Public health emergencies of international concern (PHEIC), disease outbreaks and pandemics are gendered with regard to the differential impact they can have on prevalence and mortality among males and females, the differential socio-economic burdens that fall to women on account of social norms, the exacerbation of female insecurity and threat of violence, the feminized health care workforce, and the dominance of male representation in decision-making and pandemic response and planning. Gender can therefore determine who gets sick and how, who makes decisions in a health emergency and who performs the frontline response, and who suffers the long-term consequences of an outbreak. These issues have long been documented in research on HIV/AIDS, Ebola and Zika. Yet until 2020 the issues of women and gender in health emergencies were ‘conspicuously invisible’; while women are evident at every level of global health work, and successful interventions rely on their paid and unpaid labour and compliance, issues of gender were either token or absent from policy and strategy around pandemic preparedness and response.

In 2020 the visibility and scale of the understanding of gender in health emergencies changed. In the first six months of the COVID-19 pandemic, multiple multilateral institutions, women’s groups and organizations, philan-
thologists, experts, media commentators, journal editors and social media groups acknowledged and stressed both the importance of gender in understanding pandemics and how gender was shaping the differential impacts of this particular outbreak on societies. Women’s advocates, such as UN Women and Global Health 50/50, mobilized to collate sex-disaggregated data, compiled information briefs and tracked state COVID-19 policies that supported gender-sensitive responses. In April 2020 the Secretary-General of the United Nations, António Guterres, announced that ‘the pandemic is having devastating social and economic consequences for women and girls’. The previous month, the director-general of the World Health Organization (WHO), Tedros Adhanom Ghebreyesus, told a Gender Champions Network that ‘the response to the COVID-19 pandemic must be gender-sensitive and responsive’.

While not specifically focused on gender, the first UN Security Council resolution on COVID-19, Resolution 2532, acknowledged ‘the critical role that women are playing in COVID-19 response efforts, as well as the disproportionate negative impact of the pandemic’; and similarly, UN General Assembly Resolution A/74/92 extended such recognition to women’s role in health care work and emphasized the need to engage women and girls in recovery plans. The Bill and Melinda Gates Foundation, the largest philanthropic donor in global health, funded a US$1.6 million project on gender and COVID-19 and a US$2.2 million project to set up a Gender and Health Policy Hub at the United Nations University, with a total of US$59.8 million funding commitments on ‘gender equality’ in the year 2020 alone. Melinda Gates used her platform to publish an article in Foreign Affairs highlighting the toll taken on women by COVID-19.

The change in five years—from 2015, when gender advocates were ‘never allowed in’ or dismissed with ‘you’re always women, everybody is dying … You know everybody is dying, this is an emergency, we have no time for that’, to 2020, with acknowledgement at the highest political levels of the relationship between gender and public health emergencies and funding of work to understand this relationship better—suggests a significant change in visibility of the gendered drivers and outcomes of such emergencies. The purpose of this article is 4 For the scale of this work, see the ‘Resources’ page and updated publications list of the Gender and COVID-19 working group, https://www.genderandcovid-19.org/resources-page/. 5 UN Women, In focus: gender equality matters in COVID-19 response (New York, 2020), https://www.unwomen.org/en/news/in-focus/gender-equality-in-covid-19-response?gclid=CjwKCAjAv4n9BRApEiwA 30WND2pqd3hGAG9sg_cWsd_prQWgtVLVB1WMIAmjXRZ2vziriGRuxlsV_Sx0ColQQvD_BwE; Global Health 50/50, The COVID-19 sex disaggregated data tracker (London, 2020), https://globalhealth5050. org/the-sex-gender-and-covid-19-project/. 6 Secretariat of the International Gender Champions and Martin Chungong, COVID-19: what does it mean for gender? (Geneva: Inter-Parliamentary Union, 2020), https://www.ipu.org/news/voices/2020-03/covid-19-what-does-it-mean-gender. 7 UN Security Council Resolution 2532, 1 July 2020, https://undocs.org/en/S/RES/2532(2020); UN General Assembly Resolution A/74/L.92, 10 Sept. 2020, https://undocs.org/en/A/74/L.92. 8 Bill and Melinda Gates Foundation, Awarded grants (Seattle, 2020), https://www.gatesfoundation.org/How-We-Work/Quick-Links/Grants-Database#q/program=Gender%20Equality&year=2020&page=2; Melinda Gates, ‘The pandemic’s toll on women: COVID-19 is gender-blind, but not gender-neutral’, Foreign Affairs, 15 July 2020, https://www.foreignaffairs.com/articles/world/2020-07-15/melinda-gates-pandemics-toll-women. 9 Interview 1, international organization, Skype interview, 14 Feb. 2020.
to explore the relationship between neglect and visibility around gender in global health security, the factors that drive both, and what this means for the relationship between gender equality and global health security.

The article explores this relationship in the following way. First, it situates the relationship between gender and global health security within existing debate on the topic. Second, it provides an empirical account of how gender has been neglected in global health security with reference to the Ebola outbreak of 2014–16 in Sierra Leone, with additional insights arising from subsequent outbreaks of Zika in 2015–16 and of Ebola in the Democratic Republic of Congo (DRC) in 2019–20. Third, it briefly considers what led to the high levels of visibility around gender in the COVID-19 pandemic and the implications of this for advancing gender in global health security. Finally, the article draws together its main findings in conclusion, to make the argument that the change in visibility, research and advocacy around gender equality during the COVID-19 outbreak does not demonstrate an advancement in gender equality in global health. On the contrary, such visibility reinforces the inherent problems of global health security evident in the 2014–16 Ebola outbreak that create and reproduce binaries of neglect and visibility, and hierarchies of the global health issues that matter, the people who matter and the women who matter. What unites the neglect and visibility of gender in global health security is that gender is erroneously understood as a solution rather than as a threat. Combined, these factors make gender equality incompatible with global health security.

Method

This article is drawn from a wider research project on women, gender and global health between 2019 and 2021. The project uses the following combination of qualitative primary methods. First, 75 in-depth semi-structured interviews were conducted with actors working on women and gender in global health in international organizations, civil society organizations, academia, publishing and government. Research participants were selected from stakeholder mapping of gender specialists in these sectors, key policy and academic publications, and those working in these sectors and health emergency response and reproductive health in the two case-study countries of Kenya and Sierra Leone. The second element is policy, strategy and funding analysis of all the major bilateral and multilateral funders of global health projects in 2019 and 2020 (before and during COVID-19). The third component is an ethnographic account of the author’s own participation in high-level briefings and research development around gender and COVID-19. This involved briefings to the executive board of UN Women, submission of oral and written evidence to the UK government, survey work with women’s charities in the UK, and participation as a founding member of the Gender and COVID-19 working group. Discussion of any specific event or meeting in this article has been checked with the participants for any accuracy or ethical concerns; however, all interpretations are my own. Finally, primary research methods were
triangulated with existing literature on women and global health; gender and global health; women, gender and global health security; and women, gender and health emergencies and/or outbreaks.

This article specifically draws on research from the case-study of Sierra Leone. Here, 39 interviews took place in Freetown in January and February 2020, prior to COVID-19 being declared a PHEIC by the WHO. As I shall discuss in the next section, the gender determinants of health emergencies were not a novel feature of the earlier Ebola outbreak, but existed in previous health emergencies such as that surrounding the H1N1 flu virus, and pandemics such as HIV/AIDS; similarly, the impact of Ebola fell not just on Sierra Leone but also on Guinea and Liberia. I focus here specifically on Ebola and Sierra Leone to provide an in-depth case-study on the question of neglect. This case-study was chosen because the 2014–16 crisis was a pivotal moment in documenting evidence of the gendered drivers and consequences of health emergencies;\(^{10}\) because it became a benchmark for reflecting on the state of contemporary pandemic preparedness and global health security; and because it led to adaptations and changes in pandemic surveillance and response. The lessons of Ebola in 2014–16 presented an opportunity to reconsider and examine the evidence on contemporary health emergencies, yet failed to fully integrate gender into such considerations.\(^{11}\)

A note on terminology is apposite here. The article uses the term ‘health emergencies’ throughout to encapsulate the WHO’s definition of PHEIC, those public health emergencies that existed prior to the formal use and definition of PHEIC (e.g. SARS), and pandemics (e.g. HIV/AIDS). As I shall discuss in the next section, not all health emergencies reach pandemic status and not all pandemics have been classified as PHEIC. Gender is understood as a social construct, wherein norms shape (1) vulnerability to and drivers of infection; (2) the burden of formal and informal care during a health emergency; (3) the wider impact of the emergency on people’s well-being and safety, and their social, economic and political lives; (4) whose labour matters, is recognized and is valued within the response to the emergency; and (5) what is prioritized in both immediate and long-term response and recovery planning.

\(^{10}\) Seema Yasmin, ‘The Ebola rape epidemic that no one’s talking about’, Foreign Affairs, 2 Feb. 2016, https://foreignpolicy.com/2016/02/02/the-ebola-rape-epidemic-west-africa-teenage-pregnancy/; Lisa Denney, Rachel Gordon and Aisha Ibrahim, Teenage pregnancy after Ebola in Sierra Leone: mapping responses, gaps and ongoing challenges, Secure Livelihoods Research Consortium working paper 39 (London: Overseas Development Institute, 2015), https://securelivelihoods.org/wp-content/uploads/Teenage-Pregnancies-after-Ebola-in-SierraLeone_-Mapping-responses-gaps-and-ongoing-challenges.pdf; Harriet Mason, A second chance at schooling for pregnant teenagers in Ebola-affected Sierra Leone (New York: UNICEF, 2016), https://www.unicef.org/stories/second-chance-schooling-pregnant-teenagers-sierra-leone.

\(^{11}\) UN General Assembly, Strengthening the global health architecture: implementation of the recommendations of the High-level Panel on Global Response to Health Crises, A/70/824 (New York: 8 April 2016), https://www.un.org/ga/search/view_doc.asp?symbol=A%2F70%2F824&Submit=Search&Lang=E; Harvard Global Health Institute, Harvard–LSHTM Panel on Ebola (Cambridge, MA, 2013), https://globalhealth.harvard.edu/domains/pandemics/programs/harvard-lshtm-panel-on-ebola/; Margaret Chan, ‘From crisis to sustainable development: lessons from the Ebola outbreak’, LSHTM ‘Women in science’ lecture series, 2015, https://vimeo.com/121210752; Bill Gates, ‘The next epidemic—lessons from Ebola’, New England Journal of Medicine 372: 1381, 2015, pp. 1381–4, doi: 10.1056/NEJMmp1502918; African Union, 14 lessons to prepare for future health emergencies, 20 July 2015, https://au.int/fr/news/events/27030/14-lessons-prepare-future-health-emergencies-au-support-ebola-outbreak-west-africa.
Gender and global health security

The prevention and detection of disease outbreaks, responding to them in such a way that they do not become emergencies, and the definition of what constitutes a health emergency and/or a pandemic are the principal concerns of global health security. The gender determinants of such outbreaks and emergencies and their consequences are thus of fundamental importance to global health security; and in turn, the tools, institutions and conceptual understanding of global health security shape how gender is understood or neglected during health emergencies. Feminist contributions to global health, specifically in relation to the HIV/AIDS pandemic, have advanced understanding of the gendered impacts of health security. However, the emphasis remains on reforming the institutions and tools of global health security to recognize gender, rather than on thinking analytically about how global health security operates and is structured to constrain gender equality.

The basic premise of global health security is one of collective security across states, international institutions and non-state actors, where everyone works together to detect and ameliorate health concerns that threaten the health of populations, of societies and economies, and of security worldwide. This normative idea of collective security is rooted in wider principles of a human right to health and the recognition of common vulnerability to pathogens. That common vulnerability requires the development of tools and institutions of international cooperation and state commitment that encourage states to report threats; to share information about the nature of the threat, how it evolves, and pharmaceutical and non-pharmaceutical measures to respond to it; to support and build capacity to detect outbreaks; and to promote health diplomacy and solidarity. The WHO performs these functions through the International Health Regulations 2005 (IHR2005) and the associated Global Outlook Alert and Response Network, Health Emergencies Programme and IHR Emergency Committee. One of the central powers of the WHO is that of raising the level of alert to that of a health emergency, achieved by the director-general declaring a disease outbreak to be a PHEIC. It has done so six times: in the cases of H1N1 swine flu (2009); polio (2014); Ebola (2014–16); Zika (2015–16); Ebola (2019–20); and COVID-19 (2020). This system has evolved in response to previous outbreaks and issues around state compliance and willingness to report (e.g. in the case of China and SARS) and capacity to detect (e.g. in Guinea and Ebola) outbreaks.

This neat conception of global health security obscures the political constraints and challenges that impinge on both the practice and the normative underpinnings of the concept. The WHO is at the centre of these constraints and challenges, which affect whether it functions effectively in its mandate, technical guidance

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12 Sara E. Davies and Clare Wenham, ‘Why the Covid-19 response needs International Relations’, *International Affairs* 96: 5, 2020, pp. 1227–51.
13 Sara E. Davies, ‘Securitizing infectious disease’, *International Affairs* 84: 2, 2008, pp. 295–313; Sara E. Davies, ‘What contribution can International Relations make to the evolving global public health agenda?’, *International Affairs* 86: 5, 2010, pp. 1167–90.
and relationships with member states, and the relevance of the IHR. Debates on these topics are of long standing in global health and have led, among other things, to a more dispersed global health security constellation involving the World Bank in health emergency financing, the UN Security Council in framing health concerns as security threats through formal resolutions, and a greater degree of influence for those funding research into global health security, such as the Bill and Melinda Gates Foundation.

The WHO’s standard defence against criticism is to blame member states and how the institution is financed: you get the WHO you pay for. The challenges faced by the WHO are indicative of how states limit the notion of collective health security, being interested in global health security only for what they can get out of it. Global health is thus far more strongly linked to state security than to human security, and to the protection of some states and populations than others. As a consequence, states with greater financial and diplomatic leverage in institutions such as the WHO and UN Security Council are able to shape decisions as to which threats matter. This points to the common assertion that global health security is primarily concerned with ‘protecting the west from the rest’. While this has been overturned by COVID-19, in respect of which the West is arguably threatening the rest, the important issue here is that health security threats are constituted through the global politics of not just what the threat is but whom it threatens and who pays for it. This concern is increasingly related to the securitization of health, whereby a threat is constructed as exceptional and thus afforded greater political attention. The most notable example of this phenomenon has been the securitization of HIV/AIDS, the first health issue to be declared a potential threat to international peace and security (the exceptional threat) by the UN Security Council (the security actor), in Resolution 1308 (the act). Resolution 1308 both followed and triggered years of speech acts declaring a ‘war on AIDS’ and ‘the battle against HIV’, and a discussion about the efficacy of ‘doing an AIDS’ in global health if you want to get funding and draw political attention to an issue. Notably, securitization comes with consequences for those who constitute the ‘threat’. There is thus concern about how health security and securitization practices exacerbate and even create inequality and discrimination.

14 Kelley Lee, *The World Health Organization* (Abingdon: Routledge, 2008); Sara E. Davies, Adam Kamradt-Scott and Simon Rushton, *Disease diplomacy: international norms and global health security* (Baltimore, MD: Johns Hopkins University Press, 2015).

15 Sophie Harman, ‘COVID-19, the UN, and dispersed global health security’, *Ethics and International Affairs* 34: 3, 2020, pp. 373–8.

16 Christian Kreuder-Sonnen, ‘China vs the WHO: a behavioural norm conflict in the SARS crisis’, *International Affairs* 95: 3, 2019, pp. 535–52.

17 Simon Rushton, ‘Global health security: security for whom? Security from what?’, *Political Studies* 59: 4, 2011, pp. 779–96.

18 Sara E. Davies and Sophie Harman, ‘Securing reproductive health: a matter of international peace and security’, *International Studies Quarterly* 64: 2, 2020, pp. 277–84; Sophie Harman, ‘15 years of “war on AIDS”: what impact has the global HIV/AIDS response had on the political economy of Africa?’, *Review of African Political Economy* 42: 145, 2015, pp. 467–76.

19 Stefan Elbe, ‘Should health professionals play the global health security card?’, *Lancet* 378: 9787, 2011, pp. 220–21.

20 Stefan Elbe, ‘Risking lives: AIDS, security and three concepts of risk’, *Security Dialogue* 39: 2–3, 2008, pp. 177–98; Clare Wenham, ‘The oversecuritization of global health: changing the terms of the debate’, *International Affairs* 00: 0, 2021.
The issues that are framed as security threats may not pose the greatest risk to the world’s health, but tend to get the most funding and political attention, at the expense of other issues. Financing of global health is a significant problem. Most funding is allocated to specific health issues that appeal to a donor’s interests. This distorts the allocation of funding and often leads to significant deficits in funding where it is needed. Global health security is one of the most well-funded programmes of the WHO. This funding goes into improving surveillance, detection and response mechanisms, so is technically impartial; however, it can affect which health threats are prioritized as health emergencies. This exacerbates a wider distinction between horizontal approaches and funding models (attending to health systems) and vertical approaches and models (focusing on specific health issues, e.g. pandemic flu), diverts political attention away from everyday health needs to the emergency imperative, and creates hierarchies of health issues in respect of attention, political will and funding. This in turn creates a double penalty for people living in low- and middle-income countries. The health issues that threaten millions of lives in low- and middle-income countries but pose very little risk to high-income countries are rarely considered to be matters of global health security and so are not prioritized, while simultaneously people living in low- and middle-income countries are then framed as the threat to the West, as vectors of disease, and are thus subject to discrimination which is often highly gendered and racialized. Global health security thus both exacerbates and reproduces inequality by creating a hierarchy of health issues.

Gender cuts across all these concerns, and feminist research has been central to criticism of both the concept and the practice of global health security. Much of this criticism has been expressed in response to the HIV/AIDS crisis and, to an extent, reproductive health. HIV/AIDS has been pivotal in establishing a body of research on the feminization of disease and the gender determinants of health; the feminization of pandemic response, notably with regard to women’s paid and unpaid care roles in the health sector and the family; how gender shapes access to

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21 Sophie Harman, *Global health governance* (Abingdon: Routledge, 2012).
22 WHO, *Driving impact in every country: results report programme budget 2018–2019* (Geneva, 2020), https://www.who.int/about/finances-accountability/reports/results_report_18-19_high_res.pdf?ua=1.
23 Michael A. Stevenson and Michael Moran, ‘Health security and the distortion of the global health agenda’, in Simon Rushton and Jeremy Youde, eds, *Routledge handbook of global health security* (Abingdon: Routledge, 2015), pp. 328–38; Debra L. DeLaet, ‘Whose interests is the securitization of health serving?’, in Rushton and Youde, eds, *Routledge handbook of global health security*, pp. 339–48.
24 Adia Benton and Kim Yi Dionne, ‘International political economy and the 2014 West Africa Ebola outbreak’, *African Studies Review* 58: 1, 2015, pp. 223–36; Stefan Elbe, ‘Risking lives’; Stefan Elbe, ‘Should HIV/AIDS be securitized? The ethical dilemmas of linking HIV/AIDS and security’, *International Studies Quarterly* 50: 1, 2006, pp. 119–44.
25 Elbe, ‘Risking lives’; Davies and Harman, ‘Securing reproductive health’.
26 Lesley Doyal, Jennie Naidoo and Tamsin Wilton, eds, *AIDS: setting a feminist agenda* (London: Taylor & Francis, 1994); Jelke Boesten and Nana Poku, eds, *Gender and HIV/AIDS: critical perspectives from the developing world* (Abingdon: Routledge, 2009).
27 Sophie Harman, ‘The dual feminisation of HIV/AIDS’, *Globalizations* 8: 2, 2011, pp. 213–28.
28 Boesten and Poku, eds, *Gender and HIV/AIDS*. 
treatment; 29 the structural violence of the disease burden, 30 and the way in which, if women in sub-Saharan Africa make up the majority of people living with HIV, then securitizing HIV positions these women as the global threat; 31 cash transfers to incentivize behaviour change; and the wider relationship between HIV, security, gender and conflict. 32 This research has been instructive in bringing feminist terms such as gender burden, feminization of incidence of disease and the response to it, structural violence, the care economy and gender blindness to global health research and practice. This broadened understanding has aligned with policy priorities around HIV/AIDS adopted by actors such as UNAIDS and UN Women, which have sought to put the gender drivers of disease at the centre of their work, and to focus on how these shape access to health care and treatment in their response planning. 33 However, the salience of such research has not spilled over into global health more broadly, specifically with regard to health emergencies.

HIV/AIDS is a health crisis and a pandemic, and has underpinned much of the policy and practice on global health security outside the WHO. However, while it was the subject of a UN Security Council resolution, it has never been declared a PHEIC. This observation is not a minor issue of bureaucracy or institutional procedure, but is central to understanding why the lessons learned from HIV/AIDS have not been integrated into health emergency planning and response. While HIV/AIDS is a health crisis and a pandemic, it is not seen as an outbreak threat or a health emergency in the same way as pandemic flu, Ebola or the emergence of new pathogens. It has an exceptional status in terms of funding, visibility and its relationship to health security. It is a health security concern but not a health security emergency. As a consequence, the rich research on the gender aspects of HIV/AIDS that are highly relevant to health emergencies are also seen as exceptional or as somehow irrelevant to different emergency health contexts and response structures.

Feminist research on Ebola, Zika and reproductive health has begun to develop and apply insights from the HIV/AIDS response in forming wider understandings of health emergencies. Such research has introduced concepts such as ‘conspicuous invisibility’ to convey the scale of women’s involvement in health emergencies and the impacts they experience, along with the absence of gender from decision-making and strategy; 34 ‘stratified reproduction’ to account for the hierarchies and imbalances in who can reproduce and why this matters in health emergencies; 35 and the ‘tyranny of the urgent’ to explain how gender is always secondary in

29 Leanne Welham and Sophie Harman, Pili (London: Kuonekana Films/Studio Soho Films, 2017).
30 Confortini and Vaittinen, eds, Gender, global health and violence; Anderson, Gender, HIV and risk; Anderson, ‘Infectious women’; O’Manique and Fourie, Global health and security.
31 Colleen O’Manique, ‘The securitisation of HIV/AIDS in sub-Saharan Africa: a critical feminist lens’, Policy and Society 24: 1, 2005, pp. 24–47; Tony Barnett and Gwyn Prins, ‘HIV/AIDS and security: fact, fiction and evidence—a report to UNAIDS’, International Affairs 82: 2, 2006, pp. 359–68.
32 Hakan Seckinelgin, International security, conflict, and gender: ‘HIV is another war’ (Abingdon: Routledge, 2012).
33 UNAIDS, Gender (New York 2020), https://www.unaids.org/en/topic/gender; UN Women, HIV and AIDS (New York, n.d.), https://www.unwomen.org/en/what-we-do/hiv-and-aids.
34 Harman, ‘Ebola, gender and conspicuously invisible women’.
35 Candace Johnson, ‘Pregnant woman versus mosquito: a feminist epidemiology of Zika virus’, Journal of International Political Theory 13: 2, 2017, pp. 233–50.
or exempt from health emergency planning and response. An emerging debate considers the possibility of a feminist global health security—one that emphasizes a reorientation to protecting the rights of individuals and sees states as the threat to health. However, by 2020 such research had not crossed over into wider policy and practice on global health security in the same way it had in the HIV/AIDS response. Gender is not a component of the IHR2005. Prior to the outbreak of COVID-19, gender only once featured in a health-related UN Security Council resolution, UNSC 2439 (2018) regarding Ebola in the DRC. Until the outbreak of Ebola in 2014, data on the incidence and prevalence of a health concern were not disaggregated by sex, and little if any social protections were put in place to manage some of the wider gendered impacts of the outbreak.

The lack of attention to gender in disease outbreaks or PHEIC cannot be attributed to a lack of research on or understanding of the gender dynamics of disease and health emergencies, as is clear from the rich body of literature on HIV/AIDS, Ebola, reproductive health and Zika. Other possible explanations are that those working on health emergencies are not looking at or aware of this evidence, that there are too few gender experts in health institutions or that such expertise is sidelined in specific contexts. These issues, combined with wider concerns around global health security, suggest the problem is not just that health emergencies interact with societal inequalities to exacerbate gender inequality, but that the framing and structures of global health security reproduce gender inequality in the privileging of some issues at the expense of others, and the wilful disregard or false celebration of the gendered labour that underpins its functions. Gender is not just excluded from health emergency planning and response because of a lack of inclusion of knowledge or experts; it is excluded by the structures of global health security, which create hierarchies of issues and of the people who matter. The two case-studies presented here, of neglect of gender in the 2014–16 Ebola outbreak and of the change in rhetoric and visibility of specific issues in the 2020 COVID-19 pandemic, demonstrate how global health security constructs hierarchies of neglect and visibility that limit gender equality in global health.

Neglect

This section considers five explanations for the neglect of gender during the 2014–16 Ebola outbreak in Sierra Leone. It then considers how, if at all, gender factored into post-Ebola recovery and lesson-learning processes, and the implications of this for the inclusion of gender in responses to the 2015–16 Zika and 2019–20 Ebola outbreaks. In so doing, it demonstrates how global health security creates neglect of gender through hierarchies of importance and claims to ignorance, and how gender is considered in global health security only as a solution rather than a threat.

36 Julia Smith, ‘Overcoming the “tyranny of the urgent”: integrating gender into disease outbreak preparedness and response’, Gender and Development 27: 2, 2019, pp. 355–69.
37 Clare Wenham, Feminist global health security (Oxford: Oxford University Press, 2021).
38 UN Security Council Resolution 2439, 20 Oct. 2018, https://www.un.org/press/en/2018/sc13559.doc.htm.
The first and most commonly cited reason for the neglect of women and gender in this context was the ‘putting out the fire’ argument of emergency exceptionalism, or the ‘tyranny of the urgent’ explanation.\(^{39}\) This explanation has a great deal of traction among those involved in the Ebola response, many of whom have expressed remorse for not having done more on gender while stressing the intensity of the period. Even those who were trying to raise the issue of women and gender concede that the circumstances were so chaotic that it is understandable these issues got missed. The most common responses to questions about neglect tended to centre on the same theme: ‘it was too much’,\(^{40}\) the problem was one of such ‘sheer scale’,\(^{41}\) ‘everyone was completely overwhelmed’.\(^{42}\) As one respondent put it when talking about violence in areas under quarantine, I remember flagging it with some people from other government agencies. And you know we were just used to, I think people get overwhelmed with the crisis, you know, and sometimes even when you tell them it’s trying to digest the information and try to think ‘okay so what do we do or is this just another issue we have to deal with?’ … I mean even having to deal with something like Ebola was stress and pressure itself, because nobody really knew what to do so I guess it was . . .\(^{43}\)

Here the explanation is one of understanding and frustration: everyone was overwhelmed and gender issues got missed. This explanation suggests that at the time gender was seen as separate from or of secondary concern to the main response rather than fundamental to its success. What is interesting is how this perception changed over time: two respondents argued that once they showed the efficacy of the work they were doing with rural women in the response, national and international coordinators started to pay attention—but only because such work proved useful to bigger priorities such as contact-tracing efforts.\(^{44}\) The approach was very much about what women could do for the response (through domestic labour, community mobilizing, safe burial, behaviour change communication) rather than what the response could do for women (through protection from violence and provision of gender-based violence services, reproductive health services and protection of health care workers).

The second explanation was the lack of reliable data and what counted as evidence. As one leading person on the gender aspect of the response explained to me:

So, UN WOMEN insisted on doing the gender impact assessment of Ebola. Only when the data came out, they were like, you people, okay, so let’s pay attention to the differentials … the day I walked into the, it was called the Situation Room, the day I walked into the Situation Room to present this data, it was, Sophie, a dead silence in the room.\(^{45}\)

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\(^{39}\) Smith, ‘Overcoming the “tyranny of the urgent”’.  
\(^{40}\) Interview 2, former health official in Ebola response, government of Sierra Leone, Freetown, Sierra Leone, 27 Jan. 2020.  
\(^{41}\) Interview 3, non-governmental organization, Freetown, Sierra Leone, 29 Jan. 2020.  
\(^{42}\) Interview 4, international organization, Freetown, Sierra Leone, 22 Jan. 2020.  
\(^{43}\) Interview 5, gender consultant, Freetown, Sierra Leone, 31 Jan. 2020.  
\(^{44}\) Interview 1 and Interview 6, international organization, Freetown, Sierra Leone, 22 Jan. 2020.  
\(^{45}\) Interview 1, international organization.
Some got it; however other people present sought to discredit the data: It was amazing ... Dr Y, discredited the data and said, rubbish, you know, that men/women study is not based on scientific data, I said, wow.46

The data issue maps onto a wider problem in global health governance: unless there is quantitative verifiable evidence, an issue can be easily dismissed—especially if the issue is not well understood, such as the gender outcomes of disease outbreaks.47 Anecdotal reports, small-n case studies or qualitative evidence often are not considered hard evidence sufficient to warrant action. Numbers are political currency in global health security. Such dismissals are partly about legitimate concerns over assessing the severity of the issue and the extent to which it warrants attention in a crisis when attention is a limited commodity; but they are also political, brought into play when a policy-maker or strategist does not want to act on an issue.

The third explanation is that gender issues did matter to the Ebola response, but in a hierarchy where other issues mattered more. The impacts of Ebola on reproductive, maternal and new-born child health were well known, studies having been published in high-profile, prestigious outlets such as the Lancet.48 However, as one respondent acutely noted, women’s health interests were always second to more prominent issues on the agenda:

I would walk into meetings with my colleague with donors and we would be screaming about you know we need to ensure there is a minimum package available for reproductive health no matter what’s going on with Ebola, and even though we’re often overlooking reproductive health in emergencies. People will just say well what are we doing with the immediate response? They didn’t want to talk about reproductive health.49

Contact tracing, protection of front-line health workers, mobilization of equipment and materials: these tend to be the focus of the immediate response. Reproductive health, women’s safety, the burden of work women do: these are all seen as secondary to the most urgent needs. Another respondent explained that every time they brought up increased numbers and reports of domestic violence and the need for money to address this, they would have the same response: ‘Well, you know, donors are basically focusing on addressing Ebola and reducing transmission, so you know ... it’s not a priority.’50 Again, there is little acknowledgement not only of the scale of the impact on these ‘secondary’ issues, but of how gendered contact tracing, health workers’ protection and community mobiliza-

46 Interview 1, international organization.
47 Sara E. Davies, Sophie Harman, Rashida Manjoo, Maria Tanyag and Clare Wenham, ‘Why it must be a feminist global health agenda’, Lancet 393: 10171, 2019, pp. 601–603.
48 Megan Lyman, Jonetta Johnson Mpofu, Fatma Soud, Titilope Oduyebo, Sascha Ellington, Gabriel W. Schlough, Alimany P. Koroma, Jevon McFadden and Diane Morof, ‘Maternal and perinatal outcomes in pregnant women with suspected Ebola virus disease in Sierra Leone, 2014’, International Journal of Gynecology and Obstetrics 142: 1, 2018, pp. 71–7; Alexandre Delamou, Rachel M. Hammonds, Séverine Caluwaerts, Bettina Utz and Thérèse Delvaux, ‘Ebola in Africa: beyond epidemics, reproductive health in crisis’, Lancet 384: 9960, 2014.
49 Interview 4, international organization.
50 Interview 5, gender consultant.
tion are, and how the women being subjected to domestic abuse are the same women who are vulnerable to Ebola.

The hierarchy of issues was also evident in where issues were discussed. One interviewee described the National Ebola Response Centre (NERC) that ran the national operation:

Yes, there were layers of NERC meetings. If you were here you would know they were there, there were layers, particularly the decision-making places, people like us were never, when I see people like us, institutions like us were never allowed in.51

The national response to the outbreak was organized into key clusters that then fed into the central operations of the NERC. Women’s issues and interests, including domestic and gender-based violence, were designated to the ‘social protection’ cluster.52 This cluster was the destination for a number of the difficult elements of the response no one wanted to deal with: ‘We put all of them, yes, we put all of them under that area, dealing with the welfare of women, the welfare of children, survivors and everything.’53 Despite, or perhaps because of, the fact that it was dealing with so many issues no one wanted to address, this cluster was described as a ‘marginal seat at the table’.54

Marginalizing gender issues is an effective way of marginalizing gender experts. Marginalization allows for the illusion of inclusion: gender experts are included in the response, but such inclusion is on the fringes of the response, in the ‘social protection’ cluster. This observation signals the importance not just of inclusion, but of how issues are included. Gender has a long history of being linked with ‘women-and-children’ in global health, an association that narrows the scope of how gender in pandemics and global health more widely is understood and acted upon.55 When asked how they understood the issue of gender in global health, most respondents would discuss maternal health or women and children as a health priority.56 It was rare that such responses included recognition of women and children as a priority during outbreaks. Only those with a specific background in gender—rather than in women’s health—expressed some understanding of the ways in which gender norms shaped health outcomes, perceptions of the risks and outcomes of outbreaks, and responses to them.

Fourth, cutting across all of these explanations of why women’s issues were omitted, ignored or sidelined was the fact that many working on the response just did not get gender: they did not understand the concept, they did not understand what gender had to do with Ebola or health, and from that basis could dismiss its relevance. The problem with infectious diseases is they are seen as the great equalizer—anyone from the person on the street to the president is vulnerable to infection: hence there should be no differential impact, and if there is it can be

51 Interview 6, international organization.
52 Interview 7, non-governmental organization, Freetown, Sierra Leone, 21 Jan. 2020.
53 Interview 8, former official in Ebola response in Sierra Leone, Freetown, Sierra Leone, 23 Jan. 2020.
54 Interview 7, non-governmental organization.
55 Sophie Harman, ‘Women and the Millennium Development Goals: too little too late too gendered’, in Rorden Wilkinson and David Hulme, eds, Beyond the Millennium Development Goals (Abingdon: Routledge, 2012).
56 Interview 9, official in Ministry of Health and Sanitation, Sierra Leone, Freetown, Sierra Leone, 3 Feb. 2020.
addressed through equity in public health interventions. This is a point that has come up in conversation with individuals working in the wider WHO system, a lack of understanding as to why gender would ever come up in pandemic preparedness.\(^\text{57}\) Those working on issues of gender found that communities were more open to understanding these issues than the elites working for the UN, donors and governments.\(^\text{58}\) Communities were open and receptive to exploring and addressing gender issues and their impacts on the Ebola response. Decision-makers and those working for international organizations concerned with global health security, by contrast, were not.

Finally, the extent to which gender was not considered a primary concern is most clearly reflected in the numerous 'lessons learned' reports and recovery plans written in the aftermath of the outbreak. The shift to recovery is a critical point at which to recognize the gendered determinants and consequences of health emergencies, and is in many respects the second battle: after convincing those involved in the response that a gender lens is fundamental to an effective response, the same advocates have to lobby a different set of actors involved in recovery to inform future lesson-learning and obtain recovery funds. Evidence on the gendered impact of the outbreak was acknowledged in the National Ebola Recovery Strategy for Sierra Leone 2015–17,\(^\text{59}\) but somehow went missing in the lessons learned reports, statements and policy documents from the WHO, the Harvard University–London School of Hygiene and Tropical Medicine (LSHTM) panel on Ebola, Bill Gates and African Union that gained international attention.\(^\text{60}\) The only international exception was the UN panel on health crises, which emphasized female representation and engagement in decision-making during pandemics,\(^\text{61}\) and the European Parliament’s comprehensive recommendations.\(^\text{62}\)

Since the Ebola outbreak of 2014–16, there have been three PHEIC: Zika (2015–16); Ebola again (2019–20); and COVID-19 (2020). During the five years between the outbreak of Ebola in west Africa and of COVID-19, there were some incremental changes in how gender, or more pertinently the experience of women and girls, was understood in health emergencies—but little change in how this issue was systematically addressed. The Zika outbreak distinctly showcased the tensions involved in trying to address a disease with particular impact on women without considering gender inequality. Zika is a disease spread by the \textit{Aedes aegypti} mosquito: specific to the 2015–16 outbreak was the relationship between Zika in pregnant women and the birth of babies with microcephaly and other congenital Zika syndrome (CZS) complications. Instead of exploring the gender dimensions

\(^{57}\) Interviews 1, 8 and 10, international organization, Nairobi, Kenya, 21 Nov. 2019.

\(^{58}\) Interviews 6 and 11, international organization, Freetown, Sierra Leone, 22 Jan. 2020.

\(^{59}\) Government of Sierra Leone, \textit{National Ebola Recovery Strategy for Sierra Leone, 2015–2017} (Freetown, 2015), https://ebolaresponse.un.org/sites/default/files/sierra_leone_recovery_strategy_en.pdf.

\(^{60}\) Harvard Global Health Institute, \textit{Harvard–LSHTM Panel on Ebola}; Chan, ‘From crisis to sustainable development’.

\(^{61}\) UN General Assembly, \textit{Strengthening the global health architecture}, point 19.

\(^{62}\) European Parliament, \textit{Ebola crisis: long-term lessons} (Strasbourg, 27 Oct. 2015), https://www.europarl.europa.eu/docstring/document/TA-8-2015-0374_EN.pdf?redirect; EU/Government of Luxembourg, \textit{Lessons learned from the Ebola outbreak in West Africa—how to improve preparedness and response in the EU for future outbreaks}, 12–14 Oct. 2015, https://ec.europa.eu/health/sites/health/files/preparedness_response/docs/eu_20151012_ss_en.pdf.
of women’s access and right to sexual and reproductive health, structural inequalities that exacerbated risk factors such as poor housing, and lack of antenatal care, the response to the outbreak was behavioural: do not get pregnant, keep your house clean, do not keep stagnant water.63 Governments told women not to get pregnant with complete disregard to the policies and structures in place that limit that choice, such as lack of access to contraception, safe abortion, and safe and suitable housing.64 It placed the burden of response on women, removed men from any association with pregnancy, and exacerbated inequalities in who could follow the guidelines and risks for those who could not.65 The contradictions of the Zika response were a red flag to women’s rights advocates, but not to the institutions of global health security. Recognition of the gender drivers of Zika and how they shaped the response was confined to women’s rights activists and key UN programmes such as UNFPA’s ‘More Rights, Less Zika’ campaign.66 Zika advanced the understanding of gender during disease outbreaks in stressing the importance of human rights, women’s rights and the right to health during a public health emergency, and the role of reproductive rights advocates such as UNFPA and women’s rights groups in campaigning for change.67

The 2019–20 outbreak of Ebola in the DRC marked three important turning-points in understanding of how gender drives and shapes the response to health emergencies. First, it consolidated knowledge and evidence on the gendered aspects of outbreaks. Reports from the DRC contributed evidence in highlighting how the feminization of health and care work increased female vulnerability and risk to infection, negatively impacted on health-seeking behaviour, disrupted reproductive health services, violence against women and girls as a risk factor for infection, and a secondary health issue associated with Ebola: resourcing and communication gaps, and the need for female representation in decision-making.68 What was important here was the building of a body of evidence that could not be attributed solely to specific circumstances—as, for example, in the argument that maternal mortality and gender-based violence were already high in

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63 Clare Wenham, Amaral Arevalo, Ernestina Coast, Sonia Corrêa, Katherine Cuella, Tiziana Leone and Sandra Valongueiro, ‘Zika, abortion and health emergencies: a review of contemporary debates’, Global Health 15: 49, publ. online July 2019, https://doi.org/10.1186/s12992-019-0489-3.
64 Wenham, Feminist global health security.
65 Davies and Bennett, ‘A gendered human rights analysis of Ebola and Zika’; Wenham et al., ‘Zika, abortion and health emergencies’.
66 Deisy Ventura, Danielle Rached, Jameson Martins, Cristiane Pereira, Paulo Trivellato and Lúcia Guerra, ‘A rights-based approach to public health emergencies: the case of the “More Rights, Less Zika” campaign in Brazil’, Global Public Health, publ. online Oct. 2020, DOI: 10.1080/17441692.2020.1830425.
67 Ventura et al., ‘A rights-based approach’.
68 Julia Smith, ‘Gender matters in responding to major disease outbreaks like Ebola’, ReliefWeb, 22 July 2019, https://reliefweb.int/report/world/gender-matters-responding-major-disease-outbreaks-ebola; International Rescue Committee, ‘Everything on her shoulders’: rapid assessment on gender and violence against women and girls in the Ebola outbreak in Beni, DRC (London, March 2019), https://www.rescue.org/sites/default/files/document/3593/genderandgbvfindingsduringevdresponseindrc-final8march2019.pdf; Nidhi Kapur, Gender analysis: prevention and response to Ebola virus disease in the Democratic Republic of Congo (London: Care International, 2020), https://www.care-international.org/files/files/Ebola_Gender_Analysis_English_v2.pdf; WHO, Women are key in Ebola response (Geneva, 2019), https://www.who.int/news-room/facts-in-pictures/detail/women-join-hands-to-oust-ebola-from-drc; UN Population Fund, New Ebola outbreak hits women and girls hardest in the Democratic Republic of the Congo (New York, 10 Sept. 2018), https://www.unfpa.org/news/new-ebola-outbreak-hits-women-and-girls-hardest-democratic-republic-congo.
Sierra Leone, so the effects of Ebola could be dismissed—but represented a pattern of the gendered risks and outcomes of health emergencies. The second turning-point was the introduction of new risk factors such as mobility analysis, which showed how women’s wider ‘environmental ranges’ made them susceptible to infection; gender inequality in access to vaccines; and, crucially, how the response to Ebola itself could exacerbate gendered risk.69 Two reports on gender and the DRC highlighted the impact of extra resources and personnel as increasing the risk of sexual exploitation and abuse, particularly of women and girls.70 As one report noted, ‘the influx of Ebola responders and associated cash flow may also inadvertently have created conditions which favourise economic or sexual exploitation and abuse’.71 The final turning-point was the inclusion of gender in UNSC Resolution 2439 on the threat posed by Ebola in the DRC to international peace and security, which unequivocally ‘emphasizes that men and women are affected differently by the Ebola outbreak and underlines that a gender-sensitive response that addresses the specific needs of both men and women is required, and stresses the importance of the full, active and meaningful engagement of women in the development of such responses’.72 Such inclusion is an important marker for the inclusion not just of women and girls, but of gender, in global health security. In contrast, the WHO’s statement to accompany its declaration of a PHEIC on 17 July 2019 signalled towards gender issues such as community engagement, ‘at risk populations’ and ‘cultural norms and beliefs’, without making any explicit comment with regard to women, girls or gender.73 The first situational report on Ebola in 2019 failed to disaggregate data by sex; however, this was quickly adjusted for the third situational report on 22 August 2018.74

The five years from 2015 to 2020 provide substantial evidence of the gendered impacts of health emergencies and their neglect in global health security. The case of Ebola in 2014–16 suggests that this neglect results from a combination of factors: a perceived lack of data and evidence; ignorance of the potential gender issues that could arise from both an outbreak and the response to it; the sidelining of gender expertise; the hierarchy of issues within a health emergency; and a perception that gender mattered only as a subordinate element in the service of issues higher up that hierarchy. While communities involved in the responses to Ebola in 2014–16 and Zika in 2015–16 understood aspects of the gendered impacts of outbreaks, decision-makers apparently did not. In the cases of Zika and the later outbreak of Ebola in 2019–20 there was a slight change in the form of wider recognition of the gender impacts of the outbreaks; but that elicited a similar focus on the inclu-

69 Kapur, Gender analysis.
70 Kapur, Gender analysis; International Rescue Committee, ’Everything on her shoulders’.
71 Kapur, Gender analysis.
72 UN Security Council Resolution 2439, pp. 3–4 (emphasis in original).
73 WHO, Statement on the meeting of the International Health Regulations (2005) Emergency Committee for Ebola virus disease in the Democratic Republic of the Congo on 17th July 2019 (Geneva, 2019), https://www.who.int/ihr/procedures/statement-emergency-committee-ebola-drc-july-2019.pdf.
74 WHO, Ebola virus disease Democratic Republic of the Congo: External situation report 01, 2018, https://apps.who.int/iris/bitstream/handle/10665/273640/SITREP_EVD_DRC_20180807-eng.pdf?ua=1; External situation report 03, https://apps.who.int/iris/bitstream/handle/10665/274258/SITREP_EVD_DRC_20180820-eng.pdf?ua=1.
sion of women at every level of the response rather than on how gender norms determine health outcomes and the short- and long-term response to outbreaks. This slippage from ‘gender’ to ‘women’ is important. It follows a wider trend in international public policy to use women and gender synonymously as a means of simplifying the issues and demonstrating action through emphasizing female inclusion. What is pertinent in health emergencies is how the conspicuousness of women becomes a means of making gender invisible. For example, because Zika had conspicuously severe impacts on women, it became easier to make gender invisible: a focus on women could be presented as self-evident while ignoring the gendered determinants of infection and long-time consequences of the outbreak.

The drivers of neglect reveal a more substantive point about gender and global health security. Gender is constructed as a secondary or marginal concern, relevant only in service to the immediate crisis. This comes about not by accident but as a systematic part of how global health security works in practice: namely, by creating hierarchies of what constitutes a health emergency and, within that hierarchy, deciding what issues and people take priority. As Ebola and Zika suggest, women—and most notably poor women living in low- and middle-income countries and those who undertake advocacy on their behalf—are at the bottom of this hierarchy. Gender is never seen as a threat, despite the significant impacts it has on the health of women and men. If gender is considered at all, it is as a solution to the health emergency: something that constructs and maintains free or low-paid labour, voluntary care work, social protection and absorption of the crisis—all of which are fundamental to pandemic response. It is not that actors and institutions of global health security do not understand gender—they do; they just understand it as fundamental to response rather than threat. As a consequence, the solution to gender determinants of health emergencies is always to add more women to solve the crisis. Visibility of women as the solution to the crisis then becomes a justification for further neglect of the gender determinants, their consequences and the gendered power relations inherent in global health security.

Empirically, neglect of the gender drivers of outbreaks could be addressed by situating gender as fundamental to outbreak response in understanding and management, the production of better data and evidence, and involvement of women and diverse genders in decision-making. However, as I shall explore in the next section in the context of COVID-19, applying such measures does not necessarily lead to better outcomes. Neglect and visibility work together to maintain gender inequality within global health security.

Visibility and COVID-19

The COVID-19 pandemic of 2020–2021 has marked a clear change in the visibility and positioning of gender in health emergencies: a growing body of research and funding for research, institutional acknowledgment of the issues by the

75 Gender and COVID-19 Working Group, Gender Working Group projects, 2020, https://www.genderand-covid-19.org/gender-working-group-page/.
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UN, 76 public advocacy of understanding gender and COVID-19, 77 global media coverage, 78 the development of new accountability tools to track gender-responsive policy and strategy, 79 and at the very least indications that gender may be included in future pandemic preparedness. This section considers the factors that led to such visibility and the ways in which, instead of advancing gender equality in global health security, visibility works in tandem with neglect to reinforce gender as a solution to global health security rather than a threat.

Recognition of the gendered impacts of outbreaks during the COVID-19 pandemic would not have come about without the evidence supporting action drawn from Ebola in 2014–16 and 2019–20, and Zika in 2015–16, and the wider understanding of gender and disease arising from the HIV/AIDS pandemic. Building an evidence base, highlighting the tensions that limit and reproduce gender inequalities, and demonstrating the utility and centrality of gender to outbreak control response have constructed solid foundations on the basis of which to demonstrate the relevance of gender to policy-makers and agenda-setters. The leveraging of evidence on gendered outcomes of health emergencies involved a combination of (1) pre-existing initiatives on gender and global health; (2) a loosely formed epistemic community of academic and UN researchers and policy-makers interested in these issues; 80 and (3) the creation of new umbrella groups and networks aligned with wider women’s organizations and high-profile women’s advocates and policy influencers. The last five years have seen a growth in interest in gender and global health, reflected in initiatives such as Global Health 50/50, which seeks to ‘advance action and accountability for gender equality in global health’; Women in Global Health, which describes itself as a ‘global movement that brings together all genders and backgrounds to achieve gender equality in global health leadership’; and the work of high-profile publications, such as the Lancet special issue on ‘Advancing women in science, medicine, and global health’ and its Commission on Gender and Global Health. 81 These initiatives have highlighted issues of representation, the feminized nature of the health care workforce and the inclusion of gender-based or gender-sensitive policies and practices within global health institutions, and have galvanized support for and attention to these issues. It is thus unsurprising that the outbreak of COVID-19 was followed by a groundswell

76 UN Security Council Resolution 2532.
77 Gates, ‘The pandemic’s toll on women’.
78 Helen Lewis, ‘The coronavirus is a disaster for feminism’, Atlantic, 19 March 2020, https://www.theatlantic.com/international/archive/2020/03/feminism-womens-rights-coronavirus-covid19/608302/; Amanda Taub, ‘Pandemic will “take our women ten years back” in the workplace’, New York Times, 26 Sept. 2020, https://www.nytimes.com/2020/09/26/world/covid-women-childcare-equality.html; Edith M. Lederer, ‘UN chief: virus reversed fragile progress on gender equality’, Associated Press, 1 Sept. 2020, https://apnews.com/article/72763baedf1d92aa24ea7d78beb3c4d1.
79 UN Development Programme (UNDP), ‘COVID-19 global gender response tracker’ (New York, 2020), https://data.undp.org/gendertracker/.
80 Jeremy Shiffman, ‘Knowledge, moral claims and the exercise of power in global health’, International Journal of Health Policy Management 3: 6, 2014, pp. 297–9.
81 Global Health 50/50, ‘About us’ (London, 2020), https://globalhealth5050.org/about-us/; Women in Global Health, ‘About’ (2020), https://www.womeningh.org/about; Sarah Hawkes, Pascale Allotey, As Sy Elhadj, Jocelyn Clark and Richard Horton, ‘The Lancet Commission on Gender and Global Health’, Lancet 396: 10230, 2020, pp. 321–2; The Lancet, ‘Advancing women in science, medicine, and global health’ (special issue), Lancet 393: 10771, 2019.
of expert activism aimed at collecting data and evidence on all potential and early indications of the gender outcomes of the pandemic. New umbrella groups such as the Gender and COVID-19 working group formed to capture, share and loosely coordinate the wide range of work being done on research and advocacy.\(^{82}\) Such activism was aligned with and supported the work of UN institutions such as UN Women and UNFPA. These institutions identified the potential gender impacts of COVID-19 and the need to do something about them. The work began with webinars and internal meetings, briefings and publications, advocacy for better data from member states and the WHO and, in the case of UN Women and UNDP, the production of both a data and policy hub that measures gender difference with regard to prevalence and impact of COVID-19 and monitors gender-sensitive policy within member states.\(^{83}\)

The change here was that, instead of waiting for the WHO to lead on issues of gender in the context of COVID-19, the partner programmes recognized the scale of the pandemic and the alignment of the issues raised with their institutional mandates. Gender and global health security were dispersed from the WHO to the wider UN system.\(^{84}\) Advocacy drew on expertise from outside public health—in the humanitarian and Women, Peace and Security sectors—and aligned itself with the wider women’s movement and national organizations.\(^{85}\) International NGOs, domestic women’s groups, think-tanks, medical journals and media outlets all developed an interest in the gendered aspect of the pandemic. This expanding interest helped shape and mirror public understanding of gender during COVID-19, fed into domestic public policy-making and agenda-setting, and contributed to the mass of support for consideration of these issues, along with knowledge and evidence about them, and their growing legitimacy at the international level. Tolerance for a lack of understanding of gender was minimal when many advocates were explaining the gender impacts of pandemics at multiple levels of governance. The combination of different actors working on gender and COVID-19 has had a co-legitimation and reproducing effect that has created greater attention to and investment in gender work. State advocates could point to the transnational evidence being produced within the UN system, and in turn UN programmes could draw on best practice and evidence from state-funded research projects and initiatives that focused on gender and COVID-19.

Creating attention to and awareness of an issue is one thing; creating receptiveness to that issue among institutions and actors is another. COVID-19 is the first pandemic since #metoo and coincided with the resurgence of Black Lives Matter following the killing of George Floyd in the United States. Both of these factors necessitated at the very least a token awareness of gender and racial inequality,

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\(^{82}\) Gender and COVID-19, ‘About’ (2020), https://www.genderandcovid-19.org/about/.

\(^{83}\) UNDP, ‘COVID-19 global gender response tracker’.

\(^{84}\) Harman, ‘COVID-19, the UN, and dispersed global health security’.

\(^{85}\) Sara E. Davies and Sue Harris Rimmer, Mapping the impact of COVID-19 on women, peace and security practitioners in the Indo-Pacific region, Gender, Peace and Security Centre (Melbourne: Monash University, May 2020); UN Women, COVID-19 and conflict: advancing women’s meaningful participation in ceasefires and peace processes, policy brief no. 19 (New York, 2020), https://www.unwomen.org/en/digital-library/publications/2020/08/policy-brief-covid-19-and-conflict.
institutional bias and injustice within institutions themselves. As inequalities in impacts, prevalence and mortality from COVID-19 became apparent, it was difficult for key actors to avoid acknowledging the issue.

The final explanation for the change in the visibility of gender during COVID-19 is the scale of the pandemic and whom it affected. While the first six months of outbreak suggested that prevalence rates were similar among men and women (non-binary data were not captured), and the availability of reliable sex-disaggregated data remains problematic, there are indications of higher rates of vulnerability and mortality among men.\(^{86}\) Explanations of why this may be the case have considered male physiology, male behaviour and male social and economic roles.\(^{87}\) The latter two factors are clearly shaped by gender norms, opening the way for an argument that when gender norms start negatively affecting men and their mortality, the world pays attention to them. However, this is only part of the story, as much of the coverage of gender and COVID-19 has focused specifically on the gendered burdens and impacts on women and girls. The high-level political declarations, research projects and advocacy on gender and pandemics have centred the experience of women during COVID-19.

The gender impacts of COVID-19 did not just fall on poor women in low- and middle-income countries, but were felt by poor and rich women in high-income countries.\(^{88}\) A reason why gender became more prominent during the first six months of the COVID-19 pandemic than at any previous time in the 15 years since the reform of the IHR2005 is that gender mapped onto existing trends in global health security: issues become prominent or of concern when they posed a threat to people living in high-income countries. One interpretation of this claim is that it is a scale issue: COVID-19 has pandemic status, and the more women are affected around the world, the higher is the profile of the pandemic, and the more groups, networks and women’s advocates take notice of the issue. Another interpretation is that gender and COVID-19 followed the pattern of global health security in an issue—here the gender impact of pandemics—becoming relevant only once it posed a threat to the West or global North. The difference with COVID-19 is that instead of global health security loosely being about protecting the West from the rest, or the global North from threats emerging from the global South, COVID-19 turned the nature of the threat on its head, making it one about protection from the failing interventions in key western states. The threat lay with internal government responses to the outbreaks rather than those of external states or institutions. And yet, while the source of the threat changed, the identity of those who are to be protected did not: people living in high-income countries.

Protecting women in high-income countries from the threat is only part of the explanation as to why gender issues got greater attention during COVID-

\(^{86}\) Global Health 50/50, ‘The COVID-19 sex disaggregated data tracker’.
\(^{87}\) Global Health 50/50, ‘The COVID-19 sex disaggregated data tracker’.
\(^{88}\) For example, as of November 2020, the ten countries with the highest numbers of COVID-19 cases were, in order: US, India, Brazil, Russia, France, Spain, Argentina, UK, Colombia and Mexico. Those with the highest numbers of deaths were: US, Brazil, India, Mexico, UK, Italy, France, Iran, Spain and Peru (Johns Hopkins Centre for Systems Science and Engineering, ‘COVID-19 dashboard’, https://coronavirus.jhu.edu/map.html).
19: more specifically, it is about protecting rich, white women in high-income countries from the threat. The gendered impacts of COVID-19 are highly intersectional, with class and socio-economic status, race, indigeneity and disability all crucial factors in shaping the lived experiences, risk exposures and vulnerabilities of women around the world and in different contexts. COVID-19 has been repeatedly proven to exacerbate existing inequalities in health care and wider society.\textsuperscript{89} The burdens and inequalities are not new; what is new is how acutely these are felt by the most vulnerable, marginalized and/or discriminated against in society, and the expansion of those burdens—to a greater and lesser extent—across women at all levels of socio-economic status. There is an argument that if the impacts of COVID-19 had been confined to lower-income women, minority ethnic women, women living with disabilities, migrant women or indigenous women in high-income countries, these issues would not have gained such prominence. This argument is based on the marginality of these women and their health issues and needs within both the health care sector and wider society. One of the stark indicators of this marginality and neglect is maternal mortality. In the UK, research published a year before the COVID-19 pandemic showed that black women were five times more likely to die in childbirth than white women.\textsuperscript{90} This shocking statistic was well known in black health care and in some reproductive health care groups in the UK, but was not widely acknowledged or publicized by the women’s sector, any political party or in wider society. In Australia between 2006 and 2010, ‘Aboriginal and Torres Strait Islander women were almost 3 times as likely to die as non-Indigenous women, with a maternal mortality ratio of 16.4 deaths per 100,000 Indigenous women giving birth’,\textsuperscript{91} and while there has been government recognition of such poor maternal mortality rates for indigenous women, ten years later maternal mortality remained higher in Aboriginal and Torres Strait Islander women than in non-indigenous women.\textsuperscript{92} Australia is not an outlier: according to the UN, ‘indigenous women die in pregnancy and childbirth more often than other women’ around the world.\textsuperscript{93} Pregnant women in immigrant detention centres in the United States are reportedly denied access to adequate care and treated improperly by officials.\textsuperscript{94} These are just a handful of examples which reflect a wider concern that acute health care needs and burdens

\textsuperscript{89} Kunal Sen, ‘Five ways coronavirus is deepening global inequality’, \textit{The Conversation}, 18 Aug. 2020, https://theconversation.com/five-ways-coronavirus-is-deepening-global-inequality-144621; Aaron van Dorn, Rebecca E. Cooney and Miriam L. Sabin, ‘COVID-19 exacerbating inequalities in the US’, \textit{Lancet} 395: 10232, 2020, pp. 1243-4; Joseph Stiglitz, ‘Conquering the great divide’, \textit{Finance and Development}, Fall 2020.

\textsuperscript{90} MBRRACE-UK, \textit{Saving lives: improving mothers’ care 2019} (Oxford, 2019), https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Mortality%20Report%202019%20-%20Lay%20Summary%20v1.0.pdf.

\textsuperscript{91} Australian Institute of Health and Welfare, \textit{Maternal deaths in Australia 2006–2010} (Canberra, 2019), https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia-2006-2010/contents/table-of-contents.

\textsuperscript{92} Australian Institute of Health and Welfare, \textit{Maternal deaths in Australia}.

\textsuperscript{93} UN Population Fund, UNICEF and UN Women, \textit{Indigenous women’s maternal health and maternal mortality}, factsheet (New York, 2018), https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/10/2018/04/factsheet_print_Mar27.pdf.

\textsuperscript{94} Physicians for Human Rights, \textit{Health harms experienced by pregnant women in US immigration custody}, factsheet (New York, 2019), https://phr.org/wp-content/uploads/2019/12/PHR-Pregnant-Women-in-Immigration-Custody-Fact-Sheet-Nov-2019.pdf.
were a prominent, urgent issue for some women in high-income countries. In some cases this issue was ignored, in some it was acknowledged by politicians, but in few has it been acted on. Poor health outcomes and wider burdens of disease have existed not only for women living in low- and middle-income countries, but—in acute form—for certain groups of women in high-income countries. What unites them is neglect of these issues.

In sum, the change in attention to gender and pandemics brought about by COVID-19 can be attributed to a number of factors: the evidence accrued from previous health emergencies, leveraged by a loose epistemic community working on gender and global health that connected researchers, high-profile advocates and lobbyists, civil society and UN programmes; the scale of the gendered impacts of the pandemic on women and men; and the reproduction of patterns of global health security that create hierarchies in the issues that get attention based on perceived threats to the West. In contrast to previous health emergencies where gender was neglected, the gender determinants and consequences of COVID-19 have been visibly recognized. Recognition and visibility did not, however, lead to substantive change in policies, programmes or initiatives to address both the gendered determinants and outcomes of the pandemic within state response planning. When UNDP and UN Women’s gender policy tracker was launched in September 2020, it had reviewed 2,500 measures across 206 countries and found that only 25 (or 12 per cent of) states had measures in place that addressed all three areas of concern (violence against women and girls, support for unpaid care and strengthening women’s economic security), and 42 (or 20 per cent of) states had no measures whatsoever in these areas. What had changed was a growth in noise, visibility and research efforts to capture the gendered drivers and consequences of COVID-19. That noise, visibility and research, aimed at centring gender within current structures of global health security, creates a dual risk. First, visibility in a hierarchy of global health security creates the risk that those gender issues that appeal to health security actors will be picked out to the exclusion of others. Hierarchies of health are anathema to gender equality in global health. As when gender was relegated to the social protection cluster during the Ebola outbreak, where gender is recognized as an important issue it is reduced to a matter of representation and women’s inclusion, or seen as marginal to the central organizing bodies of the COVID-19 response. It is only when gender becomes a solution to the crisis—for example, by assuming gender norms that women will home-school their children, or providing ‘safe space’ exemption to lockdown rules—that gender is deemed relevant. The threat the same gender norms represent to women’s health and well-being—that the burden of managing home-schooling, work and psycho-social family support during the pandemic gives women little time to prioritize their own health, will damage their mental and physical well-being and could result in their looking for loopholes in the guidelines that may undermine the response—is seen as less relevant, separate from the health emergency or (in the case of action prompted by the search for loopholes) something to be punished.

95 UNDP, COVID-19 global gender response tracker.
Second, the visibility of gender becomes reduced to the visibility and representation of women. The visibility of gender in COVID-19 is increasingly performative, with multiple actors involved in global health security showcasing their gender credentials by including women on panels, hosting webinars on gender and COVID-19, virtue signalling on social media and emphasizing ‘intersectionality’ by reducing the concept to diversity of women on panels rather than diversity of opinion, interests, expertise or experience. Visibility is a tool used by global health security actors to acknowledge gender and the research around it on public platforms while perpetuating neglect in policy and strategy spaces and/or using gender as a topic of concern to advance their own interests. This is an old trick that feminists have been wise to for decades. What is different about its use in health emergencies, and specifically in the COVID-19 pandemic, is that the language around gender and outbreaks is made visible in such a way as to maintain gender as the solution rather than the threat in health emergencies. Gender norms and roles are recognized and praised with regard to health workers and the potential value of women as caring leaders and decision-makers. This reproduces the very gender norms that make gender a threat to women’s health security.

Neglect and visibility work in relation to one another in global health security. For every focus of attention in global health security there is a corresponding exclusion: another health issue, a global health security concern or a group of people—more specifically, women with low socio-economic status. Some women will matter more than others (the rich minority over the majority) and some gender issues will take priority. These priorities will be assessed not according to need but according to factors that are recognized by decision-makers: the ability to act or ignore, what can be counted and presented as data, and the willingness of global health actors to understand the issues and deem them relevant. Attention to COVID-19 has immediate knock-on effects for gender equality in health care, economic livelihoods and political participation, and will potentially affect long-term funding of and investment in women’s health in domestic and global settings as the financial implications of paying for COVID-19 become evident. The inequalities in global health revealed by COVID-19 existed before the pandemic, and the rhetoric to ‘build back better’ will once again depend on a narrow reading of gender where women are the solution. This will not advance gender equality in global health security but will reproduce gender assumptions that women will absorb the impact and cost of pandemics. Gender equality in global health security will not advance until gender is recognized as the threat, not the solution.

96 See e.g. Anne Phillips, *The politics of presence: the political representation of gender, ethnicity, and race* (Oxford: Oxford University Press, 1995); Sandra Harding, ‘Just add women and stir?’, in Gender Working Group of UN Commission on Science and Technology for Development, ed., *Missing links: gender equity in science and technology for development* (Ottawa: International Development Research Centre, 1995), pp. 295–308.

97 Jane Dudman, ‘Female leaders make a real difference. Covid may be the proof’, *Guardian*, 16 Dec. 2020, https://www.theguardian.com/society/2020/dec/16/female-leaders-make-a-real-difference-covid-may-be-the-proof.
Conclusion

The aim of this article was to explore how issues of gender during health emergencies shifted from neglect during the 2014–16 Ebola outbreak in West Africa to high-profile political attention during the COVID-19 pandemic, and the implications of this change for understanding the relationship between gender and global health security. Drawing on original research, the article has presented explanations for the neglect of women and gender during Ebola—relating to the emergency imperative, the use of data and evidence, the prevailing hierarchies within global health security and the wilful neglect of an understanding of gender—and how these changed, if at all, during the outbreaks of Zika in 2015–16 and of Ebola again in 2019–20. The article then considered why and how gender became a prominent issue in the COVID-19 response, with reference to the mobilization of epistemic communities around gender and global health, high-profile advocates and, crucially, who was affected by the pandemic. Finally, the article discussed the implications of the relationship between neglect and visibility to suggest that gender equality is incompatible with current structures and processes of global health security.

This incompatibility can be attributed to the ways in which the concept and practice of global health security produce hierarchies of health threat based on state interest and investment. Such hierarchies apply to both the gendered determinants and the gendered consequences of health emergencies in respect of which women are deemed to matter and the marginalization of gender in emergency response practice. Neglect and visibility work together to reproduce these hierarchies and make issues of female representation central and gender peripheral. Gender is a health security threat in that gender norms around labour, family roles, care, access to health care and leadership all create poor health outcomes and burdens on women, notably low-paid women. Gender becomes an even bigger health security threat in an emergency, when all of these dynamics are intensified. Gender as threat is rarely acknowledged in the practice of global health security. When gender is recognized at all, it is as a solution to health outbreaks, where gender norms and expectations as to who does care (women), who leads (men) and who counts (men and women, but not non-binary people) are maintained. Further research into the gendered aspects of health emergencies and COVID-19 will enrich our understanding of these issues; however, this will not solve global health security’s gender problem. Evidence has existed from the time of the HIV/AIDS pandemic, through the outbreaks of Ebola and Zika, to the COVID-19 pandemic, that what matters is how gender is understood and how this understanding is acted upon. Gender equality is incompatible with global health security for as long as gender is seen as the solution to health emergencies rather than the threat.