



IFMSA

International Federation of
Medical Students' Associations

IFMSA Policy Document Gender Equity

**Proposed by Team of Officials
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Policy Statement

Introduction

According to the current understanding, gender is an umbrella term for norms and roles determining which characteristics and behaviours are perceived masculine or feminine and hence considered appropriate for men or women according to societal beliefs. Contrary to our biological sex - male or female - gender is a social construct that varies across societies and changes with time.

While gender inequality refers to the undeniable differences between the variety of sexes and genders, gender inequity is an unfair inequality, an obstacle to a person's enjoyment of rights and opportunities based on their gender identity or expression. Moreover, individuals who do not follow established gender norms and women often face severe stigma and discrimination and are more vulnerable to gender inequity. Gender inequity exists in the social determinants of health, including levels of exposure to disease and injury; investment in nutrition, care and education as well as access to and utilisation of health services. Gender-based social exclusion and discrimination also have direct adverse effects on physical, social and psychological health. Improving gender equity in health is therefore one of the most direct and potent ways to reduce health inequalities and ensure effective use of health resources. Since the health impacts of gender relations are multidimensional, they cannot be addressed through a traditional binary male-female approach. This further calls for both healthcare systems and societies to aim for an inclusive, sensitive and non-binary perception of gender identities.

Gender equity must not be seen as a regional concern, but should be advocated through international networks, as gender inequity exists worldwide in a variety of ways and its consequences on people's health can be devastating. For instance, in the countries of the West Pacific Region boys are more likely than girls to receive full immunisation, many females of the African Region are affected by harmful traditional practices such as female genital mutilation, and violence against women is still prevalent in all regions of the world. These examples show that striving for gender equity is essential to ensure people's right to health globally.

IFMSA Position

IFMSA emphasises gender equity as an essential factor to ensure the human right to health: this includes one's freedom to control one's health and body and the entitlement to a health system that protects and grants equal opportunities to everyone. As future healthcare providers, we are committed to supporting gender equity within and outside of medicine as it is a prerequisite to fulfilling The Universal Declaration of Human Rights which stipulates that everyone is entitled to human rights "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

Call to Action

Therefore, IFMSA calls on:

1. Medical students and national medical students' associations to:
 - a. Promote awareness on the health impacts of gender inequity at both individual and collective levels.
 - b. Promote awareness on the consequences of gender inequity in the medical profession, especially for women, and non-cisgender people.
 - c. Develop strategies that actively promote educational and leadership opportunities for all medical students, irrespective of their gender.
 - d. Promote the usage of gender inclusive language and pronouns in all internal processes and reform official documents in order for them to be entirely gender sensitive.



- e. Actively engage in peer education programs to increase their competences on gender related issues.
2. Medical schools to:
 - a. Educate and encourage students to uphold gender equity in a clinical scenario, ensuring a holistic professional development of future health workers in collaboration with local organizations or individuals who have experienced gender-based discrimination.
 - b. Develop and implement gender sensitive medical education to all students.
 - c. Eliminate study materials that reinforces stereotypes, leading to gender-related stigma and discrimination
 - d. Provide support, resources and opportunities for students who may be disadvantaged on the basis of gender.
 - e. Promote an inclusive and respectful learning environment and ensure every student's safety from physical or psychological harassment and assault.
 3. The health sector to:
 - a. Promote and educate on gender equity in order to ensure a safe environment for both employees and patients, especially women and non-cisgender people.
 - b. Develop policies that enforce equal gender representation in specialties, leadership and research positions.
 - c. Ensure working conditions which enable all people to have equal career options and possibilities. This includes the provision of opportunities for flexible working conditions that allow people from all genders to participate in child rearing and home duties without detriment to their future career possibilities.
 - d. Ensure that staff employed in the health workforce receive equal remuneration for equal work, irrespective of their gender.
 4. Governments to:
 - a. Ensure government employees receive equal remuneration for equal work, irrespective of gender, and moreover promote equal pay in all non-governmental sectors.
 - b. Promote large-scale research and segregated data collection aimed at studying the health, healthcare and socioeconomic gaps in people of diverse gender identities and expressions.
 - c. Develop and implement strategies to increase representation of women and non-cisgender people in all decision-making organs and in leadership positions within the government.
 - d. Implement parental leave policy that encourages equal participation in child rearing and absence from paid work.
 - e. Promote recognition of people who identify as non-binary through more than two gender options on legal documents and also through inclusive infrastructures.
 - f. Actively support the legal empowerment of all people to make autonomous decisions in regards to gender-affirming processes.
 5. NGOs and international agencies to:
 - a. Advocate for and work alongside women and non-cisgender people when developing and implementing policies, programs and research.
 - b. Ensure equal representation of genders in leadership roles and support the training of leaders from minority backgrounds.
 - c. Ensure equal remuneration for equal work irrespective of race, colour, gender, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.



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Position Paper

Introduction

According to the current understanding, gender is an umbrella term for norms and roles determining which characteristics and behaviours are perceived masculine or feminine and hence considered appropriate for men or women according to societal beliefs. Contrary to our biological sex, male or female, gender is a social construct that varies across societies and changes with time [1].

While gender inequality refers to the undeniable differences between the variety of sexes and genders, gender inequity is an unfair inequality, an obstacle to a person's enjoyment of rights and opportunities based on their gender identity or expression [1]. Moreover, individuals who do not follow established gender norms and women often face severe stigma and discrimination and are more vulnerable to gender inequity [2]. The IFMSA is committed to supporting gender equity within and outside of medicine as stated in The Universal Declaration of Human Rights, which articulates that everyone is entitled to human rights "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

IFMSA recognises that non-cisgender individuals face unique challenges and discriminatory practices. For this reason, we defend their rights and address their needs and struggles across all our policies and actions. However, research in the field of non-cisgender individuals and health is very limited, limiting our ability to provide reliable evidence that strays away from a female-male binary perspective.

As the voice of medical students across the globe, the IFMSA emphasizes that gender equity is essential to the human right to health, which includes the freedom to control one's health and body, and the entitlement to a system of health protection granting equal opportunity for all to attain their highest possible health [3]. Gender inequity exists in the social determinants of health, including levels of exposure to disease and injury, investment in nutrition, care and education as well as access to and use of health services [4]. Improving gender equity in health is therefore one of the most direct and potent ways to reduce health inequalities and ensure effective use of health resources [5].

Gender-based social exclusion and discrimination also have direct adverse effects on physical, social and psychological health [5]. Since health impacts of gender relations are multidimensional, they cannot be addressed through a traditional binary male-female approach. [4] This further calls for both healthcare systems and societies to aim for an inclusive, sensitive and non-binary perception of gender identities [5].

Gender equity must not be seen as a regional concern, but should be advocated through international networks, as gender inequality exists worldwide in a variety of ways [6] and its consequences on people's health can be devastating. For instance, in the countries of West Pacific Region boys are more likely than girls to receive full immunisation [7]; many females of the African Region are affected by harmful traditional practices such as female genital mutilation/cutting[8]; and violence against women is still prevalent in all regions of the world [8]. These examples show that striving for gender equity is essential to ensure people's right to health globally.



Background

Driving forces of gender inequity

Globally, women are poorer, have less access to education, experience higher levels of violence and are underrepresented in senior and government positions compared to cisgender men [9]. One important driving force behind the persistence of these trends is the presence of gender-based bias and discrimination within customs, laws, and institutions. These pillars of society perpetuate and normalize gender inequity systemically, starting at an early age with education.

As a result of these gender-specific barriers to schooling, women compose over two-thirds of the world's illiterate population [10]. The World Bank identifies five main barriers driving gender inequality in education: educational quality, access and retention, post-primary education, the transition from school to the labor market, and "emerging issues" including HIV/AIDS, violence, and conflict [11]. Further, many girls enrolled in school will be forced to abandon it within a few years in order to do chores, prepare for marriage, or out of fear of harassment, particularly in sub-saharan Africa [10].

To promote equity in access to education and therefore economic resources is to promote socio-economically prosperous and healthier nations. Women who have more schooling participate in the labour market and earn wages, effectively reducing poverty. They are more likely to increase well-being in the household by allocating more resources to food, healthcare and education. Women's education also decreases both mother and infant mortality rates, lowers rates of HIV transmission and reduces violence against women [11].

A variety of interventions have successfully increased enrollment of girls in school [11]. Because educational facilities are spaces that embody cultural values and imply standards of behaviour, and where individuals build and form their identities [12], they can be powerful drivers of equity, promoting tolerance and respect among the new generations. They also provide girls with role models through female teachers [10].

Women's increased education, followed by better health and economic empowerment are also a path to increasing their political participation and capacity to drive equity. Evidence exists that the presence of women in government is associated with gender-sensitive legislation and higher levels of gender equality [13].

Women play a diverse range of roles within families and communities around the world, and therefore development initiatives can never be gender-neutral. Decisions made about initiatives such as infrastructure, governance, and community resources all have an effect on gender equity, whether gender is explicitly considered or not. In fact, gender roles and socio-economic development shape each other and evolve together within all societies [14].

Both men and women are advocating for women's rights in each nation, as well as driving the commitments to gender equity made by numerous governments. Indeed, women's organizations across the globe are the pioneers and key agents in identifying gender issues and proposing gender equity strategies that are culturally appropriate, while redefining the relationship between gender, nationality, tradition and religion [14].

Efforts to promote female empowerment and gender equity in leadership, government, business and the community must include dialogue with local women's and gender-diverse organizations so that all people may have access to their human rights of expression, safety, education, marriage, and equal opportunity to participate in the workforce and contribute to societal socioeconomic development.



Societal Impacts of Gender Disparities

Gender inequity is a major impediment against societal advancement, particularly in reducing poverty [1]. It also enlarges inequalities in education, work and pay, leadership and political representation and property ownership and rights. Data concerning gender equity markers are still largely focused on women rather than trans and non binary people and therefore quantitative inequalities are difficult to assess.

Girls are still more likely than boys to never set foot in a classroom especially at a younger age, despite the tremendous progress made over the past 20 years [2]. There are approximately 60 million primary school-age children (6-11 years old) that are missing from classrooms, 23% of girls are not in school compared to the proportion of boys which is 19%, half of them are from sub-saharan Africa [2].

Workforce participation

Globally, it is estimated that 49% of the female population participates in the paid workforce, compared to 75% of males. [3] Female labor force participation is lowest in the Middle East and North Africa (26%) and South Asia (35%) and highest in East Asia and Pacific (64%) and Sub-Saharan Africa (61%).

The gender wage gap is quite variable across regions of the world, with some countries making excellent progress towards economic gender parity while in others the gap widens. In lower and upper-middle income countries women earn on average 68% of male wages and in lower-middle income countries 67% [5]. The pay gap still exists even for high-income countries with women earning on average 72% of male wages and in all OECD countries (those which have signed the convention on the Organisation for Economic Co-operation and Development) median wages for men are higher than those for women [6].

Women spend 2 to 10 times more time on unpaid work than their male counterparts. Unpaid care work includes preparing food, cleaning, caring for children, ill and elderly family members. This difference is most significant in the Middle East, North Africa and Sub-Saharan Africa but is present in all areas of the world. This may contribute to a double burden of work and impacting on the ability of women to succeed in the paid workforce. [7]

Women are less likely to hold leadership and political positions compared to men. Overall, 22% of national parliamentarians were women in 2016, ranging from 42% in Nordic countries to only 17% in the Arab States and the Pacific region. [8] There is increasing evidence to suggest that political decision making is improved with increasing gender equality among participants. Women also have limited presence on boards of directors around the world. [9]

Discriminatory legislation and customs have led to men having disproportionate access to property ownership and land rights. Women own less than 20% of the world's land despite being important contributors to the agricultural workforce and the world's food production. [10] [11] Furthermore, while legally in most places of the world, women have equal rights to inheritance, customary laws and traditions have hindered equality of property distribution and too often women remain excluded from legal and official inheritance. [12]

Health Consequences of Gender Disparities

Health differences between men, women and other genders may be explained by biological sex, the cultural experience of gender, or both.



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Despite having an increased need for healthcare in the reproductive age group, women often face barriers in access to healthcare and health services. The poorest women are the most likely to be excluded from healthcare.[13] However even in developed countries women may still face relative barriers to healthcare, especially those facing other kinds of discrimination such as race or religion. A Canadian study found a higher percentage of women had unmet care needs compared to men and in the US women are more likely to experience delay in having care needs met. [14][15]

Children's Health

The under 5 child mortality rate has fallen by more than half since 1990 and with that, ratios of female to male under 5 survival are rising.[16] However, given that female infants have a biological survival benefit, sociocultural disadvantage in survival is often underestimated and remains significant in many parts of the world.[17] In Sub-Saharan Africa improvements in many countries were offset by worsening gender survival ratios in others. In India and China, female under 5 survival was worse than for males and has in fact worsened over time. In India, girls are 75% more likely to die than boys between the ages of 1 to 5.[18] Son preference has led to a 'missing girl' phenomenon seen particularly in India and China. In China there are 37 million more males than females and in India it is estimated that 50 million girls are missing from the population.[19][20]

Infectious Diseases

While in some countries, the burden of HIV and AIDS is mostly carried by men, and in particular, men who have sex with men, globally the burden of HIV amongst women is far bigger. Worldwide, women (15-24 years) are twice as likely to be at risk of HIV infection than young men and HIV/AIDS is the leading cause of death of women aged 15-44.[21][22] Tuberculosis, linked to HIV, is among the top 5 causes of death in women aged 20-59. Gender inequity is often drivers of vulnerability and exposure to infection. For example people who cook indoors with open fires, people in contact with animals, people who take care of ill family members and being pregnant increases the risk of infections.[23] Having limited control over family decisions, finances and limited autonomy to seek and utilise health-protective equipment such as mosquito nets increases risk of diseases like malaria.

Mental Health

Poor mental health can be linked to stressors, negative life events, discrimination and gender-based roles. Common mental illnesses have been found to disproportionately affect women. Unipolar depression affects women at twice the rate of men.[24] Additionally, people who identify as LGBT (lesbian, gay, bisexual, and transgender) are at much higher risk of mental illness, with one study finding almost 60% of transgender women met the criteria for major depression.[25] On the other hand, men are more likely than women to suffer from substance dependence and abuse and are more likely to complete suicide.[24][26] Despite declining rates worldwide, far more males than females smoke tobacco, putting males at significant increased risk of cardiovascular and respiratory conditions secondary to smoking.[27] Men are also more likely to die from causes associated with excess alcohol intake. [28]

Gender-based Violence

One in three women will experience gender-based violence and in some countries up to 70% of women will experience physical or sexual violence by an intimate partner.[29] Women who have experienced violence are 1.5 times more likely to have an STI such as HIV, more than twice as likely to have depression or alcohol abuse.[30] Almost half of murders of women were committed by an intimate partner or family member, compared to 6% of the murders of men.[29] Worldwide, 100–140 million girls and women have suffered female genital mutilation (FGM.) The procedure has no health benefits and can cause bleeding, infection and sepsis. FGM also leads to higher rates of obstetric complications and higher perinatal mortality rates.[31]



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Both sex and gender may account for morbidity associated with pregnancy, particularly termination of unwanted pregnancies. Around 25% of all pregnancies end in induced abortion and every year around 25 million unsafe abortions occur, mostly taking place in developing countries. Up to 13% of maternal deaths can be attributed to unsafe abortions.[32] While pregnancy itself accounts for differences in health outcomes due to biological sex, most maternal deaths worldwide are preventable and are at least partly due to gender discrimination. [33]

While in many areas the sociocultural bias favours the health and wellbeing of males in comparison to other genders, in other areas males are at greater risk of illness and injury. Globally, men have a shorter life expectancy than women from birth - observed in both low and high-income countries men are more likely to experience a fatal injury in the workplace.[27][34] Additionally, men are less likely to utilise healthcare compared to women.[28] This may be due to sociocultural attitudes towards masculinity that discourage protective behaviours relating to both physical and mental health.

Gender-Sensitive Medicine and Medical Education

The lack of gender sensitive research and guidelines leads to reduced applicability of studies in clinical settings, due to a neglect of gender differences such as in treatment and dosages, and in health seeking behaviors. [35] Sex and gender differences are often overlooked in research design, study implementation and scientific reporting, and also in scientific communications;[36] and it is necessary to compile, analyse and publish data separately for different genders. A gender-sensitive analysis of statistics should go beyond simply disaggregating data, and question underlying gender relations by using gender differentiated indicators and indices.[37] It is encouraged to create guidelines in providing a more systematic approach for reporting of sex and gender, with possible post-study evaluations on gender sensitivity.[36]

Medical education acts as a foundation building block for a more gender sensitive academia, and should be regarded as the frontline for change and improvements. Fairness and justice should be given for gender equity in enrollment of medical students to ensure accessibility for all. Gender sensitive content should be included in the curricula, as it will not only give students a better understanding of patients' perspectives for improved service, but also affect students' career trajectories and hence demographics of medical profession, e.g. abolishing the gendered norms of certain specialties.[38] Schools should actively monitor the experiences of their trainees and target interventions where problems still exist in order to ensure that progress toward gender equity is maintained in medical education.[39]

Improvements in women's health are intrinsically linked to women in academic medicine, with many recent advances in women's health being made by female doctors and scientists. Thus, it is critical to the advancement of women's health that women's leadership in academic and clinical medicine is encouraged and supported.[40]

Gender Disparities in the Medical Students, Workforce and Workplace

Despite medicine traditionally being a male-dominated profession [41], in recent years, women have had an increasing presence in the medical field, bridging the gender divide in terms of numbers of medical students in over the past 30 years in a wide range of countries including the United Kingdom, the Netherlands, Norway, Sweden, Finland, Russia, Australia, Canada and the United States [42, 43]. However, in countries such as Japan, medicine remains a male-dominated profession both in clinical and academic settings [44]. It has been shown that a gender-balanced workforce is beneficial to both students [45,46] and patients [47], providing a more effective health care system that parallels societal evolution.



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Yet, despite this influx of women into the medical field, there is still a significant gender disparity in pay rates, and women in leadership positions [48]. Several international studies [48,49,50] have demonstrated that although there is an extensive pool of women academics from which future leaders can be drawn, this is not reflected in the number of female applicants or appointed professors due to gender-biased expectations and recruitment methods, inflexible working environments and a range of other factors. Moreover, gender bias, whether unconscious or implicit, persists in the appointment, evaluation and promotion of females for medical school faculty positions [51], as women's intellects are given significantly less repute than their male counterparts'.

Gender inequity among physicians starts in medical schools. A recent article in the African Journal of Health Professions Education [52] found that 51% of female South African medical students felt they were professionally viewed differently to their male counterparts. Furthermore, female medical students experience less attention and support than their male peers, in addition to experiencing sexual harassment, sexist jokes [53] and direct gender discrimination [54]. Women in cultural minorities are also more likely to expect gender discrimination within medical school than men [55]. Combined, these gender-specific barriers can impact women's medical school experiences and their persistence into a career as a doctor.

Many female medical students and doctors feel that family demands limit medical career paths, yet males do not demonstrate the same concerns [56,57]. Women also feel greater pressure to conform to normative gender expectations [58]. Furthermore, women report less confidence in their clinical abilities than their male colleagues, although often perform better [59,60]. Lower confidence results in less career satisfaction which also influences women's decision-making with regards to continuation as a doctor [44].

In countries such as Pakistan, although female medical students outnumber male students, only approximately half of them actually work as doctors primarily due to family commitments. This lack of female practitioners has resulted in disproportionately high rates of female-specific cancers and subsequent mortality, particularly in rural areas of Pakistan [61].

In many, if not all, countries, male physicians have higher earnings than female physicians, even after adjustment for medical specialty, practice setting and number of hours worked. [62-65]. In the United States, male doctors earn 20% more than their female counterparts [65]. Although much progress has been made in the past 30 years in narrowing the gender pay gap, there remains significant work to do [66].

Although women represent large proportion of physicians in many countries, there remains a pattern of gender segregation within many medical specialties, primarily as the result of historical gender stereotypes [67]. Aspects of some medical training programs including gender discrimination and sexual harassment from nurses, patients, and colleagues, have been shown to influence specialty choice for many women [68].

As a result, many specialties have a strong gender-skew that may lead to shortage of specific professionals. For example, surgery remains a significantly male-dominated field [69], while paediatrics, psychiatry, general practice, obstetrics and gynaecology tend to have a greater proportion of females [69]. Underrepresentation of females in the field of surgery has been well documented around the world, for example in the USA [70], the UK [71] Malawi [72] and Israel [73].



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