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Accounting for gender when it is not counted

Highlighting the importance of sex-disaggregated data in understanding the impacts of attacks on healthcare

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Brief Summary:

This brief makes a plea for organisations to collect and report sex-disaggregated data about attacks on healthcare in conflict. Initiatives exist to record these violations, and these data contribute to our understanding of attacks. Data also help to assess the broader impacts of attacks on healthcare workers, systems and patients' access to healthcare. However, a persistent data gap about the sex of those involved *in* and *affected by* attacks means that we still cannot account for the gendered dimensions of attacks on healthcare.

The collection of more sex-disaggregated data about conflict has highlighted that women and men face distinct risks and harms in conflict. This has enabled the analysis of gendered violence: the forms of violence that men, women, transgender or non-binary people are more likely to face because of their gender identity, or understanding how vulnerability to conflict violence may be rooted in gendered societal marginalisation. If other forms of targeted violence are driven by gender dynamics, we need to consider this may influence the nature, instances and impacts of attacks on healthcare.

This brief highlights the importance of sex-disaggregated data to developing policies to protect and mitigate against the effects of attacks on healthcare in ways that take gender seriously.

This policy brief:

- Advocates for the systematic collection and reporting of sex-disaggregated data about attacks on healthcare in conflict as an important step in identifying the gendered dimensions of attacks on healthcare in conflict.
- Highlights the gap in our knowledge about the ways gender influences attacks on healthcare.
- Recommends organisations record and report attacks on healthcare with sex-disaggregated data to develop appropriately gender-sensitive protection and mitigation strategies.
- Recommends collecting basic data on which healthcare roles are more likely to be carried out by men, women, or people of diverse gender identity.

Background

Examination of the gender dynamics of attacks on healthcare is largely missing from both qualitative and quantitative studies on the topic (Haar et al., 2021). Research has already highlighted how little we know about the ways in which gender can influence the location and nature of the violence faced by healthcare workers (Foghammar et al., 2016) and that women tend report higher stress-level exposure and non-physical violence, often in lower paying jobs, while men report more exposure to physical violence (Habib et al., 2020: 4342). Despite these advances, we still cannot say whether men and women in the same roles face the same risk, or if gender plays a role in shaping the kind of attacks they face. Nor do we understand the extent to which gender influences the likelihood of an attack being reported or investigated. Without this knowledge it is not possible to design effective prevention and mitigation strategies that account for gendered vulnerabilities.

The need for sex-disaggregated data

To address these problems and conduct gender analysis of these problems, a clear first step is the need for sex-disaggregated data. Two kinds of sex-disaggregated data are necessary for thinking about understanding how attacks on healthcare may be gendered or may have gendered implications. Attacks are gendered if they target particular individuals or groups because of their gender, or if attacks take different forms because of the gender identity of either the attacker or the victim. However, even without gender targeting or gendered forms of violence, there can still be significant gendered implications if roles associated with particular genders face specific vulnerabilities. Gender and conflict researchers have long noted different risks for men and women. In 2011, a preliminary analysis found that, among aid workers, women were more vulnerable to crime and threats, particularly in locations where they ought to feel safe (e.g. workplaces and residences), while men experienced higher numbers of incidents involving lethal weapons and those on the road (Wille and Fast, 2011).

To understand any of these dimensions requires sex-disaggregated data about attacks on healthcare, including about healthcare workers and patients targeted by attacks and about the perpetrators of attacks. We also need basic sex-disaggregated data about healthcare roles in the contexts where attacks occur.

Data about attacks on healthcare

Having incident data on attacks on healthcare that records the sex of the victims is an essential starting point for understanding whether gender plays a role in determining the nature of attacks, the location of attacks, and the impact of attacks. Having these data on conflict and non-conflict setting can also help researchers to determine if the gender dynamics of violence against healthcare changes in conflict settings.

When thinking about the impacts of attacks on healthcare in conflict, it is important to consider sex-disaggregated patient data, to see whether attacks limit patient access in any systematically gendered ways. Research in conflict contexts has considered, for example, the rise in elective caesareans as women do not want to risk going into labour and having to travel at night (Bodalal et al, 2015). In other contexts, hospital births may go down as patients are less likely risk travelling to hospitals unless they are facing severe complications (Chi et al., 2015). The resulting impact of this lack of access, such as possible rises in maternal and infant mortality or the long term maternal and infant health consequences of these conflict-related access challenges, are even less well understood.

It is also important to explore whether gender dynamics influence who perpetrates violence against healthcare. In many contexts the assumption remains that men are overwhelmingly the perpetrators of violence, and much feminist research explored how we can understand this as a feature of patriarchal systems and the forms of masculinity they promote. Women can also be perpetrators and not merely victims of violence.

Sex-disaggregated perpetrator

data would enable investigation into whether men/women are more likely to carry out certain kinds of attacks and to enable mitigation and security strategies that consider this.

Data on healthcare roles

Sex-disaggregated data about attacks on healthcare in conflict provides us with only one part of the picture. To better understand risk, it is important to know the gendered distribution of the healthcare workforce for a given context; whether there are particular healthcare roles that are more likely to be carried out by men or women. In 2019, a WHO study on gender and the make-up of the health and social care workforce, globally, found that women account for 70% of the workforce, though hold only 25% of senior roles (Boniol *et al.*, 2019)[12]. It is vital to know how existing disparities influence vulnerability to attacks on healthcare in conflict.

Understanding how men and women's contributions are subjectively recognised in particular contexts is essential to understanding how existing discrimination and under-valuing may make female/male HCWs (Healthcare Workers) more vulnerable.

Existing forms of discrimination and marginalisation will differ from context to context. Therefore it is important that these sex-disaggregated data about healthcare roles are analysed in order to explore how societal gender expectations shape the choice of roles available to people and the violence to which they are exposed, leading to the design of effective protection strategies. The Global (formerly European) Interagency Security Forum (2018) (GISF) has advocated for security management plans that consider how personal identity characteristics in conjunction with role and organisational factors interact to create risk in specific contexts.

Barriers to reporting of sex-disaggregated data

Privacy concerns have been cited as a key reason organisations do not report sex-disaggregated data (Foghammar et al., 2016). This is especially an issue in relation to sexual violence where there is a fear or stigma and/or reprisals (Cadesky, Lundberg and Clomén, 2015).

Organisational power dynamics act as barriers to reporting, however good safeguarding and reporting mechanisms can empower individuals to come forward. Without more systematic sex-disaggregated data, we lack an evidence base from which to build gender-sensitive mitigation and security measures. Organisations need to prioritise gender-sensitive analysis of the risks associated with attacks on healthcare, for which sex-disaggregated data are an important first step.

Conclusion

If we are serious about both developing a greater understanding of the nature of attacks on healthcare in conflict and the gender impacts of conflict, it is imperative that we start by collecting sex-disaggregated data. Data are never a panacea, but their absence profoundly shapes what we know about a phenomena. Without sex-disaggregated data we cannot know how gender influences attacks on health and our knowledge base about how to mitigate and prevent them is weakened as a result.

Recommendations

- When collecting data on attacks on healthcare, systematically collect sex-disaggregated data; including sex-disaggregated data on the victims of attacks (healthcare workers and patients) and perpetrators.

a) Organisations' incident reporting forms should include this as standard, unless there is a safeguarding issue.

b) This information should be passed to bodies that aggregate data about attacks on healthcare, such as the World Health Organisation's Surveillance System for Attacks on Health Care (SSA) and Insecurity Insight's Healthcare in Conflict dataset.

[1]It is important to note that this review drew overwhelmingly on evidence from the global North, especially the United States.

- Collect and collate context-specific and global records of healthcare roles, disaggregated by sex. Other important disaggregated data include age, location and nationality, and also the type of organisation and the programmes affected.

- Draw on person-centred approaches to security management (GISF 2018) when analysing risk factors. Intersectional analyses that consider how, for example, gender, role, nationality and socio-economic status might combine to create specific vulnerabilities is necessary to develop specific approaches to protection. This can help to better understand vulnerability to attacks in order to design more gender-sensitive security and mitigation strategies.

- Data collection efforts must sensitively account for the privacy of those affected, as well as concerns about potential retribution, such as developing secure reporting mechanisms and better legal protection for whistleblowers.

a) Recent policy developments around the reporting of sexual exploitation and abuse in humanitarian settings have outlined principles and guidance for better policies, procedures and responses.

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Citations

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The Project

Researching the Impact of Attacks on Healthcare (RIAH) is a multi-institution and interdisciplinary research programme that aims to improve understanding of the immediate, long-term, and wider impacts of attacks on healthcare on populations in contexts that have experienced armed conflict. HCRI leads the research consortium in collaboration with the University of Geneva, Johns Hopkins, Insecurity Insight, and Chatham House.

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The Humanitarian and Conflict Response Institute (HCRI) is a leading global centre that is part of the University of Manchester. HCRI combines multiple disciplines from medicine to the humanities for the study of humanitarianism and conflict response, global health, international disaster management and peacebuilding.