DOCUMENTATION REPORT

Gender Champions in Health Systems

Second Roundtable held on 6 & 7 June 2024 at Hotel Bawa International, Mumbai

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Introduction

Earlier in the year 2024, in partnership with Quicksand, Oxford Policy Management (OPM) hosted a Gender Champions Roundtable in New Delhi, under the ambit of GenderCollab, and in collaboration with ICRW, CEHAT, WGHI, and Dr Sundari Ravindran. This event served as a pivotal moment for exploring the purpose and potential of establishing a community of practice (CoP) for Gender Champions within the health system. During the Roundtable, various themes were explored underscoring the critical need for deeper engagement and actionable strategies to advance gender integration in the health system. To further delve into these themes, smaller Learning Circles are to be organized where select topics will be focused upon for more in-depth discussions.

The first of these sessions was led by CEHAT on the theme of *Advancing Gender Championship in Medical Education and Health Research*. This 1.5-day workshop was conducted on 6th and 7th of June 2024 in Mumbai. The agenda encompassed intensive discussions on the selected thematic area on the first day, followed by deliberations on CoP agenda setting and operations on the subsequent day.

Objectives of the roundtable were as follows:

1. To understand the efforts made in the direction of Gender integration in medical education with a focus on three key themes:
    a. Research and Scholarship
    b. Integration of Gender in Medical Curriculums, and
    c. Influencing academic and government bodies to integrate gender in medical education
2. To further the discussion on the functional and operational aspects of the Gender Champions CoP and set the agenda for the next six months.

DAY 1

Context setting

In this session, Dr Priya Das from OPM, Ms Sangeeta Rege from CEHAT, and Mr Rohan Patankar from Quicksand provided a background to the present roundtable.

Dr Priya explained that the present work in GenderCollab was being carried out by OPM under a grant by the Bill & Melinda Gates Foundation, whose objective was to look at different aspects of gender in health systems, such as midwifery, leadership in health systems, etc. In the course of their work, they interacted with many individuals and organizations working in the field of gender in the health systems, however, this work was being carried out in silos, and not coming together as one collective effort; it was this observation which gave rise to the idea of Gender Championship. The first meeting was held in January 2024, wherein many thematic areas of work were discussed by different individuals and organizations. Today, one of the first thematic areas, i.e. gender in medical education, was being explored in greater detail, helmed by CEHAT. The prime objective of the meeting was not only to strengthen gender championship in the health systems, but also collating and presenting useful information on the different types of work being actively carried out so that professionals in the field could benefit from the same.

Sangeeta elaborated upon the Gender in Medical Education (GME) programme by CEHAT. The GME programme was initiated in 2014 by CEHAT with much support from experts like Dr Sundari Ravindran, De Renu Khanna, and Dr Jagdeesh Reddy, who had been long working in the field for many years prior. She spoke about how a new "wave" of professionals were now working in this area such as Dr Arjunkumar Jakasania, Dr Harshal

Sathe and Dr Anshu. The vision that gender could become mainstream in medical education was not conceived in the year 2014, but it is now slowly reaching a stage where gender is being integrated into medical education.

Sangeeta concluded her talk with the thematic areas of exploration. The first meeting encompassed 11 themes, and CEHAT had worked on most of these themes, but what resonated the most with CEHAT was the theme of GME, which it had been engaging closely not only through colleges, but also with policy-makers, and also through fellowship for gender in education research. CEHAT has come up with three broad themes:

- How to integrate gender in medical education? Since medical students have competency-based exams, how can gender be made a part of the same?
- What can be done to enhance the status of gender in medical research, which is a little-explored field in medical research so far?
- What can be done to integrate gender in the health systems at the policy level? For example, gender in medical education is not a part of the hospital accreditation system presently, what can be done to include it?

Rohan introduced GenderCollab, which was established in the year 2022 with the aim to advance gender in the health systems. A website www.gendercollab.in was set up in order to bring together the work which was already done in the field of gender in health and to be used as a knowledge repository. The website comprises of a tab "Knowledge Centre" which contains resources on topics viz.:

i. Gendered research in health

ii. Respectful care
iii. Gender-responsive spaces
iv. Enabling women's leadership in health

The section on "Reflections" comprises of blogs on learnings shared by partners in various programmes. Learning events were also conducted which have been documented on the website.

His talk concluded on the note that it was important for like-minded people to meet and share their work and their learnings on the field so that ongoing work on gender in health systems could advance. Moreover, there was a need to institutionalize this work, and there was a need to define a language to speak about it, and hence objectives out forth in this work needed to be timebound.

Following this context setting by the speakers, a short film showcasing CEHAT's efforts on gender in medical education project across Maharashtra was screened.

Theme I: Gender in Medical Education Learnings from Gender Champions in Medical Education

This session encompassed champions in the field of gender in medical education sharing their experiences and learnings from their years of work in the area. They primarily shared: (i) the current status of the design and delivery of gender in medical curriculum in India, and (ii) key gaps and needs they see in the design and delivery of gender-integrated curriculum across India.

SPEAKER 1: Dr Nancy G, Associate Professor of Community Medicine, St. John's Medical College, Bangalore

Dr Nancy began her talk by sharing an example of an attitude quiz exercise she conducted in her class where MBBS students would be asked professionals belonging to which gender were in greater number among health workers. The answer would invariably be "Male". The professors would then bust that myth among students, and speak of health workers such as ASHA, ANM, and so on, after which they are introduced to community medicine. The foundation course comprises the topics of life skills and workplace harassment.

In the first year Community Medicine exposure programme called the "Rural Orientation Programme", the students are taken to a village where they stay and observe the social dynamics the people: the patriarchy, social determinants of health, gender roles and how they affect health.

Dr Nancy also spoke of the Family Adoption Programme for which the faculty had been very enthusiastic initially, and had developed a module for, which included also a clinical mentorship programme; however, on implementation it was found that it had become a completely biomedical programme where the social aspects were absent, and ended up mainly consisting of camps where the people were invited to visit for any health problems they may have. She however added that they had also seen instances where the Family Adoption Programme worked where students were taken house to house and made to observe how gender dynamics plays out in the household as well as in the village at large.

In the second year the students had the Urban Orientation Programme wherein student were taken to urban underprivileged areas wherein they observed and interacted with families and understood interaction of urbanization with gender.

Gender was also integrated into clinico-social discussions where small group teaching was carried out. Integrated teaching also provided avenues to expose student to gender in health wherein other departments such as Psychiatry and Humanities collaborated with Community Medicine wherein ideas related to gender were incorporated into topics such as adolescence health.

In the third-year programme Community Health and Action Programme (CHAP), students were taken to NGOs wherein they were exposed to public health issues and the work carried out to address them. However, she pointed out that these NGOs carried out work in the biomedical aspect of medicine, and NGOs which worked in the arena of gender were not readily accepted as public health organizations.

During the internship period, students got a chance to observe the Panchayati system and how health committees' function within villages, for example, the committees comprised mainly of males, and decisions in health committees were taken primarily by males.

The students also undertook activities such as surveys wherein topics such as intimate partner violence (IPV) was explored. Though the ethics committee of the college does take objections to undertaking research on sensitive topics, interns are encouraged to undertake surveys on simple gender-related topics.

All interns have to undergo the objective structured clinical examination (OSCE) in order for them to pass the course. Dr Priya spoke of the challenge in integrating gender-related aspects in the OSCE as the university did not want to digress from the standard format and add anything additional related to gender.

Dr. Nancy spoke of the benefits of collaborating with the humanities division wherein the student mentorship programme is conducted, and students are paired up with faculty members and it is a space for them to address personal issues such as their own gender identities, feelings of belonging, and so on. Other activities such as guest lectures, interactions with commercial sex workers are also held.

Dr Nancy pointed out gaps in gender in medical education viz. there a few gender-related competencies in NMC, and the ones which are present are very broad, such as gender

equality. Moreover, work and integration are done with only medical students, and not those of nursing, and other cadres. Moreover, the AETCOM (Attitude, Ethics & Communication) module too do not comprise gender-related aspects and comprise of topics such as how to be empathetic to patients in general. The university schedule of exams arrives at the last minute raising stress among students as well as professors, and therefore there is little time to incorporate gender-related teaching. The academic field is ridden with rigid hierarchies and old leadership styles resistant to change, hindering gender related work in medical education. The utilization of grievance committees and anti-sexual harassment committees is also low. Finally, Dr Nancy voiced that a lot of time was expended on administrative work and institutional commitments, thus leaving little time for creative thinking and teaching.

SPEAKER 2: Dr Padmaja Samant, Professor and Head, KEM Hospital

At the outset, Dr Padmaja said that since she was from the ObGyn department, she had more scope of incorporating aspects of gender into teaching. The gender-related teaching has been divided into UG and PG level at the college. She mentioned that it was a challenge to get the faculty members to include gender-related aspects in teaching as the teaching was primarily disease-based rather than woman-based, and the focus was on pathology.

The college developed a foundation course when competency-based medical education (CBME) was introduced. This comprises topics such as cultural diversities and competencies, wherein the focus is on the impact of culture and gender on health-seeking behaviours.

Gender sensitivity in doctors has been introduced which encompasses behavioural aspects as well as institutional level aspects such as sexual harassment. In bioethics lectures, a theme is chosen where a student makes a presentation, and an ethics expert discusses the same. This is carried out by PG students, though the UG students attend it too. In Medical Humanities guest lectures are held where gender-related topics are covered.

Humanities conferences were held where themes such as impact of gender on health are included. Open, online courses are run by the department wherein one of the courses was gender and health which ran for about 3 months, where Dr Jagadeesh was also present, where the areas of narrative medicine[1] and reflective practice were discussed where the impact of gender can be highlighted.

Dr Padmaja added that the UG schedule was very busy, and the students could study the syllabus included in the exam, and hence there was little scope for gender related teaching. She also pointed out that the competencies do not touch sexual diversities and populations, and teachers do not have the knowledge of how to teach these topics. She voiced that the National Medical Commission (NMC) and Medical Education Units (MEUs) can focus on GME, failing which it would not be taken up by all teachers.

The postgraduate students were given gender-related topics for their dissertations. Multidisciplinary programmes were being conducted in GME which included topics such as comprehensive care for sexual assault survivors. Orientations were held for UG students in gender in medical education.

Dr Padmaja stated that there was a need for creating PG competencies; currently competencies were established only for undergraduate students. Also, there was a need to create IEC material on sexual diversities, and Standard Operating Procedure (SOP) for instances of late abortion, Medico legal cases (MLC), unmarried patients, young mothers, interface with the police and forensic procedures, which were at present not existent. She concluded her talk by stating that these aspects were very important as otherwise it is the most vulnerable patients who suffer.

[1] Narrative medicine is the discipline of applying the skills used in analysing literature to interviewing patients and analysing how a patient speaks about his or her illness, so that clinicians are equipped to better comprehend their patients' experiences and perspectives so as to deliver equitable and effective health care.

Discussion on Theme I: *Gender in Medical Education Learnings from Gender Champions in Medical Education*

Dr Jagdeesh voiced that health economics was inherent topic and of utmost importance to the field of gender in health, and medical colleges have been given the task of equipping PG students in the same. However, colleges lacked the expertise to teach the same.

Dr Anshu stated that there were two important aspects to village programmes: the academic institute must have strong links with the rural community where the programme is carried out, and the community must be actively involved in the programme. One had to be clear of each day's tasks or objectives so that they could be completed by the end of the day. NMC has asked medical colleges to carry out these programmes, but it is important to define the tasks so that the project can meet its aim. Finally, she stated that one could not copy another's design (for the rural programme) and that each programme had to be tailored to the community and its needs.

Ms Dipika Saluja asked what was student feedback about their experiences on the gender-integrated rural programme. Also, most of the gender championship was individual driven; what were the challenges in institutionalizing the same. To this Dr Nancy replied that the student feedback was largely positive and enriching; at one time she had 150 essays to go through. Sometimes the feedback was not what was expected, such as 'we learnt Kannada and felt nice', 'we couldn't promise them community discounts which they asked for'. She explained that when a programme was handheld by faculty members it was executed very well; but when supervision was low the execution and feedback too were affected adversely. She added that individual-driven programmes (e.g. led by faculty members or professors) faced problems in sustainability, and it was relatively easy to get like-minded faculty members together, but making a collective effort was difficult. She also spoke about the issue of burnout among faculty and students alike, and how that was a pressing issue to be addressed.

Theme II: Influencing academic bodies to integrate Gender in Medical Education

This session entailed expert speakers sharing about the current status of uptake of gender-integrated medical curriculums across states in India, and the key gaps and needs for advocating the uptake of gender-integrated medical curriculums across India.

SPEAKER 1: Dr Pravin Shingare, Ex-DMER Director of Maharashtra, Current Pro-chancellor, Krishna Institute of Medical Sciences

Dr Shingare began the talk by voicing that the term "Gender in Medical Education" must be done away with, and the new term in its place must be "Gender in Health Sciences". This would ensure that not only medical students, but also students of other cadres such as nursing would be included.

Secondly, he said that in Maharashtra, out of 10 universities, only 1 university had been covered under the GME programme. There is a need to encourage and compel the other universities to accept the GME curriculum.

Thirdly, he pointed out that there were 70,000 to 80,000 students studying in Maharashtra in the field of health sciences; however, only about 20,000 students were in medicine (i.e. MBBS), the others were in fields such as ayurveda, paramedical courses, etc. Hence, these students too had to be targeted for the programme, and not focus on medicine students only.

Dr Shingare shared an incident from his life where one of his friends stopped his daughter from pursuing physiotherapy as he was worried that she would have to touch male patients, hence underlining the need for such a programme to be implemented for other disciplines.

Dr Shingare highlighted the need for approaching the Indian Council for Alternative Medicine which housed about 3 lakh students, National Counsil of Paramedical Sciences, and the Dental Council, if one wanted to truly advance the work of gender in health systems.

SPEAKER 2: Dr Anshu, Professor at MGIMS Wardha, Medical Education Unit Head

Dr Anshu began her talk by stating that one of the issues with the existing (non-gender-integrated) curriculum was that the issue of gender was seen as a domain of the Community Medicine department or the ObGyn department; the other departments did not consider the topic of gender in health as important or coming under their purview. For example, the paediatrics department may speak of ambiguous genitals, but not about issues of transpersons. Next, she voiced that though a lot of effort was put into creating the GME modules, she questioned whether they had been implemented in all the colleges as they were intended to be.

She spoke about AETCOM module being introduced in the year 2013 itself. Though the structure of the modules and the suggested methods of teaching were sound, the topics entailed only communication, bioethics, and so on; the aspect of gender was missing.

Dr Anshu however said that there were silver linings at the individual institute levels, such as KEM Hospital, UCHS under Dr Satendra Singh, MGIMS and CEHAT's collaboration, Sangath, and so on. She gave examples of work which has been done, such as two workshops conducted by MGIMS in collaboration with CEHAT named "I Believe" and "We Believe", where faculty as well as students were introduced to the concept of gender identities. It was observed that the faculty too were not aware of these issues, and there is hence a pressing need to educate the faculty in these topics.

Dr Anshu put forth a few points which were important for the institutionalization of GME. All the work being done on GME was headed by gender champions who were individuals either passionate about the topic or had a lived experience of it, for example, Dr Aqsa Shaikh and Dr Satendra Singh. Hence it was important to have a good leader who had the qualities to put together a team and carry forward the programme. Secondly, the educational institution must be supportive. Thirdly, power and hierarchy played an important role in promulgating the programme; if one held a position of power in an institute, he/she then had the power to incorporate the programme by implementing the programme, raising funds, getting permissions, and so on.

Dr Anshu spoke about the importance of looking at the bottom-up approach rather than waiting for the top-down approach to work; to let individuals who are working to continue working in their own style. Another important aspect was to create spaces to talk about such

topics. They need not necessarily have to be the lecture hall, which would be a very formal set-up, but any space where such topics surrounding gender, which were otherwise considered taboo, could be discussed. She provided the example of Sevagram, where they utilize theatre of the oppressed, poetry workshops, paintings, and interactions with individuals with lived experiences, as well as meeting community members who can share their experiences. She spoke about how earlier, the topics related to transgender community and homosexuality were considered taboo, but interactions with people with lived experiences opened the minds of students and faculty as they got to understand them and their experiences better and get to know their commonalities as well as challenges. She added that the discourse must not just encompass gender, but inclusion as a whole (i.e. including issues such as disability, caste, etc.)

Dr Anshu ended her talk with the point that students learnt more by watching than through lectures; they learnt more from the hidden curriculum, and hence it was of utmost importance for teachers to be good role models and illustrate through their actions rather than words. She also stated that it was better to deliver curriculum in small doses rather than overwhelm students with a lot of information all at once.

Discussion on Theme II: *Influencing academic bodies to integrate Gender in Medical Education*

Dr Padmaja said that AETCOM module has opened up an avenue to discuss gender-related issues. Since AETCOM is only a guiding module, one could incorporate gender-related aspects if one could widen the reach.

Dr Jagadeesh cited a case where the Chennai high court pulled up the NMC over the competencies it had laid down. In 2018, CEHAT had questioned certain medical competencies which were then removed, and a revised circular was issued in 2022 for the psychiatry and Forensic Medicine competencies. However, 6-7 medical colleges in the country are not implementing it yet. Whereas there is a directive not to conduct the two-finger test while examining sexual assault survivors due to its unscientific nature, it is still being taught. Similarly, conversion therapy is banned, but this information is not reaching medical colleges. He voiced that the field of Psychiatry too remains a challenge; whereas the Indian Psychiatric Association is progressive, their decisions are not reaching medical colleges.

Dr Jagdeesh also spoke about how AETCOM module was envisaged in 2015, and became a reality in 2018, and the foreword included the aspect of gender sensitivity. However, this message has not reached many colleges. When the NMC was confronted as to why the aspect of gender-sensitivity was not elaborated upon in the module, they responded saying that they could not give a detailed script for the same, and that there must be scope left to the teachers to incorporate these aspects into their teaching as they deemed best. He stated that the Module 4.2 of the AETCOM "*Case studies in medico-legal and ethical situations*" has the highest publication rate in India, and it is seen that faculty and students explore the vast number of possibilities through these case studies given in the module. This presents one avenue to push the work on gender in health through the AETCOM module. However, he pointed out that government colleges were also marred by problems of recruitment, thus posing challenges in curriculum delivery.

Dr Priya Prabhu voiced that having a top-down approach to GME would work better as that was the approach which had enabled the acceptance of GME modules. Similarly, when the intake form for sexual assault survivors was introduced by CEHAT, they were questioned as to why would hospitals accept an NGO's work. However, once the proforma was accepted and issued by the MoHFW, the hospitals had to follow the same since the directive came from an apex authority.

Theme III: Advancing Gender scholarship in the health system

This session entailed speakers sharing about the current status of biomedical research from a gender lens in India, and key gaps and needs for advancing biomedical health research from a gender lens in India.

SPEAKER 1: Dr Sonali Deshpande, Professor, Department of Obstetrics and Gynaecology, GMC Aurangabad

Dr Sonali joined the roundtable through video call. She introduced herself as having teaching experience of 24 years, and having being associated with CEHAT since 2014. She spoke of her journey from being gender blind to gender sensitive. She voiced that teaching in medical colleges revolved around the biomedical aspects and administrative work. In India, there is not much research available in gendered aspect of health, and gendered research is not considered as a part of medical research.

She elaborated that the current scenario is of healthcare providers' convenience over the patients' needs, which perpetuated from the teacher to the students. There was constant confusion between sex and gender, and medical textbooks were stereotyped and male-centred, based on the 70 kg male as the ideal. Moreover, there was no talk of the issue of gender-based violence.

Dr Sonali pointed out various gaps in gendered medical research, such as current research topics focusing on biomedical aspects of medicine and the absence of sociocultural factors. In research too, healthcare providers convenience is prioritized where topics which healthcare providers (i.e. faculty and students) find easier to execute or more convenient are chosen, which seldom include the aspect of gender.

In December 2021, CEHAT awarded research fellowships to medical educators who have completed GME training. Dr Sonali Deshpande was part of two research studies wherein each proposal was scrutinized before being passed, and CEHAT provided support in the research process, data analysis and drafting of the research paper. The research topics were: (i) Factors associated with the uptake of the COVID vaccine among pregnant women (carried out by Dr Deshpande), and (ii) Provision of medicolegal care for survivors of sexual assault (carried out by Dr Srinivas Gadappa). In Dr Sonali's study pregnant women above 18 years of age were selected to take part. Important factors found to be associated with vaccine

uptake were poor educational status of the husband and presence of complications during pregnancy, both which deterred vaccine uptake.

Moreover, Dr. Sonali and Dr. Gadappa also allocated thesis topics related to gender to PG students such as: domestic violence during pregnancy, sexual violence at tertiary care centres, quasi-experimental study to understand the effect of respectful maternity care on maternal and newborn health outcomes, effect of ambulation in active phases of labour, upright and dorsal position on labour and their effect on perinatal outcomes, and so on.

She concluded her talk by saying that faculty could be encouraged to undertake gender-based topics in medical research through support and mentorship, and capacity building. Moreover, a catalyst was always required to keep the movement ongoing, which could be the Director, Dean, Head of Department, or Professor.

SPEAKER 2: Dr Harshal Sathe, Associate Professor, Psychiatry, MGIMS Wardha

Dr Sathe stated at the outset that he would be presenting an experiential review derived from his personal experiences in the field. HE spoke about the time when he was asked by his seniors which topic he wished to carry out his thesis on, which was "Attitudes of People Towards ECT", and focused on social determinants of health. He narrated how the topic was immediately rejected by his seniors citing that it was a topic suited for social workers, not doctors. Hence, the research carried out on biological aspects of health was perceived as worth doing, but those on the social aspects of health was not. There are many "biological psychiatrists" who believe that all mental ailments are seated in the brain structure, and that social factors have little to do with them.

Dr Sathe had joined the work of GME in August 2022 following a training by CEHAT where he was introduced to the topic as well as was provided actionable points and encouragement to carry out his work. He opined that the top-down approach was important as following the training, their department carried out various research studies on topics such as IPV, gender comparisons in organophosphate poisoning, gender comparisons in deliberate self-harm, and so on. He observed how medical students had started engaging in qualitative research, something which could not be conceived when he was a student.

However, Dr Sathe mentioned that whenever he spoke about the social aspects of health, he was asked questions by his peers such as "What is this? Will it make any difference? What will we get out of it?" He opined that many medical students and professionals would be

attracted to such research if there were incentives, and cited the example of CEHAT's fellowship programme. Moreover, he mentioned how there was no in-depth analysis in the research projects already being carried out; there were only one or two lines written about the gender differences in results without an effort to explore the reasons behind the same. Another example was where pregnant women were excluded from all studies, hence inclusive and integrative research was very important to get true and meaningful results.

Dr Sathe cited an example of a research carried out by their department on IPV. He narrated how to get a sample size of 100, they had to interview nearly five times the number of women. They hence got two sets of responses: women who *did not* take part in the study said that they had to continue staying with their abusive spouses/relatives, and hence they did not wish to take part in the study; women who *did* take part in the study asked the researchers what would happen of them and what benefits they would get now that they had taken part. He opined that research should have tangible benefits so that it will not hinder further research in the field – otherwise individuals may feel that their personal information is being taken from them for no perceivable reason. He concluded that the attitudes of doctors should change with regard to sociocultural aspects in medical research, that ICMR too should change its approach of viewing social determinants of health, and that there should be a conducive and encouraging environment for integrating gender in medical research.

SPEAKER 3: Dr Devaki Nambiar, Programme Director, George Institute for Global Health, India

Dr Devaki shared a video message with the group. At the outset, Dr Devaki stated that sex and gender should be made part of medical research. She spoke of global level

recommendations and guidelines for gender in research which are present in many countries. She added that in her opinion, the aspect of building upon work which has already been done is not present in India, owing to the lack of knowledge repositories and forums where such information can be shared.

She cited two examples of research being conducted in the UK. The first was project was on sex and gender equity in medical science, which aimed to improve integration of gender in biomedical research in UK. The second was the Policy Lab model where a sex and gender framework in research was created, which could then guide and support research in the whole country. She suggested that these programmes could be tailored to the Indian context and emulated here. She hence spoke of the need for developing such guidelines for the Indian context, and asked if there was interest in the GenderCollab community for creating the same. she also suggested staring mailing groups to bring in research funders voicing interest such as ICMR.

Discussion on Theme III: *Advancing Gender scholarship in the health system*

Ms Sarojini spoke about how in her work on clinical trials in biomedical trials, while developing guidelines for engaging human participants, when the issue of inclusion and exclusion criteria are discussed, there are reasons such as unethical research practices, the medicines or vaccines given to the treatment group not being developed fully, and so on, for the exclusion of women and vulnerable groups from research. This is done to prevent risks such as exposure of the foetus to harm. She cited the example of the COVID vaccine and whether it was safe to administer it to pregnant women, and how there was much confusion about it at the time, and also how coronary disease was less researched among elderly women

as opposed to men. Hence the question arises on how to perform inclusive research while following ethical protocols and safeguards. She added that funding for biomedical research too was a challenge. She spoke of the need of influencing policy makers, since she faced a lot of challenges in her interactions with government authorities while pushing for equality of vulnerable groups.

Energizer activity: *Who is a gender champion?*

In this session the participants were asked to think of how a "gender champion" would be described in their own languages, in their arenas of work. Dr Priya explained how the term "Gender champion" was used very widely, but it was also important to pause and deliberate upon what the term actually entailed.

Dr Sundari said that the term male-female equality or gender equality, was used (in Tamil) in the course of her work, and a gender champion was someone who was upholding the equality of genders. She added that there were terms in Tamil language for transpersons, but there was no term for "gender". Sangeeta shared an incident where the CEHAT team had gone to visit the NMC Director to review the GME modules, and if she deemed it fit, to write a covering note for colleges to uptake the modules. The NMC Director dismissed the request stating various bodies would approach the NMC asking them to include subjects such as ecology, etc, in their curriculum which was not possible for them, and asked CEHAT to approach individual colleges, which are about 530 in number, and ask them to take up the modules of they wished to, following which CEHAT was compelled to abandon discussions with the NMC.

Dr Padmaja stated that they used the term “ling bhaav” (in Marathi) for gender identity, which has become better understood in her area of work by her colleagues and students, but it was a term for the people who are already sensitized towards gender-related issues, and not for lay people. Dr Priya Prabhu added that for her, in the gender hierarchy, a gender champion was a “gender transformative” person, who was actively engaged in actions to bring about gender equity, and not only one who understood gender related concepts. The person was sensitive to not only the needs of women, but also of men. She added that such a person incorporated gender-related aspects in his or her own personal life, e.g. raising the son and daughter equally. Here, Dr Harshal spoke about terminologies used for men and women in Marathi, i.e. “manus”, which meant “man”, as well as “human” – and in one of his lectures, a student pointed out that ‘*bai pan manus aahe’* (‘the woman too is a human being’) which made him question this term.

Ms Sapna stated that a gender champion was one who identified gender discrimination or wrong practices in his or her everyday life and tried to end them. Dr Nancy shared her personal experiences where her parents were very religious and patriarchal, but hers going on the path of working towards gender issues made her parents question their upbringing; hence for her, a gender champion was one who paved their own path going against society to work on gender issues. She added that in her department, she is often labelled as “sensitive” and “triggered”; but her patients see her as a sensitive doctor, whereas her colleagues said that, “she was there to heal her own trauma.” Moreover, she said that a gender champion is an activist who is called a “*mytri*” or “*sakhi*”; she added the term “*manushatva*” where everyone was treated as an equal; a gender champion is someone who is seen as an impartial person and as a friend.

Dr Renu said that a person who advocated for equality between men and women, and is an example in his or her own life. Other aspects put for the by the participants for a gender champion were someone who instills feelings of safety, is non-judgemental, and makes others feel cared for. Dr Jagdeesh and Ms Shweta opined that it was difficult to come up with a language for gender champions, and even if terms existed in one language, say English, it was equally important for the same to be expressed in other regional languages.

Dr Jagdeesh also said gender and feminism were different issues, and that he would term it a right-based approach, rather than feminism. For example, the discourse was not only about males and females, but also females and alternate genders, adult and children, able and differently-abled, and so on. Hence a better approach would be to take a rights-based approach keeping in mind intersectionalities. To this, Dr Arjunkumar added that there was a need to treat individuals with empathy and dignity, not pity. Dr Shingare said that the word "champion" signifies victory or a winner; in his work with the Ministry of Women and Children, the term "*ling samaanta samarthak*" was used, which implied a "supporter" rather than a winner.

Group work and group presentations

The participants were divided into three groups. The objective of this session was for groups to have focused discussions to develop two to three strategies for moving their work forward on:

- What are the most critical gaps in integrating gender-related issues into health systems?

- Based on your experiences, what are the possible ways in which these gaps can be addressed (actions)?
- What ways can the Community of Practice (CoP) support to take these actions forward?

Each group then had to come to a consensus on two to three action points to take forward with the CoP that are feasible and doable.

GROUP 1: Strategies for implementing gender-integrated curricula in community medicine, gynaecology, and psychiatry in MBBS

Group members: Dr Jagadeesh Reddy, Dr Arjunkumar Jakasania, Dr Priya Prabhu, Dr Nancy

The presentation of the group was as follows:

Critical gaps:

- ✔ Need to have structured curriculum, competencies with SLOs (Specific Learning Objectives) to be defined
- ✔ "Gender sensitive Indian medical graduate" to be defined
- ✔ Sensitising and training a student to gender sensitivities
- ✔ There is no gender in assessments; students' interests are not on areas where they are not assessed
- ✔ Updated competencies not implemented uniformly
- ✔ University and apex authority curricula designs are not streamlined across the institutes.
- ✔ Faculty training, interest and intention is also a gap
- ✔ There is no channel for faculty training or motivating teachers
- ✔ Adding gender-related aspects into assessment
- ✔ Gender sensitive textbooks are absent
- ✔ We say medicine is art and science, but more focus goes in science

Possible ways in which the gaps can be addressed:

- ✔ Define structured curriculum, competencies with SLOs (Specific Learning Objectives)
- ✔ Resources for different teaching modalities to be created

- ✔ Assessments should have ATCOM competencies - bring in a gender component
- ✔ Universities should align with apex authority directions as and when done to become gender sensitive
- ✔ Textbooks integrated with gender-related issues, and other such resources to be created
- ✔ Integrating gender issues in the existing methods and materials available will be useful for faculty training instead of developing a completely new methods and material
- ✔ Compulsory humanities division in institutes
- ✔ For other subjects (besides Psychiatry) include diversity and inclusion related (LGBTQ) assignments, e.g. effects of therapies on individuals

Ways the CoP can take the work forward:

- ✔ Curate gender sensitive resource material
- ✔ COP to define “the gender sensitive attributes for Indian medical graduate”
- ✔ Checklist on minimal things that any institute can do to integrate gender sensitivity in institutes, for example integrated orientation programme, compulsory lectures, etc.
- ✔ Mentoring and identifying individuals
- ✔ CoP can also help prepare comprehensive guidelines for gender sensitive clinical practices in medical institutes
- ✔ All institutes can have individuals from the LGBTQ community for conversations, e.g. a doctor who is a transperson giving a talk to the students

Discussion on Group 1 presentation

Dr Sundari Ravindran stated that coming up with a definition for the “gender sensitive Indian Medical Graduate” would not be very difficult as there was already a lot of material available. However, without the definition, people would keep questioning about what was to be achieved. Dr Renu spoke about having multiple convenings with multiple stakeholders to come to a consensus on the definition; this could include students who have undergone the GME training too. She added that the trained medical educators too had created material which has to be pooled together.

Sangeeta put forth the issue of information fatigue, wherein clinical practitioners were interested in the topic, but could not create materials for teaching the same, and CEHAT would get requests to give them material on topics such as organophosphate poisoning and so on. Hence, it was important to address what the CoP could do for such individuals. The other issue was the lack of feedback from students; as CoP could there be a way to document student feedback, which could encourage others to join the programme. Finally, she spoke of how humanities departments exist only in high-rung colleges, what could be done in low resource settings. A student-led initiative and online courses were posed as a solution to this. Dr Jagdeesh suggested adding GME as an elective.

Dr Shingare suggested grouping the outputs as requiring financial assistance, and those not requiring financial assistance, since the non-financial aspects would get a quicker approval from the government. Another point raised was the need to add student assessment, as other students would have little incentive to learn GME. Dr Renu spoke about the importance of going to organizations for residencies as a powerful way of teaching. Dr Priya Prabhu spoke about bringing in people with lived experiences, like Dr Trinetra, who could share their experiences.

GROUP 2: Strategies to engage curriculum committees of medical colleges and bodies such as the board of studies

Group members: Sapna Kedia, Dr Anshu, Shweta Bankar, Kuhika Seth, Deepika Saluja

The presentation of the group was as follows:

Critical gaps:

- ✔ Rationale towards integrating gender into curriculum: (i) linkages to outcomes within founding documents, (ii) linkages to entry points (foundational courses)
- ✔ Identifying opportunities within existing curriculum for integrating gender
- ✔ Identifying gender champions at the leadership positions and across different levels
- ✔ Need gender audit of institutions
- ✔ Pressure from accreditation bodies
- ✔ Need for sensitization of seniors and medical educators where there is lack of awareness
- ✔ How to teach gender in medical education
- ✔ Lack of clear work plan with channels and mechanisms for implementation
- ✔ Lack of gender inclusive infrastructure within hospitals

Possible ways in which the gaps can be addressed:

- ✔ Target conferences of medical educators, speciality conferences (as a workshop or key note speech) and webinars
- ✔ Mapping of founding documents (e.g. vision and mission, etc.) and curriculum, graduate medical regulations, to identify entry points
- ✔ Engage in advocacy, grant for activities
- ✔ Integrating gender-related aspects into their conferences, gatherings and meetings, a small workshop or keynote speech
- ✔ Integrating a component on teaching gender with medical education
- ✔ Not seeing it as a one-time activity but as continuous education/sensitization, and hence there is reinforcement
- ✔ Creating spaces of opportunities like workshops to share experience, enhance learnings, sharing stories
- ✔ Initiating conversations within hospital staff, educators, students

Ways the CoP can take the work forward:

- ✔ Identifying, sharing and amplifying success stories from institutes for role model (publishing, social media)
- ✔ CoP can support and amplify identification of gender champions
- ✔ Support in their capacity strengthening for championing institutional change
- ✔ Self-paced virtual modules to be designed: credit based, certification course for faculty, students and medical/non-medical staff (including case studies)

- ✔ Referring them to workshops and opportunities for learning and networking
- ✔ Process documentation, sharing stories, creating feedback and monitoring mechanisms
- ✔ Developing communication and engagement plan with the bodies to highlight their successes

Discussion on Group 2 presentation

The existing online learning portal was identified as an avenue for online self-paced learning. Dr Padmaja spoke of how they had put up their modules on their college website. Dr Sivakami spoke of how it was important to engage with the leaders or gatekeepers. For example, if OPM were to engage with the reporting officer of the hospital, then the work would be easier. Hence not only is the work facilitated, but it is also fostering gender championship. Dr Shingare spoke of how the CEHAT GME modules were not being passed until the question how long teaching of the modules would take; when Dr Shingare explained that it was not an addition to the syllabus, but a modification, the modules were immediately passed.

GROUP 3: Scope for gender-focused research in medical education and propose strategies for collaborative research on gender-related themes

Group members: Dr Sundari Ravindran, Renu Khanna, Kuhika Seth, Sarojini, Dr Sivakami, Dr V. Jithesh, Dr Harshal Sathe

The presentation of the group was as follows:

Critical gaps:

- ✔ Lack of dedicated structure for research/bureaucratic hurdles/no administrative support
- ✔ Overcrowded medical curriculum for undergraduates
- ✔ Overcrowded medical facilities
- ✔ Lack of gendered research expertise in methodology
- ✔ Lack of exposure awareness to multi-disciplinary platforms, publications
- ✔ Lack of mapping and dissemination
- ✔ Priority of medical education is disease and pathology focused
- ✔ Lack of sex-disaggregated data
- ✔ Lack of funding
- ✔ Lack of gender mentorship
- ✔ Lack of inter-departmental/institutional collaboration
- ✔ Lack of forums/conferences dedicated to inspiring students to take up gendered research topics
- ✔ Prevailing systemic mindsets that privilege biomedical research

Possible ways in which the gaps can be addressed:

- ✔ More fellowships
- ✔ Peer to peer mentoring & faculty to student mentoring
- ✔ Strengthening and repetition of training
- ✔ Budgeting time for gender research/studies
- ✔ Writing workshops
- ✔ More financial support for gender research
- ✔ Designing studies using gender lens
- ✔ Awards & recognition
- ✔ International networking opportunities

Ways the CoP can take the work forward:

- ✔ CoP can offer a mentorship to faculty members to provide guidance to students
- ✔ Design fellowships
- ✔ Platform for medical student writing workshops
- ✔ Seek funding and mapping of existing resources: research gaps in gender and health
- ✔ Publicize the CoP's work

- ✔ Creating a repository of research/thesis topics which include gender-related topics
- ✔ Organize networks and conferences to disseminate information

Discussion on Group 3 presentation

Dr Sivakami pointed out how it was important to formulate the research questions with a gender lens. Qualitative research training was pointed out to be an important aspect for gender in health research. Moreover, it was important for keep in constant interaction with other scholars in the field so as to keep updated with the latest developments in the field of gender and health research. Dr Sundari spoke about a dated training manual on gender in health research worked upon by Dr Renu, which could be adapted to the present needs, and there was no need to begin from scratch. Sangeeta seconded Dr Sivakami's point about the amount of time CEHAT's fellowship programme took, and stressed on the need for such training. Moreover, the project outlasted the funding, but the funders still wished to see the results. Dr Renu spoke about the focus to be on capacity building of medical educators, and not students, as it was the educators who would guide the students. Dr Nancy spoke of the need to present the findings in an aesthetic manner such as infographics, creation of videos and IEC materials, which NGOs were little equipped to do. The need for a charter of values in gender in health research was highlighted for new generations of researchers which would emerge.

DAY 2

Recap of Day 1

The second day of the roundtable began with a recap of Day 1 by Dr Priya Das. She summarized the actionable points put forth by the groups in the previous session, and pointed out the key gaps in medical research and lack of a knowledge repository and dissemination, at the same time, cautioning against an overcrowded medical curriculum. She spoke about how time constraints among faculty members were cited to be a great deterrent in carrying forwards gender-related work in medical education. The point of lack of sex and gender disaggregated data was put forth. The lack of funding was highlighted as the white elephant in the room which everyone was aware of. The important issue of lack of mentorship was brought up; how existing mentorship programmes could be expanded. She also mentioned the lack of inter-departmental collaboration, and how when a person interested in the issue of gender in health is not in a position of power in the institute, his or her work becomes very difficult. There was a lack of forums to disseminate such research, and few incentives for students to pursue research in gender in health, especially with the biomedicalization of research.

Some of the solutions discussed were having more fellowships to encourage students to take up such research. There was also a need to mentor faculty and staff. Gender training was also discussed where though many professionals have been trained at different stages, how could this be sustained. The issue about (academic) writing was also put forth, where it was discussed that since student graduates are not best-equipped to write, workshops must be held for the same. the need to incentivize research in the form of fellowships and awards was discussed; this was especially important for the upcoming generation of students where there was no larger institutional support. International networking opportunities had to be identified – which had become more widespread since the COVID pandemic. She pointed out that not only in India, but the issue of integrating gender into health systems was a challenge in countries worldwide, and hence networking and conferences could prove an effective forum to disseminate information and learnings.

With regard to how could the work be taken forward in the CoP, some of the suggestions were offering of mentorships by the CoP, offering fellowships, mapping existing resources and seeking funding. In order to close gaps in gender research in medicine, the CoP's work

could be publicised, a repository of research/thesis topics could be created, and partnerships could be established to expand the CoP.

Discussion on registration of the CoP

Dr Shingare asked the wider group if the CoP was a registered NGO with the government. Since it was not, Dr Shingare opined that the CoP must be registered with the government and also with the Ministry of Health and Family Welfare so that it could be deemed legitimate. Only then could the CoP disseminate information and could other medical professionals join the group. This would also answer the question of how to ensure professionals joined the CoP and not some other organization.

In reply to this, Dr Renu spoke about her experiences with CommonHealth (CH) coalition. Initially, the CH founders had discussed registering the coalition, but decided not to. However, the coalition presently is thriving and conducts various activities. Despite not having government legitimacy, the coalition has legitimacy among its members, and its work is being used as teaching material in India and abroad, including the World Health Organization. She added that at the present stage, the CoP was too immature to be registered, and it could be registered only once its work was done and tested. Dr Jagdeesh added that in his experience, coalitions were seldom registered, and even if it was registered, the question arose about who would register it as everyone was an individual member or entity. Dr Shingare here suggested that the CoP could be a partner of Indian Institute of Public Health in its work in domestic violence and GME.

The immediate action points for the CoP were hence decided to be creating visibility by drafting an article and co-creating a document on Dr Arjun’s work along with OPM and

Quicksand. There was also a need for having a deeper conversation on how the CoP should operate, and where it will stand/what tasks it would have achieved in the next six months.

Dr Sundari Ravindran on the CommonHealth coalition

Dr Sundari Ravindran offered to speak about CommonHealth and her experiences with the same in order to enlighten the group on what the prospects for the current CoP could be. CH was not backed by any funding, and was initiated by Dr Sharad Iyengar of ARTH, Udaipur. The initial idea emerged in year 2001, and caught up in 2003-04 with the advent of GME and making pregnancies safer. There was a momentum again, and in the year 2006, Dr Sundari and Dr Renu reached out to professionals in the field, and shaped the coalition.

The organizational structure remained a loose network of individuals and institutional members. A Steering Committee was elected which took important decisions. Three thematic areas of work were identified: (i) maternal health, (ii) safe abortion, and (iii) neonatal health (now reproductive health). it began with minimal funding, and time contribution is on a voluntary basis. There is a virtual Secretariat, and a fund receiving organization, which was initially ARTH, then RUWSEC, and currently SAHAJ. The executive committee has some say in how the funds are handled, but all activities and budgets are handled by the steering committee. There is one individual who works part-time for the coordination and logistics of the coalition. There is local leadership among the coalition, and annual general meetings take place. The coalition encourages all members to come up with ideas for its work and research, and bottom-up research studies carried out by coalition members for evidence building and local advocacy have worked very well. It is an 18-year-old coalition whose work has not slackened, and most members are from the grassroots who work on these issues.

Dr Renu Khanna on the COPASAH network

Dr Renu spoke about the Community of Practitioners on Accountability and Social Action in Health or COPASAH, which is an unregistered, multi-country network. It is spread over Latin America, Africa, Asia, and East Europe. It works on the thematic areas of private sector regulation, indigenous issues, and sexual and reproductive health. the leadership comprises Convenor and Co-convenor. There is exchange of communication and information, and engagement in joint activities such as conferences, studies, etc. Dr Renu stressed that the aforementioned was the essence of a coalition or CoP, and if these do not happen, then it is a weak coalition. In order to achieve this, a good Secretariat was required which could link the practitioners to one another.

One of the challenges faced were that of language; it was found that there was a need to budget for language as it was a multi-country coalition, and members from Latin America were left out as most material was in English. There were residential learning exchanges between practitioners which proved to be very useful. Since it is a South led CoP, a lot of bottom-up practices were documented, and theories were created from practice, which included the strategies used, what worked and what were the barriers, and so on.

Dr Renu once again cautioned against expansion of such coalitions until they had been tested. People usually asked the question about what they would get out of the coalition and what they could contribute. Hence, the coalition needs something concrete to show them in order to win their confidence, and forms a part of the ethics of the CoP.

The Secretariat rotates from one region to another, and members handle the

Secretariat and the funds. The leadership must hence be persons with vision to identify

opportunities for practice, and not simply tend t their organization's cause. She observed that it was usually very tempting for members to identify opportunities for their own organizations, but as leadership of a coalition one had to put the coalition above their own organization, otherwise it was unethical.

Sangeeta pointed out that the CoP must not become a project. If the CoP is concerned with from where the funding comes, then it runs the risk of becoming a project. For example, the Men Engagement Network was initially a coalition, but when it broke into projects it started to slip. The internal system of the CoP hence had to be well-defined and robust so as to sustain it. This point was agreed upon by everyone in the group.

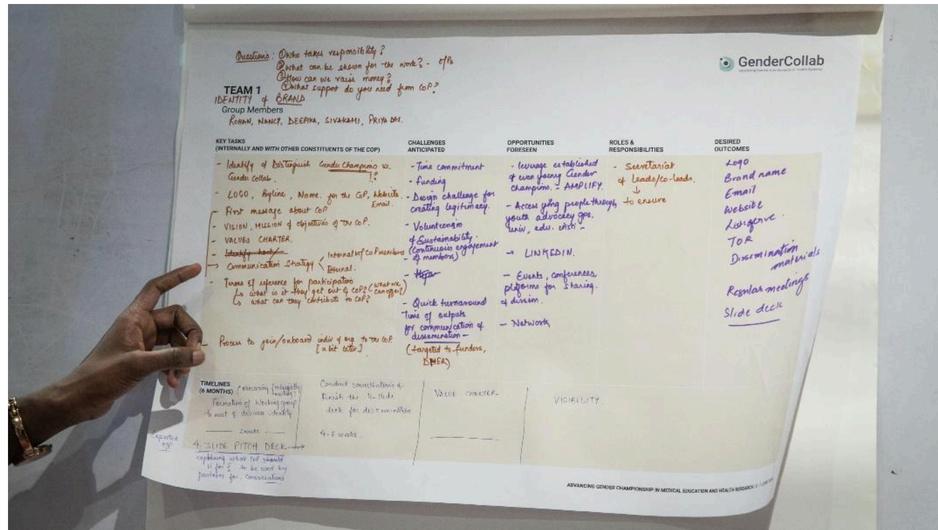
Next, the topic of caring for gender champions was brought up. It was discussed how challenging the work of a gender champion was, and carrying out gender-based research as well as mentoring students to do it was very difficult and draining work. It was easy to speak about these issues in a group of like-minded people such as this, but going back to their individual organizations and working in different, and much less supportive environment was a great challenge. Hence, there was a need to draft guidelines on how gender champions could be cared for. Dr Renu suggested that one of the studies the coalition could carry out collectively was what was the cost of being a gender champion. Dr Shingare said that it was not only the emotional needs, nut the financial too which needed looking at.

Group work: *How to make the Gender Champions CoP successful in the long run?*

The participants were divided into seven groups. Each group was given a thematic area (most actionable points as derived from the previous day's exercise) and the participants had to create a work template which included in that theme: (i) key tasks foreseen, (ii) key challenges and opportunities anticipated, (iii) any support required from other constituents of the CoP, and (iv) timelines, roles and responsibilities.

GROUP 1: Identity and brand of the CoP

Group members: Rohan, Dr Nancy, Deepika, Dr Sivakami, Dr Priya Das



The presentation of Group 1 was as follows:

Key tasks: To differentiate between the name and logo of the GenderCollab and the Cop; to create a logo, tag line, website and email id; to develop a value charter (along with Group 2); develop a communication strategy (internally for group members as well as external for information dissemination); develop Terms of Reference for participation; outline what members will get from participating and how they can contribute to the CoP

Challenges anticipated: Time commitment from members; creating legitimacy for audiences like funders; sustainability, i.e. continuing engagement of members; quick turnaround time of communication outputs for dissemination

Opportunities foreseen: Leveraging the established gender champions; reaching young people through youth advocacy in universities and educational institutes; using social media and LinkedIn for networking and disseminating information; using events and conferences and existing networks to build connections

Roles and responsibilities: To work with the Secretariat and leads/co-leads

Desired outcomes: Logo; brand name; website; email; ToR for participation; dissemination material; slide deck introducing the CoP; regular meetings

Six-month timeline: Creation of a 4-slide pitch deck explaining what the CoP is and the work it does, to be used by partners for communication; fortnightly meetings for keeping the work ongoing; creation of a value charter (Dr Priya Das pointed out that the GenderCollab website is live only until September 2024, and one could change the name, logo, etc. to keep it alive)

GROUP 2: Operational structure, steering, participation, championing

Group members: Dr Sundari Ravindran, Renu Khanna, Sangeeta Rege, Amruta Bavadekar, Dr Harshal Sathe

The presentation of Group 2 was as follows:

Key tasks: Developing vision and mission statements; inculcating members free of cost or at a nominal fee; creating a Secretariat; creation of a separate structure for coordination (steering group with nominated members); creating working groups for thematic areas; nominating a coordinator of all groups; having experienced faculty on board as mentors; identifying networking opportunities; developing a value system; developing criteria for membership (individual or institutional)

Challenges anticipated: Tendency to be extractive or exploitative (by the more powerful members) hence the value document should state that this is not an extractive medium; bringing like-minded people to the forum; agenda being hijacked by more powerful groups/individuals

Opportunities foreseen: Mentorship programme with experts as mentors; mentors could look for opportunities to expand the work

Roles and responsibilities: CEHAT can manage the Secretarial for the time being; Renu Khanna to send the draft of vision and mission statements; Dr Sundari Ravindran to be the mentor during the process and provide feedback

Desired outcomes: Draft documents (vision, mission, SoP, etc.) which will be carried over to the next meeting

Six-month timeline: To have a reasonable draft of the above within 2 to 3 months; be prepared for the next physical meeting

GROUP 3: Financial sustainability

Group members: Dr Priya Das, Sapna

The presentation of Group 3 was as follows:

Key tasks: Setting up a pitch brief and proposal, set up meeting at upcoming events such as ICRW and Packard; maintaining GenderCollab

Challenges anticipated: New name to be thought of; need to understand how the structure will function vis-à-vis a CoP; communication material to be created

Opportunities foreseen: UHC Grant; collaborating with other CoPs such as COPASAH, Dasra, Equilead; GH 50-50 Global Consortium; in the current times there is a lot of investment in women's issues and the CoP can benefit from the same; members of the CoP can be nominated to take part in women leadership programmes which can become avenues for funding; GenderCollab is already working with ICMR to make clinics more trans-friendly, and there is scope for the CoP to come into this work

Roles and responsibilities: Anchored by Dr Priya and Sapna, but drawing on core groups and others as relevant

Desired outcomes: Representative partnership building; greater visibility in funding forums (the CoP should be known by at least 5-6 funding organizations); ready to share communication pitches on different forums; developing proposals

Six-month timeline: one proposal; one network; a pitch brief; one funding meeting (The team requested all participants to think of more funding bodies and gender champions who could advance the cause)

GROUP 4: Training and capacity building (incl. online modules)

Group members: Dr Arjun, Deepika, Dr Anshu; Shweta, Amruta

The presentation of Group 4 was as follows:

Key tasks: There are already a lot of available materials, hence the task is to organize them; creation of any new resources if required; training packages to be created (training plan and material, video links, games, resource persons, modules, etc.), and organize by levels e.g. beginner, intermediate advanced'; create a platform for reflection and sharing learnings; enhance visibility in the area of gender training

Challenges anticipated: Time constraints; technical expertise e.g. website creation, etc.; secretarial assistance; sustainability

Opportunities foreseen: In-house expertise in the CoP; incentives from accreditation bodies; in-house linkages with authorities e.g. the NMC

Roles and responsibilities: Mapping: Dr Arjun and Shweta; Editing sorting and creating: Dr Anshu; Website: OPM; Case studies and videos: CEHAT and OPM; Language: CoP; Advocacy: Dr Shingare; Funding opportunities: CoP

Desired outcomes: Increased visitors of the website; testimonials; reflections and feedback

Six-month timeline: mapping (3 months), sorting and editing (3 months)

GROUP 5: Mentorship programme

Group members: Kuhika, Dr Sivakami, Shweta, Sapna

Kuhika spoke of being a part of the John Hopkins University mentorship programme and GHE Rwanda, both which were structured mentorship programme. Yield Action Learning Groups of Rutgers International was run by people below 35 years of age, and worked in the field of sexual and reproductive health, where a nominal stipend was given, and a meeting was held once a month.

The presentation of Group 5 was as follows:

Key tasks: Develop structured mentorship framework for peer to peer and senior/mid-level professionals, and early career professionals, students; develop a template for discussions for each session for a period of 1 year; develop a database of mentors; development of mentorship guide; pairing of mentors and mentees; recognize mentors as "Gender mentors" and mentees as "Gender champions" following the mentorship programme; develop guidelines for mentors and mentees; identify 3-4 themes which will enable the matching of mentors and mentees

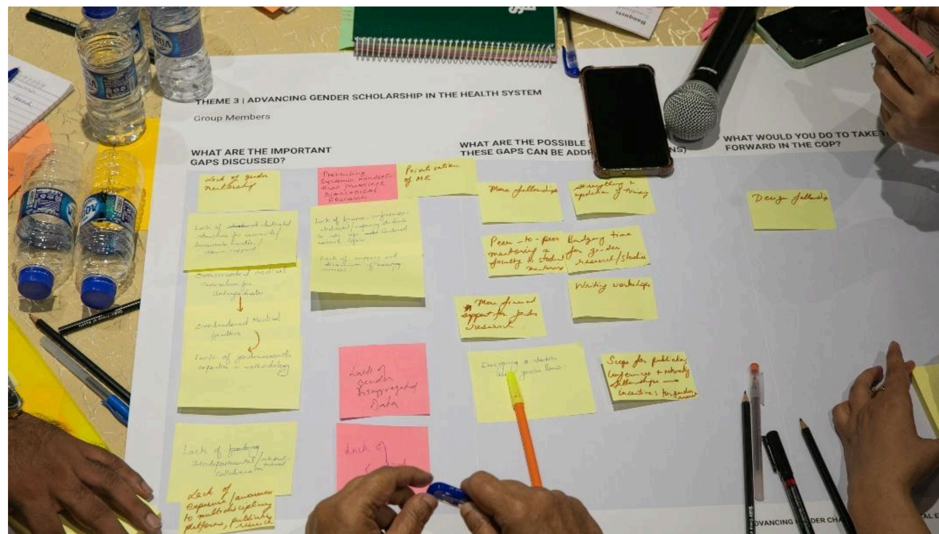
Challenges anticipated: Funding to run the mentorship programme as a lot of time and efforts area expended in it; time constraints; identifying the expertise and matching of mentors and mentees; expectation setting

Opportunities foreseen: Expertise to run the mentorship programme within the CoP; broadening networks; increased recognition for mentors and mentees in the field of gender in health research

Roles and responsibilities: CoP members

Desired outcomes: Development of gender and health research expertise and evidence; providing opportunities for professional networking

Dr Priya Das spoke about the importance of putting down more concrete aspects such as how much will the programme cost, and what is on offer. Another question asked was what could be done right away with regard to the timeline; Sapna mentioned that in the Women and Global Health Group by ICRW there were many early researchers where the mentorship programme could be executed.



GROUP 6: Defining the "Gender Sensitive Indian Medical Graduate"

Group members: Dr Pravin Shingare, Dr Priya Prabhu, Dr Jagdeesh, Dr Uvika

The presentation of Group 6 was as follows:

Key tasks: In clinical practice – follow a rights-based practice which is inclusive, sensitive, empathic, and ethical; in training – creating a cadre of gender sensitive professionals; in

research – including gender dimensions, fostering mentorship and creating fellowships for gender in health research

Challenges anticipated: In clinical practice – reluctance of healthcare providers, poor motivation, lack of role models, biases among healthcare providers; in training – overworked curriculum, lack of funds, assessment driven system; in research – lack of funds and incentives to conduct gender-based research

Opportunities foreseen: In clinical practice – NMC mandate, SDG goals, NAAC criteria, GME modules; in training – availability of tested training models, credit hours from the medical council; in research – publications enhance the professional's profile, promotions

Roles and responsibilities: CEHAT and GenderCollab in coordination with the rest of the CoP

Desired outcomes: "Gender-responsive health systems"

Six-month timeline: Upscaling of the modules

The questions raised in this group were: *what would be the competencies*, and *how would gender-sensitive be defined*.

GROUP 7: Promoting gender in health research

Group members: Devaki, Harshal, Uvika, Kuhika, Ajinkya, Jitesh

The presentation of Group 7 was as follows:

Key tasks: Capacity building of researchers; concept building about gender in health; map and apply to calls for proposals therefore proposal development; being part of gender in health research networks

Challenges anticipated: Funding; time constraints; limited capacity for medical educators in gender research; time taken for ethics clearances and chances of disapproval in research with vulnerable groups

Opportunities foreseen: Availability of experts for guidance; increased appetite for inclusion of gender aspects in health research; scope for publications; creating strategic data for further interventions

Roles and responsibilities: Identification and coordination at pilot sites by CEHAT; Development of a directory of people/groups working in gender in health research by OPM and Quicksand

Desired outcomes: Group of well-trained researchers willing to take up gender in health research; collating a list of topics for research; prioritized topics to be converted to proposals

Six-month timeline: 1st month – reaching out to relevant individuals/organizations; 2nd month – repurposing existing resources for capacity building; 3rd month – capacity building; 4th month – call for proposals; 5th & 6th months – reviewing and finalizing proposals

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