**Gender Perspective In Medical Education**

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**Abstract**

It is a universally acknowledged truth that medical students have to go through an incredible number of pages of textbooks in their undergraduate years. But most learn next to nothing about the intricacies of the social determinants of health and the larger socio-political-cultural spaces they will have to negotiate. Without any exposure to the larger economic, patriarchal and historical systems which are bound to collide with their book learning, they will be highly un-prepared to locate their own bio-medical skills within the larger context. The objective of this article is to analyze the current level of gender sensitivity in the textbooks being used for undergraduate medical training, and the potential impact that it has on developing attitudes towards a gender and rights based approach.

**International commitments to integrate Gender in Medicine**

Gender sensitive medical training aims at rectifying the imbalance and injustice in the system of knowledge which have failed to acknowledge the issues women face as a result of their gendered lives. International Conference on Population and Development in Cairo, Egypt, in 1994 followed by the Fourth World Conference on Women in Beijing, China, in 1995 conferences identified gender-based inequalities as crucial determinants of health. [1][2] In reference to the WHO 2006 GWH meeting report, internationally, there are documented examples of integrating gender studies across all years of the under­graduate medical curriculum. For example; gender was integrated into the curriculum for medical education in the Chulalangkorn medical school in Thailand in 2003–2004. An evaluation of the new gender-integrated programme was undertaken in 2006, one year after its introduction, using a questionnaire. Ninety per cent of the respondents were medical doctors, 5 per cent were nurses and 5 per cent were social workers. About 55% were men and 45% were women. The evaluation showed that most of the respondents had a positive attitude to gender issues, and applied gender concepts in their work and in their personal lives. [3] There have also been attempts to integrate gender considerations into a part of the curriculum or as an integral part of topics such as sexual and reproductive health and sexuality (Turkey and China), and intimate partner and family violence (Philippines). These have been achieved by various methods like using web-based modules, building faculty capacity, promoting and winning institutional support. [3]

The National Health Policy (2017) in India mentions gender sensitive provision of healthcare facilities and promoting equity, but there is no discussion on how that aim is to be achieved. [4] The policy does not state the need for gender sensitive medical education including medical textbooks, no mention of sexuality when speaking of Reproductive and Sexual Health, and a total absence of rights based perspective when talking about reproductive and sexual health, and its linkage to the considerations on health being considered a fundamental right. This is one of the explanations of why the medical curriculum is in much need of a gender sensitive approach, and why India is yet lagging behind in gender sensitive training, and thus in the provision of effective healthcare services.

**What should be the Objectives of Medical Training?**

Medical training needs to guide students not only on arriving at a clinical diagnosis and planning the appropriate treatment of a condition, but also needs to guide them about the healthcare frameworks which can lead to a better quality of life, since medical conditions that people face are a by-product of their living situations and intersectionalities. There are important biological and behavioral differences between the genders, affecting manifestation, epidemiology and pathophysiology of many widespread diseases and the approach and access to health care. They need to understand that several health needs are a result of gender inequity which is a consequence of gender roles and unequal gender-relations in society, coupled with social inequality and economic deprivation, restricting access to healthcare.

For example, the women who seek healthcare from a gynaecologist may also need support or protection from intimate partner violence, or for ensuring that she can use a contraception of her choice without the family members controlling her options. It is necessary to remember that these women approaching the public healthcare system are survivors of socio-economic injuries, putting them in a vulnerable state, and therefore making them prone to discriminatory treatment and potential exploitation of their rights.[5] Thus, it is important that women’s health needs are addressed with sensitivity.

**Literature reviewed**

All latest editions of textbooks of subjects Obstetrics and Gynaecology, Forensic Medicine and Preventive and Social medicine have been reviewed by this author, taking into consideration the focus on women’s health, addressing social determinants of health (or lack of it) and topics related to gender based violence. The textbooks reviewed for this paper are commonly used by teachers and undergraduates as well as postgraduate students across most medical colleges in India. medical

**Rape**

Since ages, young girls have been taught to be passive and boys to be aggressive. When these stereotypes and gender roles become extended to our sexual roles, it is conveniently assumed that women want to be sexually dominated by men, and that men have the right to demand sexual compliance from any woman while neglecting consent. This can be seen as a reflection of the male-dominated society, and the control over a woman’s body and sexuality. Despite the perpetrators of sexual violence being men in the vast majority of cases, the discussion of the issue is often relegated to a ‘women’s issue’ corner.

*“The material facts to be considered are the conduct and behavior of the victim. It is not rape where a woman initially objects, but subsequently gives her consent to sexual act.” (Forensic Medicine, Reddy, p 385)*

The definition of rape/sexual violence yet excludes marital rape, men as a possibility of being victims of sexual violence, rape laws differing for married and unmarried minors and the varying reactions of the victims. It is important to understand that the social behavior of rape victims is often generalized, the social reality of women who are raped is completely different, and their reactions may be diverse with varying degrees of fear, embarrassment, guilt and anger. And anything inconsistent or considered a *bad fit* can get contemplated as a false rape accusation, a mental disorder, or merely just be dismissed.[6] When a woman is seeking medical attention after being raped or sexually assaulted, healthcare providers often ask hostile and irrelevant questions concerning her clothing, marital status, sexual history, and level of resistance during rape, dwelling on the sexual aspect of rape instead of considering it as an act of violence. [7][8] Doctors do not always react sympathetically and portray a sense of disbelief. This can cause delay or reluctance to get medical help and reporting the act.[6] But whether or not a rape victim intends to report an attack to the police, medical care and counseling should be provided.

*“Rape and gender – in law, rape can only be committed by a man, and a woman cannot rape a man…” (Forensic Medicine, Reddy, p 388)*

Men are not seen as being as susceptible to sexual violence as women. Men being victimized for rape is considered incompatible with their masculinity, particularly in societies in which men are discouraged from talking about their emotions. The society assumes that a man should be able to prevent himself from being attacked, and deal with the consequences of the attack ‘like a man’. Although these findings relate to male sexual violence committed in time of peace, there is nothing to suggest that it does not also pertain to male sexual violence committed in time of conflict. [9] Sexual violence can also be viewed as a way to prove an individual’s masculinity and power through physical triumph. If a man feels his masculinity is being questioned or challenged, he may use sexual violence as a vehicle to reaffirm his position. This acting out of power roles, rather than expression of a sexual need is seen in case of armed conflict, presence of military, or in custody. [9][10] These situations are not presented in UG textbooks, thus medical students often lack the perspective to understand sexual violence of males. Sexual violence of males is still a [taboo](https://en.wikipedia.org/wiki/Taboo" \o "Taboo) topic since there is no recognition of consensual sex between two males due to the Section 377 IPC. Community and service providers often react negatively to the [sexual orientation](https://en.wikipedia.org/wiki/Sexual_orientation" \o "Sexual orientation) of male victims and the gender of their perpetrators. [11] Due to this, male victims try to hide and deny their victimization under the fear of humiliation, imprisonment and being tagged homosexual, bearing in mind the stigma around homosexuality. [9][12] Eventually, the male victims may be very vague in explaining their injuries when they are seeking medical or mental health services. It is difficult for a male victim, heterosexual or gay, to report the sexual violence that was experienced by him. Male sexual violence victims reported a lack of services and support, and legal systems are often ill-equipped to deal with this type of crime. [9][11]12] Laws dealing with sexual violence and rape should be gender-neutral.

*“Many lesbians are masculine in type, possibly because of endocrine disturbances and are indifferent towards individuals of the opposite sex. The practice is usually indulged in by women who are mental degenerates or those who suffer from nymphomania.” (Forensic Medicine, Reddy, p 401)*

Textbooks make no efforts to clarify that sexual orientation and expressions of gender identity occur naturally and are an essential component of one’s identity, and pose no threat to societies in which they are accepted as normal variants of human sexuality. Instead, without any scientific evidence homosexuality is being viewed as a pathological condition indicating presence of a disorder. Using the words ‘mental degenerates’ is a clear example of discrimination against an individual on the basis of sexual orientation, which is deeply offensive to the dignity and self-worth of the individual, violating their right to privacy and protection of sexual orientation.

**Virginity**

Rape survivors in India continue to be subjected to intrusive tests like the two-finger/virginity test for assessment of sexual violence.[[1]](#footnote-1) The two common techniques are inspection of the hymen for size and tears, and two finger insertion to measure the size of introitus and laxity of the vaginal wall. Both these techniques are performed under the belief that there is a specific appearance of genitalia that demonstrates habituation to sexual intercourse. There is no mention in the textbooks of hymenal features varying with age and the heterogeneity existing in regards to the knowledge and experience of the examiner. Textbooks do not take into consideration that the vagina is a dynamic muscular canal that varies in size and shape depending on individual, developmental stage, physical position, and various hormonal factors such as sexual arousal and stress. A W.H.O. study by Olson and Garcia-Moreno [13] shows that hymenal opening size also is found to be an unreliable test for vaginal penetration. Hymen opening size varies with the method of examination, the position of the examinee, the cooperation and relaxation of the examinee, and the examinee’s age, weight, and height. With regards to healing of hymenal injuries, it was found that most hymenal injuries heal rapidly and leave no evidence of previous trauma. The studies indicate that the inspection of the hymen cannot give conclusive evidence of vaginal penetration, or any other sexual history. Instead, virginity testing can cause serious physical, long-term psychological effects of self-hatred, loss of self-esteem, violation of privacy, fear and re-traumatization the examination causes, and social harm. The prevailing social rationale for testing is that an unmarried female’s virginity is indicative of her moral character and social value, bringing in shame and dishonor to families and communities, and a way to separate ‘pure’ from ‘impure’ females. [13]

*“VIRGINITY:**A female is called a virgin (Virgo intacta) if she has never experienced any sexual intercourse.” (N.G.Rao, p351, Reddy, p364)*

Virginity as a concept exists for men too but it doesn’t have the same social implications or significance at all. The textbook is perpetuating this negative gender stereotype without offering any counter position or explanation of the need for a patriarchal society to control women’s sexuality and hence the stigma around pre-marital sex for women. Virginity is thus a social construct and not a medical fact. Why is it still being taught to medical students when it has no medical relevance? From a human rights perspective, virginity testing is a form of gender discrimination, as well as a violation of fundamental rights, and when carried out without her consent, a form of sexual violence.

The Forensic Medicine textbook in fact shares a table to explain the differences between a virgin and ‘deflorate’ which is not just offensive labeling but also factually incorrect and legally of no relevance to rape. The focus should be more on victim and witness testimonies, rather than relying on physical examinations to check for injuries to the genital area, because absence of injuries is frequently equated with the absence of assault and denies their rights and autonomy Health professionals must be better informed and medical and other textbooks updated to reflect current medical knowledge. [13]

**Contraception**

*“The aims of family planning are: (1) To bring down population growth, so as to ensure a better standard of living.*

*(2) From economic and social point of view – already existing population of nearly 1027 million are deficient in their basic needs of food, clean water, clothing, housing, education and proper health care. Spacing of birth and small family norm will improve the health of the mother and their children, so that a healthier society can emerge.*

*(3) To reduce the maternal and infant mortality rates…” (Dutta’s textbook, p 494)*

This text assumes the notion of population control is the goal and it is the main justification for providing services such as contraception rather than seeing contraceptive methods as facilitating women’s control over their own bodies. It also does not offer the perspective of unequal distribution of resources and inadequate public sector spending on health as being a barrier to a better standard of living. It does not reflect upon the politics of the globalized world where the consumption patterns of the Global North are ignored and only birthrate of the Global South is focused on. Despite the International Conference on Population and Development (ICPD) held in Cairo in 1994 which ushered in a paradigm shift from population demographics to individual sexual and reproductive rights and health, and India being signatory to the ICPD PoA (Programme of action), access to ‘family planning’ is being projected as a solution to population growth.[1]

The use of Family Planning rather than contraception also assumes a heteronormative married couple as the basis of a family, and heterosexuality being the only sexual orientation or the only norm, and that sexual and marital relations are most (or only) fitting between people of opposite sex. Thus, this excludes any discussion around other sexualities and family structures. There is no discussion to orient medical students as to how the unequal gender relations put women at risk of unwanted pregnancies and how they affect women’s mobility, decision-making and access to contraceptives. For example, in the section on condoms, students need to be aware of the difficulties that women face in negotiating condoms use; and adverse consequences (fear of violence, accusation of infidelity, abandonment etc.) they might face if they insist.

*“Indications (of female sterilization): (1) Family planning purposes: This is the principle indication for most of the developing countries. (2) Socio economic: An individual is adopted to accept the method after having the desired number of children. (3) Medico-surgical indications (therapeutic): Medical diseases such as heart disease, diabetes, chronic renal disease, hypertension, are likely to worsen, if repeated pregnancies occur and hence sterilization is advisable. During third time repeat caesarean section…., sterilization operation should be seriously considered.” (Dutta p 513)*

In the section on female sterilization in Dutta’s, only the procedure (how to carry out the surgery) has been described and there is very little guidance on the comparison of female and male sterilization or the need to promote male sterilization as a less invasive and safer procedure. Surely if the woman should avoid future pregnancies because she has a serious heart disease, it makes sense to not do an invasive surgery on her but instead encourage the male partner to undergo vasectomy? At various places under the section on sterilization, there is mention of camps, but there is no reference to quality issues that need to be taken care of during camps.[[2]](#footnote-2) There should be reference to “Standards to sterilization”, published by Government of India in 1992, which students may consult for further information.[15] There is no guidance on how to determine whether or not a woman has made an independent decision free of any pressure or coercion. For each of the medico-surgical conditions listed, long term reversible methods could also be a reliable alternative and certainly each one of their husbands/partners can undergo vasectomy.

*“If a woman is considered unfit to bear children, and permanent method considered, a written opinion regarding psychiatric problem should be obtained. The written consent should be obtained from the husband or guardian, as the psychiatric patient may not be mentally aware of the nature of sterilization.” (Shaw’s textbook of Gynecology, p286)*

Shaw’s textbook states psychiatric disorder is an indication to undergo sterilization, without much justification, except ‘unable to bear children’. Such an approach towards patients suffering from a mental illness is serious exploitation of their reproductive rights, violating their right to make decisions about their bodies regarding sterilization and contraception.

The discussion on contraception counseling should be given more attention to, in both textbooks and in practice. The woman should be presented with all the options and empowered to make choice. In India, decision for removing IUD is not always in women’s hands, and providers often hesitate in removing IUD. It would be desirable that the textbook guides students about the rationale for choosing each method and guide the students on the right of the woman to discontinue a contraceptive method which does not suit her or for non-medical reason such as family/husband/partner opposition. The section on contraception does not orient students to areas where reproductive rights are likely to be violated during the provision of contraceptive services – e.g. overt or covert coercion for sterilization or IUDs, coercion for contraceptives while providing MTP services or caesarean section.[16]

There has been considerable scientific progress in areas of contraception, leading to the liberalization of medical eligibility criteria, which has the potential to considerably increase access to contraception. The textbooks, on the other hand recommend unnecessary and excessive requirements for starting a contraceptive, which reduces access for women. For example, Dutta's textbook suggests that breast, blood pressure and pelvic examination are mandatory before starting oral pills. However, recent WHO guidelines do not consider these necessary and state that oral pills can be started even by non-medical persons by using a checklist.[17]

*“Adolescents are often tempted to respond to their physical and emotional changes by indulging in high-risk sexual behavior to gain peer group approval, they are often ignorant of the consequences that may follow or willfully choose to ignore them. It is not unusual to find them in relationship with multiple partners and failing to use barrier contraceptives.” (Shaw’s textbook of Gynecology, p168)*

The text uses words like ‘high-risk’, ‘consequences’ and ‘ignore’ for engaging in consensual sexual activity and merely stigmatizes sex further. The focus in the text is on discussions of abstinence and contraception to help young people avoid unintended pregnancy or diseases. It does not talk about sex and sexuality education playing an important role in providing young people with honest, age-appropriate information, and providing the ability, and comfort to manage their sexual health and relationships throughout life in an empowered way.

Medical training should remember the needs of adolescents’ patients keeping in mind the lack of information about contraception and sexuality, difficulty in talking to adults, financial barriers, and stigma around pre-marital sex. This ultimately results in delay in care seeking. Doctors should be trained and sensitized to address a woman’s contraceptive needs, expectations and concerns, while clearing out misperceptions about contraceptive methods in a way that is compatible with patients’ health literacy, regardless of their age or previous sexual history. Emergency contraception should routinely be included in discussions about contraception, including access issues. An adolescent patient at no time should be forced to use a method chosen by someone other than herself, including a parent, guardian, partner or healthcare provider.

**Abortion**

Dutta’s textbook does not give any information on the rationale to provide abortion services, e.g. lack of access to safe abortion and high levels of illegal abortion nor the rationale behind the passing of the Medical Termination of Pregnancy Act in 1971. There is very little information on the implications of this Act for service providers, except for mentioning that the husband's consent in not required. [16] Textbooks should include sections on interpretation of the Act, including how its provisions related to confidentiality and consent give women space for making informed decisions. It is important that women with unwanted pregnancy are provided counseling on several issues, including whether they wish to terminate or continue, and issues related to the procedure pain, time taken, cost, choice for the procedure etc. However, there is no section on pre-abortion counseling and provider-patient communication for abortion.

*“It is worth emphasizing that in India, when a newly married couple in a stable relationship presents with an unplanned pregnancy and is considering the alternative of MTP, it is worth spending time with them. Counseling them about all aspects of MTP, giving them time to mull over their decision and encouraging them to continue the pregnancy unless there are pressing needs to the contrary. In practice, it has been seen that more than 50% of such couples opt out for continuation of pregnancy and that they have not later regretted their decision, whereas a frivolous decision on the part of the couple often ends up in regret. All patients undergoing MTP should be counseled to accept contraceptive advice in order to avoid future unplanned pregnancies.” (Holland and Brews, p 582)*

Textbooks encourage doctors to accept the idea of an ideal family as heteronormative and for the purpose of reproduction. Healthcare of young and single women is often compromised because of negative attitudes towards them. It also judges the decision to abort as ‘frivolous’ and urges doctors to counsel mainly to get the women to continue the pregnancy. This simply does not create a rights based framing for providing safe abortion access. There is no reference to the relationship between gender inequality and the power dynamics of married women in our society and women’s need for terminating an unwanted pregnancy, nor to repeated abortions sometimes being a marker of intimate partner violence. There is no mention of gender-based violence as a high risk factor to continue the pregnancy. [14][18] Textbooks should sensitize medical students on the women’s lack of decision making power regarding sex and contraception, its relation to unwanted pregnancies and the constraints that women, especially poor and rural women face in seeking access to abortion. This could be due to the need to obtain approval from the family, not having any free public sector services in their area, not being able to afford the cost of services in the private sector, lack of mobility, issues related to confidentiality and lack of information. In the section on history taking, students should also be taught to ask for the woman’s Social relations in family, support or lack of it, history of violence, or any anxieties or worries.

Especially in public facilities, women seeking abortion or coming in for repeated abortions are pressurized to adopt certain methods of long term contraception and may even be pressurized to go in for sterilization. [16]

*“Drugs inducing abortion produce congestion of the uterine mucosa and then uterine bleeding, followed by the contraction of the uterine muscle and expulsion of fetus, or they cause uterine contractions by stimulating the myometrium directly. There is no drug which when taken by the mouth causes abortion without endangering the life of the woman.” (Forensic Medicine, Reddy p 376)*

Reddy’s Forensic Textbook gives gross mis-information about the medical abortion pill which is the safest and non- invasive method for performing an abortion. Mifepristone and Misoprostol were registered in India in 2002. Medical abortion using these pills offers several advantages in terms of improved access, and its potential to be used by practitioners who are not skilled in surgical abortion. In several countries in the developed world it has in fact become the preferred method of termination. The textbooks continue to describe outdated, less effective or dangerous methods for abortion like aspirotomy, intra-amniotic instillation. Ethacrydine lactate, which is widely used in India for second trimester abortion, is no more considered the most appropriate choice. [16]

**Pregnancy and Labour Care**

In most developing countries including India, maternal morbidity and mortality remains a major public health challenge despite multiple efforts aimed at improving the quality of maternal health care delivery and creating an approachable environment for women seeking reproductive healthcare. Health advocates worldwide claim that even though maternal services are provided, women’s utilization of such services has not been ascertained. Erratic availability of medical resources and unethical practices among health workers adversely affect the quality of maternal health care service delivery and utilization.

*“Encouraging the patient to discuss her fears, apprehensions, expectations, and perceived problems-opportunity to allay anxieties and emphasize co-operation.” (Holland and Brews, p 59)*

While the point of providing comfort to the woman seeking antenatal care is put forth, the ways to organize ANC in a woman friendly way, ensuring privacy, maintaining the dignity of the woman, and other issues like winning the confidence of the woman, getting her consent for various examinations and procedures, need for proper communication, empathy, encouraging men’s participation, are not described.[18][19] There is no mention of the misbehavior of healthcare providers for various reasons for e.g.; coming too late to the hospital, having multiple pregnancies (having more than two children), seeking services from unsafe abortion providers, opting for home delivery. In addition, lack of privacy, confidentiality, and concerns about high cost of treatment often delay women from rural families to seek care. Inappropriate language is also commonly seen in our textbooks where women coming to health care facilities for ANC services, with normal pregnancies and in a state of normal labour are addressed as ‘patients’. Tags like ‘multi’ and ‘primigravida’, while medically relevant, are used to address women on general basis and is an example of casual objectification of women. [14]

In the chapters, Physiological Changes during Pregnancy and Endocrinology of Pregnancy, there is in depth discussion on physiological and anatomical changes. However, there is no mention of the psychological changes that occur throughout the different stages of pregnancy. [14]

*“…In India where nearly 40-90% of pregnant women are considered anemic.*

*The most common cause of anemia in India is nutritional anemia.*

*Causes: Diminished intake of iron- faulty diet habits…” (Holland and Brews, p 104)*

While talking about anemia and women’s nutrition, the text does not highlight that most women in both rural and urban India, begin eating their meals once all the men in the house are done, pushing women to consume food last and least, the issue of intra family inequality in food distribution and calorie consumption which majorly contributes to the poor nutrition levels in women and young girls in general and during pregnancy.[14][20] Also, violence during pregnancy is an important cause for delay in seeking antenatal care, and for poor weight gain, low birth weight and bleeding during pregnancy.[21] The role of gender-based violence in the causation of various health problems in pregnancy is missing. Studies show that nearly 40 per cent of women suffer from domestic violence. This aspect is not highlighted anywhere in the textbook. Health providers must be able to identify and guide women suffering violence. [14][18][19]

*“Many HIV infected women choose to become pregnant, continue their pregnancies despite of counseling and making MTP services available to them.” (Shaw’s textbook of Gynecology, p166)*

There is no guidance in the textbook on the importance to have non-discriminatory and nonjudgmental behavior towards HIV positive patients. [16] The text calling them HIV infected is undignified and also sounds as though she is infected in isolation, since there is no mention of partner counseling, keeping in mind confidentiality as well. Many pregnant women who are HIV-positive drop out of these programs or don’t adhere to medical protocols because of a variety of social barriers, including stigma.

**NOTE:** This paper reviews the latest editions of textbooks of Obstetrics and Gynaecology, Forensic Medicine and Preventive and Social Medicine from a gender perspective and compares it to the analysis of the articles in Economic and Political Weekly (2005). Even after more than a decade later, while there have been minor changes, many of those observations are still relevant and gender biases are yet persistent and its reflections seen in the examples below.

* The text lacks a rights’ based approach to reproductive and sexual health, in terms of contraception and access to safe and legal abortion.
* There is no mention of the role of the father/partner/husband during pregnancy.
* There is no discussion on how the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act (amended in 2003) is confused with the Medical Termination of Pregnancy (MTP) Act, thus targeting abortion services rather than targeting sex determination by commonly using the term ‘sex selective abortions’.
* In the section on False charges, ‘Sometimes, false charges are made by a consenting woman, when the act is discovered by the parents or someone else, when she becomes pregnant or for purposes of revenge or blackmail’ (Reddy, p395) shows deep rooted hostility against women even in our textbooks.[22]
* Women’s health issues are only spoken under ‘Maternal and Child Health’ and fails to address her health needs as a separate entity.
* The text constantly talks about a patriarchal family with well-defined gender roles.
* There is a general lack of research on women’s health issues and evidence based studies.[23][24]

**Conclusion**

Gender differences in health and illness are due to biological, psychological, social, cultural and political factors, and affect how health care is organized, accessed, provided and received. It is critical that doctors be aware of the gender norms, values and power relations of both the provider and patient influence the nature and quality of their interaction. Medical professionals bear witness to rights violations on a daily basis; they are key players in advocating for sexual and reproductive health rights. Doctors’ awareness of these issues aims toward better health for everyone and contributes to equity and equality in health. Doctors can act as agents of change, since as healthcare providers and healthcare system leaders, they are in a position of privilege to be able to support and empower women when they access facilities by creating an environment that is respectful, ensuring that they have choices that are safe and effective, provide dignified care that is suited to their needs and where they can trust the providers –doctors and nurses to be ready and willing to support them in times of need. As research and evidence is critical to changing attitudes in medicine, there is a need to strengthen the evidence base on gender differences, critically evaluate new information through a gender lens, demonstrate understanding of the differential impact by gender of health care systems (e.g. the way they are organized and financed) on populations and individuals receiving health care, and adopt best practices that incorporate knowledge of sex and gender differ­ences in health and disease. And even if textbooks don’t change easily at least critiques should be offered during the process of training and this will happen only if the medical faculty members are also sensitized and aware. Integrating a gender perspective in medical education in a systematic and progressive manner at all levels will result in greater gender awareness among future doctors.

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**List of textbooks reviewed:**

Obstetrics and Gynaecology-

* *DC Dutta’s Textbook of Obstetrics including Perinatology and Contraception*. 9th Edition, 2017. Edited by Hiralal Konar.
* *Howkins and Bourne Shaw’s Textbook of Gynaecology*. 16th Edition, 2015. Edited by VG Padubidri, SN Daftary.
* *Holland and Brews Manual of Obstetrics*. 4th Edition, 2017. Edited by Murlidhar Pai, Shirish N. Daftary, Prahalad Kushtagi, Sudip Chakravarti.

Forensic Medicine and Toxicology-

* *The Essentials of Forensic Medicine and Toxicology.* 34rd Edition, 2017. Dr. K.S. Narayan Reddy, Dr. O.P. Murty.

Preventive and Social Medicine-

* *Park’s Textbook of Preventive and Social Medicine*. 24th Edition, 2017. K. Park.

**References**

1. International Conference on Population and Development held in Cairo in 1994; <http://www.unfpa.org/icpd>
2. Fourth World Conference on Women in Beijing, China, 1995; <http://www.un.org/womenwatch/daw/beijing/beijingdeclaration.html>
3. [WHO, Meeting report of Integrating gender into the curricula for health professionals](http://www.who.int/gender-equity-rights/knowledge/gwh_curricula/en/), 2006: <http://www.who.int/gender/documents/GWH_curricula_web2.pdf>
4. National Health Policy, 2017. Ministry of Health and Family Welfare and Government of India: <http://cdsco.nic.in/writereaddata/National-Health-Policy.pdf>
5. Prakash, Padma; George, Annie; Rupande, Panalal. “Sexism in medicine and women's rights”. The Indian Journal of Social Work, Focus Issue, Patients' Rights, LIV(2), April 1993, pp. 199-204
6. Ahrens CE. Being Silenced: The Impact of Negative Social Reactions on the Disclosure of Rape. *American Journal of Community Psychology*. 2006;38(3-4):263-274.
7. Doctors to cops: The horror of rape examination in India, 3013; <https://www.firstpost.com/india/doctors-to-cops-heres-the-horror-of-rape-examination-in-india-577953.html>
8. The shocking questions lawyers ask rape survivors, 2017, The Times of India; <https://timesofindia.indiatimes.com/india/the-shocking-questions-lawyers-ask-rape-survivors/articleshow/60365331.cms>
9. Sandesh Sivakumaran; Sexual Violence Against Men in Armed Conflict, European Journal of International Law, Volume 18, Issue 2, 1 April 2007, Pages 253–276
10. Clayton M. Bullock, Mace Beckson. Male Victims of Sexual Assault: Phenomenology, Psychology, Physiology. *Journal of the American Academy of Psychiatry and the Law.* April 2011, 39 (2) 197-205.
11. Jordan Leith. Male Sexual Victimization: Victim Response, Reporting Barriers, and Treatment. Bemidji State University Honors Program. Department of Psychology, 24 April 2017.
12. Male survivors of sexual assault. Sexual Assault Prevention and Awareness Center, University of Michigan; https://sapac.umich.edu/article/53
13. Rose McKeon Olson, Claudia García-Moreno. “Virginity testing: a systematic review”. Reproductive Health, 2017, Volume 14, Number 1, Page 1.
14. Khanna, Renu. “Obstetrics and Gynaecology: A Women's Health Approach to Textbooks.” *Economic and Political Weekly*, vol. 40, no. 18, 2005, pp. 1876–1881.
15. Standards of Sterilization; <http://www.nhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines/family-planning-guidelines.html>
16. Keerti Iyengar. “How Gender-Sensitive Are Obstetrics and Gynaecology Textbooks?” *Economic and Political Weekly*, vol. 40, no. 18, 2005, pp. 1839–1846.
17. WHO guidelines for starting OC pills; <http://www.who.int/bulletin/archives/78(8)1015.pdf> ; For Emergency Contraception; <http://www.who.int/mediacentre/factsheets/fs244/en/>
18. Nirmala Sudhakaran. “Teaching Clinical Obstetrics: A Short Note.” *Economic and Political Weekly*, vol. 40, no. 18, 2005, pp. 1867–1869.
19. WHO guidelines on Respectful Maternal care; <http://www.who.int/reproductivehealth/news/antenatal-care/en/>
20. Padma Prakash. “Where Is the Woman in Preventive and Social Medicine? Sociological Perspectives.” *Economic and Political Weekly*, vol. 40, no. 18, 2005, pp. 1828–1834.
21. Domestic Violence During Pregnancy in India, Meerambika Mahapatro, PhD, R.N. Gupta, PhD, Vinay Gupta, and A.S. Kundu, PhD, *Journal of Interpersonal Violence,* Vol 26, Issue 15, pp. 2973 – 2990, January 30, 2011.
22. Flavia Agnes. “To Whom Do Experts Testify? Ideological Challenges of Feminist Jurisprudence.” *Economic and Political Weekly*, vol. 40, no. 18, 2005, pp. 1859–1866.
23. Kamaxi Bhate, and Shrikala Acharya. “Preventive and Social Medicine: Practitioner's Review of Gender Content.” *Economic and Political Weekly*, vol. 40, no. 18, 2005, pp. 1870–1875.
24. Rakhal Gaitonde. “Community Medicine: Incorporating Gender Sensitivity.” *Economic and Political Weekly*, vol. 40, no. 18, 2005, pp. 1887–1892.

1. While the two-finger test has been officially delegitimized by the Ministry of Health and Family Welfare, according to a study by Human Rights Watch (HRW), doctors continue to conduct this test for rape survivors in India.

   <https://www.hrw.org/news/2017/11/09/doctors-india-continue-traumatise-rape-survivors-two-finger-test>

   <https://www.hrw.org/report/2017/11/08/everyone-blames-me/barriers-justice-and-support-services-sexual-assault-survivors>

   Guidelines and Protocols for medico-legal care for survivors/victims of sexual violence- <https://mohfw.gov.in/sites/default/files/953522324.pdf>

   <https://www.thehindu.com/news/national/No-two-finger-test-for-rape-SC/article12141055.ece>

   https://scroll.in/article/857169/doctors-in-india-continue-to-traumatise-rape-survivors-with-the-two-finger-test [↑](#footnote-ref-1)
2. Bilaspur sterilization camp tragedy, November 8 2014- 83 sterilization procedures carried out in six hours violating the guidelines for the procedure.

   <https://en.wikipedia.org/wiki/2014_Chhattisgarh_sterilisation_deaths>

   <https://indianexpress.com/article/india/india-others/bilaspur-8-women-dead-20-others-in-a-serious-condition/> [↑](#footnote-ref-2)