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A gender-responsive Pandemic Accord is needed for a healthier, equitable future

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From HIV and influenza, to Zika virus, Ebola virus disease, and most recently COVID-19, the gender implications of disease outbreaks and the detrimental effects of a lack of a gender lens in the way governments and societies respond to large-scale and contained epidemics are well documented (panel).[1–8] Pandemics create differential vulnerabilities with particular negative implications for women in all their diversities and their health, and further exacerbate long-existing, deep-rooted gender inequalities and social injustices, more severely disadvantaging women in low-income and middle-income countries, women in marginalised communities, and women who are criminalised.[9,10]

Despite widespread advocacy from civil society and women's health advocates,[11–14] governments still fail to apply a systematic intersectional gender lens to the ongoing discussions around epidemic preparedness, control, and response, including in the Pandemic Accord negotiations by WHO member states.[15] Similarly, WHO's proposal for an interim medical countermeasures platform has yet to include any mention of sex or gender, let alone other intersectional factors.[16]

3 years into the COVID-19 pandemic, a massive data gap remains around sex and gender differences in infection rates, hospitalisations, morbidities, and deaths, or the uptake of vaccines or effectiveness of the widely used countermeasures.[17,18] WHO has reiterated its commitment from the World Health Resolution 60.25 in 2007, and its more recent 13th General Programme of Work to systematically collect, analyse, and report sex-disaggregated and gender data and embed them in policy making and programme design.[19,20] Yet, in its 2019 World Health Statistics report, WHO noted

insufficient availability of sex-disaggregated data at a global level for most of the relevant Sustainable Development Goal indicators.[21]

Data on the intersection of gender with other axes of marginalisation, such as racial and ethnic identities, sexual orientation and gender identity, disability, poverty, and migration status, are even more scarce.[10,22] Post-COVID-19 inquiries have also paid scant attention to the effects of intersectionality, leading to a high risk of not embedding gender and equity considerations into future pandemic preparedness or response efforts.

We are at a crucial juncture: a globally binding international health instrument with long-lasting effects on future responses to public health emergencies is being negotiated in the midst of a polarising global health environment, where sexual and reproductive health and rights are under siege and women's rights and those of people of diverse sexual orientation and gender identities are infringed and retracted. It is crucial that global health stakeholders and especially governments take concrete measures now to ensure that gender-related concerns will not fall by the wayside in future pandemic preparedness and response, including in research and development efforts for medical countermeasures.[23]

There is irrefutable evidence of the positive and sustainable effect of adopting a gender, equity, and

Panel: **Examples of gender implications and impacts in outbreak and pandemic response**

Exposure to pathogens and severity of disease

- Exposure to pathogens can be influenced by sex and gender, due to biological factors as well as harmful gender norms, gender-based violence, and gender inequality.
- Women often carry heightened caring roles for children and family members, including sick family members, and as such, can face greater exposure to pathogens.
- Women face a greater share of the disease burden (eg, Zika virus causing fetal abnormalities and miscarriage).
- The omission of pregnant women from clinical trials means they either do not receive adequate evidence-based care or receive it late.
- Women are over-represented in health care (paid and unpaid), particularly as front-line workers and in service jobs, which increases their risk of exposure.
- Manifestation, presentation, and progression of disease, treatment response or experience of adverse events can vary across sexes due to biological factors.

Access to prevention and treatment information and services

- Differential access to information and services concerning disease prevention, treatment, and management is influenced by various factors, such as lower health literacy, financial barriers, limited decision-making power among women, and traditional notions of masculinity among men, all of which impact health behaviours.
- Personal protective equipment (PPE) with ill-fitting designs raises infection risk for women and can create unhealthy conditions, exacerbated by shortages or challenges in accessing facilities, such as toilets, or changing sanitary napkins due to PPE disposal requirements.

Violence, mental health, and other health implications

- Crises and confinements increase the risk of violence against women and people of diverse sexual orientation and gender identities. Fear of stigma in the community and in health-care facilities can exacerbate women's exposure to violence as with front-line health workers.
- Crises frequently disrupt the supply and access to sexual and reproductive health services.
- Gendered roles often place the responsibility of providing emotional support and care within workplaces on women during crises, leading to a higher risk of mental health issues. This burden is especially pronounced for women in general, and health-care workers in particular, who experience significant mental health challenges during pandemics.

Economic implications

- Individuals who work in the informal economy, often women and migrants, frequently lack paid sick leave, social coverage, and may face limited childcare options when schools and daycare centres close. Consequently, these groups might take greater risks to sustain their income, potentially increasing their exposure to pathogens.

Data and evidence

- Substantial data gaps exist regarding potential sex-based and gender-based differences in infection rates, disease manifestation and progression, hospitalisations, mortality, vaccination, and related factors.

Countermeasures

- Lack of sex and gender considerations in research and innovation, including design, data collection, analysis, and reporting, hampers the development of effective and equitable products and interventions.
- The absence of sex-based and gender-based analysis and gender-insensitive evidence leads to policies and actions that overlook important gender and equity considerations.

Decision-making power

- Restricted decision-making power among women detrimentally impacts their access to sexual and reproductive health care and rights, especially during epidemics.
- The under-representation of diverse women in decision-making bodies, both nationally and internationally, leads to a lack of emphasis on gender-specific responses.

human rights lens to health and development, and the knowledge and experience to do so.[24] Studies show how addressing gender equity in health care, including improving access to sexual and reproductive health services, can lead to a considerable reduction in maternal mortality rates.[25,26] Other reports emphasise how collecting and analysing sex-disaggregated and gender data can help identify disparities in access to education, health care, and other services that are crucial for overall development.[27–30] Ignoring sex and gender differences in study designs to assess the safety and efficacy of medical products can lead to subsequent harm.[31] But is there political will to truly learn the lessons from past epidemics, and recognise the crucial need and value of embedding gender as an integral and cross-cutting theme in the Pandemic Accord and the interim medical countermeasures platform?

For the **Consensus Statement** see https://www.gendro.org/consensus-statement

In 2022, in a Consensus Statement nearly 30 civil society organisations and academic institutions called on WHO member states to recognise and reaffirm their commitments and obligations to equitable and gender-responsive prevention, preparedness, and pandemic response.[11] A year after the publication of the Consensus Statement and after successful convening with representatives from member states,[32] the lack of due attention to any of the recommendations in the ongoing discussions is alarming. The following key areas have been particularly overlooked in the current discussions, and have yet to be duly incorporated in the most recent draft of the Pandemic Accord.

First and foremost, binding commitments are needed for generating sex-disaggregated data and gender-responsive evidence to guide pandemic preparedness, control, and response. Investment into data systems and research processes that enable systematic collection, analysis, and reporting of gender-sensitive evidence is imperative. These include (but are not limited to) designing studies to also collect, analyse, and report data disaggregated by sex and age as a minimum when performing epidemiological studies, research and development for countermeasures, and research on access to services and socioeconomical effects of pandemics.[23,33] Specifically, the inclusion of pregnant and lactating women in research and development for diagnostics, vaccines, and therapeutics and implementation research should be encouraged and adequately supported.[31,34] Equally important is to ensure that this evidence is reported and used to inform development of gender-responsive policies, strategies, and interventions.[33]

Second, strategies, policies, and response plans should be inclusive, equitable, account for gender dimensions, and align with human rights standards. Meaningful efforts should be scaled up to prevent discrimination and violation of rights of marginalised groups (particularly women), people of diverse sexual orientation and gender identity, adolescents, sex workers, people who use drugs, people living with HIV, migrants and refugees, people in a situation of disability, people in constrained settings and prisons, and older people. We also recommend explicit language guaranteeing uninterrupted access to sexual and reproductive health services, and prevention of and adequate response to gender-based violence, including for health-care workers. It is crucial that new policies, such as research and development or industrial policies, economic recovery plans, or mitigation strategies, are effectively designed to be gender transformative, address harmful gender norms, and strive to eliminate the root cause of gender inequality. It is imperative that these policies account for the multitude of gendered social, economic, and human rights repercussions and health effects of pandemics.

Finally, meaningful participation of diverse groups in the negotiations and development of the Pandemic Accord is imperative. For any measures to be effective, they need to result from an inclusive, consultative, transparent, and participatory decision-making process that considers the diverse needs and perspectives of different groups when shaping a global instrument that will guide future pandemic preparedness, control, and response.

The Pandemic Accord and interim medical countermeasures platform hold unique and transformative potential for a future promising a more equitable global health agenda. Aligned with the promising adoptions of feminist foreign policies by several countries, similar measures are needed to create an enabling environment for future feminist global health policies.[35] Today, the global community stands at an open window of opportunity—a chance to show future generations that lessons learnt from the past have inspired bold steps to enshrine gender equity to shape a healthier and fairer world for all.

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