Gender and Weaponization of Healthcare in Conflict: A Feminist Discourse Analysis

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In March 2022, a maternity hospital in Mariupol, Ukraine, was bombed by Russian forces, injuring 17 people, including women in labour (Davies, 2022). The High Representative of the EU for Foreign Affairs and Security Policy described the attack as a 'heinous war crime' (Sandford, 2022). Here, the weaponization of healthcare in conflict (WHC) is a strategy of systematically depriving healthcare during conflict, which foundationally threatens the international humanitarian concept of medical neutrality due to the strategic and intentional interference with medical services in conflict. Nevertheless, when evaluating the effects of the WHC, there is a critical gap in understanding its gendered implications. Feminist academia has established that violent conflict magnifies gender inequalities (Jansen, 2006) and that women are more vulnerable to a range of health and mental health concerns in conflict (Knapik et al., 2009). Therefore, I will focus on the gender impacts on women first because conflict exacerbates patriarchal gender structures that exist during peacetime, victimizing women in conflict at a higher rate than men (Carvalho, Costa and Torres, 2019). Secondly, when exploring the gendered implications of conflict, feminist academia has almost exclusively been concerned with gender-based violence and conflict-related sexual violence (Buvinic et al., 2012; Krause, 2015). Thus, I believe it is crucial to understand the effect of the WHC on women.

My research question asks: 'How is the weaponization of healthcare in conflict gendered?' Here, I will advance two key arguments: (1) The weaponization of healthcare in conflict is gendered because, in addition to not being able to access general healthcare services, women cannot access reproductive healthcare, thus disproportionately affecting women; (2) When paired with the systematic use of conflict-related sexual violence against women, the weaponization of healthcare in conflict prevents them from accessing urgent reproductive care, but also medical support for long-term issues, such as psychological or other mental health services—henceforth creating a compounded form of violence against women. I will evaluate the understanding of this topic from the perspective of non-governmental organizations using Feminist Critical Discourse Analysis, as these organizations are central in shaping the understanding and knowledge of the gendered implications of the weaponization of healthcare in conflict, alongside the responses to the issue.

Literature review

This literature review will focus on three central themes to highlight areas where there are gaps in the current literature, primarily focusing on conflict-related sexual violence and reproductive healthcare services in conflict. The principal gap in the literature that has been identified focuses on the gender imbalance and absence of consideration of women's disproportional suffering as a result of the weaponization of healthcare in conflict.

Healthcare in conflict

Attacks on healthcare in conflict breach International Humanitarian Law, as healthcare facilities are not military objectives, making intentional attacks and war crimes (UNHCR OHC, 2016). Within the social and behavioural sciences in public health literature, there is a notable stream of debate surrounding the identification of motivations and perpetrators of attacks on healthcare during conflict. Firstly, attributing the blame for the destruction or damage of healthcare is complex and is predominantly left unaddressed in academic literature (Buckley, Clem and Herron,

2019). Scholars suggest that commonly the opportunistic deprivation and destruction of healthcare facilities is mostly done by the enemy side in conflicts (Afzal and Jafar, 2019; Buckley, Clem and Herron, 2019; Foghammar et al., 2016; Haar et al., 2021; McLean, 2019). Damaging the enemy's civilian population is the primary, if not the sole, intention of perpetrators behind attacks on healthcare (Crombé and Kuper, 2019). Others argue that there is a strategic motivation for attacks on healthcare to prove that the government, which the attackers are fighting against, has no concern for citizen's welfare, damaging the hope of restoration of the area, or simply as an intimidation tactic (Cliff and Noormahomed, 1988).

A rapidly growing body of security studies and public health literature focuses on the impacts of healthcare in conflict zones (Haar et al., 2021). For instance, suspension and relocation of healthcare facilities due to attacks in conflict is one of the most common impacts (Cliff and Noormahomed, 1988), including primary care services and secondary health services such as blood donation centres, clinics or medical education centres. Armstrong (2017) evaluated how health facilities needed to relocate in Syria, as a consequence of constant attacks on farms or schools, redirect crucial resources and time away from hospital care into reorganization and reconstruction. Overcrowding, bad ventilation, and poor lighting decrease the effectiveness of healthcare. Here, the attacks on facilities can be categorized as chronic and strategic, as observed in Syria, where high-profile hospitals were targeted (Jabbour and Fardousi, 2021) or more casual and opportunistic (Rushton and Devkota, 2020). The majority of the literature on the weaponization of healthcare in conflict focuses on zones with distinguished violent conflicts (Crombé and Kuper, 2019), such as Syria (Armstrong, 2017), while less attention is given to other zones where attacks on healthcare also happen, such as Northern Nigeria or Ukraine. Gender structures are historically and socially constructed systems of power relations between women and men and create a foundational hierarchical disparity between them (Carvalho, Costa and Torres, 2019). Gender structures continue to exist, even during times of conflict. However, the literature does not evaluate the gender disparities that arise as a result of the weaponization of healthcare in conflict.

What is Conflict-Related Sexual Violence?

Conflict-related sexual violence has been an endemic occurrence in civil wars in Congo, Sierra Leone, Bosnia, El Salvador, Pakistan and a myriad of other countries (Cohen et al., 2013). Conflict-related sexual violence or wartime rape includes sexual violence such as military sexual slavery, forced prostitution, forced 'marriages', rape camps, forced pregnancies, and mass rapes, with gang rapes and multiple rapes being a common occurrence (McGinn and Purdin, 2004). Therefore, conflict-related sexual violence is not a static occurrence, as feminist scholars point out that it can take forms of differing nature and scale before and during the conflict, which can range from spontaneous acts of violence to adversary troops, border guards or bandits, to rape as a tactical act of war excused by military officials (ibid). Therefore, the literature points out the difficulty in making an overarching statement of the causes of wartime rape to refine its definition.

Nevertheless, differing perspectives in which scholars defend a sole theoretical explanation for the causes of wartime rape are explored below. McGinn and Purdin (2004) point out that women and girls are at greater risk of wartime rape, specifically if they are alone, and have a higher death rate when it occurs. Patriarchal standards and gender structures increase women's likelihood of being the victims of it (Cohn, 2013). It is unclear if this conclusion is a consequence of an absence of study of the other demographics, such as sexual violence against men (Charman, 2020), but in this dissertation, I will focus on women as primary victims of conflict-related sexual violence.

There is a large body of literature within security studies that is focused on determining the causes of conflict-related sexual violence. Firstly, a large number of studies highlight that there is an international and strategic practice of rape by armed groups to counter the 'enemy' civilian population (Koos, 2015). This is known as rape as a weapon of war, thus punishing groups based on religion or ethnicity, loyalty to enemy armed groups, regional identities etc. The use of conflict-related sexual violence is utilized to displace and terrorize the civilian population by targeting women (True, 2012; Sharlach, 2000; Laplante, 2017; Jansen, 2006). Contrastingly, feminist scholars state that it is less about controlling a population but rather the construction and continuation of gender inequalities (Cockburn, 2001). A major concern raised in this literature is the lack of empirical evidence of its strategic use, as there is no public military strategy that orders to systematically commit conflict-related sexual violence (We Are NOT Weapons of War, 2017). Some cases, such as Bosnia or Rwanda, undoubtedly use rape strategically, while in other cases, such as

Sierra Leone, the use of it is indiscriminate and untargeted (Jansen, 2006).

Opportunity structures and contextual conditions (Koos, 2015) are another aspect of conflict-related sexual violence. Most academics acknowledge that the breakdown of the rule of law and a concealed acceptance of violence against women catalyzes the chances of using sexual violence in religious, ideological, and ethnic conflicts (Brownmiller, 1975; Cockburn, 2001; Cohn, 2013; Gottschall, 2004; Laplante, 2017). Recent literature agrees that the contextual conditions of insecurity and instability affect conflict-related sexual violence, but these conditions should not be considered in isolation; rather, they are linked with other factors, such as gender structures. Another debate in the literature is the role of individual motivation. Elbert et al. (2013) demonstrated that 80% of demobilized fighters from a variety of armed groups believed that fighters were out of control, while 44% took satisfaction in harming others, which led to an increased bloodlust culminating in murders and rapes. Intragroup dynamics are also linked to the importance of individual motives. Butler et al. (2007) postulate that principal-agent relationships offer a tool to understand the opportunistic occurrence of wartime rape. Here, ordinary soldiers can advance their agendas, such as rape, and rely on asymmetries of information that impede leaders from knowing what is happening on the battlefield.

Within academia, three disciplines investigate the consequences of conflict-related sexual violence. The psychological literature demonstrates that survivors often suffer from post-traumatic stress disorder, depression, and suicidal tendencies (Josse, 2010). The literature on societal consequences emphasizes how perpetrators utilize it to carry a message not only to the survivors but the community as a whole, as it damages emotionally charged values regarding virtue, honour, shame, and sexuality (Gottschall, 2004). Stigmatization, having a child born of rape as a reminder of wartime rape and survivor's anticipation of rejection (Koos, 2015) are also briefly mentioned within the literature.

However, currently, there are no intricate theories or comparative research on the social dimension of conflict-related sexual violence. Physical impacts are mostly evaluated by medical research to comprehend the physiological aftermath of survivors. For instance, wartime rape often results in chronic pain, infertility and fistula, which directly affect the survivors' economic and social well-being within the community (Schull and Shanks, 2001). Fistula causes the lack of control of bodily fluids, which leads to a rejection from husbands and culminates in social isolation (ibid); infertility has a similar effect on survivors. Furthermore, survivors have a higher chance of contracting HIV/AIDS or other STDs (Supervie, Halima and Blower, 2010). Physical consequences are aggravated in the long term by the lack of opportunity to get treatment due to the limited or non-existent medical facilities during the conflict.

Reproductive healthcare in conflict

As established above, I will focus on women as the central victims of conflict-related sexual violence. Before I review this literature, I preface that not all women have different sexual characteristics or are assigned female at birth; they may pertain to the intersex spectrum or be transgender, thus having other medical necessities. Nevertheless, I will focus on cisgender women and their access to reproductive healthcare, specifically in post-rape scenarios. Moreover, within reproductive healthcare in conflict, most academic debates are underdeveloped and understudied. This has been verbalized by Foghammar et al. (2016), who highlight the gap in knowledge on how gender affects the nature and locations of attacks on healthcare. They furthered this by stating that gender data is not usually recorded or disclosed in academic research due to a lack of awareness of the relevance of gender-sensitive data collection or privacy concerns (ibid). Nevertheless, within feminist texts, I could detect some relevant information that correlates with this subfield of study. Prevalent feminist scholars, such as Cohn (2013), have stated that women bear the additional burden of insecurity of losing access to reproductive healthcare, which has long-term implications and may also cause an environment for sexual exploitation and violence. NGO reports state that access to antenatal and obstetric care, access to contraceptive survives, and access to abortion and post-abortion healthcare are among the most urgent issues for women during conflict, specifically in fragile states, where maternal mortality is high (Center for Reproductive Rights, 2017).

Regarding conflict-related sexual violence victims and reproductive healthcare, there is even less literature. Scholars established that survivors tend to seek medical aid due to the concern over STIs, pregnancies, etc. (McGinn and

Purdin, 2004; Swiss, 1993). Others claim that during conflict, formal structures, such as reproductive healthcare, become unreliable to victims due to the association with the perpetrators (McGinn and Purdin, 2004). However, it is clear that healthcare, in general, is often not prepared adequately to aid victims. Humanitarian aid organizations recognize its importance and will help guide my dissertation, as they provide a more profound theoretical contribution and relevant practical findings. After evaluating the literature, there is an identifiable gap in the area of reproductive healthcare for conflict-related sexual violence victims during conflict. However, when compounded with the weaponization of healthcare in conflict, this can be perceived as an attack on women. Nevertheless, this compounded effect has not been studied in the literature. Therefore, the gap in the literature is the absence of consideration of its gendered implications, specifically for women, when evaluating the weaponization of healthcare in conflict.

Methodology and Analytical Framework

This chapter outlines suitable methodology and methods employed in this dissertation. To reiterate, this research seeks to answer the question, 'How is the weaponization of healthcare during conflict gendered?' When reviewing the literature on the impact of conflict on healthcare, there is a tendency to utilize a quantitative approach to the issue (OCHA, 2017). However, Weissman (2016) criticizes the use of quantitative studies as they offer a reduced interpretation of violence in healthcare; they merely quantify violence as a violation of international humanitarian norms. Therefore, qualitative gender-sensitive alternatives, such as Stacy's (2018) and Charman's (2020) employment of discourse analyses to study the framing of sexual violence, offer a contextual and analytical approach. Moreover, I focus on discourse because it allows me to evaluate the importance of language. Language is powerful; it reinforces specific views of the world and understanding of certain events (Charman, 2020). Language focuses on or conceals particular realities of understanding the gendered dimensions of the WHC. Thus, discourse analysis is necessary to assess this research question.

Discourse is an interpretative strategy which studies the meaning bound to objects and subjects and how said meaning is created, negotiated, and contested (ibid). There is no objective or pre-discursive meaning to 'things'; meanings are contingent on the representation of 'things' through discursive practices (ibid). Discourse analysis helps me answer my research question because it makes connections between language, power, and ideology (Fairclough, 2008) to study the relationship between NGO reports' rhetoric and the influence and implications on the understanding of the weaponization of healthcare in conflict. I analyze the texts through 'articulation', which is the process by which meaning is created through linguistic resources and cultural materials, to identify the central elements of the discourse and how they link to each other (Weldes, 1996). The purpose of discourse analysis in this dissertation is to question how knowledge on the topic is initially produced and how it reinforces or interplays with current realities to construct a detailed understanding of the topic.

A Feminist Approach to Discourse Analysis

I use 'feminist critical discourse analysis' (FCDA) proposed by Lazar (2007) to read my texts, as it merges feminist studies with critical discourse analysis and provides a rich political critique. This methodology will demonstrate the complicated, subtle and not-so-subtle ways in which hegemonic power relations and gendered assumptions are discursively created, sustained, challenged, and negotiated in differing contexts (Lazar, 2007). Feminist discourse praxis will help me challenge the dominant liberal ideology that assumes that all women are equally subordinated in the patriarchal gender order and proposes a study of the intersections of gender with other systems of power within a social class, race/ethnicity, culture, sexuality, and geography (Hooks, 1989). Therefore, it elucidates that gender oppression is not discursively enacted nor materially experienced equally for all women. This choice of approach highlights the differing oppressions of women in conflict areas in contrast to women in non-conflict areas.

Reproductive Justice Analytical Framework

To reinforce the analytical capacity of feminist critical discourse analysis, I utilized a 'reproductive justice' framework to provide a more specific level of evaluation of reproductive healthcare. Moreover, this framework contextualizes reproductive healthcare with socio-political complexities and gender power dynamics, which shape women's

reproductive experiences and lives (Morison, 2021). This framework questions the homogenization of women's reproductive rights, meaning that it emphasizes how reproductive 'choices' and 'rights' are only available to privileged women. (Ross et al., 2017). Marginalized women have differing socio-cultural contexts that affect their access to resources and power regarding reproduction. In this case, this framework allows an assessment of the extent of women's ability to control their reproductive lives in conflict (Smith, 2005). Therefore, a reproductive justice framework offers a nuanced, intersectional, complete, and critical perspective that identifies systematic and structural issues of blocking access to reproductive healthcare, alongside analyzing the power dynamics that construct them.

Operationalizing Feminist Critical Discourse Analysis

To investigate the creation of discourses, I apply feminist critical discourse analysis to six written documents produced by relevant non-governmental organizations: Human Rights Watch, Center for Reproductive Rights, Swedish Red Cross, International Peace Institute, and the World Health Organisation's Department of Reproductive Health (WHODRH), and the Office of the United Nations High Commissioner for Human Rights (OHCHR). I chose NGO reports because NGOs hold discursive power, which is essential in the construction of social power and the reproduction of hegemony and dominance (Dijk, 1989). These reports present a variation of NGO stances on the topic of the gendered implications of the weaponization of healthcare in conflict. After extensive online research, these reports were the only available sources that explicitly recognize these elements and outline in detail the effects this has on women.

Another factor is the respectability of the selected NGOs; thus, these reports are vital in informing the world regarding human rights abuses and inequality, as well as potentially shaping responses to these. Doty (1993) suggests that international relations are constructed through the representations of what is perceived as 'truth', which shapes responses; therefore, NGOs have discursive power in the creation of global understanding and what is perceived as the 'truth'. Moreover, these reports reach a wide audience ranging from the international community, the United Nations, states, the media, and policymakers (Charman, 2020). Patriarchal gender ideology is structurally renewed and sustained through institutions (Weedon, 1997). Therefore, even if these reports present awareness of gender inequality, they implicitly may still perpetuate gender hierarchies. Thus, this methodology allows me to explore the gendered gaps and implicit biases of NGO reports.

After collecting the NGO report mentioned above, the documents were imported into NVivo, a qualitative data analysis software where the discourse analysis was applied to them. Here, I identified the themes 'Healthcare in conflict', 'weaponization of healthcare', 'reproductive healthcare' and 'conflict-related sexual violence' and manually coded them to aid the dissection of the overall themes of the NGO reports and to help structure the analytical sections of this dissertation. This was paired with an in-depth reading and evaluation of each NGO report to fully grasp the contextual aspect of the language used in each report, thus providing a multidimensional insight into these documents. This interpretative strategy allowed me to delineate sections of texts that were relevant to my research and later apply the analytical framework of reproductive justice.

Reliability, Validity, and Replicability

Feminist theory is a post-positivist approach that questions the 'scientist' ontologies and methods of political research (Charman, 2020). Thus, the positivist concepts of 'reliability' and 'validity' cannot be measured due to the post-positivist problematization of neutrality and objectivity in political research. Lather (1986) suggests that politics in itself is subjective and inherently ideological, and beliefs of 'neutrality' and 'objectivity' only obscure politics in itself. Thus, critical discourse research is not neutral, and rather, these biases are what form arguments (ibid). Maxwell (1994:47) suggests an alternative, the measurement of 'coherence' to the texts to prove useful. Therefore, to adhere to this, I am transparent about how I reached specific conclusions and clearly outline the analytical processes used.

Conclusions

Henceforth, this dissertation uses Feminist Critical Discourse Analysis and a Reproductive Justice Framework to

provide an understanding of how NGO reports present the gendered dimension of the weaponization of healthcare in conflict. Therefore, this dissertation aims to advance two key arguments:

- The weaponization of healthcare is gendered because, in addition to not being able to access general healthcare services, women cannot access reproductive healthcare. Therefore, it disproportionately affects women.

- When paired with the systematic use of conflict-related sexual violence against women, the weaponization of healthcare prevents them from accessing urgent reproductive care but also medical support for long-term issues, such as psychological or other mental health services, thus creating a compounded form of violence against women's bodies that is left unaddressed in the literature.

NGO Discourses of the gendered dimensions of the weaponization of healthcare in conflict

The purpose of this chapter is to apply a Feminist Critical Discourse Analysis to evaluate how gendered implications of the WHC in conflict are presented through the selected NGO reports. Analysing said discursive strands will provide an essential understanding of how the language of the NGO reports influences and constructs perspectives on the topic and guides institutional responses and practices.

Weaponization of healthcare

This discursive thread focuses on how the notion of 'weaponization' of healthcare in conflict is portrayed differently through representational and textual practices. I map out how several reports evaluate this notion and how it disproportionately affects women. Here, its definition plays a central role in deciding how certain demographics, based on gender, suffer more or less. However, only two reports explicitly utilize the term weaponization of healthcare. The International Peace Institute (2018:17) report states:

'The politicization of health services is closely tied to militarization. In many conflict-affected contexts, governments, militaries, and armed groups may instrumentalize health services by denying access to or imposing conditions on healthcare providers as a political or military strategy'.

Here, the weaponization of healthcare in conflict is presented as having strategic, military, and political value. Therefore, the representation of these uses provides an elaborate definition that lists the causing actors that may strategically use access to healthcare as a weapon of war. Similarly, Human Rights Watch's (2021:8) country-specific report broadens its scope by asserting: 'The Ethiopian government has also obstructed the access of senior international humanitarian officials and humanitarian agencies providing aid in the region'.

Thus, extending the conceptualization of weaponization of healthcare in conflict to include the instrumentalization of blocking humanitarian aid. This report also directly uncovers the Ethiopian government's actions while implicitly holding the state accountable. Nevertheless, the report does not explicitly accuse the Ethiopian government but hints at the actor's intentionality by stating that they are obstructing access, which highlights its strategic value. This thematic strand is also present in the Center for Reproductive Rights (2017:2) report by briefly stating that the weaponization of healthcare in conflict affects women to a greater extent due to their additional healthcare needs. This report takes a gender-specific approach which focuses on the affected demographic of weaponization in comparison to the Human Rights Watch and International Peace Institute reports, which have a heavy focus on acknowledging the reasons why the weaponization of healthcare in conflict is used in conflict while simultaneously holding the causing actors accountable. However, a more comprehensive definition that includes a gender-sensitive focus while attributing accountability would improve its gendered understanding. Moreover, the lack of an explicit textual mention of the gender impacts when defining the concept implicitly creates the assumption that this strategy is not gendered. Therefore, this thematic strand provides insight into the absence of a gender-sensitive definition.

Nevertheless, I note that definitions do not appear in the remaining three reports; rather, they focus on the importance of gender in determining the asymmetric impact of an absence of healthcare on women. This discourse assumes that

states do not strategically block or impede access to healthcare in conflict. A representative example of a report stating that women lose healthcare in conflict but does not state who took it from them is the report by the OHCHR (2020:35) that asserts:

'States Parties to enact and enforce laws and policies that protect women and girls from violence and abuse, and to provide for appropriate physical and mental health services'.

Equivalently, the WHODRH (2000:14) prefaces that their report's intended audience is national bodies, such as the Ministry of Health, who are responsible for ensuring health services, including reproductive healthcare, are maintained in conflict settings. Therefore, these reports assume that the states will adhere to their obligation to ensure that their citizens have access to healthcare and that states cannot be the causing actors. This presumes that states cannot be causing actors and, therefore, cannot be held accountable for the weaponization of healthcare in conflict.

Moreover, the passivization of language, such as *'health facilities may have been destroyed, or may have become inaccessible'* (WHODRH, 2000:13) or *'Women are also the first to suffer from the general lack of access to medical care'* (International Peace Institute, 2018:13) has a crucial ideological function, which is the deletion of accountability alongside reifying processes (Billing, 2008). The transformation of a statement into an agentless statement that conveys less information, as Fowler et al. (2018) claim, is a way of maintaining and perpetuating unequal power relations. This is further reinforced by Rauh's (2012) criticism of NGOs' use of passive language in reporting as an inefficient mechanism to hold actors accountable and consequently further legitimizes power imbalances. Hence, the framing of the WHC through a passive voice omits the agent of the action, thus impeding accountability, and rather focuses on the patient of the sentence, in this case, the victims. The Human Rights Watch (2021:6) exertion also utilizes passivization throughout:

'The lack of safety, information, health facilities, medications, trained staff, and transport prevented survivors of sexual violence from seeking or receiving time-sensitive treatments'.

Even if the report attaches accountability to the Ethiopian government once, the continuous use of passive language that does not attach accountability throughout is counterproductive in evaluating the gendered effects of the weaponization of healthcare in conflict. By doing so, the discourse removes the question of who is destroying and making healthcare and frames the weaponization of healthcare in conflict as unavoidable and unchangeable. Henceforth, the removal of accountability and intentionality, specifically state accountability, serves as a mechanism to sustain power structures, specifically patriarchal power structures. This is illustrated by states being shaped by patriarchal structures, playing a central role in the creation of state identities, transformation, maintenance, and societal practices (True, 2018). Therefore, the absence of state accountability in NGO reports fails to deconstruct implicit patriarchal structures instilled within states, which is essential to fully comprehend how the WHC is gendered.

However, the discourses held in these reports still evaluate the gendered implications of accessing healthcare in conflict. Fouad et al. (2017) claim that the weaponization of healthcare in conflict strategically uses people's necessity for healthcare as a weapon against them by depriving them of this necessity. This demonstrates that the lack of access to healthcare is not a synonym for weaponization but is rather a part of the weaponization due to the importance of deprivation of healthcare and the consequences on people. Therefore, these reports remain instrumental and relevant in comprehending and evaluating the discourses around the gendered impact. Nonetheless, the absence of adequate gender-sensitive definitions, alongside the preclusion of accountability and intentionality of the causing actors through the use of passive language, needs to be taken into consideration.

Women and reproductive healthcare

Whilst the weaponization of healthcare in conflict is not framed as a widespread issue in NGO reports, the lack of access to healthcare during conflict is explored in great depth. This discursive thread is centred around how NGO reports representationally and textually convey the lack of access to reproductive healthcare in conflict and the impact it has on women.

A significant discursive strand present in certain reports is the assumption that stating that women's need for reproductive healthcare is equivalent to a gendered understanding of the WHC. I preface that only women need reproductive healthcare, so it is a gender issue; therefore, if healthcare is weaponized, it impacts women more than men. However, a reductionist perspective on reproductive needs that is solely based on child-bearing women is highly exclusionary. I suggest that the constant and sole association of women's needs to reproductive capabilities overlooks other reproductive healthcare needs, such as non-maternal needs, and presents an essentialist and problematic conception of gender. For example, *'women often endure poor sanitary conditions and lack sexual, reproductive, and maternal health services'* (International Peace Institute, 2018:13) illustrates the exclusive discourse that essentializes womanhood to their reproductive capabilities. By doing so, women's bodies are perceived solely by their ability to reproduce, which heavily correlates with their sex, a biologically determined factor (Torgrimson and Minson, 2005), rather than gender. Within conflict, safe womanhood is not solely being able to have safe motherhood (Meleis, 2005). This does not mean that reproductive roles do not put women at a greater healthcare risk, but rather, it is essential to evaluate these issues symbiotically alongside the importance of gender for making women culturally, socially, and also biologically at a greater risk of mortality (Crockett and Cooper, 2016). Thus, a more comprehensive understanding of reproductive healthcare, which acknowledges patriarchal reinforcements, is essential for understanding my key argument.

To overcome essentialization, another discursive strand presents a more holistic conception of reproductive healthcare to elevate the assessment of the gender dimensions of the weaponization of healthcare in conflict. The WHODRH (2000:7) explicitly criticizes essentialist reproductive healthcare conceptions:

'Women bear by far the greatest burden of reproductive health problems and that biological, social, cultural and economic factors increase a woman's vulnerability to reproductive ill-health. But reproductive health has to be understood within the context of relationships between men and women, communities and society since sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors.'

This approach to reproductive healthcare acknowledges the expansive nature of the concept that goes beyond the health of reproductive organs or reproduction, but rather how social factors and external behaviours, such as conflict, influence and construct ill health. Social gender arrangements do not flow from the properties of women's bodies but rather precede their bodies and shape the conditions in which their bodies live and develop (Connell and Pearse, 2015). This allows an understanding of why women suffer more from the WHC: firstly, due to the removal of reproductive healthcare in the weaponization of healthcare in conflict, and secondly, due to gender structures that encourage and enable violence against women (Jansen, 2006). These reports convey that women's bodily autonomy to control their reproductive lives is eroded in conflict (ibid). Furthermore, the report acknowledges psychological and social health issues as caused by the lack of reproductive healthcare, which is usually unrecognized in conflict and is essential in securing justice and preventing lifetime health issues (Jansen, 2006). Access to reproductive healthcare does not occur in a vacuum; the government, community safety, and violence play a role in reproduction (Smith, 2005).Therefore, I suggest that, to overcome the essentialization of women's needs in conflict, a focus on a holistic perception of reproductive healthcare that interlinks how conflict affects and perpetuates violence against women is needed. Henceforth, I am developing my central argument that the weaponization of healthcare in conflict disproportionately affects women because, in addition to not being able to access general healthcare services, women cannot access reproductive healthcare.

To understand the gendered implications of the weaponization of healthcare, a discursive strand centralizes identifying who is the most affected by the weaponization of healthcare in conflict. The OHCHR (2020:31) acknowledges that CRSV survivors, with a focus on women and girls, face additional 'social barriers' when accessing healthcare: 'Social barriers created by the high level of stigmatization of sexual violence often lead survivors to seek care only after the development of medical complications'.

The focus on barriers and burdens is present throughout other reports, such as the International Peace Institute (2018:19) report, which states that conflicts exacerbate people's pre-existing vulnerabilities; for instance, women with disabilities who are displaced face what the report calls a *'triple burden'*. The words 'burden' and 'barriers' to healthcare for women are commonly used in non-conflict settings (Shahali et al., 2016) to address external factors,

such as geographical location, that impede women's access to health services after being victims of sexual assault (Logan et al., 2005). Thus, I suggest that many reports present an intersectional feminist subtext, which refers to how individuals' social identities, such as race, gender, age, disability, and ethnicity, overlap (Crenshaw, 2017), therefore affecting how individuals are discriminated against and oppressed differently due to these differing social identities (ibid). Furthermore, these reports outline populations at higher risk of suffering the most from the WHC. These include women from ethnic minorities and disabled women (International Peace Institute, 2018:15; Human Rights Watch, 2021:21), which correlates to the populations who are more likely to suffer conflict-related sexual violence (Austin and Campos, 2019). Nevertheless, the use of terms such as 'burdens' does not acknowledge the deep-rooted gendered power imbalances in societal orders that impede women from accessing healthcare in conflict. A more explicit intersectional approach that acknowledges intertwining factors, such as race, ethnicity, disability, and social class, and how these limit the ability to access healthcare, specifically reproductive healthcare, in conflict (Smith, 2005) would have highlighted in greater depth how gendered the weaponization of healthcare in conflict is, and how this is aggravated by other systems of oppression. Nevertheless, these reports illustrate that women, specifically survivors, suffer the most from the lack of access to healthcare, including reproductive healthcare. To overcome the essentialization of women's healthcare needs, the holistic conception of reproductive healthcare proposed by the WHODRH that acknowledges psychosocial healthcare needs, alongside an intersectional understanding, is central to adequately capturing the gendered impacts of the weaponization of healthcare in conflict.

Conflict-related sexual violence survivors' need for healthcare

Further emphasis on how women, specifically conflict-related sexual violence survivors, face increased suffering due to the weaponization of healthcare in conflict is necessary to understand how this is gendered. Within this last discursive strand, I map out the overarching consensus that survivors need urgent medical care. When considering the gendered implications of the weaponization of healthcare, the selected reports emphasized how it greatly affects survivors, specifically women, when they need urgent medical care but overlooks survivors' needs for long-term medical support. All 6 reports delineate how the effects of sexual violence in conflicts are aggravated by the lack of access to healthcare. For example, the report from the Center for Reproductive Rights (2017:2) explicitly states that: 'Women and girls affected by conflict face increased risks of sexual violence and urgently need sexual and reproductive healthcare services, such as obstetric and antenatal care for pregnant women, access to contraceptive information and services, including emergency contraception, and access to safe abortion and post-abortion care'.

Before moving to the next example, I point out the textual importance of the words 'urgently' and 'emergency', which emphasize the necessity of immediate need for healthcare due to conflict-related sexual violence. Another example of this is portrayed in the WHODRH (2000:113) report:

'Women who have been sexually assaulted may have mutilation or damage to the genitals, including bruising, lacerations, tearing of the perineum and damage to the bladder, rectum and surrounding pelvic structures. Untreated wounds may be infected- In the short term, there may be feelings of shock, a paralyzing fear of injury or death, and a profound sense of loss of control over one's life.'

Both excerpts utilize descriptive medical jargon to textually list all the immediate physical harm that is caused by conflict-related sexual violence to women, placing representational importance on the short-term necessity for healthcare. Moreover, the second excerpt evidences the inclusion of social and psychological factors linked to conflict-related sexual violence. Therefore, the textual and representational practices in the NGO reports demonstrate an overarching consensus in their discourse that survivors need urgent medical care, which cannot be accessed. Nevertheless, neither addresses the role of the weaponization of healthcare in impeding CRSV survivors from accessing healthcare as a compounded issue.

However, there is a limited discursive stream that briefly acknowledges that the lack of access to healthcare for long-term medical issues associated with conflict-related sexual violence perpetuates violence against women. In the paragraph above, the need for access to safe abortions for survivors is highlighted; however, there is limited reference to the long-term medical complications of not being able to access a safe abortion after conflict-related sexual violence. I suggest this may occur due to the previously mentioned essentialization of women's medical needs

as solely based on child-bearing reproduction healthcare. For example, the WHODRH report provides a detailed assessment of which reproductive healthcare practices get prioritized over others for immediate post-trauma healthcare. Here, the WHODRH (2000:13) claims that the healthcare focus is on necessary and life-saving interventions while '[l]ess visible problems such as STIs, HIV/AIDS, female genital mutilation, the complications of unsafe abortion – and other traumas are frequently neglected'.

Nevertheless, the report does not criticize this response because it blames the conflict for disintegrating health infrastructure that critically compromises reproductive healthcare (ibid). Therefore, this report presents a plausible approach to the capabilities of health infrastructure in conflict while also being critical of the impacts of this on survivors. However, when the strategic weaponization of healthcare is factored into the WHODRH's statement, this illustrates how long-term healthcare needs for survivors are often ignored. Moreover, I suggest that leaving survivors without medical care to alleviate long-term psychological medical consequences becomes a form of perpetuating violence on women's bodies because their health and bodily autonomy are removed. Moreover, these reports highlight how immediate life-saving healthcare for survivors in the NGO reports is prioritized over long-term medical issues. However, both affect women because of the WHC. Similarly, the OHCHR (2020:4) report elucidates that many survivors do not immediately seek healthcare but rather wait until the situation is critical enough to urgently need it:

'Indeed, they often seek treatment at health facilities only after developing complications, such as sexually transmitted infections (STIs), unwanted pregnancy and complications arising from unsafe abortions- if the survivor is a married woman or the pregnancy resulted from a rape perpetrated by armed elements reportedly siding with "the enemy"'.

The use of an authoritative and medical tone in this quote, alongside the more critical tone when referring to the strategic implications of conflict-related sexual violence, shows how the right to any bodily autonomy and reproductive choices is removed through the weaponization of healthcare alongside the systematic use of conflict-related sexual violence. Moreover, the textual practice of symbiotically addressing the medical consequences with social issues, such as forced pregnancies, which may lead to ostracisation from families and communities if women survivors forcibly have a child with the 'enemy', shows the multidisciplinary and complex breakdown of support networks of survivors when healthcare is weaponized in conflict. Alongside this, the WHODRH (2000:113) briefly mentions the long-term psychological problems: 'In the longer term, there may be profound feelings of shame, depression, anxiety and grief, characterized by persistent fears, avoidance of situations that trigger memories of the violation'.

When considering the long-term medical consequences of survivors who are not able to access healthcare, in this case, psychosocial therapy, survivors cannot achieve justice nor reconcile the violence they endure due to the deliberate and strategic blocking of healthcare. Moreover, the feelings described above often fail to be addressed in more depth. Feminist scholars claim that this occurs due to the perception of women's bodies being used as battlegrounds in conflict (Namibia, 2007; Jansen, 2006). Women are disadvantaged in conflict, not only because of conflict-related sexual violence but also because of the lack of healthcare services, which creates a 'circle of negative factors all reinforcing each other, creating a downward spiral in people's lives (Brittain, 2003:43). This gap in understanding of the discourse highlights the necessity to focus on these factors, to allow survivors to heal physically and psychologically

Conclusions

At first glance, these reports provide useful insight into how the weaponization of healthcare in conflict is gendered. However, I problematized the essentialization of reproductive healthcare in certain reports that do not acknowledge non-maternal reproductive healthcare and the concurring psychosocial healthcare needs that emerge from the lack of reproductive healthcare. Secondly, the discourses fail to evaluate the compounded nature of the weaponization of healthcare in conflict when paired with the systematic use of conflict-related sexual violence to alleviate not only urgent medical impacts but also psychosocial long-term healthcare needs. Moreover, the discourses elucidate that women, as central victims of systematic conflict-related sexual violence, need urgent healthcare. However, certain

reports' textual and representational practices remove accountability and intentionality of the causing actors of the weaponization of healthcare in conflict. Henceforth, an understanding of the implications these discourses hold is necessary and will be explored in the next chapter.

Implications of NGO discourses on the weaponization of healthcare in conflict

In this chapter, I examine the implications that these discursive streams hold. To do this, I utilize relevant scholars to interrogate the implications and provide critical insight into how the weaponization of healthcare in conflict is gendered. However, as mentioned above, specialized literature is absent from my research question, therefore I draw from a myriad of academia ranging from psychosocial medicine to gender studies. Here, I question what implications these discourses have, alongside the areas they contribute to and their limitations to answer my research question. Finally, I examine the possible difficulties for practitioners, policymakers, and researchers (Charman, 2020) to evaluate how the weaponization of healthcare is gendered.

Womanhood and reproductive health in conflict

In all the samples, there is a recognition of women as suffering more from WHC due to the inaccessibility of reproductive healthcare and endemic targeting of conflict-related sexual violence. However, I point out that NGO's reduction of womanhood as solely based on their biological composition, in this case, reproductive capabilities, provides a superficial understanding of women's increased suffering by the weaponization of healthcare (see The International Peace Institute, 2018:13; WHO DRHR, 2000:11; Center for Reproductive Rights, 2017:1). I problematize the reports' essentialization of womanhood as inherently connected to the female sex, throughout the constant link of womanhood to access to maternal reproductive healthcare (Reproductive Health Journal, 2022). Moreover, this essentialization of women as sole reproducers neglect other psychosocial healthcare needs of women in conflict. This is demonstrated by the neglect of the NGO reports of long-term psychosocial health consequences of survivors. Here, Janses (2006) states that reproductive and psychosocial healthcare should be essential for women in conflict, specifically if they are survivors of conflict-related violence. However, I preface that a focus on reproductive healthcare in conflict is beneficial to improving humanitarian responses to healthcare needs in conflict (McGinn, 2005). A more holistic perception of reproductive healthcare should be undertaken that accounts for non-maternal reproductive issues alongside psychosocial long-term health issues that emerge from the lack of reproductive healthcare in conflict.

Importantly, gender is a social process which meshes the social and the biological (Connell and Pearse, 2015). Nevertheless, the representational practices of most NGOs report that framing womanhood solely with maternal reproductive healthcare implies that the terms gender and womanhood are simply biological concepts. This broadly aligns with Biologism, a problematic gender essentialist theory, which defines men's and women's essence based on their biological capacities (Grosz, 1995). This method of essentialism is established by reductionism, which means that biological causation creates cultural and social factors (DiQuinzio, 1993), thus undermining the need for psychosocial and long-term healthcare to alleviate the urgent but also the long-term medical effects of conflict-related violence. This theory uses the function of reproduction to limit women's identity and establishes a permanent form of societal containment for women (Grosz, 1995). Moreover, this narrow reproductive lens is highly exclusionary, and older women's different reproductive needs, which include cervical and breast cancers or ageing with fistula, become ignored (Crockett and Cooper, 2016) due to the sole focus on women of childbearing age. A single report briefly states that older women face difficulties in getting help for their specific healthcare needs (Human Rights Watch, 2020:3). Thus, non-maternal older women become absent from reproductive healthcare discourse in conflict in these reports, which makes older women's needs invisible. Therefore, when looking at the gendered implications of the weaponization of healthcare, the gendered essentialization of women as biologically determined by their reproductive capabilities presents a problematic and universal image of women's needs in conflict that perpetuates the reductionism of women—henceforth, presenting challenges for policymakers that are influenced by this narrative to accurately understand the gender structures within the conflict that make women suffer more by the weaponization of healthcare in conflict.

Moreover, the implication of essentializing women's healthcare needs solely on reproductive healthcare within NGO

reports creates an absence of addressing women's psychosocial healthcare needs to alleviate the long-term effects of conflict-related sexual violence, thus limiting comprehensive humanitarian healthcare assistance as their single source of information does not address the issue adequately. This criticism aligns with Brown et al.'s (2019) research that determines psychosocial sequential illnesses that additively worsen health after sexual violence. These create a pathway of negative long-term health issues; for instance, post-traumatic stress disorder is linked to the increased risk of cardiovascular disease, hypertension, and gastrointestinal problems (ibid). Therefore, sexual violence cannot solely be alleviated with urgent reproductive care but necessitates long-term healthcare support to prevent long-term disabilities (Pietrzak et al., 2011), which gets overlooked within the report's discourses. Reproductive healthcare and its delivery should go beyond the narrow biomedical understanding and interrogate the importance of race, sex, gender, class, sexuality, and nation to guide how governments and NGOs understand the concept of reproductive healthcare (Gurr, 2015). Moreover, this would factor in the issue of the weaponization of healthcare and its effects on women as this framework considers socio-political factors, such as conflict, in its understanding of the scope of reproductive healthcare. Therefore, a holistic outlook of reproductive healthcare that incorporates psychosocial health issues is central to understanding how the WHC affects women because of their loss to said healthcare.

Compounding the issue

The entrenched representational practices seen in the NGO reports of how conflict-related sexual violence and the weaponization of healthcare in conflict are viewed as isolated issues in conflicts have implications for the understanding and the response to these issues and how they are gendered. Firstly, these reports address both conflict-related sexual violence and the lack of access to healthcare; however, they fail to assess how both issues are mutually reinforced in certain conflicts and how their compounded nature serves to further violence against women. This is illustrated in a case study that determined that a lack of mutual understanding between healthcare providers and sexual violence survivors' healthcare needs obscures the ability to provide comprehensive healthcare for sexual violence survivors (Shahali et al., 2016). After conflict-related sexual violence, survivors always need urgent healthcare, alongside long-term treatment; when it cannot be accessed due to its weaponization, there is a deprivation of the right to health, which primarily targets women.

The representation of women as victims is a common feature in NGO reports, which are represented through discourses on how, in conflict, women's bodies are viewed as territory to be overthrown by male opponents, and rape represents the message that the 'human territory' has been conquered (see WHODRH, 2000:110; OHCHR, 2018:10). This resonates with the theoretical understanding of rape as a weapon of war, in which by dishonouring women's bodies through conflict-related sexual violence, a man can symbolically disrespect the opponent's lineage, honour, ethnicity, and nation (Buvinic et al., 2012; Snyder et al. 2006). Women are perceived as ideological reproducers, cultural carriers, and signifiers of one nation (Yuval-Davis, Anthias and Campling, 1989). Therefore, acknowledging that women's bodies are perceived as reproducers connects reproductive healthcare, women, and the use of conflict-related sexual violence as a strategy of war. Moreover, gender intersects with other systems of oppression that worsen this type of violence; the different ethnicity and religion of the perpetrators increase the probability of being a victim of conflict-related sexual violence (Laplante, 2017). This violence causes survivors to need healthcare, which was not needed before; when this is weaponized, women suffer the compounded form of violence through wartime rape and the inability to mitigate the injuries (Brown et al., 2019), thus perpetuating suffering on women's bodies. Nevertheless, the limited textual representation in the NGO reports of survivors' need for long-term medical support implies that women's health needs are essentialized solely to reproductive healthcare after said violence, which undermines the need for psychological healthcare. When women's bodies become battlegrounds, women's physical and mental health is threatened (Jansen, 2006).

The assessment of both factors as individuals creates a subtextual understanding that there is no premeditation but is rather an 'unforeseeable' by-product of conflict. The implications of an explicit denunciation of the compounded effects of both issues are presented through the lack of accountability of the perpetrating actors and undermining of the premeditated and strategic value these issues have during conflict. For example, during the first five months of the Tigray conflict, the Ethiopian government utilized rape as a weapon of war; here, the data suggests a conservative estimate of 10,000 women being raped (Gesesew et al., 2021). Alongside this, a blockade of aid, looting, vandalism, and seizing of hospitals by armed groups are central components of this dispute (ibid). The

Human Rights Watch (2020:5) report reaffirms the role of weaponization of healthcare and conflict-related sexual violence due to *'the presence of soldiers at checkpoints on the roads and near or inside health facilities also deterred survivors from seeking health services'*, thus demonstrating its compounded nature. I cannot establish intentionality, but my dissertation aims to bring to light how the weaponization of healthcare does not occur in a cultural and political vacuum but can, and if paired with other conflict-related strategies, lead to a furthering of harm to women alongside perpetuating patriarchal gender orders. Without the adequate consideration of these mutually reinforcing factors within NGO reports, there cannot be adequate institutional responses to violence against women and an acknowledgement of the compounded nature of this issue.

Thus, the discursive lack of acknowledgement of the compounded nature of conflict-related sexual violence and the weaponization of healthcare in conflict fails to depict a rounded and critical insight into the gendered implications of the weaponization of healthcare in conflict. Nevertheless, the reports bring to light an issue which is broadly undisclosed within academia regarding the complexities of gender dynamics in conflict and their multidimensional effects on women's physical and mental health.

Accountability, intentionality, and gender structures

NGOs play a central role in creating knowledge and understanding of the topic; thus, these discourses are reproduced in global politics and our understanding of the issue. Making women's health front and centre in policy agendas and international consciousness during conflict is essential for achieving national and international security (Meleis, 2005). For instance, empirical evidence states that NGO reports regarding conflict-related sexual violence

inform policy (Boesten, 2017). However, NGOs as institutions still structurally sustain and renew patriarchal gender ideologies (Weedon, 1997). Therefore, their reports will still perpetuate these. As evaluated above, the lack of accountability or intentionality through the discursive passivization of language in NGO reports (see OHCHR, 2020:35; WHODRH, 2000:14; Human Rights Watch, 2021:6) can be replicated in perceiving the weaponization of healthcare as unavoidable or without a perpetrator. Thus, NGOs' discursive power in the creation of this global understanding can make adequate institutional responses difficult (Doty, 1993). Furthermore, the absence of accountability for the actors that weaponize healthcare can be perceived as a reproduction of patriarchal gender structures, as the status quo and the causing actors are left unquestioned. In conflict, these patriarchal structures concur and catalyze an increased use of violence against women (Jansen, 2006).

The WHC is a war crime under the International Criminal Court statute (Omar, 2020). Therefore, when NGO discourses avoid the term 'weaponization' or acknowledge the strategic and military use of healthcare, they create a gap in attaching accountability and intentionality to the causing actors. The prosecution of the weaponization of healthcare under international law has only occurred twice and is a slow and complex process (Davies, 2022). Henceforth, the absence of discourse on the topic, specifically when gender issues are accounted for, can potentially be overlooked by the international community or even intergovernmental organizations that prosecute these actions. Additionally, the compounded effect of the weaponization of healthcare in conflict and conflict-related sexual violence needs to be acknowledged by these reports to further attach accountability, given they both contribute to harming women and, therefore, should not be considered in isolation. Henceforth, the discursive gap in acknowledging accountability and intentionality serves to maintain current patriarchal orders with the failure to prosecute the perpetrators, having a possibility of being replicated in institutional responses. This feminist discursive evaluation of the reports highlights how the reports implicitly contribute to the perpetuation of gender structures, as conflict catalyzes underlying societal issues such as gendered inequality in healthcare (Jansen, 2006). Therefore, these reports can bring urgency and the necessity to focus on this issue. However, a greater understanding of how gender structures exist in conflict, statehood, and healthcare is central to providing an adequate in-depth evaluation of how the weaponization of healthcare in conflict is gendered.

Conclusions

In this chapter, I considered the representational practices of NGO's gendered discourses around the WHC and the implications they may have for creating an understanding and responses to the issue. I highlighted how the

essentialization of reproductive healthcare as solely focused on child-bearing women in certain reports ignored other demographics of women and other psychosocial healthcare needs that primarily affect women in conflict. Moreover, the absence of NGO reports acknowledging conflict-related sexual violence and the WHC as a compounded issue in certain conflicts can detract from comprehensive and adequate institutional responses that include the role of gender. Finally, I claim that the lack of accountability and intentionality for perpetrators in the discourses in NGO reports perpetuates patriarchal gender orders that enable violence against women.

Conclusion

In this dissertation, I have made several interconnected arguments to discern how the weaponization of healthcare is gendered. I have advanced two key arguments throughout: firstly, the weaponization of healthcare in conflict is gendered because, in addition to not being able to access general healthcare services, women cannot access reproductive healthcare, therefore, disproportionately affects women; secondly, when paired with the systematic use of conflict-related sexual violence against women, the blockage of healthcare prevents them from accessing urgent reproductive care, but also medical support for long-term issues, such as psychological support, thus creating a compounded form of violence against women's bodies.

To evaluate this, I applied a Feminist Critical Discourse Analysis alongside a Reproductive Justice Framework to the selected NGO reports. Here, I problematized and critically engaged with the representational and textual practices of the perception of gender issues regarding the weaponization of health care. Furthermore, I have explored the implications these discourses hold. After doing so, I developed my key arguments to include a holistic and intersectional understanding of reproductive healthcare that does not exclude non-maternal reproductive issues and includes psychosocial healthcare needs that emerge due to conflict-related sexual violence. Moreover, the absence of NGO reports acknowledging the compounded issue in certain conflicts can detract from comprehensive and adequate institutional responses that include the role of gender. Finally, I stated that the lack of accountability and intentionality for perpetrators in the discourses in NGO reports perpetuates patriarchal gender orders that enable violence against women.

Nevertheless, the findings of this dissertation have to be seen in the light of certain limitations. The absence of previous academic research on the topic removes the possibility of applying a specialized theoretical foundation to my research. Moreover, this dissertation is limited by the lack of available data, which created a small sample size of NGO reports. However, these limitations allow an opportunity to develop this area of study alongside providing preliminary findings on the topic. To overcome the textual limitations within NGO discourses, this research can be supplemented with international legal cases that explore the issue of weaponization of healthcare to evaluate how these discourses present gender, therefore providing a more comprehensive analysis that deconstructs other dominant sites of discourse that produce essential knowledge in global politics. Other possible avenues for further study can include the focus on the compounded weaponization of healthcare and conflict-related sexual violence on ethnic minority women. For example, the case study of Tigrayan women in the Ethiopian Civil War (Gesesew et al., 2021) provides a more intersectional, empirical, and critical insight into the asymmetries of how the weaponization of healthcare is gendered.

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