VIOLENCE AGAINST HEALTH CARE MUST END

IT'S A MATTER OF LIFE & DEATH

STUDY ON ACCESS TO HEALTH CARE DURING ARMED CONFLICT AND OTHER EMERGENCIES:

EXAMINING VIOLENCE AGAINST HEALTH CARE FROM A GENDER PERSPECTIVE

SwedishRedCross

REPORT

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FOREWORD

Many of today's complex crises are marked by indiscriminate violence, extreme brutality and systematic violations of international humanitarian law and human rights. Amongst these breaches, we see worrying patterns of violence directed against, or directly affecting, humanitarian missions such as health care, manifesting as direct attacks, murder, abuse, threats, kidnapping, obstructions and discrimination. The humanitarian needs are immense and the pressure, particularly on local communities, is enormous. At the same time, humanitarian access is limited and complex.

In 2008, the International Committee of the Red Cross (ICRC) started to collect and analyze data on security incidents affecting health care in a more systematic way. In 2011, a first report was published, which gave an initial understanding of the major trends, but also recognized that it was only the tip of the iceberg. At the 31st International Conference of Red Cross and Red Crescent in November 2011, the States Parties to the Geneva Conventions and the Red Cross Red Crescent Movement agreed that we must act together to overcome the problem. *The resolution Health Care in Danger: Respecting and Protecting Health Care* was adopted.

Expert consultations were initiated to discuss practical recommendations. To mobilize broad support and worldwide engagement, an awareness raising campaign was launched. Major stakeholders such as the World Medical Association, the World Council of Nurses and the International Committee of Military Medicine have joined the initiative. The security of health care has also been addressed by the World Health Organization and recently by the UN General Assembly. Key health NGOs have started campaigns such as "Medical care under fire" by Doctors without Borders.

In our efforts to support the implementation of the Health Care in Danger Resolution, the Swedish Red Cross initiated a dialogue with the ICRC on how gender perspectives could be integrated into our work addressing violence against health care. An important first step was to promote collection of data that was sex disaggregated. The Swedish Red Cross and the ICRC decided jointly that a study on the impact of gender – particularly looking at access to health care – would benefit the overall objective of Health Care in Danger to improve respect and security for health care.

This report echoes what we as a humanitarian community have learned from other studies and reflections. We know that men, women, boys and girls are impacted differently by armed conflict. For International Humanitarian Law – and its interpretation and application – to stay true to its humanitarian quest, it is important to identify and react to the specific needs, risks and vulnerabilities that conflict today is causing men and women respectively, and to recognize how power relations affect the abilities to access support.

Our understanding is that a lack of consistent, adequate gender and diversity analysis is a missed opportunity since it ignores a wider holistic analysis of complex systems based on the context, roles and responsibilities, access to and control over resources, specific needs, capacities and rights, simply by not having a gender and diversity lens on and asking the right set of questions. A proper gender analysis that takes into account other factors of diversity could identify, prevent and mitigate potential negative effects, as well as avoiding doing harm.

It is necessary for every organization that wants to be relevant in today's world to take into account the different conditions that exist due to gender differences and to adopt a gender and diversity perspective that permeates both its structures and the activities it performs. If this is done well, greater organizational efficiency and effectiveness will result.

We hope that this report will be one amongst a series of steps to rectify this oversight and to begin to adopt practices that meaningfully address the needs of men, women, girls and boys in their pursuit of the right to health care, even in times of conflict and emergency.

Eva von Oelreich
President, Swedish Red Cross

EXECUTIVE SUMMARY

Why this study?

Violence against health care has emerged as a major humanitarian challenge, with wide-reaching consequences for sick and wounded men, women, girls and boys who are entitled to health care under International Humanitarian Law. There has been much progress made in understanding the problematic of violence against health care and working towards solutions, notably through the ICRC-initiated Health Care in Danger campaign. Despite this momentum, however, a gender lens has not been applied to look at how violence against health care in the context of armed conflict and other emergencies affects men and women health workers differently, as well as how these threats and attacks differently affect the extent to which men, women, girls and boys are able to access health care. This study was conceived as a first step in filling the knowledge gap of the interplay between gender and access to health care within a context of violence against health care. The study endeavours to contribute to a more nuanced understanding of the issues with an aim to inform more practical, applicable, and appropriate measures on the ground. Ultimately, the study seeks to strengthen current and future work by all stakeholders involved in ensuring safe access to health care by all.

Research Questions and Methodology:

The study sought to answer the following research questions:

1 What are the main obstacles and challenges to safe access to and provision of health care in conflict for women, girls, boys and men?

2 Are the diverse needs, strengths and vulnerabilities of women, girls, boys and men properly identified and assessed in order to facilitate access to and provision of health care?

3 What are the consequences and effects arising from the identified gendered differences to access to and provision of health care?

4 Given the important role IHL plays in providing protection and justice to the victims of armed conflict, how can the knowledge about the different ways men, women, girls and boys are affected by violence against health care impact the application of IHL?

The study was marked by three research phases: desk research (July 2014-January 2015); field research visits to Lebanon and Colombia (12-23 November 2014 and 31 November 8-December 2014, respectively); and finally a stakeholder's workshop to discuss the study's findings (Stockholm, Sweden, 27 January 2015). The study used secondary sources from published documents, journal articles, blog posts and news reports, as well as primary sources including focus group discussions and key informant interviews conducted before, during and after field visits to the two case contexts of Lebanon and Colombia. Four respondent groups were identified to participate in the study: state actors; NGOs and Red Cross movement actors; health care providers; and community members. Various challenges meant that the methodology was not applied uniformly in both contexts. The remaining gaps and unanswered questions revealed in this report should motivate other actors to continue exploring the role that gender plays in different groups' access to health care and what implications these pose for our approach to mitigating the impacts of violence against health care.

Key Findings:

- The specificity of a given context cannot be overstated while analyzing particular risks and dynamics of access to health care; even adjacent neighbourhoods may be faced with different realities and requiring different approaches to improving access

THE CHALLENGES OF SADD: ASSUMPTIONS AND PRACTICE

- Adequate sex- and age-disaggregated data (SADD) on violence against health care is generally lacking, which prevent proper risk analyses to inform appropriate and effective mitigation strategies
- In addition to logistical challenges, attitudes and a lack of understanding of the relevance of SADD to health care delivery may impede its collection on the ground

GENDERED DIVISION OF LABOUR IN HEALTH CARE AND LINKS TO VIOLENCE

- In roles that are disproportionately male (eg. ambulance drivers) or female (eg. health outreach workers), it is unclear whether and to what extent risks associated with these positions are exacerbated or mitigated by one's gender

SETTINGS AND TYPES OF RISKS OF VIOLENCE

- Certain areas within a health facility may expose health care personnel to different risks eg. emergency room
- Time of day may also be a factor in health care personnel's level of risk
- Treating survivors of sexual violence may expose health care personnel to risks of threats and/or violence, which may deter some health care personnel from providing services, the majority of whom are likely to be women and girls
- Official or de facto control over certain neighbourhoods or areas may pose physical barriers to access to health care, which in some cases may be lessened by one's gender eg. women being able to cross 'invisible borders' due to the perception that they are less likely to be associated with the conflict

- Cultural factors related to gender may pose challenges for men and women to receive health care eg. women requiring a male family member to accompany her to a health facility
- Men may face unrecognized barriers to health care if threats of recruitment or other violence exist en route to a health facility

OTHER FACTORS AFFECTING ACCESS TO HEALTH CARE

- Depending on the context, other factors may act as determiners to access to health care eg. religious sect/ethnicity; social connections; and association with a given side of a conflict.

PRACTICES AND POLICIES OF HEALTH CARE PROVIDERS RELATED TO GENDER AND RISK

- Health care delivery practices may be reflective of perceived and/or actual gender dynamics in the communities they serve. Some examples found were: all female community outreach teams to increase likelihood of acceptability and access; assigning a male interlocutor to negotiate ambulance access at checkpoints; deploying all-male first response teams based on perceptions of female inadequacies under stress.

Recommendations:

A full set of recommendations specific to five concerned stakeholder groups (armed actors; state actors; health care providers; NGO and Red Cross Red Crescent movement; and community members) can be found in the full report.

Main Recommendations:

- Systematically collect and analyze sex- and age-disaggregated data (SADD) and adapt operations and policies accordingly
- Base operational and security decisions on an analysis of gender and diversity dynamics specific to the operational context
- Ensure the inclusion of a gender and diversity perspective – assessing the different status, needs, and capacities of men, women, girls and boys – in the implementation and fulfilment of obligations to provide health care under relevant IHL, IHRL and domestic laws in order to give effect to the principle of non-discrimination
- Design facilities and outreach activities in a manner that reduces and mitigates risks of violence towards both health care providers and health care seekers
- Conduct regular check-ins with male and female staff, volunteers and health care seekers to identify new or changing risks associated with health care delivery
- Conduct further research to deepen stakeholders' understanding of the challenges and capacities of different groups in providing and accessing health care (see Suggested Further Research Topics)

Suggested Further Research Topics:

- In general, conduct more in-depth, multi-country comparison studies on whether and to what extent gender influences safe provision of and access to health care, including case studies from high-income countries and outside the context of armed conflict or emergencies
- Do male and female health care personnel face different risks of violence while delivering health care? How do these risks relate to their specific job function?
- What are the specific challenges and capacities of young and adolescent girls and boys in accessing safe health care during conflict and other emergencies?
- Given the important role IHL plays in providing protection and justice to the victims of armed conflict, how can the knowledge about the different ways men, women, girls and boys are affected by violence against health care impact the application of IHL?

INTRODUCTION AND BACKGROUND

Violence against health care in armed conflicts and other emergencies has emerged as one of the key humanitarian challenges of our time. The knock on effects of threats and attacks against health care severely impact whether and to what extent sick and wounded men, women, girls and boys are able to enjoy their right to health. International Humanitarian Law (IHL) requires that health care facilities shall be respected and protected at all times and shall not be the object of attack, and that health care should be provided to those most in need without adverse distinction. In addition to IHL, International Human Rights Law (IHRL) provides the framework for protecting health care in all times, during both peace and conflict[1].

To address these humanitarian challenges, the 31st International Conference of the Red Cross Red Crescent adopted a resolution, 'Health Care in Danger: Respecting and Protecting Health Care', which calls upon States to do their utmost to protect, respect, and ensure safe access of the sick and wounded to health care in times of conflict, as well as the protection of medical personnel, facilities, and transports. Further, in the same resolution, States party to the Geneva Conventions and the Movement are *"recalling* the basic obligation to provide all possible health care to the wounded and sick without discrimination[i]."

Much has been written about how armed conflict affects access to health care in general. However, a gender lens has not been applied specifically to look at how violence against health care in the context of armed conflict and other emergencies affects men and women health workers differently, as well as how these threats and attacks differently affect the extent to which men, women, girls and boys are able to access health care.

1 Please see Annex I

Although some data and analyses on trends of violence against health care personnel, sick and wounded exists, it is largely gender-blind. A better understanding of the dynamics that render certain groups relatively more vulnerable to being adversely affected by threats and violence – and why – will help to improve efforts to mitigate risks of and response to violence and will ultimately contribute towards improved access to health care for men, women, girls and boys.

This study was conceived as a first step in filling this knowledge gap of the interplay between gender and access to health care within a context of armed conflict and emergencies. The study endeavours to contribute to a more nuanced understanding of the issues with an aim to inform more practical, applicable, and appropriate measures on the ground. Ultimately, the study seeks to strengthen current and future work by all stakeholders involved in ensuring safe access to health care by all.

Key Definitions:

Access

According to the International Covenant on Economic, Social and Cultural Rights (ICESR), accessibility to health care is understood as having four 'overlapping dimensions': 1. Non-discrimination; 2. Physical Accessibility; 3. Economic Accessibility (affordability); and 4. Information Accessibility[ii].

Gender

Gender refers to the social differences between females and males throughout their life cycles. Although deeply rooted in every culture, these social differences between females and males are changeable over time and are different both within and between cultures. Gender determines the roles, power, and resources for females and males in any culture[iii].

Diversity

Diversity means acceptance and respect for all forms of difference. This includes, but is not limited to, differences in: gender, sexual orientation, age, disability, HIV status, socio-economic status, religion, nationality and ethnic origin (including minority and migrant groups). Gender interacts with other aspects of diversity as there is an important interrelationship between discrimination on the basis of gender and discrimination because of other forms of diversity[iv].

Health Care

Health care refers to the facilities and services provided in the contexts under consideration and includes:

- hospitals, clinics, first-aid posts, laboratories, blood transfusion centres, pharmaceutical stores of those facilities; this term includes but goes beyond the different categories of "medical units", specifically protected under IHL and entitled to use the RC emblems for protective purposes, ambulances and support vehicles;
- personnel working in the above facilities or in the community in their professional capacity;
- staff of the International Red Cross and Red Crescent Movement, including volunteers working in the delivery of health-care;
- State armed forces' health-care facilities and personnel;
- Medical personnel of armed groups;
- Health-oriented NGOs and first aiders[v].

Violence

Violence means the intentional use of physical force or power – threatened or actual – against oneself, another person, or against a group or community that results in or has the likelihood to result in injury or death, psychological harm, maldevelopment or deprivation[vi]. For the purpose of this study, violence will refer to both *collective* and *interpersonal* violence[vii].

METHODOLOGY, LIMITATIONS AND CHALLENGES

The overall approach of this study was to probe into the experiences of health care providers and health care seekers to learn from these so that we may better inform further research and action on ensuring access to health care for men, women, girls and boys. As such, the study was not designed to provide a new set of recorded incidents or trend analysis. Rather, this study seeks to apply a gender lens to the issue of violence against health care in order to begin to unearth some issues that may not have otherwise been considered. Lebanon and Colombia were selected as case contexts and are used here as concrete examples through which to illustrate how some of these issues may unfold on the ground.

The central research questions for this study are as follows:

1 What are the main obstacles and challenges to safe access to and provision of health care in conflict for women, girls, boys and men?
2 Are the diverse needs, strengths and vulnerabilities of women, girls, boys and men properly identified and assessed in order to facilitate access to and provision of health care?
3 What are the consequences and effects arising from the identified gendered differences to access to and provision of health care?

4 Given the important role IHL plays in providing protection and justice to the victims of armed conflict, how can the knowledge about the different ways men, women, girls and boys are affected by violence against health care impact the application of IHL?

METHODOLOGY

The research for this study included primary and secondary sources. Due to the nature and purpose and scope of the study, the focus was on collecting qualitative rather than quantitative data, especially during primary research.

The first phase of research included a desk review of documents and materials from a variety of sources and disciplines, including UN and NGO documents; news reports; databases; academic journals; and blogs associated with established organizations. Desk research began in July 2014 and continued into the second phase, the field research. One field visit each was conducted in Lebanon (12-23 November 2014) and Colombia (31 November-8 December 2014) respectively. The contexts and locations within each country were chosen with a view to represent diverse contexts such as geography and nature of the conflict(s). Logistical and accessibility factors also determined the selection of the case contexts. All locations selected within each country were affected by armed conflict and/or other emergencies characterized by collective violence, and were chosen to provide the highest degree of representation possible, including differences in sectarian and/or political identity of the community, urban vs. rural environments, and different manifestations of conflict. It is worth noting that the information gathered cannot be understood as being fully representative of the respective country or even the local region. Rather, this is a very small-scale, preliminary exploration into the issues faced in a few communities as expressed by a relatively small number of people.

Four categories of respondents were identified to participate in the study: state actors (eg. representatives of the Ministry of Health); NGO and Red Cross Red Crescent staff and volunteers; health care personnel; and community members. Key informant interviews were conducted with selected respondents, while focus group discussions (FGDs) were held with community members, groups of health care providers and Red Cross staff and volunteers.

Where possible, especially for FGDs, a native speaker of the local language (Arabic or Spanish) provided translation support or led the facilitation of the session. With informed consent from participants, notes were taken on the spot in all interviews and FGDs. When additional informed consent was provided, an audio recording device was used to increase the accuracy of transcriptions[2]. All participants were given information on the purpose of the study before the session commenced, and information on supportive services for survivors of violence was available in case any disclosures arose.

As part of the study's process, an Expert Consultation was hosted by the Swedish Red Cross on 27 January 2015 in Stockholm, Sweden. Participants from the Red Cross Movement, NGOs and government agencies were invited to the one-day workshop, which elicited reactions and recommendations to the study's initial findings from a selected group of stakeholders. The Recommendations section of this report is largely reflective of discussions and recommendations emerging from this workshop.

CHALLENGES

The four research questions presented above proved to be ambitious, given the time and resources available to conduct this study. This section describes some of the challenges that prevented these questions from being fully answered. The remaining gaps and questions revealed in this report should be taken as motivation to continue probing into the role gender plays in access to health care in contexts marked by violence against health care.

Several challenges arose during the field research process, including limited time in a given location and low attendance at the focus group discussion sessions. Although efforts were made to address these challenges, the result was that the methodology was not uniformly applied in both countries. For example, time pressures did not allow for an interview with any state actor in Colombia, therefore it is not possible to make any comparison of state actors' responses between countries. For Lebanon, only two state actor respondents participated in the study, which by no means constitutes a meaningful representation. The result is that it is not possible here to present any substantial view of either state's perceptions of the gender dimensions of violence against health care.

In Lebanon, it was possible to conduct two sex-segregated FGDs with community members, however low attendance and logistical challenges meant that this was not possible in any location in Colombia. Being able to compare responses to the same questions posed separately to men and women in the same context would have provided a window into the different experiences and perceptions of each group. Lastly, in Colombia, the presence of some health care providers during the focus group discussions for community members meant that some questions related to the perception of treatment of different groups by health care personnel were likely influenced by the presence of the very people to whom these questions referred[3].

2 Due to pervasive feelings of suspicion linked to the conflict, this was more problematic in Colombia than in Lebanon

3 Once it became clear that health care personnel were present, this line of questioning was abandoned

Table 1: Total Number of Respondents in Lebanon and Colombia (including in-country briefings)

	Gender					
	Female			Male		
Age:	18-25	26-49	50+	18-15	26-49	50+
Total by age, sex:	1	47	9	7	29	9
Total by sex:	57			45		
TOTAL:	**102**					

Table 2: Number of Respondents in Lebanon by Gender and Category

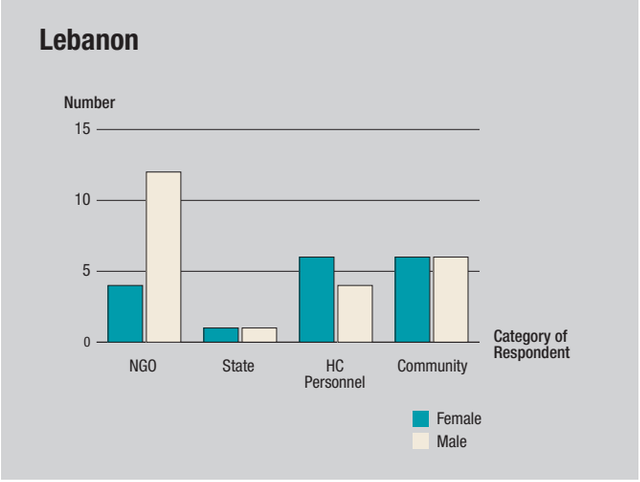
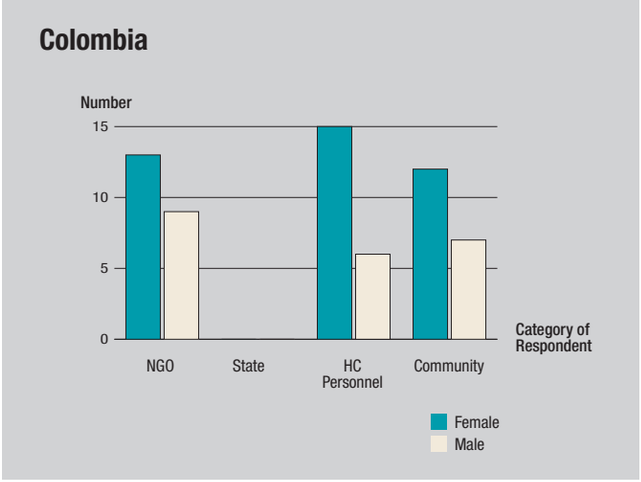


Table 3: Number of Respondents in Colombia by Gender and Category



RESEARCH FINDINGS

The Challenge of SADD: Assumptions and Practice

The ICRC's *Sixteen Country Study: Health Care in Danger* (2011) provided a significant advancement in our knowledge around where incidents occur, which categories of victims experience which types of violence, and which agencies are affected[viii]. The ICRC, in its second interim report on violent incidents affecting the delivery of health care, showed that far more local than international health care providers bear the brunt of violence, accounting for 91% of recorded incidents[ix].

This important trend would only be possible to ascertain through the collection and analysis of data using national and international parameters. Similarly, in order to further analyze trends on who is exposed to which kinds of risks of violence, where, when, and by whom, we would need to collect and analyze data that is sex- and age-disaggregated (SADD). Analyses resulting from reliable SADD will help to inform the policies and practices of all stakeholders involved in safeguarding effective and indiscriminate health care[x].

When thinking of SADD, it should be highlighted that collecting information not only by sex but also by age is important. Currently, there is very little data around how violence against health care affects the access of girls, boys, adolescent girls, adolescent boys, elderly men, and elderly women. Collecting information of different age groups will also help to determine who may be facing which types of risks and barriers, and who may not be able to enjoy the health care to which they are entitled.

Despite the repeated call for agencies and actors involved in the provision of health care to begin collecting and analyzing SADD, there remains a dearth of this data related to violence against health care[xi]. The Security in Numbers Database, which collects information on security incidents against aid workers including those involved in health care provision, estimates that 42.8% of reports that feed the database did not include information about the sex of the perpetrator and/or victim of an incident[xii]. Several factors contribute to a lack of SADD, including efforts to protect the privacy of those involved in the case of incidents affecting NGO workers, and reports being made in languages including English that are largely gender-blind. For health care providers, collecting data around incidents of violence against health care in general – let alone data that is disaggregated by sex and age – may not take place systematically. Further, data collection systems may not be adapted to allow for the collection of information on sex and age. Also, for cases of violence against health care workers, health care staff may not be aware of how or if a report should be made. This may be especially true for incidents of 'lesser' violence, such as insults or threats against health care personnel. These factors have contributed to an inadequate availability of SADD, and therefore makes understanding gender trends of violence related to violence against health care extremely difficult to ascertain.

In addition to logistical and operational challenges of collecting SADD, there may exist some underlying attitudes that have prevented a systematic collection of this type of data. In both Lebanon and Colombia, it was reported by respondents from NGOs and Red Cross Red Crescent and health care personnel groups that there simply was no interest in collecting SADD since there was no indication that patients were treated differently once they arrive at a facility. This narrow interpretation of gender and access to health care – i.e. as only related to patient care once she or he has arrived at a health facility – seems to have contributed to an absence of attention to other ways in which different people could be facing different risks along the pathway of accessing health care. As one senior-ranking health care provider in Colombia stated, "No, it is not difficult [to collect SADD]. We don't consider that information important."[xiii] When SADD is not collected, the result is an incomplete picture that does not reliably represent or reveal who is affected by which forms of violence, where and when, and how this may affect their ability to offer and receive medical care.

Gendered Division of Labour in Health Care and Links to Violence

A common question raised in previous research and reports has been whether male or female health care personnel, or aid workers including those involved in health care, faced more risks of violence while fulfilling their duties. Looking at how men and women are represented across health care roles, it may be that male or female personnel face different types and levels of risks. In some countries, 75% of the overall health workforce is female[xiv]. Having more women represented in health care that is targeted by violence would thereby lead to a higher number of incidents involving female health care workers. The case contexts of this study echo global trends whereby women comprise the majority of nurses and auxiliary nurses, including community outreach workers. Men generally hold the majority of more senior positions, such as doctors, hospital administrators and management. In Lebanon, the gender composition of emergency medical service (EMS) teams is usually mixed, however this varies according to location; sometimes there can be more women than men at an EMS station, and vice versa. Ambulance drivers are often male, and drivers of NGO vehicles in both contexts are almost exclusively male.

Respondents in Lebanon anecdotally report that nurses, the majority of whom are female, are subject to higher risks of violent incidents, usually related to the higher numbers of nurses working in the emergency room (ER) and other settings of violence. These are usually incidents of verbal/emotional violence such as insults, however some respondents reported that cases of physical violence against nurses have known to take place. One study in Lebanon found that nurses were "disproportionally exposed to physical violence", with more than one third of surveyed nurses reporting having experienced at least one incidence in the past 12 months[xv]. In Colombia, female vaccinators reported that in rural communities, resistance to vaccinations has sometimes led to verbal/emotional violence and even incidents of physical violence against them[xvi].

In other contexts, the confluence of gender and the nature of services health care personnel provide may render some particularly at risk of experiencing violence and even death. In Iraq in 2007, male gynecologists were specifically threatened or killed by extremists who considered them to be violating women's privacy. The deaths of these doctors, compounded by several doctors forced to cease their practice amidst violence, further undermined an already paltry existence of gynecological services for women in Iraq[xvii].

Looking at the distribution of males and females in health care may point to a possible gendered exposure to violence. However, without a robust set of sex-disaggregated data, it is difficult to identify any hard trends on sex-specific risks facing health care personnel. More research and data on the intersection between job function, gender and violent incidents are required in order to better understand who may be vulnerable to threats and attacks related to their function in the health care system.

Settings and Types of Risks of Violence

Although some settings may be understood to be generally risky, it is important to break down what those risks are and to whom they apply, since not all men, women, girls and boys will necessarily face the same risks even if in the same setting. Previous research on gender, security and humanitarian aid work, including health care providers, has suggested that female aid workers may face higher risks of violence in urban communities, in their residences or place of work, and via communication methods such as SMS and email. Male aid workers, on the other hand, may be more at risk of violence in rural areas, and while traveling via road and water[xviii]. Unfortunately, due to the limited sample size and specificity of contexts, these trends cannot be supported or refuted by this study.

Health Care Providers

According to health care personnel in Lebanon, the settings in which they are most exposed to violence include the ER, followed by the intensive care unit and administration offices. The risk of violence in these settings may be exacerbated at different times of day, such as evening time when the ER may function as the intake location while other parts of the facility are closed[xix].

In Colombia, for those working in community outreach programmes, such as vaccination teams, the community as a whole was reported as unsafe. The majority of these teams were comprised of women. It seems that the exposure associated with community work was a factor in perceptions of safety. As one female health care worker in Colombia stated, "[l]eaders of armed groups see us in rural areas, then we see the leader in town, even if we did a good job we get scared when that happens. No one sees the work we do inside the hospital, so we don't face the same risk as those working outside in the rural areas."[xx]

Where health care personnel, specifically doctors, are required to sign a medical certificate in the case of sexual violence, doctors may be reluctant to do so if this is linked with potential retaliation by the families of the perpetrators and/or the survivors, or the perpetrators themselves. Further, health care personnel who are involved in the treatment of a survivor of sexual violence may be summoned to court to testify. Local health care workers are often themselves members of the community they serve, and thus it is not uncommon that staff and volunteers may know and be known by the survivor and/or the perpetrator. This may expose certain workers to risks of violence as a result of their involvement treating survivors of sexual violence. In Kenya, it is for this reason that some health care personnel working in the Kibera slum have reported feeling less safe when treating survivors of sexual violence[xxi]. In some cases, this perceived insecurity could translate into health care personnel refusing to treat survivors of sexual violence. This would effectively restrict the availability of and therefore access to essential health services for survivors of sexual violence, the majority of whom are usually women and girls, but also includes men and boys.

Although this research did not purposefully seek out information on perpetrators of violence, one male respondent in Lebanon alluded to some possible gender differences in who commits acts of violence: "I never saw any female committing any violence against health care workers, but they can insult; no shooting armed violence, but verbal violence."[xxii] While no conclusions can be made here, this comment may suggest certain gender differences in the types of violence levied by men and women against health care workers, with women perhaps more likely to use emotional or verbal violence and men perhaps more likely to use physical violence. Having gender-specific information about perpetrators of violence would be useful in helping organizations, states and health care providers to make decision on who to target with which messages using which medium.

Health Care Seekers

Health care seekers and those accompanying them may face different risks in three different points along the access pathway: firstly, at home or in the community; secondly, *en route* to the health care facility; and thirdly, while at the facility. In both Lebanon and Colombia, many respondents stated that adult men are more readily perceived as being party to a conflict than women, and therefore face particular risks such as harassment, threats, or physical violence *while en route* to a health care facility. Unfortunately, the lack of opportunity to conduct sex-segregated FGDs with community members in both contexts negated the possibility to compare responses.

In Lebanon, one NGO working with the Syrian population observed that men are less likely to report to health facilities, including mobile clinics[xxiii]. This is tied to economic pressures of finding daily work to support their families, which takes precedent over any illness or injury that is not urgent. Health facilities may only be open during hours when men are at or are seeking work, which further deters some men from deciding to seek care. Still referring to the Syrian population in Lebanon, it was also reported that men often feel at a higher risk of harassment or other violence since their age and gender may lead them to be perceived as associated with armed groups. As a result, these men often restrict their movements, especially later in the day and evening, even if no curfew is officially imposed.

In some communities in Lebanon, including amongst some Syrian communities, the cultural norms dictate that women need to be accompanied in public by male family members. This becomes complicated when, if as above, these men do not feel comfortable circulating on the streets after a certain hour due to perceived risks of being questioned, harassed or targeted.

According to the ICRC's Sixteen Country study, from the 199 events occurring *en route* that involved attacks on medical vehicles and personnel trying to reach the sick or wounded, or the sick or wounded trying to report to a health facility, 17.6% took place at checkpoints[xxiv]. If we target those responsible for operating checkpoints with certain

messages related to allowing medical transports and personnel and the sick and wounded to pass, information on which groups face the highest degree of difficulty in safe passage should shape the messaging.

Little information was revealed during the field research that spoke to the gender-specific risks that patients face while at a health care facility. However, when asked what different risks exist for men, women, girls and boys while *en route* to a facility, some NGO/Red Cross volunteers working in urban and rural contexts in Colombia mentioned that girls may face risk of rape or kidnapping if they travel on their own[xxv]. This was the only explicit reference to sexual violence that was raised during field research. Recruitment, especially of boys under the age of 18, was also listed as a particular risk for males in certain parts in Colombia[xxvi]. When considering obstacles *en route* to safe access to health care, impediments to timely passage may be critical in certain cases that are time sensitive. For example, it is crucial for survivors of rape to access medical care within 72 hours of the incident in order to receive post-exposure prophylaxis and other treatment. If traveling to a health facility entails risks of (further) violence or other barriers, this would effectively reduce or even block one's ability to access required health care.

Other Factors Affecting Access to Health Care

There are several factors of diversity that work to shape and influence an individual's experience during armed conflict and other emergencies. Gender has been chosen as the central focus of this study since gender, along with age, is arguably the most universal of such factors. For this study, the importance of understanding how one's gender may interact with other elements of one's identity (as perceived both by one's self and by external actors) became apparent in order to understand individuals' experience providing and/or accessing health care. The following were raised during both field and desk research as contributing factors impacting access to health care.

Social Connections and Influence:

One factor that was mentioned in Lebanon is a system of social connections – or *wasta* in Arabic – that would grant access to a bed or quicker care that one might not necessarily have been otherwise able to command. In terms of perpetrators of violence, one study suggests that someone who has these types of connections may expect preferential treatment regardless of their condition, and if not granted, the patient and/or their family may exhibit violent behavior[xxvii].

Religious Sect or Ethnicity:

On the health care seeker side, one national study in Lebanon found that the widest variance between those who are able to access high quality health care and those who are not exists not between men and women, but rather between sects, with Christians[4] reporting the highest quality of care, while Shi'a reported the lowest[xxviii]. From this study's field research, community members in one location in Lebanon and of one religious sect reported that they would not feel comfortable reporting to a hospital that had clear affiliations with another sect. The respondents reported that they did not trust that they would receive care, although they believed that women would likely not be threatened or killed[xxix]. Concerning health care providers, a study conducted by Médecins Sans Frontières (MSF) in Lebanon suggests that doctors who belong to one sect could be specifically targeted during or after clashes. In Colombia, sect or religion was not mentioned as a factor in accessing health care. Tribal and ethnic identities may also play a role in one's risk of experiencing violence while providing health care. During the post-election violence in 2007 in Kenya, MSF was compelled to temporarily relocate some of their male and female national staff who belonged to a certain ethnic group amidst credible threats of ethnically-motivated violence.

Affiliation:

One's affiliation with a party to a conflict or armed group was also raised as a factor affecting patients' and health care providers' safety when providing or accessing health care. In Lebanon, incidents of ambulances being stopped on the road and asked about the patient's identity was seen as a setting of threats and physical violence[xxx]. In terms of gender, it is unclear whether the sex of the patient makes a difference in the type of risk faced both for the patient and the EMS workers. In Lebanon, EMS workers report that they face risks of threats or other violence while transporting patients associated with different groups. As one EMS worker stated, "they don't see whom exactly we are transporting, they just see us getting someone from one side or the other and they would think, 'My son was killed by those people, their injured should be allowed to die, why you are transporting them?'"[xxxi]. A similar situation was described in a rural area in Colombia[xxxii]. Further, in some specific urban areas in Colombia, criminal groups referred to as *bandas criminales,* or *bacrim*, have *de facto* control over several neighbourhoods and have drawn 'invisible borders'. In some cases, these borders have excluded nearby health care facilities so that sick or injured men, women, girls and boys must cross boundary lines in order to reach the closest facility. It was reported that in some cases this may be slightly easier for women – especially pregnant women – again due to perceptions that adult men are likely taking part in the conflict and/or acting as messengers. However, it was also noted that if a particular woman is seen as having a personal association with leaders of a particular group, neither she nor her family would be able to pass[xxxiii]. Here it seems that any advantage in access afforded to a woman by her gender would be overridden by her affiliation.

Practices and Policies of Health Care Providers related to Gender and Risk

In terms of human resources practices, one NGO in Lebanon reported purposefully employing only female community health workers

4 Unfortunately, this study does not specify to which denomination of Christianity this refers

for outreach programmes in certain communities. They report that women are more easily able to penetrate an environment of fear and suspicion since they are less likely to be perceived as being associated with one armed group or side of a conflict. This was echoed by health personnel in Colombia, where some female community outreach workers reported feeling that they are better able to build trust with communities, and therefore better able to gain acceptance and access to the population.

Conversely, in Lebanon, EMS volunteers in one location reported that if the team leader is female, she may not be accepted by some armed groups, and therefore may not be able to negotiate access to a certain area. As such, some EMS teams will opt to send out a male team leader in order to increase the chances of successful negotiation for access.

This research shows that assumptions based on gender stereotypes may sometimes influence practice. In Lebanon, EMS volunteers reported that female colleagues were not sent on calls if active conflict was underway. Some volunteers reported that women face a higher risk of kidnapping, and therefore female volunteers were encouraged to stay at the station and support administrative aspects of the operation. It was also mentioned by some male volunteers that women are not as well-equipped as men at dealing with armed conflict and may be more fearful, and therefore would create more problems for more experienced (male) responders. Some volunteers did say that they would prefer to work with older female volunteers who have more experience. However, it is unclear how female volunteers would be able to gain this experience if they are not encouraged or even permitted to go on calls during conflict periods. These attitudes were not unique to EMS volunteers. A state representative in Lebanon reported that in times of conflict, female health care staff were not deployed on the first response rotation, because "women are different from men; they can't handle it."[xxxiv]

In terms of how those concerned and responsible for providing safe health care, it is worth mentioning that some previous reports have included considerations for special risks that could impede certain groups' access to health care during armed conflict and emergencies, such as children, older people, and people with disabilities. However, the focus is usually on the vulnerability of these groups, and not on their unique capacities to circumvent challenges to access health care. Casting certain groups, such as all women or all children, as inherently vulnerable fails to recognize that not only are these groups not homogenous and therefore broad generalizations cannot be made, but this also obfuscates other groups who may be at a higher risk but who are not traditionally seen as being vulnerable, such as men of fighting age. Given that this study's research identified several examples where men were actually less able to access health care than women, this becomes an important consideration for decision makers and those responsible for programme design and service delivery.

GENDER IMPLICATIONS RELATED TO OBLIGATIONS TO PROVIDE HEALTH CARE UNDER IHL

As mentioned, it was unfortunately not possible during this research to consult state actors in a meaningful way in either of the case contexts, and thus it was not possible here to obtain any substantial view of either state's perception of the judicial, administrative and legal aspects of ensuring the right to health care in their respective country. This was a missed opportunity given the fourth research question relating to the application of IHL relating to obligations to provide access to health care without adverse distinction.

Provisions under IHL are mainly gender-neutral, and include a non-discrimination principle. Identifying and addressing the effects armed conflict has on individuals, and the different status, needs and capacities of individuals before, during and after armed conflict, is critical in order to ensure that those who benefit from the protection of IHL are granted this protection without discrimination. The inclusion of a gender perspective when applying IHL therefore enhances the operational effects and strengthens the protection of individuals in times of armed conflict. Without such a contextual analysis that includes gender perspectives, the protection of, respect for, and care of the persons entitled to health care run the risk of being discriminatory. Looking at the research questions of this study, a revision of the fourth question to focus more on how information on gendered dimensions of access to health care may impact the application of IHL would be a useful topic to explore in future research (please see Suggested Further Research Topics).

The examples in the study findings above clearly show that structures in one society differ from another. Taking a gender perspective in the application of IHL therefore means to analyze the specific gendered impact on men, women, boys and girls in a specific context and time. These aspects must be considered in order to fully comply with the provisions under IHL.

RECOMMENDATIONS

Main Recommendations:

- Systematically collect and analyze sex- and age-disaggregated data (SADD) and adapt operations and policies accordingly
- Base operational and security decisions on an analysis of gender and diversity dynamics specific to the operational context
- Ensure the inclusion of a gender and diversity perspective – assessing the different status, needs, and capacities of men, women, girls and boys – in the implementation and fulfilment of obligations to provide health care under relevant IHL, IHRL and domestic laws in order to give effect to the principle of non-discrimination

- Design facilities and outreach activities in a manner that reduces and mitigates risks of violence towards both health care providers and health care seekers
- Conduct regular check-ins with male and female staff, volunteers and health care seekers to identify new or changing risks associated with health care delivery
- Conduct further research to deepen stakeholders' understanding of the challenges and capacities of different groups in providing and accessing health care (see Suggested Further Research Topics)

State Actors

- Set up and/or sustain systems to regularly collect SADD on incidents of violence against health care and encourage health facilities to regularly report SADD; update current systems of data collection to include fields for sex and different age categories[5]
- Sign, ratify and enforce international and domestic legal instruments pertaining to equal access to health care for all, including special groups eg. women, children, older people (IHL, IHRL, CEDAW, etc.)
- Ensure the inclusion of a gender perspective – assessing the different status, needs and capacities of men, women, girls and boys – in the implementation and fulfilment of the obligations to provide health care under relevant IHL and IHRL.
- Plan and design health facilities with a gender perspective to ensure the highest degree of safety for all personnel, patients and visitors eg. adequate lighting, emergency buttons to call for help, ensuring location of services for sexual violence survivors are not identifiable, etc.
- Conduct context-specific studies on the barriers for different groups of men, women, girls and boys in accessing health care, and what risks male and female health care personnel may be facing across their work

Armed Actors

- Collect and share SADD with trusted interlocutors eg. ICRC where possible
- While meeting the obligations under IHL, IHRL and domestic law, gender and diversity factors must be considered, including the special provisions protecting women, children and the elderly
- Adopt and promote a culture of zero tolerance for sexual violence perpetrated both within ranks and externally
- Consider whose access to health care may be affected when planning location of checkpoints i.e. which men, women, girls and boys and make appropriate provisions to reduce potential barriers to health care accordingly
- IHL dissemination activities should include specific reference to the obligation to extend access to health care with no adverse distinction, including based on gender or other diversity factors, with consideration of the expected operational effects of contextual analysis in the application of IHL, including gender and other diversity issues

Health Care Providers

- Collect and regularly analyze SADD to identify trends and adapt operations accordingly
- Make operational decisions based on contextual knowledge of gender dynamics to identify factors that may expose male and female personnel, wounded, and sick to different risks in order to be able to best meet respective health care needs
- Ensure where possible that teams are gender-mixed in order to maximize capacity to appropriately respond to needs as well as to reflect cultural considerations eg. female staff tending to female reproductive health patients
- Create systems that prevent preferential treatment or prioritization of certain groups of patients over others
- Set up a system to promote safe and confidential reporting of all types of incidents of violence against health care personnel and patients including insults, harassment, and other 'lesser' types of violence; ensure these reports include breakdowns of sex and age of those involved
- Conduct regular check-ins with personnel to assess locations of high-risk for violence, discuss who is often targeted (positions, sex, age) and adapt operations accordingly
- Conduct regular trainings for staff on IHL, IHRL and medical ethics and make sure that internal regulations, guidelines and routines effectively reflect these rules.

NGOs, Red Cross Red Crescent Movement and United Nations Agencies

- Collect and share SADD where possible; consider using and promoting technology such as crowd-sourcing to expand the available pool of data
- For organizations with the appropriate mandate or mission, discuss with armed actors which profile of sick and wounded eg. young men, may be prevented from reaching and receiving care at a health facility, and promote appropriate ways to ensure access for these groups while maintaining strategic objectives
- For organizations with the appropriate mandate, IHL dissemination activities should include specific reference to the obligation to extend access to health care with no adverse distinction, including based on gender or other diversity factors, with consideration of the expected operational effects of contextual analysis in the application of IHL, including gender and other diversity issues

5 The European Commission's *Gender and Age Marker Toolkit*, for example, uses the following age brackets: 0-59 months (infants); 5-17 years (children); 18-49 (adults); and 50+ (elderly). Please see http://ec.europa.eu/echo/files/policies/sectoral/gender_age_marker_toolkit.pdf

- Consider how gender-unbalanced health care teams could affect operations (i.e. access to certain areas and/or patients) and encourage male and female staff and volunteers to attend trainings, gain experience, and be considered for promotions
- Develop, sign and enforce a code of conduct including provisions for child protection and prevention of sexual exploitation and abuse, and promote understanding of these policies by all staff and volunteers
- Revisit Health Care in Danger Expert Consultation recommendations and those arising from other workshops to apply a gender lens (see Annex II)

Community Members

- Community members must respect health care and not behave in a way that obstructs, hinders or damages ability of health care providers to deliver safe health care to all sick and wounded
- Encouraged to participate in surveys and SADD gathering initiatives (eg. crowd-sourced data)

SUGGESTED FURTHER RESEARCH TOPICS

- More in-depth, multi-country comparison studies on whether and to what extent gender influences safe provision of and access to health care, including case studies from high-income countries and outside the context of armed conflict or emergencies

- Do male and female health care personnel face different risks of violence while delivering health care? How do these risks relate to their specific job function?

- What are the specific challenges and capacities of young and adolescent girls and boys in accessing safe health care during conflict and other emergencies?

- Given the important role IHL plays in providing protection and justice to the victims of armed conflict, how can the knowledge about the different ways men, women, girls and boys are affected by violence against health care impact the application of IHL?

CONCLUSIONS

Each context of armed conflict or other emergency is highly specific and encompasses different dynamics, both of the conflict itself and in terms of how socially constructed dynamics between males and females may affect how health care is delivered and accessed by those who need it. This study has uncovered some examples of how gender may influence the experiences of men and women health care personnel, as well as those of the men, women, girls and boys who are entitled to health care. For health care providers, male and female personnel may both enjoy and be hindered by certain assumptions related to their gender, such as the ability to negotiate access to communities. For health care seekers, it is not possible to separate out pre-existing gender dynamics in communities or regions, which will influence how and if men, women, girls and boys are able to access health care. The planning, delivery and evaluation of adequate health care with no adverse distinction in accordance with IHL, IHRL and domestic law must include information on the different needs and capacities of men, women boys and girls respectively in the specific context.

Further, this research suggests that gender and other factors of diversity and identity influence access to health care. The combination of these identifiers – gender, affiliation, age, sect, etc. – work as determining factors of men's, women's, girls' and boys' experiences. Although gender and age are universal determinants, in certain contexts, the challenges or advantages associated with being a girl, boy, women or man may be overridden by other factors, such as affiliation with one side of the conflict. A holistic approach that includes an analysis of gender and diversity is essential when seeking to understand the problematic of violence against health care and responsive actions.

This study points to some remaining knowledge gaps related to gender and violence against health care that further research and data collection would help fill. Without adequate and reliable data that is disaggregated by sex and age, amongst other factors, it is difficult to identify which groups may be facing particular challenges in accessing health care, and even the nature of violence to which these groups are most vulnerable.

The study's original research questions, while ambitious, helped to guide this inquiry into how gender and other diversity factors influence access to health care. Although it was not possible to adequately address all four questions in this study, it is hoped that other actors involved in the safe provision of health care will take up the reins and advance our collective understanding of the issues from a gender and diversity perspective. There are several stakeholders involved in ensuring that men, women, girls and boys are able to access safe and impartial health care in timeres of armed conflict and other emergencies. Each has a special role to play, and incorporating a gender and diversity perspective in each of these roles will help work towards improving the efficiency and effectiveness of health care delivery.

ANNEX I:

International Humanitarian Law and International Human Rights Law

International humanitarian law (IHL) protects access to health care in times of armed conflict. In situations that do not reach the threshold of armed conflict only international human rights law (IHRL) and domestic law apply. In principle, IHRL applies at all times. Though less specific than IHL, IHRL contains several rules protecting access to health care. While IHL binds States as well as non-State armed groups, IHRL only applies to states[6]. Relatively few provisions of IHRL refer specifically to health workers or humanitarian workers more broadly; instead these individuals are protected under laws affirm the right to health.

INTERNATIONAL HUMANITARIAN LAW

International humanitarian law, also known as the Law of Armed Conflict, is based on treaties, in particular the Geneva Conventions of 1949 and their Additional Protocols, and a series of other conventions and protocols on specific topics. There is also a substantial body of customary law that is binding on all States and non-State parties to armed conflicts.

Most treaty based IHL is applicable only in international armed conflict. Fewer treaty rules are applicable in non-international conflict. However, today most basic rules of IHL relating to the medical mission are considered customary law and as such they are applicable in international and non-international armed conflicts[7]:

- the wounded and sick must be respected and protected and must not attacked;
- the wounded and sick must be provided with medical care and attention, to the extent possible, with the least possible delay and without any adverse distinction on any grounds other than medical ones;
- the wounded and sick must be searched for, collected and evacuated, to the extent possible, particularly after the fighting has ended;
- health-care personnel must not be attacked, unless they commit, outside of their humanitarian function, acts that are harmful to the enemy;
- medical units, such as hospitals and other facilities that have been set up for medical purposes, must be respected and protected;
- medical units may not be attacked and access to them may not be limited;
- parties to an armed conflict must take measures to protect medical units from attacks;
- the red cross, the red crescent or the red crystal are the visible signs of the protection conferred by the Geneva Conventions and their Additional Protocols on medical personnel, medical units and medical transports;
- the passage of medical transports conveying the wounded and sick or health-care personnel must not be arbitrarily denied or restricted;
- medical units and transports will lose their protection if they are used, outside their humanitarian function, to commit acts harmful to the enemy; and
- Health-care personnel must not be punished for carrying out activities compatible with health-care ethics.

INTERNATIONAL HUMAN RIGHTS LAW

International human rights law refers to a collection of international rules, most of which are treaty-based, which recognize the inherent dignity and equality of all individuals and spell out the rights that individuals have by virtue of being human. Specific treaties include the International Covenants on Economic, Social and Cultural Rights and Civil and Political Rights of 1966, The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979 and the 1989 Convention on the Rights of the Child.

6 For more information on IHL and IHRL see Breitegger, A., 'The legal framework applicable to insecurity and violence affecting the delivery of health care in armed conflicts and other emergencies', *International Review of the Red Cross*, vol. 95, no. 890 (June 2013), pp. 83–127;Marks, S. P., *Health and Human Rights: Basic International Documents* (Harvard University Press: Cambridge, MA, 2004); International Committee of the Red Cross, *International Humanitarian Law and International Human Rights Law: Similarities and Differences* (ICRC: Geneva, Jan. 2003); and International Committee of the Red Cross, *Respecting and Protecting Health Care in Armed Conflicts and in Situations Not Covered by International Humanitarian Law* (ICRC: Geneva, Mar. 2012).

7 See First, Second and Fourth Geneva Conventions of 1949; Additional Protocol I, Part II (Articles 8-34); Additional Protocol II, Part III (Articles 7-12) of 1977; and customary humanitarian law (ICRC Study on customary international humanitarian law, Rules 25-32, 53-56, 92, 109-111, J-M Henckaerts, L. Doswald-Beck, 2005.

IHRL is applicable at all times, in and out of conflict, although some governments may choose to suspend aspects of IHRL in emergency or conflict situations[8]. IHRL protects the rights of individuals, but the state bears responsibility for protecting these rights. Non-state organized groups are not obligated to protect human rights, although this is currently an area of discussion. Individuals may be prosecuted for violations of IHRL (e.g. genocide or crimes against humanity). Specific aspects of the right to health include the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'; and the states parties to specific treaties within IHRL are responsible to ensure the 'creation of conditions which would assure to all medical service and medical attention in the event of sickness'[9].

General Comment no. 14 to the International Covenant on Economic, Social and Cultural Rights notes that the Right to the Highest Attainable Standard of Health (2000) elaborates on Article 12 of the International Covenant on Economic, Social and Cultural Rights, taking into account the right to health during armed conflict. Specifically, it:

- reaffirms the right to be free from torture;
- reaffirms the responsibility of states to ensure that third parties limit access to health services;
- prohibits states from 'limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law'; and
- reaffirms the responsibility of states to 'cooperate in providing disaster relief and humanitarian assistance in times of emergency'

8 See e.g. the International Covenant on Economic, Social and Cultural Rights (1966), Article 4., <http://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>.

9 International Covenant on Economic, Social and Cultural Rights, Article 12

ANNEX II:

HCiD Expert Consultations and Discussion of Gender

HCiD Expert Consultation	Discussion of Gender
The Role and Responsibilities of National Red Cross Red Crescent Societies in Delivering Safe Health Care in Armed Conflict and Other Emergencies *(Oslo, Norway; 3-5 December 2012)*	• Women may be denied the opportunity to volunteer, or are denied access to health care • Female doctors may be at particular security risks • Using nicknames during communication makes volunteers and staff unidentifiable by gender, religion
Ensuring Better Protection for the Medical Mission in times of Armed Conflict and Other Emergencies: the Role of Civil Society, Muslim Scholars and Religious Leaders in Promoting Respect for Health Care *(Dakar, Senegal; 24-25 April 2013)*	• Islamic scripture mentions women's special role as tending to the wounded and sick during wartime • Islamic customary law calls for special protection for women and children during wartime Female religious leaders should be involved and included in raising awareness for protection of the medical mission
Ambulance and Pre-Hospital Services in Risk Situations *(Toluca, Mexico; 20-24 May 2013)*	• Discussing psychosocial support to first responders, gender is included as one of many factors determining individuals' coping mechanisms
Expert Workshop on Ensuring the Safety of Health Facilities *(Ottawa, Canada; 24-27 September 2013)*	• When providing emergency rations for staff and patients at a facility, how would the gendered needs of staff be taken into account? • Recommendation to allot specific time slots for elderly care (men and women, presumably) • To increase staff retention, facility needs to plan for child care, safe accommodations, social support, food and relief distributions taking into account familial duties of personnel • The roles and specific needs of different groups and subgroups must be understood and analyzed with respect to their vulnerability, special status, and gender • Location of patients is key, eg. not putting war wounded next to pregnant women • Design of the facility is important to respect cultural considerations eg. if men and women need separate entrances • To combat challenge of stigma associated with certain services eg. HIV, provide multiple integrated clinical services that are perceived by patients as safe • Data collected should be disaggregated by sex, age, ethnicity, etc. to further identify trends
Ensuring the Safety of Health Care Facilities *(Pretoria, South Africa; 8-10 April 2014)*	• In Addition to Recommendations from Ottawa Expert Consultation: • Call for adequate lighting at facilities • Buffer zones should be cultural/gender sensitive • Some participants suggested that female health care personnel should be trained in self-defense in some contexts, particularly related to sexual violence

ANNEX III:

Selected Resources

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