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Integrating Gender in Medical Education
A Step in Addressing Health Inequities

Sangeeta Rege[1] and Padma-Bhate Deosthali[2]

Medicine, as a field, has been critiqued for being gender biased and not accounting for social determinants that shape health conditions, access to healthcare, and health outcomes. Gender bias permeates many aspects of medicine in India: clinical practice, research, health program delivery, and medical education. In 2007 the World health organization (WHO) acknowledged the imperative of systematic integration of gender in the curricula of undergraduate medical students.

This paper is a case study describing the process of implementing the 'Gender in Medical Education (GME)' project in Maharashtra by the Centre for Enquiry into Health and Allied Themes (CEHAT), the Department of Medical Education and Research, Maharashtra (DMER) and the Maharashtra University of Health Sciences (MUHS). The paper aims to illustrate the complex steps involved in integrating gender concerns into an undergraduate medical curriculum.

The GME project consisted of five components, some implemented sequentially and others taking place simultaneously. Three of the components are relevant to this paper. The first component involved ascertaining interest and support for the project from the concerned authorities. The second component consisted of identifying from among medical educators in the state, a core group of champions for the integration of gender into the undergraduate medical curriculum and building their capacity for gender-analysis of health issues. A third component involved the core-group of-medical-educators working with experts to revise the UG medical curriculum and make it gender-sensitive.

Medical educators were found to be unaware of the differences between the terms gender and sex. They relegated the issue of gender to the discipline of community medicine and did not think that gender should be integrated into other subjects of the medical curriculum. Capacity-building of medical educators from seven medical colleges under the Department of Medical Education and Research (DMER) exposed educators to ways in which gender gaps led to health inequities. The team prioritised five disciplines for integrating gender concerns: gynaecology and obstetrics, community medicine, forensic science and toxicology, internal medicine and psychiatry. Our team reviewed the undergraduate medical curricula of each of these disciplines from a gender-lens and identified topics for gender-integration. The core-group of medical educators worked with experts to weave-in gender issues as an integral part of what was already being taught. Innovative teaching methods and the fact that the revised gender-integrated curriculum did not increase the number of mandated teaching hours made the revised curriculum acceptable to teachers and students.

Working with a team of dedicated and trained medical educators as champions is an effective strategy to integrate gender into the undergraduate medical curriculum, and to successfully implement the revised curriculum in medical colleges.

Keywords : gender bias, gender gaps, medical curriculum, training of medical educators, integration of gender content in medical education

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I

Introduction

Scholars have critiqued the field of medicine as being gender-blind (Verdonk P et al., 2009) and male-biased because the body of medical knowledge views the male body as the norm, with men's experiences forming the basis for describing signs and symptoms of illness. Gender-based inequalities between women and men have not usually been factored-in as critical social determinants of health and disease. One of the consequences of gender-blindness in medicine is the limited gender-sensitivity among medical practitioners, contributing to the compromised quality of care. The World Health Organization (WHO) acknowledges the imperative of integrating gender in medical education specifically in the pre-service-training curriculum (World Health Organization (WHO), 2007) to reduce gender inequities in health. Globally, there have been efforts to integrate gender in the pre-service training of health professionals for at least two decades, in High-Income countries such as the US, Canada, Australia and Germany, and in LMICs including the Philippines and Thailand, among others.

In the context of India, systematic critiques of medicine and public health curricula have highlighted many lapses related to the inclusion of social determinants of health in medical education (Qadeer and Nayar, 2011). Evidence from studies points to gender biases prevalent amongst medical professionals and medical students. For example, a study among medical interns in Maharashtra found that almost 25 per cent of nearly 2000 students considered abortion to be morally wrong (Sjöström et al., 2014). Two-thirds of 75 undergraduate medical students in Pondicherry believed that spousal consent was essential for the provision of abortion services to women (Hogmark et al., 2013). Further, although health providers are the first point of contact for victims of violence against women, and can help women through their sensitive response, providers appear to be reluctant to acknowledge intimate-partner-violence as a health issue (Garcia-Moreno et al., 2015).

Early efforts to integrate gender in medical education in India were made by the Achuta Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology in Trivandrum, Kerala. As a part of this initiative, systematic gender-reviews of medical textbooks for gynaecology and obstetrics, forensic science, psychiatry and community medicine were published in the *Economic and Political Weekly* (2005); and two-week-long workshops were conducted to build the capacity for gender-sensitive teaching in medicine among mid-level medical educators from several Indian states.

Several efforts have also been made in India to address in-service training of medical professionals to respond to the issue of violence against women (Government of India 2016). In Maharashtra, Dilaasa has been an evidence-based crisis centre located in a public hospital to respond to gender-based violence. In 2014, the National Urban Health Mission (NUHM) replicated this model in 11 additional hospitals of Mumbai. Other states have also adopted the model of Dilaasa.

The National Health Policy of 2017 has acknowledged the adverse effects of gender-based violence on women's health and urged states governments to take steps to provide dignified, free and comprehensive services to such survivors/ victims both in private and public-sector health institutions. Although the National Health Policy also makes a passing reference to the urgent need to review and revise the medical and nursing curricula, it does not explicitly mention the integration

of social determinants of health and especially gender and other axes of social vulnerabilities (Government of India, 2017).

Against this backdrop, our paper describes an intervention to integrate gender concerns in the undergraduate medical curriculum of one state of India, viz., Maharashtra. The intervention was carried out by Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai in collaboration with the Directorate of Medical Education and Research (DMER), Maharashtra, and the Maharashtra University of Health Sciences (MUHS).

II

Approach to integrating gender in medical education in Maharashtra

This section describes the implementation of different components of the collaborative project related to integrating gender into the curriculum.

Winning support for and conceptualising the project

Building on past efforts in India and abroad, CEHAT embarked on the 'Gender and Medical Education (GME)' project which aimed to integrate gender in the undergraduate medical curriculum.

The first component of our strategy was to win the support of the concerned authorities in the state of Maharashtra. We used the gender review of medical textbooks, published in 2005, to highlight to the Maharashtra University of Health Sciences (MUHS) and DMER, the gender gaps in the undergraduate medical curriculum. During discussions with DMER and MUHS, we discovered that the MUHS has the mandate to implement curricular changes to integrate gender concerns. The team, therefore, decided to implement GME as a joint project of CEHAT and DMER. We also agreed that medical educators from selected medical colleges in the state, trained by us on gender issues in health, will play a key role and be centrally involved in the rolling out of the project. This would ensure that there was ownership from medical educators for the revised curriculum and besides, we would be able to test the revised curriculum in the medical colleges, to ascertain the feasibility of implementing it.

To ensure that the integration of gender in the curriculum could be done without increasing the teaching load significantly, we had to decide on core disciplines and themes to include. A series of meetings and discussions led to identifying five disciplines taught in MBBS as the subjects in which we would integrate gender concerns. These were: gynaecology and obstetrics, forensic science and toxicology, community medicine, internal medicine, and psychiatry. We chose these disciplines because they are considered to be core disciplines of the undergraduate (UG) medical curriculum. These disciplines also offered significant scope for integrating gender perspectives in teaching UG students. Regarding themes through which we would introduce gender, we zeroed-in on public health concerns such as access to abortion, the challenges in ensuring access to safe abortion while also preventing sex selection, and impact of violence on women's health. These themes were found to be conspicuously absent in the existing undergraduate medical curriculum.

Seven rural medical colleges were identified to participate in the project, and medical educators from the five selected disciplines were to be trained in gender issues in health. We envisaged that champions for gender-integration would emerge from among this group.

Perspectives of medical educators on gender in medical education

Before identifying medical educators who would receive training on gender, we wanted to understand how medical educators perceived the role of gender and other social determinants in medical education as well as practice. A situational analysis exercise was conducted by CEHAT in 2014 with the seven participating colleges.

The situational analysis aimed to understand the gender perspectives of the medical educators and to elicit their opinions, suggestions, challenges, and apprehensions related to integrating gender in medical education and practice. As part of this study, we interviewed 60 medical educators, 24 other staff, and 12 medical students.

The findings of this study indicated that gender was understood by the medical educators in a variety of ways, from a demographic category to health issues of women, to violence against women or increased presence of women in the workforce. A few of the professors referred to gendered social systems and structures. Most of them were of the opinion that gender as a social determinant was irrelevant to the medical curriculum. They also opined that sexual harassment was an outcome of increased women's work participation. The study revealed stereotypes commonly held by educators about women patients. Some of these were that women gave vague histories while men provided clear histories; and that women reported more somatic complaints than men, which implied the presence of intentional hysterical syndrome among women.

The study further found that gender-biased-notions influenced how healthcare providers dealt with women seeking abortion care, or those seeking contraception. Doctors had no qualms stating that they did not offer medical termination of pregnancy to married women unless women had the consent of their spouse or family members. Healthcare providers firmly believed that decisions on abortion and contraception ought not to be the woman's alone. All requests for second-trimester abortions were suspected to be sex-selective and often refused or provided conditionally on women undergoing post abortion sterilisation. Several medical educators had encountered women subjected to violence and were able to list numerous adverse health consequences that women suffered as a consequence. And yet, all of them perceived violence as a legal issue and not a health issue. They could not see any role that medical professionals could play beyond providing medical treatment to a survivor of violence. (John, Bavadekar, Hasnain & Karandikar, 2015)

Building capacity among medical educators

A key component of incorporating gender concerns in medical curricula is the availability of medical educators in the form of trainers and for them to become "change agents" to make revisions in the curriculum and spearhead the implementation of the revised curriculum.

We chose to recruit middle-level faculty such as assistant professors and associate professors who had a fair amount of autonomy and many years of service ahead. They were from six rural government medical colleges and one private medical college and drawn from the five core disciplines in which we were to implement curricular changes.

We developed a two-week course for medical educators for Integrating Gender in Medical Education. The content of the course drew on the earlier courses for medical educators run by Achutha Menon Centre for Health Science Studies in Trivandrum in the early 2000s and on CEHAT's course on