

# Preventive and Social Medicine Practitioner's Review of Gender Content

*This paper explores the inclusion of social inputs, with gender as a central theme for the causation and management of different diseases, in textbooks of preventive and social medicine. It finds that prevalent gender stereotypes get consistently reinforced in the analysis of family and community dynamics. Women's reproductive health needs only come into focus in discussions on family planning and the 'population problem'. Both the books examined were found lacking in class and gender specific research data on disease causation and management. It is apparent the authors pick up progressive ideas but fail to integrate them into the text. As a result, gender, equity and social justice in the analysis of health issues and health care needs appear as unintegrated concepts, easily ignored by student users of these books.*

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Modern medical education was introduced in India by the British during the early 19th century with the objective of training doctors to serve the military and the colonial administration in India. Sanitary and public health measures were instituted, initially only for army and cantonment areas, to control the spread of tropical diseases.

Thus medical education in India has not evolved from concerns of the Indian social reality, its social inequality of caste and class, poverty and the different pattern of diseases among the general population. After independence, the emphasis on western sciences in medical education continued and with discovery of microbes, antibiotics and new drugs, the curative model became firmly established as did searching for the causes of health problems and their solution within a technological framework got reinforced. The multi-dimensional role of social, cultural and economic factors in the causation of these health problems remained neglected in the training of the doctor as well as in provision of the health care services.

Various studies by social scientists and committees set up by the government show that the social science content in present health and medical education is inadequate to provide even a basic understanding of Indian society; the social context of health and ill health; developmental issues related to health and health care in India; and class, community and gender issues affecting access to health care facilities. Medical doctors need to have a comprehensive understanding of the roles women play in society, their differential health needs and poor access to health services due to their subordinate position in society. This gender sensitivity has to be reflected in the undergraduate training of medical doctors and in textbooks of preventive and social medicine.

The present review looks at two textbooks on preventive and social medicine by Park and Mahajan and Gupta respectively. The textbook on preventive and social medicine (PSM) by K Park is widely – and rightly considered a standard academic treatise on the subject. It is the only book in medical curriculum revised 17 times in just 32 years. The textbook is popular all over Asia as a source book for PSM. The other book under review is

*Textbook of Preventive and Social Medicine* by B K Mahajan and M C Gupta for undergraduate students.

## I Evolution of Preventive and Social Medicine

In 1848, Virchow said, "Medicine is a social science and politics is medicine on a large scale". But it took almost a 100 years for social medicine to be given its due recognition. Health and diseases are multifactorial entities. There are some social determinates of health and diseases. Without addressing social realities, one can neither prevent disease nor achieve health. The Park's book contains evidence that the author has taken pains to incorporate a multifactorial approach to the health. In his second chapter, he gives a diagram showing gender as one of the determinants of health and diseases; it also mentions equity and social justice as yet another determinate of the same. The textbook by Mahajan fails to even mention gender as one of the determinants of health and disease. Such lacunae are not expected in any book on preventive and social medicine. When they are present in a standard textbook on the subject used in most medical colleges, not only in India but also many parts of south and south-east Asia, they assume a serious character as the students who learn from them remain ignorant of the gender and equity dimensions of public health.

Both the books, like any other medical textbook, have a 'single sex' attitude. This attitude assumes that the doctor is male and patient is also male. The irony is that more than 50 per cent of medical students – and hence future doctors – are women and more than 50 per cent of patients are also women. These authors have totally ignored the role that women play in the family, society and the health care system.

According to the 'Right to Health' in the Universal Declaration of Human Rights, "Every one has the right to a standard of living adequate for the well-being of himself and his family". Here a woman is just a part of a family; apart from that she has no independent existence in enjoying that human right.

Park in the same chapter while summing up the world health situation of the 'health gap' between developing and developed

regions, comments, "Over 1,000 million people in the developing world have income too low to ensure basic nutrition and have little access to essential health services". Here the blame for the 'health gap' is put on the growth rate of these countries. Whereas over-expenditure and wasteful lifestyles of western countries, food wastage and military expenditure is not even made mention of; the primary health care approach is offered as the only way to close this 'gap'. Surprisingly, it is not emphasised enough that the primary health care approach is important for developing and developed countries, because the rapid increase in the health cost of developed countries is not essentially reflected in the improvement of health indicators.

## II Epidemiology of Diseases

Mortality indicators are an important epidemiological tool to assess the trends in overall mortality, setting priorities for health action and monitoring the impact of public health programmes. This data is compiled based on the 'cause of death' mentioned in death certificates. As it is well known, a death certificate has three components: the disease or cause directly leading to death, the antecedent causes and other significant conditions of the deceased person. The antecedent causes and other significant causes, if they are of social origin, may not get recorded if the doctors are not gender sensitive. For example, while recording the death of a woman, significant conditions like domestic violence, dowry abuse or neglect of nutritional needs may not get recorded. Similarly, while recording infant mortality, discrimination against the female child in the family on account of son preference may not find a mention. While describing the burden of any disease in the community, one needs to know where, when and who are getting affected. The occurrence and manifestation of any disease (whether communicable or non-communicable) are determined by the interactions between the agent, the host and the environment.

"The host is the Man Himself", writes Mahajan. While describing 'sex' as an important host factor, it mentions that sex differentials in the occurrence of disease are documented and may be due to metabolic or structural differences, differences in exposure or genetic background. Park does mention cultural and behavioural differences between the sexes, due to different social roles, as being responsible for the variation in disease frequency. However, the examples given are those caused by smoking, automobile use and alcoholism! The wide range of cultural and social exposures determining the differential disease occurrence in women is completely excluded.

Park includes cultural values, customs, habits, beliefs, attitudes, morals, religion, education, social organisation, lifestyles and community life as social factors affecting health, without giving any explanation or examples for the same. The position of women in society, their access to education, job opportunities and health services, which can affect their decision-making power and ultimately health, finds no mention in both the books. Under 'Agent Factors in Relation to Environment', Mahajan writes, "Social environment operates in case of diseases requiring close human contact such as venereal diseases, leprosy and viral infections like measles and influenza". So much for the author's awareness about the social environment! How do we expect any awareness and sensitivity about gender? Under epidemiology it is necessary to make a 'community diagnosis'. If a gender perspective is lacking, it may not be possible to make the right

community diagnosis and hence, planning, implementation or evaluation of the programme can be defective.

### Tuberculosis

The most common killer infectious disease in India is tuberculosis. This disease affects those with low immunity. However, both the textbooks mention that "the incidence of tuberculosis is less in women compared to men", although it is a known fact that women have lower immunity and lower nutritional status than men. The reasons for this are social-cultural and not biological. Both the books do mention "poverty, poor quality of life, early marriage, multiple children, etc." as the environmental and social factors contributing to TB. But they fail to acknowledge that it is women who are more affected by poverty, they have a poorer quality of life, and bear multiple children. Still, if it is claimed that the occurrence of TB is less among women, it is fair to suspect that the morbidity statistics are incomplete for women.

The government establishment generally ignores the social implications of common medical diseases like tuberculosis. There is a stigma attached to TB, but the stigma is heavier for women than for men. In a typical Indian family, a woman suffering from TB tends to hide it from others in the family, or her family conceals the fact from outsiders. Thousands of women who suffer from TB in India are rejected by their families and this results in either the denial of treatment or partial treatment for women.

These are the likely explanations for the skewed distribution of the prevalence of TB between the sexes. If books on social and preventive medicine do not discuss social-cultural aspects that have a determining impact on common diseases and treatment modalities, how will medical students ever know why treating TB is so difficult? In the absence of this knowledge, how can policy-makers design effective plans and control measures?

### Sexually Transmitted Diseases (STDs)

STDs are rightly considered as social diseases with medical manifestations. However this social reality gets scant attention or is distorted in the textbooks. Mahajan has not included any social factors as contributing to the prevalence of TB while Park says, "Prostitution is a major factor in spread of disease" and elaborates, "Promiscuous women are usually drawn from broken families." This creates a gender bias amongst medical students because they begin to believe that 'prostitutes' are the cause for the spread of STDs, and put the blame for this social evil on women.

As far as the increased prevalence of STDs in the population Park most shockingly lists, "increase in educational opportunities for women and delaying their marriage" as some of the causes. Mahajan corroborates this by putting down "Increased use of oral contraceptives with corresponding decrease in use of condom" as one of the causes. Both the authors are unanimous in putting the blame for the spread of STDs on women.

Women's vulnerability to STDs and its reasons are totally ignored in both textbooks. The 'triple jeopardy of women' making them vulnerable to these infections, is primarily due to the anatomy of the vagina, which is elongated and out of sight, with a long area covered by mucous membrane. Semen has a high concentration of pathogens and the quantity of semen is much more than the vaginal fluid. Contact time between semen and the vaginal mucosa is longer. Perhaps the most important reason

for women's vulnerability to STDs is the prevailing social status of women, where even if they know of their husbands' sexual behaviour, they cannot say 'no' to sex with them and cannot even insist on the use of condoms.

'Social welfare measures' for the control of STDs include 'social therapy', which conveniently overlooks and ignores the children of prostitutes. There is no mention of preventing the 'commodification of women', providing education and employment opportunities for them, in general, and not just as rehabilitative measures for prostitutes. Mahajan advises that, "Unhappy and strained married life leads to extramarital intercourse, increasing the chance of exposure to STDs", again applicable to men alone and providing the most common and biased excuse for men contracting STDs.

Mahajan has been similarly insensitive while describing preventive measures for STDs. "Control of prostitution" is the first priority even before "diagnosis and treatment for STD". However the author does not discuss any social measures for the rehabilitation of prostitutes or to alleviate the poverty of women. For case detection among high-risk groups, he advises, "To find cases among prostitutes and call girls in brothels and red light areas...interrogation, search, interview, some persuasion or even coercion may be necessary to detect them"! This insensitivity from the author of a social medicine book is serious and worrisome.

### **HIV/AIDS and Infectious Diseases**

The high-risk group for contracting HIV infection in Park includes all groups but women whose only 'high-risk' behaviour is getting married to men, infected with the virus. Park also mentions "women are two times more vulnerable to HIV infection than men". Here only anatomical and biological explanations given. This being a social medicine book, social reasons for women's vulnerability are expected.

Women are routinely exposed to internal examination of the vagina, IUD insertion, MTP procedures and deliveries in health care facilities. Proper aseptic precautions during these procedures are essential to prevent hospital-acquired infections. But this important fact does not find a mention in both the books though even trivial procedures like dressing, suturing are mentioned as examples causing hospital infections. Aseptic conditions in labour wards in particular are pathetic.

To be fair to Park, he has provided useful social explanations in his book for the differences in morbidity between the sexes in some infectious diseases. For example, in trachoma, incidence of the disease is more in women and children. This disease flares up with dirt and smoke. The explanation given by the author is that women are in greater contact with children and with household sources of smoke.

Nevertheless, such explanations are few and far between. Tetanus is a peculiar example of gender omission. Mahajan mentions that 5-20 per cent of tetanus cases are puerperal and post-abort types but does not elaborate. Park mentions, "puerperal tetanus follows abortions more frequently than normal labour. This is because post-abortal uterus is a favourable site for the growth of tetanus organisms". But in control measures, only the measures for the prevention of neonatal tetanus and prevention of tetanus after injury are discussed. Essential preventive measures for safe abortions and delivery should have been included to make the students realise the interrelationship

between health problems and necessary intervention of the programme.

### **Non-Infectious Diseases**

Hypertension and CHD seem to be 'male diseases' as studies that are mentioned in the books, conducted in various countries, have not included women. Mahajan mentions, "CHD was virtually unknown in pre-menopausal Indian women till about three decades ago. During recent decades the increased female prevalence observed is primarily attributable to changing lifestyles, especially female smoking." The author again presents his biased opinion about female smoking, the prevalence of which in the general female population is almost negligible. He does not highlight changing environmental and social factors which are equally stressful for women and ignores their triple burden of bringing up children, household chores and proving themselves at work places. There is also no mention of studies on women describing their response to treatment and other risk factor reduction interventions.

Park writes, "there is higher prevalence of blindness in women than in men due to higher incidence of cataract, trachoma and conjunctivitis", while Mahajan attributes "compromised nutritional status of mothers, infants and children as major factor responsible for blindness in India." However, when it comes to treatment, Mahajan writes, "women are more commonly affected but men have been observed to be 1.6 times more likely to have undergone cataract extraction" without the obvious explanations of lack of access to health care for women. Park does not even mention whether women with blindness get any treatment at all.

Pap smear is an important screening test for cancer of the cervix, the most common and most fatal cancer, if not detected early, for women in developing countries. In textbooks of PSM, the simplicity of the test to be conducted needs to be emphasised. Also, for the universal reach of screening programmes, how trained health workers can take the smear needs to be highlighted. The social problems encountered for making this test more popular need to be discussed.

### **Social Sciences and Environment**

This section should be the soul of any text book on preventive and social medicine, in order to help medical students understand the social reality, power dynamics at the family and societal level, community structures, interrelationships between various groups and their impact on the health and disease of any individual and community.

Park starts the chapter with the moral: 'The secret of national health lies in the homes of the people' by giving the example that a person with a broken leg has complex social and personal factors influencing 'his' recovery. Park observes that many health programmes, e.g, family planning, immunisation have been only partially successful due to the resistance of people. "Why do people behave as they do? Many community health problems are in essence social problems". The author has started with the right approach, viz, knowing the community before any intervention. However, he later on loses this perspective by just defining a long list of various terms from sociology.

Park has totally forgotten to mention the ascribed roles for women in Indian society, their contribution towards family and the various responsibilities, both productive and reproductive, which affect their health status. Mahajan says, "Man may be a

member of some political party, the women may be attending a religious gathering”, again expressing his biased opinion about the role of women in the society. Gender roles, their complexities and the need for social change to improve women’s health seems to be outside the purview of these books.

Park does identify social problems like, housing, divorce, population growth, ageing of the population as having public health implications, such as alcoholism, venereal diseases, etc, and that require combined sociological and public health action. However, the prevailing social status of women in India, their low educational level and gender discrimination does not get recognised as a social problem.

Family has an important role to play in promoting health and preventing disease. Park has explained these roles in detail. The responsibility for child rearing and caring for the sick, injured and old is entirely on women. “Care of women during periods of recognised dependency, i.e., pregnancy and child birth is an important function of the family”. It can be noted that the general illness of a woman apart from her reproductive dependency is not worthy of consideration. Also the fact that the quality of care a woman receives during these recognised dependency phases depends on her status in the family, the sex of the child/children she has borne, is overlooked.

Similarly Mahajan writes, “Everybody is assigned a responsibility in [the] family. Elders look after and nourish children and educate them. Male[s] busy themselves mainly with outdoor activity and physical protection. Some members have the responsibility of looking after others, e.g., looking after infants, pregnant women, the old and the sick and the handicapped”. The author fights shy of mentioning who these ‘some members’ are? Who does all the work but is not worth being recognised in a book of social medicine?

Mahajan also writes, “From the point of view of social security, especially to women and children matriarchal system is better. The patriarchal society has an inbuilt bias against women. Patriarchal values need to be changed in order to provide gender just environment for girls and women”. The author has just rendered ‘lip service’ to the gender bias in patriarchy and forgotten about it in the rest of the textbook.

In cultural factors affecting health and disease, Park writes, “Hindu women often take food left over by their husband. In some societies, men eat first and women last and poorly”. Park does not recognise this as gender discrimination and fails to stress its adverse impact on women’s health. He further adds, “In Indian society the family is incomplete without the birth of a male child. This has obvious implications in the context of the country’s populations problem.” The author has highlighted son preference but has not linked it with social evils like prenatal sex determination, sex selective abortions and declining sex ratios. He has also ignored the adverse effects of repeated abortions and late abortions on the health of women. Implying that son preference is the cause for the population problem is too narrow a view and ignores other factors like socio-economic status and problems of access to health care services for vulnerable groups resulting in high infant and child mortality rates, and so on.

Highlighting the importance of marriage in health and disease Park writes, “due to universality of marriage in India, there are no problems such as unmarried mothers and of illegitimate births, as in western countries”. While it is a well known fact that India is one of the first countries to have passed the MTP Act to prevent illegal abortions and to reduce maternal mortality resulting from

septic abortions, Park has described the problem of unmarried mothers very abruptly.

### Occupational Health

Mahajan writes, “Like the home and the school, the place of work is also an important part of man’s environment.” Park says “There are three types of interactions in a working environment: Man and physical, chemical and biological agents, Man and machine, man and man”. With all due respect to the English language and acknowledging that ‘man’ means ‘men and women’, the problems faced by women at the workplace are not discussed anywhere in the entire chapter. Although there are legislations to protect the health of workers, as most women are employed in non-organised sectors, they are not benefited by these protective acts.

### III Demography and MCH

The sex ratios are just made a mention of in Park. Mahajan does show his concern for the declining sex ratio. “The sex ratio should be more than 1.0 as women have slightly longer lifespan than men. In India sex ratio has been consistently falling, not due to decrease in biological survival capacity of women but because of higher mortality due to environmental factors (social environment)”. However, there is no mention of son preference, infanticides, or sex selective abortions as some reasons for declining sex ratios. The authors have also not thought of offering the social implications of such a phenomenon.

Higher fertility in India is attributed to the “limited use of contraceptives and traditional ways of life”, among other factors, but the most important factor, of men not taking responsibility for birth control, the low use of condoms and low vasectomy rates are not mentioned. These social issues need to be discussed in a social medicine book.

Yet the reproductive health problems of women are of no significance to Mahajan, as he writes, “It is advisable to insert the loop after a child has been born. Retro-verted uterus is no contraindication. Slight discharge does not matter. Mild erosion results in no harm and prolapse can be ignored. Cervical tear, infection, caesarean section, myomectomy and lactational amenorrhoea are not contraindications” for IUD insertion.

Infertility is a major social problem resulting in mental stress, anguish and social ostracism for women. Neither of the textbooks of social medicine recognises this social problem. Mahajan writes, “Management of infertility should not end with the clinical examination, lab test and prescription of medicine. Efforts should continue till a child is born to the couple or till they decide to adopt a child or to terminate their efforts.” Medical students need to be sensitised about this social problem, the burden of tests the woman alone has to undergo to prove her fertility and the need for social support and counselling during this entire process of management of fertility. Mentioning only technical interventions does not serve the purpose.

### Maternal and Children’s Health

Targeting women for family planning starts with the antenatal care as indicated in this objective: “To sensitise the mother to the need of family planning”. It is further emphasised by saying, “Family planning is related to every phase of [the] maternity

cycle. The mother is psychologically more receptive to advise on family planning. If she has had two or more children she should be motivated for puerperal sterilisation”.

Low birth weight, a major public health problem in India has been attributed to malnutrition, infection and unregulated fertility in Park. Mahajan has added factors affecting the antenatal health of woman as being responsible for this. But both the books have not described social factors like gender discrimination that lead to an inter-generational cycle of malnutrition in women and heavy workloads.

### **Nutrition and Health**

While discussing the ecology of malnutrition, Park writes, “Many customs and beliefs apply most often to [the] vulnerable group to pregnant and lactating women and children.” He also adds “In some communities, men eat first and women eat last and poorly. Consequently the health of women in these societies may be adversely affected.” The gender discrimination affecting the nutritional intake (quantity and quality) of the girl child and woman is not recognised as a social factor responsible for malnutrition. Similarly child rearing practices fail to identify premature curtailing of breastfeeding for female infants.

Nutritional anaemia affects women the most, and still the epidemiology of nutritional anaemia is not discussed in both the textbooks. Mahajan adds, “Iron deficiency can either occur because of excessive body loss or because of inadequate intake. The former is much more common. Gastrointestinal and female genital tract are the two most common modes of blood loss. Iron intake in Indian diet has, in fact, been estimated to be 108 per cent.” Whether Indian women have such a high iron intake in reality is not discussed.

### **Mental Health**

Mental health is dependent on the balanced development of an individual’s personality and emotional attitudes towards others. Park writes, “Mental health is a matter of relation of the individual towards the community he lives in, towards the social institutions which for a large part guide his life, determine his way of living, working, leisure and the way he earns and spends his money, the way he sees his happiness, stability and security.” It is the man who decides the way ‘he’ earns and spends it and it is the way ‘he’ perceives ‘his’ happiness, which determines ‘his’ mental health. Women do not get considered in this section as if they do not deserve mental health!

Vulnerable phases in a women’s life, where she needs extra care, support and assurances like adolescence, marriage, puerperium should get its due attention in a book on social medicine. Sensitive issues like child sexual abuse and its impact on mental health should be discussed. Women facing marital problems like dowry demands, domestic violence and compulsion to bear a male child, also undergo tremendous mental stress affecting their health. Medical students need to be sensitised to these situations through textbooks. For the prevention and control of mental illness in family life, Mahajan writes, “A major source of mental tension now-a-days is the decline in joint family system and disruption of smooth family life because of the dual demands of family and career upon working women. Efforts aimed at preservation of joint family and at provision and support and amenities to women will go a long way towards promotion of mental health.” The

author has rightly identified the stresses on working women but fails to describe what support amenities are required to reduce these stresses.

The population problem is highlighted in terms of the effect of the population explosion on the environment and on overall development. Inability to reduce the population growth rate to 1.2 has been cited as the biggest problem facing the country. Both books on social medicine have failed to discuss the role of population dynamics, social contexts and lack of economic opportunities as the reasons for this problem. The prevalence of malaria, filarial, and diarrhoeal disease has been enumerated in communicable disease problems but their differential occurrence and access to treatment for both sexes has not been highlighted.

The National Health Policy has been mentioned in Park only in terms of demographic goals to be achieved while Mahajan has replicated it verbatim with appropriate critical remarks as:

The policy does not speak even once about social justice (in health and in other fields such as land reforms and wages), which is an essential prerequisite for health for all. No definite programme has been suggested for community participation in health. Health policy is an integral part of [the] broad movement of radical redistribution of economic assets and political power and of deep transformation of ideas, attitudes and values, which are essential for achieving health for all.

Though the author has recognised the importance of social transformation and radical redistribution of resources, this perspective has not been reflected throughout the book.

Primary health care with its evolution, elements and functions has been explained in detail in both the books. The staffing pattern at primary health centres, sub-centres and community health centres has been enumerated but how primary health care services are provided to people, in a comprehensive manner, at each facility, are not discussed at all. The implementation of national health programmes through these primary health facilities is not explained. As a consequence, medical students at the end of a complete training do not even know about common health problems and their management, e.g., emergencies in villages like snake bite, scorpion bite, injury and accidents in the fields.

A cunning rationale is used in the ‘All India Postpartum Programme’ introduced in 1969. In this hospital-based, maternity centred approach to family planning, the rationale was “(1) women who have recently delivered have proven fertility and are at the risk to get pregnant again. (2) They are a ‘captive audience’” (Mahajan). Both the books assert that at the time of delivery and during the ‘lying-in’ period women are more receptive to one or other family planning method. Here again the programme has chosen the easiest target, that is, women.

## **IV Conclusions**

It is necessary to have gender-just medical care to achieve health for all in the true sense. This gender sensitivity has to be inculcated through training in medical colleges and reinforced by textbooks. In a male dominated society and western science oriented medical education, special efforts are needed to make textbooks gender sensitive. This is especially essential for textbooks of preventive and social medicine, the course designed to orient medical students to the social reality of communities.

We explored the inclusion of social inputs in textbooks of preventive and social medicine, with gender as a central theme

for the causation and management of different diseases. While analysing the power dynamics at a family level and interrelationships in community in sociology, we found that prevalent gender stereotyping was consistently reinforced. Women's reproductive health needs were either exploited in the target approach of family planning or looked down upon as a cause for the spread of sexually transmitted infections in the community. Both the books were found lacking in class-gender specific research data about most health parameters.


Gender, equity and social justice get mentioned as one of the determinants of health and disease in Park. This makes one think that the book is serious about the concerns being increasingly voiced by women's movements, nationally and internationally. However, the authors of both the books do not live up to this promise. They pick up progressive ideas in isolation, but do not make them the main perspective of looking at problems in public health, especially those affecting women and the poor.

Women become visible to these authors only while discussing demography and population problems. High fertility, unmet needs for family planning and low acceptance of contraceptives have all been the result of women's ignorance, low literacy and traditional ways of life. Books on social medicine have reinforced the state's population policy and family planning programme without considering the social reality of women. Long duration hormonal contraceptives over which women have no control have been eulogised as safe, effective, requiring minimum or no motivation and the books have gone to the extent of giving wrong/contradictory information about the side effects of these

contraceptive methods. High maternal mortality and technical interventions to reduce this rate are emphasised in both the books but for each such maternal death, 20 women suffer from morbidities ranging from mild infections, cervical tears, to severe and lifelong debilitating complications like prolapse and genito urinary fistulas. Unless sustained quality health services and social measures are instituted to improve the status of women, they will continue to suffer from these avoidable maternal illnesses.

There is a need to incorporate the gender perspective throughout the five-and-half years of medical training and it has to be linked with teaching and learning of all medical subjects. This is essential for the inculcation of knowledge, attitudes and skills in medical students to understand, analyse and deal sensitively with women patients in the health care facility and in the community.

This could be facilitated if gender training is interwoven through existing committees in medical colleges like the Medical Education Technology Cell and Medical Ethics Committee. Regular meetings and sharing of ideas/suggestions at these academic fora could help streamline and sustain these efforts. Gender sensitisation workshops and CMEs need to be conducted regularly for medical teachers to inculcate gender sensitivity as a basic skill.

Medical students, during their family studies, learn to correlate social factors affecting health at the family level. Gender analysis can be incorporated in family studies to understanding community diagnoses. This will help students learn to plan certain health and social actions. 

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