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# WHO runs the world – (not) girls: gender neglect during global health emergencies

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## ABSTRACT

During health emergencies, neglect of gender experiences and needs can compromise the outbreak response. Ebola in West Africa and Zika in Latin America had gendered effects that were evident during the crises, yet governments and international organizations failed to prioritize a gender-inclusive response. There is the same risk that gender-inclusive responses and knowledge will continue to be neglected during the COVID-19 pandemic. In this article, we examine the drivers of gender exclusion in health emergency response. We ask: where can we locate institutional responsibility for taking gender seriously to inform and improve sustainable disease control? The article addresses this question by turning to feminist institutional theory to explain why gender inclusion in decision-making processes is vital for effective response and post-crisis recovery. We argue that the institutional responsibility to recognize gender within the global health emergency regime lies with the World Health Organization (WHO). WHO has neglected to mainstream gender in the policies and practices that it promotes for the prevention and detection of, and response to, infectious disease outbreaks. WHO is in a position to support gender-inclusive practices, but this requires the technical agency to recognize the value of having a gender-inclusive framework to inform outbreak response, financial models, and recovery.

**KEYWORDS** Global health security; gender; World Health Organization (WHO); COVID-19; women

## Introduction

The World Health Organization (WHO) has a clear mandate to coordinate and participate in health emergency responses (WHO 2018a). Yet recent reports of sexual exploitation by WHO emergency responders in the Democratic Republic of Congo (DRC) demonstrate the systemic and ongoing lack of gender awareness within this international organization (IO) (*Guardian* 2020). There remains no guidance on gender inclusion in the global health security

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architecture, which we consider to be highly problematic. In a crisis, such as a public health emergency, gendered vulnerabilities can have a huge effect on society; such emergencies can reinforce unequal gender structures or reverse gender progress. The neoliberal system presents crises as blips in the workings of an otherwise sound market economy. However, the experiences of marginalized groups (such as women, the disabled, those with little education, or racial minorities) highlight how this system has steadily contributed to vast systemic inequalities and disparities (Hozic and True 2016, 10).

WHO remains the lead technical and normative actor in global health governance. In 2005, states agreed to adopt the International Health Regulations (IHR) to cooperatively govern Public Health Emergencies of International Concern (PHEICs). These regulations encourage states to build their capacities to detect, assess, and report public health events and, in the event of a PHEIC, to adopt specific measures to limit the spread of health risks. Within the IHR, states agreed to WHO's central role in leading and coordinating the response to health emergencies, and the organization thus continues to wield normative power over disease control within the multi-stakeholder framework (Davies, Kamradt-Scott, and Rushton 2015; Kamradt-Scott 2015). Ultimately, when outbreaks emerge, all roads lead back to WHO. As such, for gender in epidemics to be taken seriously, and for international, national, and local actors to recognize and address gender inequalities during outbreaks, WHO must recognize and mainstream gender in its legal and normative work in this area.<sup>1</sup>

WHO's persistent failure to provide gender-inclusive recommendations dedicated to health emergency response is a problem for three reasons:

- (1) Direct and indirect effects of pandemics expose women to insecurity in a range of ways. An external review of its H1N1 response noted that "WHO does not monitor whether human rights are being respected in implementing the IHR" (WHO 2011a). During H1N1, pregnant women and newborns were particularly vulnerable to the disease (WHO 2011a, 28), as were ethnic minority and Indigenous women (NCCA 2016). Respecting the human rights of these groups requires that their particular vulnerabilities be considered. After the Ebola outbreak in 2014, an external review of WHO's response again found that gendered experiences during the health emergency were not considered in recommendations for risk communication. The report noted: "Engagement with local community leaders is essential. Women, who were often not mobilized effectively in this outbreak, are particularly important to this effort" (World Health Assembly 68 2015, 20).
- (2) When women are referred to in PHEIC recommendations, these references lack any gender perspective. During the Zika outbreak, WHO recommended that women in endemic areas abstain from sex during

pregnancy and that those of childbearing age be given the “necessary information and materials to reduce risk of exposure” (WHO 2016a). These recommendations mirrored guidance by many states that women should delay or avoid pregnancy. In the disease epicenter of Latin America, women face significant barriers to accessing contraceptives and abortion and to living in violence-free households where they exercise authority over their own bodies (Wenham et al. 2019). This meant that, in a region where 56 percent of pregnancies are unintended, the health emergency recommendations were unimplementable and even dangerous for women (Johnson 2017).

- (3) There remains a significant lack of sex-disaggregated data during outbreaks. WHO has advised that sex- and age-disaggregated data should be collected (WHO 2016d), but this has not been evident in the actions of states during health emergencies. It has also been absent from their use of the self-assessment tools for meeting the IHR-proscribed core capacities for pandemic preparedness (WHO 2005a; UN GHCTF 2017, 17). This means that we simply do not know how incidence of disease differs between women and men, how women and men identify their symptoms, and when they seek medical attention. Without this data, it is hard to ensure that the policies created reflect needs.

This article argues that we must promote and incorporate meaningful gender inclusion in health emergency response. The article was written between January and March 2020, before and during the early stages of what we expect will be many years of COVID-19. The COVID-19 pandemic has led to United Nations (UN) institutions and global civil society organizations issuing statements and reports on the gender harms of health emergencies (UNICEF n.d.). By May 2020, WHO had also released a gender and COVID advocacy brief (WHO 2020c). Yet the brief contained no WHO advice on gender and pandemic preparedness, because there was no such advice available in its Health Emergencies Programme (HEP) (see below). In the same month, the IHR Emergency Committee (EC) issued guidance on monitoring the unintended consequences of public health lockdowns, including increased gender-based violence and limitations on access to sexual and reproductive healthcare (SRH) (WHO 2020b). This was the first time such guidance was included in the IHR EC Temporary Recommendations for any PHEIC. The COVID-19 pandemic reveals a historical neglect of gender in WHO’s health advice that has ramifications for how the institution protects the health of women and marginalized groups; and it is a neglect that compromises their entire health emergency response.

This article unfolds in five sections. First, we detail why gender-blind responses in health emergencies are harmful. Second, we engage feminist institutional theory to explain why gender inclusion in decision-making

processes is vital for effective response and post-crisis recovery. Gender-inclusive practices require actors to commit not only to ensuring women's representation in decision making but also to gender mainstreaming in policies and programs. Third, we identify the institutional responsibility with WHO. As the central actor within the global health regime, WHO has systematically failed to mainstream gender in the policies promoted for infectious disease outbreak prevention, detection, and response. While there have been attempts to mainstream gender within the institution (WHO Regional Office for Europe 2001; WHO 2011b), this has not trickled down to its practices in health emergencies. Fourth, we consider why COVID-19 offers an opportunity for change if WHO is willing to be bold. Finally, we suggest how gender inclusion could inform outbreak response and decision-making processes and complement epidemiological analysis.

To identify WHO's neglect of gender in health emergency preparedness and response, we analyzed WHO's gender, equality, and human rights initiatives, the HEP, and the IHR team. The policies covered in our search included advice, guidance, and advocacy on gender and/or women during health emergencies, IHR core capacity strengthening, and evaluations of national action plans for health security. We extended our analysis to speeches given by the former and current WHO Directors-General concerning health emergencies since Ebola in West Africa (2014) and statements issued by the IHR EC in relation to those emergencies between 2009 and 2020. There were nine of these in total: H1N1, Polio, Ebola (West Africa, DRC Equateur, DRC Kivu), MERS, Yellow Fever, Zika Virus, and COVID-19. We also followed debates taking place within the broader global health community and UN bodies, and in the media, gray literature, and beyond. In our research, we consciously looked for references to representation, inclusivity, and reflexivity within the advice being issued on emergency preparedness and response (Tickner 2006, 38). We noted and considered whose voices were missing and whose experiences were absent from these documents. We discussed the barriers to participation that exist due to the formal rules, structure, and power of WHO and its member states (Davies et al. 2019). It is worth noting that we revised this article in September 2020. In the midst of the COVID-19 pandemic, information changes frequently. We welcome important changes to WHO's engagement with gender in health emergencies between our submission and our revision, and we hope to see increased WHO gender mainstreaming after its publication.

For this article, we adopt the WHO definition of gender as

[t]he characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as the relationships with each other. As a social construct, gender varies from society to society and can change over time. (WHO 2021)<sup>2</sup>

While gender is context specific, we can identify a range of gender stereotypes and inequalities exacerbated in health emergencies that especially affect women. These include the impact of their being expected to fulfill both formal and informal care roles, the disruption to routine SRH services, increased risks of gender-based violence, and significant economic turmoil.

### **Why is gender blindness harmful?**

Ignoring gendered vulnerabilities and impacts of health emergencies is harmful. Women, men, and those of other genders experience epidemics differently, just as a variation of experience also occurs between other sectors of society, along economic, racial, and urban–rural lines.

We identify both the primary and secondary impacts of epidemics on women. The primary effects of an outbreak refer to the risks of infection and adverse health outcomes, which are often more acute for women; we see a higher incidence of “health emergency” pathogens among women than men (Thorson and Diwan 2001; Coelho et al. 2016). This greater susceptibility to infection is linked to social factors as well as biological ones. For example, women are more likely to be exposed to the virus in professions that require increased labor during a crisis, such as healthcare (Lee and Frayn 2008).

The secondary effects refer to the downstream consequences of public health responses to outbreaks: disruption to routine healthcare services, often particularly affecting SRH services; greater domestic care responsibilities if schools are closed; increasing rates of gender-based violence; and women’s economic instability, given that they are more likely to be in less secure employment or to work in sectors of the economy shuttered by quarantine interventions (International Rescue Committee 2019; Wenham, Smith, and Morgan 2020). The Ebola outbreak in West Africa (2014–2015) created economic insecurity for female-headed households when market stallholders were forced to close their businesses (Bandiera et al. 2018). Similarly, most of those raising children with Congenital Zika Syndrome are now single mothers, unable to return to work due to the complex needs of their children, and reliant on social welfare payments (Human Rights Watch 2017). Failure to prepare for and respond to gendered vulnerabilities in health emergencies demonstrates a broader systematic problem with gender neglect in health emergencies that pre-dates COVID-19.

It was not simply the evident gendered effects that were problematic, but the mechanisms by which WHO sought to collect data and respond to health emergencies that entrenched those effects. WHO did not collect sex-disaggregated data on Zika, instead focusing on the narrower category of Zika infection among pregnant women. They often collected data from maternity clinics rather than seeking to systematically understand community incidence (Diniz 2017). It was not until after the peak of the crisis that

a true picture emerged of the higher incidence among women more broadly (Pacheco et al. 2020).

Moreover, public health efforts in relation to Zika were not gender inclusive. The public health recommendations made by WHO and affected states were that women should avoid pregnancy and reduce the risk of infection through household vector control (Wenham 2021). Gendered norms in Latin America (especially in poor and ethnic minority communities) led to the responsibilities for controlling the disease falling on women. Feminist methodologies and gender analysis would have identified this pattern and guided the creation of policies more suited to the everyday experience of women.

The exclusion of gender had similar impacts during the recent Ebola outbreak in the DRC (2018–2019) (CARE International n.d.). It was reportedly difficult to control the virus among women due to their exclusion from risk communication strategies, their at-home caregiving roles, and their survival-sex strategies (Holt and Ratcliffe 2019). The consequences of this lack of gender analysis became evident when the false promise of access to early vaccine interventions was used by men to procure sex from women (McKay et al. 2019).

This article is not the first study to identify the failure to consider gender in global health security (Davies and Bennett 2016; Harman 2016; Johnson 2017; Smith 2019; Wenham 2021). It is, however, the first to position WHO at the center of these failures. We also seek to move beyond recognition of the problem (which is, in and of itself, an important step in moving toward gender inclusivity) and seek paths to overcome the differential challenges faced by men and women during outbreaks.

## **Feminist institutions, crisis response, and international organizations**

Elite-level initiatives, such as Women in Global Health and Global Health 50/50, have secured greater gender parity and equality in global health-affiliated organizations. Representation is vital, but feminist change does not come from representation alone (Childs and Lovenduski 2013). Individual women still work within the structures, norms, and practices of patriarchal institutions. IOs have their own institutional cultures that “sustain and enable their particular modalities of operation” (Ní Aoláin and Valji 2019, 61). These organizations craft their legitimacy within particular methodologies of knowledge production that determine what and who should be prioritized – and, by default, what and who should not. As such, institutions, including WHO, are gendered in how they view and privilege power, scientific truth, particular theories of change, and even technical subject matter (Chorev 2012).

A feminist critique of IOs recognizes that representation is vital to address the historical exclusion of women from decision making and adopts a critical understanding that women and people who challenge the gender binary experience social, political, and economic norms, practices, and structures in unjust and unequal ways (Ackerly and True 2019). Adding women is not enough; gender-inclusive methods and knowledge must be comprehensively mainstreamed. This requires the transformation of the processes, norms, and behaviors of institutions to bring tangible benefits to women (and men) (Daly 2005; Ní Aoláin, Haynes, and Cahn 2011; Shepherd 2017). In this article, we thus consider the formal and informal processes within WHO that determine gender inclusion. In doing so, we think through whether, as an IO, WHO is able to move beyond representation and lead the institutionalization of a gender-mainstreaming approach to future health emergencies.

IOs have pathologies. Like state bureaucracies, political parties, and civil society organizations, IOs adhere to their own rules at the “expense of primary missions and ultimately produce inefficient and self-defeating behaviour” (Barnett and Finnemore 1999, 700). Rules exist in both formal and informal practices – for example, in mandates and in practices such as ostracism (Waylen 2014). Rules determine hierarchies of knowledge and allocation of power according to organizational design – that is, through professional roles and responsibilities (see Acker 2006) and using data collection to inform policy and program design (Mukhopadhyay and Prügl 2019). Formal and informal rules can change, and the path to change “runs both ways” – formal to informal and informal to formal (Waylen 2014, 214). However, formal and informal rules can also become entrenched and dictate behavior that goes against the “best” interests of individuals and organizations. Both types of rules are particularly harmful when they neglect, exclude, and oppress populations.

The adoption of the Beijing Declaration and Platform for Action (UN 1995) was a normative turning point for promoting gender mainstreaming in bureaucracies and IOs (Swiss and Fallon 2017). The Declaration recommended that,

[t]o enhance the work for the advancement of women at the national, sub-regional/regional and international levels, Governments, the United Nations system and all other relevant organizations should promote an active and visible policy of mainstreaming a gender perspective. (UN 1995, Paragraph 292)

The Declaration suggested mechanisms for gender mainstreaming with clear commitments to achieving “standards of equality between women and men as a basis for all actions” in policies, programs and services (UN 1995, Paragraph 291). Furthermore, it noted, the effective implementation of gender mainstreaming requires “changes in the internal dynamics of institutions and organizations, including values, behaviour, rules and procedures that are inimical to the advancement of women” (UN 1995, Paragraph 290).



Shared understandings and practices of gender mainstreaming have been the subject of numerous studies (see, for example, True and Mintrom 2001; Hafner-Burton and Pollack 2002). True and Mintrom (2001) found that changes to formal policy and laws that treat women and men differently have been nearly universally adopted; few states prohibit women from voting, running for parliament, accessing education, or enlisting in the military or police (Waylen 2014, 217). States upholding gender-discriminatory laws are increasingly in the minority (Bush 2011; Swiss and Fallon 2017). Likewise, IOs have removed formal discriminatory rules based on sex and gender (Hafner-Burton and Pollack 2002; Joachim 2003).

Yet formal gender-mainstreaming activity does not automatically lead to gender-inclusive practices (Tryggestad 2010). Informal rules persist that perpetuate harmful gender discrimination. These “inequality regimes” prevent women from advancing (Acker 2006) and entrench gender stereotypes that subject women and non-gender binary individuals to discrimination and abuse (Gharib 2019). Informal rules concerning dress codes, work times, sanitation (particularly regarding menstruation), and the gendered division of labor are the common barriers to realizing gender equality.

The implementation of new formal and informal rules ending gender discrimination and promoting gender equality led to the appointment of gender advisors and the establishment of departments within states and IOs, including UN Women. However, these gender expert roles still involve intense power politics over the prioritization, necessity, and contribution of gender expertise (Smith 2019). In humanitarian disasters, gender advisors (and affected women) are often the last to be asked about gender-inclusive solutions to accessing food, sanitation, and shelter (Martin and de la Puente 2019). Overlooking gender expertise is harmful and prevalent. Unfortunately, this practice is especially rife in IOs that build prestige around technical proficiency, including WHO (Harman 2016). It is also common where informal rules concerning epistemological authority remain strongly masculinized, positivist, and anti-feminist (Kunz, Prügl, and Thompson 2019).

Many epistemological battles have been fought to include feminist methodologies in sciences, technology, and medicine (Mukhopadhyay and Prügl 2019). A review of global gender data found that “the overall pattern of gender equality for women in science, medicine, and global health is one of mixed gains and persistent challenge” (Shannon et al. 2019, 560). Women are disproportionately represented in low-income healthcare roles. There are few women in senior positions in the health sciences, health insurance, research, and pharmaceutical companies, and few gender-inclusive policies exist in health-related IOs and civil society and philanthropic organizations (World Health Assembly 68 2015; Dhatt and Dodson 2019; Global Health 50/50 2019). The consequences of these persistent gaps are particularly harmful in health emergencies.<sup>3</sup> Research and policymaking

remain focused on quantitative epidemiological data from cases, rather than recognizing that these cases are individuals experiencing the outbreak in myriad ways. Each of the PHEICs declared by WHO has directly affected women's health, demanded high levels of engagement from women in the community, and required the delivery of risk communication messages to, or about, women identified as responsible given their (social) reproductive roles (Wenham 2021). However, gender expertise, gender-inclusive data, and feminist-informed methodologies have been absent from WHO's response to these emergencies.

Informed by other studies on gender and global governance and epistemic communities (see, for example, Joachim 2003; True 2003; Tryggstad 2010; George and Shepherd 2016), we suggest that WHO's gender lacuna is the result of informal institutional barriers. These barriers can be traced to epistemological boundaries between expertise (seen as technical and functional) and feminism (seen as political and radical). In the next section, we identify the formal inclusion of women through the application of a quota in WHO's health emergency work. We also consider the ongoing exclusion of informal gender methods and knowledge from the so-called core work of WHO.

### **WHO's feminism problem**

Judged on its own formal rules, WHO scores favorably in the Gender and Health Index on the basis of its gender-inclusive policies, programs, and workforce (Global Health 50/50 2020). WHO Director-General Tedros Adhanom Ghebreyesus (Tedros) has been a vocal supporter of gender equality. In his leadership bid, he referred to his tenure as Ethiopia's Minister of Health, during which he introduced a female-focused primary care system that deployed 38,000 community health workers to help to reduce maternal and child mortality (Ducharme 2019). In recognition of the social contribution made by this female-majority workforce, WHO co-chaired a much-publicized gender analysis of the global health workforce and declared 2020 as the Year of the Nurse and Midwife (WHO 2019).

A formal commitment to gender has been embedded within the pathology of the organization for nearly two decades. In 2001, WHO adopted a commitment to gender mainstreaming (WHO 2001). Seven years later, a Gender Strategy was adopted by WHO's Executive Board (EB120.R6.2) and the World Health Assembly (WHA60.25) (WHO 2009). This strategy introduced mechanisms to operationalize gender mainstreaming within WHO and included the development of training materials, a toolkit for gender analysis, and a gender roadmap (for action) (WHO 2003, 2011b).

Arguably, the formal adoption of WHO's Gender Strategy was a game-changer (Waylen 2014). The strategy was governed by a set of principles:

- Addressing gender-based discrimination is a prerequisite for health equity.
- Leadership and ultimate responsibility for gender mainstreaming lie at the highest policy and technical levels of the Organization.
- Programmes are responsible for analysing the role of gender and sex in their areas of work and for developing appropriate gender-specific responses in all strategic objectives on a continuing basis.
- Equal participation of women and men in decision-making at all levels of the Organization is essential in order to take account of their diverse needs.
- Performance management should include monitoring and evaluation of gender mainstreaming. (WHO 2009, 9)

Despite existing policies and practices, an internal review in 2011 of WHO gender mainstreaming demonstrated that fewer than one-quarter of WHO publications use sex-disaggregated data; few WHO units integrate gender in the implementation, monitoring, or evaluation of programs; and only a third of public speeches from WHO representatives mention gender (WHO 2011c). The report concludes that gender mainstreaming's "impact on day-to-day work has been limited" (WHO 2011c). That is, despite the formal rules that require it, informal rules hinder mainstreaming within the institution. The latest reports highlight that WHO has made considerable progress toward mainstreaming since the adoption of the Gender Strategy. However, this progress has not been demonstrated against baseline indicators. The reason for this is that these reports focused on case studies of successful implementation efforts rather than gathering and presenting data to reveal where policy and programmatic gaps in gender mainstreaming persist (WHO 2016b). This means that we are unable to assess whether gender mainstreaming has increased across WHO and its programmatic activity.

The central unit for gender guidance and mainstreaming advice within WHO sits within the Department of Equality and Human Rights and comprises five people (WHO directly employs 7,500 people). This contextualizes the institutional capital that this team has, and indeed the normative commitment to gender within the organization. Moreover, the team's work has been conducted vertically through addressing the individual pillars of health such as "gender and tobacco" and "gender and tuberculosis." Recently, the team has almost exclusively focused on gender within universal health coverage and gender challenges within the health workforce, particularly linked to migratory patterns of care. This focus reflects trends in global health and Tedros' manifesto for his term. Missing from this focus has been gender and health emergencies. However, since their work is funded by voluntary contributions to WHO, the team's focus is dependent on what member states wish to fund. Yet the failure to attend to gender

considerations within health emergencies is illuminating, given the number of such emergencies over the past decade and the gender-specific harms that these create and exacerbate. At the start of the COVID-19 pandemic, WHO had no formal position on how gender manifests within health emergencies.

Despite progressive formal steps to recognize gender in the institutional practices of WHO – in senior leadership, public commitment statements, definitions, and programming – there remains an absence of feminist knowledge in its response to health crises (Davies et al. 2019). In an epidemic where women and girls may be particularly vulnerable to both the disease and the social, economic, and legal crises that emerge, there remains an absence of gender sensitivity in WHO's overall institutional response. Thus, there is a mismatch between the institution's principles of governance and gender-inclusive responses for those at risk of infection. This gap has broader implications if WHO is meant to be the norm entrepreneur in relation to coordinated health emergency response (Kamradt-Scott 2010).

At a formal level, the key governing framework for health emergencies within WHO is the IHR (2005a), which neglect gender. Women and gender are mentioned twice within the IHR: as a category of travelers whose rights must be protected under Article 32, and in Article 50, recommending gender parity on the IHR Review Committee. Informally, there has been increased female participation in the EC, which designates an event as a PHEIC. For H1N1 (2009), two of the 15 members were women, and similar levels of representation were seen for MERS (three of 13), Ebola (2014) (two of 13), and Zika (six of 21). Representation has become more equitable, with (almost) equal ratios for Ebola (2018–2019). Unfortunately, in relation to COVID-19, there has been a regression; for that EC, only four of 16 members are women. Moreover, of the 11 ECs formed to date, only one has had a female chair (WHO Regional Office for Europe n.d.). While this can be seen as evidence of informal gender inclusion within the IO, we argue that this inclusion is mostly in relation to women's representation. Given the lack of transparency in the EC processes, we have no indication of the inclusivity of their meetings (Eccleston-Turner and Kamradt-Scott 2019). It is unclear whether women are afforded equal opportunities to voice their concerns or to speak as members. Evidence from other disciplines suggests that women get less airtime and are often interrupted (Kendall and Tannen 1997). It is also not clear that EC recommendations, policies, and inclusions specific to the respective health emergencies have included discussions or reflections on gender-mainstreaming practices in their deliberations. Moreover, from an intersectional view, the women in these EC discussions are elite, highly educated, and professional. They likely come from or have been educated in the Global North and/or represent an elite social group, which facilitates their access to WHO. Thus, they too may overlook the individual

and structural constraints on women and marginalized groups in affected locations.

Similarly, within the WHO HEP, when gender is mentioned, it has been interpreted as applying self-referentially and pertaining to women being present within the outbreak response system. The HEP reports that 55 percent of staff are women, but representation at senior levels of the program (Grade D1 and above) drops to 27 percent (WHO Regional Office for Europe [n.d.](#)). Again, representation is presented as the primary measure of gender inclusion in programmatic activity. This approach of “add women and stir” is problematic in that it presumes that representation equals inclusion (Davies et al. [2019](#)). Women public health officials are not automatically feminists (Harman [2016](#)). Thus, while more women may be formally present in the WHO HEP (Lowndes [2020](#)), gender-inclusive policies and gender empowerment practices are missing from the front-line practices in health emergencies.

The IHR state party self-assessment annual reporting (SPAR) tool makes no reference to gender considerations in capacity building, preparedness, or outbreak response (WHO [2005b](#)). There is no obligation to collect sex-disaggregated data (WHO [2018a](#)). In the Joint External Evaluation (JEE) reviews regarding states’ performance, there is no consideration of gender equality measures for the workforce, risk communications, human rights legislation, and human resourcing (for example, childcare and schooling) during emergencies, or of the gendered impact on healthcare workers’ access to personal protective equipment (WHO [2018a](#)). The HEP toolkits to manage outbreaks make no mention of gender, nor does the guidance for each PHEIC, nor do the “What can WHO do in health emergencies?” pages on its website. This is despite a publication on gender and health emergencies by the WHO Regional Office for the Western Pacific that discussed, in 2011, the importance of disaggregated data in health emergencies (WHO Regional Office for the Western Pacific [2011](#)). Such inclusions have been recommended in previous after-action reviews of WHO’s performance during emergencies. Yet gender concerns are still not included in the primary materials that inform capacity building and preparation for outbreak response (UN GHCTF [2017](#)).

The gap between formal participation and the inclusion of gender knowledge, methods, and approaches within the HEP confirms that while equal representation matters, it is not enough. Women’s participation is not the same as creating a space for feminist knowledge (either formally or informally) to ensure that programs account for the particular vulnerabilities of women with respect to infection and neglect. This is fundamentally at odds with WHO’s own Gender Strategy, which states that “programmes are responsible for analysing the role of gender and sex in their areas of work and for developing appropriate gender-specific responses in all strategic objectives on a continuing basis” (WHO [2009](#), 9).

In the next section, we examine WHO's emergency response to COVID-19 and its apparent steps in the right direction. Statements and advocacy briefs must break through the formal and informal barriers that remain within the organization. The HEP and the IHR remain sites of gender exclusion in health emergency response. This exclusion of feminist knowledge involves the omission of both formal and informal understandings of how culture, knowledge, and behaviors affect outbreak response on the ground.

## COVID-19 as a test for WHO

COVID-19 offers another stark reminder of the gendered impact of epidemics. First, as of September 2020, only 19 percent of global cases are sex disaggregated when reported to WHO (UN Women 2021). This means that the organization is unable to make conclusive statements about the sex- or gender-based effects of the pathogen. The incomplete data suggests that COVID-19 leads to worse health outcomes in men (another important gendered effect) and has several indirect effects on women. These have ranged from increased gender-based violence during lockdown (Peterman et al. 2020) and supply-and-demand impacts on women accessing SRH services (Wenham et al. 2020), to macro-level changes to women's labor force participation, with feminized sectors of the economy closed due to social distancing (Madgavkar et al. 2020; Wenham 2021). In Asia, families are heavily dependent on remittances secured by female domestic workers in high-income countries (UN Women AP 2020). Travel bans affect these women and their extended families already struggling in labor-intensive and exploitative employment.

In the initial months of the pandemic, there was little institutional consideration of its gendered effects at WHO. The organization's outbreak management and response focused on infection prevention, surveillance, laboratory testing, risk communication, clinical management, and travel advice (WHO 2020a). However, by April 2020, we welcomed signs of change seen in the organization's recognition of the differential impact of outbreaks on women and other marginalized groups. There have been numerous publications detailing gendered vulnerabilities to contracting the virus and the secondary effects of outbreak interventions (UN DGC 2020; Wenham 2021; UNICEF n.d.). Rapid gender analysis by CARE International outlined how first responders can consider the multi-faceted challenges that women face in the design and implementation of response efforts (Haneef and Kalyanpur 2020). The WHO country office in Lebanon was first to present a gender framework analysis within their programmatic response to COVID-19 and, with UN Women, to identify how underlying gender inequalities compromise the containment response (UN Women 2020). These initial steps were followed by a wealth of reports on the

gendered effects of the pandemic from the UN Secretary-General and other IOs, including UN Women, the World Bank, the International Monetary Fund (IMF), and WHO itself (WHO 2020c). By the third meeting of the EC in May 2020, Tedros expressly raised concerns about the impact of the outbreak in relation to gender-based violence and women's ability to access SRH services (WHO 2020b). In September 2020, he held an audience with Women in Global Health and the organization Gendro and committed to forming a Gender and COVID Working Group to understand these concerns more deeply. Finally, in 2020, the WHO HEP created the Gender Working Group. The Gender Working Group is in its early stages and still developing terms of reference and objectives. These are important first steps, but there remains no formal institutional process within WHO that requires the inclusion of gender knowledge in health emergency policy development and EC consideration of the specific vulnerabilities of women and marginalized groups in the face of health emergencies. The media attention and press briefings have not (yet) translated into wholesale institutional change and a commitment to country-level monitoring of the gendered effects of COVID-19 health advice and policy.

Cynically, WHO's shift might result from the reality of which women were affected. Whereas Ebola and Zika affected women living in the Global South, COVID-19 has affected all women everywhere in the world. Notably, it has affected both women in the Global North seeking to juggle paid and unpaid work and the elite women working in the WHO system. This has meant that the gendered effects have been recognized by those women with greater political capital both within WHO and among member states who can push the organization to act. Regardless of this Global North–Global South dynamic, we welcome all changes to ensure meaningful gender mainstreaming within WHO. However, knowing that women are not homogeneous and that further drivers of vulnerability exist, we imagine that women in the Global South will suffer considerably worse socio-economic effects and associated downstream health impacts than those in the Global North. The question is how we can maintain the momentum from this recognition of the gendered effects of COVID-19. The concern is that the impetus will be lost if those in the Global North mitigate some of the effects – for example, through changes to lockdown conditions to allow for childcare provision or increased social protection for women at risk of redundancy. We assume that such actions in mitigation will not fall uniformly across the globe – for example, within the informal economy in low- and middle-income settings which disproportionately employs women. It is thus essential to seek greater gender inclusion and ensure that WHO and the global community recognize this further aspect of gender inequality.

We wait to see whether there will be further changes to WHO's formal and informal practices in health emergencies. A continuation of the shift would allow for a cascade of recognition by other actors within the global health

space. For now, we suggest three immediate gender-inclusive reforms that could be prioritized within WHO to support its feminist journey.

### **Gender-inclusive health emergency response**

The Zika (2016) and Ebola (2018–2019) outbreaks demonstrated how the exclusion of feminist knowledge and methods from WHO's health advice, response, and communication led to clear gender injustices (McKay et al. 2019; Wenham and Farias 2019). COVID-19 is a chance to right these wrongs. However, the gender-mainstreaming project requires three deep institutional and cultural changes within WHO.

First, formal institutional change prioritizing gender-inclusive responses within health emergencies requires a gender analysis framework to identify the potential impacts on women (Quay 2019). To date, there is no such framework that informs WHO's health emergency rapid response. As the normative leader for health emergencies, WHO must identify the direct and indirect effects of outbreaks on women and provide public health recommendations to identify gender-based (and intersectional) risks specific to each outbreak. It is crucial that recommendations identify the responsibilities of WHO and states also identify the responsibilities of civil society. The formal rules most in need of gender analysis are the IHR (2005a). There must be an analysis of how the IHR can require states and WHO to prepare for and respond to gendered effects during future health emergencies to mitigate gender harms. This analysis should be conducted in cooperation with the Committee for the Convention on the Elimination of Discrimination Against Women (CEDAW) and WHO's Gender Equity Programme. In the IHR, Articles 3 and 32 include provisions to protect human rights, but this formal mechanism has not been enough to ensure gender rights and equality. In addition, gender inclusion could be furthered through the application of a gender analysis framework in several key areas: the JEE's assessment of a state's IHR core competencies, after-action reviews, and national health security action plans. Finally, the HEP should develop a differential gender analysis framework for use in its response to Grade 1, Grade 2, and Grade 3 health emergencies.

Second, WHO must prioritize equal representation of women in preparedness, response, and recovery. One simple step would be to ensure parity between men and women in the make-up of ECs. The risk is that such a quota confuses representation with gender inclusion. The former might be achieved without advancing the latter. Inclusion requires not only women at the table but also gender-inclusive data collection and the appointment of gender advisors. There is precedent within the UN system (however imperfect) to invite gender specialists into decision-making processes. For example, the Inter-Agency Standing Committee requires gender specialists to be in



attendance during its emergency-phase response meetings and requires the inclusion and adoption of gender methods in the response to humanitarian emergencies (Quay 2019). There is no reason why the health emergency response by WHO should be any different. Indeed, the UN Global Health Committee Taskforce recommended the inclusion of gender specialists in 2017 (UN GHCTF 2017). Connected to this is a need for transparency in the institutional procedures for declaring and advising on health emergencies and, in particular, an end to the opaque decision-making process of ECs. At present, there is no way of knowing when gender and intersectional approaches are raised in the ECs, nor how the formal and informal rules of the IO may affect gendered outcomes.

Third, WHO needs to include feminist methods in responding to global health emergencies. It should move beyond positivist epistemologies premised on epidemiology and virology as the gold standard and engage in gender-inclusive methods of data collection, health emergency preparedness, and public health recovery planning. These methods require an expansion in whose knowledge is valued. Public health interventions are administered in societies. We need to understand these societies in the context of this pandemic including the barriers, concerns, and enabling factors that determine access to, and belief in, the healthcare solutions provided. For that, we need social science (Davies and Wenham 2020), specifically feminist, methodologies of ethnography, participant observation, storytelling, or participatory action research with those at risk or infected (Smythe et al. 2020). There have been some, albeit limited, efforts to move beyond positivist approaches in outbreak response, particularly in Ebola (2014) through the Ebola anthropology platform, SONAR-Global, and WHO's Knowledge Action Portals. These have, however, mostly overlooked feminist research methods (WHO 2016c, n.d.).

## Conclusion

This article documents sites of gender injustice evident in health emergencies. Women are systematically excluded from decision making. Furthermore, gender-blind policies fail to recognize and reduce the direct and indirect consequences of epidemics that disproportionately affect women. We contribute to the literature by recognizing that gendered inequalities within IOs arise because of neglecting to ask "Where are the women?" and that the institutional responsibility for gender inclusion and mainstreaming lies with WHO. We believe that this IO should champion a feminist global health security regime. As a normative leader in health emergencies, WHO encouraging such methodological approaches could influence other actors in the global health landscape to follow suit and mainstream gender across health emergencies. Through considering

institutional structures and gender, we identify that there is a tension between formal and informal efforts to mainstream gender at WHO. While WHO conducts some gender analysis within the Department of Equality and Human Rights, and there are gender consultants hired within HEP, the siloed structure of the organization, compounded by funding structures that promote donor-driven activities, has meant that gender activity has not been mainstreamed in the HEP, IHR, and broader outbreak response structure. Formal policies have not been applied across the whole institution, and one consequence has been a lacuna of feminist or gendered perspectives on infectious disease control. Beyond this, the informal mechanisms of WHO have not facilitated more inclusive approaches to outbreak response, internally or externally. As a result, women are disproportionately burdened in outbreaks. This will continue to be the case until the recognition of the importance of gender and the accumulation of political, financial, and human will and resources to support this recognition.

This is problematic for global health security, and we propose three measures that WHO could undertake to reform its formal and informal practices concerning gender and health emergencies. First, WHO should include gender analysis frameworks and advisors as part of the immediate response processes to understand the risks posed by outbreaks, such as within the IHR (2005a) and JEE. Second, WHO should improve representation in EC decision making and ensure the presence of gender advocates within decision-making bodies for pandemic preparedness and response. This is standard procedure in other areas of emergency response and governance, such as humanitarian crises and climate change. Finally, WHO should include feminist methodologies among the means of collecting evidence for informing policy for each outbreak. We recognize COVID-19 as an opportunity to change this institutional pathway. We implore WHO to take women and gender considerations seriously and to institutionalize these within its formal and informal processes to ensure sustainable disease control and minimize longer-term impacts on those most vulnerable to crisis.

## Notes

1. We recognize that not all readers will agree with our assessment of WHO's position within global health governance. This is a multi-stakeholder framework that includes states, international organizations, non-state actors, and others. However, while there has been considerable literature considering the waning power of WHO, particularly in health emergencies (see, for example, Kamradt-Scott 2015; McInnes 2015), we do not see that an alternative lead institution will emerge. Indeed, we argue that placing WHO at the center of this piece is not only to create a case study but also to support a normative commitment to the centrality of WHO in global health emergencies.

2. This definition of gender is the same as that provided by UN Women in the Gender Glossary (UN Women Training Centre [n.d.](#)) and fails to consider non-binary genders.
3. The WHO HEP grades health emergencies from Grade 1 (low) to Grade 3 (high) according to the scale of WHO's assistance or response. In this article, we focus on the IHR-declared PHEICs because WHO leads the technical and institutional response to these (see WHO [2018b](#)).

## Disclosure statement

No potential conflict of interest was reported by the authors.

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