

# A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies

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Globally, gender remains a key determinant of health.<sup>1</sup> Alcohol consumption, violence, deaths related to road injuries and sexually transmitted infections may be accounted for by the intersecting gendered inequalities and gender norms that determine the health of both men and women. Any attempt to address the gendered dimensions of health faces complex challenges that go beyond sex-specific health needs based on biological difference to understandings of health as socially and economically determined.<sup>2</sup>

The diplomatic attention given to health issues has grown dramatically in the past 20 years.<sup>3</sup> Accompanying this growing interest has been a marked increase in investment in development assistance for health—from US\$5.7 billion in 1990 to US\$28.2 billion in 2010<sup>4</sup>—alongside new and well-funded investment from private philanthropic organizations.<sup>5</sup> Such economic and political investments have brought undeniable benefits: life expectancy at birth increased by 10.7 years for males and 12.6 years for females between 1970 and 2010, while between 1970 and 2013 childhood (under age five) mortality fell by 64 per cent, from 17.6 million deaths to 6.3 million a year. The proportion of births attended by skilled health personnel in developing countries rose from 56 to 68 per cent between 1990 and 2012.<sup>6</sup>

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<sup>1</sup> Sarah Hawkes and Kent Buse, 'Gender and global health: evidence, policy and inconvenient truths', *Lancet* 381: 9879, 2013, pp. 1783–7.

<sup>2</sup> Hawkes and Buse, 'Gender and global health: evidence, policy and inconvenient truths.'

<sup>3</sup> Ilona Kickbusch, Gaudenz Silberschmidt and Paulo Buss, 'Global health diplomacy: the need for new perspectives, strategic approaches and skills in global health', *Bulletin of the World Health Organization* 85: 3, 2007, pp. 230–32; Ronald Labonté and Michelle L. Gagnon, 'Framing health and foreign policy: lessons for global health diplomacy', *Globalization and Health* 6: 14, 2010, pp. 1–19; Jeremy Youde, 'High politics, low politics, and global health', *Global Security Studies* 1: 2, 2016, pp. 157–70.

<sup>4</sup> Nathan Blanchet, Milan Thomas, Rifat Atun, Dean Jamison, Felicia Knaul and Robert Hecht, 'Global collective action in health: the WDR+20 landscape of core and supportive functions', working paper for The Lancet Commission on Investing in Health, July 2013, <http://globalhealth2035.org/sites/default/files/working-papers/global-collective-action-in-health.pdf>. (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 2 Aug. 2016.)

<sup>5</sup> Devi Sridhar, 'Who sets the global health research agenda? The challenge of multi-bi financing', *PLoS Medicine* 9: 9, 2012, e1001312, DOI:10.1371/journal.pmed.1001312.

<sup>6</sup> Institute for Health Metrics and Evaluation, 'Percent decline in mortality rate, 1970–2010', <http://www.healthdata.org/infographic/percent-decline-mortality-rate-1970-2010>; Haidong Wang, Chelsea A. Liddell,

However, the gains resulting from this overall rise in economic investment in health have varied widely among regions, states and individuals.<sup>7</sup> In particular, persistent patterns of gender inequality are highlighted by the health burdens borne by women. Four out of every five deaths of children under age five continue to occur in sub-Saharan Africa and southern Asia. Every year 300,000 women die from causes related to pregnancy and childbirth, and 6 million sustain serious injuries from childbirth, such as obstetric fistula. Women are repeatedly risking their lives to have healthy children who survive to adulthood. Women are 14 times more likely to die as a result of childbirth in a developing than in a developed country, and 95 per cent of deaths of adolescent girls as a result of childbirth occur in developing countries; indeed, pregnancy/childbirth remains the leading cause of death for adolescent girls in Africa and south Asia.<sup>8</sup> It is young women in these regions, and their partners, who continue to report an unmet need for sexual and reproductive health services to enable them to plan pregnancies and prevent sexually transmitted infection. The fifth Millennium Development Goal (MDG 5) was to reduce maternal mortality by 75 per cent; but by 2015 only a 45 per cent reduction had been achieved, while universal access to reproductive health and family planning (also included in MDG 5) had not been achieved either.<sup>9</sup> As Ely Yamin and Boulanger have recently argued, MDG 5 promoted a limited set of indicators

ignoring complex power relations, human rights principles, and established international legal frameworks, and [excluded] certain SRHR [sexual and reproductive health and rights] issues. Efforts to address the root causes of maternal mortality, let alone broader aspects of SRHR and gender inequality, were lost.<sup>10</sup>

Similar criticism of the narrow conceptualization of women's health in terms of reproductive rather than sexual and reproductive health has been levelled, for example, at the target-centric focus of disease eradication programmes for HIV/AIDS and even of mother and child care.<sup>11</sup> Within this narrow framing, women

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Matthew M. Coates, Meghan D. Mooney, Carly E. Levitz, Austin E. Schumacher et al., 'Global, regional, and national levels of neo-natal, infant, and under-5 mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013', *Lancet* 384: 9947, 2014, pp. 957–79, DOI: 10.1016/S0140-6736(14)60497-9; UN Population Fund (UNFPA), *Accelerating progress towards MDG 5: 3* (New York, 2014), [https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Accelerating%20Progress%20to%20MDG%205%20Report%202014\\_o.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Accelerating%20Progress%20to%20MDG%205%20Report%202014_o.pdf).

<sup>7</sup> Suerie Moon and Oluwatosin Omole, *Development assistance for health: critiques and proposals for change*, Centre on Global Health Security working group papers, Working Group on Financing paper 1 (London: Chatham House, 2013), pp. 7–8, [https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0413\\_devtassistancehealth.pdf](https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0413_devtassistancehealth.pdf).

<sup>8</sup> UNFPA, *Universal access to reproductive health: progress and challenges* (New York, Jan. 2016), [http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA\\_Reproductive\\_Paper\\_20160120\\_online.pdf](http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf).

<sup>9</sup> We note that the language used on reproductive health and family planning in MDG 5 is not the same rights language used in General Committee Recommendations 12 and 24 of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and does not refer to the full range of services and access to them set out under the right to sexual and reproductive health in those recommendations.

<sup>10</sup> Alicia Ely Yamin and Vanessa M. Boulanger, 'Why global goals and indicators matter: the experience of sexual and reproductive health and rights in the Millennium Development Goals', *Journal of Human Development and Capabilities* 15: 2–3, 2014, pp. 218–31 at p. 219.

<sup>11</sup> Emma-Louise Anderson, 'Infectious women', *International Feminist Journal of Politics* 14: 2, 2012, pp. 267–87; Hakan Seckinelgin, Joseph Bigirimwami and Jill Morris, 'Conflict and gender: the implications of the Burundian conflict on HIV/AIDS risks', *Conflict, Security and Development* 11: 1, 2011, pp. 55–77; Colleen O'Manique and Sandra J. MacLean, 'Pathways among human security, gender, and HIV/AIDS in sub-Saharan Africa',

are seen as either care-givers or mothers when it comes to health-care access and rights. Provision tends to focus on the 'immediate' health-care problem, while the status of gendered inequality that underpins the prevailing unhealthy conditions is considered 'beyond' the capacity of many public health interventions.<sup>12</sup>

This persistent failure of global health initiatives to decouple women's health from sexual reproduction (that is, the priority accorded in respect of women's health to ensuring healthy childbirth, as part of an overriding focus on reproduction) has led to the promotion of multiple health programmes that continually fail to address women's marginalization in society and the effect this has on their health.<sup>13</sup> Ely Yamin and Boulanger argue that, as a consequence, health goals, targets and indicators have failed to adopt a 'transformative development agenda based upon realizing human rights for all', and that any future health goals and targets must adopt

a robust narrative of social transformation, which incorporates aspects of progress that are not measurable, but are critical to changing the social relations that impede some people—and women in particular—from escaping poverty, realizing their rights, and living lives of dignity.<sup>14</sup>

In this article we explore the extent to which this broader criticism about the gender blindness of global health governance applies to public health emergencies. Specifically, to what extent do international advisories during health emergencies acknowledge the impact of gender inequalities existing within these health emergencies? In the space of 18 months, the Ebola outbreak in Guinea, Liberia and Sierra Leone led to a 75 per cent increase in maternal mortality across the three countries, while untreated malaria cases may have risen up to 45 per cent in Guinea, 88 per cent in Sierra Leone and 140 per cent in Liberia.<sup>15</sup> Sophie Harman has argued that although women were visibly affected by the outbreak, they were 'invisible' at every point in the international response to the outbreak, from data disaggregation to the promotion of gender-informed responses to the crisis:

The 2014 Ebola outbreak provides an acute case study on conspicuous invisibility, where issues of women and gender have been invisible in both the emergency response and in long-term planning on health system resilience. The short- and long-term responses to Ebola show that the male bias is very much present in thinking about disease outbreaks: there is little to no discussion about gendered impacts of the disease in framing the crisis, data disaggregated by sex were late in coming, and no strategy includes gender indicators.<sup>16</sup>

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*Canadian Journal of African Studies* 44: 3, 2010, pp. 457–78; Rebecca J. Cook and Bernard M. Dickens, 'Ethical and legal issues in reproductive health: human rights to safe motherhood', *International Journal of Gynecology and Obstetrics*, vol. 76, 2002, pp. 225–31.

<sup>12</sup> Amanda D. Watson and Corinne L. Mason, 'Power of the first hour', *International Feminist Journal of Politics* 17: 4, 2015, pp. 573–94 at p. 589. See also Sophie Harman, 'The dual feminisation of HIV/AIDS', *Globalizations* 8: 2, 2011, pp. 213–28.

<sup>13</sup> Bergen Cooper and Cailin Crockett, 'Gender-based violence and HIV across the life course: adopting a sexual rights framework to include older women', *Reproductive Health Matters* 23: 46, 2015, pp. 56–61.

<sup>14</sup> Ely Yamin and Boulanger, 'Why global goals and indicators matter', p. 228.

<sup>15</sup> Zoe Mullan, 'The cost of Ebola', editorial, *The Lancet Global Health*, 9 July 2015, [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(15\)00092-3.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)00092-3.pdf).

<sup>16</sup> Sophie Harman, 'Ebola, gender and conspicuously invisible women in global health governance', *Third World Quarterly* 37: 3, 2016, pp. 524–41 at p. 535.

We examine Harman's argument in detail to compare the international emergency responses activated in the wake of the Ebola and Zika outbreaks. What we find particularly troubling in both cases is the paucity of engagement with human rights language and the diverse backgrounds of women in these locations of crisis when women-specific advice is being issued. We find that the lessons that should have been learnt from the Ebola experience have not been applied in the Zika outbreak and that there remains a disconnect between the international public health advice being issued and the experience of pervasive structural gender inequalities among those experiencing the crises. In both cases we find responses at the outbreak of the crisis, such as women asserting reproductive autonomy, giving way to what Watson and Mason call the 'tyranny of the urgent', particularly prevalent in health programming concerning women,<sup>17</sup> which puts aside for 'later' the structural issues—in this case, whether women have economic, social or regulatory options to exercise the autonomy presumed in the international advice. The problem in the case of both Ebola and Zika has been that leaving structural gender inequalities out of the crisis response has further compounded those inequalities.

Although this article focuses on gendered dimensions of global health for women exacerbated by complex emergencies, in writing about gender we recognize and acknowledge the multiplicity of cross-cutting factors that characterize women's lives. Accordingly, in analysing gender we also acknowledge the interdependence of age, disability, race, ethnicity, sexuality and socio-economic status in shaping the lived experience and health outcomes of women and girls, as well as men and boys. In the case of both Ebola and Zika, women of reproductive age with few socio-economic resources in low- to middle-income countries have been particularly vulnerable to the broader impacts of these emergencies.

## Gender and complex emergencies

A complex emergency is

a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country program.<sup>18</sup>

The emergency context may be caused by an outbreak of infectious disease,<sup>19</sup> a

<sup>17</sup> Watson and Mason, 'Power of the first hour', p. 577.

<sup>18</sup> UN Office for the Coordination of Humanitarian Affairs (OCHA), *UN OCHA orientation handbook on complex emergencies* (Geneva, 1999), [http://reliefweb.int/sites/reliefweb.int/files/resources/3D153DA3049B322AC1256C30002A9C24-ocha\\_ocha\\_orientation\\_handbook\\_on\\_.html](http://reliefweb.int/sites/reliefweb.int/files/resources/3D153DA3049B322AC1256C30002A9C24-ocha_ocha_orientation_handbook_on_.html).

<sup>19</sup> An emergency committee convened by the WHO Director-General under the International Health Regulations (IHR) of 2005 may declare an outbreak a 'public health emergency of international concern' (PHEIC). In August 2014 the WHO declared the outbreak of Ebola virus disease in west Africa to be a PHEIC: 'WHO statement on the first meeting of the International Health Regulations Emergency Committee regarding the 2014 Ebola outbreak in west Africa', 8 Aug. 2014, [www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/](http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/). The Zika outbreak was declared a PHEIC by the WHO on 1 Feb. 2016: 'WHO statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neo-natal malformations', 1 Feb. 2016, [www.who.int/mediacentre/news/statements/2016/1st-emergency-committee-zika/en/](http://www.who.int/mediacentre/news/statements/2016/1st-emergency-committee-zika/en/).

natural disaster such as a flood or earthquake, or a humanitarian crisis caused by large-scale displacement of people as a result of conflict. The social disruption caused by the emergency may heighten existing social and economic vulnerabilities, including for women and children, the elderly and for people with disabilities.<sup>20</sup>

What are the unique conditions women and girls face in the aftermath of complex emergencies?<sup>21</sup> Fionnuala Ní Aoláin points out that: 'The combination of pre-existing biological and socio-cultural factors means that while the health status of populations as a whole deteriorates during complex humanitarian crisis, women and children are especially vulnerable.'<sup>22</sup> Domestic violence, as well as broader patterns of sexualized violence against women and girls, have been reported in humanitarian emergency and post-disaster situations.<sup>23</sup> Displaced women and girls face a higher risk of being subjected to forced marriages, domestic violence,<sup>24</sup> and constrained access to resources such as food. In addition, in emergency contexts there may be difficulties in accessing contraceptives,<sup>25</sup> lack of access to obstetric care, and increased neo-natal death rates. In conditions where women face more risk of violence against their bodies, it is an obvious imperative to prioritize gender protection procedures as well as sexual and reproductive health in emergency response planning.<sup>26</sup>

Lessons have been drawn from past crises, but there are still difficulties in addressing how they intersect.<sup>27</sup> The vulnerabilities of women and girls during complex emergencies are equally present during a public health emergency but are relatively underexamined in these circumstances compared to the study of gender, health and inequality during natural disasters. In the remainder of this article, we examine two recently declared international public health emergencies: the Ebola and Zika outbreaks.<sup>28</sup> After examining the pre-existing relationships between gender, health and inequalities, and the effects of these relationships during the crises, we then examine the extent to which these pre-existing inequalities were factored into

<sup>20</sup> Sharona Hoffman, 'Preparing for disaster: protecting the most vulnerable in emergencies', *University of California at Davis Law Review* 42: 5, 2009, pp. 1491–547.

<sup>21</sup> WHO, *Gender and health in disasters* (Geneva, 2002), [http://apps.who.int/gender/other\\_health/en/genderdisasters.pdf](http://apps.who.int/gender/other_health/en/genderdisasters.pdf).

<sup>22</sup> Fionnuala Ní Aoláin, 'Women, vulnerability, and humanitarian emergencies', *Michigan Journal of Gender and Law* 18: 1, 2011, pp. 1–23 at p. 8.

<sup>23</sup> Aoláin, 'Women, vulnerability, and humanitarian emergencies', p. 12; Claudia Felten-Biermann, 'Gender and natural disaster: sexualised violence and the tsunamis', *Development* 49: 3, 2006, pp. 82–6; Sarah Fisher, 'Violence against women and natural disasters: findings from post-tsunami Sri Lanka', *Violence against Women* 16: 8, 2010, pp. 902–18.

<sup>24</sup> Felten-Biermann, 'Gender and natural disaster'; Fisher, 'Violence against women and natural disasters'.

<sup>25</sup> Ophra Leyser-Whalen, Mahbubur Rahman and Abbey B. Berenson, 'Natural and social disasters: racial inequality in access to contraceptives after Hurricane Ike', *Journal of Women's Health* 20: 12, 2011, pp. 1861–6.

<sup>26</sup> WHO, 'Integrating sexual and reproductive health into health emergency and disaster risk management', policy brief (Geneva, 2012), [http://www.who.int/hac/techguidance/preparedness/SRH\\_policybrief/en/](http://www.who.int/hac/techguidance/preparedness/SRH_policybrief/en/).

<sup>27</sup> Olena Hankivsky, 'Women's health, men's health, and gender and health: implications of intersectionality', *Social Science and Medicine* 74: 11, 2012, pp. 1712–20.

<sup>28</sup> For discussion of the PHEIC declarations in respect of the Ebola and Zika outbreaks, see James G. Hodge, 'Global and domestic legal preparedness and response: 2014 Ebola outbreak', *Disaster Medicine and Public Health Preparedness* 9: 1, 2015, pp. 47–50; Colin McInnes, 'WHO's next? Changing authority in global health governance after Ebola', *International Affairs* 96: 6, Nov. 2015, pp. 1299–316; Lawrence O. Gostin, 'The WHO has not done enough to fight Zika', *Time*, 2 Feb. 2016, <http://time.com/4204079/who-zika/>.

the international advice given for both emergencies. In both cases, we find very few instances where gender inequality and gender discrimination were factored into the international response and the measures suggested at the initial stages of the outbreaks. Despite pervasive patterns of gender discrimination in the affected communities, there were too few occasions where international advice appeared to take account of diminished rights and right to access health care when promoting the choices that women, in particular, had to protect themselves and their families.<sup>29</sup> We argue that future institutional responses to global public health emergencies must consider, at the earliest stages of the outbreak, the relationships between public health measures, human rights and gender equality to ensure that populations have access to the necessary care and containment provisions and measures.

## Gender and Ebola

The Ebola outbreak in west Africa of 2014–15 highlighted the consequences of failing to adopt a gender perspective on infectious diseases. It was by far the largest outbreak to date of this disease. From the first reported case in Guinea in March 2014 (the index case was infected in December 2013),<sup>30</sup> by 27 March 2016 there had been 28,646 cases of Ebola virus disease worldwide, with 11,323 deaths.<sup>31</sup>

The crisis demonstrated how easily infectious diseases overwhelm fragile health systems in low-resource countries. Guinea, Liberia and Sierra Leone, all among the poorest countries on Earth,<sup>32</sup> bore the overwhelming burden of the outbreak. Of the 28,646 cases of Ebola virus disease recorded by 27 March 2016, 28,610 occurred in these three countries.<sup>33</sup> Furthermore, these countries were recovering from highly complex emergencies that had arisen as recently as the previous decade. Liberia had been hosting a UN peacekeeping mission, UNMIL,<sup>34</sup> since the end of its civil war in 2006, and in August 2014 the UN Special Envoy to Liberia noted the destabilizing impact of the Ebola outbreak on the already fragile political and security sectors.<sup>35</sup> Guinea was still experiencing intense phases of violence and political instability after a violent coup in 2009.<sup>36</sup> Of the three countries, Sierra Leone had experienced the longest period of stability, its decade-long civil war having ended in 2002. This relatively recent history of violence and political

<sup>29</sup> Harman, 'Ebola, gender and conspicuously invisible women'.

<sup>30</sup> UN, *Report of the High-level Panel on the Global Response to Health Crises*, 25 Jan. 2016, p. 21, [www.un.org/News/dh/infocus/HLP/2016-02-05\\_Final\\_Report\\_Global\\_Response\\_to\\_Health\\_Crises.pdf](http://www.un.org/News/dh/infocus/HLP/2016-02-05_Final_Report_Global_Response_to_Health_Crises.pdf).

<sup>31</sup> WHO, *Ebola: situation report 30 March 2016*, Geneva, <http://apps.who.int/ebola/current-situation/ebola-situation-report-30-march-2016>.

<sup>32</sup> See World Bank, 'Poverty headcount ratio at \$1.90 a day (2011 PPP) (% of population)', 2015, <http://data.worldbank.org/indicator/SI.POV.DDAY/countries?display=map>.

<sup>33</sup> As at 27 March 2016, in Guinea there have been 3,811 cases with 2,543 deaths; in Liberia there have been 10,675 cases with 4,809 deaths; and in Sierra Leone there have been 14,124 cases with 3,956 deaths: WHO, *Ebola: situation report 30 March 2016*.

<sup>34</sup> Sara E. Davies and Simon Rushton, 'Public health emergencies: a new peacekeeping mission? Insights from UNMIL's role in the Liberia Ebola outbreak', *Third World Quarterly* 37: 3, 2016, pp. 419–35.

<sup>35</sup> UN Security Council, *Twenty-eighth progress report of the Secretary-General on the United Nations Mission in Liberia*, S/2014/598 (New York, 15 Aug. 2014).

<sup>36</sup> International Crisis Group, 'Statement on Ebola and conflict in west Africa', 23 Sept. 2014, Belgium. <http://www.crisisgroup.org/africa/west-africa/statement-ebola-and-conflict-west-africa>.

instability in each country contributed to a high baseline disease burden among the population even before the outbreak. There has been considerable debate and reflection on the failure of the international community to realize the particular vulnerability of these countries to the outbreak of Ebola, and to appreciate what was required to effectively curb the spread of the disease at an earlier stage.<sup>37</sup>

One particular concern has been the ‘feminization of the EVD [Ebola Virus Disease]’ during the outbreak.<sup>38</sup> Existing gendered roles of women and girls in west Africa posed Ebola-specific risks related to the disease itself and broader gender-related risks arising from the social upheaval caused by Ebola. In terms of Ebola-specific risks, women’s traditional roles as carers (both within the family and as health-care workers), and as the people who traditionally prepare bodies for burial, placed them at particular risk of exposure to Ebola.<sup>39</sup> Although there is limited information on the effect of Ebola on pregnancy, the evidence available suggests that pregnant women with Ebola are at increased risk of spontaneous abortion, pregnancy-related haemorrhage, stillbirth, death and neo-natal mortality.<sup>40</sup> Preliminary results also indicate that Ebola can persist in the semen of male survivors for some months after infection,<sup>41</sup> thereby posing additional gender-related risk of infection to women in the context of gender-related powerlessness in negotiating safe and consensual sex.

By 4 November 2015, in the three West African countries most affected by Ebola, there had been a total of 8,703 cases of Ebola in women compared to 8,333 cases in men.<sup>42</sup> The impact of Ebola on the health and well-being of women and girls went beyond the risk of contracting the disease itself. The outbreak had a huge impact on the economies of affected countries. The United Nations Development Programme has estimated that in 2014 economic growth in Guinea declined from 4.5 per cent to 1.6 per cent, in Liberia from 5.9 per cent to 1.8 per cent, and in Sierra Leone from 11.4 per cent to 7.4 per cent.<sup>43</sup> The budget deficits

<sup>37</sup> Lawrence O. Gostin and Eric A. Friedman, ‘A retrospective and prospective analysis of the west African Ebola virus disease epidemic: robust national health systems at the foundation and an empowered WHO at the apex’, *Lancet* 385: 9980, 2015, pp. 1902–909; Bill Gates, ‘The next epidemic: lessons from Ebola’, *New England Journal of Medicine* 372: 15, 2015, pp. 1381–4.

<sup>38</sup> United Nations Development Programme (UNDP), *Socio-economic impact of Ebola virus disease in west African countries* (New York, 2015), p. iii, <http://www.africa.undp.org/content/dam/rba/docs/Reports/ebola-west-africa.pdf>.

<sup>39</sup> UN Women Inter-Agency Standing Committee, Reference Group for Gender in Humanitarian Action, ‘Humanitarian crisis in west Africa (Ebola) gender alert: February 2015’, <http://www.unwomen.org/~media/headquarters/attachments/sections/library/publications/2015/isc%20gender%20reference%20group%20-%20gender%20alert%20west%20africa%20ebola%20%20-%20february%202015.pdf?v=1&d=20150204T233706>; Clara Menéndez, Anna Lucas, Khátia Munguambe and Ana Langer, ‘Ebola crisis: the unequal impact on women and children’s health’, *Lancet Global Health* 3: 3, 2015, e130.

<sup>40</sup> A. Kitching, A. Walsh and D. Morgan, ‘Ebola in pregnancy: risk and clinical outcomes’, *British Journal of Obstetrics and Gynaecology* 122: 3, 2015, p. 287.

<sup>41</sup> Gibrilla F. Deen et al., ‘Ebola RNA persistence in semen of Ebola virus disease survivors: preliminary report’, *New England Journal of Medicine*, published online 14 Oct. 2015, DOI: 10.1056/NEJMoa1511410; Suzanne E. Mate et al., ‘Molecular evidence of sexual transmission of Ebola virus disease’, *New England Journal of Medicine* 373: 25, 2015, pp. 2448–454.

<sup>42</sup> WHO, *Ebola: situation report 4 November 2015*, <http://apps.who.int/ebola/current-situation/ebola-situation-report-4-November-2015>, table 2.

<sup>43</sup> UNDP, *Getting beyond zero: early recovery and resilience support framework: Guinea, Liberia and Sierra Leone, May 2015 to October 2016* (Nairobi, 2015), p. 5.

in these three countries are estimated to have increased by US\$500 million in 2014 as a result of reduced economic activity, lower tax income and increased spending to respond to the crisis.<sup>44</sup> This economic impact of Ebola may have had a disproportionate impact on women,<sup>45</sup> who comprise much of the smallholder farming sector.<sup>46</sup> Women make up 70 per cent of the cross-border traders in the Mano River Union region, and the closure of borders due to Ebola restricted their access to markets.<sup>47</sup> Ebola has also disrupted trade within countries. In Liberia, for example, women comprise 85 per cent of daily market traders.<sup>48</sup> Delay in delivery of goods owing to travel restrictions, and increases in transport fares, have adversely affected the businesses of these women and their economic security.<sup>49</sup>

Closure of schools in response to Ebola has disrupted the education of girls, already lagging behind that of boys,<sup>50</sup> while school closure has also been associated with an increase in adolescent pregnancies.<sup>51</sup> Disruption to the health systems of affected countries and restrictions on movement of people have made it difficult for women to access pre- and post-natal care and increased the likelihood of their having unassisted deliveries,<sup>52</sup> resulting in a situation where 'pregnant women are faced with the double fear of dying from Ebola and during childbirth'.<sup>53</sup> The disruption to health systems also had broader impacts: one study of malaria case management in Guinea estimated that 74,000 fewer malaria cases were seen and treated in 2014 compared to 2013 owing to the impact of Ebola,<sup>54</sup> and a modelling exercise estimated that in 2014 up to 10,900 additional deaths from malaria in the three west African countries most affected by Ebola were attributable to the disruption to health systems.<sup>55</sup> Ebola also had a disproportionate impact on health-care workers,<sup>56</sup> with consequent longer-term impacts in countries already under-resourced in terms of health-care personnel. It has been estimated that an additional

<sup>44</sup> UNDP, *Getting beyond zero*, at p. 5.

<sup>45</sup> UNDP, *Recovering from the Ebola crisis: submitted by the United Nations, the World Bank, European Union and African Development Bank as a contribution to the formulation of national Ebola recovery strategies in Liberia, Sierra Leone and Guinea* (Nairobi, 2015), p. 12.

<sup>46</sup> UN Women Inter-Agency Standing Committee, Reference Group for Gender in Humanitarian Action, 'Humanitarian crisis in west Africa (Ebola) gender alert: February 2015'.

<sup>47</sup> UN Women Inter-Agency Standing Committee, Reference Group for Gender in Humanitarian Action, 'Humanitarian crisis in west Africa (Ebola) gender alert: February 2015'. The Mano River Union comprises Côte d'Ivoire, Guinea, Liberia and Sierra Leone.

<sup>48</sup> UN Women, 'In Liberia, mobile banking to help Ebola-affected women traders', 14 Nov. 2014, <http://www.unwomen.org/en/news/stories/2014/11/in-liberia-mobile-banking-to-help-ebola-affected-women-traders>.

<sup>49</sup> UN Women, 'In Liberia, mobile banking to help Ebola-affected women traders'.

<sup>50</sup> UN Women Inter-Agency Standing Committee, Reference Group for Gender in Humanitarian Action, 'Humanitarian crisis in west Africa (Ebola) gender alert: February 2015'.

<sup>51</sup> UNDP, *Recovering from the Ebola crisis*, p. 6.

<sup>52</sup> UN Women Inter-Agency Standing Committee, Reference Group for Gender in Humanitarian Action, 'Humanitarian crisis in west Africa (Ebola) gender alert: February 2015'.

<sup>53</sup> Babatunde Osotimehin, 'Urgent needs and participation of women must be prioritized in the Ebola response', *Reproductive Health Matters* 22: 4, 2014, p. 163.

<sup>54</sup> Mateusz M. Plucinski et al., 'Effect of the Ebola-virus-disease epidemic on malaria case management in Guinea, 2014: a cross-sectional survey of health facilities', *Lancet Infectious Diseases* 15: 9, 2015, pp. 1017–23.

<sup>55</sup> Patrick G. T. Walker, Michael T. White, Jamie T. Griffin, Alison Reynolds, Neil M. Ferguson and Azra C. Ghani, 'Malaria morbidity and mortality in Ebola-affected countries caused by decreased health care capacity, and the potential effect of mitigation strategies: a modelling analysis', *Lancet Infectious Diseases* 15: 7, 2015, pp. 825–32. Also see Mary J. Hamel and Laurence Slutsker, 'Ebola: the hidden toll', *Lancet Infectious Diseases* 15: 7, 2015, pp. 756–7.

<sup>56</sup> WHO, *Health care worker Ebola infections in Guinea, Liberia and Sierra Leone: a preliminary report*, 21 May 2015, <http://www.who.int/csr/resources/publications/ebola/health-worker-infections/en/>.

4,022 women will die annually in childbirth in Guinea, Liberia and Sierra Leone as a result of the Ebola-related deaths of health-care workers in these countries.<sup>57</sup>

In all these ways, women and girls have been at disproportionate risk from Ebola. They have also been central to the recovery efforts. The UN Inter-Agency Standing Committee of the Reference Group for Gender in Humanitarian Action noted that ‘the role of women and girls in the post-crisis recovery will be essential to facilitate an expedited normalization of the social and economic landscape’.<sup>58</sup> The same report noted that there were some unexpected benefits from the Ebola outbreak: UN Women reported ‘anecdotal evidence that FGM [female genital mutilation] has drastically reduced in Sierra Leone’. While it is unclear whether this temporary ban on and reluctance to carry out FGM will endure, there is a renewed focus on how to advance the anti-FGM movement on the back of the Ebola outbreak.<sup>59</sup> Indeed, there is now a belated but accelerated awareness of the disproportionate gendered impact of the Ebola outbreak. But was this foreseeable?

## Gender and Zika

The emergence of the Zika virus in the Americas, and the now causally established link between Zika and microcephaly,<sup>60</sup> triggered the declaration by the WHO of a PHEIC on 1 February 2016.<sup>61</sup> During the initial phase of the Zika outbreak, the links between the location of microcephaly cases, poverty, public health, the women most affected—the urban poor, the indigenous in remote locations—and their lack of access to contraceptives and abortion emerged as matters of particular concern.<sup>62</sup> In particular, already marginalized women were being asked by governments to avoid pregnancy, apparently without any acknowledgement by these same governments of their own role in hindering women’s access to contraceptives, sex education and safe abortion practices in the first place.

<sup>57</sup> David K. Evans, Markus Goldstein and Anna Popova, ‘Correspondence: health-care worker mortality and the legacy of the Ebola epidemic’, *Lancet Global Health* 3: 8, 2015, e439.

<sup>58</sup> UN Women Inter-Agency Standing Committee, Reference Group for Gender in Humanitarian Action, ‘Humanitarian crisis in west Africa (Ebola) gender alert: February 2015’.

<sup>59</sup> UN Women Inter-Agency Standing Committee, Reference Group for Gender in Humanitarian Action, ‘Humanitarian crisis in west Africa (Ebola) gender alert: February 2015’.

<sup>60</sup> Sonja A. Rasmussen, Denise J. Jamieson, Margaret A. Honein and Lyle R. Petersen, ‘Zika virus and birth defects: reviewing the evidence for causality’, *New England Journal of Medicine* 374: 20, 2016, pp. 1981–7. There is also evidence of an association between Zika and Guillain-Barré syndrome: see Lyle R. Petersen, Denise J. Jamieson, Ann M. Powers and Margaret A. Honein, ‘Zika virus’, *New England Journal of Medicine* 374: 16, 2016, pp. 1552–63.

<sup>61</sup> ‘WHO statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus’.

<sup>62</sup> Susana T. Fried and Alice Welbourn, ‘The confinement of Eve: resolving Ebola, Zika and HIV with women’s bodies?’, *Open Democracy*, 29 Feb. 2016, <https://www.opendemocracy.net/5050/susana-t-fried-alice-welbourn/confinement-of-eve-resolving-ebola-zika-and-hiv-with-women-s-bodi>; Rachel Schmidt, ‘What does Zika have to do with equality? Everything’, *Open Democracy*, 9 Feb. 2016, <https://www.opendemocracy.net/rachel-schmidt/what-does-zika-have-to-do-with-inequality-everything>; Office of the High Commissioner for Human Rights, ‘Upholding women’s human rights essential to Zika response—Zeid’, 5 Feb. 2016, [www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=17014&LangID=E](http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=17014&LangID=E); Susana T. Fried and Debra J. Liebowitz, ‘What the solution isn’t: the parallel of the Zika and HIV viruses for women’, *Lancet Global Health Blog*, 16 Feb. 2016, <http://globalhealth.thelancet.com/2016/02/16/what-solution-isnt-parallel-zika-and-hiv-viruses-women>.

The potential link between the Zika virus and microcephaly is particularly alarming for pregnant women in affected areas. Governments in Colombia, Ecuador, El Salvador and Jamaica have all recommended that women delay becoming pregnant until more is known about the mosquito-borne virus.<sup>63</sup> The WHO has recommended that pregnant women be advised not to travel to affected areas.<sup>64</sup>

Recommendations that women avoid or delay pregnancy, practise safe sex or abstain from sex during pregnancy all assume that women in affected regions have high levels of reproductive freedom and self-determination. Yet the high rate of unintended pregnancies in these regions suggests the contrary,<sup>65</sup> indicating a lack of official understanding of the pre-existing conditions of structural gender inequality in these situations. In Brazil, for example, a public health adviser could point out that 79 per cent of women use contraceptives.<sup>66</sup> However, in the areas most affected by Zika—the north and north-eastern regions of the country—women are less likely to have access to contraceptives, less likely to be using a contraceptive method that works, and less likely to have access to necessary medical care.<sup>67</sup> The women in these regions are among the poorest in the country, with unmet needs for water, sanitation and education, and denied sexual and reproductive rights.<sup>68</sup> As with other pandemics, there is the potential for the impact of the Zika virus to fall most heavily on the most disadvantaged members of society.<sup>69</sup>

For women who do become pregnant, the WHO's interim guidance on 'pregnancy management in the context of Zika' includes that: 'Women who wish to discontinue their pregnancy should receive accurate information about their options to the full extent of the law, including harm reduction where the care desired is not readily available.'<sup>70</sup> However, restrictive abortion laws in many countries in Latin America leave women who may wish to discontinue their pregnancies with little access to safe, legal termination and leave women exposed to the risks of unsafe procedures. The Guttmacher Institute has estimated that there were 4.4 million abortions in Latin America in 2008, and that 95 per cent of these were unsafe.<sup>71</sup>

<sup>63</sup> 'Zika virus triggers pregnancy delay calls', BBC News, 23 Jan. 2016, [www.bbc.com/news/world-latin-america-35388842](http://www.bbc.com/news/world-latin-america-35388842); Jorge E. Machado-Alba, Manuel E. Machado-Duque, Andres Gaviria-Mendoza and Viviana A. Orozco-Giraldo, 'Hormonal contraceptive prescriptions in Colombia and Zika virus', *Lancet* 387: 10032, 3 May 2016, p. 1993, [http://dx.doi.org/10.1016/S0140-6736\(16\)30429-9](http://dx.doi.org/10.1016/S0140-6736(16)30429-9).

<sup>64</sup> 'WHO statement on the second meeting of IHR Emergency Committee on Zika virus and observed increase in neurological disorders and neo-natal malformations', 8 March 2016, [www.who.int/mediacentre/news/statements/2016/2nd-emergency-committee-zika/en/](http://www.who.int/mediacentre/news/statements/2016/2nd-emergency-committee-zika/en/).

<sup>65</sup> Monica Roa, 'Zika virus outbreak: reproductive health and rights in Latin America', *Lancet* 387: 10021, 12 Feb. 2016, p. 843, [http://dx.doi.org/10.1016/S0140-6736\(16\)00331-7](http://dx.doi.org/10.1016/S0140-6736(16)00331-7).

<sup>66</sup> 'Contraception and family planning around the world—interactive', *Guardian*, 8 March 2016, <http://www.theguardian.com/global-development/datablog/2016/mar/08/contraception-and-family-planning-around-the-world-interactive>.

<sup>67</sup> Nicole Froio, 'Zika's spread in Brazil is a crisis of inequality as much as health', *Guardian*, 3 Feb. 2016, <http://www.theguardian.com/commentisfree/2016/feb/03/zika-virus-brazil-inequality-microcephaly-access-water-contraception>.

<sup>68</sup> Guttmacher Institute, *Investing in sexual and reproductive health in Latin America and the Caribbean* (Dec. 2014), New York, <https://www.guttmacher.org/fact-sheet/investing-sexual-and-reproductive-health-latin-america-and-caribbean>.

<sup>69</sup> Lisa H. Harris, Neil S. Silverman and Mary F. Marshall, 'The paradigm of the paradox: women, pregnant women, and the unequal burdens of the Zika virus pandemic', *American Journal of Bioethics* 16: 5, 2016, pp. 1–4.

<sup>70</sup> WHO, 'Pregnancy management'.

<sup>71</sup> Guttmacher Institute, *In brief: facts on abortion in Latin America and the Caribbean* (May 2016), New York. <https://www.guttmacher.org/fact-sheet/in-brief-facts-on-abortion-in-latin-america-and-the-caribbean>.

The Zika outbreak, like the Ebola outbreak, has revealed the ‘conspicuous invisibility of women’ in outbreak response.<sup>72</sup> The socio-economic status of women, always a determining factor in their experience of gender inequality and gender discrimination, takes on heightened significance during complex emergencies. For example, even in a country where there are restrictive abortion laws, such as Brazil, women of higher education and socio-economic status are more likely to gain access to safe abortion.<sup>73</sup> As the International Planned Parenthood Federation points out:

Poor women and adolescents living in rural areas, where mosquitoes are a part of everyday life, are more susceptible to infection and less likely to have access to sexuality education, contraception, and safe abortion services where legal. In Brazil, for example, [it is no coincidence that] the epidemic is concentrated among young women of color living in the least developed areas of the country.<sup>74</sup>

These examples illustrate that, while public health interventions to support women in making autonomous sexual and reproductive choices are vital, advice and programming may not adequately address the socio-economic options open to these young women that determine their sexual and reproductive ‘choices’. Therefore, in a public health emergency, where a virus (like Ebola and Zika) can be spread by sexual relations, attention to the location and equality of the women and girls affected by the disease outbreak is vital to ensure that advice on containment and treatment compensates for the limited choices likely to be available to this population.

## **Disease and inequality: compounding disadvantage**

In the three countries affected by the Ebola outbreak, the extent of disease morbidity and mortality in general prior to the Ebola outbreak reveals the complexity of health-care provision in an environment where health inequality is high in both communicable and non-communicable diseases. In Guinea, the leading causes of premature death are malaria, lower respiratory infection, and neo-natal pre-term birth (2013 data). The highest risk factors, in terms of disability adjusted life years, are child and maternal malnutrition, air pollution and unsafe sex.<sup>75</sup> In Liberia, collective violence as an attributable cause of death and disability fell significantly over the past decade, to be overtaken by malaria, lower respiratory infection and diarrhoeal disease. Child and maternal malnutrition, unsafe water and poor sanitation, and air pollution remain leading causes of death and disability. A similar picture is present in Sierra Leone, one notable difference being

[www.guttmacher.org/fact-sheet/facts-abortion-latin-america-and-caribbean](http://www.guttmacher.org/fact-sheet/facts-abortion-latin-america-and-caribbean).

<sup>72</sup> Harman, ‘Ebola, gender and conspicuously invisible women’.

<sup>73</sup> Tábata Z. Dias, Renato Passini Jr, Graciana A. Duarte, Maria H. Sousa, and Aníbal Faúndes, ‘Association between educational level and access to safe abortion in a Brazilian population’, *International Journal of Gynecology and Obstetrics* 128: 3, 2015, pp. 224–7.

<sup>74</sup> Jazmyan Henry, ‘A comprehensive approach to tackling Zika virus’, *International Planned Parenthood Federation*, 4 Feb. 2016, <https://www.ippfwhr.org/en/blog/a-comprehensive-approach-to-tackling-zika-virus>.

<sup>75</sup> Institute for Health Metrics Evaluations, country profiles, 2015, data for Guinea, <http://www.healthdata.org/results/country-profiles>.

that HIV/AIDS ranked third here, behind malaria and lower respiratory infection, as a cause of death in 2013.<sup>76</sup>

Compounding these indicators of poor health in the Ebola outbreak was the lack of access for women to the health-care services necessary to support their own and their children's health. To what extent could the relationship between gender, health and women's access to health-care services have been determined at the point of the crisis? The OECD Social Institutions and Gender Index (SIGI) is a composite measure of each country's gender inequality score, drawn from five sub-indices (restricted physical integrity, discriminatory family code, bias in favour of sons, restricted resources and assets, and restricted civil liberties) that provide a broad snapshot of the economic, political and social status of women in each country.<sup>77</sup>

The 108 countries measured are ranked in five categories from very low (inequality) to very high. All of the three countries most affected by the Ebola outbreak were above the average SIGI score for gender discrimination: Guinea ranked 'high' and Liberia and Sierra Leone 'very high' (the difference between high and very high is negligible in these cases: all three countries' scores were within 0.05 per cent of each other). In the area of restricted physical integrity, which refers to women's autonomy and control over their bodies, all three countries score 'very high' in terms of gender inequality. In Guinea, for example, approximately 92 per cent of women have experienced domestic violence, and 95 per cent have been subjected to FGM. In Sierra Leone, despite the recent introduction of rather progressive legislation to prevent violence against women, including banning FGM and outlawing early marriage, the low social and economic status of many girls and women continues to render them vulnerable to these practices.<sup>78</sup> Liberia's data on restricted physical integrity also reveal the difficulties attending any attempt to measure the relationship between gender inequality and health indicators. While according to official government data 'few women' aged 15–49 have undergone FGM, UNICEF estimates that 66 per cent of women in Liberia in that age group have experienced some form of FGM.<sup>79</sup> Similar difficulties arise when attempting to trace the observance in practice of sexual and reproductive rights. Women in Liberia have access to free contraceptives, and the take-up is reported to be quite high; however, the reported use of contraceptives is quite low.<sup>80</sup>

In Brazil and Colombia, the two countries most affected by the Zika outbreak at the time of writing, the picture for gender inequalities is markedly different to countries most affected by Ebola in west Africa. Both countries have a 'low' SIGI score for gender discrimination. Yet, like the African countries discussed above, the sub-index scores that make up the overall SIGI score reveal gender inequalities that may hinder access to treatment and care for particular segments

<sup>76</sup> Institute for Health Metrics Evaluations, country profiles, 2015, data for Liberia and Sierra Leone.

<sup>77</sup> OECD, *Social Institutions and Gender Index: Guinea, Liberia and Sierra Leone* (Paris: OECD, Nov. 2014), <http://genderindex.org/countries/Sub-Saharan%20Africa>.

<sup>78</sup> OECD, *Social Institutions and Gender Index: Guinea, Liberia and Sierra Leone*.

<sup>79</sup> OECD, *Social Institutions and Gender Index: Liberia*, section on restricted physical integrity, Nov. 2014, <http://genderindex.org/country/liberia>

<sup>80</sup> OECD, *Social Institutions and Gender Index: Liberia*, section on restricted physical integrity.

of the population. In particular, the sub-index 'restricted civil liberties' places Brazil at 'medium' level relative to other states and Colombia at 'high'.<sup>81</sup> The significance of the score, in this case, is that civil liberties measure women's access to political and social movements as well as to community actions and 'public decision making for a range of development outcomes such as governance, health and education'.<sup>82</sup>

Given that most of the population groups affected by Zika are of lower socio-economic status, and that levels of access and inequality differ markedly across the rural–urban divide, these scores indicate a clear need to prioritize differentiated levels of access and support. In recent months this point has been noted in relation to Zika by the UN High Commissioner for Human Rights, who has said that upholding the human rights of women is an essential element of an effective response to the outbreak.<sup>83</sup> The United Nations Population Fund has also pointed out that sexual and reproductive health services must be included in the response to Zika.<sup>84</sup> Yet to date the focus seems to be on advising women on preventive measures such as practising safe sex, avoiding pregnancy, and avoiding mosquito bites.<sup>85</sup> In the case of Ebola, the earliest advice provided that recognized women's right to access social and economic services to protect their health security was UN Security Council Resolution 2177, adopted in September 2014, which stated in operational paragraph 2: 'Responses to the Ebola outbreak should address the specific needs of women and ... the importance of their full and effective engagement in the development of such responses.'<sup>86</sup> In both health emergencies our concern is the lack of early discussion and engagement in this same advice on *how* to support women who suffer social and economic constraints on taking such preventive measures.<sup>87</sup>

In view of the importance of contemporary research on the risk, incidence, harm and prevalence of the Zika infection, we were interested to see whether the 'invisibility' of women and gender that we found in the case of the Ebola outbreak was also evident in published research that addressed the vulnerabilities and needs of the populations most affected by Zika (namely, rural and poor urban women and their children). Had lessons been learnt from the Ebola outbreak to enable the differentiated gender experience of a public health emergency to be better addressed? We were also interested to know how the social conditions of

<sup>81</sup> OECD, *Social Institutions and Gender Index, 2014 results: restricted civil liberties*, <http://www.genderindex.org/civilliberties/>.

<sup>82</sup> OECD, *Social Institutions and Gender Index, 2014 results: about the SIGI*, <http://www.genderindex.org/content/team>.

<sup>83</sup> OHCHR, 'Upholding women's human rights essential to Zika response—Zeid'.

<sup>84</sup> Ulisses Lacava Bigaton and Midia Santana, 'Zika outbreak: ensuring that sexual and reproductive health services are part of the response', *UNFPA News*, 26 Feb. 2016, [www.unfpa.org/news/zika-outbreak-ensuring-sexual-and-reproductive-health-services-are-part-response](http://www.unfpa.org/news/zika-outbreak-ensuring-sexual-and-reproductive-health-services-are-part-response).

<sup>85</sup> 'WHO statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus'.

<sup>86</sup> UN S/Res/2177, 18 Sept. 2014.

<sup>87</sup> Similar concerns have been raised concerning the relationship between gender dynamics, gender violence and women-focused HIV prevention: see Sofia Gruskin, Kelly Safreed-Harmon, Chelsea L. Moore, Riley J. Steiner and Shari L. Dworkin, 'HIV and gender-based violence: welcome policies and programmes, but is the research keeping up?', *Reproductive Health Matters* 22: 44, 2014 pp. 174–84.

the women affected by Zika have been researched with a view to better understanding the relationship between infection and gender.

In a 'title, abstract and keyword' document search of articles published in the Scopus journal database (which covers 29 million abstracts in over 15,000 peer-reviewed titles from more than 4,000 publishers, 265 million references and 265 million web pages),<sup>88</sup> we found that, of the 608 publications on Zika between 1 January 2015 and 15 May 2016, 21 articles explored the relationship between 'Zika' and 'human rights'. Just two articles explored the relationship between 'human rights', 'gender' and 'Zika infection', and only one considered the relationship between 'gender' and 'Zika infection'.<sup>89</sup> (As there is a high volume of discussion about women's especial physical vulnerability to the disease while pregnant, we did not search for articles on Zika with 'women' in the title, abstract or keyword.) Given the association between risk of infection and social vulnerability to this disease for women in particular, it is disappointing to see so little discussion about engaging with the gendered social conditions that have led to the vulnerability of women (and their children) to this disease.

As the Zika outbreak is still under way, however, it may be too soon to judge the direction of research. We therefore decided to explore the status of contemporary research on the role of human rights and gender in the case of the Ebola outbreak in west Africa. Using a date range from 1 January 2014 to 15 May 2016, we conducted three searches similar to those on Zika: 'Ebola' and 'human rights'; 'Ebola' and 'gender'; 'Ebola' and 'human rights' and 'gender'. Of the 4,236 articles published on Ebola in Scopus during this period, 335 examined Ebola and human rights; 14 examined gender relations in the context of the Ebola outbreak; and one paper examined the relationship between human rights, gender relations and the outbreak. Overall, then, less than 1 per cent of published research papers on the recent Ebola and Zika public health emergencies have explored the gendered impact and implications of these outbreaks.

During the Ebola and Zika outbreaks a range of social and economic conditions have affected women's options and their ability to control their bodies. Women's health care is determined not solely by the provision of health-care treatments, but also by whether they can freely access and use these services. The complex emergency created by the Ebola outbreak fuelled health inequalities that women were already experiencing as a result of their status in each of the three worst-affected countries. A similar situation is occurring today in Zika-affected populations in South America. In other words, there was enough evidence to indicate that women and children would be rendered particularly vulnerable to an infectious disease and that it would exacerbate already existing health inequalities for these vulnerable groups.<sup>90</sup>

<sup>88</sup> <https://www-scopus-com.libraryproxy.griffith.edu.au/>.

<sup>89</sup> Roa, 'Zika virus outbreak'.

<sup>90</sup> Children were reported to be particularly vulnerable to Ebola, and poverty indicators already show that women are more likely to be affected by the economic downturn due to Ebola than men in all three countries. See UNDP, *Socio-economic impact of Ebola virus*.

One lesson from the Ebola outbreak in west Africa, and now the Zika outbreak, is that renewed priority needs to be given to human rights-focused approaches in addressing prevailing health vulnerabilities in post-conflict countries and situations where a PHEIC has been declared under the IHR. In both the Ebola and Zika cases, the populations most vulnerable to the consequences of these infections, women in particular, were rendered particularly susceptible by a combination of poverty and pervasive gender inequalities. Prioritizing health as a human right is essential not only in addressing future public health emergencies, but also if the Sustainable Development Goals (SDGs) are to be met by 2030. Below, we focus on one particular way to align health and human rights that has been relatively underappreciated to date: the Office of the Special Rapporteur on the Right to Health.

## **Gender and global health: the importance of human rights**

The WHO's constitution states that health is a universal right. In so doing, it defines health as 'a state of complete physical, mental and social well-being'.<sup>91</sup> The association between health and human rights has been reaffirmed several times since the establishment of the WHO. It was enshrined, for instance, in the 1948 Universal Declaration of Human Rights; and the 1966 International Covenant on Economic, Social and Cultural Rights, which came into force in 1976, declared its signatories' recognition of 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.<sup>92</sup> However, according to Paul Hunt, the former UN Special Rapporteur on the Right to Health, the 'right to health' remained 'little more than a slogan for more than 50 years'.<sup>93</sup> It was not until the UN Economic and Social Council adopted General Comment 14 in 2000 that it became clear that:

The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.<sup>94</sup>

In 2002 the Commission on Human Rights adopted the mandate for the appointment of a Special Rapporteur on the Right to Health. The replacement of the Commission in 2006 by the Human Rights Council reaffirmed the appointment of the Special Rapporteur, whose mandate is to provide an annual report to the Human Rights Council and General Assembly on investigation and discussion of general trends related to the right to health; country visits and reports on specific countries; and investigation and advice on alleged cases of violations of the right to health.<sup>95</sup>

<sup>91</sup> WHO, Constitution of the World Health Organization, 1946, preamble, [http://www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf).

<sup>92</sup> OHCHR, International Covenant on Economic, Social and Cultural Rights, 1966, art. 12, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

<sup>93</sup> Paul Hunt, 'Right to the highest attainable standard of health', *Lancet* 370: 9585, 2007, pp. 369–71.

<sup>94</sup> UN Committee on Economic, Social and Cultural Rights, General Comment 14, 'The right to the highest attainable standard of health', 22nd Session, 2000, UN Doc. E/C.12/2000/4 (2000).

<sup>95</sup> OHCHR, 'Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard

For the twelve years that the Rapporteur has provided annual reports to the Human Rights Council and General Assembly, as well as country visit reports and thematic reports, the inclusion of women's right to health care has been a reporting priority under his/her mandate: 'The Special Rapporteur is further asked to apply a gender perspective and to pay special attention to the needs of children in the realization of the right to health.'<sup>96</sup> To date, the three Special Rapporteurs (Paul Hunt, 2002–2008; Anand Grover, 2008–2014; and Dainius Pūras, 2014 to date) have not provided a thematic report specifically on General Recommendation 24 of CEDAW, the 1979 Convention on the Elimination of all Forms of Discrimination Against Women, concerning women and health. However, each has reported on the gender dynamics of HIV/AIDS infection, as well as the specific rights of women to access sexual and reproductive health care, both in thematic reports and in specific country reports.<sup>97</sup> Indeed, in late 2014, Mr Pūras was a signatory to a letter signed by a number of Special Rapporteurs calling for the SDGs to include specific references to 'sexual and reproductive health services [and] information on such services', and insisting that 'sexuality education must not only be universal but also accessible, acceptable, available, affordable for all women'.<sup>98</sup>

The 17 SDGs adopted by the UN General Assembly in September 2015 include two expansive but complementary goals: Goal 3, 'ensure healthy lives and promote well-being for all at all ages', and Goal 5, 'achieve gender equality and empower all women and girls'. Significantly, two of the targets essential to meet Goal 3 (Health) are Target 3.7, 'By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes,' and Target 3.8, 'Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.' These goals were adopted by all member states in the 70th UN General Assembly, and during 2016 there have been consultations to discuss the development of milestones to measure, inform and advocate the achievement of all 17 goals with their attached 169 targets.<sup>99</sup>

The intervention of the Special Rapporteurs was well placed in highlighting the relationship between the social institutions vital to deliver these services and equitable access for both sexes and all genders. We are not arguing that Special Rapporteurs have powers that are independent of the control and influence of the Human Rights Council, nor are we presuming that Special Rapporteurs are well-funded, empowered agents who are invulnerable to the politics and dimin-

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of physical and mental health', <http://www.ohchr.org/EN/Issues/Health/Pages/SRRrightHealthIndex.aspx>.

<sup>96</sup> OHCHR, 'Overview of the mandate', <http://www.ohchr.org/EN/Issues/Health/Pages/OverviewMandate.aspx>.

<sup>97</sup> For details of the thematic reports, see <http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx>.

<sup>98</sup> For details of the country visits, see <http://www.ohchr.org/EN/Issues/Health/Pages/CountryVisits.aspx>.

<sup>98</sup> OHCHR, 'Open letter on the inadequate recognition of sexual and reproductive health and rights in the post-2015 development agenda', 4 Nov. 2014, <http://www.ohchr.org/Documents/Issues/Women/WRGS/OpenLetter4Nov2014.pdf>.

<sup>99</sup> UN Sustainable Development Knowledge Platform, 'UN adopts new global goals, charting sustainable development for people and planet by 2030', 25 Sept. 2015, <https://sustainabledevelopment.un.org/?page=view&n r=971&type=230&menu=2059>.

ished resources of the United Nations. Given that they exist, however, we seek to suggest steps to ‘reduce the imperfections and to increase and expand the achievements’ of these roles,<sup>100</sup> advocating promotion of and engagement with their mandate in order to support both the person and the Office and thereby to deliver more for the health rights of women. This intervention, we contend, illustrates the particular importance of the Special Rapporteur on the Right to Health’s engagement with the SDGs to begin articulating what steps states must take, including tracking progress, to realize the specific rights that improve the health quality of women and identify the relationship between gender inequality and health—as permitted in the Special Rapporteur’s mandate.

The relationship between the specific aspects of women’s rights and the universal aspect of human rights has often been complex. As Charlesworth has noted:

The universality of application of human rights is indeed their most radical feature. To suggest there is a special category of women’s human rights may undermine the claim of universality by fracturing the field. At the same time, it has provided a powerful political platform for women to draw attention to continuing areas of inequality.<sup>101</sup>

The human rights focus on women’s health is important. As one of us has argued previously, the linking of health with human rights and of women’s rights with human rights has ‘reshaped the scope of the potential for women’s health into the future, opening new avenues for real and practical improvement in the lives of women around the world’.<sup>102</sup> We suggest three human rights-informed interventions the Special Rapporteur could contribute as discussions crystallize around the development of milestones to measure, inform and advocate the achievement of all 17 goals and their targets.

First, the Special Rapporteur could provide a *thematic report* on states’ responsibility to facilitate gender-equitable health care. The timing of such a report now would significantly add to its impact, as the Ebola and Zika outbreaks provide an important opportunity to examine the lessons that need to be learnt from the complex relationship between health care, gender equality and governance. Furthermore, given the international consensus on the need for a framework of implementation for the SDGs that is gender-sensitive to indicators at both the national and regional levels,<sup>103</sup> the Special Rapporteur could use the thematic report to pilot qualitative tools of analysis in line with the need for ‘inclusive and people-led participatory monitoring methodologies that can be employed for monitoring of the SDGs and their associated targets’.<sup>104</sup> This type of analysis,

<sup>100</sup> Michael Kirby, ‘United Nations special procedures: a response to Professor Hilary Charlesworth’, *Australian Yearbook of International Law* 29, 2010, pp. 17–25 at p. 25.

<sup>101</sup> Hilary Charlesworth, ‘Two steps forward, one step back? The field of women’s human rights’, *European Human Rights Law Review* 6, 2014, pp. 560–65 at p. 560.

<sup>102</sup> Belinda Bennett, ‘Women’s health and a Framework Convention on Global Health’, *Global Health Governance* 9: 1, 2015, pp. 149–63 at p. 150.

<sup>103</sup> UN, Third International Conference on Financing for Development, outcome document, 15 July 2015, para. 6, [http://www.un.org/ga/search/view\\_doc.asp?symbol=A/CONF.227/L.1](http://www.un.org/ga/search/view_doc.asp?symbol=A/CONF.227/L.1)

<sup>104</sup> UN High-level Political Forum on Sustainable Development, interactive dialogue 2, ‘Tackling inequalities, empowering women and girls and leaving no one behind’, Sept. 2015, <https://sustainabledevelopment.un.org/content/documents/8146Interactive%20Dialogue%202020-%20Inequalities.pdf>.

already facilitated under the mandate of the Special Rapporteur, can serve as a 'reality check' on the quantitative measurement of the SDGs and address the vital need for baseline data on sex-disaggregated health measures.

Second, the Special Rapporteur should be permitted by the Human Rights Council to prioritize country visits to the countries affected by Ebola and Zika. These visits would have a threefold purpose: (i) they would provide important cases for piloting the implementation of the thematic report on gender-equitable health care while serving as a direct assistance tool to these affected countries; (ii) they would entail engagement with a variety of actors whose voices and experiences may not have received as much attention as those of governments, including health-care workers, civilians and civil society groups affected by the Ebola and Zika crises; and (iii) the Ebola and Zika outbreaks provide an important but underexplored lesson on gender relations.

For example, investigating the reduction in FGM in Sierra Leone and the impact of Ebola on the availability of obstetric and neo-natal care could inform better understanding of the relationship between a crisis, the introduction of legislation to protect women's physical integrity, and the distribution of services to protect and address women's health-care needs and rights. Specific reference to sexual and reproductive health has been included as one of the five attributes of physical and mental health under the Special Rapporteur's framework. As such, these country visits would serve to focus not just on states' performance in implementing legal provisions concerning human rights, but also on the formulation of indicators to identify what legislative and service provision targets must be addressed to support a gender-equitable right to health. This assessment framework would require tracing states' legal ratification of rights as well as their efforts to provide—in this case—the policy, economic and social initiatives necessary to ensure women can access and use health care.

Third and finally, the Ebola outbreak in particular reveals that donor investment cannot be adequately matched to the need of the target health system without factoring in the equity and stability of service provision across urban and rural locations. The types of political structures and institutions that underpin the provision of health care in 'peace' time are even more important in emergency situations. The Ebola outbreak was particularly devastating because health systems in the countries affected were already fragile, weakened by decades of political instability and conflict. A rights-based indicator model permits more discussion about the performance of states in meeting their population's needs, and also provides the opportunity to have more discussions about the responsibilities of donor states for ensuring that they support countries that are particularly vulnerable after conflict, disasters and other emergencies. Realization of the SDGs will come about not only through efforts made at domestic level to improve gender-equitable health care, but also through donor states' fulfilling their obligations to assist others in meeting the SDGs.

In advocating strengthened engagement of the Special Rapporteur on the Right to Health, we are calling for WHO and future IHR Emergency Committees to

incorporate in their meetings and advice the findings of the Special Rapporteur on the gender-related aspects of public health emergencies. As the report of the UN Secretary-General's High-level Panel on Responses to Global Health Crises pointed out, women faced disproportionate exposure to the Ebola virus through their care-giving roles and their roles in burial practices; the virus placed pregnant women at risk of death or loss of the pregnancy; and women were also more likely to be affected by the negative broader socio-economic impacts of Ebola.<sup>105</sup> The Panel noted that 'the underrepresentation of women at all levels of the national and international response' made it more difficult to redress these imbalances. It recommended that: 'Outbreak preparedness and response efforts should take into account and address the gender dimension', and asserted that: 'Women must be included at all levels of planning and operations to ensure the effectiveness and appropriateness of a response.'<sup>106</sup>

The emergency posed by the Zika virus has prompted much-needed discussion about the sexual and reproductive rights of women in Latin America. But our concern remains that gender-responsive language, particularly in the WHO advisory and government responses to the Zika outbreak, have to date presented gender awareness as 'simply' encouraging governments to permit women to realize their sexual and reproductive choices. Addressing the legal barriers to reproductive freedom is necessary and essential, yet in complex health emergencies more advice must be directed towards predicting the likely constraints on women's right to exercise their choice and rights arising from pre-existing social and economic disadvantage.

## Conclusion

Statistically, women's experience in the Ebola virus outbreak in west Africa and the Zika outbreak in South America has been different from men's. Women have been, and continue to be, disproportionately affected by both outbreaks. The dramatic drop in primary health-care services during the Ebola outbreak continues to bear heavily on women and children.<sup>107</sup> Furthermore, both outbreaks have illustrated—as other complex emergencies have shown in the past—that women are more likely to experience social and economic deprivation, and limited access to resources. Addressing gender inequality in health programming, including in emergency settings, entails more than addressing reproductive and maternal services; it requires understanding the social status of women in that society to respond to the particular challenges that will be present in relation to the nature of the crisis. It was disappointing to see in both outbreaks that despite information being available to indicate that these health emergencies would be gendered and would affect different communities differently, international public health advice rarely engaged with rights language that recognized these challenges.

<sup>105</sup> UN, *Report of the High-level Panel on the Global Response to Health Crises*, p. 41.

<sup>106</sup> UN, *Report of the High-level Panel on the Global Response to Health Crises*, p. 41.

<sup>107</sup> Erika Check Hayden, 'Maternal health: Ebola's lasting legacy', *Nature* 519: 7541, 2015, pp. 24–6; Bigaton and Santana, 'Zika outbreak', n. 115.

Looking ahead, the necessary response is twofold. First, there is a need to address sexual and reproductive rights and the positive duty of governments to assist women in realizing their rights; second, the advice issued in health emergencies must address the social and economic conditions that restrict women's ability to exercise those rights. Gender inequality and gender discrimination must be named and rendered visible in the public health emergency response. This article has sought to identify an institution that could contribute to ongoing discussions and consultations on the development of milestones to measure, inform and advocate the achievement of the SDGs, informed by lessons learnt from the Ebola and Zika outbreaks. We argue that the Special Rapporteur on the Right to Health has the mandate and responsibility to articulate what the positive right to equitable health care entails, the responsibilities of states to fulfil that right, and the particular provisions necessary to deliver gender-equitable provision and delivery of health care in crises.

This institutional engagement, we believe, is required to redress the absence of human rights in the WHO-coordinated emergency response to disease outbreaks. In the formal global responses to the Ebola and Zika virus there was a notable absence of women's voices and social science methodologies informed by women's perspectives to assist with understanding the events and the social environment in which any research and intervention must take place, and to respond to the lived experience and needs of those most affected by these global public health emergencies. The absence of human rights advice was striking in the response to both outbreaks.

An effective global response to public health emergencies must engage with the rights and needs of affected women. The Ebola and Zika outbreaks provide tragic, important lessons that should not be forgotten as, it is to be hoped, these countries move towards containing the crisis. Access to essential health services during complex emergencies is determined not solely by the provision of care, but also by the status of human rights and equity in that society. The provision of health care and treatment requires understanding the conditions that determine gender-equitable health care.