gaps.

Intersectionality

Gender bias intersects with race, ethnicity, age, disability, and socioeconomic status. Women from marginalised groups face compounded exclusion from research participation.

International Legal and Policy Framework

- CEDAW (1979): Article 12 obliges States Parties to eliminate discrimination in healthcare and ensure equal access to health services, including research participation. [12]

- Beijing Platform for Action (1995): Calls for integrating a gender perspective into all health policies and programmes, including research. [13]

- WHO Gender Strategy: Advocates for sex- and gender-based analysis (SGBA) in health research to improve equity and outcomes. [14]

Case Studies

- Cardiovascular Research: The Multiple Risk Factor Intervention Trial (MRFIT) (1970s) screened 325,000 white men for cardiovascular risk and excluded women entirely. Prevention strategies derived from this trial were applied universally, despite being validated only in men. [15]

- COVID-19 Research: Early pandemic studies often failed to disaggregate data by sex, obscuring differences in infection rates, immune responses, and vaccine side effects. • Pharmacology: The sleep medication zolpidem (Ambien) was prescribed at the same dose for men and women until 2013, when the FDA halved the recommended dose for women after discovering slower metabolism rates.

Implications for Global Health and Development

- Undermines evidence-based medicine.
- Exacerbates health inequities.
- Increases healthcare costs due to misdiagnosis and ineffective treatment.
- Hinders progress toward SDGs and universal health coverage.

The persistence of gender bias in medical research is both a scientific flaw and a human rights issue. Addressing it requires coordinated action across governments, international organisations, academia, and industry. The Commission on the Status of Women is uniquely positioned to catalyse this change by framing it as a matter of gender justice, health equity, and sustainable development.

Current Situation

Gender Bias in Medical Research and Healthcare Practice

The question of gender bias in medical research has a deep impact on a variety of different aspects regarding women's health and well-being. Medical research is impacted not solely by a gender gap in the research, but also by misogyny [18], which means that solutions aiming at addressing this problem need to contend with both these aspects. Research shows that women and men are perceived differently throughout medical research and practice [19]. This is not solely related to problems in 'female' health concerns, but spreads across the board, with women being less likely to receive the correct levels of treatment or pain management than their male counterparts [19].

Overall, the question of bias in research is intertwined with overall issues of gender discrimination in the field of medicine and healthcare. This is because medical research informs the practices and education that go on to shape the outcome of patients.

Contemporary Examples of Gender Bias in Healthcare

In recent years, this issue has been spotlighted, especially after the COVID-19 pandemic, where only 4% of the clinical trials actively sought to include women, despite differences in infection rates [20]. This impacted overall population health and could slow down the response to future pandemics [21].

Since then, studies have shown that while men have suffered from higher mortality rates [22], women are more likely to develop long COVID [23]. These findings showcase how gender differences play out in health emergencies, and how biased research can impact health outcomes not only for women, but for men as well. Gender bias becomes an issue that impacts all potential patients, not only women, and can have huge ramifications for other aspects of public health and overall societal health outcomes.

The COVID-19 pandemic is not the only example of contemporary issues around gender bias in medical research. Cardiovascular disease has long been perceived

as a man's disease, impairing women's access to both diagnosis and effective treatment [24]. They are more likely to have cardiovascular disease diagnosed as anxiety or gastrointestinal problems [25], impacting both short and long-term health outcomes. This misdiagnosis can be caused by a disregard for women's symptoms and the general belief, even among medical professionals, that cardiovascular disease is not that prevalent among women.

Structural and Methodological Sources of Bias

However, bias is also reflected in patients themselves. In the case of cardiovascular disease (CVD), women are also less likely to take their symptoms seriously and seek medical treatment, due to the perception of CVD as not being a major health concern for women [26]. This shows the multifaceted aspects of bias, and how solutions towards this issue need to address not only medical researchers and practitioners but also look to the wider public.

One issue is related to medical research methodology and design. A study shows how US clinical

trials involve a majority of male participants over female participants [27]. This means that data informing medical treatments, devices, etc., is biased from the start, which can result in poorer outcomes for women. As discussed previously, there are a variety of reasons for this exclusion, including institutionalised policies that excluded women from medical research. This gets particularly worse if we look at women belonging to minority ethnic groups, which are themselves underrepresented.

In this case, androcentrism is still a very present belief in the medical field, be it due to institutional bias which centres men, and particularly white men [28]. In the case of CVD, for example, the perception that it impacts men more than women can affect how the research is designed, through determining who it considers to be impacted by the disease and therefore who should be part of any trials. More broadly, such bias can cause losses for men and women – it does not allow for targeted approaches or consider differences in practice that could provide more helpful outcomes to all patients.

Access, Participation, and Funding Inequalities

The lack of women's participation in research is not solely due to researcher bias – there are considerable barriers in women's accessing healthcare and research facilities. Women living in rural areas might have considerable difficulty in travelling to undertake medical research and care, as well as have higher distrust in medical institutions [29]. The latter can be emphasised through the medical bias itself, which might alienate women from medicine and medical research. Furthermore, other contexts might impact women's ability to participate in research. A study in India showed that women in lower socioeconomic households, not involved in professional work and/or with a lower educational background, were less likely to engage with medical research [30]. Such barriers are not relegated only to specific countries but can apply across the board in relation to women's access to healthcare facilities and treatment as well.

Another issue that primarily affects research is funding. This is related to which issues are perceived to be important in the field and therefore merit funding. Recently, discussions around the lack of funding for research on menopause have emerged, highlighting how this phenomenon, which impacts half the world's population, is still chronically underfunded [31]. This is one example of underfunded research that directly correlates to gender bias, but studies have shown that women's health is underfunded even in issues that are not usually considered to be a 'women's health' problem – for example, anxiety disorders. These tend to affect women more than men and are underfunded in relation to other conditions that impact men more severely, such as substance abuse [31].

Research shows that "in nearly three-quarters of the cases where a disease afflicts primarily one gender, the funding pattern favours males" [32]. To combat that, policies need to be in place that provide robust guidelines for funding, which should include gender and other biases as part of their metrics and approaches. Furthermore, organisations and governments can provide incentives to offset this funding disparity through resource allocation, tax incentives, public information campaigns and other forms of public policy.

Bias in Medical Technology and Evidence-Based Practice

Beyond disease research, there is another aspect of medical research which is also impacted by gender bias, and that is medical technology. Medical technology can broadly be defined as the “the creation of tools with the broad goal of improving the quality of life of patients” [33].

One of the most persistent issues in this field is that medical devices are often designed and tested primarily on male bodies, which can lead to systematic exclusion of women’s needs and experiences. For instance, devices such as artificial heart valves, pacemakers, and prosthetics have historically been modelled on average male anatomy, resulting in poorer fit, reduced effectiveness, and increased complication rates for women [16. This problem mirrors the broader gender gap in medical research, where the male body is frequently taken as the default, while women’s physiological differences are seen as secondary. As a result, female patients may be subjected to higher risks of device failure, slower recovery, and decreased trust in technological interventions.

In addition, technologies specifically designed for women’s health often receive less funding and are slower to reach mainstream clinical practice compared to technologies addressing conditions that affect men. For example, innovations in menstrual health, fertility tracking, and menopause management—sometimes grouped under the label of “femtech”—have historically been marginalised or dismissed as niche markets despite addressing conditions that affect half of the population [34]. This lack of investment perpetuates inequities in access to effective medical tools for women and underscores how gender bias not only shapes the design of technologies but also influences the priorities of research agendas and funding decisions. Recognising these disparities is crucial for creating inclusive medical technologies that serve diverse populations equitably.

Social Inequalities in Healthcare Application

Besides the choice on what to fund, there are also disparities in funding between researchers themselves. In Australia, a recently conducted study shows that women are less likely to receive funding, and that the funding they do receive tends to be smaller than that of their male counterparts [35]. Studies led by

women tend to include more female participants [20] [36], which means that the lack of funding for women researchers directly impacts medical research bias.

One of the main consequences of this is the lack of evidence-based practices when it comes to women. Evidence-based practices emerged in the 1990s as a new frontier in healthcare, and highlighted the importance of systematic research as crucial to healthcare provision [37]. Its focus on research was meant to discourage 'intuition' and 'experience' in favour of evidence-led medicine. This recognised the limitations of such ideas around intuition and experience, and how they could reflect underlying bias. Evidence-based practice, however, has not been implemented in a way that fully addresses the issues around gender bias.

Global Inequalities in Healthcare Application

One of the issues has been previously discussed - the lack of research in itself causes a scarcity of evidence to support such healthcare. Another problem is how the existence of evidence does not translate into its use in clinical settings. Childbirth is a good example of this, as it has historically been very dangerous for women, and there is no doubt that the mortality of women in childbirth

has decreased dramatically in the last century. While this is largely due to medical advancements, it does not mean that those have been implemented equally across countries and populations. Lack of access to technology, research and education impacts the implementation of evidence-based practice, creating gulfs between developed and developing countries and regions. As discussed by the WHO, there are high disparities between low-income and high-income countries in terms of best practices at childbirth (2025). An example of this is Mexico, where women suffer abuse and disrespect during childbirth, and where evidence-based practices are scarce [39]. This is also present in other regions, such as sub-Saharan Africa and Southeast Asia [38].

Besides differences across states, such imbalances are reflected in intranational social disparities. Studies have shown that Black and Indigenous women suffer discrimination and racism in healthcare, directly impacting their medical outcomes, the care which they receive and their perception of the healthcare system [40]. Therefore, when thinking about improving the research, it is also

important to reflect on how this will be applied throughout healthcare and how medical advances can be better propagated to address social inequalities.

Policy Responses

The current situation on the question of gender bias in medical research is therefore multifaceted and ever evolving, and policymakers seeking to address those would do well in thinking about the many dimensions in which bias operates. However, certain countries and organisations have taken steps to address the issue. As highlighted, the U.S. National Institutes of Health (NIH) now requires grant applicants to justify the inclusion—or exclusion—of both sexes in research designs [41]. This policy aims to ensure that findings are more broadly generalizable, rather than based solely on male models. Expanding similar policies on a global scale would promote greater accountability and consistency across research institutions and funding agencies, thereby narrowing the knowledge gap in women's health outcomes.

Another measure would be to encourage and promote journals and regulatory agencies' requirements for the reporting of gender-disaggregated data in both publications and clinical trial submissions. Research shows that including this allows for a more nuanced gender analysis, making gender-mindful research a requirement rather than an optional practice [42]. Efforts like this highlight gender transparency as a non-negotiable part of scientific reporting. This means that the research community can discourage data homogenisation and reveal clinically relevant differences that might otherwise remain hidden. This cultural and regulatory shift would ultimately improve the safety and efficacy of medical interventions for all patients.

Finally, meaningful inclusion also depends on engaging women from local communities in the design and execution of clinical trials. Barriers such as lack of childcare, transportation, or flexible scheduling frequently prevent women from participating in research [43]. Sponsors can address these challenges by offering practical solutions and ensuring trials are accessible to diverse populations. Moreover, new technologies such as artificial intelligence and computational modelling offer promising tools to predict sex-specific drug responses prior to

human testing [44]. Such approaches can reduce risks for women while providing valuable insights that guide more equitable trial design, bridging the gap between preclinical and clinical research.

Historical Solutions

Despite the equivalent ratio of the male to female global population, socially constructed gender divisions exist. Women wait longer than men for both medical diagnosis and pain relief. They are also more likely to be misdiagnosed or prematurely discharged than their male counterparts [18]. Medical research has also widely excluded females or intersex individuals, instead generalizing research data and applying conclusions taken from male medical studies. This divide has its roots in ancient Greece. Philosopher Aristotle championed the male-female dichotomy; women were in effect inferior men. The primary and important difference between them was the uterus, the possession of which engendered the female as child bearer. As ideas of female biology have evolved, "medical myths about gender roles and behaviours…have resonated perniciously" [45]. While it is unclear why such a gendered gap exists in the modern medical arena, several reasons have been put forward by researchers. These grounds include concerns relating to pregnancy or decreasing fertility, researcher bias from male researchers, and the presentation of man as a representative of the human species [18].

Androcentrism

Androcentrism is a socio-cultural phenomenon characterized by the prioritization of male perspectives, experiences, and values over those of women [46]. In medical research, androcentricity has historically disadvantaged female patients, from inaccurate diagnoses of "hysteria" and often harsh or cruel treatments (such as forced bed rest or genital mutilation) [18]. The discourse of hysteria, of women being "mad" or "crazy," has been used to describe "difficult" women, often those who do not respond to medical intervention as expected [18]. Aside from its more

extreme implications, androcentricity can be a contributing factor in the lessening of women's experience. In a paper entitled "Do mad people get endo or does endo make you mad?" [47]. examined the discourse surrounding patients with endometriosis, discovering that endometriosis patients' pain was frequently dismissed as psychological [18].

Gender may impact career opportunities in medicine, with women being disadvantaged in academic medicine. [48]. broach this divide with the "gender mainstreaming" approach, a strategy to improve gender equality by maintaining a gender perspective in policies and programs, as well as in medical education to increase health equity, diminish gender biases, and improve equal opportunities for men and women [48].

Yentl Syndrome

Inspired by the short story "Yentl the Yeshiva Boy" written by Isaac Bashevis Singer, Dr. Bernadine Healy has coined the term "Yentl syndrome" with regard to women as patients. In her 1991 paper, Healy suggests that for a woman to be taken seriously in a medical setting, she must comport herself as a man, proving herself to be "as unwell as a male counterpart," much as Yentl in the story had to disguise herself as a man to attend school [18]. Healy cites two studies as examples of such inequality. In Ayanian and Epstein in Massachusetts and Maryland, researchers found a disproportionate ratio of necessary medical intervention and testing with regard to male/female coronary angiography, angioplasty, or surgery [17]. Steingart et al. determined that women's

angina before myocardial infarction was frequently more severe than men's, yet women were half as likely to undergo cardiac catheterisation [17]. Healy suggests that "once a woman showed that she was just like a man, by having severe coronary artery disease or a myocardial infarction, then she was treated as a man would be. The problem is to convince both the lay and the medical sectors that coronary heart disease is also a woman's disease, not a man's disease in disguise" [17].

National Institute of Health (USA)

In the United States, the National Institute of Health (NIH) Guide for Grants and Contracts, published in 1987, established a policy that encouraged researchers to include women in medical studies. In 1989, NIH announced a Memorandum on Inclusion, facilitating the inclusion of women and minorities in research solicitations; if they were excluded, scientists would need to include a rationale [49]. In 1991, NIH established the Office of Research on Women's Health (ORWH), with Dr. Bernadine Healy becoming the first female NIH director and launching the Women's Health Initiative. The Women's Health Initiative enrolled over 150,000 postmenopausal women in a set of clinical trials and an observational study on hormone therapy, diet modification, and vitamin supplements on heart disease and cancer [49]. In 1993, Congress wrote the NIH inclusion policy into Federal law via the NIH Revitalization Act. Since, the ORWH has been tasked with monitoring the adherence to policy, with grantees delivering annual reports on the sex, race, and ethnicity of research participants enrolled in clinical trials [49].

Despite this, a 2019 literature review supported that females remain underrepresented in medical literature [18]. Additionally, the review showed that "the gender gap and misogynistic studies" continue to exist.

Relevant UN Actions

UN (2015) Sustainable Development Goal 5 is "achieve gender equality and empower all women and girls". Its focus is "on closing the gender gap and ensuring equal opportunities for all". It is argued that gender equality is a basic human right. Yet despite the fact that "women and girls represent half of the world's population", the concept of gender equality remains unresolved.

Globally, between 2019 and 2024, 99 legal reforms have been established to improve gender equality. Child marriages and female genital mutilation (FGM) have declined in recent years but remain significant challenges world-wide. In 2024, only 38 countries have a minimum marriage age of 18 years. Although

Southern Asian child marriages have decreased, they are projected to rise in sub-Saharan Africa [50]. Globally over 230 million have been subjected to FGM (4 million each year). Thirty-five per cent of women aged 15-49 years have experienced partner violence or non- partner sexual violence [50]. Women still lack control over their bodies; 43.7 per cent of married women are disallowed from making decisions about their reproductive health and rights [50].

Global awareness, spurred by education and political reform, is key to spearheading this UN initiative.

Beijing Platform for Action (1995) put forth initiatives to change women's rights on a global scale. In 1995, during the Fourth World Conference on Women, 189 governments adopted the Beijing Declaration and Platform for Action. It set objectives in 12 areas for the advancement of women and gender equality: women and poverty, education and training of women, women and health, violence against women, women and armed conflict, women and the economy, women in power and decision-making, institutional mechanism for the advancement of women, human rights of women, women and the media, women and the environment, the girl-child. Gender equality, specifically women's rights and representation, became a global concern.

Women's Rights in Review 30 Years After Beijing (2025) investigated how women's rights have progressed since 1995. Since 2019, 90 per cent of States reported measures to address violence against women, while 79% have created national action plans to halt this violence. Despite this, violence against women persists; 1 in 3 women worldwide are still subjected to sexual violence by a partner or non-partner in 2024.

A "gender data revolution" is transforming data gathering, in relation to UN Sustainable Development goals. The Women Count programme has focused on data gathering and global measurement of gender indicators in relation to UN Sustainable Development Goals. Six further initiatives were delineated for ALL women and girls, worldwide; digital revolution, freedom from poverty, zero violence, full and equal decision-making power, peace and security, and climate justice.

Questions A Resolution Must Answer

1. How should gender bias in medical research be defined?

   Delegates need to reflect on what elements of bias are most significant, and how a shared definition can set the foundation for international cooperation.

2. What are the main consequences of gender bias in research?

   This invites exploration of how bias impacts health outcomes, knowledge production, and equality in access to care.

3. How can funding be redirected or expanded to support gender-sensitive research?

   Delegates should think about the structures that shape where money flows, and how these can be influenced to close gaps in research.

4. Should there be international guidelines for gender-inclusive research practices?

   This raises questions about the role of global standards, the diversity of national contexts, and the balance between flexibility and uniformity.

5. How can participation in clinical trials be made more representative?

   Delegates may need to consider barriers to participation and ways research design can address differences in populations.

6. How should intersectionality be addressed in research?

   Delegates should examine how gender interacts with other factors and what this means for collecting and interpreting data.

7. What reforms to medical education and training could reduce gender bias?

   This question encourages reflection on how knowledge is taught, how professional attitudes are formed, and how future researchers and practitioners can be shaped.

8. What accountability mechanisms could ensure compliance with new standards?

Delegates should consider how institutions can be encouraged - or required - to follow through on commitments.

9. How can governments, universities, and pharmaceutical companies be encouraged to cooperate?

   This asks delegates to think about relationships between different actors, how responsibilities are shared, and how collaboration might be fostered.

10. Should there be an international platform for sharing gender-disaggregated data?

    Delegates must reflect on whether shared data would strengthen global research, and what challenges such cooperation might entail.

11. How can research into women-specific conditions be prioritised?

    This question points to long-standing imbalances and asks delegates to consider how agendas in research can be shifted.

12. What ethical safeguards must be put in place for participants?

    Delegates should reflect on how the rights, safety, and dignity of participants can be protected while broadening inclusion.

13. How can public awareness campaigns highlight the dangers of gender bias in research?

    This invites exploration of who needs to be informed, how awareness can shift attitudes, and how public pressure can drive institutional change.

14. What role should the CSW and other UN bodies play in monitoring progress?

    Delegates need to think about which bodies are best placed to oversee commitments, and how accountability can be maintained at the international level.

15. How should progress be measured over time?

    This requires reflection on what success looks like, how it can be tracked, and how evaluations can guide future work.

Proposed Solutions

The lack of gender equality throughout the world impacts many areas: health and longevity, violence against women and girls, economic gains, social standing, political representation, the right to make personal care and medical decisions. Gender bias in medical care and research perpetuates these issues.

Focus on Medical Education

It is possible to consider that medical gender bias be dealt with from the ground up. Medical school curriculum may be designed to better address the topic of women's health care. Pain recognition and management is an area where gender bias prevails. Studies show that chronic pain primarily affects females, but most pain studies have been conducted on men [51]. Female pain is regularly ignored or minimized by medical professionals [51]. Male pain symptoms are often considered "organic" while those of females may be viewed as "psychosomatic" [51]. Altering medical school curricula to include a course of study which reflects sex and gender awareness would be a first step in educating/re-educating medical professionals. Additionally, teaching doctors to listen to their female patients' complaints more closely may aid in more timely and accurate diagnosis and subsequent treatment.

Focus on Medical Workforce

Research demonstrates that women in the medical profession respond differently to patients than their male counterparts. Women may be better at communication and are more likely to engage on an emotional level with their clients [52]. Female medics are more in tune to the severity of symptoms in women and are more likely to follow clinical guidelines and adopt preventative care strategies [52]. Making provisions for females to attend school, stay in school, and engage in STEM (Science-Technology-Engineering Math) learning can help set the stage for life choices leading to medical careers.

Roots of Gender Bias

The roots of gender bias in medicine run deep, all the way back to ancient Greece.

Women's health issues have "often been misunderstood, ignored, or dismissed as anxiety" [53] It is challenging to affect a global mindset. Stereotypes prevail. Women are not small versions of men; they have unique biology and responses to medical catalysts. It is important to recognize and applaud those differences, from a young age.

A National Priority

The United Nations Sustainable Developmental Goal 5 includes a focus on the achievement of gender equality and the empowerment of women and girls. Accordingly, gender equality is a fundamental human right. National policies should reflect that right. Women should be allowed and encouraged to have leadership positions within their communities such as land holding, farming, owning businesses, political aspirations.

Raising Awareness

The Spotlight Initiative is an EU/UN (European Union and United Nations) partnership designed to eradicate violence against women. It is a global, multi-year initiative, culminating in 2030. Its success may be mirrored by other countries. The premise is that by calling attention to the issue

(spotlighting it), more attention will be paid to gender equality and women's rights, including the right to be safe.

Focus on Women's Wellbeing

The United Nations Sustainable Development Goal 3 (Good Health and Well-Being) supports healthy lives and well-being for all people, of all ages. The promotion of healthy living rubrics and preventative care are paramount. Women's health issues before, during and after pregnancy may be supported to help reduce maternal and infant mortality. Patient communication with medical and mental health professionals should be encouraged. Research into communicable diseases and epidemic illnesses should incorporate subjects from a cross-section of the population, especially females versus their male counterparts.

Bloc Positions

Western Europe & Other Group (WEOG)

WEOG includes countries with some of the most advanced medical research systems and home to major pharmaceutical companies. These states often pride themselves on being champions of gender equality and are accustomed to pushing for progressive global norms. Their domestic public opinion and NGOs strongly pressure governments to ensure equity in healthcare.

They will generally support ambitious, binding international standards that directly address gender bias. This could include requirements for sex-disaggregated data in research, equal representation in clinical trials, and regular UN monitoring. Their proposals are often detailed and technical, reflecting their research capacity.

WEOG states are motivated both by principle (gender equality as a human right) and by pragmatism (ensuring that medical products developed in their markets are effective for all populations). They also face reputational pressure to maintain leadership in ethical research and health policy.

Expect WEOG delegates to push for strong accountability and enforcement. However, they may face criticism from developing blocs for being unrealistic or imposing one-size-fits-all solutions without providing adequate funding and support.

Latin America & Caribbean (GRULAC)

Many GRULAC countries have strong women's rights movements and vocal civil society groups that bring attention to inequalities in healthcare. However, the region is marked by uneven research capacity – Brazil and Mexico are leaders, but smaller Caribbean states may struggle to participate fully in global initiatives.

GRULAC will likely support reforms aimed at equity and inclusion. They will highlight the way gender bias in research directly contributes to unequal

healthcare outcomes in their populations, particularly among rural, poor, and indigenous communities. Their approach is often rights-based.

Delegates from this bloc are driven by the need to reduce inequality, both within their own countries and between the Global North and South. They may stress that addressing gender bias also advances broader goals of social justice, poverty reduction, and sustainable development.

GRULAC is likely to call for international funding and technical assistance. They may also push for regional cooperation initiatives. Expect them to be persuasive in linking gender bias to wider human rights issues, which helps them attract cross-regional support.

Africa Group

The Africa Group represents countries facing some of the most pressing health challenges globally, including maternal mortality, infectious diseases, and underfunded health systems. Local research institutions exist but are often limited in capacity compared to those in WEOG or Asia-Pacific.

African states will support measures to reduce gender bias but will emphasise practicality. They are unlikely to back proposals that require costly reforms unless there is clear international support. Their focus will be on capacity-building, fair access to funding, and technology transfer.

This bloc is motivated by the need to ensure its populations are not left behind in global health research. They want solutions that reflect African priorities and acknowledge the continent's limited resources. They will likely resist proposals that appear to burden them without offering assistance.

Expect Africa Group delegates to stress equity, fairness, and the need for tangible support from developed countries. They may form alliances with GRULAC or parts of Asia-Pacific to demand funding commitments and ensure flexibility in implementation.

Asia-Pacific Group

This is the most diverse bloc, containing wealthy, research-intensive states (like Japan, South Korea, and Australia), emerging powers (India, China), and small developing nations in South and Southeast Asia. Cultural attitudes toward gender vary widely, influencing domestic policy positions.

The bloc will be divided. Advanced economies will support ambitious reforms and global standards, while developing members will emphasise flexibility, cost effectiveness, and cultural sensitivity. Sovereignty is a recurring theme for many countries in the bloc.

Advanced states are motivated by scientific leadership and alignment with Western allies, while developing states focus on balancing reforms with immediate public health needs. Many states will also argue that international frameworks must respect cultural diversity and national autonomy.

Delegates from this bloc may act as both allies and sceptics. Expect some to align with WEOG on accountability measures, while others side with Africa and GRULAC to push for capacity- building and looser commitments. This bloc often becomes the swing group in negotiations.

Eastern European Group (EEG)

EEG includes both EU and non-EU members. EU members follow strict gender and research directives, while non-EU states often take a more cautious stance. Research systems in the region are relatively developed, but many countries still face economic pressures.

EEG countries will generally support action on gender bias but prefer pragmatic approaches. EU members will align with WEOG, pushing for strong standards, while others will seek to limit financial and administrative burdens. They are unlikely to oppose reforms outright but may try to water down overly ambitious measures.

EU members are driven by obligations under EU law and political alignment with

Western Europe. Non-EU members are motivated by sovereignty concerns and the need to protect limited resources. Both groups, however, are invested in maintaining credibility as research actors.

Expect EEG delegates to act as mediators. They may propose compromises between ambitious WEOG proposals and the resource-based concerns of Africa and Asia-Pacific. Their ability to build bridges can make them influential in shaping final resolutions.

Major Non-Aligned / Developing Countries (Cross-Regional)

This grouping includes influential Global South states such as India, Brazil, and South Africa. These countries often lead calls for fairness in global governance, arguing against donor-driven agendas. They have strong research capacity but also face deep inequalities in healthcare access.

They will support addressing gender bias but demand equity in how responsibilities are shared. They tend to oppose measures that they see as reflecting Western priorities at the expense of developing countries' needs. South–South cooperation is often proposed as an alternative to dependency on Northern aid.

These states are motivated by protecting sovereignty, gaining recognition as leaders of the Global South, and ensuring their populations benefit fairly from global reforms. They will argue that solutions must not reproduce global inequalities in research and funding.

Expect them to challenge WEOG proposals if they lack financial fairness. They may insist on global funding pools, stronger recognition of national contexts, and more representation for the Global South in decision-making structures. Their leadership can shape whether Africa and GRULAC align with or against WEOG.

Suggestions for Further Research

The Women and Equalities Committee of the UK House of Commons published a report on ‘Women’s reproductive health conditions’. It can be found here:

https://committees.parliament.uk/committee/328/women-and-equalities-committee/news/20 4316/medical-misogyny-is-leaving-women-in-unnecessary-pain-and-undiagnosed-for-years/

There are a number of specific studies on gender bias regarding treatment of specific conditions. You may wish to find some of these, along with a literature review here:

Merone, L., Tsey, K., Russell, D., & Nagle, C. (2022). Sex Inequalities in Medical Research: A Systematic Scoping Review of the Literature. Women's health reports (New Rochelle, N.Y.), 3(1), 49–59. https://doi.org/10.1089/whr.2021.0083

For a different perspective, numerous books have been published detailing experiences and intersectionality within gender bias in medical research.

- Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick by Maya Dusenbery
- Medical Bondage: Race, Gender, and the Origins of American Gynaecology by Deirdre Cooper Owens
- Sex Matters: How Male-Centric Medicine Endangers Women’s Health and What We Can Do About It by Alyson J. McGregor

Bibliography

1. Bargeri, Silvia, et al, “Exploring the definitions of gender bias in healthcare literature: a scoping review protocol”, MethodsX, 15, 2025.

2. Plevkova, Jana, et al, “Various Aspects of Sex and Gender Bias in Biomedical Research,

Physiol Res, 69, 2020.

3. Science Museum, “Thalidomide”, 2019.

4. National Cancer Institute, “Diethylstilbestrol (DES) Exposure and Cancer”, 2025.

5. National Institutes of Health, “History of Women’s Participation in Clinical Research”, 2024.

6. Mount Sinai, “Women and Heart DiseaseL We Are Not Just Small Men”, 2022.

7. BMJ. “Under-representation of women in research: a status quo that is a scandal.” 2023.

8. U.S. FDA. Guidance on the Inclusion of Women in Clinical Trials. 2020.

9. Nature Communications. “Sex bias in biomedical research.” 2021.

10. European Heart Journal. “Gender differences in diagnosis and treatment of acute coronary syndromes.” 2019.

11. Wilson, L. A., et al. (2022). Sex differences in biomedical research: a comparative analysis of pre-clinical traits and their implications for adverse drug reactions. Nature Communications, 13, 7616.

12. United Nations General Assembly, “Convention on the Elimination of All Forms of Discrimination against Women New York”, 1979.

13. UN Women, “Beijing Declaration and Platform for Action”, 2015.

14. World Health Organisation, “WHO gender strategy”, 2007.

15. National Library of Medicine, “Multiple risk factor intervention trial. Risk factor changes and mortality results. Multiple Risk Factor Intervention Trial Research Group”, 1982.

16. Criado Perez, C. Invisible Women: Exposing Data Bias in a World Designed for Men. Chatto & Windus, 2019.

17. Healy, B. “The Yentl Syndrome.” New England Journal of Medicine, 1991.

18. Merone, L., Tsey, K., Russell, D., & Nagle, C. (2022). Sex Inequalities in Medical Research: A Systematic Scoping Review of the Literature. Women's health reports (New Rochelle, N.Y.), 3(1), 49–59. https://doi.org/10.1089/whr.2021.008.

19. Cabral M, Dillender M. Disparities in Health Care and Medical Evaluations by Gender: A Review of Evidence and Mechanisms: GENDER DISPARITIES: EVIDENCE ON CAUSES AND IMPLICATIONS. AEA Pap Proc. 2021 May; 111:159-163. doi: 10.1257/pandp.20211016. PMID: 38125738; PMCID: PMC10732547.

20. Singh, Kavita, and Renu Swarup. “Women Are Poorly Represented in Clinical Trials. That’s Problematic.” Nature India, March 8, 2025. https://www.nature.com/articles/d44151-025-00036- y

21. Stillwell, Sarah B. “Gender Bias in Medical Research.” Women’s Health Reports 3, no. 1 (2022): 49–59. https://doi.org/10.1089/whr.2021.0083

22. Spagnolo, P., Manson, J. and Joffe, H. (2020) Sex and Gender Differences in Health: What the COVID-19 Pandemic Can Teach Us. Ann Intern Medicine 173:385-386. doi:10.7326/M20- 1941

23. Cohen, J., van der Meulen Rodgers, Y. An intersectional analysis of long COVID prevalence. Int J Equity Health 22, 261 (2023). https://doi.org/10.1186/s12939-023-02072-5

24. Al Hamid, Abdullah, Rachel Beckett, Megan Wilson, Zahra Jalal, Ejaz Cheema, Dhiya Al Jumeily Obe, Thomas Coombs, Komang Ralebitso-Senior, and Sulaf Assi. “Gender Bias in Diagnosis, Prevention, and Treatment of Cardiovascular Diseases: A Systematic Review.” Cureus 16, no. 2 (February 15, 2024): e54264. https://doi.org/10.7759/cureus.54264.

25. Murga-Eizagaetxebarría N, Rodríguez-Padial L, Muñiz J, et al. (2019). The gender perspective within the OFRECE study: differences in health care among patients consulting for chest pain and/or palpitations. Rev Esp Cardiol (Engl Ed). 72:813-9.

26. Sjöström-Strand A. and Fridlund B. (2008) Women's descriptions of symptoms and delay reasons in seeking medical care at the time of a first myocardial infarction: a qualitative study. Int J Nurs Stud. 45:1003-10. 10.1016/j.ijnurstu.2007.07.00472.

27. Sosinsky, A., Rich-Edwards, J., Wiley, A., Wright, K., Spagnolo, P. & Joffe, H. (2022) Enrollment of female participants in United States drug and device phase 1–3 clinical trials between 2016 and 2019, Contemporary Clinical Trials, Volume 115.

28. Marie V. Plaisime, Marie-Claude Jipguep-Akhtar, Harolyn M.E. Belcher, 'White People are the default': A qualitative analysis of medical trainees' perceptions of cultural competency, medical culture, and racial bias, SSM - Qualitative Research in Health, Volume 4, 2023, 100312, ISSN 2667-3215, https://doi.org/10.1016/j.ssmqr.2023.100312.

29. Michele Statz, Kaylie Evers, Spatial barriers as moral failings: What rural distance can teach us about women's health and medical mistrust, Health & Place, Volume 64, 2020, 102396, ISSN 1353- 8292, https://doi.org/10.1016/j.healthplace.2020.102396.

30. Pradhan, M.R., De, P. Women's healthcare access: assessing the household, logistic and facility- level barriers in India. BMC Health Serv Res 25, 323 (2025). https://doi.org/10.1186/s12913-025-12463-9

31. 2019, Nature (2025) "Menopause research is globally underfunded. It's time to change that." Nature. Published from 22nd January 2025, https://www.nature.com/articles/d41586-025- 00150- y

32. Mirin AA. Gender Disparity in the Funding of Diseases by the U.S. National Institutes of Health. J Womens Health (Larchmt). 2021 Jul;30(7):956-963. doi: 10.1089/jwh.2020.8682. Epub 2020 Nov 27. PMID: 33232627; PMCID: PMC8290307.

33. Bosque Ortiz G, Hsiang W. Medical Technology. Yale J Biol Med. 2018 Sep

21;91(3):203– 5. PMCID: PMC6153631.

34. Wuest, J. (2020). “The rise of femtech: Harnessing innovation for women’s health.” Social Studies of Science, 50(5), pp. 783–810.

35. Borger JG, Purton LE. Gender inequities in medical research funding are driving an exodus of women from Australian STEMM academia. Immunol Cell Biol. 2022 Oct;100(9):674-678. doi: 10.1111/imcb.12568. Epub 2022 Jul 5. PMID: 35748687; PMCID: PMC9796819.

36. Nielsen, M.W., Andersen, J.P., Schiebinger, L. and Schneider, J.W. (2017). “One and a half million medical papers reveal a link between author gender and attention to sex and gender analysis.” Nature Human Behaviour, 1(11), pp. 791–796.

37. Guyatt G, Cairns J, Churchill D, et al. Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine. JAMA. 1992;268(17):2420–2425. doi:10.1001/jama.1992.03490170092032

38. WHO site, 2025.

39. Montoya, A., Fritz, J., Labora, A., Rodriguez, M., Walker, D., Treviño-Siller, S., Dolores González-Hernández, D., and Lamadrid-Figueroa, H. ‘Respectful and evidence-based birth care in Mexico (or lack thereof): An observational study’, Women and Birth, Volume 33, Issue 6, 2020.

40. Washington A, Randall J. "We're Not Taken Seriously": Describing the Experiences of Perceived Discrimination in Medical Settings for Black Women. J Racial Ethn Health Disparities. 2023 Apr;10(2):883-891. doi: 10.1007/s40615-022-01276-9. Epub 2022 Mar 3. PMID: 35239178; PMCID: PMC8893054.

41. Clayton, J.A. and Collins, F.S. (2014). “Policy: NIH to balance sex in cell and animal studies.” Nature, 509(7500), pp. 282–283.

42. Holdcroft, A. (2007). “Gender bias in research: How does it affect evidence-based medicine?”Journal of the Royal Society of Medicine, 100(1), pp. 2–3.

43. Banda, Y. and Mehta, N. (2016). “Barriers to women’s participation in clinical research: Addressing inequalities through structural change.” Global Health Research and Policy, 1(1), pp.15–23.

44. Wetherington, C.L. and Roman, A.B. (2021). “Leveraging AI to predict sex differences in drug response.” Frontiers in Pharmacology, 12, pp. 1–10.

45. Cleghorn, Elinor. “Medical Myths About Gender Roles Go Back to Ancient Greece. Women Are Still Paying the Price Today.” TIME, June 17, 2021. https://time.com/6074224/gender- medicine-history/.

46. Editorial Office. “Androcentrism.” Encyclopedia, February 8, 2024. Accessed September 27, 2025. https://encyclopedia.pub/entry/54911.

47. Young, Kate, Jane Fisher, and Maggie Kirkman. “‘Do Mad People Get Endo or Does Endo Make You Mad?’: Clinicians’ Discursive Constructions of Medicine and Women with Endometriosis.” Feminism & Psychology 29, no. 3 (2019): 337–356. https://doi.org/10.1177/0959353518815704.

48. Arsever, S. et al. (2023) ‘A gender biased hidden curriculum of clinical vignettes in undergraduate medical training.’, Patient Education and Counseling, 116, p. 107934. Available at: https://doi.org/10.1016/j.pec.2023.107934.

49. U.S. Department of Health and Human Services, Office of Research on Women's Health. “History of Women’s Participation in Clinical Research.” Last modified April 24, 2024. https://orwh.od.nih.gov/toolkit/recruitment/history.

50. UN-Women (United Nations Entity for Gender Equality and the Empowerment of Women). 2025. Women’s Rights in Review30 Years After Beijing. New York: UN-Women.

51. Moretti, Chiara, Enrico De Luca, Clelia D'Apice, Giovanna Artioli, Leopoldo Sarli, and Antonio Bonacaro. “Gender and Sex Bias in Prevention and Clinical Treatment of Women’s Chronic Pain: Hypotheses of a Curriculum Development.” Frontiers in Medicine 10 (2023): Article 1189126. https://doi.org/10.3389/fmed.2023.1189126.

52. Whiting, Kate. “Getting Girls into STEM Can Help Close the Gender Health Gap.” World Economic Forum, October 14, 2024. https://www.weforum.org/stories/2024/10/women- health gap-healthcare-gender/.

53. Koven, Suzanne. “How Gender Bias in Medicine Has Shaped Women’s Health.” Harvard Medicine Magazine, October 2024. https://magazine.hms.harvard.edu/articles/how-gender- bias medicine-has-shaped-wo mens-health.


INTERNATIONAL
DIVISION