Conclusion

With the turn of this century public health services in India across primary, secondary and tertiary level care have increasingly been exposed to commodification and marketization through outsourcing and P3 models. Health movement and academicians have time and again raised concerns about subsidizing P3 models and enabling the expansion of private sector in health care at the expense of public fund. This has contributed to the fragmentation of health care services, creation of newer structures, indirect governance, and increased the tensions between the different partners competing for resources. P3 models have scarcely addressed and contributed towards strengthening of the public health services. The future high costs of P3 will bear an impact on the provision of merit good impeding equity, sustainability and quality of care. Despite its unproven efficiency track record P3 continues to be promoted in India.

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Note

[1]http://blogs.worldbank.org/ppps/sustainable-health-diagnostics-network-in-Jharkhand-India

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Reorienting Medical Education to address Health Inequities

Sangeeta Rege

Despite an established role of social determinants in health care , neither medical education nor public health services in India have taken cognizance of it. Scholars have critiqued the field of medicine as being gender-blind and male-biased because the body of medical knowledge views the male body as the norm, with men's experiences forming the basis for describing signs and symptoms of illness. Gender-based inequalities between women and men have also not been factored-in as critical social determinants of health and disease. One of the consequences of gender-blindness in medicine is the limited gender-sensitivity among medical practitioners, contributing to the compromised quality of care. Another manifestation of gender inequities is violence against women and children; laws in India cast legal obligations on the health sector to provide comprehensive services to survivors of violence against women(VAW) and children. Years of struggle by civil society organisations in India have led to some reforms in the health sector in the context of seeking accountability of the sector vis a vis violence against women. This piece describes two important efforts made with the formal health system to mainstream gender sensitive response to VAW and integrate gender concerns in the medical education system.

Creating gender responsive health services for VAW: An evidence based model Violence of any kind is known to have an adverse impact on the health of those impacted. Despite an association between violence and health, health sector in India has yet to take cognizance of it in a systematic manner. One of the first efforts to address violence as a public health issue was made by MCGM (Municipal Corporation of Greater Mumbai) in collaboration with CEHAT. Such a joint venture led to setting up of a public hospital based crisis center, Dilaasa for responding to violence against women and girls. Key features of this model comprised of engaging health providers to recognise reasons for occurrence of violence, health consequences of such violence, their legal responsibilities to respond and refer survivors to Dilaasa centers. Over the past 17 years,4000 survivors accessed Dilaasa services, 75% of who had reached hospital with health consequences of violence, such as assaults, suicide attempt, sexual violence, unwanted pregnancies, sexually transmitted infections and the like.

An important reason that has enabled the continued functioning of Dilaasa centre was the recognition of its relevance by the public hospital, namely, that counselling is a health care need and health providers have a role to play in mitigating consequences of violence. As responding to VAW was enshrined in the job responsibilities of health providers it became a set practice to orient newly appointed resident medical officers and nurses to be oriented to VAW as a health issue as a part of the existing hospital orientation and seek reporting from respective departments on referrals made to Dilaasa. The next step was to mainstream these centers in the health sector. The following important and visible indicators helped in the process of mainstreaming the Dilaasa model; one was the evidence that this model had sustained for more than 17 years in a public hospital within the existing resources of the hospital, second was the

emerging evidence from Dilaasa regarding the sheer number of survivors accessing services because of the health consequences suffered by them as a result of violence. NUHM as a flagship program had the scope to allocate budget for training of health providers as well as appointment of counsellors for providing psychosocial care. Strategic dialogues along with existing evidence enabled the replication of 11 Dilaasa centres in public hospitals of Mumbai. The replication is a clear acknowledgment by Maharashtra government of violence being a health issue and that the public health sector has a role to play in responding to it.

Integrating gender concerns in medical education: An experiment As far as medical education is concerned, WHO (2006) recommendations of integrating gender concerns in medical curricula both in service and pre-service provided the foundational base for an experiment; Maharashtra department of medical education and research(DMER) in collaboration with CEHAT made efforts to facilitate gender perspectives in medical educators of seven medical colleges in Maharashtra. Medical educators from disciplines of medicine, gynecology and obstetrics, psychiatry, community medicine and forensic science and toxicology underwent a rigorous training to understand associations between gender and diseases, gender biases in diagnosis, gender discrimination in health services planning and delivery and the like. The training enabled medical educators to review their medical textbooks and teaching critically. Having developed a gender lens, educators collaboratively designed gender integrated curriculum for MBBS students so as to facilitate gender sensitivity in health care. The efficacy of the gender integrated modules was also tested through a research study which clearly showed a positive shift in gender attitudes of medical students. An important learning of this effort was that ‘gender” cannot be relegated to just an introductory lecture but should be integrated in all medical topics where social determinants have a role to play. This enables better retention of concepts and enables a continuum of gender informed health care. Importantly medical educators teaching gender integrated curriculum achieved doing so in existing lecture time dispelling the myth that additional teaching time is required if gender concerns have to be integrated in MBBS curriculum. These modules were reviewed by board of studies and academic council and approved by the Maharashtra university of medical science (MUHS) for implementation in all medical colleges of Maharashtra from 2018 . This successful experiment at Maharashtra has come at an opportune time where the NHP 2017 speaks of creating patient centered high quality care and strongly recommends strengthening access to care for marginalized groups. Additionally, MCI is also making efforts towards competencies based medical curriculum. There is a clear opportunity to use the gender integrated medical curriculum by MCI and other states for developing competencies in students to deal with medical illnesses and also prevent gender biases. Gender mainstreaming by strengthening access to health care for marginalised communities , addressing social determinants of health and responding to violence against women are key principles in NHP 2017; each of which fit well with the successful initiatives described in this piece and therefore there is a clear opportunity to use emerging evidence and the policy directive to make the health sector responsive to gender and other social determinants of health that play a pivotal role in addressing health inequities.

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The impact of NEET on an individual institution

Anand Zachariah

This article is a view on the ground as a teacher in CMC, Vellore indicating how NEET is affecting our medical education. Christian Medical College is celebrating its 100th year of medical education. At this time we are both looking back at the developments in our education over 100 years, and looking forward on how to address the challenges of medicine in our country at the present time. Towards this, CMC Vellore has initiated a process of curriculum renewal to strengthen and energise our undergraduate and postgraduate education. It is at this critical juncture in our history that the force of the NEET regulations is beginning to affect us.

CMC’s model of medical education and selection process

Through its 100-year history CMC, Vellore has tried to orient its medical education towards meeting health care needs. CMC is owned by about 50 protestant churches that run over 200 mission hospitals across the country many of them in rural and underserved areas. Students of all courses both undergraduate and postgraduate courses are sponsored from these hospitals. Students are selected by a combination of academic merit based on an all India entrance examination followed by a second stage of assessment that includes interview and skills test to assess aptitude, teamwork and motivation to work in needy areas. CMC’s entrance examination was not based on CBSE but a more pan-India secondary board syllabus. The selection system at the undergraduate level, is based on inter se merit, which allows for equity of opportunity between different churches, so that there is geographic representation of students from across the country. This allows students who are from a disadvantaged background from Orissa or Jharkhand