

# Gender Inclusion in the Pandemic Agreement: A Growing Gap?

Sara E. Davies and Clare Wenham

MARCH 2024

Sara E. Davies is a Professor of International Relations at Griffith University and Deputy Director of the Australian Research Council Centre of Excellence for the Elimination of Violence Against Women.

Clare Wenham is an Associate Professor of Global Health Policy at the London School of Economics and Political Science.

Professor Davies' research was partially funded by the Australian Government through the Australian Research Council DP220100587.

This issue brief is part of IPI's COMPASS Initiative on multilateral approaches to pandemics, which is made possible by support from the Stavros Niarchos Foundation (SNF).

The views in this publication represent those of the authors and not necessarily those of the International Peace Institute (IPI). IPI welcomes consideration of a wide range of perspectives in the pursuit of a well-informed debate on critical policies and issues in international affairs.

## Executive Summary

There is increasing evidence of the gendered outcomes and secondary effects of epidemics and pandemics. Women make up a disproportionate share of the healthcare workforce, absorb much of the additional unpaid labor during health crises, and are exposed to increased gender-based violence and insecurity around sexual and reproductive healthcare during pandemics, among other effects. A gender-sensitive approach to health emergencies is essential for pandemic preparedness, prevention, response, and recovery.

Despite the World Health Organization's (WHO) awareness of these impacts, it does not systematically consider them in its pandemic preparedness and response. WHO's historical "add women and stir" approach is evident in the proposed amendments to the International Health Regulations (IHR), whose attention to gender focuses primarily on committee representation. Gender sensitivity is also limited in the drafts of the WHO Convention, Agreement or Other International Instrument on Pandemic Prevention, Preparedness and Response (CA+), currently in development. Gender-inclusive language in the CA+ is essential for effective international coordination to prepare, prevent, respond to, and recover from health emergencies.

In this context, CA+ negotiators, WHO, and member states should consider the following recommendations.

- Future drafts of the CA+ should have provisions that address a wider range of the gendered impacts of pandemics;
- WHO should develop an IHR/CA+ repository;
- INB negotiators should directly engage relevant UN entities to recommend methods of integrating gender into the CA+;
- States that claim to have a principled stance on gender equity should transparently champion gender-inclusive language; and
- The CA+ should consider and incorporate initial lessons learned from the implementation of the gender-inclusive language in the IHR's Joint External Evaluation (JEE) of states.

## Introduction

In the wake of the failures of the global response to the COVID-19 pandemic, there have been multiple reviews to assess what went wrong and what lessons can be learned for future pandemic preparedness and response. One of the key weaknesses identified has been the global governance of how states prevent, detect, and respond to emerging infectious disease threats and other health emergencies, both independently and collectively.<sup>1</sup> This has resulted in a proposed process for amending the International Health Regulations (IHR), the sole piece of existing international law that codifies the responsibility states have to each other and the international community to mitigate the threats posed by infectious disease. In addition, the World Health Assembly (WHA) created an Intergovernmental Negotiating Body (INB) in May 2021 to draft and negotiate a World Health Organization (WHO) Convention, Agreement, or Other International Instrument on Pandemic Prevention, Preparedness and Response (CA+). This was instigated by Charles Michel of the European Council to complement the technical public health policymaking of the IHR with a political commitment by member states.<sup>2</sup> The negotiated text has been ambitiously slated for delivery at the seventy-seventh WHA in 2024, though negotiations are not currently on track to meet that goal.

Laws and policies are the products of the people and institutions that create them, including their socially constructed norms and their understanding of and approaches to issues. Traditionally, the institutions that make policies for responding to emergencies have been dominated by cisgender, able-bodied, masculine approaches to policymaking.<sup>3</sup> The resulting policies reflect these individuals' experiences and thus often fail to consider the

differential effects and impacts of policies.<sup>4</sup> This is evident in WHO, where there is a recent history of neglecting gender in pandemic preparedness and response.<sup>5</sup> There is a risk that this institutional shortcoming will lead to a CA+ that, if adopted, neglects gender.

This paper examines the extent to which gender has been included in the zero-draft CA+ process through a desk review of the drafts that have been published (as of March 2024), focusing on explicit mentions of gender and women.<sup>6</sup> The report also draws on the recorded verbatim statements by member states and submissions, when available, including reports from civil society organizations. In addition, semi-structured informal interviews were conducted with representatives of member states, civil society organizations, and think tanks that are involved in or engaged with the INB process. This combination of desk review and interview data informed our understanding of the process involved to secure gender-inclusive language in the CA+.

The objective of this report is to document the progress to date on integrating gender equality into the CA+. First, the report outlines the consequences of gender-blind responses to health emergencies, examining the lessons learned from the COVID-19 pandemic and previous health emergencies. Second, it examines the absence of a gender lens (and, therefore, gender equality) in international health emergency coordination. Third, it identifies the changes to gender-inclusive language in the six zero drafts of the CA+ that have been presented to member states and notes a weakening commitment to gender equality in successive drafts. Finally, it tries to make sense of why gender may be losing out to competing agendas and looks ahead to what is next for gender-inclusive language in the CA+ and other policies on health emergencies.

1 World Health Organization (WHO), *Independent Oversight Advisory Committee for the WHO Health Emergencies Programme: Looking Back to Move Forward*, UN Doc. A73/10, November 4, 2020; The Independent Panel for Pandemic Preparedness and Response (IPPPR), "COVID-19: Make it the Last Pandemic," May 12, 2021.

2 David M. Herszenhorn, "Charles Michel Proposes 'International Pandemic Treaty,'" Politico, November 12, 2020.

3 Dyan Mazurana, Prisca Benelli, and Peter Walker, "How Sex- and Age-Disaggregated Data and Gender and Generational Analyses Can Improve Humanitarian Response," *Disasters* 37, no. 1 (July 2013).

4 Naila Kabeer and Ramya Subrahmanian, "Institutions, Relations and Outcomes: Framework and Tools for Gender-Aware Planning," Institute of Development Studies, January 1996; Diane Elson, "Labor Markets as Gendered Institutions: Equality, Efficiency and Empowerment Issues," *World Development* 27, no. 3 (March 1999); Georgina Waylen, "Informal Institutions, Institutional Change, and Gender Equality," *Political Research Quarterly* 67, no. 1 (March 2014).

5 Clare Wenham and Sara E. Davies, "WHO Runs the World—(Not) Girls: Gender Neglect during Global Health Emergencies," *International Feminist Journal of Politics* 24, no. 3 (July 2022).

6 We do not intend to suggest that gender and women are synonymous; rather, we look for both terms in the provisional texts to assess where gender-sensitive perspectives might appear in the treaty text.

If the CA+ is successfully negotiated without substantial gender-inclusive language that reflects gendered experiences, it could fail to recognize and mitigate the numerous gendered impacts of health emergencies. Additionally, the treaty could be used as a precedent for adopting regressive language on gender rights previously secured in international texts.

## Gendered Impacts of COVID-19 and Previous Epidemics

Gender is increasingly recognized as a key determinant of infection and of the outcome and secondary effects of epidemics and pandemics.<sup>7</sup>

### Box 1. Key terminology

There is a multitude of definitions available for the terms used in this report. We have based some of our definitions on those of the European Institute for Gender Equality.<sup>8</sup>

**Gender** refers to the socially constructed characteristics of men, women, and nonbinary individuals; the norms, behaviors, and roles associated with a particular gender; and the relationship between these.

**Gender analysis**, rooted in feminist research, is the process of analyzing how gendered power relations affect people's lives by creating differences in their needs and experiences and how policies and services can address these differences, including differential access to resources and different norms and values, roles, and practices. In the field of health, gender analysis also examines decision-making on policies that create differences in health outcomes and health system experiences.<sup>9</sup>

**Gender roles** are context-specific and can be dynamic across time and geographies. A hierarchical power structure produces gender-based inequalities in areas such as access to resources, public and private roles, decision-making power, and societal relations. Gender intersects with additional drivers of inequality and social determinants of health, including sexuality, class, religion, ethnicity, citizenship, and disability.<sup>10</sup>

**Gender-balanced participation or representation** is the “representation of either women or men in any decision-making body in public and political life not falling below 40% as a parity threshold.”<sup>11</sup>

**Gender equity** is the “provision of fairness and justice in the distribution of benefits and responsibilities” between women, men, and nonbinary individuals.

**Gender equality** refers to the “equal rights, responsibilities and opportunities” of women and men, girls and boys, and those of other genders.

**Gender indicators** are “tools for monitoring gender differences, gender-related changes over time and progress towards gender equality goals.”

**Gender mainstreaming** is the “systematic consideration of the differences between the conditions, situations and needs” of women, men, and nonbinary individuals “in all policies and actions.”

**Gender parity** refers to “relative equality in terms of numbers and proportions of women and men, girls and boys, and is often calculated as the ratio of female-to-male values for a given indicator.”

7 This includes both social gendered differences in adherence to public health measures and health-seeking behavior and biological differences in infection and outcomes. Ellie Lee and Elizabeth Frayn, “The ‘Feminisation’ of Health,” in *A Sociology of Health*, David Wainwright, ed. (London: SAGE Publications, 2008).

8 European Institute for Gender Equality, “Glossary and Thesaurus,” 2023, available at [https://eige.europa.eu/publications-resources/thesaurus#letter\\_g](https://eige.europa.eu/publications-resources/thesaurus#letter_g).

9 Rosemary Morgan et al., “How to Do (or Not to Do)... Gender Analysis in Health Systems Research,” *Health Policy and Planning* 31, no. 8 (October 2016).

10 Kimberlé Crenshaw, “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics,” *University of Chicago Legal Forum* 1989, no 1 (1989).

11 This and all of the subsequent definitions are based on those of the European Institute for Gender Equality.

First, women are more likely to be exposed to pathogens and to the physical and mental burden of a pandemic response because they make up a disproportionate share of the global health workforce—around 67 percent, according to one study.<sup>12</sup> Beyond women’s disproportionate share of risk due to their high representation in the health workforce, women health workers also tend to be more negatively impacted by disease outbreaks than men health workers. Women health workers also often disproportionately absorb the additional household burdens resulting from disease outbreaks on top of their professional duties.<sup>13</sup>

Second, women are more likely to work in the sectors of the economy that are most sensitive to social distancing restrictions and other public health measures. For example, women are more likely to be employed in education, retail,

Women are more likely to be exposed to pathogens and to the physical and mental burden of a pandemic response because they make up a disproportionate share of the global health workforce.

hospitality, and tourism, all sectors that are among the most likely to face closures or other restrictions to limit interaction between individuals during a disease outbreak.<sup>14</sup> This means that during the COVID-19 pandemic and previous epidemics, women have lost jobs at a greater rate than men—not just in the acute phase of the crises, but also in the longer term. An analysis of Sierra Leone in the wake of Ebola showed that thirteen months after the acute phase had ended, only 17 percent of women previously employed had returned to work, compared to 63 percent of men.<sup>15</sup> This higher unemployment among women can have direct impacts on food security for households. For

example, women in Myanmar, Papua New Guinea, and the Philippines reported a reduction in their household calorie intake due to income lost because of the COVID-19 pandemic.<sup>16</sup> This loss of income can also have further knock-on effects within families, such as a reduction in children’s participation in school (if schools remain open), increased teenage pregnancy, and less health-seeking behavior by all family members.<sup>17</sup>

Third, women absorb much of the additional unpaid labor during health crises. Women are more likely to assume additional childcare duties if

schools are not open and to perform community activities, such as providing food to neighbors, navigating access to social security funding, and implementing community projects.<sup>18</sup> This is in part because if women are not in paid employment, they have

additional time to assume such roles, but it is also due to cultural norms that women perform such roles in their community and family.<sup>19</sup> These functions performed by women are often vital to the health emergency response, as they provide unpaid care to make up for the lack of formal care from government or nongovernmental sources.<sup>20</sup> Moreover, traditional gender norms may become entrenched and intensify during times of crisis. For example, during the Zika crisis, mothers of infected children were initially blamed for “getting themselves pregnant” when there was a virus circulating which might affect unborn children, and later, they were seen as responsible for ensuring

12 Mathieu Boniol et al., “Gender Equity in the Health Workforce: Analysis of 104 Countries,” WHO, 2019.

13 Rosemary Morgan et al., “Women Healthcare Workers’ Experiences during COVID-19 and Other Crises: A Scoping Review,” *International Journal of Advanced Nursing Studies* 11, no. 1 (December 2022).

14 Abi Adams-Prassl et al., “Inequality in the Impact of the Coronavirus Shock: Evidence from Real Time Surveys,” *Journal of Public Economics* 189 (September 2020).

15 Oriana Bandiera et al., “The Economic Lives of Young Women in the Time of Ebola: Lessons from an Empowerment Program,” World Bank Group (WBG), February 2019.

16 Sara E. Davies et al., “Centering Social Reproduction during Crisis: Women’s Experiences of Food Insecurity in Myanmar, Papua New Guinea, and the Philippines during the COVID-19 Pandemic,” *Review of International Political Economy* (2023).

17 Bianca Rochelle Parry and Errolyn Gordon, “The Shadow Pandemic: Inequitable Gendered Impacts of COVID-19 in South Africa,” *Gender, Work & Organization* 28, no. 2 (March 2021); Kelly Kons, Adriana A. E. Biney, and Kristin Sznajder, “Factors Associated with Adolescent Pregnancy in Sub-Saharan Africa during the COVID-19 Pandemic: A Review of Socioeconomic Influences and Essential Interventions,” *International Journal of Sexual Health* 34, no. 3 (2022).

18 Kate Bahn, Jennifer Cohen, and Yana van der Meulen Rodgers, “A Feminist Perspective on COVID-19 and the Value of Care Work Globally,” *Gender, Work & Organization* 27, no. 5 (September 2020); Masooma Rahmaty and Jasmine Jaghab, “Peacebuilding during a Pandemic: Keeping the Focus on Women’s Inclusion,” International Peace Institute, September 2020; Selima Sara Kabir et al., “A Social Cure for COVID-19: Importance of Networks in Combatting Socio-economic and Emotional Health Challenges in Informal Settlements in Dhaka, Bangladesh,” *Social Sciences* 12, no. 3 (March 2023).

19 Akosua K. Darkwah et al., “Women’s Organising in Nigeria during the COVID-19 Pandemic,” *Feminist Africa* 3, no. 1 (2022).

20 Sophie Harman, “Threat Not Solution: Gender, Global Health Security and COVID-19,” *International Affairs* 97, no. 3 (May 2021).

their homes were clean and free from mosquito reservoirs and for preventing mosquito bites.<sup>21</sup>

Fourth, gender-based violence (GBV) increases during health emergencies. While GBV is notoriously hard to measure accurately, proxy measures such as calls to domestic violence hotlines, administrative records of GBV from police and hospital systems, and femicide rates all increased during the COVID-19 pandemic.<sup>22</sup> This could partly be because of physical restrictions on mobility (i.e., stay-at-home orders) that placed women in confinement with their abusers. There is also a direct correlation between economic insecurity and increased GBV within households, particularly when there may be reduced access to prevention and support services.<sup>23</sup>

Fifth, health emergencies disrupt the routine provision of sexual and reproductive healthcare.<sup>24</sup> This can be because of both supply and demand factors.<sup>25</sup> For example, closures of manufacturers of contraceptives can reduce supply, which can be further compounded by travel disruption and restrictions, the closure of shops where contraception can be obtained, and the diversion of healthcare resources to respond to the acute demands of the health emergency. Demand for routine services can also be reduced if women following stay-at-home orders are not able to go to the providers of such services.<sup>26</sup> Additionally, during emergencies, women and girls may have less freedom (and be less safe) to make reproductive choices, go out to collect water, and maintain personal hygiene, in addition to being more at risk of GBV, as mentioned above.<sup>27</sup> This can increase reproductive health complications, sexually transmitted infections, and unwanted pregnancies,

all of which have lifelong implications. Health emergencies also affect maternity care, reducing both the face-to-face services offered and women's use of these services.<sup>28</sup> For example, one study of eighteen low- and middle-income countries found that between March 2020 and June 2021, the impact of the COVID-19 pandemic on access to health services led to a 3.6 percent increase in child mortality and a 1.5 percent increase in maternal mortality.<sup>29</sup>

Looking beyond the impact of pandemics on women, it is also important to consider the impact of women leaders on the pandemic response. Women comprise 70 percent of the health workforce but hold only around 25 percent of the most influential leadership and governance roles in global health agencies.<sup>30</sup> Media attention has been placed on the visible “success” of countries with women heads of state in 2020 and 2021, such as New Zealand, Taiwan, Germany, and Finland.<sup>31</sup> One study found that “while women [leaders] were less willing to take risks with lives, they were more willing to accept risks in relation to the early lockdown of economies.”<sup>32</sup> However, other studies have found little evidence that countries with women leaders had lower mortality rates.<sup>33</sup> Instead, factors like investment in health and social care and a stronger social contract between governments and populations may be more important. It follows that the “add women and stir” approach, whereby many gender policies across the health sector have mainly focused on increasing women's participation, does not automatically lead to gender-inclusive health policies.

21 Clare Wenham, *Feminist Global Health Security* (Oxford: Oxford University Press, 2021).

22 Addisu Dabi Wake and Usha Rani Kandula, “The Global Prevalence and Its Associated Factors toward Domestic Violence against Women and Children during COVID-19 Pandemic—‘The Shadow Pandemic’—A Review of Cross-Sectional Studies,” *Women's Health* 18 (2022).

23 Amber Peterman et al., *Pandemics and Violence against Women and Children*, Center for Global Development, April 2020.

24 Sara E. Davies and Belinda Bennett, “A Gendered Human Rights Analysis of Ebola and Zika: Locating Gender in Global Health Emergencies,” *International Affairs* 92, no. 5 (September 2016).

25 Maira L. S. Takemoto et al., “How Can Countries Create Outbreak Response Policies That Are Sensitive to Maternal Health?” *BMJ* (June 2021).

26 Hannah VanBenschoten et al., “Impact of the COVID-19 Pandemic on Access to and Utilisation of Services for Sexual and Reproductive Health: A Scoping Review,” *BMJ Global Health* 7, no. 10 (October 2022).

27 Clare Wenham et al., “Women Are Most Affected by Pandemics — Lessons from Past Outbreaks,” *Nature* 583 (2020).

28 Barbara Chmielewska et al., “Effects of the COVID-19 Pandemic on Maternal and Perinatal Outcomes: A Systematic Review and Meta-analysis,” *Lancet Global Health* 9, no. 6 (June 2021).

29 Tashrik Ahmed et al., “Healthcare Utilization and Maternal and Child Mortality during the COVID-19 Pandemic in 18 Low- and Middle-Income Countries: An Interrupted Time-Series Analysis with Mathematical Modeling of Administrative Data,” *PLOS Medicine* 19, no. 8 (August 2022).

30 Mehr Manzoor et al., “Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce,” WHO, 2019.

31 Jon Henley, “Female-Led Countries Handled Coronavirus Better, Study Suggests,” *The Guardian*, August 18, 2020.

32 Supriya Garikipati and Uma Kambhampati, “Leading the Fight Against the Pandemic: Does Gender Really Matter?” *Feminist Economics* 27, no. 1–2 (2021).

33 Leah C. Windsor et al., “Gender in the Time of COVID-19: Evaluating National Leadership and COVID-19 Fatalities,” *PLOS ONE* 15, no. 12 (2020).

Finally, while member states have committed to addressing the gendered effects of pandemics, they have not always implemented these commitments. For example, in the Convention on the Elimination of Discrimination Against Women (CEDAW), member states committed to “ensure that women are not discriminated against in the field of health care and that they have equal access to health-care services, including sexual and reproductive health services.”<sup>34</sup> At the onset of the COVID-19 pandemic in April 2020, the CEDAW Committee outlined the disproportionate impacts the pandemic could have on women, including exacerbated inequalities and heightened risks of gender-based violence and discrimination.<sup>35</sup> The committee called on member states to protect, fulfill, and respect women’s human rights while combating the pandemic. However, these recommendations were not consistently reflected in WHO’s advice in the early stages of the pandemic response.<sup>36</sup>

The “add women and stir” approach, whereby many gender policies across the health sector have mainly focused on increasing women’s participation, does not automatically lead to gender-inclusive health policies.

## Institutional Gaps in Gender Mainstreaming

Despite WHO’s awareness of the gendered impacts of epidemic and pandemic disease, it does not systematically consider these impacts in its pandemic preparedness and response. These institutional gaps will impact the extent to which the CA+ incorporates gender. WHO is arguably the central actor in the global health security landscape. Its constitution establishes it as the

“directing and coordinating authority on international health work,” and the IHR of 2005 give it the role of global epidemic coordinator.<sup>37</sup> Nonetheless, WHO has not issued relevant policy guidance, considered gendered impacts, or required gender- or sex-disaggregated data. At worst, the institution has presided over gendered harms, including sexual exploitation at the hands of WHO staff during health emergencies.<sup>38</sup>

WHO is required to mainstream gender across the organization under the General Programme of Work 13.<sup>39</sup> However, at the start of COVID-19, WHO had no gender-related activities or indicators for health emergencies. Until the pandemic, gender-related evaluations of WHO’s Health Emergencies Programme had only considered women’s participation as staff members and had not assessed the impact of programmatic activity on women experiencing a health emergency.<sup>40</sup> Moreover, during the COVID-19 pandemic, less than a fifth of all published policies related to the emergency explicitly recognized gender, despite the requirement to mainstream gender in all areas of work.<sup>41</sup>

Multiple global reviews have been conducted in the wake of the COVID-19 pandemic, including multiple internal reviews by member states and WHO.<sup>42</sup> The Working Group on International Health Regulations (WGIHR) was established in 2022 on the advice of the WHA following the work of the Working Group on Pandemic Response (WGPR), which recommended that the IHR be

34 Office of the High Commissioner for Human Rights (OHCHR), “The Convention on the Elimination of All Forms of Discrimination against Women and its Optional Protocol: Handbook for Parliamentarians,” 2023.

35 CEDAW, “Guidance Note on CEDAW and COVID-19,” April 2020, available at <https://www.ohchr.org/en/treaty-bodies/covid-19-and-human-rights-treaty-bodies>.

36 Wenham and Davies, “WHO Runs the World—(Not) Girls.”

37 WHO, “Constitution of the World Health Organization,” 2020, available at <https://www.who.int/about/governance/constitution>; Sara E. Davies, Adam Kamradt-Scott, and Simon Rushton, *Disease Diplomacy: International Norms and Global Health Security* (Baltimore: Johns Hopkins University, 2015).

38 Independent Commission on Allegations of Sexual Exploitation and Abuse, “Final Report of the Independent Commission on the Review of Sexual Abuse and Exploitation during the Response to the 10th Ebola Virus Disease Epidemic in the Provinces of North Kivu and Ituri in the Democratic Republic of the Congo (DRC),” WHO, September 2021.

39 WHO, “Thirteenth General Programme of Work 2019–2023,” May 2018.

40 Wenham and Davies, “WHO Runs the World—(Not) Girls.”

41 Emily Tomsick, Julia Smith, and Clare Wenham, “A Gendered Content Analysis of the World Health Organization’s COVID-19 Guidance and Policies,” *PLOS Global Public Health* 2, no. 6 (June 2022).

42 These include but are not limited to the Independent Panel for Pandemic Preparedness and Response (IPPPR) and the Independent Oversight and Advisory Committee of the WHO Health Emergencies Programme (see footnote 1).

## Box 2. Gender and the International Health Regulations

Gender is omitted from the core capacity requirements under the IHR and has historically been neglected by some states in implementing the regulations. The IHR, binding on all member states under Article 19 of the WHO Constitution, obliges states to “prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interferences with international traffic and trade.”<sup>43</sup>

Gender-inclusive language is notably absent from the IHR. Women and gender are only mentioned once each: women are mentioned as a category of travelers whose rights must be protected (Article 32), and gender parity on the IHR Review Committee is recommended (Article 50).<sup>44</sup> These references do not capture the full gendered impacts of health emergencies and pandemic events outlined above. There was no language that specified the need for WHO, states, and other actors to embed meaningful and inclusive gender considerations in public health responses to mitigate a pathogen’s spread. It could be argued that gender considerations within the IHR fall under Article 3, which offers guiding principles, including respect for human rights and the universality of application of the IHR, but this has never been expressly stated.

subject to targeted amendments.<sup>45</sup> As part of the process, the WHA requested that member states submit proposed amendments. Over 300 proposed amendments were initially submitted, encompassing edits to over half of the articles, in addition to proposals for new articles. Six planned consultations on the amendments have been held with member states.<sup>46</sup> The WGIHR is meant to finalize the package of amendments in time for the seventy-seventh WHA in May 2024. Given the lack of gender sensitivity in the current IHR (see Box 2) and the move by many states influential in global health to adopt feminist foreign policy positions, there was some hope that these amendments might increase gender sensitivity in the revised regulations.<sup>47</sup>

However, the proposed amendments to articles of

the IHR have only considered gender in one area: the representation of women on WHO committees. This is evident through the proposed amendments to Article 48, the terms of reference for the composition of the Emergency Committee, and the proposed new Article 54 regarding the creation of an Implementation Committee.<sup>48</sup> These amendments are welcome, but they represent the continuation of WHO’s “add women and stir” approach in that they only consider gender through the addition of elite women within committees rather than considering the downstream effects women may face in health emergencies. There is further engagement with gender in the proposals in Annex 1, but these relate to a trained healthcare workforce with equitable representation. Given the disproportionate representation of

The proposed amendments to articles of the IHR represent the continuation of WHO’s “add women and stir” approach in that they only consider gender through the addition of elite women within committees rather than considering the downstream effects women may face in health emergencies.

43 WHO, “International Health Regulations (2005): Third Edition,” 2005.

44 The review committee provides technical advice on the functioning of the IHR; this requirement was not included for the IHR Emergency Committee, which was to be convened for each international public health emergency to provide advice to the WHO director-general and member states.

45 WHO, *Zero Draft Report of the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to the Seventy-fifth World Health Assembly*, UN Doc. A/WGPR/9/3, May 3, 2022.

46 See: WHO, “Working Group on Amendments to the International Health Regulations (2005), available at [https://www.who.int/teams/ihr/working-group-on-amendments-to-the-international-health-regulations-\(2005\)](https://www.who.int/teams/ihr/working-group-on-amendments-to-the-international-health-regulations-(2005)) .

47 At the time of publication, the following countries have declared themselves to have feminist foreign policies: Argentina, Canada, Chile, Colombia, Finland, France, Germany, Liberia, Libya, Luxembourg, Mexico, Mongolia, the Netherlands, Scotland, Slovenia, and Spain. Brazil and Belgium are exploring avenues toward a feminist foreign policy. The Swedish foreign minister announced an end to Sweden’s feminist foreign policy in October 2022.

48 WHO, *Proposed Amendments to the International Health Regulations (2005) Submitted in Accordance with Decision WHA75(9) (2022)*, UN Doc. A/WGIHR/2/6, February 6, 2023.

women within healthcare workforces worldwide, this may imply giving more roles to men in the healthcare sector.<sup>49</sup> The majority of sessions discussing the amendments are being held behind closed doors between member states and non-state actors in official relations with WHO. To date, there has been no public comment on the consideration of gender either as proposed or more broadly.

These proposed amendments to the IHR need to be considered alongside the changes to the operationalization of the IHR made through the Joint External Evaluation (JEE). The JEE is the operational tool used to monitor and assess countries' compliance with their responsibility to build core capacities to prevent, detect, and respond to public health emergencies, as defined in Annex 1 of the IHR, and to ensure greater commitment to building the capacity of national health security. In the wake of COVID-19, WHO's Health Emergencies Programme established a Gender Working Group, which has been a forum for discussion and action in this space and has developed a number of measurements and requirements for including gender in the updated JEE 2022 tool.<sup>50</sup> These include legal mechanisms to support gender equity at a national level, including requirements for disaggregated data; gendered impacts on the healthcare workforce; an understanding of gendered exposure to disease; and structural barriers to women accessing health services and countermeasures. Given their recent introduction, these gender indicators have only been used in a few JEE missions. To date, we are unable to assess their utility, whether they have been implemented fully, and their effects, but they represent an operational development that is lacking in the legal text of the IHR.

## Gender in the CA+

At the same time as member states submitted proposals for targeted amendments, they have started a parallel process for negotiating a pandemic convention, accord, or other instrument to tackle the political commitments to international cooperation in pandemic preparedness and response absent from the IHR. This section outlines how gender has been considered in the drafts of the text to date.

The first consultation with WHO member states and stakeholders on substantive elements to include in the CA+ was conducted via online survey between April and May 2022.<sup>51</sup> The online survey was organized around the four strategic pillars of equity, leadership and governance, systems and tools, and financing. A total of fifty-eight substantive elements were listed under the four strategic pillars. A dropdown menu allowed respondents to answer “yes” or “no” regarding whether a particular substantive element should be included in the potential instrument. All questions were optional. There was one specific survey item related to gender under the pillar on equity: “Equitable gender, geographical and socioeconomic status representation and participation in global and regional decision-making processes.” This limited reference to gender did not receive unanimous support from survey respondents, and it was noted in the report that a number of “no” respondents suggested that this item fell under “WHO normative functions.”<sup>52</sup> Other member states and respondents suggested referencing a human rights–based approach to pandemic response, including nondiscrimination, which would inherently include women's rights and nondiscrimination on the basis of gender.<sup>53</sup> This minimalist inclusion of gender was the beginning of a trend that has continued throughout negotiations.

49 WHO, *Article-by-Article Compilation of Proposed Amendments to the International Health Regulations (2005) Submitted in Accordance with Decision WHA75(9) (2022)*, UN Doc. A/WGHR/2/7, February 6, 2023.

50 WHO, “International Health Regulations (2005) Joint External Evaluation Tool: Third Edition,” June 2022, available at <https://www.who.int/publications/i/item/9789240051980>.

51 The member state category included 194 member states, three associate members, and one regional economic integration organization (the European Union). The relevant stakeholder category included seventeen United Nations and other intergovernmental organizations in effective relations with WHO, eight observers, 217 non-state actors in official relations with WHO, and forty-three other stakeholders, as decided by the INB. WHO, *Summary Report on the Results of the INB Digital Platform*, UN Doc. A/INB/1/9, June 3, 2022.

52 *Ibid.*, para. 14. In other words, representation in global and regional decision-making processes can be the responsibility of WHO—which it cannot be if the process requires member state representation.

53 *Ibid.*, paras. 31–33.



Below, we trace the development of gender-inclusive language within the six drafts of the CA+ that exist to date. It is important to note that our assessment of gender-inclusive language relates only to explicit recognition of gender, such as through the use of the words “gender” and “women.” This is obviously a limitation in that many provisions will have gendered outcomes that may not be explicitly labeled, such as impacts on labor markets or care economies. We also note that gender is not synonymous with women, but we use these words as proxies for evidence of inclusive and intersectional feminist recognition in the text. We analyze these references to gender chronologically to demonstrate that gender-inclusive language is being continually eroded in subsequent drafts of the CA.

As of March 2024, there have been six iterations of the development of the potential negotiating text of the CA+. At its first meeting in June 2022, the INB agreed to provide a working draft of the CA+, based on the inputs received from member states and stakeholders, for discussion at the second meeting in July.<sup>54</sup> In November, the INB presented a conceptual zero draft for consideration at its third meeting in December.<sup>55</sup> In February 2023, a revised zero draft, based on revised text submissions from member states, was presented at the fourth INB meeting.<sup>56</sup> Following this, the INB created the bureau text in June 2023.<sup>57</sup> In October 2023, the bureau’s proposal for the draft negotiating text was released.<sup>58</sup> A revised draft was released to member states for discussion in March 2024.<sup>59</sup>

Analysis of gender-inclusive language reveals several trends that have emerged over the course of the negotiations (see Table 1). Overall, these point

Analysis points to the weakening of gender-inclusive language by the INB draft of March 2024.

to the weakening of gender-inclusive language by the INB draft of March 2024. We base this claim on the following understanding of how the six drafts developed. The first two drafts (the July 2022 working draft and November 2022 conceptual zero draft) were introductory starting documents and did not include sections on processes. The first substantial draft was the “zero draft” (February 2023), which had a substantial number of articles and sections on processes and commitments. The zero draft was followed by the bureau text (June 2023), the Negotiating Text of the WHO Pandemic Agreement (October 2023), and the Revised Negotiating Text of the WHO Pandemic Agreement (March 2024).

Arguably, the progression of references to gender in these draft texts demonstrates how member states are engaging with the texts. In particular, we identify a difference between references to gender and women in the preamble and general principles and in the articles themselves. This distinction is important because the preamble and general principles are meant to apply to the whole treaty.

First, as mentioned above, in the October and March drafts, all mentions of gender and women were removed from the preamble and the section on principles. References to gender in these sections actually increased between the working draft and the conceptual zero draft. The working draft had one generic reference to gender in the preamble and included gender equality as an overarching principle, as well as a more general reference to respect for human rights, nondiscrimination and respect for diversity, and rights of vulnerable populations. The conceptual zero draft

54 WHO, *Draft Annotated Outline of a WHO Convention, Agreement or Other International Instrument on Pandemic Prevention, Preparedness and Response*, UN Doc. A/INB/1/12, June 14, 2022.

55 During the drafting of the zero draft, the INB received thirty submissions from member states, two submissions from regional offices, and thirty-six submissions from stakeholders. The INB held consultations with all WHO regional offices; four informal hearings on legal matters, operationalizing and achieving equity, intellectual property, and production and transfer of technology and know-how; One Health in the context of strengthening pandemic prevention, preparedness, and response, with reference to antimicrobial resistance, climate change, and zoonoses; and public hearings. All references to the IHR were removed from the conceptual zero draft, and by this stage, the decision had been made that the instrument would take the form of a Convention or Agreement under Article 19 of the WHO Constitution. WHO, *Conceptual Zero Draft for the Consideration of the Intergovernmental Negotiating Body at Its Third Meeting*, UN Doc. A/INB/3/3, November 25, 2022.

56 WHO, *Zero Draft of the WHO CA+ for the Consideration of the Intergovernmental Negotiating Body at Its Fourth Meeting*, UN Doc. A/INB/4/3, February 1, 2023.

57 WHO, *Bureau’s Text of the WHO Convention, Agreement or Other International Instrument on Pandemic Prevention, Preparedness and Response (WHO CA+)*, UN Doc. A/INB/5/6, June 2, 2023. “Bureau” refers to the Bureau of the INB, comprised of one representative from each WHO region, with a secretariat in support. Notably, this is not a member state-led group.

58 WHO, *Proposal for Negotiating Text of the WHO Pandemic Agreement*, UN Doc. A/INB/7/3, October 30, 2023.

59 WHO, *Revised Draft of the Negotiating Text of the WHO Pandemic Agreement*, March 7, 2024.

Table 1. References to gender/women in CA+ drafts

		<i>INB Working Draft A/INB/2/3 July 2022</i>	<i>INB Conceptual Zero Draft A/INB/3/3 Nov 2022</i>	<i>INB Zero Draft A/INB/4/3 Feb 2023</i>	<i>INB Bureau Text A/INB/5/6 June 2023</i>	<i>Negotiating text of the WHO Pandemic Agreement A/INB/7/3 October 2023</i>	<i>Revised negotiating text March 2024</i>
<b>Preambular references to...</b>	<b>Gender</b>	1	2	2	N/A	0	0
	<b>Women</b>	0	1	1	N/A	0	0
<b># of articles that reference...</b>	<b>Gender</b>	3	3	5	9	3	1
	<b>Women</b>	1	3	4	2	2	1
<b>Total # of articles that reference...</b>	<b>Gender and/or Women</b>	3	5	6	9	3	1

and zero draft also included gender equality as a principle and increased the number of gender references in the preamble to three—“gender-balanced,” “gender inequality,” and “gender equality.”<sup>60</sup> The principle of gender equality was removed from the bureau text, as were all the preambular paragraphs, including all references to gender, which were replaced by a statement that this section would “be addressed at a later time in the work of the INB.” These provisions did not return when the preamble was added again in the negotiating text (October 2023) or the revised negotiating text (March 2024).

Second, after small but significant gains in the bureau text (June 2023), the number of areas where the texts address gender diminished by the time of the negotiating text (October 2023) and decreased further in the March 2024 text. The conceptual zero draft and bureau text referenced gender in six out of seven thematic areas (see Table 2). The October negotiating text referenced gender across only three thematic areas, and the March negotiating text only referenced one thematic area. There are no preambular references in the October

Limiting references to gender and women to the areas of gender representation, the collection of gender-disaggregated data, and gendered impacts on the healthcare workforce risks ignoring gendered impacts that efforts to prepare, prevent, and respond to pandemics need to focus on.

2023 text or the March 2024 text. There are three references to gender and two references to women across three articles in the October 2023 text. In the March 2024 text, there is only one reference each to gender and women in a single article regarding the representation of women in the healthcare workforce. In addition to the watering down of member states’ commitment to consider gender in their pandemic preparedness, response, and recovery planning, provisions to address the impacts of gender inequity and inequality in a health emergency response are missing in successive drafts, despite all the lessons learned from previous health emergencies.

Instead, as with most areas of WHO activity, the texts primarily focus on gender in three areas: gender representation, referred to in this text as women in leadership and decision-making roles (which carries the risk of focusing on elite women’s participation); the collection of gender-disaggregated data; and gendered impacts on the healthcare workforce. These are undeniably important areas, and we do not wish to minimize the inclusion of

<sup>60</sup> Reports on the regional committee on the earlier working draft recorded no objection to these inclusions (see UN Doc. A/INB/3/INF./1). The public hearings heard no objection and noted one submission in support (see UN Doc. A/INB/3/INF./3). The focused consultations included no discussion on the implications of gender inclusions in the instrument (see UN Doc. A/INB/3/INF./2). Thus, at this stage, these inclusions appeared to be relatively uncontroversial in the text.

Table 2. Gender inclusions in CA+ zero drafts

Inclusions	INB Working Draft A/INB/2/3 July 2022	INB Conceptual Zero Draft A/INB/3/3 Nov 2022	INB Zero Draft A/INB/4/3 Feb 2023	INB Bureau Text A/INB/5/6 June 2023	Negotiating text of the WHO Pandemic Agreement A/INB/7/3 October 2023	Revised Negotiating text March 2024
Recognition of gender in preamble	X	X	X			
Gender equality as guiding principle	X	X	X	X	*Reference to human rights	
Access and benefit sharing		X	X	X	X	
Workforce		X	X	X	X	X
International cooperation and coordination	X	X	X	X	X	
Whole-of-government/society approach		X		X		
Representation on committees				X		

gender language in these areas, particularly compared with the IHR, which contains many fewer substantive references to gender. However, limiting references to these areas risks ignoring gendered impacts that efforts to prepare, prevent, and respond to pandemics need to focus on. At a minimum, the text should include provisions on the collection of data on the socioeconomic impacts of pandemics on social care or other forms of informal care (in addition to the collection of sex-disaggregated biomedical data); the need to protect access to sexual and reproductive health-care; the disproportionate risks women face in feminized labor markets; and the increased risk of gender-based violence.<sup>61</sup>

## Understanding the Growing Gaps on Gender Language in the CA+

Our findings lead to two questions: why are specific provisions to mitigate the harmful gendered experiences of health emergencies missing from the draft, and why is gender equality language being progressively minimized? We sought to answer these questions through two processes. First, we considered the extent to which there are structural and power imbalances in advancing gender-inclusive language in the INB process and, more broadly, international health governance. Second,

61 Sara E. Davies et al., "Why It Must Be a Feminist Global Health Agenda," *Lancet* 393, no. 10171 (February 2019).

we held informal discussions with representatives of a number of member states that identify as having a feminist foreign policy or promote gender equality as central to their foreign policy on their engagement in the CA+, as well as with health and human rights advocates.<sup>62</sup> Several explanations emerged from these conversations.

First, the original survey to member states did not sufficiently seek out gender-specific inclusion in the instrument. This represents both a design flaw and a limited normative understanding of gender among those developing the instrument. Much of the draft text in the different versions is, laudably, focused on the prevention and detection of potential pandemic pathogens and making health infrastructure less vulnerable to acute events. The harms and consequences of the COVID-19 pandemic for member states' populations is not the instrument's core concern in the drafts to date. This aligns with the initial proposal from European Council President Charles Michel that the CA+ take a framework convention format, with the high-level agreements and approaches to be agreed in principle and the finer details worked out in due course. The consequence is that the gendered impacts of health emergencies are being viewed and treated as "secondary" impacts of public health policies rather than the direct result of a failure to consider gender in the preparedness and prevention stages. In light of the lessons learned about preventable gender harms in previous health emergencies, it is alarming that from the outset, negotiations included such limited discussion of gendered impacts and gender-inclusive language.

Second, the limited normative understanding of gender among those developing the instrument may be connected to WHO's role in leading the negotiations. WHO often considers the broader gendered impacts of health emergencies as beyond its mandate, as it is a technical body focused on health rather than broader socioeconomic concerns. According to member-state representa-

tives in Geneva from high-, middle-, and low-income countries, the institutional location of the CA+ was an area of consideration and contestation during the discussions that led to the development of the INB. Some suggested that the instrument would have had more teeth if it were housed in New York rather than Geneva. This would have allowed more New York-based member-state delegations to engage with the treaty process, which might have facilitated whole-of-government engagement rather than engagement solely from health ministries.

This decision to house the negotiations in WHO likely impacted the development and inclusion of gender concerns in the negotiations and, ultimately, the text of the CA+. With its narrow clinical and public health focus, WHO has faced challenges with mainstreaming gender, both in formal policies and in informal working practices.<sup>63</sup> Indeed, the ways we see gender emerging—that is, the almost exclusive focus on women's representation—may demonstrate the influence of the institution's pathology on the development of the instrument text.<sup>64</sup> This could be an important lesson for future technical-based international cooperation instruments.

A third explanation is that negotiators who have promoted the inclusion of language on gender have faced obstacles to their success. It would be expected that states with feminist foreign policies would push for greater consideration of gender and a feminist approach to negotiation of the CA+. We have not been able to view individual or collective state submissions to the INB, but we have talked informally to representatives of states that claim to have feminist or gender-progressive foreign policies. These representatives described undertaking collective efforts to promote articles addressing the reduction of intimate partner violence during pandemics; continued access to sexual, reproductive, and maternal healthcare; and prioritization of access to education for children,

62 Interviews were conducted between July and November 2023 by Sara Davies and Clare Wenham under LSE Ethics Approval "Negotiating a Pandemic Treaty" (Approval No. 83732). We agreed not to identify individuals, member states, or organizations or to quote them directly, even anonymously. This level of concern for anonymity indicates the high politicization of the CA+ process and, as acknowledged in a number of our conversations, the sensitivity of the question of gender-inclusive language in the negotiation process.

63 "As at April 2023, women composed 61% of the WHE [World Health Emergencies] Programme headquarters workforce. However, the percentage of women staff members decreases in relation to increase in grade, with women representing only 38% of the workforce at P-6 and higher categories." WHO, *Public Health Emergencies: Preparedness and Response*, UN Doc. A76/8, May 17, 2023, para. 21.

64 David Scott and Elisabeth Olivius, "Making Gender Known: Assembling Gender Expertise in International Organizations," *International Studies Quarterly* 67, no. 2 (June 2023).

especially girls. However, these efforts did not result in the inclusion of these articles in draft texts.

Delegates put forward a number of reasons for why these articles did not appear. One is that the states involved in promoting this language have relatively little power in INB negotiations. Notably, none of the chairs from each region is a member state that has adopted a feminist foreign policy. Another reason is that there is often tension between ministries of foreign affairs that promote a feminist foreign policy and those who are in the INB negotiations, who are usually from the ministry of health and may not have a feminist approach embedded in their negotiation and working practices. A final explanation is that gender-inclusive language is often considered a “trade-off” in the negotiation discussions. As a result, the language is being removed to ensure that agreement on medical countermeasures does not break down over disagreements on gender-inclusive language.

Fourth, some of the civil society advocates with the most influence in the INB bureau that drafts the texts have promoted a targeted approach to gender. In global health, discussions on gender have been particularly influenced by the Women in Global Health (WiGH) movement, an NGO advocacy group that encourages greater participation and representation of women in the global health space, notably in leadership roles. WiGH has been growing since it was established in 2015 and currently has chapters from over forty-five countries and approximately 100,000 members. This volume of members, combined with the advocacy skills of the organization, has given WiGH considerable influence over policymaking across the global health landscape. The group is now in official relations with WHO via a memorandum of understanding, allowing it to attend and contribute to INB negotiations.<sup>65</sup>

Gender-inclusive language is often considered a “trade-off” in the negotiation discussions. As a result, the language is being removed to ensure that agreement on medical countermeasures does not break down over disagreements on language.

Given the *raison d'être* of the organization, it may not be a coincidence that gender-inclusive language in the drafts focuses on women's representation on international committees on pandemic preparedness and response and on the needs of the healthcare workforce. This is not problematic in and of itself, and these areas should be included in the CA+, but it does raise risks. Policymakers can state that they listened to advocates with high-level access such as WiGH without listening to those advocating for other issues, such as safe and timely access to sexual and reproductive health services and domestic violence services during health emergencies.<sup>66</sup>

In informal discussions, we found that gender advocates in the international health arena have to navigate the terrain carefully, both in terms of resources and politics. Per WHO policy, NGO engagement with the WHA (and WHO) is limited to technical health matters.<sup>67</sup> Moreover, advocates need to make decisions about whether to invest their time and resources in one proposed draft treaty among many gender-related public health matters. Politics is also a major consideration. Gender advocacy remains contentious among member states. Recently, there has been strong member-state opposition in the WHA to gender-inclusive language that had previously been secured in public health statements concerning sexual and reproductive health and human rights. There is growing concern among member states and advocates that demanding gender-inclusive language could lead to the treaty including regressive language that backtracks on previously secured rights. The absence of specific language could therefore be a strategic act of negotiators and advocates to stick to language that emphasizes quotas and representation, which most states can agree on, without opening up other gender-related issues that may be more controversial.<sup>68</sup>

65 WHO, “WHO Signs MoU with Women in Global Health on International Women's Day,” March 10, 2021.

66 We would like to note that there have been additional excellent contributions, including DAWN and the Third World Network Feminists for a People's Vaccine Initiative, which has five papers providing analyses informing their campaign for equitable, accessible, and affordable COVID-19 vaccines, drugs, therapeutics, and equipment. See: DAWN Feminist, “Feminists for a People's Vaccine (FPV),” 2021, available at <https://www.dawnfeminist.org/projects/peoples-vaccine>.

67 WHO, “Handbook for Non-state Actors on Engagement with the World Health Organization,” October 2019.

68 Waylen, “Informal Institutions, Institutional Change, and Gender Equality.”

Fifth, the process may not permit those who are negotiating and drafting the instrument to access the expertise they need to understand the range of gendered impacts of health emergencies and incorporate such concerns into the CA+ drafts. Interviewees suggested that it is hard to convince many healthcare professionals, members of national health bureaucracies, and politicians that gender indicators and impacts need to be included in health security preparedness. While this challenge could potentially be overcome through greater collaboration with other UN entities, such as UN Women and the UN Population Fund (UNFPA), both of which are invited stakeholders, the contributions of these actors are unclear. Moreover, we have observed little to no engagement with women human rights defender organizations and women, peace, and security (WPS) advocates in the CA+ debates, even though pandemics pose significant gendered humanitarian and human rights risks. Member-state representatives noted that the institutional location appears to

impede opportunities to promote the importance of a gender-inclusive CA+ to the negotiators and member-state delegates. Indeed, we heard of little outreach and engagement to persuade the member states that oppose gender-inclusive language. This again speaks to structural constraints within WHO.

Finally, there is a view that the instrument cannot be expected to solve the social, political, and economic inequalities that exist prior to a pandemic. As evident in other negotiating fora, states often trade language on gender for priorities they see as more pressing as negotiations continue.<sup>69</sup> At present, the main issues in the INB negotiations for most member states are vaccine equity and access to countermeasures. Negotiations on these issues will be the priority going forward. However, despite the weakening of language on gender, we do not see strengthening of the language on access to medical countermeasures and vaccine equity.

**Box 3. Specific provisions that could promote gender equity, gender equality, and gender-balanced participation and representation in pandemic prevention, preparedness, response, and recovery<sup>70</sup>**

- Address the disproportionate impact of pandemics on women's health.
- Provide sexual and reproductive health as essential services.
- Establish prevention and protection measures to combat gender-based violence.
- Ensure equal participation of women in decision-making.
- Ensure the provision of continuous education for women and girls.
- Provide socioeconomic support to women.
- Adopt targeted measures for groups of women that are disadvantaged or face discrimination, including older women; women and girls with disabilities; women and girls in poverty (with limited access to cash, water and sanitation, and affordable food); migrant women and girls; refugee and internally displaced women and girls; Indigenous women and girls; lesbian, bisexual, transgender, and intersex women and girls; and women political prisoners, including women human rights defenders.
- Protect women and girls in humanitarian settings and continue implementing the women, peace, and security agenda.
- Strengthen institutional responses, dissemination of information, and data collection to ensure comprehensive age- and sex-disaggregated data.

<sup>69</sup> Laura Wise, "Peace Agreements with a Gender Perspective Are Still an Exception, Not the Rule," LSE Women, Peace and Security Blog, June 18, 2021.

<sup>70</sup> List devised from CEDAW, "Guidance Note on CEDAW and COVID-19," April 2020, available at <https://www.ohchr.org/en/treaty-bodies/covid-19-and-human-rights-treaty-bodies>.

## Conclusion

The INB process to date reflects the structural, power, and normative constraints to achieving gender equity and promoting gender-inclusive language across the peace and security, economic, scientific, and human rights international arenas.<sup>71</sup> Given the collective global experience of the negative gendered impacts of COVID-19 and their incremental recognition at all levels, it is concerning to observe the progressive decline of gender-inclusive references in the six INB draft texts. In our informal discussions with member-state representatives and advocates, it was clear that there is awareness of the need to promote gender-inclusive language, but overcoming the obstacles requires leadership and resourcing.

The question is to what extent the current negotiating text will be taken up by member states. Many state representatives we interviewed suggested that if the text is to be negotiated at the 2024 WHA, it will deviate significantly from the current version. If negotiations do occur, we propose the following recommendations for advocacy and strategic engagement in the lead-up to May 2024:

There is awareness of the need to promote gender-inclusive language, but overcoming the obstacles requires leadership and resourcing.

- **The CA+ should have provisions that address a wider range of the gendered impacts of pandemics.** At a minimum, the CA+ should include specific language such as “Member states and the World Health Organization shall pursue gender equity, gender equality, and gender-balanced participation and representation in their approaches to pandemic prevention, preparedness, response, and recovery.” Securing such human rights language in the instrument, at a minimum, is vital to protect the rights member states have already committed to through the international human rights conventions and covenants deposited with the Office of the High Commissioner for Human Rights (OHCHR), including CEDAW. Beyond this minimum benchmark language, we recommend that member states champion

the specific provisions listed in Box 3.

- **WHO should develop an IHR/CA+ repository.** There is no source available for advocates to keep track of language submissions to the IHR or CA+ processes, including gender-inclusive submissions. We found it difficult to keep track of and locate individual statements made during the recorded INB sessions. Because the INB’s discussions take place behind closed doors, the submissions put forward by member states are not publicly available. This lack of transparency reduces trust in the process, and without knowing member states’ positions and statements, it is difficult to locate and support like-minded states during the process, either formally or informally.
- **INB negotiators should directly engage relevant UN entities to recommend methods of integrating gender into the CA+.** The CA+ may be housed in Geneva, but the whole UN system is affected by pandemics. UN agencies and offices beyond WHO will be required to support countries’ response to pandemics, coordinate the pandemic response, and prevent humanitarian crises. These UN entities can also help bring a gender lens to the prevention and containment of pandemics.
- **States that claim to have a principled stance on gender equity should transparently champion gender-inclusive language.** It is not clear that silence or quiet diplomacy is working in this context. There is an opportunity for states with feminist foreign policies (FFPs) or FFP-minded states to design gender-inclusive language and promote its inclusion in the text in preparation for May 2024. Many interviewed member states expressed a sense of urgency but noted that the treaty text is one of many gender-related priorities. Indeed, gender is one of many priorities within the CA+. A champion state should seize the opportunity to gather like-minded delegations in person to discuss shared priorities, understandings, and “red lines” for the text’s language.

71 Shirin Heidari et al., “A Gender-Responsive Pandemic Accord Is Needed for a Healthier, Equitable Future,” *Lancet* 402, no. 10418 (December 2023).

- **The CA+ should consider and incorporate initial lessons learned from the implementation of the gender-inclusive language in the IHR's Joint External Evaluation (JEE) of states.** Even if the language of the CA+ cannot be made explicitly gender-responsive or gender-transformative by May 2024, the CA+ could be complemented by greater gender inclusion in the practice of health security,

such as through the National Action Plans for Health Security and the JEE. Despite limited references to gender in the IHR, the revised JEE has already offered insight into how to shift norms, bolster institutional commitment to gender inclusivity, and build capacity to address a range of gendered needs across the life cycle of health emergency preparedness, prevention, response, and recovery.



The **INTERNATIONAL PEACE INSTITUTE** (IPI) is an independent, non-profit organization working to strengthen inclusive multilateralism for a more peaceful and sustainable planet. Through its research, convening, and strategic advising, IPI provides innovative recommendations for the United Nations System, member states, regional organizations, civil society, and the private sector. With staff from around the world and a broad range of academic fields, IPI has offices facing United Nations headquarters in New York and an office in Manama.



**777 United Nations Plaza, New York, NY 10017-3521, USA**  
TEL +1-212-687-4300 FAX +1-212-983-8246

**52-52 Harbour House, Bahrain Financial Harbour**  
**P.O. Box 1467, Manama, Bahrain**

[www.ipinst.org](http://www.ipinst.org)