BPW INTERNATIONAL

THE UNRECOGNIZED BURDEN

Sex-Specific Adverse Drug Reactions in Women

IFBPW International Side Event
at the
69th Session of the Commission on Narcotic Drugs
(UN Vienna)

ABOUT THIS EVENT

Why We Gathered

For decades, medical research has operated under a deeply flawed assumption: that the female body is simply a smaller version of the male body. As a result, the male body became the medical default — and women's health was systematically overlooked, understudied, and undertreated.

BPW International convened this side event at the 69th Session of the Commission on Narcotic Drugs to place this reality — the unrecognized burden of sex-specific adverse drug reactions — squarely within the frame of professional rights, economic empowerment, and fundamental human dignity.

"A woman cannot bring her full potential to a workplace, to leadership, or to her community if her very biology is being systematically overlooked by systems never designed with her in mind."
— Opening Remarks, Rita Volgger, BPW International–Austria

53%
Women experience adverse drug reactions more often than men (FDA data, 2004–2013)

90%
Of pharmacological articles describe studies conducted only on male animals

€8.4M
Committed by Austria's Ministry for Women to gender medicine research — an important but long-overdue step

32%
Higher risk of dying in surgery when women are operated on by a male surgeon vs. a female surgeon

EVENT BACKGROUND

The 69th Session of the CND

The Commission on Narcotic Drugs (CND) is the central policymaking body of the United Nations responsible for addressing global drug-related issues. Established in 1946 as a functional commission of ECOSOC, it oversees the implementation of international drug control conventions and provides policy guidance to Member States and to the United Nations Office on Drugs and Crime (UNODC).

The 69th Session (9–13 March 2026) brought together representatives of governments, UN agencies, intergovernmental organizations, civil society, and experts from around the world at the Vienna International Centre.

NGO-organized side events play a critical role in enriching CND policy dialogue by presenting perspectives not always fully reflected in formal intergovernmental negotiations. This BPW International side event — held on 12 March 2026 in Room MOE79 — examined the underappreciated issue of sex-specific adverse drug reactions and explored strategies to ensure medication safety and efficacy for women worldwide.

The event was co-organized by NGO-CSW Vienna and co-sponsored by the International Association of

Women, Servas International, and partner organizations, reflecting broad civil society commitment to this agenda.

EVENT DETAILS

Title
The Unrecognized Burden: Sex-Specific Adverse Drug Reactions in Women

Date & Time
12 March 2026 · 15:00 PM

Venue
Room MOE79, UN Vienna International Centre (+ Online via Zoom)

Organizer
BPW International (IFBPW) with ECOSOC Consultative Status

Session
69th Session of the Commission on Narcotic Drugs

SPEAKER PRESENTATIONS

From the Floor

Opening Remarks

RITA VOLGGER · BPW INTERNATIONAL-AUSTRIA

BPW International, founded in 1930 in Geneva, connects business and professional women in more than 100 countries. With consultative status at the United Nations, BPW works to strengthen women's leadership, economic empowerment, and equal participation in all areas of society.

> *True professional equality is not just about boardroom quotas or equal pay. It runs deeper. A woman cannot bring her full self to the workplace, to leadership, or to her community if her very biology is being systematically overlooked. A woman cannot lead effectively if her fundamental health and safety are compromised by systems designed to ignore her.*

The opening remarks framed this event's fundamental premise: the topic before us is not only a medical issue — it is a professional, economic, and fundamental rights issue. For decades, medical research has operated under a deeply flawed assumption that the female body is simply a smaller version of the male body.

Austria has begun to address this imbalance. The Austrian Ministry for Women has recently committed €8.4 million euros to support research in gender medicine — an important and encouraging step. But it also raises an important question: why has it taken so long to invest seriously in research that reflects the health realities of half the population?

> *When medicine works for women, it ultimately works better for everyone.*

How to Close the Gender Data Gap: Lessons Learned from a Clinical Trial

DDR. BELINDA PLETZER · UNIVERSITY OF SALZBURG

DDr. Pletzer opened by explaining her motivation for focusing on women's health research. As a scientist, her primary concern is data quality — and the gender data gap is damaging science itself.

> *We are all facing a huge gender data gap. And it is my mission to close it — because that gap is hurting science. And by hurting science it is hurting people — people of all genders, not "just" women.*

Over the past five years, DDr. Pletzer has been running a clinical trial on how hormonal contraceptives shape the female brain. This experience exposed four structural challenges to closing the gender data gap in clinical research:

01 **Trust**

DDr. Pletzer spent 90% of her time building trust with research participants — and failing spectacularly. Women do not trust the healthcare system, because the healthcare system was not built for them. Many drugs were not designed with women in mind. From a business perspective, this is absurd: no company would offer services not tailored to the needs of their most frequent consumers — that would be entrepreneurial suicide. In clinical trials, this trust deficit is compounded because trials come with inherent uncertainty about unknown adverse reactions.

02 **Psychology**

Psychological side effects are critically important to women, who already carry the lion's share of the global mental health burden — yet science is notoriously poor at assessing them because there are no sensors or machines to measure subjective experience. Feelings of being unwell, depressed, or "off" are the body's first signal that something is wrong. Clinical trials must systematically expand to address psychological side effects.

03 **Change — The Illusion of Female Instability**

Women have been excluded from studies because they "change" — they cycle, get pregnant, go through menopause. But men change too; it is simply less visible. Women are like Schrödinger's cat for science. The fallacy lies in assuming that women change and men do not. Simply ignoring change does not improve research results — we need to start accounting for intra-individual variation for everyone.

04 **Vulnerability — A Legal and Societal Challenge**

Women of reproductive age are classified as a "vulnerable group" in clinical trials due to their childbearing potential. This imposes disproportionate administrative, legal, and procedural burdens on researchers — effectively discouraging women's inclusion. A female research participant is never treated as a single participant; the hypothetical consequences for a hypothetical child are always a factor.

> *As a non-pregnant woman, I wonder — is that really all I am? My childbearing potential? We can never have true equality as long as womanhood is a protected occupation. (Virginia Woolf, 1929 — who imagined that in 100 years' time, we would no longer be the protected sex.)*

DDr. Pletzer closed by calling for a serious, unbiased, and unemotional public discussion about whether women of reproductive age need this extra protection in clinical trials — and who gets to decide.

Patriarchy and Women's Health: Moving Towards Change

DR. MIRIJAM HALL · AIDS HILFE WIEN / AUSTRIAN SOCIETY FOR FAMILY PLANNING

Dr. Hall delivered a comprehensive, evidence-driven account of how deeply patriarchy is embedded in every sector of the healthcare system — from the cellular level to clinical practice — and what this means for women's health outcomes.

The Patriarchy in the Petri Dish: `90%` of all pharmacological articles describe studies conducted only on male animals — even in cell research. The mystery of why transplanted muscle stem cells sometimes regenerated and sometimes did nothing was solved only when researchers realized female stem cells led to regeneration, while male stem cells had little to no effect.

`Only 12%` of studies on diseases that primarily affect women include female animals — and when they do, testing is timed to the follicular phase (when hormonal influence is lowest), making females "more like males" to simplify study design. Only `14%` of medical device studies treated sex as a key factor; only `4%` analyzed results separately by sex. As a result, stents are less effective in women than in men.

The Patriarchy in the FDA: In 1977, FDA guidelines prohibited women of childbearing age from participating in drug trials — a consequence of the thalidomide scandal. It was not until 1993 that the NIH Revitalization Act required women's inclusion in US government-funded studies. Critically, these requirements do not apply to generic drug research studies, independent pharmaceutical studies, or self-studies. Many medications approved during this period were simply never tested on women.

> *50% of people living with HIV are female worldwide. In Sub-Saharan countries, women face a 6 times higher risk of HIV infection than men. Yet in antiretroviral medication studies, only 19.2% of participants were women — and in cure studies, only 11.1%.*

The Yentl Syndrome — Clinical Practice: The Yentl Syndrome describes the phenomenon whereby women receive misdiagnosis and mistreatment when their symptoms do not match those typically observed in men. Autism provides a stark illustration: for years, boys were believed to be affected four times more often. In reality, girls simply showed different symptoms — and female socialization leads to masking, which goes undetected because diagnostic criteria were based on studies conducted almost exclusively with boys.

78% of women report moderate-to-severe pain during IUD insertion — yet recommendations to take this pain seriously and offer medication were only issued in the last few months. Cervical biopsies are routinely carried out without local anesthesia. Pain medication during abortion is often insufficient or not provided. Epidural anesthesia during childbirth is often refused as "weak and unnatural."

The Patriarchy as a Cause of Death: Women have a 32% higher risk of dying in or after surgery when operated on by a male surgeon compared to a female surgeon. This difference remained after adjusting for complexity, age, and chronic illness. Women are 18% less likely than men to be admitted to ICUs after cardiac arrest. Young women die twice as often as men of the same age after cardiac arrest. Yet many physicians still do not know that cardiovascular disease is the number one cause of death among women.

> *The result of all this is a gender data gap, a gender pain gap, a gender health gap, a gender morbidity gap. Poorer health for women. Dying women. The patriarchy is not a law of nature — it is a system. Let's change it together.*

Sharing Experiences: Women's Health, Awareness and Screening in Nepal

DR. SAUJANYA KARMACHARYA · NEPAL ARMED POLICE FORCE HOSPITAL (VIDEO)

Dr. Karmacharya marked the completion of 20 years of service dedicated to women's health, sharing field evidence from health awareness campaigns across Nepal — and demonstrating the life-or-death consequences of the gender health gap in low-resource settings.

The Awareness Gap: Many women in Nepal do not prioritize their own health, placing family needs first even when unwell. Specialist healthcare services are centralized in urban areas, forcing rural women to travel vast distances — spending $60–70 of their own money on transportation, food, and lodging just to attend a health camp offering free services.

> *A study in Nepal found that nearly 70% of cervical cancer patients had not undergone a physical examination at their first medical consultation. They were prescribed medications based only on their symptoms. Cervical cancer is 100% preventable — yet it reaches advanced stages because early signs are missed.*

The Power of Awareness: In western Nepal, many women from Muslim communities initially refused medical examinations due to cultural and social reasons. After participating in health awareness sessions, many of these women themselves requested check-ups. This clearly demonstrates the power of health education.

During a campaign in the mid-western region, over 8,000 women participated in screening and awareness activities. Dr. Karmacharya encountered a 21-year-old woman with excessive vaginal discharge who had decided to undergo a hysterectomy instead of seeking medical treatment — largely due to lack of knowledge. Over 90% of women were unaware that vaginal discharge can be a normal physiological phenomenon.

HPV Vaccination — Trust as a Public Health Challenge: During a health camp in Rasuwa district, the government had provided HPV vaccination against cervical cancer. Only two students received the vaccine. Most parents refused, believing their children were being used for experimental purposes — despite evidence showing over 90% vaccine efficacy and minimal side effects.

Pharmacovigilance in Nepal: According to studies in Nepal, 63.2% of depressed patients experiencing adverse drug reactions were female. Women are more prone to lithium-induced thyroid dysfunction, skin reactions, and hyponatremia. Healthcare professionals often have inadequate pharmacovigilance knowledge, with barriers to adverse drug reaction reporting including lack of knowledge, limited time, and absence of reporting forms.

> *To recognise what is abnormal, we first need to know what is normal. Health awareness is the most important step toward better outcomes — not only in rural areas, but everywhere.*

Closing the Gender Data Gap is a Global Challenge

RITA ASSOGNA · BPW INTERNATIONAL

Rita Assogna drew the threads of the event together in her closing summary. We have learned that across healthcare systems, the research systems were not designed to include women, nor to listen to them. It is considered that women are “difficult to study.” Women of reproductive age are considered a vulnerable group in clinical trials, requiring special protection due to their childbearing potential.

> *Yet this protection creates a paradox: the very group deemed most in need of safeguarding is also the most underserved by the healthcare system. Women are protected from research, yet prescribed medications never tested on them; protected from hypothetical fetal risks, yet exposed to real, documented adverse drug reactions.*

The consequences are dramatic worldwide: missed diagnoses, ineffective treatments, ignored pain, and higher mortality for women.

In Nepal this is more evident, where the greatest obstacle to women’s health is a lack of knowledge. Women prioritize family over their own health; there is widespread misunderstanding of normal female physiology, leading to unnecessary procedures or failure to recognize warning signs. Moreover, specialist care is centralized in cities, forcing rural women to travel vast distances, while those who stay behind often rely on briefly trained health workers who may misdiagnose serious conditions.

The foundation of improved women’s health in Nepal is awareness. By first understanding what is normal, women and healthcare providers can accurately identify what is abnormal, leading to earlier intervention, better treatment outcomes, and a more effective and equitable healthcare system.

Closing the gender data gap requires moving beyond the assumption that women are difficult to study. Instead, it demands acknowledging that research systems were built around men and against women’s inclusion.

> *The central question posed is whether women wish to remain “the protected sex.” This is a difficult question to answer because of the ethical and moral implications, which should not be underestimated. Therefore, it is very important to explore this theme on multiple levels.*

DATA SPOTLIGHT

Numbers That Cannot Be Ignored

4%

Of medical device studies analysed results separately by sex

19%

Women included in antiretroviral HIV drug studies — despite 50% of HIV patients being female

30min

Longer women wait for pain relief in emergency departments compared to men (22,000+ patient records, Israel & US)

260K

Women die every year from pregnancy and childbirth complications — one every two minutes (UN estimate)

QUOTABLE QUOTES

Voices from the Event

> *A woman cannot bring her full self to the workplace, to her leadership role, or to her community if her very biology is being systematically overlooked. A woman cannot lead effectively if her fundamental health and safety are compromised by systems designed to ignore her.*

RITA VOLGGER · BPW INTERNATIONAL-AUSTRIA · OPENING REMARKS

> *We are all facing a huge gender data gap. And it is my mission to close it — because that gap is hurting science. And by hurting science it is hurting people — people of all genders, not "just" women.*

DDR. BELINDA PLETZER · NEUROSCIENTIST, UNIVERSITY OF SALZBURG

> *Women are the most frequent consumers of healthcare services. No company would offer services not tailored to the needs of their most frequent consumers — that would be entrepreneurial suicide. In healthcare, apparently, we can afford that.*
>
> DDR. BELINDA PLETZER · UNIVERSITY OF SALZBURG

> *As a non-pregnant woman, I wonder — is that really all I am? My childbearing potential? We can never have true equality as long as womanhood is a protected occupation.*
>
> DDR. BELINDA PLETZER · CITING VIRGINIA WOOLF, 1929 — WHOSE PREDICTION REMAINS UNFULFILLED A CENTURY LATER

> *This would be like dentists only starting in 2025 to offer anesthetic injections before performing root canal treatment. Imagine removing a piece of tissue from a man's penis without anesthesia.*
>
> DR. MIRIJAM HALL · ON WOMEN'S PAIN BEING ROUTINELY DISMISSED DURING CERVICAL AND GYNECOLOGICAL PROCEDURES

> *The result of all this is a gender data gap, a gender pain gap, a gender health gap, a gender morbidity gap. Poorer health for women. The patriarchy is not a law of nature — it is a system. Let's change it together.*
>
> DR. MIRIJAM HALL · GYNAECOLOGIST AND PUBLIC HEALTH ADVOCATE, VIENNA

> *To recognise what is abnormal, we first need to know what is normal. Health awareness is the most important step toward better outcomes — not only in rural areas, but everywhere.*
>
> DR. SAUJANYA KARMACHARYA · GYNAECOLOGIC ONCOLOGIST, NEPAL

> *Women are protected from research, yet prescribed medications never tested on them. Protected from hypothetical fetal risks, yet exposed to real, documented adverse drug reactions. The time for reform is now.*
>
> RITA ASSOGNA · BPW INTERNATIONAL · CLOSING REMARKS

DISTINGUISHED SPEAKERS

Presenting Voices

DDr. Belinda Pletzer

Professor of Psychoneuroendocrinology, Department of Psychology, University of Salzburg, Austria. Leads the ERC Starting Grant project BECONTRA, investigating hormonal contraceptives and the female brain. Two PhDs and a habilitation in psychology.

Presented four structural challenges to closing the gender data gap in clinical trials: trust, psychological side effects, the "illusion of female instability," and the administrative burden of reproductive-age vulnerability classifications. Called for urgent public debate on whether women of childbearing age need extra protection in clinical trials — and who gets to decide.

Dr. Mirijam Hall

Specialist in Gynaecology and Obstetrics, Vienna. President, Austrian Society for Family Planning. Chairwoman, AIDS Hilfe Wien. Teaches at the Medical Faculty of Sigmund Freud University. Active in civil society on sexual health and reproductive rights.

Delivered a comprehensive evidence-based account of systemic bias from cell studies to surgical practice. Named and documented the Yentl Syndrome, sex-specific drug metabolism differences, cardiovascular care disparities, and the undertreatment of female pain. Closed with a direct call: the patriarchy is a system — and systems can be changed.

Dr. Saujanya Karmacharya

Consultant Gynecologic Oncologist and Certified Pranic Healer, Nepal Armed Police Force Hospital, Kathmandu. 20 years of service dedicated to women's health. Fellow, International Gynecologic Cancer Society. Presidential Award (Janasewashree Rastrapati Padak) 2022; IGP Commendation Medal 2026.

Shared 20 years of field evidence from Nepal: the power of health awareness campaigns, barriers of geography, culture, and trust, the tragedy of preventable cervical cancer missed at first consultation, HPV vaccine uptake collapse due to unfounded fear of experimentation, and the critical gap in pharmacovigilance knowledge among healthcare workers.

GLOBAL PERSPECTIVES

One Problem, Many Contexts

AUSTRIA / WESTERN EUROPE

A Top-Ranked System Still Failing Its Women

Even within one of the world's highest-ranked healthcare systems, the gender data gap persists. Clinical research primarily recruits highly educated, healthy women — excluding those most in need of equitable evidence. Austria's €8.4M gender medicine commitment is welcome but long overdue.

Ethics committee fragmentation blocked the collection of COVID-19 vaccine safety data from 2,000 consenting pregnant women — a researcher vaccinating women at the Vienna International Centre was refused permission to collect prospective data by multiple ethics committees, each citing jurisdictional grounds. Critical safety evidence was lost.

Generic drug studies, independent pharmaceutical trials, and self-studies remain exempt from women's inclusion requirements — meaning many medications in common use today were never tested on women.

NEPAL / SOUTH ASIA

Where Awareness Is a Matter of Life and Death

Nearly 70% of cervical cancer patients present without having received a physical examination at first consultation — prescribed medications based only on symptoms. The disease is 100% preventable, yet reaches advanced stages because early recognition fails.

Women spend $60–70 of their own money just to attend a free health camp for specialist consultation. In a mid-western campaign, over 8,000 women participated. A 21-year-old chose hysterectomy over treatment because she lacked knowledge of her condition — while 90% of participants were unaware vaginal discharge can be physiologically normal.

In western Nepal, Muslim women initially refused medical examination for cultural reasons — after health awareness sessions, they requested check-ups themselves. Awareness is not a luxury; it is the foundation of health.

ETHIOPIA / SUB-SAHARAN AFRICA

The Dual Economy and Its Health Consequences

Ethiopia — a country of 110 million people — illustrates the "dual economy" health challenge. In Addis Ababa, healthcare coverage for women approaches 98%. Nationally, it stands at 23–30%. Research is almost entirely concentrated in urban areas, making rural women invisible to clinical science.

The lesson for global researchers: representative sampling must account not only for sex and gender, but for the profound geographic and economic divides that determine who gets counted. A 50/50 gender balance in research means little if participants can only be found in cities serving a minority of the population.

This "dual economy" challenge is not unique to Ethiopia — it characterizes much of Africa and reflects how research infrastructure and health policy systematically exclude the communities most in need.

SYNTHESIS

Closing the Gender Data Gap is a Global Challenge

Across healthcare systems, the research infrastructure was not designed to include women — nor to listen to them. Women are considered “difficult to study.” Women of reproductive age are classified as a vulnerable group in clinical trials, requiring special protection due to their childbearing potential. Yet this protection creates a paradox: the very group deemed most in need of safeguarding is also the most underserved by the healthcare system.

In Nepal this is more evident, where the greatest obstacle to women’s health is a lack of knowledge. Women prioritize family over their own health; there is widespread misunderstanding of normal female physiology, leading to unnecessary procedures or failure to recognize warning signs. Specialist care is centralized in cities, forcing rural women to travel vast distances, while those who stay behind often rely on briefly trained health workers who may misdiagnose serious conditions.

Closing the gender data gap requires moving beyond the assumption that women are difficult to study. It demands acknowledging that research systems were built around men and against women’s inclusion.

The central question posed throughout this event is whether women wish to remain “the protected sex.” This is a difficult question to answer because of the ethical and moral implications, which should not be underestimated. It is very important to explore this theme on multiple levels.

> *"If the answer is no — if we are ready to stop being treated as potential mothers first and as patients second — then we must redesign research, rebuild trust, take subjective experience seriously, embrace change, and rethink vulnerability."*
>
> RITA ASSOGNA · BPW INTERNATIONAL · CLOSING REMARKS

ACTION POINTS

From Insight to Change

FOR POLICYMAKERS & MEMBER STATES

- Champion a UN resolution requiring consistent sex-disaggregated data across all phases of drug and medical device research — from cell studies to post-market surveillance.
- Extend the NIH 1993 inclusivity mandate to generic drug research, independent pharmaceutical studies, and publicly funded AI training datasets.
- Reform ethics committee frameworks to enable prospective data collection from pregnant and reproductive-age women during public health emergencies, without jurisdictional fragmentation.

- Establish a publicly accessible global scoreboard tracking national investment in gender medicine research, creating accountability and reputational incentives for governments.

FOR RESEARCH & HEALTH INSTITUTIONS

- Mandate female cell lines and female animals at all preclinical stages of drug development — not only during the hormonal trough.
- Systematically include psychological and subjective wellbeing endpoints alongside biomarkers in all clinical trial protocols.
- Actively recruit underrepresented women in clinical trials — including those with pre-existing conditions and from lower socioeconomic backgrounds — to improve research quality for all.
- Audit AI training datasets for gender bias before deployment in any diagnostic or treatment algorithm — and require gender-balanced datasets as a condition of regulatory approval.

FOR BPW & CIVIL SOCIETY

- Launch a coordinated, well-resourced public awareness campaign on women's health — modelled on the impact of equal pay campaigns — uniting BPW national associations, corporate partners, and health ministries.
- Integrate gender medicine into the BPW Young Women's Conference agenda (April 2026) to build the next generation of advocates across 100+ countries.
- Mobilise private sector partners — for whom women's health is also a workforce productivity and ESG issue — to fund research and campaigns where government budgets fall short.
- Maintain a consistent narrative across UN Vienna, CSW New York, and all other multilateral fora to embed gender medicine permanently in global health policy agendas.

BPW International

Founded 1930 · Geneva · Consultative Status, UN ECOSOC

Connecting business and professional women in more than 100 countries

Strengthening women's leadership, economic empowerment, and equal participation

CND SIDE EVENT · 69TH SESSION

UN VIENNA · 12 MARCH 2026

PROCEEDINGS REPORT