

Ebola, Gender, and Conspicuously Invisible Women in Global Health Governance

The international response and rhetoric to Ebola Virus Disease (Ebola) in Guinea, Liberia and Sierra Leone in 2014 brings into stark contention a central paradox in global health governance: the conspicuous invisibility of women and gender. On the one hand women such as World Health Organisation (WHO) Director General Margaret Chan and Medecins Sans Frontieres (MSF) International President Joanne Liu have been conspicuously visible in the Ebola response and actors such as Melinda Gates have a high profile in promoting reproductive health issues of women, however on the other hand the differing impacts of the disease on women and men, the gendered role of women as carers, and the role of women in health systems in West Africa have been invisible. Other than a handful of high-profile women leading global institutions, women are conspicuously invisible in global health governance: people working in global health are aware and see women in care roles that underpin health systems, yet they are invisible in global health strategy, policy or practice.¹ Women are only made visible through motherhood. The problem here is not only the conspicuous invisibility of women but that of gender, as global health policy and practice ignores and subsequently reinforces gendered norms of care and social reproduction. Ebola provides an insightful case study in which to demonstrate the conspicuous invisibility of women and gendered care roles in emergency and long-term global health policy and practice. This article will demonstrate that gender and women are conspicuously invisible at every point in the international response to the outbreak: first, with regard to data on the number of males and females contracting and dying from Ebola; second, the lack of any discussion on gender as an analytical lens in the emergency and long-term response; third, little critical engagement on gender and Ebola in wider academic debate on the response; and finally, the complete absence of discussion as to the role of social reproduction and women in the care economy in strategies to strengthen health systems.

The article develops its argument by first situating the concept of conspicuous invisibility within wider feminist debate on gender blindness in international policy-making, care and social reproduction. The article then provides an overview of the literature on Ebola from January 2014 – January 2015 to demonstrate how the ‘crisis’ has been represented by key opinion and knowledge formers in global health governance. The inclusion of women and gender in the response to Ebola is then reviewed with reference to initiatives from the World Bank and WHO as two of the key leaders in the response. The article goes on to explore discussions over the long-term strategy towards health system strengthening by the Bank and WHO to show how the role of women in the care economy is invisible at every stage of the planning process. The article then considers

what could be done differently as a basis for thinking about gender in future disease outbreaks and long term health system strengthening. In conclusion, the article argues that should women and issues of gender remain invisible, health systems will remain weak, precarious, and dependent on the resilience of women to address deadly viruses such as Ebola. This will be to the detriment of women's health, well-being, and will reinforce gender assumptions and the conspicuous invisibility of women in care.

Gender, Care and Social Reproduction

Care is a critical issue of inquiry for scholars of feminist political economy and public health with regard to women's under-valued, often unpaid labour in the care economy and the burden of social reproduction roles in the family and community. The burden of care-giving at multiple levels, public and private, is highly feminised. Studies show that the burden of care falls to women across a range of incomes, education, and welfare systems.² Feminised burden of care can be explained by the gender norms and expectations of women as a gender with regard to social reproduction in the family and wider communities in which they live. Adopting Rai's definition, social reproduction refers to biological reproduction, unpaid production in the home of good and services, and the reproduction of culture and ideology, notably the expectation women will suspend periods of employment for biological reproduction.³ Such roles are under-valued or assumed in society and international public policy-making and tend to be unpaid or low paid. Women are overly represented in this low/unpaid reproductive economy but under-represented in the paid productive economy in which economists, policy-makers and society recognise and place value.⁴ The feminised unpaid reproductive care economy 'acts as a 'shock absorber' in periods of crisis' by taking on the care and welfare functions when the state, employer or individual can no longer pay for them.⁵ The ability of the individual or state to address such welfare and care provisioning can have a direct impact on intersectional inequalities and risk vulnerability across gender, race, class and geography.⁶ Women absorb the burden of care through self-exploitation (leading to direct and indirect health impacts on women as a gender), reliance on family, or outsourcing care roles to poorer women.⁷

According to feminist research, the performance of women in social reproduction and care roles is either assumed or ignored in the design of public policies.⁸ Care roles and social reproduction are commonly naturalized in public policy in such a way that the cost of care is unacknowledged or assumed. Such a lack of engagement with the gendered dimensions of care can be explained by

the presence of what Elson terms ‘male bias’ in the policy process. According to Elson, male bias is not deliberate but is a blindness to the economic structures ‘that operate in favour of men as a gender, and against women as a gender, not that all men are biased against women’.⁹ Elson argues for the need to move away from the emphasis on ‘women in development’ that generalises women and makes them the problem rather than the structural constraints and injustice afforded to them on account of their gender. Elson emphasises the need for gender-aware and gender-visible policy that recognises conscious and unconscious bias in the policy process.¹⁰ On account of women’s over-representation in the reproductive sector and the lack of social and financial value placed on such roles, feminist political economists argue that the unpaid care economy must become a highly visible part of policymaking.¹¹

The formal and informal care economy and assumptions of gender in the policy-making process are vital, yet often overlooked, components of global health. Provision of care, healthcare and reproduction of healthy bodies is a core part of social reproduction and social reproduction is integral to the functioning of health systems: care in the home and the community, provision of infant and child health, and expectations that such care roles are given to women as a gender. Women perform these social reproduction roles in a way that underpins health systems and through labour that is normally unpaid. The formal care economy is also highly feminised, with healthcare being a core driver of skilled female migration.¹²

The gendered dimensions of care and burden of care in public health has long been recognised by prominent scholars such as Lesley Doyal¹³ and has gained increased attention with regard to HIV/AIDS. The HIV/AIDS pandemic has drawn attention to gender and sexuality,¹⁴ gender, risk, and structural violence,¹⁵ gender, conflict and HIV/AIDS,¹⁶ governance,¹⁷ and the feminised response to the disease that has highlighted the care roles of women, particularly grandmothers.¹⁸ Such attention has been reflected by increased prominence of gender issues in institutions such as the Joint United Nations Programme of HIV/AIDS (UNAIDS) and flagship reports such as ‘Women and Health’ by the World Health Organisation (WHO) that recognise the feminised burden of care, the structural limitations to why women do (not) access key health services, and the gendered mortality rates regarding children and AIDS.¹⁹ Such recognition is to be welcomed. However there is much to suggest that such recognition is isolated to key reports and sectors of these institutions and does not cut across a range of health issues or pandemic outbreaks. Increasingly, gender issues have been reduced to the issues of maternal (and at times, reproductive) health strategies that while of great importance are evoked by health actors as evidence of doing gender.²⁰ Studies on key global health issues such as WHO’s work on the social determinants of

health have shown how such work 'is at odds' with contemporary work on gender and women's health.²¹ Contemporary feminist theory and debate, the role of the informal and formal care economy, and issues of intersectionality all remain absent from global health strategies or are instrumentalized in a way for women to deliver on wider health goals and targets. This is a central paradox in global health: women are conspicuous in the delivery of care and thus the delivery of health, but are invisible to the institutions and policies that design and implement global health strategies.

Adopting the intent of feminist political economy to recognise reproduction in our understanding of the dynamics of international policy and economic structures, this paper uses the concept of conspicuous invisibility to demonstrate how women and gender are left out of the 2014 Ebola 'crisis' and wider long-term strategies of health systems resilience. The conspicuous invisibility of women in global health governance confirms what we know about gender assumptions and male bias in international public policy-making, but also extends our knowledge to show how women's care roles can be such a conspicuous essential of everyday healthcare yet are wilfully invisible from discussion or strategy on global health.

Depicting the Ebola 'crisis'

Research and opinion pieces are critical signifiers in global health policy, and thus integral to understanding policy responses to Ebola and the role of women and gender within global health. Scholarly research and opinion pieces in flagship publications such as *The Lancet* and the *New England Journal of Medicine* have core advocacy and policy-shaping functions in global health, they publish research from policy-makers working in institutions such as the World Bank, and they provide the research that underpins evidence-based policy-making. 2014 was the year Ebola was confirmed to be a 'public health emergency of international concern',²² the result of which was much scholarly debate in the correspondence pages and opinion pieces of noted journals over what led Ebola to become an emergency, how the international response has functioned, and the future needs of the health systems in the three countries. Four key narratives framed such debate. These four key narratives have been identified by an extensive literature review through a RefWorks database search of articles, correspondence and opinion pieces on 'Ebola' in the fields of public health, politics, and social sciences from January 2014 – February 2015. The RefWorks search generated 2,311 possible scholarly publications on Ebola for the time period: the abstracts for each of these papers were reviewed and any duplications in the search, clinical or biomedical

papers were then discounted. This reduced the relevant literature to 61 articles. Each article was read to note the main content of argument and see if any reference was made to gender, women or men, male or female, and verified by a word search using these terms. The categorisation of each of the four frames became apparent as many of the papers were arguing similar points and spoke to each other. Earlier papers focused on the US response and the need for a vaccine, later papers discussed the failure of the international community. Women and gender are, on the whole, absent from the framing of the crisis.

The first narrative focuses on the response of the United States government to the outbreak²³ and the perceived utility and ethics of quarantine for those personnel returning from West Africa, particularly those that volunteered in the Ebola response. Much of this debate is critical of the use of excessive quarantine measures that were seen to act as a potential deterrent to volunteers, and ineffectual given an individual is not infectious until they show symptoms of Ebola.²⁴ Authors such as Hankivsky have highlighted the racial metaphors evident in this narrative and how intersectional axes of privilege - e.g. race, gender, class, sexuality – structure the perceptions of disease in the US.²⁵ Gender here is thus considered as part of a wider intersectional lens for understanding not only perceptions of Ebola but how such analysis needs to be integrated in thinking about future processes of global health governance.

The second narrative surrounds the need for vaccines and treatment for Ebola²⁶ and the wider ethical debate over the use of randomised controlled trials and the use of unproven treatment in an emergency health context.²⁷ Part of this narrative engages in advocacy over the need and urgency of a vaccine and timely intervention based on epidemiological modelling.²⁸ This advocacy positions the response to Ebola as an ethical obligation of the global public health community. Such an ethical obligation takes a public health approach to delivering on Ebola treatment that seeks to deliver health provision to all, and thus gender is not highlighted as a concern within this.

The third narrative centres on how the Ebola crisis in West Africa is an emergency and was a ‘perfect storm’ arising from under-funded health systems and failing post-conflict public infrastructure that has been undermined by structural adjustment programmes and international capital flight.²⁹ A vocal proponent of this ‘perfect storm’ narrative is Peter Piot, Director of the London School of Hygiene and Tropical Medicine who co-discovered Ebola in 1976.³⁰ This narrative primarily concentrates on the domestic infrastructures within Guinea, Liberia and Sierra Leone, how domestic governments were slow to act, and the problems of burial practices and relationships with healthcare workers that made preventative behavioural change difficult.³¹ The explanation here was that health systems had been a neglected part of global and domestic health

policy strategies and that given the lack of clinicians, hospitals, primary treatment centres, educational and training facilities, laboratories, drug procurement facilities and cold chain supplies required for a functioning health system, these countries were particularly susceptible to disease outbreaks. For the ‘perfect storm’ narrative, the core solution to preventing the impact and rapid spread of outbreaks such as Ebola is to build strong health systems.³² The role of women as informal carers within the health sector and their relationship to the bodies and burial practices of the dead are not acknowledged within this debate. Their role is conspicuously invisible in the need to rebuild health systems and care for the children who have been orphaned by the disease. This is a core omission in the debate on health systems reform in the post-Ebola process.

The fourth narrative is around the international response to the outbreak and the perceived failure of key institutions such as the WHO to respond in a timely and sufficient manner.³³ This narrative provides an overview of the response in 2014, advocates for the international community to do more and commit more funds, and the need for greater co-ordination.³⁴ A key under-current of the narrative is the perceived failure of the WHO. The Ebola outbreak happened when the WHO was mid-way through an extended consultation on institutional reform. Such reform has been the result of external challenges to its mandate on account of a growth of institutions working on global health issues such as the World Bank and Global Fund to Fight AIDS, Tuberculosis and Malaria, and internal problems of a lack of core financing and leadership divisions that have historically plagued the leadership of the institution.³⁵ A core part of this narrative developed by global health lawyer Gostin is the role of the 2005 International Health Regulations (IHRs). The IHRs are a global tool in which to protect and prevent the spread of disease and provide a public health response to any outbreak. The failure to fully equip states to deliver on the core requirements of disease surveillance under the IHRs was seen as a key problem in the mismanagement of Ebola; thus going forward the narrative here is for the international community to be responsible for investing in and strengthening the IHRs in low and middle income countries.³⁶ The central focus of this narrative is to learn the lessons of the past as a means of greater and more directed investment in health in the future. However, similar to the first narrative there is very little on the need to consider gender as an analytical concern in the implementation of the IHRs. Of the articles surveyed, the care roles of women are acknowledged in two pieces, one by the public health advocate Farmer and another by Martin-Moreno.³⁷ These two articles position women as a risk category because of their role as caregivers in the family and primary healthcare providers. This is an important acknowledgment, however the gender structures that reproduce norms of women as maternal carers and the future role of global health policy in reproducing such norms are not considered. Moreover, given the wealth of correspondence and

opinion pieces on Ebola in 2014, two sentences acknowledging women as maternal caregivers being disproportionately affected by the outbreak shows the otherwise invisibility of women and the gendered impacts of the outbreak.

Of all the papers reviewed only one focused explicitly on women and one on gender. The first is a piece of correspondence in *The Lancet* that highlights the impact the Ebola outbreak is having on maternal and newborn child services, stigma, and the vulnerability of women as primary caregivers. Menendez et al note Ebola 'is exacerbating problems that have persisted for decades' yet the main argument of the letter is that the global response needs to safeguard women and children's maternal and newborn child health services rather than address the gendered aspect of care.³⁸ The second paper contributes to wider discussion over the lack of funding to health systems by the international development community and reinforces concern over the increase in maternal mortality, suggesting Ebola presents a dual crisis: one of the disease itself and that of maternal and newborn child death.³⁹ The paper acknowledges the care dynamics that underpin the health systems of the three countries in question and argues for the need to address the structural dynamics of such systems. Both of these pieces, though short briefing interventions, highlight important issues concerning women and gender but do not fully engage how these issues are being considered within the wider response. They are isolated as stand-alone pieces and not fully integrated within the mainstream narratives on Ebola and show that the only (narrow) space women occupy within this debate is with reference to their role as mothers.

The narratives that have emerged in reaction to the Ebola response have not fully addressed how women may be disproportionately infected and affected by the disease and the gendered dynamics of health system resilience and access and provision of care and treatment. Where gender has been considered, it has been reduced to women as a vulnerable risk group in their role as carers or as mothers accessing maternal and newborn child health services. The Ebola crisis is not depicted as a gendered crisis or that women are a particular analytical concern in the response both in with regard to short term issues of how to stop the spread of Ebola and long-term strategies of how to develop resilient health systems. The construction of these narratives and the framing of women and gender within them are important as they both reflect and set the wider debate for international public policy on Ebola and demonstrate the invisibility of women and issues of gender in global health opinion and research.

Gender and emergency policy: The Ebola Response

The lack of engagement with gender and women in discussions around the Ebola response is reflected in international public policy strategies. These strategies developed by institutions such as the WHO and World Bank rarely include how the short and long term effects of Ebola may impact on women and men differently and do not include any acknowledgement of gender as a factor in how care is produced and consumed. Institutions such as UN Women and the African Development Bank have engaged the issue of gender when discussing both the short and long term response and impact of Ebola. However these institutions based such discussions on unconfirmed data that does not correspond with official WHO epidemiological data on the epidemic. This section reviews the international policy response to Ebola to show how first women and gender are invisible in the short and medium term policy response.

As the leading UN agency on health, the WHO had a core role in the Ebola response. The WHO Ebola Response Roadmap was the flagship co-ordination document of the international response to Ebola, it had the stated purpose of assisting government and building on ‘country-specific realities to guide response efforts and align implementation activities across different sectors of government and international partners.’⁴⁰ The Roadmap included a set of priority activities as part of each of its three objectives.⁴¹ ‘The needs of women’ are highlighted within one sentence alongside vulnerable groups such as cleaners in the twenty page document. There is no elaboration on what the ‘needs’ of women are beyond them constituting ‘a significant proportion of care providers.’⁴² The ‘needs’ of women are not listed anywhere else in the Roadmap as a priority activity and there are no gender disaggregated indicators or metrics in its monitoring and evaluation framework. This is a notable omission as a failure to measure the potentially different impact and death from Ebola on women and men suggests WHO did not recognise or was not concerned with how gender can impact on disease transmission and treatment.

WHO did not publish data on confirmed and probable Ebola cases disaggregated by sex until its 17th Situation Report in December 2015; one year on from the first suspected Ebola case in Guinea.⁴³ WHO’s ‘One year into the Ebola epidemic’ report only mentions women at the very end with reference to ‘Given the fear and stigma associated with Ebola, people who survive the disease, especially women and children, need psycho-social support and counselling services as well as material support.’⁴⁴ However it does not explain why women as a gender require such services especially more than men as a gender. The report tells the story of Ebola in 2014, and highlights the cultural and health systems aspects to its spread, but gender is not considered anywhere in the document.

Since the outbreak of Ebola, the World Bank has played a key role in galvanising resources for the response and for reviewing the economic impact of the disease on Guinea, Liberia and Sierra Leone. As of February 2015, the Bank committed US\$1 billion of International Development Agency (IDA) and International Finance Corporation (IFC) funds to its Ebola Recovery and Reconstruction Trust Fund, making it a significant player in the immediate response and long term recovery.⁴⁵ The focus of the Bank was to highlight how unprepared the three countries in West Africa and global health institutions were in responding to Ebola⁴⁶ and the potential short and long term economic losses to these countries.⁴⁷ The Bank saw women as particularly vulnerable to such economic losses as they work in informal, self-employed jobs. As one World Bank study in Liberia suggests that since the outbreak, ‘60 percent of women are not currently working, compared with 40 percent of men; and women have been consistently more likely to be out of work compared with men.’⁴⁸ The Bank does not have comparable studies for Sierra Leone and Guinea, but suggested such a vulnerable trend would be similar in Sierra Leone.⁴⁹ For Sierra Leone, a Bank report notes ‘Gender impacts are inconclusive,’ there is some evidence of a decline in post-natal services in Freetown but not the rest of the country.⁵⁰

The World Bank’s consideration of gender is limited to two small sections of country reports on the socio-economics impacts of Ebola. Gender or women and men are not mentioned in any of the Bank’s multiple press releases or President Jim Kim’s statements or speeches on Ebola as of February 2015. The World Bank’s report on ‘The Economic Impact of the 2014 Ebola Epidemic’ received considerable attention given the estimated restrictions on growth on account of Ebola.⁵¹ The Report detailed the potential impacts of Ebola on aspects of the economy such as mining, agriculture, services and food prices, but did not discuss potential gendered impacts or the role of women within these economies. The issue of gender was not systematically included in each round of the country-specific studies on socio-economic impact of Ebola. Hence the Bank has not fully considered the gendered impacts of Ebola on both Guinea, Liberia and Sierra Leone’s health systems and economy.

The only institutions to note concern over the gendered aspects of Ebola have been UN Women and the African Development Bank. A blog by the African Development Bank Special Envoy on Gender, highlights restrictions on women’s access to health services and the impact of Ebola on their employment given the impact on the agricultural and tourism sectors, and informal economy in which women work. The over-arching argument of this gender-approach is to think about the long-term effects of Ebola on the working lives and livelihoods of women. However the most interesting element of the blog is the citation of Washington Post data suggesting women made

up 52% of deaths from Ebola in Sierra Leone, 55% in Guinea and 75% in Liberia.⁵² The data used in this blog entry was similarly cited in UN Women's Inter-Agency Standing Committee 'Gender Alert' on Ebola.⁵³ This alert used historical evidence to highlight the primary care roles of women in the formal health sector and informally within the family and communities in which they live and the increased risk to pregnant women given their heightened contact with health services. Accompanying the issues raised in the alert are a number of action points that provide helpful tools for international policy and strategy.

Importantly, however, once WHO stratified data by male and female in December 2014 it turned out that the data cited in the UN Women and African Development Bank papers was inaccurate (significantly so with respect to Liberia) and evidence from research in the three countries suggests assumptions about body-washing made by UN Women (i.e. that women wash both male and female dead bodies) to be incorrect (in most countries it is custom for men to wash male dead bodies and women to wash female dead bodies).⁵⁴ Since stratifying the data on cumulative confirmed and probable cases 'the number of cases in males and females is about the same'⁵⁵ and has continued to be the same in all reports published up to January 2015. Hence, one could argue that there is no gender disparity in the number of people dying and infected with Ebola, there is no gender difference in who is washing the bodies, and hence it is not an issue of concern or priority in the global response to Ebola.

Discrepancy over the data is problematic for the visibility of women and gender for several reasons. First, there is much to suggest that such data is inconclusive. The WHO acknowledges that confirmed and suspected cases are estimates and could be 2-4 times higher than the situation reports suggest.⁵⁶ Given the infrastructural problems of the health systems in Guinea, Liberia and Sierra Leone mapping the outbreak and confirming Ebola cases has been particularly difficult. The small number of laboratories, problems with information management between IT services and the health sector, and stigma and secrecy within communities that leads people to hide or dispose of the dead themselves without reporting them can each cause problems in tracking and recording confirmed and suspected cases. Second, the research that is disseminated and published by the World Bank and WHO tends to be based on quantitative estimates and does not take into consideration on-the-ground qualitative studies that may tell a different tale, particularly when it comes to gender sensitivities, hierarchies and the different health, social, and economic impacts of Ebola on men and women. Third, the publication of conflicting data by UN Women can be used to discredit the institution and, in so doing, the need to ask questions of gender in the Ebola response. Therefore, while the WHO data suggests no gender difference in confirmed and

suspected cases of Ebola, this pertains to one (albeit important) aspect of the disease, rests on estimates that are difficult to make, and does not employ a range of research methods to address various aspects of impact that cannot be quantified. In sum, just because delayed data suggests no difference in male and female confirmed and suspected cases of Ebola does not mean gender is not an issue with regard to Ebola.

The data and evidence collated on Ebola by leading institutions such as the WHO and World Bank did not systematically take gender into account and did not see the impacts on men as a gender and women as a gender as potentially different or of concern. The conspicuous invisibility of women and gender has precluded any systematic and continued research on potential gender difference not only in confirmed and suspected cases but the wider socio-economic impacts on men and women by the WHO and World Bank. This is an important omission in both the response to Ebola and the position of women in global health governance: it assumes that there is no gender bias in the delivery and uptake of health services and that gender is not of concern or consideration in public health emergencies.

Gender and long-term strategy: health systems

If gender was not a concern in the immediate, emergency response to Ebola, it is important to consider whether women and gender remain conspicuously invisible in long-term strategies of health system strengthening. One of the core priorities emerging from the Ebola response is the need to strengthen health systems in low and middle income countries. According to WHO, there are five central elements to a functioning health system: leadership, information systems, health workforce, financing, supplies and service delivery.⁵⁷ As the previous sections have demonstrated, part of the blame for the spread of Ebola has been on weak country health systems that were ill-equipped to address the outbreak. In a similar pattern to the absence of women or gender in the framing of the Ebola outbreak, those that have used Ebola as a basis to argue for further health system strengthening and commitment to the IHRs do not say anything about gender within this process.⁵⁸ Strategies to address and strengthen health systems focus on the formal economy and government practices, however such systems also depend on an informal care economy. Weak health systems are often under-pinned by an informal care economy made up of voluntary carers working with community-based groups, non-governmental organisations, or independently in response to the needs of the community and carers working in extended families. These roles tend to be occupied by women. However because these roles are informal and assumed because of

gender norms over what women's work is and what men's work is, such care roles are conspicuously invisible in international public policy-making: people know they exist, that women are over-represented in them, yet women are invisible in global health planning, strategy and implementation beyond the role of women as mothers.

As with the emergency response to Ebola, strategies for health system strengthening firmly locate women as mothers in global health strategies. This is particularly the case in the WHO's Framework for Action on strengthening health systems 'Everybody's Business.'⁵⁹ Gender within the action plan is framed in the wider context of the WHO's commitment to human rights and the 'gender mix' of the health labour of different countries. Gender is acknowledged at in three parts of the document:

'in many countries, groups such as the poor – and too often women more than men – migrants and the mentally ill are largely invisible to decision-makers'⁶⁰

'WHO will increase its support for realistic, national health workforce strategies and plans for workforce development. These will consider the range, skill-mix and gender balance of health workers'⁶¹

Medium-term Strategic Objective: 'To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor gender-responsive and human-rights based approaches.'⁶²

What these three excerpts suggest is while the WHO acknowledges gender difference in the health workforce, it does so within the wider context of human rights for all and places the emphasis for action on member states. The document does not stipulate what a gender-responsive health system would look like or the role of the WHO in articulating this or partnering countries to develop this. The focus on gender in the action plan is very much on formal health workers with no reference to the informal care economy or gender difference within it. Gender is seen as a barrier to accessing health services, particularly with reference to maternal health, but gender is invisible with reference to how health services are underpinned by the free labour of women. Gender only appears in the IHRs with reference to accounting for the concerns of travellers with regard to gender, ethnicity, religion, and sociocultural factors: there is no reference to gender, feminised care or the informal role of women in health system strengthening.⁶³ Thus, gender is assumed as an issue that impacts on the formal labour of health workers and accessing health services and it is assumed that states are aware of this and will both articulate and action gender-responsive health systems.

The World Bank's strategy for health, nutrition and population 'Healthy Development' incorporates gender as an indicator of health disparities and constraints. Here the Bank emphasises the need for states to disaggregate priority indicators by gender and age and commits to increased support for countries to identify health systems constraints, including gender, income and geography.⁶⁴ This, however, is only a minor part of the strategy. The main gendered focus is on reproductive and maternal health services and maternal mortality where the strategy outlines a set of indicators on contraceptive access, and safe delivery. The Bank stresses the need to improve health services to meet the needs of women because:

Women endure a disproportionate burden of poor sexual and reproductive health. Their full and equal participation in development is contingent in accessing sexual and reproductive health care, including the ability to make voluntary and informed decisions about fertility.⁶⁵

The position of gender within the Bank's strategy is therefore to improve women's maternal health as an instrumental means to enable their participation in delivering development. Nowhere in the document does the Bank acknowledge what women's role in development is, or the gendered aspects of women's labour in delivering on key health and development priorities such as MDG2 'Reduce Child Mortality' and MDG4 'Achieve Universal Primary Education.' The role of women in underpinning key development goals and health system targets and indicators is assumed by institutions such as the Bank or seen as something they need to be healthy to do. In this sense, women's health is not seen as an end in itself but as a means for them to perform social obligations and functions to deliver development expected of them as a gender.

The instrumental framing of women in the Bank's strategy and the focus on maternal health in both the WHO and Bank's strategies is unsurprising. Women have long-been positioned in instrumental roles in international development typified by what Chant depicts as 'the feminisation of poverty alleviation.'⁶⁶ What is important here is institutions do not challenge or acknowledge the role of women as a gender in providing free, elastic labour that underpins functioning health systems. The informal care economy is conspicuously invisible and women's health is framed with regard to this invisibility: women are only visible in global health policy as mothers. In making women visible as mothers global health institutions reproduce gender norms of social reproduction. The reproduction of such norms can have direct impacts on women's health – as primary carers and first responders to people sick with highly infectious diseases such as Ebola – and indirect impacts on ill health of women from the burden of care, employment, and family responsibilities. Hence conspicuous invisibility not only shows a wilful blindness on the part of

these institutions, but exacerbates the vulnerability of women in society and their susceptibility to infectious diseases such as Ebola.

Making women and gender conspicuously visible in global health

There is an argument that suggests the failure to recognise women and issues of gender in the Ebola response was not wilful blindness but born out of the emergency situation those combating the epidemic found themselves in. Ebola spread rapidly and the early days of the response were a confused and desperate time, particularly in countries such as Sierra Leon and Guinea. In these countries, the immediate response was crisis management conducted by a sporadic group of committed people rather than a systematic and well-resourced operation. Part of the problem of the conspicuous invisibility of women in the Ebola response was the lack of any professional crisis management in the early stages of the outbreak that may have recognised the need to raise questions of gender. However, this only explains part of the story, as women remained conspicuously invisible from policy and practice as such expertise arrived. The story of Ebola shows that when a health emergency arises issues of gender are forgotten and at best viewed as a side issue. Therefore the first recommendation that can be made is to build gender-awareness and planning into operational responses to complex health emergencies. This awareness should begin with the basic question of gender and feminist studies that asks – where are the women? – when formulating a plan of action. Epidemiological data needs to be disaggregated by gender from the outset. Community mobilisers need to be both male and female. Any framework for action has to understand the formal and informal roles of men and women in the local care economy. Gender affects health crises as they happen and therefore needs to be addressed as a health crisis unravels not after the event as part of the lessons learned to be ignored.

The second recommendation is that those who deliver responses to public health emergencies of international concern – the health sector, humanitarian agencies, and in this instance, domestic and foreign militaries – need to both be aware of the effect of gender on health outcomes and crisis management and know how to ask questions that make women and their needs visible in response planning. As responses to health issues increasingly involve actors from the security sector it is not enough for the gender experts of health institutions alone to be trained in such issues. The security sector, especially those military actors involved in the Ebola response in Sierra Leone, have a tendency to not only overlook issues of gender difference in how men and women experience disease, but reproduce gender norms in masculinized spaces of decision-making and implementation.⁶⁷ Women need to be conspicuously visible in the minds of all actors responding to health emergencies.

The third recommendation is to put gender and the informal economy at the forefront of debates on health system strengthening. The first step is to ask where the men and women are in health systems in both the formal and informal delivery of healthcare. The second step is then to identify how health systems can be adapted to meet the different needs of men and women, particularly in resource poor settings. The third step is to ensure that women and gender are not isolated to reproductive, maternal and newborn child health but are systematically addressed across the health sector. This requires a consistent challenge of asking where the women are in health systems and strategies and financing for health system strengthening at every stage of the policy process: from design to implementation. Such questions have to be asked by everyone involved in health policy and planning, not just by gender specialists within specific institutions as they can be systematically ignored, isolated or instrumentalized as evidence that gender was considered in the health policy process. These steps will provide a simple basis from which more systematic and long term change towards gender equality in global health governance both in crisis management and everyday health systems can be made.

Conclusion: Conspicuously Invisible Women and Global Health Governance

Women are conspicuously invisible in global health governance: everyone knows they are there and that they do the majority of the care work, but they remain invisible in global health policy. 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 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 was late in coming, and no strategy includes gender indicators. This could in part be explained by the lack of evidence to suggest Ebola is a gendered disease with regard to mortality and infection, and indeed, the data (however flawed) would suggest there is not a case to be made here. However focusing on the data alone misses the wider point: this does not explain the lack of gendered concerns with regard to the care and treatment of people with Ebola and the feminised care economy that underpins the health systems that are key to preventing an outbreak of such magnitude happening again. Women are only made visible in the Ebola response and wider strategies of global health as mothers.

This paper furthers understanding of gender and women in global governance and global health in two key ways. First the article builds on feminist research on gender blindness and the male bias

to highlight an area of concern where women are conspicuously present in a number of core roles yet remain invisible to policy-makers. These roles are hidden in plain sight of those working in global health. Global health governance at best takes women's care and social reproduction roles as a given, but at worst engages in policy practices and strategies that keeps these roles invisible to debate, knowledge creation and policy. Second, the Ebola outbreak and response is indicative of how care is unaddressed in global health governance. Care underpins various dimensions of economies and societies, but none as plain as the delivery of health and well-being. Depicting women as conspicuously invisible highlights the tension between health and care in global health, and between knowing women conspicuously underpin health systems through care roles and rendering women invisible in global health governance so as to not take any measures to recognise or address such roles.

In conclusion, the 'perfect storm' of post-conflict, lack of health system investment, and a weak WHO that led to the unprecedented Ebola outbreak in 2014 misses out a crucial part of the storm: the free, supposedly elastic work of women that underpin health systems through social and primary health care roles. To develop resilient health systems, global health policy-makers and scholars need to not only think about how gender acts as a barrier to health services and as an enabler of poor health but also about how global health strategies reproduce social and health care burdens on women as a gender. A start would be to make visible the conspicuous feminised nature of care, to consider gender in emergency and long-term health strategies, to recognise and place value on care roles that are very much a part of health systems, and crucially to ask where the women are in emergency and long term health systems policy and planning. Until care is valued and gender and women are made visible beyond issues of maternal health, health crises will continue to test health systems that rest on feminised care provision and will exacerbate the poor health of women. Health systems are not only built on leadership, information systems, health workforce, financing, supplies and service delivery, but the free labour of women in social reproduction and care.

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Notes

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² See for example: Madorin et al 'Advanced economy, modern welfare state and traditional care regimes'; Palriwala and N. (2012). 'Between the state, market and family,' 176-197

³ Rai et al 'Depletion and Social Reproduction'

⁴ Rai and Waylen, 'Feminist Political Economy,' 1-18

⁵ Razavi and Staab, 'Introduction,' 1-25; Elson, 'Economic crises from the 1980s to the 2010s,' 189-212

⁶ See for example Young, et al (eds) *Questioning Financial Governance from a Feminist Perspective*

⁷ Razavi, 'Addressing/reforming care, but on whose terms?' 114-134

⁸ Razavi and Staab, 'Introduction,' 1-25

⁹ Elson, 'Male bias in the development process,' 3

¹⁰ Elson, 'Male bias in the development process,' 1-28

¹¹ Rai and Waylen. 'Feminist Political Economy,' 1-18

¹² Yeates, 'Women's migration, social reproduction and care,' 219-243

¹³ See for example Doyal, *What Makes Women Sick*

¹⁴ Baylies and Bujra, *AIDS, Sexuality and Gender in Africa*; Doyal et al (eds), *AIDS: Setting a Feminist Agenda*

¹⁵ Anderson, *Gender, HIV and Risk*

¹⁶ Seckinelgin, *International Security, Conflict and Gender*

¹⁷ Griffin, *Gendering the World Bank*

¹⁸ Razavi and Staab, 'Introduction,' 1-25.; Harman, 'The Dual Feminisation of HIV/AIDS'; Anderson, 'Infectious Women,' 267-87

¹⁹ WHO, *Women and Health*

²⁰ Harman. 'Women and the MDGs'

²¹ Bates et al, 'Gender and health inequities,' 1002-1004; Springer et al, 'Introduction: Gender and Health,' 1661-1666; Springer et al, 'Beyond a catalogue of differences,' 1817-1824

²² WHO, 'Six months after the Ebola outbreak was declared.'

²³ Gostin, 'The President's National Security Agenda,' 27-28.

²⁴ Drazen, 'Editorial: Ebola and Quarantine,' 2029-2030; 'Ebola, Quarantine and the law' 5-6; 'Editorial: Rationality and co-ordination for Ebola outbreak in West Africa' 1163

²⁵ Alcabes, 'Race and panic: America confronts Ebola,,' Dionne and Seay, 'Perceptions about Ebola in America,' 6-7; Hankivsky, 'Intersectionality and Ebola,' 14-15

²⁶ Friedrich, 'Potential therapies and vaccines to combat Ebola,' 1503

²⁷ Trad, 'Ebola in West Africa,' 779; Kass, 'Ebola, ethics and public health: what next?' 744-745; Gupta, 'Rethinking the development of Ebola treatments,' e563-564.

²⁸ Kanapathipillai, 'Ebola vaccine – an urgent international priority,' 2249-2251; Fisman and Tuite, 'Ebola: no time to waste,' 1164-1165; Galuani, et al. (2014). 'Ebola vaccination: if not now, when?' 749-50.

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- ²⁹ O'Hare, 'Weak health systems and Ebola' e71-72; Ross et al, 'Are we ready for a global pandemic of Ebola virus?' 217-218
- ³⁰ Piot, 'Editorial: Ebola's perfect storm,' 1221; Piot et al, 'Ebola in West Africa,' 1034-1035.
- ³¹ Salmon et al, 'Community-based care of Ebola Virus Disease in West Africa,' 151-152
- ³² Kieny and Doulo, 'Beyond health systems: a new agenda for resilient health systems,' 91-92.
- ³³ Youde, 'The World Health Organisation and responses to global health emergencies,' 11-12; Busby and Grepin, 'What accounts for the World Health Organisation's failure on Ebola?' 12-13
- ³⁴ Trad et al, 'Editorial: Ebola in West Africa,' 1045; Gostin, 'The Ebola Epidemic: a global health emergency'; Baden, et al, 'Editorial: Ebola – an ongoing crisis,' 1458-1459; Mullan, 'Editorial: Ebola: the missing link'; 'Overview of Ebola Virus disease in 2014,' 51-55, 2015; Martin-Moreno et al, 'Ebola: an open letter to European governments,' 1259; 'Editorial: Ebola: a failure of international collective action,' 637.
- ³⁵ Harman, 'Is time up for WHO?'
- ³⁶ Gostin, 'Ebola: towards an international health systems understanding,' 9951; Gostin and Friedman, 'Ebola: a crisis of global health leadership,' 9951; 'Editorial: Ebola: what lessons for the International Health Regulations?' 1321.
- ³⁷ Farmer, 'The largest ever epidemic of Ebola,' 157-162; Martin-Moreno, 'The international Ebola response,' 525-526.
- ³⁸ Menendez et al, 'Ebola crisis: the unequal impact on women and children's health,' e130.
- ³⁹ Diggins and Mills, 'The pathology of inequality: gender and Ebola in West Africa'
- ⁴⁰ WHO, 'Ebola Response Roadmap,' 4
- ⁴¹ WHO, 'Ebola Response Roadmap'
- ⁴² WHO, 'Ebola Response Roadmap,' 10
- ⁴³ WHO, 'WHO Situation Reports: 17th December 2014'
- ⁴⁴ WHO, *One year into Ebola epidemic*, p50
- ⁴⁵ World Bank, 'Ebola Response Factsheet'
- ⁴⁶ World Bank, 'Press Release: World Bank Group President.'
- ⁴⁷ World Bank, 'Ebola: Most African Countries Avoid Major Economic Loss'; World Bank, 'Ebola Hampering Household Economies across Liberia and Sierra Leone.'
- ⁴⁸ World Bank, 'Ebola Hampering Household Economies across Liberia and Sierra Leone'; World Bank, 'The Socioeconomic Impacts of Ebola in Liberia – Round 3'
- ⁴⁹ World Bank, 'The Socio-economic impacts of Ebola in Sierra Leone.'
- ⁵⁰ World Bank, 'The Socio-economic impacts of Ebola in Sierra Leone,' 13
- ⁵¹ World Bank, . *The Economic Impact of the 2014 Ebola Epidemic*
- ⁵² Fraser-Moleketi, 'Ebola: the need for a gendered approach'
- ⁵³ UN Women Inter-Agency Standing Committee, 'Humanitarian Crisis in West Africa (Ebola): Gender Alert,' 2.
- ⁵⁴ Richards and Yei-Mokuwa. 'Burial Practices'
- ⁵⁵ WHO Situation Reports, 'WHO Situation Reports: 17th December 2014'
- ⁵⁶ WHO, 'Ebola Response Roadmap'
- ⁵⁷ WHO, *Key components of a well functioning health system*
- ⁵⁸ Gostin, 'Ebola: towards an international health systems understanding'; Gostin, and Friedman, 'Ebola: a crisis of global health leadership'; 'Editorial: Ebola: what lessons for the International Health Regulations?' 1321.
- ⁵⁹ WHO, *Everybody's Business*
- ⁶⁰ WHO, *Everybody's Business*, 8
- ⁶¹ WHO, *Everybody's Business*, 17
- ⁶² WHO, *Everybody's Business*, 38
- ⁶³ WHO, *International Health Regulations*
- ⁶⁴ World Bank, *Healthy Development*
- ⁶⁵ World Bank, *Healthy Development*, 88
- ⁶⁶ Chant, 'Rethinking the 'Feminisation of Poverty',' 201-20
- ⁶⁷ Kamradt-Scott, 'Saving Lives,' p16.