

STRENGTHEN GENDER MAINSTREAMING IN WHO'S PANDEMIC PREPAREDNESS AND RESPONSE

POLICY PAPER

RELEASED: 26 OCTOBER 2020





SUMMARY: The **Independent Panel for Pandemic Preparedness and Response (IPPPR)**, the **Independent Oversight and Advisory Committee** for the WHO Health Emergencies Programme (**IOAC**) and the Review Committee of **International Health Regulations (IHR)** are important opportunities to consider the **World Health Organization (WHO)** and states' response to the COVID-19 pandemic from a gender perspective. National governments are responsible for developing and implementing laws and policies to respond to crises, and mitigating outbreak impacts on different sectors of society. WHO is responsible for global priority-setting and coordination, information dissemination and knowledge sharing. IHR must mainstream gender in planned actions and obligations. This brief by Women in Global Health and the Gender and COVID-19 Project provides advice for gender mainstreaming as states and WHO i) prepare for an outbreak, ii) engage in decision making and advice during the crisis and iii) respond to epidemics and potential pandemics.

ACKNOWLEDGEMENTS:

This brief was made possible with the support of the Gender and COVID-19 Project and Women in Global Health. For further information please contact Roopa Dhatt (roopa.dhatt@womeningh.org) and Clare Wenham (c.wenham@lse.ac.uk).

SUGGESTED CITATION:

Gender and COVID-19 Project and Women in Global Health. Sumegha Asthana, Sara E Davies, Roopa Dhatt, Ann Keeling, Arush Lal, Alexandra Phelan, Maike Voss and Clare Wenham (October 2020) Strengthen gender mainstreaming in WHO's pandemic preparedness and response, Policy Brief.



Women in Global Health and the Gender & COVID-19 project view the Independent Panel for Pandemic Preparedness and Response (IPPPR) and the Review Committee of International Health Regulations (IHR) as important opportunities to consider both the World Health Organization (WHO) and states' response to the COVID-19 pandemic from a gender perspective. We must recognize the disproportionate impact that the pandemic has had on women, non-binary and other marginalized groups, and ensure that efforts to improve capacity for global pandemic prevention, preparedness, response and recovery mitigate these very real effects.

BACKGROUND

A growing evidence base is documenting the widespread gendered impact effects of the COVID-19 pandemic, as there have been in previous epidemics, ranging from the heavy burden of work for women as the majority of health and social care workers disproportionate role of women as healthcare workers, increased risks of domestic violence, disruptions to sexual and reproductive health services, disproportionate impact of lockdowns on feminized sectors of the economy, increased domestic care burden and the recognition of sexual abuse during health emergencies {*inter alia* (1),(2),(3),(4),(5)(6)(7)}. These impacts have been increasingly recognized by many global bodies, including UNGA, UN Women, UNFPA, WHO, UNISDR, GPMB, UNSC, Bill & Melinda Gates Foundation, and as well as several governments and civil society groups.

While national governments are responsible for developing and implementing laws and policies to respond to crises, and mitigating outbreak impacts on different sectors of society, WHO, as a normative organization, is responsible for global priority-setting and coordination, information dissemination and knowledge sharing. It is critical that WHO uses its normative power to signal the value of gender mainstreaming for all societies, provide guidance and tools for strengthening attention to gender as a determinant of health and economic well-being, and emphasize the indisputable importance of gender transformative work at all levels of pandemic preparedness, response, and sustainable, resilient recovery.

These norms are further reflected in legally binding obligations in treaties adopted by Member States through the World Health Assembly, such as the International Health Regulations (IHR). The IHR is the primary legal instrument and framework governing preparation and response to international health threats, including epidemics. As a result, the IHR is an appropriate starting point for considering how pandemic preparedness and response can be more gender-responsive. In their current iteration, the IHR do not sufficiently take gender into consideration. In practice, the IHR provides no express requirement that States Parties evaluate, implement, or monitor the downstream gendered effects of preparedness and response measures(8). This is despite the obligation on States Parties to implement the IHR in a manner consistent with human rights and non-discrimination.

Whilst we welcome the inclusion of gendered concerns (including protections for gender-based violence and women's ability to access sexual and reproductive health services) for the first time in recommendations issued to IHR States Parties upon the declaration of a Public Health Emergency of International Concern (PHEIC) for COVID-19, we believe that any review of the IHR must mainstream gender in planned actions and obligations for how the WHO and States Parties i) prepare for an outbreak, ii) engage in decision making and advice during the crisis, and iii) respond to epidemics and potential pandemics.

PREPAREDNESS

1. Ensure core capacities within IHR include gender awareness and sensitivities

Under the IHR, States Parties have obligations to meet core public health capacities. Current guidance for meeting these state-building core capacities to prevent and prepare for epidemics explicitly lack gender considerations. Efforts to mitigate future risks and harms should include recognition of the potential impact of outbreaks on marginalized groups, and that no policy or advice is gender-neutral. Efforts to strengthen core capacities requires consideration of how men and women may differently perceive, access or be affected by preparedness efforts, risk communication, surveillance, response and their role as health personnel etc.

At present there is no consideration or mention of gender in [WHO's concept note on developing IHR core capacities](#) or the [IHR monitoring and evaluation framework](#).

Furthermore, the [WHO Joint External Evaluation Exercise Tool \(2018\)](#), the [Country Implementation Guide of JEE \(2017\)](#), and the [JEE tool and process overview](#) similarly do not mention gender or women.

Gender mainstreaming in this preparedness phase must be matched with either additional JEE indicators or mainstreamed express consideration of gender across indicators, as well as inclusion in the State Parties Self-Assessment Annual Reporting (SPAR) tool. This is necessary to assess each State Party's capacity to reduce disproportionate harm of both public health prevention, detection and response measures to women and other marginalized groups.

2. The IHR to expressly recognize the gendered effects of health emergencies

At present, the IHR mentions gender twice: i) Article 32, in reference to ensuring that travelers should be treated equally regardless of their gender, socio-cultural, ethnicity or religion and ii) Article 50, which ensures that there is gender representation on the review committee of the IHR. However, as a whole, the IHR do not take gender mainstreaming seriously. Currently, the IHR includes no article that instructs states to evaluate, implement, or monitor the downstream gendered effects of preparedness and response measures.

We recommend a clear signal to the world that the IHR States Parties and WHO take gendered impacts seriously through explicit provision in international law for states to protect against disproportionate impacts on women as a key requirement of the treaty itself.

At a minimum, **Article 3 of IHR** must be updated to ensure that human rights and universality principles required to be considered in implementing legislation expressly includes mention of women, non-binary and other marginalized groups. It has been well

documented that human rights and civil society groups are excluded from all stages of outbreak preparedness, response, and recovery. Including representation of these groups, and equal representation of women, in preparedness activities would in turn provide greater consideration to marginalized groups during all phases of an epidemic lifecycle (9) (10)

3. National health security action plans need to include have references to gender as well.

WHO's guidelines on national health security action plans features a sole reference to gender parity -- that the national steering committee must ensure gender-inclusive planning, resourcing and evaluations. This could be linked to a country's National Action Plan as part of United Nations Security Council Resolution 1325 for Women, Peace and Security to enhance mutually reinforcing goals of participation, protection, prevention, relief and recovery. Furthermore, national health security action plans could be further linked to national strategies toward Universal Health Coverage (UHC), including ensuring primary health services are accessible by all during health crises.

DECISION/ADVICE

4. Ensure equal gender-representation on the IHR Emergency Committee

Whilst the IHR has a requirement for gender parity amongst the IHR Review Committee, this is not extended to the Emergency Committee (EC) of the IHR (which advises whether the conditions for a PHEIC declaration have been met and the content of recommendations for States Parties). The EC meetings to date do not have gender parity. Although gender parity in WHO senior leadership did appear to increase after the WHO Director General Dr Tedros' leadership transition¹, men have held the majority of decision making posts in COVID-19 has not maintained this same equal ratio(11) (12): Moreover, only one PHEIC's EC has been chaired by a woman (Polio). A review of 115 COVID-19 task team and advisory groups, from 87 countries, revealed that 85% were majority men (12).

Committee members are selected from an expert roster, but this roster is not public; we have no data on how many men/women are on it. While gender parity on national steering groups has been recommended by WHO as part of the national action plans for health security, the requirement for equal gender representation has not been applied to decision-making bodies within WHO and its Member States.(11) This must be addressed now. List(s) of expert women in health at national levels and in global health security are compiled by civil society organisations such as Women in Global Health (Operation 50/50 List) that can be used to support expert rosters.

5. Ensure participation of gender advisors as non-participant observers / contributors to EC meetings

Beyond challenges for equal representation of men/women in decision-making levels, there is no clarity on inclusion of if gender advisors have even been included in the EC formally or as non-participant observers. There is no available record on whether gender-sensitive concerns are considered within EC meetings. There must be inclusion of gender advisors in EC meetings to ensure that the EC considers the downstream gendered effects not only of PHEIC declarations themselves, but also of the EC recommendations.

6. Ensure all data collected by WHO (including reported under the IHR & by the Health Emergency Programme) is disaggregated by sex

Understanding of the differential patterns of transmission, presentation and outcome of epidemics by sex/gender and age can result in tailored measures, innovative interventions or adjustments of the responses resulting in increased effectiveness(4). Yet, as of July 2020, only 38% of COVID-19 related data reported by governments to WHO was disaggregated by sex. Standardized reporting of sex-disaggregated data must become an express requirement (within IHR article 6 public health information obligations, and in other reporting mechanisms and obligations) to be able to effectively understand disease dynamics, transmission patterns, and pertinent clinical care.

Before COVID-19, Member States adopted UNGA [69/313 \(2015\)](#) and [A/RES/71/313 \(2017\)](#): Sustainable Development Goal indicators should be disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics, in accordance with the Fundamental Principles of Official Statistics. This is also noted by [UNSC](#), [UN High Level Panel on Internal Displacement](#), and the [Political Declaration on Universal Health Coverage](#). There is a need to ascertain the barriers to the collection of sex-disaggregated data and prioritize support to Member States. This will not only improve evidence-collection and public health responses at the international level, but create norms for national collection of this data, enabling national health authorities and civil society to address health inequities and discrimination.

RESPONSE

7. Gender inclusive IHR Risk Assessments

Under the IHR, States Parties are required to develop core public health capacities. A list of core capacities has been extrapolated from the text of the treaty into a range of implementation tools to assist States Parties in building and assessing their progress in meeting these obligations. However, gender inclusive guidance and indicators are not included in WHO's IHR monitoring and evaluation framework or the revised WHO Joint External Evaluation (JEE) Tool (2018). While non-binding, these documents have normative influence, help identify capacity gaps, and develop collective understanding amongst governments of the minimum standards for outbreak preparedness, response, and recovery. While States Parties may interpret the human rights and non-discrimination provisions under the IHR's article 3 to include gender considerations during implementation, the lack of express guidance or requirement means that it is unlikely to be included in technical capacity assessments.

In addition to revising the core capacities developed from the treaty text, gender should also be mainstreamed into proposals arising out of the COVID-19 pandemic. One suggestion is the requirement that governments undertake an IHR risk assessment, using a framework to be developed, upon a declaration of a PHEIC (13). If this proposal is adopted, it is essential that this includes a requirement for gender and/or equality impact assessments. Gender advisors (recommendation 5, above) can be pivotal in such an exercise and can support governments to pre-empt potential impacts on women and other marginalized groups. Gender advisors are mandatory within humanitarian response and climate change activities to ensure that negative impacts effects do not fall disproportionately on particular groups(8). Consistent with progress in the international system, this should equally be required within WHO response and obligations on States Parties.

8. Ensuring Lessons Learned exercises mainstream gender

The After Action Review (AAR) undertaken as part of IHR Monitoring and Evaluation activities must include consideration of how the outbreak and response interventions affected women and other marginalized groups. As a qualitative tool, this provides an important mechanism to incorporate real life impacts through women's voices. Gender-related investigations must be included in the toolkit and guidance provided to member states conducting these AARs. This in turn can provide a foundation bedrock for building resilient recovery plans which incorporate diverse perspectives representing civil society, human rights and gender at the centre.

ACKNOWLEDGEMENTS

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REFERENCES

1. McLaren HJ, Wong KR, Nguyen KN, Mahamadachchi KND. Covid-19 and Women's Triple Burden: Vignettes from Sri Lanka, Malaysia, Vietnam and Australia. *Social Sciences*. 2020 May 21;9(5):87.
2. Connor J, Madhavan S, Mokashi M, Amanuel H, Johnson NR, Pace LE, et al. Health risks and outcomes that disproportionately affect women during the Covid-19 pandemic: A review. *Social Science & Medicine*. 2020 Dec;266:113364.
3. Tang K, Gaoshan J, Ahonsi B, Ali M, Bonet M, Broutet N, et al. Sexual and reproductive health (SRH): a key issue in the emergency response to the coronavirus disease (COVID- 19) outbreak. *Reproductive Health* [Internet]. 2020 Dec [cited 2020 Oct 11];17(1). Available from: <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-020-0900-9>
4. Heidari S, Ahumada C, Kurbanova Z. Towards the real-time inclusion of sex- and age-disaggregated data in pandemic responses. *BMJ Global Health*. 2020 Oct;5(10):e003848.
5. Wenham C, Smith J, Davies SE, Feng H, Grépin KA, Harman S, et al. Women are most affected by pandemics — lessons from past outbreaks. *Nature*. 2020 Jul;583(7815):194–8.
6. Hupkau C, Petrongolo B. Work, care and gender during the Covid-19 crisis. :12.
7. The Guardian. More than 50 women in DRC allege abuse by Ebola aid workers. 29th September 2020. <https://www.theguardian.com/world/2020/sep/29/women-in-drc-say-aid-workers-sexually-abused-them-during-ebola-crisis>
8. Wenham C. *Feminist Global Health Security*. Oxford University Press; 2021.
9. Davies SE. Infectious Disease Outbreak Response: Mind the Rights Gap. *Medical Law Review*. 2017;25(2):270–92.
10. Meier BM, Evans DP, Phelan A. Rights-Based Approaches to Preventing, Detecting, and Responding to Infectious Disease. In: Eccleston-Turner M, Brassington I, editors. *Infectious Diseases in the New Millennium* [Internet]. Cham: Springer International Publishing; 2020 [cited 2020 Oct 16]. p. 217–53. (International Library of Ethics, Law, and the New Medicine; vol. 82). Available from: http://link.springer.com/10.1007/978-3-030-39819-4_10
11. Wenham C, Davies SE. WHO runs the world: (not) girls. *Gender neglect during global health emergencies*. Forthcoming.
12. van Daalen KR, Bajnoczki C, Chowdhury M, Dada S, Khorsand P, Socha A, et al. Symptoms of a broken system: the gender gaps in COVID-19 decision-making. *BMJ Global Health*. 2020 Oct;5(10):e003549.
13. Wenham, C, Phelan AL, Eccleston-Turner M, Halab Si. Reforming the Declaration Power for International Public Health Emergencies. ILIAID IHR Reform White Paper Series (1). 2020.