

## Comments of "Medical SOP School Solution".

### GS 1:

There is no difference in the care of "men, women, boys and girls." Care is provided in accordance with good clinical practice. Here, there may be differences in treatment principles, but the medical staff are well aware and act according to these and shall / may act only on the basis of medical legislation based on science and proven experience. In healthcare are always treated a patient based on the clinical condition and care needs. Priority between patients must never be based on factors other than medical status and health needs.

Comment on mixed teams is very good! Very important factor in enhancing the effectiveness of a team. Also important categories are mixed on the go (MD, nurses, medics) so that not a profession is one-gendered. (This comment also applies to GS 4)

### GS 3:

In Point II General A, I would prefer that the last sentence is changed to: "As additional duty, MedCoy will assist in the collection of medical evidence related to war crimes including conflict related sexual violence."

Medical Evidence in this case the tests and / or autopsies carried out in the same way as a civilian. The documentation (medical report with photographs and samples) must maintain a quality that can handle legal review. It is not reasonable to believe that international forces should be tasked to documenting just certain war crimes, but not others. With this revised wording so clear that discovered war crimes should be documented and additionally lifted conflict-related sexual violence (CRSV) up a bit special.

### GS 5:

Normally in SOP is referred to positions with abbreviations to avoid He / She. In this case, the Field Medical Assistant is just called the FMA. Compare how the GFA is called in writing, it is never he / she but GFA. An SOP should keep even after rotation, and you never know what gender may be manning various positions over time.

### GS 6:

Normally, Medical Supplies, Including Medical Consumables be suited for the task. It is important to be aware that if the mission is to provide assistance to civilians in the area, it needs equipment and supplies adapted for these. For example, drains, infusion needles, urine catheter, sanitary pads, equipment for pregnancy , etc. must be supplied in order to be adapted for other patient groups than military hospitals normally cater for. It is not just the Senior NCO assistant responsible for this. Ultimately, it is the Medical Director and Head Nurse should analyze the medical task and ensure that the proper and adequate equipment

and supplies available. Senior NCO assistant shall ensure that the equipment is available, working and completing ordering supplies afterwards.

GS 7:

The unit's policy should strive to have all teams and groups mixed, even within the Company's logistics support. It is not always possible to organise. The first priority for a hospital will always be to give the patients the best possible care. Here, the skills of the care staff is more important than their gender. It is best to have mixed care teams, but ultimately the medical skills are more important.

GS 8:

On Male / female mixed teams, see comments on GS 7

To employ female interpreters is very important. Likewise with different ethnic backgrounds. This should be emphasised in the training course because not everyone would see how important this is. Not just to be able to conduct quality care but also to document any CRSV war crimes.

GS 9:

Subject CRSV see comments GS 3. Personally, I think it's good that you are clear about that CSRV is a war crime and not just a criminal act to be prosecuted locally.

GS 10/11

Good. Cultural Awareness is always crucial for the success of a mission.

GS 12:

Very good comment.

Normally in missions, a "Theatre Medical Information Handbook" is issued. I have attached a actual example from Bosnia in 2005. Sadly, this example and others are missing a gender perspective. Most focus on emergency care (relevant to their own troops needed). As you can see, it is missing specification of medical facilities that offer pediatric and gynecological treatment.

GS 13:

In describing the details of the brigade, one should also refer to the current document Brigade SOP, for example "of according to MNB SOP Annex R4 Decased".

GS 14:

Military hospitals usually have collectively CBRN protection. No need for a protective mask indoors as the protection most likely is based on secured gates with higher air pressure. If the hospital did not have the CBRN protection, it will be taken out by a gas attack, whereby the equipment is contaminated and can not be used. No patients are evacuated when there is a risk of gas and the ambulances do not normally have the CBRN protection.

This point C can generate a lot of unnecessary discussions that are not gender-related. Suggest that you instead describes how civilian patients' belongings to be stored. Are there gender / cultural aspects that should be considered? (prayer beads, niqab, toys, etc.)

GS 15/16/17:

good

GS 19:

I do not agree that "Women and children are more likely to become victims" at Mass Casualty Situations. To my knowledge, there is no evidence for this. It is known and accepted that children become more frequent in patients interventions in developing countries because they are about 50% of the population. For that reason they are also common as patients.

Mass Casualty Situation (MASCAL) is a situation when the number of patients exceeds medical capacity. Then it becomes a matter to move from quality to quantity. For health care, it becomes a task to help / save as many as possible with the resources available while deviating to some extent from quality to free up resources. Gender perspectives must be integrated in every MASCAL plan. Although the standard for quality decreases, it does not mean that gender perspective should be left out.

Overall, there is one large error in this subparagraph. The practice SOP provides tasks but does not describe how it will be implemented. An SOP should describe in detail the processes involved in a unit and all groups (within NATO and the EU) must have a MASCAL plan. I enclose an SOP for a multinational hospital company during exercise in Germany in 2013 during a NATO exercise. In pages 18-23 you can see how detailed a MASCAL plan should be. Not only must all units have a MASCAL plan, it should also be known by everyone in the unit and practiced on several occasions.

When medical capacities for a mission is planned, they are built om a medical intelligence report. Enclosed please find an example (South Sudan). Although gender perspective is in the last point, I think the reports are substandard from a gender perspective. It is very much lacking and there had been an advantage if a gender-educated person had been included in medical intelligence group who produce these reports. If you want you can use the report to the training to see what information you can find, but also to see what is missing.