One Day State-Level Conference On

GENDER IN MEDICAL EDUCATION

December 20, 2015

Aurangabad

Organized By

Centre For Enquiry Into Health And Allied Themes (Cehat)

CONFERENCE ON GENDER IN MEDICAL EDUCATION, AURANGABAD, DECEMBER 20, 2015

Centre for Enquiry into Health and Allied Themes (CEHAT) organized a one day state-level Conference on 'Integrating Gender in Medicine' for medical educators in the Government Colleges of Maharashtra. The Conference was held in **Aurangabad** on **December 20, 2015**. It was an MMC accredited Conference that provided CME (continuing medical education) credit hours to all the participants and speakers.

Welcome Address

Speaker 1: *Dr. Bhopale*
Observer. Maharashtra Medical Council (MMC)
Speaker 2*: Dr. KananYelekar,*
Professor and HOD, Department of OBG, GMC-Aurangabad
Speaker 3*: Dr. Bina Kuril,*
Associate professor, Preventive and Social Medicine, GME trained educator and Convener for this Conference.

The Conference was opened by Dr. Bhopale who is Former Dean of Government Medical, Aurangabad and was representing Maharashtra Medical Council (MMC) as an Observer for this Conference. Dr. Bhopale gave a brief opening remark and welcomed all the participants and Speakers at the Conference. Thereafter, Dr. Kanan Yelekar (HOD, Professor of the ObG Department, GMC Aurangabad) gave the opening address and briefly discussed the importance of including Gender in the medical curriculum. According to Dr. Yelekar, given the inferior status of women in our society, it becomes essential that we start eradicating this outlook at the grass-root level and there can be no profession better than that of the Medical practitioners to do it as they are directly faced with many patients/clients on a day to day basis. She quoted one of her discussions with a colleague, who pointed out that women coming with menorrhagia and let's say a bandage on their hand or wrist can be screened for a possible case of domestic violence or sexual assault by her partner. She further added that as responsible doctors and physicians, we should always remain alert as something else too could be at play and therefore it becomes necessary that we go beyond the treatment and ask the patient the relevant questions about the injury and the condition in detail. Dr. Kanan said that enough has been said about sexual violence and statistics have also proved it, that the act of sexual violence, in 40 per cent of the cases is done by a person known to the victim.
Towards the end of her talk, Dr. Yelekar congratulated Cehat for the effort they had been putting for sensitizing the medical professionals about gender.

Dr. Bina Kuril, after taking over the podium, briefly described her experience of attending the GME TOTs in 2014, where she explained how her perspective about inclusion of gender

in medical education improved from the first TOT to the second TOT. She concluded with thanking Cehat for convening this event.

Session 1: Gender as a Determinant of Health

***Speakers**: Renu Khanna, Dr. Padmaja Samant-Mavani*

***Discussant:** Dr. Vijay Kalyankar*

The session was commenced by Renu Khanna who introduced the audience with the conceptual understanding of gender, difference between sex and gender, gender as a system, the institutional & systemic nature of gender and Gender as a Social Determinant of health.

Gender, as Renu Khanna describes it, refers to how society ascribes meaning to the manhood and womanhood in that society, in many different ways, and it is this society that prescribes differential values to both males and females. She quotes Dr. Yelekar and says that women are given lesser value, and men and women in many parts of the world are not given equal advantage. It is important for us know that Gender goes beyond man and woman, male and female to include other sexualities. In the latest census, finally trans-genders have been included as the third category. So there are other genders which have been invisible and the idea is that we also recognize that gender is not just male and female, but as a diverse set of genders. Since it is a very fluid concept, it can take varied forms, you can be a female but you may feel like a male and vice versa and Gender as a term accommodates these diverse sexualities.

How Gender is different from sex is explained through the difference between biological characteristics and its social interpretation. Sex refers to biological or physiological characteristics of males and females. The genitalia, the reproductive organs, the chromosomal components all contribute to the sex whereas gender refers to how society constructs roles and responsibilities, privileges, rights, opportunities, possibilities and limitationswhich are assigned to men and women. To put it differently, it means what is considered masculine and feminine in a given time and place. So, masculinity and femininity are concepts that emerge from gender. To get to the root of the same, we do what is known as **Gender analysis**.

As part of gender analysis, she explains the various underpinnings that determine how gender as a system operates. She starts with explaining the **'belief system'**, that the society holds certain beliefs about men and women which are based on their biology. It is the physical differences that are used as a basis by society to construct masculinity and femininity. Given the physical structure of men, it is 'believed' that men are stronger than women and women are weak because of their small stature. Since women have reproductive organs such as uterus and breasts, they are understood to be 'nurturing'.

Other such beliefs include 'men are rational, women are emotional', anger is easily associated with men and lesser with women. Emotions that women are allowed to express are feelings of sadness, helplessness, feeling of guilt of not being able to be a good 'mother' which is again associated with the reproductive organ. These beliefs led to defining of what we call **Gender norms or behavior.** These beliefs then lead to the defining of the rules of how men and women can behave in the society. For instance, men can express themselves and can articulate and women must not express themselves and must not articulate, women are taught to contain into themselves whereas men are taught to be out there. These are some of the norms that subconsciously all of us have grown up with and have internalized in ourselves. The beliefs and the gender norms then lead to defining of another important component of gender as a system which is known as **Gender Roles for men and women.** The rationale behind assigning gender roles comes from the thinking that because men are strong, they can protect themselves and also protect women, they must be the bread winners, while women must be the 'carers' and 'nurturers' in their homes. Therefore, masculine and feminine roles are carved out by the society based on these beliefs and gender norms.

Khanna then goes on to explaining another important block of this system called as **sexual division of labour.** She begins by explaining in simple terms 'division of labour'. Economists, she adds, use the term 'productive' for men and by productive they mean the roles which would earn men income and wages, and 'reproductive' for women which are caring, nurturing, as mentioned earlier. She emphasizes that women are not just expected to fulfill their roles of physical reproduction but are also expected to take care of the *social reproduction* of the society. By Social reproduction we mean transmission of social and cultural values from one generation to the next and largely, women are entrusted with this responsibility. For instance, if the child behaves in an anti-social manner, the 'mother' is condemned of not performing her duties well. Community leadership which is formal is associated with men, whereas informal leadership to women who do not get any public stature and are not a public figure. Sexual division of labour then leads to different activities and tasks for men and women and this is where women's tasks are undervalued and rendered 'invisible'. Tasks such as cooking, cleaning, looking after the children etc. are all considered informal tasks. Segregation of space also becomes visible with this division of work, where men are given the right to be 'out there' and be a bread winner, whereas, women are confined to their homes. The indoor activities of women then become the informal work, and men do the outside work that gets them formal wages. This is how women's work becomes of a lesser value or is devalued. She illustrates this with the help of an example that some thirty years ago in Russia, there was a time when more and more women were pursuing surgery as a discipline, and as a result of which the discipline's status in the hierarchy had become low. Hence, there was an understanding that whatever women do is undervalued or women do what is undervalued. When asked some of the

home-makers about their occupation, they mostly reply ''I do nothing, I stay at home''. Therefore the understanding of staying at home is taken to be in consonance with doing nothing. By doing the invisible/reproductive and social reproductive work, women are actually preparing for others to go out and do the ''productive'' work, in short, they are creating grounds for the ''productive work'' to take place smoothly. In the similar context, she presents another example of male cooks. She says that male cooks and chefs, because they work in the hotels and restaurants, get a high status in society while on the other hand, women have been cooking at home for their families since centuries, never get the cognizance of the same.

With this, she comes to explaining the **differential access to and control over resources between men and women.** This is a fundamental link with the functions of the society and it has to do with every inequity that operates in the society. With resources, we do not only mean monetary resources but also technology, leisure, self-esteem, time and space. While doing Gender analysis, it becomes important for us to determine which resource and not just limit ourselves to cash, land or ownership. She opens the following question to the audience,

"What do we mean by access to resources and control over resources?"

Response:

Dr. Prasad Deshpande: *Access would mean that my wife has access to the money earned by me, control is that she has equal decision making as to how to utilize the money for the welfare of the family.*

She then resumes the presentation and builds further on the reply by adding that it is not just spending on the family's welfare but also about one's own personal expenditures, for instance, many of us today in the audience are working women, if the need arises that we want to spend on our mothers or fathers or any other family member, we would always feel that we first need to consult our husbands, these behaviors again, are deeply internalized by us. Hence, a lot of women do not have any control over their own earnings also. The rural women such as ASHAs and other such workers, who earn little wages, put aside some part of their money without telling other members of the family, so that they have some control over that.

This differential access to and control over resources finally leads to **differential decision making and Power.** This power influences people, relations, society and those who have power actually influence behaviors, social norms and sexual division of labour, access to and control over resources. It is a system that feeds on its sub-systems and it perpetuates itself but the beauty of it is that it can be broken anywhere. Which is what is happening now, we think our daughters are as capable as our sons. Many of us today are providing equal opportunities to our daughters as we do to our sons. Many people also take decisions

to have one child, and if that child is a daughter we are equally happy. Gender constructs, therefore can be changed over time, over space and over context. We as a generation in 2015, have gone to higher education, we as people have changed. She posits an example from her family where she says that 'I, am more highly educated than my elder siblings', and that according to her happened because she is the youngest and times had changed. She further quotes her fourteen years older sister saying that "the opportunities that you are getting were not even thought of in my time, I never got to work or to get out". So, context change the way gender norms and gender systems change.

How Gender works as a system is how each of the above mentioned themes can be broken, and each of these is a part of gender analysis that has been spoken about earlier. Time may be the same, but if the communities are different, like in Adivasi community gender norms may be different from how they are in Rajput communities, how they are in Brahman communities.

She further goes on to explaining few other related concepts. She explains, **Gender Relations** or Gender Power Relations is the relations between the different gender roles, it is not only between men and women, professor and student, husband and wife and brother and sister, but it can also be between *Devrani* and *Jethani,* hence, it is the power position. Therefore, when we say we are doing Gender Analysis, we are examining not just the condition but also the position. So there are these two things that have to happen in tandem. **Heteronormativity** is another concept, which leads to invisibilizing diverse sexualities and sexual identities. Gender operates at different levels at all the institutions and that is why, she quotes Dr. Yelekar on her discussion with a colleague that Gender is not about an individual man or individual woman or an individual transgender, it is systemic and very institutional. It begins in the family as an institution, and gets reflected in the legal system, for instance, how judges and lawyers look at rape, marital rape, sexual harassment, property rightsetc. Also, the education system, how are education and streams gendered such as science and mathematics. She quotes one of her experiences with the faculty from Maharaja Sayajirao university, where she says, people from twelve different faculties sat together to examine how mindset of teachers and families can be changed towards boys taking science and girls taking Arts stream, since any boy who wants to take Arts is victimized, boys wanting to pursue performing arts such as Dance is even worst. This is the way how gender operates and is institutionalized. And that is why, it becomes so important that we examine how different health system under the health institution is gendered. She quotes Sonali Deshpande, wherein she had explained the difference between **gender blind** and **gender aware**, and says that we are gender-blind, and adds that this kind of a sensitization gives us a gender lens of awareness so that we start recognizing where discrimination is taking place.

Intersectionalities is another important point, she says, and it is important to note that when we talk about Gender, we are not just talking about the male and female binary. Gender is only one aspect of the other axes of discrimination in society and that can be

rural urban, differences according to wealth quintile, according to social group, village group, ability or disability, sexuality etc.

She then precedes with her final discussion on **Gender as a Social determinant of Health** to which she adds that, Health is a socially constructed reality and many of us function (many of us have been trained) in the bio-medical understanding of health. However, in addition to the bio-medical understanding of health which is so extremely important, we also need to understand that it is a socially constructed reality and is a product of physical and social environments in which we live. Differences in people's health status arise not only because of bio-medical reasons but also because of differences in social and economic status, as we all are aware. It usually does not requires to be put up here, however, there will be times when it will be essential to reiterate this because then we analyze all this very systematically and have a better conceptual clarity.

She proceeds to say that women and men differ in physical spaces they occupy, as was pointed out initially, men go out to the market and women stay indoors. Many times, while cooking on bio-mass fuel, they tend to be susceptible to some of the respiratory infections to a greater degree than men for instance. Men who are out on the fields, where mosquitoes are breeding or where leptospirosis can be contracted or on the fields where snakes breed, then they are greater victims of snake bites as agriculture workers than women are for instance. Hence, this is about spaces. In almost all cultures in the world across social groups, women have less access to and control over resources than men, and are denied equal access to facilities like education and training. We have also seen that women's likelihood of contraceptive use changes with higher education, just as access to healthcare increases with higher education, hence it is recognized as a determinant of health. Gender based differences in roles and responsibilities, access to and control of resources and power & decision making has implications on women's health status.

Now the important thing about Gender Analysis in health is how it is different from, let's say, Gender analysis in education, is that Gender analysis in health combines both the biological and the gender. The social construction and the biology and physical construction interact and later, she adds, that she would tell us about different models that preview differential risks and vulnerabilities. Different perceptions of health needs and appropriate forms of treatment, differential access to health services, consequences or outcomes and social consequences, for instance: Tuberculosis in women has far more worse social consequences than it would have for men, similarly, infertility in women has far worse social consequences. So, gender as a social determinant of health, rarely operates in isolation and this is mediated by other factors. Long distance from a health centre, maybe a political factor for instance, an MLA or a Counselor of a certain ward did not get a Health centre put up in that area because it would not get him a vote bank, hence it may be politically driven but it may be affecting men and women differently because of gender. On a similar note, poverty may affect all children in a household but the ways in which girls and boys of that same household are affected maybe different. In gender Analysis, we also

see how gender acts, not only on women but also on men and women differently, or how does it manifest on both differently. Hence, Gender is not only to do with women but equally with men, and the whole concept of **Patriarchy** victimizes both men and women. However, it does give men more privileges as it means '**Rule of a Man',** hence the man does have a higher position in society, but the man also gets victimized because a man is not allowed to be a human being, as example she emphasizes her earlier discussion, where she said how men are not allowed to pursue performing arts in our society and similar other examples. This is so because men are seen to be only as earners for the family and any man wanting to pursue arts id frowned upon. Addressing causes and consequences of social and gender related inequities in health requires addressing multiple factors in a multi pronged strategy. While we need to work at the institutional level, at the social level, at the community level, on grass-root level, we also need to work at the individual level especially within our families and on ourselves to recognize the gender disparities.

The discussion was then taken over by Dr. Padmaja Samant-Mavani. At the very outset, she starts with answering first that why it that doctors have been chosen as target audience today, ''Why us as doctors?", she proceeds by saying that health as a fundamental right has been given by the constitution for everyone to avail equally. Hence, it is the responsibility and mandate of the doctors to ensure that the right is preserved. However, these rights get violated at all levels by the society which also includes the judicial system. She gives an example of the POCSO act, wherein they say about the protection that it offers to young girls below 18 years, she cites that a consensual sexual intercourse between a boy of 17.5 years and a girl of 17.5 years is considered illegal and the boy will be termed as a 'rapist'. In addition, we are required to do mandatory reporting of any such case she therefore adds that rather making a legal case around it one must sensitize the population regarding the implications of safe sex.

As health care providers, she stresses that doctors take the complete onus to decide which contraception would suit which women's needs as they consider the women as less educated, less responsible and less careful.

She then discusses **Gender budgeting** that most of the time goes unused and as doctors, as healthcare providers or as policy thinkers, our aim should be that the budgets gets used.

The next topic that was discussed was the various conditions and how Gender creates the difference into experiencing the same. She shows an image of a 'Man', who is masculine, a protector with a well-built physique while on the other hand, the woman was shown to be frustrated with her tasks as a mother and a home-maker. To talk about **masculinities**, which is identified mostly with men, is defined as patterns of practice taken up by both men and women though pre dominantly by men. For instance, if we see a dominating or an assertive woman, then according to our socialization and conditioning we believe that she is displaying 'masculine' characteristics. **Power,** she describes as ability or freedom to take decisions as they choose and a person's access to resources and ability to control them. She

goes on to divide Power into **Power to** and **Power over,** that according to her is 'ability of individuals to control their own lives and use the resources for their own benefits' and 'individuals asserting about their own wishes even in the face of opposition and also force others to act in a way that the others may not have wanted to act', respectively. In a patriarchal system, mostly it is the '**Power over'** that operates. These differences in power, however, are not absolute or universal and depend upon the position of the person, culture and the context. Classic example of the same is mother-in-law and daughter-in-law relationship, where both are women from the same family but more power is in the older woman's hands. Factors such as income and education change tend to alter power equations and it also affects men in certain contexts such as if they are poor, sick (stigmatized illness), illiterate and homosexual men may have little power and few resources.

Traditional Gender roles have always acted as obstructions in discussing sexual matters between the couples. Most men and women, in this context face inhibitions in discussing these matters with their partners owing to their socialization. It only happens in case the need arises, such as when the couple wants to conceive. As doctors, she says, that we are not taught to ask questions about the sexual health of the family, also of young couples or of single women, because of the belief that is internalized into us that 'Good single women do not have sex before marriage'. These are some of the reasons that risky sexual behavior is promoted especially in young men and boys, as they are unaware and without guidance from the elders in the family, they explore their sexuality that often gets them trapped in substance abuse, STIs and ultimately becomes a reason of their poor reproductive health.

Men's health:

A 2012 survey, she points out that 7.6 per cent deaths in males was due to substance abuse as against 4 per cent female deaths due to the same which is not surprising because women are not associated with alcohol consumption. More men than women die of tuberculosis, road traffic accidents and violence. However, this violence is outside of home and not much to our surprise, more women experience increased morbidity or suffer life-long deformities and even mortality when they are inside of their homes (domestic violence), where they are 'supposed' to stay safe. Alongside, many children also suffer violence inside the boundaries of their homes, physical, verbal, incest abuse and so on. She furthers by saying that social norms and expectations increase men's health risks and reduce their health seeking behavior. Some of the things that are considered 'unmanly' are often depicted in our movies, novels etc. that higher appreciation given to risk taking behavior of men reduces their willingness to seek health services. This also promotes behaviors such as violence against women and risky sexual practices among men. With this, men often contract diseases that can also be fatal in some instances, they tend to lose their power

position (gender role), similarly when they are poor and cannot afford health services, they tend to lose their position.

Gender and Mental health:

Here, we are looking at mental health of men, women, homosexual community and trans-gender community also. According to a co-morbidity survey that was done in United States across the years 1994 to 1998, found that women have a higher prevalence of affective disorders and non-affective psychosis, whereas men have higher rate of substance abuse disorders as well as anti-social personality disorder. Therefore, types of mental health problem have varied according to different genders. Now, we need to look at the outcome of facing violence by the weaker gender**. Depression** is one of the causes as a robust finding in psychiatric epidemiology had suggested that larger number of women are seen to be affected with depression. Also, a comprehensive review of almost all general population studies across clinical samples and communities of the globe revealed that women pre-dominated men over lifetime prevalence of major depression and it counts most significantly to global burden of disease. Depression is one of the most frequently encountered women's mental health problems and in times to come it will be the second most common cause of global disease burden and approximately twice as often in women as in men. **Gender based expectations** are a common phenomenon that are seen as proneness to depression in women and proneness to alcohol abuse in men. Reluctance in men to disclose symptoms of depression is also commonly visible owing to the gender based expectations, however, this is risky, for the individual and the people around them. With symptoms of depression—which is a indication of vulnerability—men resort to alcohol and smoking and get addicted to it and later in the period approach the health providers with the problem of addiction instead of problem of depression.

Mental Health and Violence

She begins on this by saying that there is a pressing need to identify women who have in the past or are currently facing violent victimization, their history of violence is important and therefore their history-taking becomes an integral part for the doctors belonging to all streams of medicine. According to ACOG (American Congress for Obstetrics and Gynecologists), their pregnancies must be watched closely given the sensitive nature and appropriate intervention be put in place.

Reproductive and Sexual Health

She then describes why is it that mostly women are seen to be affected with UTIs and RTIs, some of the reasons biological reasons are shorter urethra, however, some of the major obstacles that they face are lack of facilities which increases their risk of exposure to such diseases. Problems that can be solved at the social level should be considered by us. Reproductive Rights Charter is an important information source for women regarding the issue of Contraception, right

to choice, right to choice to have babies (how many, when) and so on. Information about MTP is essential because many a times post an MTP, doctors or Medical practitioners insist on tubal ligation to be done, which is solely upon the woman to decide. She states some of the rights from the charter as listed below:

- Right to share responsibilities with the partner
- Right to comfort in the health facilities
- Right to discuss sexual health issues openly with the providers
- Sexual pleasure without fear of infection and unwanted pregnancy
- Sexual expression and to make sexual decisions that are consistent with one's personal, social and ethical values.

However, in most contexts these rights are not spelt out.

She then comes to discuss that mostly the third gender and the homosexual people have difficulties in exercising these rights. According to her, we as doctors falter mostly in taking history. When patient comes with a complaint of STIs, we are conditioned to only examine the vagina because peno-vaginal sex is only the form of sex that we are aware of. We do not look at anal folds, oral cavities and so on.

Female Genital Mutilation

Under this topic she discusses that how the practice is prevalent in our society, and a large group of patients seeking this in our institutions. It tremendously puts the young girls' reproductive health at risk by increasing their morbidity to a large extent. Also, she says that these patients are largely invisible with no account of where they get these services from.

Hysterectomy

Very often, we suggest women to undergo hysterectomies for abnormal uterine bleeding when there are other options available such as thermal balloon, and we often end up advising the women that there is no point having the trouble with you, when it can be easily removed. The similar understanding is also seen within the families that it is a better option. As doctors, we do not consider the change in body image, sexual issues that the woman might go through later in her life.

Infertility

Trauma of infertility and the stigma that it causes is magnified for the woman than for the man. It has resulted, in many cases, in self destructive behaviors such as suicide attempts and divorces etc. Surrogacy also becomes important in this context, surrogacy is referred to as commodification of a female body where a women conceives the child of another couple or the clients. The laws around surrogacy are not transparent or lucid, most doctors are of the view that this exploits the rights of the patients and so on.

In case of Fertility control or Contraception, denial of contraception usage by the male partners to their female partners to exercise control is commonly seen. Alongside, many males are against undergoing vasectomy procedure when it is much simpler a procedure than ligation.

She also undertakes a detailed discussion on Communicable diseases under which she discusses the burden of tuberculosis that becomes heavier for women than men.

LGBT

Towards the end of her presentation, she discusses the issues of the LGBT communities, who have been ignored by the society on a continuous basis and who are at a much higher risk of certain diseases. Dr. Mavani stresses that it is important for us to consider them a part of us. Some of the diseases that they are prone to include, STIs, HIV, cardiovascular diseases, mental health problems, trauma due to hate crimes, obesity, substance abuse disorders. There are diverse medical health problems such as cancers (especially breast cancer) in lesbians due to obesity, excessive smoking and so on. They are also four times less likely to approach health centers for regular check-ups such as mammogram and PAP-tests. Many of the lesbians are also at risk of developing cervical cancer and HPV because 77.3 per cent of them have had sexual history with men, hence the risk of transmission of STIs is also high in them. Men having sex with men (MSM) also puts these men at a greater risk of certain diseases such as anal cancer. Approximately, 93 per cent HIV positive MSMs and 61 per cent of HIV negative men have HPV. With respect to their mental health, these people are also at an increased risk of anxiety, panic attacks and suicidal behaviors. They are also discriminated against when it comes to insurance schemes from the government.

On this note, Dr. Padmaja ends her presentation on Gender as Social Determinant. Dr. Vijay Kalyankar then takes over to discuss some of his learnings as a part of GME TOT training and also to put together the comprehensive discussion made by Renu Khanna and Dr. Padmaja Mavani. Dr. Vijay then went back to talk about how difficult it was for him to convince people around him on his inclination to pursue Obstetrics and Gynecology as his specialization since in the Indian sub-continent and many other countries, there is a stigma related to men opting for a subject like one that completely deals with women and reproduction. He further discussed about the need for Doctors to be aware of women's health with a gender lens and also the LGBT rights. With this, Dr. Kalyankar closed the session.

Discussion

Comment/Question1.:

Dr. Arun Humne: *Looking at the diversity in India, the whole idea that is woven around 'beliefs' needs to be reconsidered as there are varied communities with varied beliefs. Dr. Vijay also came with instances where he said he came across cases of gross negligence on the part of health providers, if that is the case, then it should be better if a public health person be deployed*

at every health centre so that the clinician is able to focus on his work, as they do not have time for their duties only.

The next thing I would like to discuss is sex education, will including sex education in the curriculum give a gender lens to its readers?

Next issue that I would like a clarification about is MSM, their issues, their anxieties and problems.

Response

Renu Khanna*: With respect to 'belief', what we have presented to you here is a broken down or a more simplified idea, and it is not only the belief that needs to be addressed, as I told earlier, some of these gender constructs can be dealt with at any level and mindsets need to change for this.* She presents an example of 'Raymond: the complete man' advertisement. *The 33 per cent reservation is one of the policy measure or a legal measure that is recognizing the gaps and trying to break down the same. Therefore, it's a multi-pronged approach and not just one element.*

Dr. Padmaja*: Gender is entrenched in our system since centuries, the roles were understood by the members as given however over time as roles have changed because the values and beliefs have altered significantly.*

Comment/Question2:

Farmer suicide prevalence and prevention is popular news however, in my opinion there must be biases in reporting and also what we get through the media, I would like to listen from the Honorable speakers on this.

Response

Dr. Padmaja: *Statistically, there may be more number of males than females and more males than females have gone to ask for loans or reported.*

Renu Khanna: *Once we had an activity with participants of one of the conference that I attended, we gave them a task of spelling out one statement each and to weave out a story, in all of the statements, woman as a farmer did not find a mention even once. The story that came was woven around a male farmer.*

Comment/Question3:

Why as doctors are we targeted for the issue of gender and not others? And secondly is it gender in health or gender in general? *Also, why are we not talking about Gender neutrality instead?*

Response

Renu Khanna**:** *We are primarily dealing with gender in Public health. The whole journey is towards Gender equality.*

Session 2: Gender in Medicine: What does it mean?
Speaker: *Dr. Jagadeesh Reddy, Dr. Shrinivas Gadappa,*
Discussant: *Dr. Varsha Deshmukh*

Dr. Jagadeesh Reddy starts the session where he starts with 'why do we as Doctors need to bring the change with Gender in Medical Education', where he states that as Doctors we need to perform multidisciplinary roles which are in addition to therapeutic role, preventive role, promoting role as well as holistic role in care. According to Dr. Reddy, to realize the same, we need Competency based health professionals and set an example of role models for the future Indian graduates. Dr. Reddy then went on to discuss about sex education which had been an issue of contention nationally, whether to have it included in the curriculum, but the subject already exists, as physiology and such subjects. Sexual education as a subject was always included in the medical curriculum but had never been taught to us and not much to the surprise, when we become doctors we are expected to know the things that we haven't studied.

Dr. Reddy then goes on to discuss the juvenile release who was accused of the 16th December gang rape case that rocked the nation. According to Dr. Reddy, the juvenile irrespective of whether they are victim or accused, should enjoy their rights because they are children, the problem or the crisis lies in the law and order, the policy issues. According to Dr. Reddy, as Doctors, we must also understand how laws are made in this country as it is easy to criticize laws but the process with which laws are framed are critical and if we as doctors do not raise an issue then we do not have the right to even criticize these laws. He then takes up the previous discussion on farmer's suicide, where he says that we all belong to the same society including the media men and regardless of more men or women, what we need to mind is that our house, the healthcare system is in order.

Dr. Reddy then points out to the previous discussion, in which a question was raised regarding Gender-neutrality that why is it important that women empowerment is taken up as an issue and why don't we also talk about men. Dr. Reddy pointed out that it is clearly not feminism that we are dealing with here, and in order to be able to talk about equality, we must first raise up the unequal to the level of equal. We can only talk about both men and women's welfare equally when we have women's status raised to the same level as men.

Dr. Reddy then comes to his discussion which is 'why do we need gender in medicine' at the first place. He lists out his discussion agendas.

Ethics in Practice

Under this discussion, he pointed out the issues of 'Informed Consent', and even if we say that we do take informed consent, do we really mean that. When we deal with illiterate people, we do not always go by considering their consent. Similarly, we unconsciously display bias with

women's consent, then also between rich and poor. According to him, these are some of the things that are doable and practical and will make subtle impact on the lives.

Some of the other discussions that were taken up by him include Gender and rights perspective in healthcare settings, gender competent doctors as listed by WHO and so on.

He furthers his discussion by talking about Universal Declaration of Human Rights that lists down articles and puts these articles in the context of Doctor-patient relationship. After discussing these, Dr. Reddy wraps up his discussion and gives over to Dr. Shrinivas Gadappa to take forward the proceedings.

Dr. Gadappa starts with telling about his experience of the TOT and says that initially he could not grasp the idea as to why Doctors are being targeted for this kind of a training and also why is it women are given more focus. He then takes up the difference between gender blind, gender aware and gender neutral. According to him, we don't deal with women entirely when we talk about Gender, but both male and female equally. Dr. Gadappa then discusses the various forms of violence. He states that violence are of four types, physical, sexual, economic and verbal or emotional. He says that one of the most common reasons of abortion is blow on the abdomen, and in this regards WHO has also given a definition of domestic violence. He then states definition of sexual violence, and the broadening of the definition of rape post the Nirbhaya case in the Criminal Law amendment 2013. When it comes to sexual harassment, most of the response has remained the same especially the attitude of the police when it comes to documenting the event. He then goes to discuss some of the statistics from across the globe and also India, towards the end of the presentation, he reads a very though provoking poem on domestic violence 'I got flowers today' and ends his discussion.

Dr. Varsha Deshmukh, as a discussant, makes some of the remarks at the end. She thanked the Organizers and the Presenters profusely for giving her the exposure to the concept of gender as she had been fairly new to it. She says that 'putting ones house in order first' would help the medico community greatly and we should not look for excuses. She further adds that Criminal Amendment Act as a Law should bring enough change in our country, especially the broadening of the rape definition and also sensitize doctors about details such as extent of penetration and so on, also she added that she received an all new perspective and an outlook to look towards her patients.

Discussion

Post Dr. Varsha's comments, Dr. Jagadeesh Reddy then takes over and raises the following two questions to the house:

Is marital rape punishable in India? And; what bearing do we have as doctors to respond to cases of domestic violence?

Question/Comment 1:

Dr. Prasad Deshpande: *Can we envision health utopia?*

Response

Dr. Reddy: *We presently are a country of unequals, we first need to qualify as equals in order to prepare ourselves for the utopian health system.*

Question/Comment 2:

Dr. Deshpande: Are we going have to knit in new policies for that and secondly, what are we going to do with the aggressors? since just punishing them is not enough.

Response:

Dr. Reddy: *As I have already mentioned in my presentation, we as doctors are not looking beyond therapeutic and not getting into making policies, and I can understand your intention of the question, but we need to understand the social framework under which all of it works. A person does not simply come and rape a women and a drunk will not beat any other woman but will only find his wife to beat because the power-relation is at play. For us as doctors, both accused and victims are the same, we are neither to punish nor to protect, but this does not imply that we become blind.*

Comment/Question 3:

I would like to add to Dr. Gadappa's discussion, I had been a part of data collection of a research that looked at ways of hitting while doing the act of domestic violence, to which some of the figures were shocking, 96 per cent women reported to have been slapped by their partners, and 55 per cent reported to have hit by fists to which psychological depression had been high.

Post-lunch Proceedings:

Session 3: About'Integrating Gender in Medical Education' Project

Speaker: *Priya John*

The sessions after lunch started with Priya's (Cehat) presentation, 'Integration of Gender in Medical Education'. She briefly gave an introduction of activities done by Cehat, mentioning that the primary focus areas of Cehat's work are health service and financing, health legislation and women's rights and the main strategies are research, intervention, education and advocacy.

She gave a brief information about the activities conducted all over the world and India as well around integrating gender in medical education, like 'Reorientation of Medical education' (ROME) which happened in 1977, participating of WHO since 19909s and adaptation of ROME specially in the South East Asia region.

She explained that situational analysis was Qualitative study, in depth interviews were done with 60 medical educators from 5 disciplines – FMT, medicine, OBG, PSM, psychiatry,

She further explained the need for situational analysis study and the main findings of the study were mentioned which are

- Lack of clarity and resistance to inclusion of concepts that are related to SDH, also when it comes to gender
- There is some degree of gender awareness which is really commendable, but at the same time there is lot of ambiguity as to how is it relevant to medical education
- Gender insensitivity was found among medical educators and doctors and there were lot of misconceptions and fears associated with 2 acts – MTP and PCPNDT

Priya further stated that situational analysis study gave a base as to why it is necessary to integrate gender in medical education. The presentation highlighted two works done in this direction, one by Cehat and one by Achuta Menon College in Kerala in 2002 which was a pioneering effort. Cehat is trying to bring the same concept to Maharashtra.

The presentation talked about the project objectives, the strategies which are used to fulfill the objectives that are capacity building of health professionals to gender inequality. She further explained the methodology of the project where modules having a gender component will be developed for all semesters which will be used to teach the students about 'gender'. She further mentioned that Cehat will advocate use of these modules in the MBBS curriculum.

She further explained that the GME project is divided into two phases, out of which first phase is completed, the first phase comprised of TOT of medical educators from 7 medical colleges and situational analysis. The TOTs were conducted by mentors from all over the country who are experts. Also at the end of the training modules were drafted. She further mentioned that at the end of the first TOT there were two outcomes – gender sensitive modules and pool of 19 trained medical educators. Also a virtual resource center was set up by Cehat.

She further explained the phase II of the project which is an action research project. This action research is based on two outcomes i.e. pool of trained educators and gender sensitive modules. She added that we are trying to bring a shift in knowledge, attitude and skills of a student and in turn trying to understand if students are able to identify that gender is socially constructed concept and if they are able to identify its impact on health. their attitude towards violence against women, attitude towards abortion, conditional access to safe abortion, issues of contraception and sex selection and also about ethical issues in practice. She further mentioned that it will be a quantitative study. She mentioned the names of the three participating colleges – Auranagabad, Miraj and Ambejogai and that gender sensitive modules will be used for the subjects of OBGY and PSM.

She ended her presentation saying at the end of the phase two we are hoping that we will have gender integration in medical education and we will hopefully work towards gender sensitive and competent doctors, who will look at health in a more holistic way.

Session 4: Gender perspectives in teaching medicine

Speakers: *Dr. Jagadeesh Reddy and Renu Khanna*

Renu Khanna started her presentation saying that she has been a part of this movement about integration of gender in medical education since 2002 and that she feels excited to see the development of this movement. She was expressed that it is heartening to see so many medical educators from Maharashtra at one place.

She showed websites of different medical colleges across the world who has integrated gender in medical education. She further added that the 2002 effort was not just national, but there were participants from countries like Thailand. Also simultaneous efforts were started in countries like Malaysia, Philippines, and Pakistan. She elaborated on the experiences from Thailand and Philippines.

Dr. Reddy talked about his own experiences of incorporating gender in medical teaching. He also encouraged the medical educators who were present to start the practice from them. He stated that first one should try to bring about changes in own behavior and then go back and bring changes in respective disciplines. He also showed support that Cehat as an organization is always ready for providing any type of assistance.

He elaborated on his experience of incorporating the module in his own teaching and then in his center and he further added that now he can boast that at least in all the South Indian states this practice has started picking up.

He explained the contents of the FMT modules and how gender is incorporated in all the lectures.

He added that modules for all the semesters are ready and encouraged the educators to use them in their classrooms. He further added that even though having a formal assessment on these modules depends on the decision of MUHS, still everyone can have their own internal assessment as they are free to do so.

He further added that one day MUHS would be the first university in India where gender education would be incorporated and that we all would have credit for that. He ensured that we are personally looking for incorporation of gender in MUHS curriculum and when it works out, we can extend it throughout the country. He encouraged the participants saying that if he could do it in his own FMT discipline; everyone can do it in their own disciplines.

He summed up his presentation saying that till this point we have driven the point that there is gender discrimination in the society, gender is a major issue which affects health of individuals, and also it is a public health issue and now are trying to intervene. He further added that we all are committed to the task and that modules are already prepared now only its implementation is remaining.

Session 5: Experiences of trained professors about GME

Speakers: *Dr. Shrinivas Gadappa, Dr. Sonali Deshpande and Dr. Beena Kuril*

The session started with experience sharing of Dr. Sonali Deshpande from Aurangabad Medical College, OBGY department.

Dr. Sonali stated that her journey started from being 'gender blind' to 'gender aware'.

She acknowledged that fact that the terms 'sex' and 'gender' are used interchangeably in medicine, also that women have many health problems but they are neglected and only her reproductive health is focused upon in public health. Women's non reproductive health is invisible or not emphasized because women are treated as mothers and wives and not as individuals with different potential.

She also elaborated on what she learnt from the gender training like proper examination of female patients, use of gender sensitive words. She also gave some real examples from her practice.

She further added that these experiences are not unique to Indian women but are present in all places inspite of availability of resources, women lack control over their sexuality and reproductive health, in developed as well as developing countries, and to address these needs future gender sensitive medical colleges are the need of hour.

She also shared her plan of incorporating gender in under graduate and post graduate curriculum for the students. She also explained the efforts taken for hospital staff and at institutional level.

She completed her presentation saying that sex and gender have significant impact on health and evidence supports main streaming of gender perspective. Dr. Sonali's presentation was followed by presentation by Dr. Bina Kuril

Dr. Bina started her presentation by sharing her experience from first TOT, where she said that male participants were very much reluctant, and there was lot of opposition from them. She added that in the second TOT this opposition and hesitation of male participants had greatly reduced.

She added that in the process of preparation of modules every aspect of community, discipline is taken into consideration, in short these modules are prepared wearing a gender lens.

Dr. Shrinivas also echoed the thoughts of Dr. Bina that there was lot of reluctance and resistance at the time of first TOT. He also added that he was also the one who was reluctant to attend the first TOT, but today he is standing as speaker in this conference and he attributed all the credit to Cehat.

He added that Dr. Sonali from his department has already explained the efforts that they are taking to bring about the changes in their department. He further said that when he examined the

text books of OBGY he observed the gender bias in them, so now while teaching issues like contraception he tries to bring the gender perspective in it, he also said that domestic violence and sexuality were never addressed in OBGY.

Dr. Shrinivas also mentioned that obstetric violence was well studied and talked about in GME training which is very important.

He completed his talking saying that he is very happy as 11 of his colleagues came to attend the conference voluntarily

One of the participants Dr. Humanae commented that gender issues are complex and training for them should start right from childhood. Also positive attitudes should be developed about human sexuality and gender issues.

Session 5: Looking Ahead

Speaker: *Padma Bhate-Deosthali*

Padma started with congratulating all three medical educators Dr. Shrinivas, Dr. Sonali and Dr. Beena for the type of changes that they have brought in their teaching and practice, within a year of attending the first training.

She added that Government of Maharashtra has passed the GR only recently, but GMC Aurangabad started using the gender sensitive protocols immediately after first TOT. She further encouraged them to write about their experiences and publish them, also assured any type of assistance from Cehat.

Padma facilitated the last session and asked the participants to reflect on the entire day. she asked the participants to tell about one way in which they think they can integrate gender in their teaching and practice.

The different thoughts shared by the participants were:

Rights of female students of UG and PG should be taken care of, also in terms of assessment there should be questions about gender, so that students will be bound to read about it. One of the participant said that it is necessary to spread this understanding to MBBS students that it not just women's physical health that needs attention but also her social and psychological health as well. Few participants said that they would arrange some short films or show videos related to this topic to UG students. A participant said that there will be an effort taken to find practical aspects o froot cause of violence and sensitize students. Some participants said that they would arrange discussions with other staff from the college.

After the participants shared their views, the mentors Sr. Reddy, Dr. Padmaja and Renu Khanna also shared their thoughts about the conference.

Renu Khanna expressed her satisfaction with the conference; she also narrated the experience of the first TOT where there was lot of resistance from the participants but she also added that second TOT was amazing and the type of work all of them produced of preparing the modules. She also added that it is encouraging to hear the feedback from the participants, and encouraged the participants saying that small efforts from everyone will turn into a significant change.

Dr. Padmaja Samant – Mawani said that it was a very nice experience, and that as mentors we are eager to know what all happens when the participants return to their respective institutes.

Dr. Jagdish Reddy said that he is eager to see the changes that take place over the course of program.

Padma thanked all the participants for sharing their thoughts. She also requested all the participants to register on GME website. She also encouraged them to post about their experiences on the website. She also added the Cehat website also has lot resources and they are free to use them, also there are 19 medical educators across Maharashtra, whom the participants can approach for delivering lectures at their colleges.

Closing and Vote of Thanks: *Ameerah Hasnain*