

‘Integrating Gender into Medical Education’ Workshop

**22nd September 2011
WRIC Lecture Hall, Mumbai University, Kalina**

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Organised by UNFPA and CEHAT

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Agenda for Advocacy Workshop for integrating gender into Medical Education

To be held on 22nd September 2011 at WRIC

Time	Agenda	Resource Persons
1.15 p.m. to 1.45 p.m.	Lunch	
1.45 p.m. to 2.00 p.m.	Registration	
2.00 p.m. to 2.05 p.m.	Welcome note	UNFPA
2.05 p.m. to 2.30 p.m.	Gender training of in service health care providers	Ms. Renu Khanna
2.30 p.m. to 3.00 p.m.	Global experience of integrating gender into medical education	Dr. Sundari Ravindran
3.00 p.m. to 3.30 p.m.	Work done on integrating gender into medical education in India	Dr. Kamaxi Bhate
3.30 p.m. to 4.15 p.m.	Discussion and Feedback on need to integrate gender in medical education	Session Chaired by Pro VC Maharashtra University of Health Sciences.
4.15 p.m. to 4.30 p.m.	Presentation on Proposed Project	Dr Anita Jain
4.30 p.m. to 5.00 p.m.	Recommendations and Feedback	Ms. Padma Deosthali

Report

CEHAT and UNFPA are planning a program to integrate gender perspectives in medical education in Maharashtra. A gender sensitive approach influences the way health care providers deal with women's health problems be it reproductive, maternal, surgical, medical or psychological. Further, healthcare providers have an important role to play in curbing sex-determination, and are often the first point of contact for survivors of sexual assault and other forms of violence. A strong gender perspective is hence an important prerequisite to enable medical professionals to respond to these issues.

CEHAT with its rich experience in the field of women's health, and association with the Gender & Medical Education program run by AMCHSS, will be leading implementation of this project in Maharashtra. The UNFPA has been approached to fund this program as a collaborating partner. Senior officials from the State Health Department, Directorate of Medical Education & Research, Maharashtra University of Health Sciences, Women's Commission, and experts from the field of gender and health have been invited to participate in this consultation. The consultation will serve as the first step to seek feedback and cooperation of senior health and medical education officials for this project.

A. Introduction

Ms. Anuja Gulati from UNFPA welcomed all representatives. She gave a brief background into the purpose of this consultation. All representatives then introduced themselves.



B. Gender Training of Healthcare Providers - Ms. Renu Khanna

Ms. Renu made a presentation on the work done thus far in India on gender training of healthcare providers. She shared details of the women-centered health project initiated in BMC's public health department from 1992 to 2005 to institutionalize a gender-sensitive approach and improve quality of care.

Ms. Renu also shared experiences and training models from across India that focused on sensitizing medical officers and health professionals on the role that gender plays as a health determinant.



Discussion:

A question was asked about evaluation findings from prior programs that focused on gender and health. Ms. Renu shared that while these programs had been successful initiatives, the need of the hour is to ensure sustenance of these programs by integration into medical education. She also expressed that results from these initiatives had adequately demonstrated that simply including gender concepts as part of in-service training for post-graduate doctors was not adequate. Sensitization of medical personnel needs to be initiated earlier- during undergraduate medical education itself.



C. Global Experience: Integrating Gender into Medical Education-Dr. Sundari Ravindran

Dr. Sundari gave an overview of interventions from different parts of the world for gender mainstreaming in pre-service curricula of health professionals. She outlined the need for such initiatives, and the strategies being employed globally. These include integrating gender courses in undergraduate medical curriculum, public health programs and nursing education; having the topics as free standing courses [including web-based courses] as well as integrated across disciplines.

Dr. Sundari then proceeded to highlight processes for integrating gender into undergraduate medical curriculum at 3 sites: USA, Philippines, and Thailand. She shared details of competencies identified as part of the Women's Healthcare Competencies Project, medical subjects with scope for introduction of these concepts, time allotment for gender-based courses in existing medical curriculum, teaching strategies, and resources available.



Dr. Sundari also highlighted that major obstacles for such initiatives included institutional resistance, limited funding and limited research evidence on gender and health. She encouraged the group to overcome these barriers and sustain programs for gender integration in medical education.

Discussion:

- Members from the MUHS agreed on the imminent need for introduction of gender concepts in medical education. However, they opined that there is little scope for introduction of new subjects in MBBS curriculum due to time constraints. In response, it was suggested that medical educators think innovatively for strategies to incorporate gender concepts/ courses as part of existing subjects. There exists adequate evidence globally that such models are feasible as well as effective.



- It was shared that the MCI is on the verge of introducing changes in the medical curriculum. Hence it was the right time to advocate for gender training with the MCI.
- As textbooks form a key source of learning for medical students, bringing a change in medical textbooks to address issues of gender in health was discussed. It was also reinforced

that simply changing medical textbooks is not enough. Training of medical faculty in gender perspectives is essential for greater penetration of this learning.

- It was suggested that innovative teaching methods and resources be employed to ensure students are engaged in these subjects, which can otherwise become tedious.

Dr. Sundari shared some strategies that have been employed in the past such as fellowships offered to medical students/ resident doctors for conducting research on gender and health, departmental poster exhibitions etc. She shared that for curriculum development medical institutions in Phillipines had collaborated with the women's movement; in the US and Canada women's studies' experts jointly produced the materials for training.

Ms. Renu shared that in MS University, Baroda there is a women's studies department which works closely with undergraduate medical departments. She emphasized that it was necessary to formalize such structures.

D. Work done on Integrating Gender into Medical Education in India- Dr. Kamaxi Bhate

Dr. Kamaxi presented the work done on reviewing medical textbooks across disciplines for gender sensitive concepts used. She shared the findings of this study that demonstrated that current textbooks are largely gender-blind, and often even go to the extent of casting aspersions on women.



Discussion:

- Dr. Sundari provided information on the Gender & Medical Education program undertaken by the Achutha Menon Centre from 2002-2008. Medical educators were selected from institutions across India and internationally to receive 2 weeks' training in gender concepts. The aim was also to create a movement with advocates for gender integration from within medical educators themselves. Medical educators trained from this program have led efforts in their respective institutions for integrating gender concepts in their teaching. These form a strong basis to scale up this initiative, as is being proposed through the current program for gender mainstreaming in medical education in Maharashtra.
- It was noted that it is crucial to allot specific percentage of MBBS training period for inclusion of training on gender concepts. The approach of having only medical doctors as teachers needs revision as well. It is pertinent that medical schools appoint experts from the fields of women studies, philosophy, anthropology etc. to teach concepts related to gender, humanities, ethics and so forth. It was suggested that the academic council within the university devise an interdisciplinary approach for incorporating these courses.



E. UNFPA and CEHAT Project Outline -Dr. Anita Jain

Dr. Anita gave a presentation outlining details of the proposed project for integrating gender in medical education in Maharashtra, planned as a joint initiative of CEHAT and UNFPA. The project aims to train nominated medical faculty from 6 medical colleges of Maharashtra on gender-based concepts in health. Initially, role of healthcare providers vis-à-vis responding to sexual assault, domestic violence, and sex determination will be focused on. This is aligned with the current demographic scenario in Maharashtra and the policy milieu. The project will run over a time period of 3 years, and medical faculty from specific disciplines would be trained as well as supported for incorporating the modules in their teaching. Additionally a working group will be formed to periodically review the project and comply with the MUHS protocol for incorporation into medical curriculum. Evidence base for further progression of such programs would be generated through ongoing research.



Discussion:

Selection of medical colleges: Representatives from MUHS suggested that selection of colleges for this program be given due consideration. Apart from MUHS, there were medical colleges under the State and Central Government as well as deemed universities. It was suggested that these be included for consideration as well. A recommendation was that specific criteria be prepared for selection of colleges, and that colleges be visited to thoroughly understand functioning of selected departments and the feasibility for this program.

Representatives from the MUHS suggested that a proposal letter be sent to all 42 medical colleges in Maharashtra for expression of interest to have such a program. The proposal letter must include the rationale for this program, description of the program roll-out purpose of selection of key participants, and expected outcomes.

- **Duration of training workshop:** A 7-days' training workshop was suggested to be impractical as senior cadre of medical faculty will not be deputed for such a long duration. Instead it was suggested that 2 training workshops of 5 days' duration each be held. In the interim, medical faculty would also get the opportunity to revisit feasibility of introducing concepts learnt in their existing teaching methodology. The deans from the 6 selected

medical colleges could be invited for Day 1 of the training to sensitize them to the need for this program.



- **Selection of medical faculty:** The proposal mentioned the Dean of the hospital would be consulted to select senior medical faculty for this program. However, it was determined necessary to have a panel/ external body to decide on selection of medical faculty, along with the dean. Another recommendation was to interview faculty deputed for this program to ensure their genuine interest in learning these concepts and taking them further.

There was an agreement in the group on including medical faculty from 5 departments to start with, namely Psychiatry, PSM, Medicine, Gynecology and Forensic Medicine.

- **Role of trained medical faculty:** On completion of training, medical faculty must be provided the opportunity to use innovative teaching methods for incorporation of gender concepts such as organizing debates, exhibitions, conducting reviews, paper presentations, formation of gender education cell etc. Grants for such activities need to be built into the current proposal. However it was noted that such a project grant would not be sustainable. It was essential that medical colleges be engaged to contribute and make provisions for such activities.

It was proposed that the group of trained medical faculty shoulder the responsibility of reviewing current textbooks and propose necessary changes to the Board of Studies.

- To reduce expenses and make the program feasible, it was suggested that training workshops could be hosted by the selected medical institutions. This would also help with logistical arrangements for the workshop.



- **Changes in medical textbooks:** A question was asked about the process of removing certain textbooks from the MBBS recommended list as they were grossly gender insensitive. The process for this was clarified. It would be necessary to have alternative textbooks before proposing removal of any. These new textbooks would have to be submitted to the Board of Studies for their approval. As such, it would be appropriate to include a few members from the Board of Studies in the training workshop to sensitize them to these concepts. Dr. Dalvi agreed to share a list of Board of Studies members from the 5 chosen disciplines.
- **Role of MUHS:** The role of MUHS was identified to be in facilitating implementation of the training program, evaluation, and incorporation into medical curriculum. It was thereby suggested that a MUHS coordinator be made a part of the working group. Dr. Kulkarni stated that he will be able to provide potential names for the same.

- It was suggested that constant advocacy would be required with the State and MCI for incorporation into medical curriculum. Ms. Anna Dani volunteered to lead efforts in this direction. It was suggested that a meeting be organized with the new governor of MCI.
- Dr. Sundari recommended simultaneous development of a resource center, even virtual, with materials to aid faculty in incorporating gender concepts in their teaching.
- It was also noted that meticulous process documentation of this program would be essential to facilitate evidence-based advocacy efforts in the future. Allocation of full time personnel for the same needs to be looked into.
- A suggestion was to involve Sevagram, Wardha as they have been doing breakthrough work in this field.
- The possibility of inclusion of nursing schools in the sample was discussed. The work done for inclusion of gender in the nursing education was presented and that the nursing council has accepted the proposal. However, it was suggested that incorporation into nursing curriculum could be approached as a separate initiative.

F. Next Steps

- A joint letter will be sent on behalf of MUHS, CEHAT, and UNFPA to the Secretary-Medical Education and DMER. The Pro-VC of MUHS, Dr. Kulkarni agreed to attest this letter as it would be most effective in implementing the program with cooperation of these respective authorities.
- The program proposal will be expanded with suggestions from this consultation, details of the selection and training process for medical faculty, and expected expenditure. This will be submitted to the UNFPA. Following this, engagement with senior health/ medical education officials and medical colleges in Maharashtra would be pursued.

Background Note

Gender Awareness in Medical Training

A review of the most popular textbooks in use in India's medical schools reveals extensive variation as regards gender competence and awareness. This awareness is important, both at the level of rudimentary diagnosis and to provide a comprehensive continuum of healthcare. Significant shortcomings are present across the disciplines at both undergraduate and postgraduate levels. These problems fall in three imbricate areas. First, many textbooks are missing information critical to women's health, or include it incompletely. Second, there is a frequent failure to address psychological, cultural, and social factors which are relevant to women's health outcomes. Finally, while the above are certainly the implicit result of gender discrimination, there are multiple explicit instances of such, often in the form of unfounded or demonstrably counterfactual assertions about women's "nature", biology, or health. It should be noted that the problems below provide a general picture of the current state of medical textbooks. The critiques do not apply equally to all textbooks discussed, and some treat gender more deftly than others.

I. Medical Lacunae

a. Obstetrics and gynaecology:

- i. Reproductive medicine texts contain statements such as: "the hymen is usually ruptured at the consummation of marriage".¹ This is both medically inaccurate (the hymen may be and often is ruptured by a number of things, including athletic pursuits) and makes a value judgement that is more cultural than medical. Sexuality in general is addressed poorly and sometimes inaccurately: "[M]asturbation in [a] young virgin after puberty produces leucorrhoea".² Leucorrhoea is a non-pathological symptom often related to estrogen

¹ Khanna, Renu. "Obstetrics and Gynaecology: a women's health approach to textbooks". *Economic and Political Weekly*. April 30, 2005. 1878.

² Khanna 1879.

imbalance or inflammation, and unrelated to masturbation or virginity. Neutral discussion of sexuality and sexual health are absent.³

- ii. Texts generally fail to address domestic violence, which is particularly problematic in light of the growing body of research indicating that the violence often begins or escalates during pregnancy.⁴
- iii. Contraceptive information is outdated, including recommendations for obsolete methods (post-coital douching) and a failure to discuss methods that have been available for the last 15 years (injectable contraceptives).⁵ Recommendations against prescribing contraceptives to adolescents and requiring breast and pelvic examinations are have no medical basis and are likely to reduce access to healthcare.⁶ Guidelines around abortion and sterilization are often incorrect. Sterilization is recommended for women with treatable mental illnesses. A number of outdated abortion methods are recommended, and the acceptable time frame for the administration of others is misstated. This has the effect of reducing women's reproductive autonomy.⁷ Training regarding detection and prevention of septic abortions is provided for tertiary, but not primary or secondary levels of care.⁸
- iv. Practices with no medical purpose, such as ante-natal enemas and pubic shaving, are encouraged and serve to needlessly medicalize aspects of childbirth.⁹
- v. Delays in hospital which contribute to maternal mortality are not discussed.¹⁰ Information on case fatality rates and time between complication and death is sometimes left out of presentation of post-partum haemorrhage.¹¹

³ Id.

⁴ Id.

⁵ Iyengar, Keerti. "How Gender-Sensitive Are Obstetrics and Gynaecology Textbooks?". *Economic and Political Weekly*. April 30, 2005. 1840.

⁶ Id.

⁷ Iyengar 1840-1.

⁸ Iyengar 1844.

⁹ Iyengar 1842.

¹⁰ Id.

¹¹ Iyengar 1842-3.

b. **Psychiatry:**

- i. The reviewed undergraduate text (Master, 1985) omits gender almost entirely, and uses obsolete diagnostic criteria oriented toward personality attributions rather than behaviour markers. Another dedicates only 10 pages to women's mental health. Evidence based data on postpartum disorders is supplanted by misinformation and mystification of the role of hormones.¹²
- ii. There is a general failure to examine sex disaggregated prevalence and medication data, such as the "female excess for depression [or] the male excess for Alcohol Use Disorder".¹³
- iii. Instruction on the association of domestic violence and mental health disorders is absent.¹⁴

c. **Other medical disciplines:**

- i. **Surgery:** Some texts contain inadequate coverage of preventative mammography, gynaecological surgery, and conditions particular to women which may mimic appendicitis. Stress urinary incontinence and diseases related to repetitive injuries from occupations primarily occupied by women are not addressed. Guidelines for managing surgical interventions without affecting pregnancy are missing.¹⁵
- ii. **Preventive and social medicine:** Presentation of case control studies includes discussion of selection and interviewer bias, but omits gender bias.¹⁶ Gender disaggregated data disease rates are rarely presented. Where they are presented, there is no analysis of the reasons for differentiation, complicating prevention.¹⁷ Discussion of occupational health

¹² Davar, Bhargavi. "Teaching Psychiatry with a Gender Perspective". *Economic and Political Weekly*. April 30, 2005. 1883.

¹³ Patel, Vikram. "Gender and Mental Health: A review of two textbooks of psychiatry". *Economic and Political Weekly*. April 30, 2005. 1850.

¹⁴ Patel 1855.

¹⁵ Nagral, Sanjay. "Teaching Surgery Through a Gender Lens". *Economic and Political Weekly*. April 30, 2005. 1835-38.

¹⁶ Prakash, Padma. "Where Is the Woman in Preventive and Social Medicine: Sociological Perspectives". *Economic and Political Weekly*. April 30, 2005. 1832.

¹⁷ Prakash 1833.

hazards omits ubiquitous and woman specific hazards such as sexual abuse and harassment.¹⁸ Discussion of mental health is similarly deficient.¹⁹

II. Psychosocial and Cultural Lacunae

- a. **Obstetrics and gynaecology:** Textbooks tend to ignore the relevance of sociocultural factors as related to health during pregnancy.
 - i. Instruction on episiotomies is given, but information on possible impact on sex life and marriage is not.²⁰
 - ii. The avoidability of certain factors implicated in maternal mortality is discussed, but the role of societal position and culture in inhibiting health care access is not. The important role and responsibilities of male partners during the pregnancy period is rarely addressed.²¹
 - iii. Questions regarding social relations in the family, support or lack of it, history of violence, and anxieties or worries are omitted from history-taking instructions for ante-natal care.²²
 - iv. Cultural and social dynamics are not addressed in screening for and treatment of STDs. This is important as women may be in a position where they are unable to refuse sex or insist on use of prophylactics.²³
 - v. Texts fail to emphasize the importance of explaining the nature and purpose of examinations to the patient. This lapse is problematic, particularly given the invasive nature of many obstetric and gynaecological procedures.²⁴
 - vi. The psychological impact of peri-natal mortality is not discussed.²⁵

¹⁸ Gaitonde, Rakhal. "Community Medicine: Incorporating Gender Sensitivity". *Economic and Political Weekly*. April 30, 2005. 1889.

¹⁹ Gaitonde 1891.

²⁰ Sudhakaran 1868.

²¹ Id.

²² Khanna 1880.

²³ Iyengar, Keerti. "How Gender-Sensitive Are Obstetrics and Gynaecology Textbooks?". *Economic and Political Weekly*. April 30, 2005. 1844.

²⁴ Iyengar, Keerti 1839.

b. **Psychiatry:**

- i. In general, the large body of evidence demonstrating the relationships between women's general health, social life, cultural contexts and exposure to violence and abuse is not considered, and textbooks take a heavily biomedical approach, even where identifying bio-psychosocial concerns.²⁶
- ii. Studies have made it clear that the consequences of mental illness are gender differentiated. "Whereas a mentally ill man may get married, mentally ill women are often left alone. [...] A study of mentally disabled women who had been separated from their husbands in India revealed that the vast majority had been abandoned [...] the husbands of many women who had not been legally divorced had remarried". Similarly, it has been shown that "[w]omen were required to be the primary carers if their husbands were mentally ill [and] irrespective of the sex of the person with dementia, the primary care-giver is most often a female relative." The substantial mental health burden of care-giving, then, falls predominantly on women. This is not discussed in the text.²⁷

c. **Other medical disciplines:**

- i. **Surgery:** Texts generally do a poor job of discussing psychosocial issues surrounding procedures such as radical mastectomies and hysterectomies, and attendant long term quality of life issues.²⁸ While instruction is given on surgical assessment and management of victims of warfare and other traumas is given, similar instruction regarding victims of rape and domestic violence is omitted.²⁹
- ii. **Preventive and social medicine:** Some texts exclude the notion of gender entirely. Family structures are treated neutrally, without analysis of the impact on health outcomes of women's roles in the social space. Child-rearing is often discussed as a family activity,

²⁵ Sudhakaran 1868.

²⁶ Patel 1850-1.

²⁷ Id.

²⁸ Nagral 1837.

²⁹ Nagral 1838.

without recognition that the larger part of the burden falls to women. Women, when discussed, are discussed in terms which over-emphasize a maternal role. Heads of family are presumed to be male.³⁰ One text states, “because of the universality of marriage in India there are no problems such as unmarried mothers and illegitimate births”. This is demonstrably not the case and serves to obscure a number of problems.³¹ The role of power imbalances in reproductive and sexual health is not examined.³² Gender differentiated access to sanitation, nutrition, and education is either noted but not analyzed or omitted entirely.³³³⁴

III. Gender Discrimination

a. **Obstetrics and gynaecology:**

- i. One text book states: “many believe that almost all cases of hyperemesis [i.e., “morning sickness”] have a neurotic basis”, which is both unfounded and a perpetuation of discredited and pejorative notions of women’s psychology.³⁵
- ii. Physicians are advised to “withhold internal examination to five to seven days after the bleeding in highly strung women”.³⁶ “Highly strung” is no longer a medical diagnosis, and the concept owes more to gender stereotypes than modern medicine.
- iii. Sex selective abortion is discussed minimally, if at all.³⁷ This is problematic in country where the gender imbalance now exceeds that of China.

b. **Psychiatry:**

- i. Texts include pejorative and unsubstantiated claims, such as: “Women tend to be less delighted about life than men” and “Women are more ready to adopt a sick role”.³⁸

³⁰ Prakash 1830-1.

³¹ Prakash 1831.

³² Gaitonde 1890.

³³ Prakash 1831.

³⁴ Gaitonde 1890.

³⁵ Sudhakaran 1868.

³⁶ Khanna 1878.

³⁷ Ivengar 1845.

- ii. Despite being thoroughly discredited, the notion of hysteria as a psychiatric condition is legitimized in statements like the following: “[T]here appears to be a pattern of assortative mating between hysterical women and sociopathic men.”³⁹
- iii. Information on post-partum disorders is inaccurate, and inappropriately generalized, and often reinforces stereotypes regarding gender roles: “[A]mbivalence is a universal response of all women to conception which may be verbalised and expressed in somatic complaints like sleep problems, nausea, vomiting, or may present with mood changes”.⁴⁰ Physicians are advised to mitigate maternal anxiety about reproduction by reassuring women that “women with a child enjoys better status in Indian society than women without a child”.⁴¹

c. Other medical disciplines:

- i. **Surgery:** One text contains the statement: “Spinsters, childless married women and those who have not suckled their children are the usual sufferers. In one sentence [sic?] it occurs in women who have denied the usual function of breasts”.⁴² The scientific veracity of this claim is under debate. It implies that women are at fault for increasing their risk of breast cancer by “denying” what the text books authors deem to be the normative function of breasts. It also reduces a part of the body to its reproductive function, rather than considering its relation to the whole person. This serves no medical function.
- ii. **Preventive and social medicine:** Use of gender neutral language is conspicuously absent, and the role of women in healthcare is either diminished or ignored.⁴³

³⁸ Davar 1883.

³⁹ Patel 1858.

⁴⁰ Id.

⁴¹ Id.

⁴² Nagral 1835.

⁴³ Gaitonde 1888.

List of Participants

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