

# Integrating gender into the curricula for health professionals

MEETING REPORT

4–6 December 2006



World Health  
Organization



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**Department of Gender, Women and Health (GWH),  
World Health Organization  
Geneva, Switzerland**

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# Introduction

In 2002, the World Health Organization adopted a gender policy committing itself to promoting gender equality and equity in health and to redressing health inequities that are a consequence of gender roles and unequal gender-relations in society. This was to be done through systematically analysing and addressing gender issues in the “planning, implementation, monitoring and evaluation of health policies, programmes, projects and research” (1). Key to achieving this goal is to make gender considerations an integral part of the pre-service training curricula of health professionals.

Health care personnel are uniquely placed to address issues related to gender and gender inequalities, sexuality, violence, and many culturally defined norms that increase vulnerability to human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and adversely affect the health of women in many societies. Although several gender training initiatives do exist in a number of settings, these tend to form part of in-service training, catering mainly to health professionals who have graduated and are already working in the health system. More recently, several groups have started work on integrating gender issues into the pre-service curricula, particularly those of medical, nursing and midwifery students.

In view of the centrality of integrating gender considerations into the curricula for health professionals to ensure that these are addressed in health policies and programmes, the World Health Organization’s department of Gender, Women and Health convened a consultation on this subject. The objectives of the meeting were to:

- review different approaches used in integrating gender considerations into curricula to identify strengths and weaknesses and lessons learned;
- develop consensus on the most effective proposed strategies and modalities for implementation of these approaches;
- develop recommendations based on the findings;
- identify existing materials that can be shared; and
- plan collaborative activities for further work in this area.

A review of existing work on and initiatives for integrating gender into the curricula of health professionals (doctors, nurses, midwives and public health practitioners) was conducted and presented as a background document to the meeting. A number of case examples of integrating gender considerations into the curricula for undergraduate medical students and for public health trainees were presented during the meeting. It was evident that initiatives for integrating gender into the curricula of health professionals were mainly focused on undergraduate medical education and to a much smaller extent, public health training, and that there were very few initiatives in developing countries. Moreover, most initiatives are still in their early stages, and their impact has yet to be assessed.

Based upon the review, case-studies and discussions at the meeting, and their own experiences, participants came up with basic lists of core gender competencies for physicians and public health professionals. They also made recommendations for steps to be taken by policy-makers and medical educators in order to move the agenda forward.

This report summarizes the discussion and final recommendations from the meeting. Section one presents an overview of experiences with integrating gender considerations into the curricula for health professionals, based on the background review carried out in preparation for the meeting. Section two presents case examples describing a range of initiatives presented during the meeting, on integrating gender considerations into the medical (nursing and midwifery) curriculum. Section 3 presents the results of deliberations during the consultation. It consists of a synthesis of lessons learned about enabling conditions and strategies for integrating gender issues into the curricula of health professionals; recommendations for core minimum gender competencies for physicians and public health professionals; and a consensus statement for moving the agenda forward.

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## SECTION 1

# Integrating gender into the curricula of health professionals: summary of a review of experiences

### 1.1 Background

Advocacy at the international level for women's health and against sexism (i.e. discrimination on the basis of sex) in the practice of medicine began to gain momentum in the mid-1970s, during the international women's decade of the United Nations. This had its roots in the feminist movement of the 1960s in many industrialized countries and in women's movements emerging out of progressive social movements in many developing countries during the 1970s. Women's health advocates challenged the biomedical model of health and illness and identified gender-based inequalities, in particular women's lack of control over their sexuality and reproduction, as a determinant of their poor health. During the 1970s and 1980s, women's health activists and advocates throughout the world sought to demystify medical knowledge and set up alternative models of care for women, models which viewed women holistically and not just as reproducers or carers of children. Domestic violence against women, women's occupational and mental health, sexual and reproductive health and rights beyond maternal health, were put on national health policy and programme agendas.

At the same time, women's right to equality and freedom from discrimination was gaining recognition in international fora, and legislation was adopted and affirmative action taken in many countries to encourage women's participation in education, employment and politics. Among other things, this contributed to increasing numbers of women enrolling in medical schools and in public health programmes.

Among factors that have influenced global thinking on gender issues in health were the agreements reached in the International Conference on Population and Development in Cairo, Egypt, in 1994 closely followed by those of the Fourth World Conference on Women in Beijing, China, in 1995. Both of these conferences identified gender-based inequalities as crucial determinants of health and called for the examination of these inequalities.

These major forces, combined with country-specific factors, led to the emergence of initiatives to address women's health issues, and to the recognition of the need for sensitivity to diversity and cultural and social factors including gender and gender power relations which affect health and illness worldwide.

Initiatives to address gender issues in health have included a number of attempts to build health professionals' capacity to identify and address sex- and gender-based differences in health care needs. However, many of these have been short in-service training initiatives, and only a few have been sustained interventions within pre-service training for medical, nursing or public health professionals.

This paper briefly summarizes key findings from a review of published literature in English on efforts to integrate gender considerations into the curricula of health professionals. Searches in Medline and Google were done using key words such as: women's health specialty; gender

and undergraduate medical education; gender and undergraduate medical curriculum; gender and nursing curriculum; gender and public health education; core competencies in gender; core competencies in women's health; gender and capacity building and medical faculty. Most of the published studies found were from the USA and others were from Australia, Canada and European countries. The review also drew on brief case-studies commissioned by the World Health Organization to document existing initiatives from Argentina, Canada, China, India, the Philippines, South Africa and the United States.

## **1.2 Initiatives to integrate gender and women's health issues into the curricula for health professionals**

Initiatives to integrate gender issues or women's health issues into the curricula of health professionals have included one or more of the following components:

- development and implementation of courses;
- curriculum development;
- capacity-building of faculty;
- advocacy for policy change pertaining to the curricula of health professionals.

The review of a cross-section of these experiences indicates that most of the work in this area has been done in relation to the undergraduate medical curriculum and within it, with respect to the women's health specialty (or the lack of it). Few examples of integration of gender into the nursing or public health curricula were identified.

The development of a women's health specialty, centred principally in the USA, has laid the foundation for the development of teaching modules that are multi-disciplinary and patient-centred rather than discipline-centred. It has also contributed to the development of competency-based curricula, module development and teaching and learning resources. Work has also been done on integrating education on intimate partner and other family violence into the undergraduate medical, nursing and midwifery curricula.

Varied strategies have been adopted for the integration of teaching on women's health issues and violence against women (particularly by intimate partners) into the curriculum. Often women's health is taught as free-standing modules during clerkship, clinical rotations or electives. A number of efforts have tried to introduce the issues of women's health or partner violence (Philippines) into the traditional undergraduate medical and nursing curricula through additions and modifications of individual lessons, courses and disciplines as well as through weaving of curricular themes of varying breadth throughout the curriculum. Drawing diagrams of interrelated concepts ("Concept-mapping") offers a tool for identifying areas for integration of women's health issues across disciplines. Another approach has been creating interdisciplinary curricula that are then integrated into the general curriculum. The set of "Core competencies for women's health care" developed by the Association of Professors of Gynecology and Obstetrics (APGO) are aimed at facilitating such a process and are a valuable resource.

Attempts to integrate gender considerations into the medical curriculum are more recent. There are two documented examples of integrating the study of gender across all years of the undergraduate medical curriculum. One in Monash University, Australia has integrated the subject into all five years of its new problem-based and patient-centred curriculum. The second example is the medical school at the Chulalongkorn University in Thailand. There have also been attempts to integrate gender considerations into a part of the curriculum for health professionals, as in Makerere University in Uganda, 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).

The Gender and Health Collaborative Curriculum Project in Canada has developed web-based modules as resources for course faculty who wish to integrate gender into their teaching and these may also be used by interested students. Other efforts at integrating gender have focused on creating an enabling environment and on capacity-building of medical educators.

### 1.3 Challenges and lessons learned

Some of the major challenges of such initiatives include institutional resistance and difficulties in involving key faculty and, in particular, male colleagues in this process. Another hurdle is the scarcity of faculty members in each institution who have the expertise to teach gender and women's health issues. The limited research on gender issues in health and women's health is another bottleneck reducing the extent to which evidence-based teaching on gender and health is possible.

Another significant barrier to be overcome in the process of integrating gender into the curricula of health professionals is availability of funding. Most of the projects and initiatives described are centred in Australia and North America. Although there may be no dearth of interest or awareness in Southern countries, difficulties have been encountered in initiating and sustaining projects to integrate gender into health professionals' curricula. These bottlenecks and challenges point to the need for advocacy for broader policy changes at the national and international levels and for funding guidelines or guidance to support these processes as well as funding to initiate and maintain such initiatives.

The following are some lessons that can be learnt from the review:

- *Start the process of integrating gender with undergraduate medical education*

Much work has already been done on the undergraduate medical curriculum, and it may be a good idea to consolidate these experiences and expand the work to other countries. Undergraduate medical education seems a strategic point at which the process of integrating gender may be begun. This is particularly the case given the shift to problem based learning in many settings. Nursing and midwifery schools are likely to follow suit if medical schools initiate the process.

- *Start with stand-alone modules (including web-based modules) while working at building faculty capacity and winning institutional and policy support*

Varied approaches to teaching women's health/gender issues have been tried – from stand-alone courses, to making this an integral part of the curriculum. Stand-alone courses seem a practical approach in the face of limited faculty expertise on women's health issues. However, such a strategy will reach only a small number of medical students each year

In some models of integration, the responsibility for instruction and assessment of particular aspects of the women's health curriculum are delegated to existing courses. Although this model reaches a broader audience than electives, it needs to be centrally coordinated and backed up with capacity building and support in terms of teaching and evaluation materials to assist faculty responsible for teaching.

Stand-alone modules and especially those that are web-based offer a good starting point. Despite their limitations, they can be used while efforts are under way to build the capacity of faculty, develop curricular resources and win institutional support for integrating gender across all years and disciplines.

- *Provide concrete recommendations and ready-to-use materials for course organizers*

Even when a medical educator has been convinced of the idea of integrating gender into the curriculum, the absence of concrete guidelines on how to go about this process, and difficulty in finding appropriate course materials could prove to be an important barrier. Ready-to-use materials and curricular support provided through web-based resources by a number of existing initiatives (e.g. APGO women's health competencies, and the Ontario Gender and Health curriculum) will help to overcome this barrier. These materials need to be identified and disseminated widely.

- *Promote institutional readiness*

Considerable preparatory work appears to be necessary before institutional support for integrating gender throughout the curriculum is available. Carefully thought-out and sustained advocacy with decision-makers, capacity-building and introductory workshops aimed at medical educators and students, and devising ways of integrating gender without overloading the existing curriculum would contribute to increasing institutional readiness for the process.

- *Take advantage of “windows of opportunity”:*

Larger curriculum changes such as the introduction of problem-based and patient-centred learning and the introduction of new courses offer windows of opportunities to integrate gender issues into the curriculum, and have been successfully used by a number of medical schools.

- *Advocacy is an urgent priority*

Gender-mainstreaming in health professionals’ curricula needs greater visibility in professional journals. In addition, it needs to be put on the agenda of international bodies such as the World Health Organization, health professionals’ associations and donors.

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## SECTION 2

# Approaches to integrating gender into the curricula of health professionals: case examples

This section presents some case examples of initiatives for integrating gender into the curricula for undergraduate and graduate medical education, and WHO's initiatives to integrate gender into the in-service training of health professionals.

Initiatives pertaining to undergraduate and graduate medical education may be classified into three main groups:

- development and implementation of courses;
- curriculum development;
- advocacy for policy changes pertaining to integrating gender into the curricula of health professionals.

### **2.1 Development and implementation of courses**

Five case examples of experiences with the development and implementation of courses which integrate gender were presented. The first two were examples of integrating gender into undergraduate medical curricula at the Monash University, Australia and the Chulalongkorn University, Thailand.

Two were examples of integrating specific topics within the undergraduate medical (and in some cases nursing and midwifery) curricula: sexual and reproductive health in Turkey, and domestic violence against women in the Philippines.

The fifth case example from Makerere University in Uganda described an attempt to integrate gender into one module of the undergraduate medical curriculum, namely, the community-based learning programme.

#### ***2.1.1 Integrating gender into the medical curriculum at Monash University, Australia***

##### ***Background***

The push to address gender issues in the context of the medical profession began with the shortage of rural doctors in Australia, and the government's sensitivity to voters' anxiety about access to doctors. Monash University was approached by the government to explore factors influencing women practising as doctors.

Jo Wainer, a feminist and women's health advocate with many years of experience, was entrusted with carrying out this project, funded by the Australian government. She and her team expanded the work on rural practitioners of medicine to uncovering how medical knowledge is created, and identifying the consequences of the historical exclusion of women as co-creators of this knowledge.

A window of opportunity to address this presented itself when the medical school of Monash University began a process of curriculum change to introduce problem-based learning.

### *Content and approach*

The objectives of integrating gender into the medical curriculum at Monash are to produce “gender-competent” doctors who can:

- read the medical literature through a gender lens;
- treat men and women competently, based on appropriate evidence;
- find a place for themselves in the profession, free of discrimination and honoured for the work they do;
- advocate for the poor and dispossessed.

Gender issues have been integrated into all the years of the undergraduate medical curriculum. The school has adopted a dual strategy which includes specific seminars on gender, but also integrates gender issues into tutorial and cases for teaching. Gender competence is included also in the assessment of doctors.<sup>1</sup>

The medical school of Monash University is also working towards restructuring the profession to include women. Military culture is embedded in medicine, and the toughening up process of medical school can be particularly abusive for women. The school is working to encourage women’s participation, for example, by creating formal structures for women to speak and allowing for interrupted and part-time training. Women are encouraged to maintain women’s culture and practice medicine differently, not to try to emulate men. Women in the medical profession are also encouraged to change medicine by contesting knowledge that excludes women’s perspectives and experiences and challenging science to include new ways of knowing.

### *Lessons learned*

In order to become effective advocates for integrating gender into the medical curriculum, it is crucial to understand the science and to be well-informed on the latest evidence. For example, it is desirable to develop 3–5 stories that can be told fluently in which the role of gender is compelling. It also helps if “the gender person” makes him/herself “useful” for example by volunteering to write case-studies, find literature, review documents, write exam questions and sit on curriculum committees.

There are a number of key players involved in the development and dissemination of medical knowledge. A strategy is needed to engage each of these groups:

- faculty hierarchy
- leadership of the curriculum
- course developers
- students
- tutors
- hospital and other clinicians.

For example, it is important to talk individually with key members in the faculty hierarchy and obtain their public support. Getting the vice-chancellor, the dean or the head of the curriculum committee to say gender is important is likely to help win support from other members of the faculty. Setting up international collaborations may also help gain the support of the deans and vice-chancellors because these enhance the prestige of the institution or university.

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<sup>1</sup> For more information, visit [www.med.monash.edu.au/gendermed](http://www.med.monash.edu.au/gendermed)

Support from students is perhaps the most important. Some strategies for attracting their support include:

- asking what they want;
- creating scenarios, presenting cases, and teaching opportunities that are clinically compelling to the students;
- writing cases in which lack of gender knowledge will result in injury or death for the patient;
- recognizing and working with the desire of the medical students to be competent doctors.

### ***2.1.2 Integrating gender into medical curriculum at the Chulalongkorn University, Thailand***

#### ***Background***

Gender was integrated into the curriculum for medical education in the Chulalongkorn medical school in Thailand following a number of steps. The first step was core group professional development in 2003–2004. The second step was to organize a workshop for medical educators and related health personnel in 2005. This was followed by three one-day workshops in late 2005, targeted at different levels to meet the varying needs of faculty members.

Two faculty members of Chulalongkorn medical school attended short courses for medical educators on Gender mainstreaming in medical education, organized in 2003 and 2004 by the Achutha Menon Centre for Health Science Studies, India.

The faculty members who had attended the course in India subsequently had a half-day meeting with core faculty and introduced the idea of integrating gender into the medical curriculum. Several one-to-one informal interactions with key faculty members helped build support for the idea. The next step was to hold a three-day workshop in 2005. The purpose of this workshop was to understand and learn how to integrate gender and rights into health services and medical education. Participants in the workshops included medical educators in preclinical and clinical medicine, nurses, social workers, public health practitioners from Chulalongkorn medical school, and staff from an NGO–Chulalongkorn collaborative centre to deal with child abuse.

This three-day workshop helped win support from a wider group of staff members from the medical school. A follow-up study three months after the workshop (71% response rate) showed that 81 per cent of the participants reported having an improved understanding of the concept of gender, 50–60 per cent of participants were applying these concepts to teaching and service delivery, and 63 per cent had implemented new practices or projects integrating gender issues. Between 15 and 25 per cent said that they applied their understanding of gender to their personal lives.

The third step consisted of running one-day gender workshops for faculty members at the beginner, intermediate and advanced levels. The beginners' workshop introduced the concept of gender and located gender among other social determinants of health. The intermediate workshop introduced a tool for gender analysis in health and included exercises for applying this tool to different health conditions. The advanced course included exercises in integrating gender into teaching and service delivery and applying gender analysis tools to analyse patient cases.

These steps paved the way for integrating gender issues into the medical curriculum.

#### ***Content and approach***

The undergraduate medical curriculum is divided up as follows:

- Year 1: basic sciences
- Years 2–3: preclinical sciences
- Years 4–5: clinical sciences
- Year 6: externship.

Moreover, seven vertical axes of topics are designed to be integrated into the curriculum from year 1 to year 6. These vertical axes included topics such as holistic care, medical ethics and professional laws, critical thinking and communication skills.

Gender was integrated into all six years of the curriculum. In the preclinical years, gender topics include:

- family and social factors influencing behaviours, including socioeconomic status, ethnicity and gender;
- sexuality;
- ethnic factors influencing the abnormal process of organs/systems;
- gender identity, sexual orientation and sexuality.

Gender topics covered in the clinical years are:

- risk factors for disease occurrence: age, race, gender and socioeconomic status;
- health promotion in adolescence: sexuality;
- sexual abuse, child abuse, problems related to sexuality.

A variety of teaching methods are used to teach gender issues. These include: case discussion, problem-based learning, large group teaching and lectures.

One of the most important aspects of integrating gender into the medical curriculum has been its inclusion in assessments. For example, about 28–30 items on gender are included among 300 test items in Part I of the licensing examination conducted after the first three years of medical school.

### *Outcome and lessons learned*

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. However, when asked if they would like to be a trainer in gender most of them replied

negatively saying that because of time constraints they were not able to implement some of the newly planned gender activities.

One of the major barriers to taking this work forward was the very limited evidence available on gender pertaining to many topics being taught in the medical school. It was found to be absolutely vital to increase the body of knowledge on gender as it affects different health conditions and dimensions of health. Establishment of research centres dedicated to such studies would be a good starting point. Another area for action would be publication and wide dissemination of experiences in integrating gender into the curricula for health professionals in different settings.

### ***2.1.3 Strengthening sexual and reproductive health pre-service training capacity in Turkey***

#### *Background*

The strengthening sexual and reproductive health (SRH) pre-service training capacity is a sub-project of the programme on reproductive health in Turkey. At the time the SRH pre-service training capacity project was developed, most medical schools were in the process of changing their curricula and evaluation methods. Therefore, the project came at a time of change and this provided a very effective entry point. Although the project is focused on sexual and reproductive health, gender issues are addressed within this framework. The project was piloted-tested in three universities.

The project consisted of four phases:

- a needs assessment study;
- development of curriculum;
- training of trainers; and
- monitoring and evaluation.

In the first phase, a needs assessment study was undertaken to determine the current status of SRH education and training in pilot schools, and to assess the skill levels and attitudes of medical, nursing and midwifery educators who were to participate in the project as teachers.

For the second phase, a Core Curriculum Group was established to reach agreement on the principles and topics, as well as the components of the curriculum. It was decided that the curriculum would employ a multidisciplinary approach, involve innovative and participatory education methods, begin in the early years of medical education and use various assessment methods.

In the third phase, training of trainers was provided in three phases at each pilot university. Each session was conducted by three master trainers for five days with the participation of mid-level tutors from medical, nursing and midwifery schools.

Only educators of health professionals were involved in the process – students were not. A broad curriculum was presented to the schools, and each school adapted it to its own situation.

Medical, nursing and midwifery schools in three sites (9 schools in total) have started the SRH integration from the first year of their programme, and the integration process will continue over future years. The programme has yet to be formally evaluated.

### *Content and approach*

An important learning goal of the curriculum is that “at the end of the medical education, graduates will be able to provide sexual and reproductive health services by being aware of the effects of gender issues on sexual and reproductive health and by paying attention to gender equity.”

The learning objectives of the curriculum are that at the end of their medical education students will be able to:

- explain “gender” and related concepts
- explain the effects of gender discrimination on the right to exist, on health, and especially on reproductive health;
- explain the importance of considering the needs of men and women during the provision of health services;
- appraise health indicators from a gender perspective;
- show a respectful attitude towards gender and gender equity;
- provide reproductive health services – at all levels of health service – by considering gender and gender equity.

### *Lessons learned*

Some of the factors that facilitated the implementation of this project were: approval and support from university administration obtained at the earliest stage of the project; backup by the project team for implementation of the integration; and the involvement of staff from the participating schools in the entire process through the trainers’ training, so that responsibility for implementation within their respective schools rested with them.

Early feedback from the project indicates that the curriculum has fitted best into nursing and midwifery schools, and that the integration into medical curricula still needs modifications. Among the major challenges to the integration process have been the overloaded current curriculum, which causes resistance to any new additions, and the need for training of faculty to

include innovative methods of teaching. Also, standardization of the curriculum was not feasible. Each school adapted the curriculum in its own way and each was therefore running a somewhat different programme to the others. The larger question that remained was how to win support for integrating sexual and reproductive health and gender into the curricula of health professionals beyond the project, in other words, how to “convince the others”.

#### ***2.1.4 Integrating intimate partner and other family violence issues into the medical and nursing curriculum in the Philippines***

##### *Background*

The Task Force on Social Science and Reproductive health at the La Salle University, the Philippines, felt that health professionals, including physicians, were not adequately trained to handle cases of family violence beyond treating wounds and other physical problems of survivors of violence. Therefore, in October 1996, the Task Force organised a four-day seminar for the deans and curriculum planners of 10 health training institutions. The training seminar was entitled “Improving the capability of health care systems to deal with family violence”. The Task Force’s Committee on Family Violence Issues held a follow-up meeting in February 1997 attended by nine deans of medical and nursing schools to determine how family violence issues could be integrated into their curricula. The Cebu Doctors’ University College of Medicine agreed to be the pilot school for this initiative.

The expected outputs of the curriculum revision process included the development of teaching modules for undergraduate medical education, student modules, resource guides, up-to-date lists of bills and laws relating to violence, a local resource inventory and a list of reading materials. Following gender sensitivity training for faculty, staff were asked to volunteer to write teaching modules.

Those writing teaching and student modules were provided with training on how to develop these modules by the University’s Graduate School. This was in response to the difficulty many of them reported in writing teaching modules. The modules written by faculty members were reviewed and revised by members of the Task Force, who were also present in the classes to observe the introduction of the modules and obtain feedback from students.

##### *Content and approach*

The main objective for the integration of family violence issues into the curricula of health professionals was to create “culture-sensitive, gender-sensitive, and compassionate physicians with effective communication and counselling skills”.

Specific competencies were also identified, such as:

- to understand the roots of violence in the context of culture, gender and other social aspects;
- to gain knowledge and skills related to:
  - primary interventions, particularly collaborating and networking with other professionals and developing follow-up skills;
  - secondary interventions, specifically crisis interventions, such as the identification of victims of violence, understanding basic legal procedures, preservation of evidence and referral and follow-up competencies.

Domestic and family violence issues were integrated into the course material of the first three years of undergraduate medical education as follows:

- Year 1: integrated into preventive medicine, psychiatry and anatomy;
- Year 2: integrated into preventive medicine, psychopathology and physical diagnosis;
- Year 3: integrated into preventive medicine, clinical psychiatry, internal medicine, paediatrics, surgery, gynaecology and legal medicine.

In all, 38.5 teaching hours are dedicated during these three years to meeting the objectives of enhancing the capability of physicians to address intimate partner and family violence.

Teaching strategies included a mix of traditional methods such as lectures, and innovative methods including films, group discussion, role-playing, case discussion and reading materials on domestic and family violence. A section of the library is dedicated to materials on domestic and family violence.

### *Outcome and lessons learned*

Students were generally enthusiastic about the new content. They showed interest in the subject matter, asked more questions than in other classes and participated actively in class discussions. They also seemed to become more open about discussing their personal problems related to domestic and family violence.

Faculty members had no difficulty in teaching the topics, but some felt that they were inadequate as counsellors to their students. Therefore, additional gender sensitivity training sessions were held for the faculty. The University College Guidance Office and Student Affairs Office were also involved in the project. Many faculty members have become advocates of the movement to stop violence.

The lessons learned from this process on workable strategies for integrating issues such as domestic violence and gender included the following:

- It is important to look at national priorities. For example, if a government is concerned about violence, this provides a good entry point from which to convince deans of medical colleges.
- The Dean should obtain the full support of the administration before embarking on the project.
- From the start of the project, the Dean should employ a participatory approach with the faculty to ensure their cooperation.
- Collaboration with national organizations, especially women's groups and NGOs working on these issues plays an important role in ensuring expert inputs and support for faculty members embarking on curriculum development and the teaching of an unfamiliar topic. The role of women's organizations and NGOs, in most cases as initiators of the process of gender mainstreaming, needs to be recognized and respected.
- Faculty members who participate in module-writing need to be allocated time to do this, by making suitable modifications in the timetable and reallocating responsibilities. This will ensure that faculty members are not overburdened. Some form of reward or recognition would provide an additional incentive.
- Non-teaching personnel, the guidance office, student affairs office, and all the faculty members, as well as teachers and module writers, should undergo periodic gender sensitivity training.
- The medical school should set up or link with a facility to provide support to survivors of domestic and family violence.

### ***2.1.5 Gender mainstreaming in the faculty of medicine, Makerere University, Uganda***

#### *Background*

Makerere University in Uganda made gender mainstreaming one of the priority areas in its strategic plan for 2001–2007. The Makerere University Gender Mainstreaming division is a unit under the academic registrar's department and was established in 2002. Its aim is to "gender sensitize" the entire university community – both staff and students – and to put mechanisms in place to ensure that university policies and practices are gender sensitive.

The specific objectives of the gender mainstreaming division are: to promote a gender-friendly environment for staff and students, ensure a sex balance in student enrolment, advocate increased recruitment of female staff to address the gender gap in staffing, integrate gender issues into the university curriculum and advocate integrating gender considerations into research.

Activities to increase knowledge and awareness of gender issues include the organization of gender sensitization workshops for deans, directors, heads of departments and academic staff. There are also sensitization campaigns for students. Makerere University has established 29 sentinel sites which serve as planning, implementation, capacity building and monitoring sites related to the gender mainstreaming programme. Site locations include students' halls of residence, administrative departments and faculties. The university has also encouraged the enrolment of a larger number of female students.

### *Content and approach*

In 2003, the Faculty of Medicine of Makerere University introduced changes in the forms of teaching and learning with an emphasis on innovative ways of learning such as student-centred learning, problem-based learning and community based education and service (COBES).

COBES is a four-year course, during which students spend 4–6 weeks each year at rural health centres, attend tutorials and are assigned to households. COBES has been the main focus for integrating gender into the medical curriculum. COBES is a new curriculum and is therefore still flexible, allowing for integration of gender issues in different areas. Through the COBES programme, students have contact with the community and are able to explore the impact of gender power relations, the division of labour and access to family and community resources on health.

During their house visits, students are asked to find out what is happening in the home that affects the health of the household, what kinds of illnesses are experienced, and what the responses are to these health problems. They look into the division of labour within the household, and gender differences in the experience of illness, factors affecting illnesses and responses to it. They have to plan a project in the fourth year that will address specific health problems identified in the community.

The course covers topics such as gender and health, gender-based violence, sexual abuse and reproductive health. It also introduces a gender perspective in community research methods (data collection and participatory approaches), data analysis and report writing, and proposal development, monitoring and evaluation.

### *Outcome and lessons learned*

The challenges identified in implementing the programme include the lack of training in gender among teaching staff and hence the limited capacity to instruct students on gender analysis.

Gender sensitization has not been fully accepted as a useful academic exercise and therefore there has also been some resistance to its integration into the medical curriculum. Consequently, although gender has been integrated into the COBES curriculum, there are still a number of gender related gaps.

Resistance to integrating gender into the medical curriculum comes from two main sources. The first is those who are opposed to the change from traditional to problem-based-learning (PBL), because it is within this context that gender has been introduced. PBL is perceived as causing staff redundancies because of its reliance on self-learning.

The other source of resistance is clinicians. Students enter the clinical stream of medical education in their fourth year. Clinicians find it difficult to adopt the new approaches needed to integrate gender issues within their teaching, for example, teaching students to be able to look at patterns of injuries, and then at the underlying social and gender factors.

Those responsible for implementing the project in the medical faculty believe that in order to take the process forward, it will be necessary to:

- create a task force to oversee the process;
- identify and implement strategies to address resistance;
- engage in a review of the gender-integrated curriculum and make appropriate changes;
- provide continuous training and support to faculty responsible for teaching the gender-integrated curriculum;
- conduct more gender-sensitive research in order to expand the evidence on which to base teaching;
- secure adequate and stable funding.

## **2.2 Curriculum development**

### **2.2.1 The Ontario Gender and Health Collaborative Curriculum**

#### *Background*

Attempts to integrate women’s health issues in the curriculum in Canada began in Ontario with the Women’s Health Interschool Committee, which in 1995 published a template of goals for women’s health education in medical schools. The main focus was on attitudes and behaviours that foster gender equity in medical care. The work of the Women’s Health Interschool Committee was subsequently taken on by the Gender Issues Committee (GIC) of the Council of Ontario Faculties of Medicine (GIC-COFM). The six collaborating medical schools sit together at COFM. The GIC was one of several subcommittees of COFM, and is charged with raising awareness of and responsiveness to gender as a determinant of health and encouraging sensitivity to gender issues among member schools.

In 2002, the GIC-COFM collaborated with the Undergraduate education Committee of Undergraduate Deans (UE-COFM) on the Gender and Health Collaborative Curriculum Project (GHCCP). This curriculum was officially launched on 1 May 2006.

The Gender and health curriculum developed by the Council of Ontario Faculties of Medicine is a web based learning resource that was designed by and for Ontario undergraduate medical students and faculty in all domains of medical education.<sup>1</sup> This integrated curriculum has been designed to be a common provincial resource for use by all Ontario medical schools.

The project is staffed by 25 medical students engaged in content research and module creation and six Site Coordinators responsible for student supervision, module creation and integration of modules. The project leader provides the overall vision, allocates responsibility and organizes the workload.

#### *Content and approach*

The goal of the project is to improve health and health care through the development of a collaborative, web-enabled medical curriculum that integrates gender and health into all aspects of medical education. A further aim is to help medical students to be more sensitive to the social context and needs of patients.

The curriculum includes 16 modules covering an introduction to the role of gender in health and the role of gender in specific domains (examples include cardiovascular disease, lung cancer, poverty, sex and sexuality and nine others). The curriculum also addresses issues such as the social determinants of health, advocacy, professionalism, boundaries, health as a human right, poverty and social accountability. There are additional “toolbox modules” to assist learners in thinking critically about gender in other areas of health and medical education.

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<sup>1</sup> The curriculum is available from [www.genderandhealth.ca](http://www.genderandhealth.ca)

The curriculum focuses on setting objectives for each module, including current information and demonstrating concepts with case-studies. Vertically integrated through all modules of the curriculum are the themes of:

- social determinants of health
- advocacy
- professionalism
- boundaries
- health as a human right
- poverty
- social accountability.

Concepts are conveyed in a text-based narrative, complemented by multimedia and links to other options for in-depth exploration. There are also multimedia presentations and videos, interactive activities and self-reflection exercises.

The curriculum is designed to be evidence-based, thorough and flexible. It is available for use by anyone with access to the Internet and can be added to presentations and lectures. The programme also includes a “self authoring tool” that allows educators to modify existing modules and create new ones.

### *Outcome and lessons learned*

The portfolio feature of the web site tracks learners’ use of the web site and provides a “record of engagement” with the material. As of November 2006, there were 5000 different visitors per month and more than 200 000 hits per month

A variety of changes are discernable in those from the medical schools in Ontario using this curriculum. These range from adoption of gender objectives to introducing gender and health courses and electives.

The success of Ontario’s gender and health curriculum owes itself to a number of curricular features. Foremost among these is the ease of use and flexibility of the material, offering a variety of learning options for different levels of learners. There is no competition for teaching time with any other subject or topic, making gaining the support of key faculty easier. The inclusion of “medical” modules providing evidence on gender dimensions of specific health conditions and problems has given the curriculum credibility among clinicians. Likewise, the gender and health curriculum addresses existing curricular needs related to social accountability, and fits into the goals of medical education.

A number of other factors which have contributed to the project’s success and are identified as important for other attempts at integrating gender into medical curricula include:

- effective leadership;
- a supportive group developing the curricula;
- involvement of the target audience in curriculum development;
- identifying “champions” who can support the initiative.

There is scope for collaborating with other similar initiatives around the world, building on one another’s strengths and using the web site of the Ontario project as common space from which resources for teaching gender in the medical curriculum may be accessed.

### **2.2.2 Developing women’s health competencies, USA**

#### *Background*

Women’s health as a specialty first developed in the United States during the 1990s. The women’s health approach focuses on the health needs of diverse groups of women throughout their lives and due attention is given to the ways in which gender power inequalities impact on women’s

health. This approach also seeks to demystify medical knowledge and validate the knowledge and insights of ordinary women in matters concerning their well-being and illness.

Women's health specialization offers an excellent model for educational change, being interdisciplinary and having a patient-centred perspective. The Association of Professors of Gynaecology and Obstetrics (APGO), an organization that addresses faculty development and student education, spearheaded a process for the development of a competency-based curriculum in women's health.

### *Content and approach*

The curriculum developed by APGO is organized around eight core competencies in women's health which would be expected of a physician catering to women's health needs (Box 1). The APGO also developed learning objectives for different levels of competency, identified evaluation tools and made links to residency competencies already in existence. Based on these eight competencies, a web-based "curriculum-builder" has been developed to help the user to identify gender and women's health objectives pertaining to any health topic, to develop topics for inclusion across various disciplines in the medical curriculum and to develop relevant resources for teaching.<sup>1</sup>

#### **BOX 1. APGO'S CORE COMPETENCIES IN WOMEN'S HEALTH**

**The student who is competent in women's health and health will demonstrate the ability to:**

1. Explain sex and gender differences in normal development and pathophysiology as they apply to prevention and management of diseases.
  - a. Compare differences in biological functions, development and pharmacological response in males and females.
  - b. Discuss the pathophysiology, etiology, differential diagnosis and treatment options for conditions that are more common, more serious, or have interventions that are different in women.
  - c. Discuss the pathophysiology, etiology, differential diagnosis and treatment options for conditions that are specific to women.
2. Effectively communicate with patients, demonstrating awareness of gender and cultural differences.
3. Perform a sex-specific and gender-appropriate physical examination.
4. Discuss the impact of gender-based societal and cultural roles and context on health care and on women.
5. Identify and assist victims of physical, emotional and sexual violence and abuse.
6. Assess and counsel for reduction of risk, including lifestyle changes and genetic testing.
7. Access and critically evaluate new information and adopt best practices that incorporate knowledge of sex and gender differences in health and disease.
8. Discuss the impact of health care delivery systems on populations and individuals receiving health care.

Source: *Women's health care competencies* ([www.Apgo.org/wheocomp](http://www.Apgo.org/wheocomp), accessed 10 November 2006).

<sup>1</sup> To use the curriculum builder, go to [www.apgo.org/wheocomp](http://www.apgo.org/wheocomp)

### *Outcome and lessons learned*

To encourage medical schools to integrate gender into their curricula, APGO issued a call for grants. These grants were fairly modest and were for implementation, not for design and planning. To qualify for a grant, medical schools had to have already assessed their curriculum.

The APGO curriculum on women's health has found varied applications in different settings. For example, the Indiana University School of Medicine offers web-based teaching on women's health based on the APGO women's health competencies. The medical school of the University of North Carolina at Chapel Hill offers an interdisciplinary elective on women's health for third- and fourth-year medical students, housed in the departments of Obstetrics and Gynaecology, Internal medicine and Family medicine. The medical schools in Colorado, Minnesota and Ohio weave lessons in women's health throughout their 4-year curricula engaging a variety of teachers from different disciplines.

One important lesson learned from this project is that innovation is more likely when leaders make it easy and useful. By making available a ready-to-use curriculum development tool, the APGO was able to encourage many medical educators to integrate gender and women's health into their teaching. The ultimate objective of transforming curricula however, takes a long time – always more time than anticipated at the beginning.

## **2.3 Integrating gender into accreditation and standards: The Residency Education Initiative of "Physicians for Reproductive Choice", United States**

### *Background*

The Residency education initiative of "Physicians for Reproductive Choice" (PRCH) exists to ensure that all people have the knowledge, access to quality services and freedom to make their own reproductive health decisions.

The goal of PRCH's residency education initiative is to integrate evidence-based sexual and reproductive health education into residency education in seven specialties: adolescent medicine, emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics and psychiatry. The aim is to ensure that residents receive education in sexual and reproductive health issues that reflect the unique scope of practice, educational models and clinical responsibilities of each specialty.

The decision to focus on residency education was based on a number of considerations. Accreditation standards are incredibly powerful in the USA, as universities do not want to lose their accreditation status. The PRCH assessed accreditation in the USA at the following levels – undergraduate, graduate and continuing medical education. While looking at the residency review process, they realized that this offered a good entry point for ensuring that sexual and reproductive health issues become a part of accreditation requirements. This was partly because residency reviews were relatively quiet processes that were far less public than undergraduate accreditation. PRCH also had a number of contacts and allies on residency review committees.

### *Strategies*

The project aims to influence the Residency Review Committees (RRCs), which are responsible for reviewing and revising curricula for residents, to ensure that sexual and reproductive health is put on the agenda. The strategy adopted to achieve this aim is to set up a high-powered national advisory committee, the Residency Education Initiative National Advisory Committee (REINAC) consisting of those with the expertise and influence to move the agenda forward and guide the project. Members of REINAC include executive officers of national medical associations, medical board members, RRC members, residency directors and experts in sexual and reproductive health.

REINAC leaders work together with members of the specialty subgroups to identify the most suitable strategies to make the case for including sexual and reproductive health within different specialties.

For example, when contraception, options counselling and family violence were added as new areas in the RRC requirements for family medicine, the project announced awards for best practice in residency training in these areas. They sent out an announcement of a grant, created a committee of experts to review all submissions and arranged for the best results to be included on a national family medicine web page.

Another project is the Adolescent Health Project, a collaboration between 14 national medical organizations led by PRCH. The project has created a reproductive health curriculum which has been made available in the form of CDs distributed nationally. The Residency Education Initiative has been putting up nominees to the RRCs in all six specialty areas, and some of its nominees have been included in RRCs. They will now act as advocates for including sexual and reproductive health issues as part of accreditation requirements for residency training.

## **2.4 Integrating gender into in-service training for health professionals**

### ***2.4.1 Training in gender and health for members of Medical Women's International Association***

The overall mandate of the Medical Women's International Association (MWIA) is the "health of our patients" via clinical and academic work, advocacy, fundraising and the support of women doctors. MWIA is interested in gender mainstreaming because understanding gender issues has a positive effect on health.

The MWIA developed a training manual for gender mainstreaming in health in 2001.<sup>1</sup> The manual introduces concepts and provides case-studies illustrating the application of these concepts. Based on this manual, MWIA have held gender workshops in 12 countries: Alaska, Argentina, China, Province of Taiwan, Georgia, England, Germany, Ghana, Japan, the Philippines, the Republic of Korea, Uganda and Zambia.

The experience of holding the gender workshops in many different contexts made the MWIA realize the importance not only of the gender, but also of the culture of the patient and the physician. It also highlighted the importance of devising a training module that would be robust enough to be modified for many cultures and religions.

Although MWIA started the training activity with the idea that the gender of the patient and the physician are important for clinicians, academics and health planners, it soon became clear to them that they also needed to incorporate leadership and advocacy skills for medical women in these training workshops, and have subsequently done so.

The MWIA have also actively participated in advocating internationally for the integration of gender into medical education and health policies and programmes.

More recently, the MWIA has created an information package on gender and culture competence in medical education. There is a plan to distribute this package to all medical school deans in Australia. This package outlines gender differences in areas such as cardiovascular disease and other chronic conditions such as migraines, as well as drugs and alcohol and psychiatry.

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<sup>1</sup> [www.mwia.net](http://www.mwia.net)

### 2.4.2 The WHO training curriculum on gender and rights in reproductive health

The WHO training curriculum “Transforming health systems: gender and rights in reproductive health”<sup>1</sup> started in 1996 as a collaborative project between the Women’s Health Project of the University of Witwatersrand in South Africa, The Harvard School of Public Health and the World Health Organization.

The goal of this curriculum is to build institutional capacity in training institutions worldwide to offer regionally appropriate, high-quality training in gender and rights and health. The curriculum is a session-based and case-based training resource for health trainers on how to promote gender equity and reproductive rights through the use of evidence, policy development and service delivery. The curriculum is aimed at health managers, planners, policy-makers and others with responsibilities in reproductive health.

The curriculum is organized into six modules. The first three, called the “foundation modules” introduce the concepts of gender and other social determinants of health, and rights. The next three modules are application modules, illustrating the application of gender and rights concepts in evidence and information, policies and programmes and the delivery of health care services.

Gender and rights are woven into every module to help participants internalize gender and rights concepts. Sexual and reproductive health issues are the subject of all case-studies and practical material. Thus, for example, in the policy module, population policies are assessed from a gender perspective, while in the evidence module, studies on maternal mortality are examined to see if gender issues have been addressed. Participatory methodology is integral to the curriculum.

The course has been run in Argentina (1999, 2004, 2005), Australia (1999–2005), Burkina Faso (2006), China (1999, 2004, 2005), Kazakhstan (2004, 2005), Kenya (1999–2006), Malaysia (2005, 2006), Myanmar (2003), South Africa (1997–2003) and Sudan (2004–2007).

Most of the participants have been health managers from national and provincial health departments, and staff of international agencies such as the UNFPA and WHO. Evaluations indicate that participants report having gained important analytical and advocacy skills that will be useful for changing practices and policies in their work.

Currently the curriculum and courses are available in English, French, Russian and Spanish and the Arabic version is under way. The curriculum has also been adapted or drawn on to develop many related curricula, for example for the *Gender and rights in maternal and reproductive health curricula* developed with a focus on maternal health. A curriculum aimed at medical educators on gender mainstreaming in medical education has also been developed based on this curriculum.

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<sup>1</sup> Available from [www.who.int/reproductive-health/publications/transforming\\_healthsystems\\_gender/index.html](http://www.who.int/reproductive-health/publications/transforming_healthsystems_gender/index.html)

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## SECTION 3

# Conclusions and recommendations

### 3.1 Strategies for creating an enabling environment for integrating gender into the medical curriculum

#### *Strengthening the evidence-base on gender and health*

- As research and evidence is critical to changing attitudes in medicine, there is a need to strengthen the evidence base on gender differences and gender-based inequities in health.
- All available evidence, including unpublished studies and “grey” literature, need to be reviewed for relevant findings and experiences. In addition, evidence on gender is often embedded in articles in medical journals which do not address gender as a main issue and these can provide important information. This information may be found in tables providing data disaggregated by sex, or as one of several independent variables examined.
- It is necessary to invest in generating new evidence, for example by encouraging PhD students and other researchers to address gender issues as a part of their research, and by providing technical support on “engendering” health research.
- As there is a lack of evidence on approaches to, and the impact of integrating gender in health policies and programmes and in the training of health professionals, urgent efforts are needed to fill this gap in knowledge through detailed documentation of the existing initiatives.
- Build alliances and create partnerships between individuals and institutions working on integrating gender into health curricula.

#### *Gaining the support of influential people*

- Identify the powerful actors and encourage them to support/participate in the programme/initiative.
- Identify a dean so that structures can be developed and budget assigned for integrating gender into the curriculum. Deans are convinced by evidence, accreditation, standards, political circumstances and funding opportunities. A convinced dean will also be able to champion the cause with other deans.
- Review existing international accreditation standards and ensure that gender competencies are included in these.
- Present evidence on the outcome of integrating gender into medical/health professionals’ curricula as this is important to gaining support for integrating gender and for sustaining initiatives.

- Request some key individuals from the medical establishment to teach some of the classes with integrated gender content. For example, it may be very helpful for doctors to talk to other doctors, as they are more likely to listen to those within the profession.
- Language is also key. In some instances it may be more effective to speak about women's health and in others, about gender.

### *Ensuring sustained support*

- Build leadership among junior and middle management staff and faculty as they will be the leaders in the future.
- Create "temperate radicals" who can work within the system and change it.
- Create tools that make it easier for instructors to use materials. Use materials that are easily available.
- Engage students, especially those who recognize the value of this material and who will lobby for more.
- Ensure that gender is embedded or mainstreamed within the curriculum, and included in the assessments. Students understand "add-on" courses for what they are – i.e. not essential. If gender competencies are not graded or counted in some way they will not be considered as important.
- Network and collaborate across countries and regions. Share experiences and create a collaborative web space for sharing resources.

## **3.2 Recommendations**

### ***3.2.1 Minimum core gender competencies for physicians***

A gender-competent physician will:

- Demonstrate an understanding of basic gender concepts: gender power relations, gender roles, access and control, manifestations of gender bias, gender equity and equality and of gender as one of the many social determinants of health.
- Be able to explain sex and gender differences in normal development, health and illness (psychopathology and pathophysiology) as they apply to prevention and management of health problems.
- Effectively communicate with patients, demonstrating awareness of the doctor-patient power differential and gender and cultural differences. This will be demonstrated, for example, through use of language by the provider in a way that minimizes power imbalances, validates patient experiences and minimizes gender stereotypes.
- Perform a sex- and age-appropriate and culturally sensitive physical examination
- Discuss the impact of gender-based societal and cultural roles and beliefs on health and health care of patients.
- Discuss the impact of gender-based societal and cultural roles and beliefs on the health and well-being of care providers.
- Identify and assist victims of gender-based violence and abuse.
- Assess and counsel patients for sex- and gender-appropriate reduction of risk, including lifestyle changes and genetic testing.
- Assess and critically evaluate new information through a "gender lens": identifying gender biases and gaps; and adopt best practices that incorporate knowledge of sex and gender differences in health and disease.

- 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.

### **3.2.2 Minimum core gender competencies for public health professionals**

A gender-competent public health professional will be able to:

- Recognize the effects of one's own gender identity and biases on public health work.
- Recognize the importance of a gender perspective to meet public health objectives and outcomes.
- Identify and respect gender differences and gender diversity.
- Work towards reducing gender inequalities by situating gender within a framework of the social determinants of health using an equity and rights perspective.
- Evaluate existing information, research, policies and programmes using gender analysis including gender analysis of institutions to determine the power dynamics that shape these processes.
- Develop research, policies and programmes that integrate gender perspectives and are gender transformative.
- Incorporate gender within indicators for monitoring information, research, policies and programmes.
- Identify key partners and work collaboratively towards building a gender perspective to meet public health objectives.
- Develop communication and advocacy skills that help them to become gender competent agents of change.
- Recognize the impact of a well-functioning health system including allocation and budgetary issues and the implications of other social sector allocations for gender equity in public health.

### **3.2.3 Consensus statement**

WHO hosted a meeting of global leaders in medical education, attended by representatives from 24 countries and all WHO regions from 4–6 December, 2006.

What follows is the consensus statement on gender<sup>1</sup> and medical education.

**In the context of generally accepted agreements and consensus statements, in particular:**

1. The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) 1981<sup>2</sup> and other human rights treaties,<sup>3</sup> The Beijing Platform for Action 1995,<sup>4</sup> The UN Millennium Development Goals<sup>5</sup>

<sup>1</sup> Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

<sup>2</sup> <http://www.ohchr.org/english/law/cedaw.htm>

<sup>3</sup> See for example, <http://www.ohchr.org/english/law/ccpr.htm>; [http://www.unhchr.ch/html/menu3/b/a\\_ceschr.htm](http://www.unhchr.ch/html/menu3/b/a_ceschr.htm); <http://www.unhchr.ch/html/menu3/b/k2crc.htm>; <http://www.unhchr.ch/udhr/index.htm>

<sup>4</sup> <http://www.un.org/womenwatch/daw/beijing/platform/declar.htm>

<sup>5</sup> <http://www.un.org/millenniumgoals/>

2. The WHO strategy for integrating gender analysis and actions into the work of WHO<sup>1</sup>
3. And the recognition of the priorities identified by the new Director-General of WHO<sup>2</sup>

**Recognizing that:**

1. Determinants of health such as biology, gender, socioeconomic status, ethnicity and age have significant and measurable effects on the health of all people
2. These and other contextual factors such as political, economic and cultural climate affect how health care is organized, accessed, provided and received
3. Gender intersects all other determinants of health, and impacts significantly on health outcomes
4. Gender norms, values and power relations of both the provider and patient influence the nature and quality of their interaction
5. Education of health professionals, including doctors, nurses and public health workers, provides the basis of how health care is organized, accessed, provided and received

**Recommend therefore, that health educators and institutions:**

1. Ensure that doctors and other health professionals are offered training with a gender-competent and human rights perspective
2. Encourage and train health professionals to advocate for gender equality and health equity and to serve as agents for change
3. Offer this training across all disciplines and along the learning continuum from undergraduate through continuing professional development
4. Work towards establishing accreditation standards on gender competencies<sup>8</sup> within curricula
5. Establish networks for supporting gender competency within and across institutions, disciplines and sectors in order to promote sharing of resources and integration models in gender and health
6. Support, document and evaluate educational initiatives in gender and health and prioritize capacity building for teaching in this area
7. Support the integration of gender into all research and support new research initiatives in gender and health including analysis of existing databases.

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<sup>1</sup> <http://www.un.org/womenwatch/daw/csw/GMS.PDF>

<sup>2</sup> <http://unsystemceb.org/statements/0046854e/view>

<sup>3</sup> **Competency** is noted when a student is observed **performing** a task or function that has been established as a standard by the profession. The achievement of professional competency requires the articulation of learning objectives as observable, measurable **outcomes** for a specific level of student performance. Such specific detailing of performance expectations defines educational competencies. They are verified on the basis of **evidence** documenting student achievement, and must be clearly communicated to students, faculty and institutional leaders prior to assessment. Available at: <http://wheocomp.apgo.org/definitions.cfm>

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ANNEX A

# Agenda

## Meeting on Integrating Gender into the Curricula for Health Professionals

4–6 December 2006, World Health Organization, Geneva, Switzerland

### I. DAY 1 (MONDAY 4 DECEMBER 2006)

**MODERATOR: BARBARA KLUGMAN**

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#### MORNING SESSION

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8:30–9:00 Registration of participants

9:00–10:00 Welcome remarks

**Manuel Dayrit (WHO)**

Director, Human Resources for Health

Background to the meeting and introductions

**Claudia Garcia-Moreno (WHO)**

Coordinator, Gender, HIV/AIDS and Violence

Department, Gender, Women and Health

10:00–10:30 Presentation of background paper and key findings

**Sundari Ravindran (Consultant)**

#### 10:30–10:50 COFFEE BREAK

10:50–11:10 Perspectives from the dean's office

**Carol Herbert**

Dean, Schulich School of Medicine and Dentistry, University of Western Ontario,  
Canada

**Enrico Gruet**

Dean, Cebu Doctors' University College of Medicine, Philippines

11:10–12:00 Discussion of background paper

12:00–13:00 Case-studies, gender and health

**Jo Wainer**

Monash University, Australia

**Rupa Patel**

Council of Ontario Faculties of Medicine (COFM), Canada

#### 13:00–14:00 LUNCH

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AFTERNOON SESSION

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14:00–15:30 Case-studies, women’s health  
**Annet Mutebi Kutesa and Henry Oboke**  
 University of Makerere, Uganda

**Nantana Sirisup**  
 Faculty of Medicine, Chulalongkorn University, Thailand

**Sibele Kalaca**  
 Marmara University, Medical Faculty, Turkey

**15:30–15:50 COFFEE BREAK**

15:50–16:40 **Jonas Nordquist**  
 Presentation and Discussion  
 “Learning – Integrated or Disintegrated? On Accreditation, Teaching and Assessment”  
 Karolinska Institute  
 Stockholm, Sweden

16:40–17:30 Large Group Discussion

- Participants to react to presentations and share own experiences and knowledge about integrating gender into health curricula
- Identification of target group (medical, nursing, public health)
- Identify approach i.e. gender and health, women’s health, specific issues
- Identification of key issues
- Wrap-up by moderator

**II. DAY 2 (TUESDAY 5 DECEMBER 2006)**

**MODERATOR: SUNDARI RAVINDRAN**

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MORNING SESSION

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9:00–10:30 Introduction to Day II  
 Case-studies women’s health:  
**Lourdesita Sobrevega-Chan**  
 Mindanao Working group on Reproductive Health, Philippines

**Diane Magrane**  
 Association of Professors and Gynecology and Obstetrics (APGO), USA

**Peter Sawires**  
 Physicians for Reproductive Choice and Health, USA

**10:30-10:45 COFFEE BREAK**

10:45–12:30 Large group: (led by Moderator)

- Reaction to case-studies
- Further clarification of key issues/priority-setting i.e.
  - Institutional readiness (enablers/barriers)
  - Advocacy
  - Strategies for implementation

**12:30–13:30 LUNCH**

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AFTERNOON SESSION

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13:30–15:00 Concurrent group discussions as defined by large group session

15:00–15:30 Coffee break

15:30–17:00 Report back to plenary for discussion  
Identification of key recommendations

**III. DAY 3 (WEDNESDAY 6 DECEMBER 2006)**

**MODERATOR: CLAUDIA GARCIA-MORENO**

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MORNING SESSION

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8:30–9:15 Review of key recommendations and discussion

9:15–10:00 Ongoing curricular initiatives:

**Hande Harmanci**

Medical Officer for Education and Training  
Strengthening Educational Capacity in the Prevention, Treatment and Care of  
HIV/AIDS (SEDCAP), WHO

**Jane Cottingham**

Coordinator, Gender, Reproductive Rights, Sexual Health and Adolescence, WHO

**Gabrielle Casper**

Medical Women's International Association (MWIA), Australia

**10:00–10:30 COFFEE BREAK**

10:30–12:30 Concurrent group discussions

Participants to break up into different groups to discuss how to strengthen work in this area i.e. sharing resources and expertise, future collaborative activities, the potential role of WHO, sustainability, maintenance, evaluation of efforts.

**12:30–13:30 LUNCH**

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AFTERNOON SESSION

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13:30–14:30 Report back to plenary and development of recommendations

14:30–15:30 Consensus statement

**15:30 COFFEE, MEETING CLOSES**

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## ANNEX B

# List of participants

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