



IFMSA

International Federation of
Medical Students' Associations

IFMSA Policy Document Gender Equity

Proposed by Team of Officials

Adopted at the IFMSA Online General Assembly March Meeting 2021.

Policy Commission

- **Christos Papaioannou**, HeIMSIC Greece, xrhstospap96@gmail.com
- **Mauli Mehta**, MSAI India, mehtamauli98@gmail.com
- **Ieva Berankytė**, Liaison Officer for Sexual and Reproductive Health and Rights issues, incl. HIV and AIDS, lra@ifmsa.org



IFMSA

International Federation of
Medical Students' Associations

Policy Statement

Introduction:

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. Gender inequity is included in the social determinants of health, and 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.

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, 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.

Call to Action:

Therefore, IFMSA calls for:

- **Governments to:**
 - Ensure government employees receive equal remuneration for equal work, irrespective of gender, and moreover promote equal pay in all non-governmental sectors;
 - Promote research and segregated data collection, aimed at studying diverse gender identities and expressions;
 - Develop and implement strategies to increase the representation of women and non-cisgender people in all decision-making bodies and in leadership positions within the government;
 - Implement family-friendly policies in the workplace, such as equal parental leave and childcare services.
 - Promote recognition of people who identify as non-binary through inclusive gender options on legal documents and through inclusive infrastructures;
 - Demand employers to implement sexual harassment prevention policies, diversity trainings and family-friendly working conditions;
 - Adopt gender-sensitive laws and policies on access to healthcare services and discrimination based on gender in healthcare settings;
 - In times of global crisis, recognize gender equity as a priority and continue the implementation of strategies for gender equity.

- **NGOs and International Agencies to:**
 - Advocate for and work alongside women and non-cisgender people when developing and implementing policies, programs and research;
 - Ensure equal representation of genders in leadership roles, supporting the empowerment of leaders from minority backgrounds and ensuring equal remuneration for equal work irrespective of gender and sex;
 - Organise public campaigns to promote visibility and legitimacy of gender equity issues.

- **The Health Sector to:**



IFMSA

International Federation of
Medical Students' Associations

- Promote and educate on gender equity and inclusivity in order to ensure a safe environment for both employees and patients, especially women and non-cisgender people;
- Develop policies that enforce equal gender representation in specialties, leadership and research positions;
- Ensure working conditions which enable all health professionals 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;
- Ensure that staff employed in the health workforce receive equal remuneration for equal work, irrespective of their gender;
- Make recruitment processes uniform and transparent, in order to eliminate gender bias;
- Acknowledge differences between genders in symptoms, health needs and health-related attitudes and practice gender-sensitive medicine in addition to conducting research on transgender health.

• **Medical Schools to:**

- Educate and encourage students to uphold gender equity in clinical practice, ensuring a holistic professional development of future health workers in collaboration with local organizations or individuals who have experienced gender-based discrimination;
- Develop and implement gender-sensitive medical education to all students;
- Eliminate study materials that reinforce stereotypes, leading to gender-related stigma and discrimination;
- Use or establish support systems, resources and opportunities to empower students who may be disadvantaged on the basis of gender;
- Ensure an inclusive and respectful learning environment and every student's safety from physical or psychological harassment and assault by creating functional strategies and systems (such as anonymous reporting);
- Ensure that supervisors and teachers receive diversity training in order to promote an inclusive environment.

• **Medical Students and IFMSA National Member Organisations to:**

- Promote awareness on the health impacts of gender inequality at both individual and collective levels;
- Promote awareness on the consequences of gender inequality in the medical profession, especially for women, and non-cisgender people;
- Develop strategies that actively promote educational and leadership opportunities for all medical students, irrespective of their gender;
- 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;
- Actively engage in capacity building activities to increase their competences on gender-related issues;
- Utilise existing mechanisms inside IFMSA to promote gender equity, namely participate in Gender Watch, enrol activities on gender issues in Programs and report incidences of gender discrimination;
- Promote gender equity in NMO structures and leadership positions and establish structures that uphold gender equity.

Position Paper



IFMSA

International Federation of
Medical Students' Associations

Background information:

Gender is defined as a socially constructed variable that differs considerably across societies and over time, comprises the roles, behaviours, activities and attributes of girls, women, boys, men, and gender diverse people. This leads to a distinction of expected behaviour on the basis of gender and societal norms. Gender should not be used interchangeably to the term *biological sex*, which refers to the different physical and physiological characteristics of female, males and intersex persons. (1–3)

Even though gender inequality refers to the undeniable differences between the variety of sexes and genders, its main purpose is to achieve the enjoyment of equal rights, opportunities, and treatment for all human beings regardless of their gender identity or expression. Gender equity means fairness of treatment for people of all genders according to their relevant needs. This can mean equal treatment or treatment that is divergent but seen as equivalent when it comes to responsibilities, opportunities and rights. (4) Gender equity and gender equality are used as interchangeable terms, but the two refer to different strategies that are necessary to eliminate gender-based health inequities.(5)

Gender inequity is a human rights violation, affecting many peoples' lives in various ways and therefore limiting them from reaching their full potential. (6) Moreover, individuals who do not follow established gender norms and women often face stigma, discriminatory practices, or social exclusion, hence more vulnerable to gender inequity. (7)

Equity within and outside of medicine is a prerequisite to the Universal Declaration of Human Rights (8) which affirms that: *"all persons are born free and equal in dignity and rights and that everyone is entitled to the enjoyment of human rights without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."*

(9). 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. (10) 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. (11) Since the health impacts of gender relations are multidimensional, they cannot be addressed through a traditional binary male-female approach. (10) This further calls for both healthcare systems and societies to aim for an inclusive, sensitive and non-binary perception of gender identities. (11)

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 (10) and its consequences on people's health prove to be devastating. For instance, in the countries of West Pacific Region boys are more likely than girls to receive full immunisation (12,13); many women of the EMR and African Regions are affected by harmful traditional practices such as female genital mutilation, forced marriage and deprivation of inheritance [12]; and violence against women is still prevalent in all regions of the world. (14) A similar instance is witnessed in the United States of America, where there are no federal laws regarding child marriage. (15,16)

Discussion:



IFMSA

International Federation of
Medical Students' Associations

Gender Equity Globally - a United Nations (UN) perspective

Gender equity and Women's human rights have always been central to three pillars of the work of the United Nations: peace and security, development, and human rights. The UN seeks to empower young individuals as equals in achieving gender equality. (17)

Three thematic pillars have been identified in the UN Youth and Gender Equality Strategy:

1. "Leadership of young women in all spheres;
2. Economic empowerment and skills development of young women;
3. Action on ending violence against young women and girls."

The three pillars are accompanied by cross-cutting approaches focused on participation, partnerships and the inclusion of young men. (18)

The Generation Equality Forum, an international event convened by UN Women, aims to enhance progress on gender equality and has launched six catalytic Action Coalitions:

1. Gender-based violence;
2. Economic justice and rights;
3. Bodily autonomy and sexual and reproductive health and rights (SRHR);
4. Feminist action for climate justice;
5. Technology and innovation for gender equality;
6. Feminist movements and leadership.

In line with the UN Sustainable Development Goals each of the aforementioned coalitions will establish solutions to accelerate the progress for women's rights. (19)

Societal Impacts of Gender Disparities

Workforce participation and economic discrimination

Women are still under-represented in the economic workforce. However, since the beginning of the 20th century, we can observe the increasing rates, with the most prominent changes in Burkina Faso (19x increase) and Qatar (6x increase). As of 2020, the women-to-men ratio in labour workforce participation globally is 66.5%. (20) At paid work, women are more likely to spend fewer working hours, usually not by their choice. Women are also more likely to work in family businesses (15% women vs 5.5% men) and according to the International Labour Organization (ILO), women workers are more likely to be paid poorly or nothing at all, putting them at risk of living in poverty. This situation denies them social protection and employment contracts (21). Women are also paid less for the same work, time and position, and the existence of those inequalities can be measured by observing the "gender-pay gap". According to UN estimates, the pay gap as of 2020 is at 23% across all regions, meaning that women make 77 cents for each 1 dollar men make and the factor-weighted gender-pay gap is estimated to be over 21% according to the 2018/19 ILO report (22,23). This phenomenon is shrinking since the past decades, though it still persists in societies around the world.

Equal access to education being one of the most impactful factors narrowing the gender-pay gap, was increased. However, nowadays education plays a less significant role and what matters more is the type of education. Usually, the jobs typically perceived as women-appropriate are less valued and therefore less paid. Another contributing factor is the 'motherhood penalty' which allows justification of lower salaries solely based on the ability to bear pregnancy. A study from Denmark reveals that the pattern of increasing salaries over the years stands true in groups of women who don't have a child, men who don't have a child and men who have a child but exclude women who have a child. Moreover, salaries rapidly decrease and never fully recover for women who get pregnant (24). In addition, globally 185 economies offer maternity leave (median 98 days), while 105 countries offer paternity leave (median 5 days) (25). Despite this, 60% of women do not have the statutory right to maternity leave and 66% are not legally entitled to receive paid maternity leave, that holds them to return to their job after childbirth (26). The gender pay gap is furthered by the social norms of many societies, thus



IFMSA

International Federation of
Medical Students' Associations

producing fewer opportunities for women to develop negotiation skills which predisposes the acceptance of lower wages and positions with lower promotional potential. Strategies proposed to reduce gender-pay gap call to improve and equalize education, ensure control over reproductive choices, increase access to devices alleviating domestic chores (e.g. washing machines), realize equal access to public and safe transportation, implement family-friendly labour policies, increase childcare services and early education, reduce the incentive that companies and markets get by rewarding workers that can work long, non-flexible hours and finally, to change the norms and stereotypes that limit the array of choices available for all genders. (27–29)

Moreover, many tasks that are attributed to women as a gender role are unpaid domestic or care work, which are not financially beneficial. Globally, women spend nearly three times more hours in unpaid domestic or care work than men. (30) In some countries, the ratio of women-to-men time spent on unpaid domestic and care work is more extreme, this includes 17 in Mali, and approximately 10 in Pakistan and India, lowest rate was observed in Uganda, Denmark and Sweden, with rates being below 1.5. Overall, women spend more time than men working in both paid and unpaid jobs combined. While considering the World Bank regions, the rates are the highest in the MENA region and South Asia and the lowest in Europe and North America. (28) As women work more outside the workplace, they tend to seek jobs that allow them flexibility and those types of jobs are usually lower-paid. (31) Also, globally 21.7% of women (in comparison with 1.5% men) provide unpaid care jobs on a full-time basis, which prevents them from seeking paid jobs. (32)

Unemployment is defined as people who are available for and are seeking for jobs, but don't have one. In the majority of societies unemployment rates tend to be equal, but they still exist in countries which favour men: Saudi Arabia, Egypt, Syria and Oman, among others. There are still many countries in the world that prohibit women (non-pregnant and non-nursing) to do the same job as men, putting legal barriers in access to economic participation. (33)

All of the aforementioned issues have a reflection on pensions. With lower access to social protection, lower salaries, less working hours and higher rates of informal work, women above retirement age receive a pension that is nearly 11 times lower than men's. (34) Therefore, older women suffer from the consequences of the same gravely than old men.

With the increasing need for skilled professionals, there is an increased pressure to end the gap for women in tertiary education. Otherwise, another persisting and deepening barrier for equal participation in labour will be created. It is estimated that by 2030, 40-160 million of women might need transition into higher-skilled positions. (35)

Workplace discrimination and representation

Discrimination at work is defined by the ILO (International Labour Organization) as:

"Any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin (among other characteristics), which has the effect of nullifying or impairing equality of opportunity and treatment in employment or occupation".

Many forms of discrimination were reduced, but there are still less visible aspects that await to be tackled. This visibility is highly subjective, considering what is less visible in one country may be more than clearly visible in another country. Despite facing the discrimination on the basis of gender, people might face discrimination for their other identities such as indigenous origin, migration experience, which only perpetuate the overall feeling of being underprivileged at the workplace. It is worth mentioning that eliminating discrimination is beneficial for both workers and employers, because it boosts the feeling of safety, morale and self-esteem of employees, who continue to be more productive and competent. (36)

When women earn less than men, they receive less paid courses and training to upskill, therefore they are disadvantaged in promotion considerations. Yet, reducing income inequalities will not solve



IFMSA

International Federation of
Medical Students' Associations

problems with access to opportunities and improved outcomes. A meta-analysis shows that women who apply for men-dominated jobs are evaluated more negatively. Women working for men-dominated jobs have to put even more emotional and intellectual strength to finish a given task. Some studies, in which two identical job applications were sent, varying only by gender, show that women were less likely to be called back. In addition, women managers and mid-level workers receive fewer responsibilities precursor for promotion, less challenging tasks and fewer training opportunities that result in disparities of gender representation at high-level positions, as men tend to get leadership positions in both men-dominated and women-dominated occupations. Even if women have the same qualifications, managers see them as less capable and are less likely to promote them. (37) As a result of that, in 2019, only 20% of women held board positions worldwide. (38)

Another persisting issue is sexist comments and sexual harassment, that should be targeted by inclusive workplace policies and compulsorily following those policies. In Hong Kong, 20% of women workers (vs 6.6% men) report experiencing sexual harassment at workplace; in Italy 55.45%; in the EU 40-50%; in Australia 18%; 25-85% in the USA. (39,40) One of the strategies to improve gender balance in the workplace is to recruit, retain, and develop employees from under-represented groups, rewarding managers who choose more diverse staff members, policies that prohibit discrimination and ensure family-friendly working conditions and diversity training. (37)

Lack of leadership position diversity is visible in parliamentary seats. Globally, 25% of seats are assigned to women, reaching 0-2% in Yemen, Vanuatu and Oman and 61% in Rwanda. (41) However, in all hierarchical jobs, women as leaders are evaluated more critically and have higher standards of performance than men and this phenomenon amplifies when a woman acts more assertively and in a stereotypically "masculine" way. During problem-solving spaces, women are more likely to be discredited and their expertise is doubted, while men rarely come across such a situation and very conveniently receive the benefit of doubt. (37). Men-centeredness is not only expressed in managerial or political position, but also in pop culture portrayal. In 2018, in 100 grossing movies, women and girls were only 33% of all speaking characters and only 9% of movies kept a gender-balanced cast. 39% of movies had women as a leading role and 11% had women of colour as a leading role, as one of many underrepresented groups. (42). Lack of gender balance is also prominent in the medical field- women account for 70% of the medical workforce, but hold only 25% of senior roles. (43)

Legislation discrimination

115 countries still have gender-based legislation that limits women's access to credit, therefore limiting chances to get high-value property. (44) 19 countries report not having equal access for men and women to ownership of immovable property. (45). Women own 20% of the land, while employment in agriculture tends to be equally distributed (25% of women, 27% of men). (46-48) In 2 countries women cannot sign contracts in the same way as men, while in 5 countries there are differences in terms of opening the business, and in 7 in opening a bank account.

36 countries report having different ways to apply for a passport for men and women; 15 countries report that women are not allowed to travel outside their home in the same way as men; 9 countries report gender differences in the ability to travel abroad. Women are legally obliged to obey the husband in 19 countries; in 48 countries women cannot obtain divorce judgement in the same way as their husband, while in 25 countries women don't have the same possibility to remarry. For inheritance, there is a disparity between rights to heritage for sons and daughters existing in 36 countries, while for a surviving spouse differences exist in 44 countries. (49)

Health Consequences of Gender Disparities

Infectious Diseases



IFMSA

International Federation of
Medical Students' Associations

Gender has a known impact on the patterns of exposure and treatment of infectious diseases. The main reasons identified are time spent away from home, women holding the role of caregivers for the sick, responsibility for caring for livestock, the difference in the health care and scientific knowledge regarding the treatment provided. (50) Evidently, women at the age group 15-24 have a two-times higher risk of being infected with HIV than men of the same age, while AIDS causes the most casualties for women aged 15-49 years. (51)

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. (52) On the other hand, men are more likely than women to suffer from substance dependence and abuse and are more likely to commit suicide. (53,54)

Maternal health and mortality

The ratio of boy-to-girl birth and survival is skewed from the biological ones due to factors like sex-selective abortions, femicide and favouring male offspring in food distribution contributing to malnutrition but also limiting access to medical aid. (55) The right to control one's reproductive life is heavily associated with a higher quality of life and the possibility of reaching one's full potential. As maternal health is heavily affected by the factors of gender inequality, women and adolescent girls of reproductive age are often subject to maternal health risks, such as lack of autonomy, lack of education and control over financial resources, trouble reaching healthcare facilities and power dynamics between healthcare providers and women themselves. (56)

Malnutrition and undernourishment

Women at reproductive age are at higher risk for deficiencies due to elevated needs associated with menstruation, pregnancy and lactation. Malnutrition is a result of HIV and AIDS, food insecurity and living in poverty. Iron deficiency is among the most common ones and globally affects 33% of women and is estimated to be twice as common in women than in men. On the other hand, women are more likely to be obese (15% vs 11%). Either malnutrition or obesity put women at risk of diseases resulting from this state. (57,58)

Gender-based violence

More than 35% of women will experience sexual and/or physical violence, from which the majority is caused by an intimate partner. Violence survivors are at higher risk of physical, mental, sexual and reproductive health impairments. 42% of women experiencing violence report injuries and 38% of femicides are the result of intimate partner violence. Exposure to violence can also lead to unintended pregnancies, induced abortions (2 times higher chances), gynaecological issues and sexually transmitted infections (1.5 times higher chances). It also leaves a mark on mental health leading to depression, drinking problems (both 2 times higher chances), PTSD, anxiety, sleep pattern disturbances, eating disorders and suicidal attempts. (59)

Female genital mutilation is another aspect of gender-based violence that can seriously deteriorate the health of an individual. As of 2020, approximately 200 million women worldwide had undergone this procedure with serious risk of shock, severe bleeding, impeded urination, cysts, infections, sexual dysfunctions, wound healing problems, severe pain, complications during childbirth and menstruation as well as psychological well-being. (60,61)

Sexual exploitation still poses the risk for health and life of women and girls that account for 72% of trafficked people. (62)

Access to SRHR



IFMSA

International Federation of
Medical Students' Associations

By 2020, the number of women with adequate access to family planning services to cover their needs reached 77%, with variations in different regions. Increased access to family planning caused the decrease of adolescent childbirth to 41 per 1000 births. (63)

Maternal mortality ratio fell to 211 deaths per 100 000 live births by 2017. One of the main causes of maternal deaths is unsafe abortions that are the reason for 7 million women being admitted to hospital annually due to severe complications. Unsafe abortions threaten the life of the pregnant individual because in the developed regions it is estimated that the risk of dying is 30 per 100 000 unsafe abortions, while in developing regions this number rises to 220 and to 520 in Sub-Saharan Africa. (63,64)

Non-communicable diseases and life-saving interventions

In many conditions, men are more likely to be treated more extensively than women with the same severity and their symptoms are more often considered organic, while in women - psycho-social. (65). The differential diagnosis for myocardial infarction was also less effective for women, who are 59% more likely to receive the wrong diagnosis at first. It is explained as women have less typical symptoms (that come from male-biased research) such as chest pain, and experience mostly shortness of breath, arm pain and tiredness. In addition to that, women are less likely to undergo coronary angiography, stents, heart surgery and receive most recent and appropriate medications. (66,67)

Strokes management also puts women at more disadvantage as they are 13% less likely to receive thrombolysis. However, this rate fell from 30% in the last 12 years. (68) Those differences are explained from the fact that women are in a higher risk of stroke, due to higher life expectancy, among other factors. Moreover, women present more atypical symptoms and unwillingness to receive the treatment. It is also reported that women receive less quality care and guidelines-based medications. (69)

Women are also less likely to be admitted to intensive care units and receive life-saving interventions such as CPR from bystanders. It was reported that 45% of men receive CPR in a public setting, compared to 39% of women. This results in a 23% higher survival rate for men. (65,70)

In 2020, the life expectancy of women was 75 years, while for men 70 years. (71,72). It is a result of not only biological factors but also, environmental, social and behavioural factors, as men are less likely to visit a doctor or report a symptom or illness. (73) Men are more likely to die due to excessive drinking, injury, suicide and die faster from non-communicable diseases reasons. Gender disparity in life expectancy is the narrowest in places where women lack access to healthcare. (74) Barriers that women face are institutional, financial, educational and social and include access to income, living in rural areas, social and financial status, educational status. (75,76)

Despite declining rates worldwide, far more men than women smoke tobacco, putting males at significant increased risk of cardiovascular and respiratory conditions secondary to smoking. (77) Men are also more likely to die from causes associated with excess alcohol intake. (78)

The data for transgender individuals is scarce about the general health outcomes. Although transgender people might suffer from as many conditions as the general population, research for this target group is focused solely on mental health. Trans people face many barriers in accessing healthcare, such as lack of providers skilled in transgender issues, but also fear of discrimination and financial obstacles. Additionally, their symptoms might be overlooked due to the lack of evidence-based research outcomes. (79)

Gender-Sensitive Medicine and Medical Education

The field of medicine has witnessed a dominance shift from men to women recently. Whereas, women will soon outnumber men in the global health workforce, working part-time is becoming more and more usual for women and a glass-ceiling for senior or leadership positions persists, also in the field of



IFMSA

International Federation of
Medical Students' Associations

medical education.. Surgery is still offered as a cis-hetero-male-dominated speciality. (80) Gender is included in the social determinants of health. Health professionals trained in gender issues can contribute to gender equity in health, as well as better health outcomes for all. Still, gender remains an obscure topic in medicine. First, it is stated that medicine is 'gender blind', by not considering gender whenever relevant. Secondly, medicine is said to be 'male biased', because the largest body of knowledge on health and illness concerns men and their health. Thirdly, gender norms and stereotypes exercise a negative impact on medical practice and health. Finally, gender inequality is being systematically ignored in terms of social determinants of health. (81).

Gender Disparities in the Medical Students, Workforce and Workplace

Medical Student starting point of discrimination and inequity

Gender inequity among physicians starts in medical schools. Multiple studies have shown that during their medical formation, around 60% of medical students and trainees have experienced discrimination and sexual harassment.(43) A national survey in the US had demonstrated that more than 50% of women medical students had experienced sexual harassment from the faculty's employees. (43) Furthermore, women medical students receive less support from their trainers, experience sexual harassment, sexist jokes (82,83), direct gender discrimination (84,85) and inappropriate behaviour (84) more often than their male counterparts. Women in cultural minorities are also more likely to expect gender discrimination within medical school than men. (86) An article in the African Journal of Health Professions Education (87) found that 51% of women medical students in South Africa felt they were professionally viewed differently to their male counterparts. Harassment and gender discrimination from the medical personnel and patients can also influence women's choice of specialty, pushing them away from certain specialties (43,88) or in some more extreme cases, push them away completely from the profession taking a serious toll on one's mental health.

In terms of the student's mental health, a recent article bringing together 49 American universities raised that black students and women had an increased risk of suffering from depression and anxiety symptoms than their white and men counterparts, respectively. (89) This adds to the fact that, according to several studies, the mental health of doctors deteriorates as their studies progress. (90)

Women also need to face the concept of "motherhood penalty". Pregnant residents are more inclined to compensate for their maternity leave by overworking, while truncating the duration of their leave. Several studies have shown differences in the perception of pregnant colleagues, where men tend to be less favourable specifically towards them. Other elements exacerbate this disparity between genders, namely a lack of institutional resources, such as on-call services in hospitals, breastfeeding rooms and lack of time to practice pumping milk due to busy clinics affecting the likelihood of breastfeeding and in turn the development of the child. (91)

Although women represent the majority of physicians in many countries, a pattern of gender segregation within many medical specialties remains, primarily as the result of historical gender stereotypes. (83,92–95) Women face discrimination throughout their entire careers, starting from their recruitment, during their years of training, accommodations in care and organization, even when they occupy a higher position in the medical hierarchy. (43,83,95) Women physicians face a culturally inhospitable working environment (95), where they are more likely to experience intimidation and devaluation of their work, including having their opinions ignored, their work not recognized and seeing increased workload imposed on them. (83,93)

Life balance

Many women medical students and doctors feel that family demands limit medical career paths, yet males do not demonstrate the same concerns. (96,97) Women are also more often expected to conform to stereotypical gender expectations and behaviours. (83,91,98) In a recent article discussing gender disparities in work and parenthood-profession balance among young physicians in the United States, it

could be seen that 75% of women reduced or considered reducing their working hours, in order to reconcile their new role as a parent. (99) Adapting their work to balance their different roles, especially at the beginning of their careers, contributes to the gender inequalities observed in payment, promotion and achieving positions of power.

Thus, the work status is quickly changed at the end of medical training by the patriarchy. (87,99) It is observed that married women physicians spent more time doing household and childcare activities, than their counterparts (between 67.4 minutes to 100.4 minutes more than men, depending if we add childcare).(91) All those disparities contribute to the «motherhood penalty» in salary, position and opportunity. Despite the challenges in terms of motherhood, several data show that the effects of motherhood diminish over time, but the duration depends on the number of children. (87)

Although in heterosexual couples parent roles remain strongly stereotypical, more and more young male doctors are seeking to reconcile work and family, compared to older generations. (91)

Furthermore, women are more likely to suffer from impostor syndrome. (83) They report less confidence in their clinical abilities than their male colleagues, although often performing better. (83,100,101) Lower confidence results in lower career satisfaction, which also influences women's decision-making with regards to continuation of their career as a doctor.(102)

Earning gap

In many countries, men physicians have higher earnings than woman physicians, even after adjustment for medical specialty, practice setting, and number of hours worked. (83,103) As of 2018, women medical practitioners were on average less paid than their male counterparts. (104) Women physicians start their careers with fewer resources and their starting salaries are often lower than those of their male counterparts. (95) The gender pay gap exists within each specialty as well as between specialties, especially between men-dominated and women-dominated specialties. (83) This can be seen in other healthcare professions, including home health aides and licensed practical nurses, who earned an average of \$0.83 for every dollar paid to their male counterparts in 2018. (104)

Whatever the method of remuneration, disparities persist. This gap cannot be explained by the fact that women work less or are less efficient in their tasks. Even if women are more likely to work less or part time, especially if they have children, this decrease often remains only temporary. (83)

Women occupy less of the better paid partnership positions. (83) In Canada, the mode of remuneration is fee-for-service, which contributes to inequalities, such as procedures performed more by specialties where women are overrepresented being paid less; (e.g. a penile biopsy is paid \$ 39.60 CAN vs a vulvar biopsy \$ 26.85 CAN). But we see that even by changing the remuneration model, like in the United Kingdom, where doctors are salaried, a disparity persists of around one third. (83) An American study demonstrated a referral bias among primary care physicians; if their patient had a poor result following surgery performed by a woman, physicians would generally refer less to women physicians (all specialties combined) in the future. The equivalent for men surgeons hasn't been observed. (105)

In addition, the way of practicing contributes to gender pay disparities. Women are more likely to take more time per patient, manage more issues per visit, discuss psychosocial issues and offer counselling; causing a drop in billing. Compared to men who do procedures that generate more income per hour. Moreover, patients have higher expectations of women to provide emotional support.(83)

From a representation point of view, men are also overrepresented in medical associations and in negotiating committees. (106)

Finally, women often have lower salary expectations than their men colleagues. (107) They often demonstrate less ability to negotiate a salary increase and are more likely to suffer consequences because of their demands. (83)



IFMSA

International Federation of
Medical Students' Associations

Repartition of gender towards the specialties

Many specialties exhibit a strong gender-skew that may lead to shortages of specific professionals. For example, surgery remains a significantly men-dominated field (43,108–110), while paediatrics, psychiatry, general practice, obstetrics and gynaecology tend to have a greater proportion of women practitioners (92,111). However, more and more men are choosing specialties that reconcile a more balanced lifestyle. (112)

Unfortunately, the established gender disparities persist across surgical specialties ranging from payment differences to career opportunities and institutional barriers. In 2018, the Canadian Medical Association reported that women represented 23.9% of surgeons apart from obstetrics and gynaecology. Even though the majority of women medical students (93%) have experienced or witnessed harassment or gender discrimination, more and more women are applying in surgical residences, reaching unprecedented numbers. This phenomenon has been observed around the world, which makes it possible to combat fundamental imbalances, whether in pay gaps or culture change. (95,109)

Disparity in research

The world of research has been predominantly men dominated. However, it has few research projects on gender disparities in research. A study conducted by Yale university to compare the gender gaps has reported in their findings that the work done by women was less recognized for high honours in research than their male counterparts. (113)

Representation of women in the academic field and in leadership positions

Several international studies (113–116) 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 women applicants or appointed professors due to gender-biased expectations and recruitment methods, inflexible working environments and a range of other factors. (92) In 2019, about 42.3% of university professors in medical schools in the United States are women. (117)

Moreover, gender bias, whether unconscious or done on purpose, persists in the appointment, evaluation (118), hiring (83) and promotion of women for medical school faculty positions (118), as women's intellects are given significantly less repute than their male counterparts. In the top 25 global universities of medicine only 20% of the deans were women. (43)

While women constitute the majority in the health care providers, they nonetheless represent only a minority in positions of power inside organizations. Only 19% of women lead a hospital. (119)

Gender Equity in Time of Crises

Conflicts and natural disasters adversely strike women, men, girls, and boys in different ways based on gender roles within society. (120) The gender-based difference in the impact of natural and human-inflicted disasters can be shocking as women and girls suffer greater casualties. According to the UN (121), the spread of the COVID-19 pandemic in 2020 has negatively affected the achieved progress in gender equity, deepening pre-existing inequalities, exposing vulnerabilities in social, economic, political and health systems therefore magnifying the effects of the pandemic. The immediate effects of COVID-19 on gender inequality are already showing in many fields such as economy health through the reallocation of resources and priorities, including sexual and reproductive health services, unpaid care work, and increasing gender-based violence. (122)

LGBTQIA+ people also face unique challenges and risks during the pandemic that may include stigma and discrimination while seeking health services, de-prioritization of needed health services, and domestic violence. (123)



IFMSA

International Federation of
Medical Students' Associations

Gender-blind responses can also reinforce gender-based discrimination, making bad situations worse for women and other vulnerable groups. (124) Thus, it is critical to have effective responses to crises, that consider and address all situations, needs and perspectives of women, girls and LGBTQIA+ people, to ensure that any act does not directly or indirectly discriminate based on gender. (125)

References

1. Oakley A. Sex, Gender and Society. Ashgate Publishing, Ltd.; 2015. 170 p.
2. WHO | About us. 2018 Dec 4 [cited 2021 Jan 7]; Available from: <https://www.who.int/gender-equity-rights/about/en/>
3. Government of Canada, Canadian Institutes of Health Research, Institutes, Institute of Gender, Health. What is gender? What is sex? [Internet]. [cited 2021 Jan 7]. Available from: <https://cihr-irsc.gc.ca/e/48642.html>
4. International Labour Office. ABC of women workers' rights and gender equality. 2007;(2nd ed., p. 91).
5. WHO | About us. 2018 Dec 4 [cited 2021 Jan 7]; Available from: <https://www.who.int/gender-equity-rights/about/en/>
6. Abendroth A-K. Gender Equality. In: Encyclopedia of Quality of Life and Well-Being Research. Dordrecht: Springer Netherlands; 2014. p. 2427–30.
7. Gender and health [Internet]. [cited 2021 Jan 7]. Available from: <https://www.who.int/health-topics/gender>
8. Universal Declaration of Human Rights [Internet]. 2015 [cited 2021 Jan 7]. Available from: <http://www.un.org/en/universal-declaration-human-rights/>
9. Labor force participation rate, female (% of female population ages 15+) (modeled ILO estimate) [Internet]. [cited 2021 Jan 7]. Available from: <https://data.worldbank.org/indicator/SL.TLF.CACT.FE.ZS>
10. Gender wage gap [Internet]. Earnings and wages. OECD; 2017. Available from: https://www.oecd-ilibrary.org/employment/gender-wage-gap/indicator/english_7cee77aa-en
11. Data Explorer [Internet]. [cited 2021 Jan 7]. Available from: <http://reports.weforum.org/global-gender-gap-report-2020/dataexplorer>
12. Ferrant G, Pesando LM, Nowacka K. Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes [Internet]. [cited 2021 Jan 7]. Available from: http://www.oecd.org/dev/development-gender/Unpaid_care_work.pdf
13. World Health Organization. Regional Office for the Western Pacific. Women and health in the Western Pacific Region : an overview. Manila : WHO Regional Office for the Western Pacific; 2011.
14. Facts and figures: Ending violence against women [Internet]. [cited 2021 Jan 7]. Available from: <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>
15. Brides GN. United States [Internet]. 2012 [cited 2021 Jan 7]. Available from: <https://www.girlsnotbrides.org/child-marriage/united-states/>



IFMSA

International Federation of
Medical Students' Associations

16. Ferguson S. What you need to know about child marriage in the U.s. Forbes Magazine [Internet]. 2018 Oct 29 [cited 2021 Jan 7]; Available from: <https://www.forbes.com/sites/unicefusa/2018/10/29/what-you-need-to-know-about-child-marriage-in-the-us-1/>
17. Youth [Internet]. [cited 2021 Jan 7]. Available from: <https://www.unwomen.org/en/what-we-do/youth>
18. Youth [Internet]. [cited 2021 Jan 7]. Available from: <https://www.unwomen.org/en/what-we-do/youth>
19. In lead up to Generation Equality Forum, Action Coalition themes announced [Internet]. [cited 2021 Jan 7]. Available from: <https://www.unwomen.org/en/news/stories/2020/1/announcer-generation-equality-forum-action-coalition-themes-announced>
20. World Development Indicators [Internet]. [cited 2021 Jan 7]. Available from: <https://databank.worldbank.org/reports.aspx?source=2&series=SL.TLF.CACT.FM.ZS>
21. The gender gap in employment: What's holding women back? [Internet]. [cited 2021 Jan 7]. Available from: <https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#unemployed-vulnerable/vulnerable-employment>
22. United Nations. International Equal Pay Day | united nations. [cited 2021 Jan 7]; Available from: <https://www.un.org/en/observances/equal-pay-day>
23. Global Wage Report 2018/19 – What lies behind gender pay gaps. Available from: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_650553.pdf
24. Why is there a gender pay gap? [Internet]. [cited 2021 Jan 7]. Available from: <https://ourworldindata.org/what-drives-the-gender-pay-gap>
25. Statistical Overview of Women in Global Workplaces: Catalyst Quick Take [Internet]. [cited 2021 Jan 7]. Available from: <https://www.catalyst.org/research/women-in-the-workforce-global/>
26. The gender gap in employment: What's holding women back? [Internet]. [cited 2021 Jan 7]. Available from: <https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#unemployed-vulnerable/vulnerable-employment>
27. Why is there a gender pay gap? [Internet]. [cited 2021 Jan 7]. Available from: <https://ourworldindata.org/what-drives-the-gender-pay-gap>
28. Ortiz-Ospina E, Tzvetkova S, Roser M. Women's employment. Our World in Data [Internet]. 2018 Mar 24 [cited 2021 Jan 7]; Available from: <https://ourworldindata.org/female-labor-supply>
29. Banerjee M. Gender Equality and Labour Force Participation: Mind the Gap. ANTYAJAA: Indian Journal of Women and Social Change. 2019 Jun 1;4(1):113–23.
30. The gender gap in employment: What's holding women back? [Internet]. [cited 2021 Jan 7]. Available from: <https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#unemployed-vulnerable/vulnerable-employment>
31. Why is there a gender pay gap? [Internet]. [cited 2021 Jan 7]. Available from: <https://ourworldindata.org/what-drives-the-gender-pay-gap>
32. Statistical Overview of Women in Global Workplaces: Catalyst Quick Take [Internet]. [cited 2021 Jan 7]. Available from: <https://www.catalyst.org/research/women-in-the-workforce-global/>



IFMSA

International Federation of
Medical Students' Associations

33. Why is there a gender pay gap? [Internet]. [cited 2021 Jan 7]. Available from: <https://ourworldindata.org/what-drives-the-gender-pay-gap>
34. The gender gap in employment: What's holding women back? [Internet]. [cited 2021 Jan 7]. Available from: <https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#unemployed-vulnerable/vulnerable-employment>
35. Statistical Overview of Women in Global Workplaces: Catalyst Quick Take [Internet]. [cited 2021 Jan 7]. Available from: <https://www.catalyst.org/research/women-in-the-workforce-global/>
36. DCOMM. ILO: Workplace discrimination, a picture of hope and concern. 2003 Jun 1 [cited 2021 Jan 7]; Available from: https://www.ilo.org/global/publications/world-of-work-magazine/articles/WCMS_081324/lang--en/index.htm
37. Stamarski CS, Son Hing LS. Gender inequalities in the workplace: the effects of organizational structures, processes, practices, and decision makers' sexism. *Front Psychol.* 2015 Sep 16;6:1400.
38. Statistical Overview of Women in Global Workplaces: Catalyst Quick Take [Internet]. [cited 2021 Jan 7]. Available from: <https://www.catalyst.org/research/women-in-the-workforce-global/>
39. Select Task Force on the Study of Harassment in the Workplace [Internet]. [cited 2021 Jan 7]. Available from: <https://www.eeoc.gov/select-task-force-study-harassment-workplace>
40. Sexual Harassment at Work. Available from: https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_decl_fs_96_en.pdf
41. Proportion of seats held by women in national parliaments (%) [Internet]. [cited 2021 Jan 7]. Available from: https://data.worldbank.org/indicator/SG.GEN.PARL.ZS?most_recent_value_desc=false
42. 2018 Statistics [Internet]. [cited 2021 Jan 7]. Available from: <https://womenandhollywood.com/resources/statistics/2018-statistics/>
43. Gender A, SOCIAL WORKFORCE. Delivered by women, led by men: [Internet]. [cited 2021 Jan 7]. Available from: https://www.who.int/hrh/resources/en_exec-summ_delivered-by-women-led-by-men.pdf?ua=1
44. Legal discrimination in access to credit: A global snapshot [Internet]. [cited 2021 Jan 7]. Available from: <https://datarwrapper.dwcdn.net/CxCGS/5/>
45. Gender Statistics [Internet]. [cited 2021 Jan 7]. Available from: <https://databank.worldbank.org/reports.aspx?source=283&series=SG.OWN.PRRT.IM>
46. Women own less than 20% of the world's land. It's time to give them equal property rights [Internet]. [cited 2021 Jan 7]. Available from: <https://www.weforum.org/agenda/2017/01/women-own-less-than-20-of-the-worlds-land-its-time-to-give-them-equal-property-rights/>
47. Employment in agriculture, male (% of male employment) (modeled ILO estimate) [Internet]. [cited 2021 Jan 7]. Available from: <https://data.worldbank.org/indicator/SL.AGR.EMPL.MA.ZS>
48. Employment in agriculture, female (% of female employment) (modeled ILO estimate) [Internet]. [cited 2021 Jan 7]. Available from: <https://data.worldbank.org/indicator/SL.AGR.EMPL.FE.ZS>
49. Women, Business and the Law [Internet]. [cited 2021 Jan 7]. Available from: <https://datacatalog.worldbank.org/dataset/women-business-and-law>



50. World Health Organization, Departments of Gender, Women and Health, and Epidemic and Pandemic Alert and Response. Addressing sex and gender in epidemic-prone infectious diseases. 2007;
51. The Lancet Hiv. For the HIV epidemic to end so must gender inequality. Lancet HIV. 2019 Jul;6(7):e411.
52. Gender and women's mental health [Internet]. [cited 2021 Jan 7]. Available from: <https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health>
53. Mental health [Internet]. [cited 2021 Jan 7]. Available from: <https://www.who.int/data/gho/data/themes/mental-health>
54. Gender and women's mental health [Internet]. [cited 2021 Jan 7]. Available from: <https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health>
55. United Nations, Department of Economic and Social Affairs, Population Division. Sex Differentials in Childhood Mortality (United Nations publication, ST/ESA/SER.A/314). 2011; Available from: <https://www.un.org/en/development/desa/population/publications/pdf/mortality/SexDifferentialsChildhoodMortality.pdf>
56. Maternal health [Internet]. 2018 [cited 2021 Jan 7]. Available from: <https://data.unicef.org/topic/gender/maternal-health-gender/>
57. Anemia [Internet]. 2019 [cited 2021 Jan 7]. Available from: <https://emedicine.medscape.com/article/198475-overview>
58. UNSCN. Gender [Internet]. [cited 2021 Jan 7]. Available from: <https://www.unscn.org/en/topics/gender>
59. Violence against women. Women Stud Abstr. 1995 Jun;24(2):25–8.
60. Bokaie M, Khalesi ZB, Roozbeh N, Mojahed S. Female genital mutilation in Southern Iran. Afr Health Sci. 2020 Jun;20(2):666–7.
61. Female genital mutilation (FGM) frequently asked questions [Internet]. [cited 2021 Jan 31]. Available from: <https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>
62. Facts and figures: Ending violence against women [Internet]. [cited 2021 Jan 7]. Available from: <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>
63. Goal 3 [Internet]. [cited 2021 Jan 7]. Available from: <https://sdgs.un.org/goals/goal3>
64. Mathai M. Preventing unsafe abortion in India. Indian J Med Res. 2005 Aug;122(2):98–9.
65. Hamberg K. Gender bias in medicine. Womens Health. 2008 May;4(3):237–43.
66. al. M et. Coronary Angiography and Intervention in Women Resuscitated From Sudden Cardiac Death. Mayo Clinic, American Heart Association. 2020;
67. al. W et. Impact of initial hospital diagnosis on mortality for acute myocardial infarction: A national cohort study. Editor's Choice. 2016;
68. George J. Sex Differences in Stroke Thrombolysis [Internet]. MedpageToday. 2020 [cited 2021 Jan 7]. Available from: <https://www.medpagetoday.com/neurology/strokes/86998>



IFMSA

International Federation of
Medical Students' Associations

69. Liu M, Li G, Tang J, Liao Y, Li L, Zheng Y, et al. The Influence of Sex in Stroke Thrombolysis: A Systematic Review and Meta-Analysis. *J Clin Neurol*. 2018 Apr;14(2):141–52.
70. What is CPR [Internet]. [cited 2021 Jan 7]. Available from: <https://cpr.heart.org/en/resources/what-is-cpr>
71. Life expectancy at birth, male (years) [Internet]. [cited 2021 Jan 7]. Available from: <https://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN>
72. Life expectancy at birth, female (years) [Internet]. [cited 2021 Jan 7]. Available from: <https://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN>
73. WHO | The men's health gap: men must be included in the global health equity agenda. 2019 Mar 4 [cited 2021 Jan 7]; Available from: <https://www.who.int/bulletin/volumes/92/8/13-132795/en/>
74. Uneven access to health services drives life expectancy gaps: WHO [Internet]. [cited 2021 Jan 7]. Available from: <https://www.who.int/news/item/04-04-2019-uneven-access-to-health-services-drives-life-expectancy-gaps-who>
75. Ojanuga DN, Gilbert C. Women's access to health care in developing countries. *Soc Sci Med*. 1992 Aug;35(4):613–7.
76. UN Womenwatch [Internet]. [cited 2021 Jan 7]. Available from: <https://www.un.org/womenwatch/feature/ruralwomen/overview-health.html>
77. Available UDW. Table 38 (page of 3). Occupational fatal injuries and rates, by industry, sex, age, race, and Hispanic origin: United States, selected years 1995–2011. Available from: <https://www.cdc.gov/nchs/data/hus/2013/038.pdf>
78. Tobacco control [Internet]. [cited 2021 Jan 7]. Available from: <https://www.who.int/data/gho/data/themes/theme-details/GHO/tobacco-control>
79. Safer JD, Coleman E, Feldman J, Garofalo R, Hembree W, Radix A, et al. Barriers to healthcare for transgender individuals. *Curr Opin Endocrinol Diabetes Obes*. 2016 Apr;23(2):168–71.
80. Bleakley A. Gender Matters in Medical Education. In: Bleakley A, editor. *Patient-Centred Medicine in Transition: The Heart of the Matter*. Cham: Springer International Publishing; 2014. p. 111–26.
81. Verdonk P, Benschop YWM, de Haes HCJM, Lagro-Janssen TLM. From gender bias to gender awareness in medical education. *Adv Health Sci Educ Theory Pract*. 2009 Mar;14(1):135–52.
82. Babaria P, Bernheim S, Nunez-Smith M. Gender and the pre-clinical experiences of female medical students: a taxonomy. *Med Educ*. 2011 Mar;45(3):249–60.
83. Cohen M, Kiran T. Closing the gender pay gap in Canadian medicine. *CMAJ*. 2020 Aug 31;192(35):E1011–7.
84. National Academies of Sciences, Engineering, and Medicine, Policy and Global Affairs, Committee on Women in Science, Engineering, and Medicine, Committee on the Impacts of Sexual Harassment in Academia. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Benya FF, Widnall SE, Johnson PA, editors. Washington (DC): National Academies Press (US); 2018.
85. Nora LM, McLaughlin MA, Fosson SE, Stratton TD, Murphy-Spencer A, Fincher R-ME, et al. Gender discrimination and sexual harassment in medical education: perspectives gained by a 14-school study. *Acad Med*. 2002 Dec;77(12 Pt 1):1226–34.



IFMSA

International Federation of
Medical Students' Associations

86. Henry P. Educational and Career Barriers to the Medical Profession: Perceptions of Underrepresented Minority Students. *Coll Stud J*. 2006 Jun;40(2):429–41.
87. den Heever EM, Frantz J. Short Report: Perceptions of female medical students on gender equality gains at a local university. *African Journal of Health Professions Education*. 2011;3(2):15–6.
88. Redman S, Saltman D, Straton J, Young B, Paul C. Determinants of career choices among women and men medical students and interns. *Med Educ*. 1994 Sep;28(5):361–71.
89. Hardeman RR, Przedworski JM, Burke SE, Burgess DJ, Phelan SM, Dovidio JF, et al. Mental Well-Being in First Year Medical Students: A Comparison by Race and Gender. *Journal of Racial and Ethnic Health Disparities*. 2015 Sep 1;2(3):403–13.
90. Dyrbye LN, Thomas MR, Shanafelt TD. Medical student distress: causes, consequences, and proposed solutions. *Mayo Clin Proc*. 2005 Dec;80(12):1613–22.
91. Hart KM. The Gender Penalty: Reasons for Differences in Reported Weekly Work Hours Among Male and Female Family Physicians. *J Am Board Fam Med*. 2020 Sep;33(5):650–2.
92. Bakken LL. Who Are Physician–Scientists' Role Models? Gender Makes a Difference. *Acad Med*. 2005 May;80(5):502.
93. Rouse LP, Gallagher-Garza S, Gebhard RE, Harrison SL, Wallace LS. Workplace Bullying Among Family Physicians: A Gender Focused Study. *J Womens Health*. 2016 Sep;25(9):882–8.
94. Riska E. Women in the Medical Profession: International Trends. In: Kuhlmann E, Annandale E, editors. *The Palgrave Handbook of Gender and Healthcare*. London: Palgrave Macmillan UK; 2010. p. 389–404.
95. Sanfey H, Crandall M, Shaughnessy E, Stein SL, Cochran A, Parangi S, et al. Strategies for Identifying and Closing the Gender Salary Gap in Surgery. *J Am Coll Surg*. 2017 Aug;225(2):333–8.
96. Sanfey HA, Saalwachter-Schulman AR, Nyhof-Young JM, Eidelson B, Mann BD. Influences on Medical Student Career Choice: Gender or Generation? *Arch Surg*. 2006 Nov 1;141(11):1086–94.
97. Drinkwater J, Tully MP, Dornan T. The effect of gender on medical students' aspirations: a qualitative study. *Med Educ*. 2008 Apr;42(4):420–6.
98. Riska E. Gender and medical careers. *Maturitas*. 2011 Mar;68(3):264–7.
99. Frank E, Zhao Z, Sen S, Guille C. Gender Disparities in Work and Parental Status Among Early Career Physicians. *JAMA Netw Open*. 2019 Aug 2;2(8):e198340–e198340.
100. Lind DS, Rekkas S, Bui V, Lam T, Beierle E, Copeland EM 3rd. Competency-based student self-assessment on a surgery rotation. *J Surg Res*. 2002 Jun 1;105(1):31–4.
101. Minter RM, Gruppen LD, Napolitano KS, Gauger PG. Gender differences in the self-assessment of surgical residents. *Am J Surg*. 2005 Jun;189(6):647–50.
102. Nomura K, Yano E, Fukui T. Gender differences in clinical confidence: a nationwide survey of resident physicians in Japan. *Acad Med*. 2010 Apr;85(4):647–53.
103. Women in Healthcare: Quick Take [Internet]. [cited 2021 Jan 7]. Available from: <https://www.catalyst.org/research/women-in-healthcare/>



IFMSA

International Federation of
Medical Students' Associations

104. Bureau of Labor Statistics. "Table 18: Median Usual Weekly Earnings of Full-Time Wage and Salary Workers, By Detailed Occupation and Gender, 2018 Annual Averages (Numbers in Thousands),." Women in the Labor Force: A Databook. 2019 Dec;
105. H. S. Interpreting signals in the labor market: evidence from medical referrals [job market paper]. 2017; Available from: www.fas.nus.edu.sg/ecs/events/seminar/seminar_papers/7%20Mar%202019.pdf
106. Government of Ontario, Ministry of Health, Care L-T. OHIP - Bulletins - Health Care Professionals - MOHLTC. 2016 Sep 1 [cited 2021 Jan 7]; Available from: <http://www.health.gov.on.ca/en/pro/programs/ohip/sob/>
107. Gray K, Neville A, Kaji AH, Wolfe M, Calhoun K, Amersi F, et al. Career Goals, Salary Expectations, and Salary Negotiation Among Male and Female General Surgery Residents. JAMA Surg. 2019 Nov 1;154(11):1023–9.
108. Women in Healthcare: Quick Take [Internet]. [cited 2021 Jan 7]. Available from: <https://www.catalyst.org/research/women-in-healthcare/>
109. Ma X, Luc JGY. Improving Gender Equality in the Surgical Workplace. JAMA Surg. 2020 May 1;155(5):448–448.
110. Women in Global Health, the World Health Organization, Global Health Workforce Network. Working paper on Gender & Equity in the Health and Social Care Workforce, Zero Draft. 2018; Available from: <https://www.who.int/hrh/news/2018/GEHworking-paper-ZeroDraft.pdf>
111. Women in Healthcare: Quick Take [Internet]. [cited 2021 Jan 7]. Available from: <https://www.catalyst.org/research/women-in-healthcare/>
112. Dorsey ER, Jarjoura D, Rutecki GW. The influence of controllable lifestyle and sex on the specialty choices of graduating U.S. medical students, 1996-2003. Acad Med. 2005 Sep;80(9):791–6.
113. King JT Jr, Angoff NR, Forrest JN Jr, Justice AC. Gender Disparities in Medical Student Research Awards: A 13-Year Study From the Yale School of Medicine. Acad Med. 2018 Jun;93(6):911.
114. Van den Brink M. Scouting for talent: appointment practices of women professors in academic medicine. Soc Sci Med. 2011 Jun;72(12):2033–40.
115. Morton MJ, Bristol MB, Atherton PH, Schwab CW, Sonnad SS. Improving the recruitment and hiring process for women faculty. J Am Coll Surg. 2008 Jun;206(6):1210–8.
116. Bickel J, Wara D, Atkinson BF, Cohen LS, Dunn M, Hostler S, et al. Increasing women's leadership in academic medicine: report of the AAMC Project Implementation Committee. Acad Med. 2002 Oct;77(10):1043–61.
117. Association of American Medical Colleges. "Table 8: U.S. Medical School Faculty by Sex and Race/Ethnicity, 2019,." US Medical School Faculty (2020). 2019;
118. Axelson RD, Solow CM, Ferguson KJ, Cohen MB. Assessing implicit gender bias in Medical Student Performance Evaluations. Eval Health Prof. 2010 Sep;33(3):365–85.
119. Healthcare's Gender Diversity Shortage [Internet]. 2018 [cited 2021 Jan 7]. Available from: <https://www.kornferry.com/insights/articles/healthcare-women-leadership>



IFMSA

International Federation of
Medical Students' Associations

120. Promotion of gender equality in crisis situations [Internet]. [cited 2021 Jan 7]. Available from: <http://www.unesco.org/new/en/unesco/themes/pcpd/promotion-of-gender-equality-in-crisis-situations/>
121. United Nations. Policy Brief: the Impact of Covid - 19 on Women. 2020; Available from: https://www.un.org/sites/un2.un.org/files/policy_brief_on_covid_impact_on_women_9_apr_2020_updated.pdf
122. Gender inequality and the COVID-19 crisis: A human development perspective [Internet]. [cited 2021 Jan 7]. Available from: <http://www.hdr.undp.org/en/content/gender-inequality-and-covid-19-crisis-human-development-perspective>
123. UN Human Rights Office of the High Commissioner. COVID-19 AND THE HUMAN RIGHTS OF LGBTI PEOPLE. 2020 Apr 17; Available from: <https://www.ohchr.org/Documents/Issues/LGBT/LGBTIpeople.pdf>
124. WHO | About us. 2018 Dec 4 [cited 2021 Jan 7]; Available from: <https://www.who.int/gender-equity-rights/about/en/>
125. OHCHR COVID-19 Guidance [Internet]. [cited 2021 Jan 7]. Available from: <https://www.ohchr.org/EN/NewsEvents/Pages/COVID19Guidance.aspx>



IFMSA

International Federation of
Medical Students' Associations

Bylaws Paragraphs concerning Policy

17.2 Definitions

- a) **Policy Statement:** Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement does not include background information, discussion related to the policy, a bibliography and neither does it quote facts and figures developed by outside sources. The maximum length of a policy statement is 2 pages, including introduction, IFMSA position and call to action.
- b) **Position Paper:** A detailed document supporting the related policy statement that contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper must cite outside sources and include a bibliography.
- c) **Policy commission:** A policy commission is composed of three people, with 2 representatives of the NMOs and one Liaison Officer. The proposer of the draft is part of the policy commission and is responsible of appointing its members. The tasks of the policy commission are the following:
 - a. They are responsible of the quality of the policy document with the approval of the proposal.
 - b. Ensuring the content is based on global evidence.
 - c. Collecting and incorporating NMO feedback after the call for input.
 - d. Coordinating the discussion during the General Assembly.

Adoption of policies

17.3. A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer and in accordance with paragraph 9.4. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.

17.4. The final policy statement and position paper are to be sent in accordance with paragraph 9.4, using the template provided in the call for proposals. The proposal must be co-submitted by two NMOs from different regions or the Team of Officials. A corrected version of this document may be submitted according to paragraph 9.5. Correction may not be used to add members to the policy commission.

17.5. Policy statements and position papers must be presented to NMOs during the first working day of the IFMSA General Assembly.

17.6. A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary by two NMOs from different regions or an IFMSA Official, the IFMSA Team of Officials or the IFMSA Executive Board. Adoption requires $\frac{2}{3}$ majority.

17.7. Amendments may be sent to the proposer in accordance with Annex 1. Amendments made during a General Assemblies or after the deadline stipulated in Annex 1, shall be submitted to the Chair at the latest 23:59 observed in the timezone of the relevant General Assembly on the day before the scheduled start of the session in which the policy will be voted on. These amendments require $\frac{2}{3}$ majority to pass.