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Gender Equity in Medical Education: Curriculum Analysis and Perceptions in a Chilean Faculty of Medicine.

Equidad de Género en la Educación Médica: Análisis Curricular y Percepciones en una Facultad de Medicina Chilena.

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Summary

Objective: To analyze the incorporation of a gender perspective into the curricula of a medical school in Chile, and to identify the barriers and facilitators perceived by the academic community, considering their degree of integration into the educational processes. **Materials and methods:** A qualitative collective case study was conducted in seven programs at a medical school. Two complementary qualitative dimensions were integrated: a documentary analysis of graduate profiles and course syllabi, and an interpretive analysis of perceptions through 11 semi-structured interviews and 6 focus groups with administrators, faculty, and students. The analysis was performed using thematic content analysis, supported by NVivo software, employing an inductive approach with theoretical sensitization. **Results:** The findings were organized into three analytical axes: (1) curricular incorporation of a gender perspective, (2) conceptual understanding and forms of implementation, and (3) barriers and facilitators. A fragmented incorporation of content was identified, concentrated in specific areas and lacking cross-cutting integration. The perceptions revealed a heterogeneous understanding of the concept and a non-systematic implementation, frequently dependent on individual initiatives. Among the main barriers identified were a lack of teacher training and the absence of institutional guidelines, while the commitment of motivated teachers emerged as a significant facilitator. From the perspective of gender mainstreaming, these findings represent an incipient level of integration. **Conclusions:** The incorporation of a gender perspective into health education is characterized by partial, heterogeneous, and non-systematic integration. The results allow us to propose a preliminary conceptualization of levels of integration of the approach, ranging from fragmented forms to structural mainstreaming. This approach can contribute to guiding curriculum improvement processes, highlighting the need to strengthen teacher training, develop shared conceptual frameworks, and move toward more coherent and sustainable institutional strategies.

Keywords: Gender, Medical education, curriculum, Social determinants of health

Resumen

Objetivo: Analizar la incorporación de la perspectiva de género en los planes curriculares de una facultad de medicina en Chile, así como identificar las barreras y facilitadores percibidos por la comunidad académica, considerando su grado de integración en los procesos formativos. **Material y métodos:** Se realizó un estudio cualitativo de tipo estudio de caso colectivo en siete carreras de una facultad de medicina. Se integraron dos dimensiones cualitativas complementarias: un análisis documental de perfiles de egreso y programas de curso, y un análisis interpretativo de percepciones mediante 11 entrevistas semiestructuradas y 6 grupos focales con autoridades, docentes y estudiantes. El análisis se realizó mediante análisis de contenido temático, apoyado por software NVivo, utilizando un enfoque inductivo con sensibilización teórica. **Resultados:** Los hallazgos se organizaron en tres ejes analíticos: (1) incorporación curricular de la perspectiva de género, (2) comprensión conceptual y formas de implementación, y (3) barreras y facilitadores. Se identificó una incorporación fragmentaria de contenidos, concentrada en áreas específicas y sin integración transversal. Las percepciones evidenciaron una comprensión heterogénea del concepto y una implementación no sistemática, frecuentemente dependiente de iniciativas individuales. Entre las principales barreras se destacaron la falta de formación docente y la ausencia de lineamientos institucionales, mientras que el compromiso de docentes motivados emergió como un facilitador relevante. Desde el marco de la transversalización de género, estos hallazgos corresponden a un nivel incipiente de integración. **Conclusiones:** La incorporación de la perspectiva de género en la formación en salud se caracteriza por una integración parcial, heterogénea y no sistemática. Los resultados permiten proponer una conceptualización preliminar de niveles de integración del enfoque, que abarca desde formas fragmentarias hasta una transversalización estructural. Esta aproximación puede contribuir a orientar procesos de mejora curricular, destacando la necesidad de fortalecer la formación docente, desarrollar marcos conceptuales compartidos y avanzar hacia estrategias institucionales más coherentes y sostenibles.

Palabras Clave: Género, Educación médica, currículum, Determinantes sociales de la salud

1. Introduction

Gender has been widely recognized as a social determinant of health that significantly influences health, illness, and healthcare processes. Beyond biological differences, gender is a sociocultural construct that organizes roles, power relations, and living conditions, impacting exposure to risks, access to services, and health outcomes. In this sense, incorporating a gender perspective into the training of health professionals not only responds to an ethical imperative linked to equity but also to a technical need aimed at improving the quality of care and reducing avoidable inequities (1). From a conceptual perspective, it is important to distinguish between gender perspective and gender equity. The former refers to an analytical approach that allows us to identify how gender differences and relations influence social and health phenomena, while gender equity is a normative objective that seeks to guarantee fair and differentiated conditions to achieve equivalent health outcomes (2). In this context, gender mainstreaming *is* positioned as a key strategy, aimed at systematically incorporating these considerations into policies, programs and training processes, avoiding their fragmented approach or dependence on individual initiatives (3).

From an analytical perspective, this study is situated within the framework of gender mainstreaming, understood not only as a strategy for including content, but as an approach that seeks to comprehensively transform educational processes. This implies considering not only the explicit curriculum, but also pedagogical practices, institutional dynamics, and the cultural frameworks that shape the educational experience. In this sense, mainstreaming allows us to analyze the degree to which the gender perspective is integrated longitudinally, coherently, and systematically throughout

the educational process, moving beyond its sporadic incorporation or dependence on individual initiatives.

In the field of medical education, international literature has shown that the integration of a gender perspective into curricula remains heterogeneous and, in many cases, limited (4-5). While some experiences have demonstrated improvements in knowledge, attitudes, and clinical skills by incorporating this approach, its implementation is often discontinuous, concentrating on specific modules or particular subjects, without achieving a transversal and progressive integration throughout training (5). This situation has been associated, among other factors, with the lack of shared conceptual frameworks, the limited teacher training on the subject, and the persistence of traditional biomedical models that tend to render social determinants such as gender invisible (6).

Additionally, several studies have highlighted the importance of considering the hidden curriculum and intersectionality in the analysis of health education (6-7). The hidden curriculum, understood as the set of implicit values, practices, and norms transmitted in educational settings, can reproduce gender stereotypes and biases, even in contexts where there are formal advances in the explicit curriculum (8-9). Intersectionality, for its part, allows us to understand how gender interacts with other variables, such as social class, ethnicity, or sexual orientation, generating differentiated experiences of health and access to care (10). The absence of these approaches in education contributes to the reproduction of inequities in clinical practice.

In Latin America, the available evidence on the incorporation of a gender perspective in medical education is still incipient and is mainly concentrated in descriptive studies or local experiences, which limits the understanding of its degree of institutionalization. In the case of Chile, the enactment of Law No. 21,369 has encouraged higher education institutions to develop comprehensive gender policies, creating a favorable context for advancing the integration of this approach into training processes (9). However, significant challenges remain in its implementation, particularly regarding its systematic incorporation into curricula and faculty training (10-11). Previous institutional studies have shown that the incorporation of a gender perspective in health education is characterized by a partial, heterogeneous presence and is frequently dependent on the individual initiative of motivated teachers, rather than on a planned curricular strategy (11). Furthermore, differences have been identified between graduate profiles and the implementation of these principles in the content and training experiences. Despite these advances, a gap persists in understanding how a gender perspective is effectively incorporated into educational processes, particularly in terms of its curricular integration, its implementation in teaching practice, and its articulation with the institutional context. Likewise, there is little evidence that integrates the analysis of curricular content with the perceptions of the academic community, which limits a deeper understanding of the dynamics that facilitate or hinder its incorporation.

In this context, and from the framework of gender mainstreaming, the present study aims to analyze the incorporation of the gender perspective in the curricular plans of the careers of the Faculty of Medicine of the Pontifical Catholic University of Chile, as well as to identify the barriers and facilitators perceived by the academic community, considering their degree of structural integration in the training processes.

2. Methods

2.1 Study design

A qualitative collective case study (12) was conducted, focusing on the seven programs of study at the Faculty of Medicine of the Pontifical Catholic University of Chile. The design integrated two

complementary qualitative dimensions: a descriptive documentary analysis of the curricula and an interpretive analysis of the perceptions of the academic community (13). The analytical approach was inductive with theoretical sensitization, incorporating initial categories derived from the literature as a preliminary analytical guide, which were modified, expanded, or discarded iteratively during the analysis process.

2.2 Position of the research team (reflexivity)

The research team consisted of academics affiliated with the Gender Equity Secretariat of the Faculty of Medicine, with experience in teaching, research, and management in the field of gender and health. This position allowed for a deep understanding of the institutional context, but also implied the need for constant reflection on potential biases in data interpretation. To mitigate this risk, opportunities for analytical discussion among researchers and cross-review of emerging codes and categories were promoted.

2.3 Data collection

The graduate profiles and current course syllabi of the Faculty's seven degree programs were analyzed. To this end, an analysis matrix was constructed based on a codebook (Table 1) developed from the literature, which included terms associated with gender, equity, diversity, and social determinants of health. The identification of gender-related content was carried out through a systematic keyword search, complemented by a contextual and interpretive analysis of the content, avoiding an approach based solely on the presence of terms. The document analysis included a descriptive quantification of the identified content, considering the presence and frequency of the categories defined in the codebook. This quantification was used to support the qualitative analysis but did not constitute an inferential statistical analysis.

Table 1. Codes used in content analysis.

• Gender (Gender identity) • Gender biases • Gender equality, gender inequalities • Sexual diversity, gender diversity	• Social determinants of health • Gender gap • Gender stereotypes • Sexual health, female sexuality • Women's Health
• Gender violence, sexual violence • Sexism, sex • Patriarchy	• Feminism • Masculinities • Transgender, transsexual • Intersex

Interviews and focus groups: Eleven semi-structured interviews and six focus groups were conducted with administrators, faculty, and student representatives from all academic programs. The interview guides were developed using specialized literature and subsequently reviewed by the research team to ensure their relevance and coherence with the study objectives.

Participants and sampling: Purposive sampling was used, selecting key stakeholders with experience in teaching, management, or student participation, who were contacted by direct invitation. Inclusion was defined considering representation of all academic programs and diversity of roles (administrators, faculty, students) (Table 2).

Table 2. Characteristics of the participants.

Collection technique	Men	Women	Careers represented
Teacher interviews	0	6	Dentistry, Medicine, Nutrition and Dietetics, Nursing, Speech Therapy, Kinesiology, Occupational Therapy
Teacher focus group	1	1	Dentistry, Medicine, Nutrition and Dietetics, Kinesiology
Student focus group	5	21	Dentistry, Medicine, Nutrition and Dietetics, Nursing, Speech Therapy, Kinesiology.

Data collection was carried out until thematic saturation was reached, defined as the moment when no new codes or relevant analytical dimensions emerged.

2.4 Information Analysis

The analysis was conducted using inductive thematic content analysis, supported by NVivo software. The process included a comprehensive reading of the data, followed by initial coding based on the codebook, the identification of emerging categories, and their subsequent grouping into analytical dimensions. The codebook was initially defined from the literature and used as a preliminary analytical framework for both the document analysis and the interviews and focus groups, being iteratively adapted throughout the analysis process. To strengthen the study's credibility, independent coding was performed by more than one researcher, and discrepancies were discussed until consensus was reached. Furthermore, adequate traceability of the analytical process was maintained, ensuring the construction of a chain of evidence.

Qualitative rigor criteria were considered to ensure the quality of the study. Credibility was addressed through source triangulation, integrating information from documents, interviews, and focus groups. Confirmability was strengthened through cross-referencing codes and categories among the researchers. Dependence was ensured through a detailed description of the methodological process, and reflexivity was incorporated through the explicit articulation of the research team's position.

The study was approved by the Ethics and Scientific Committee for Social Sciences, Arts, and Humanities of the Pontifical Catholic University of Chile (ID: 230307003). All participants signed informed consent prior to their participation.

Data availability: The data generated during the study are available upon reasonable request. Participant confidentiality was protected through anonymization of the information.

3. Results

The results are organized into three analytical axes that integrate documentary analysis and the perceptions of the academic community: (1) curricular incorporation of the gender perspective, (2) conceptual understanding and forms of implementation, and (3) barriers and facilitators to its integration. These axes were interpreted in light of the gender mainstreaming framework, considering the degree of integration of the approach in the explicit curriculum, training practices, and institutional dynamics.

3.1 Curricular incorporation of the gender perspective.

The document analysis included 7 graduate profiles and 423 course syllabi from the Faculty of Medicine. No explicit mention of the concept of "gender equity" was found in the graduate profiles; however, references to values and principles, such as respect for diversity and social equity, were observed, which could constitute a favorable framework for its incorporation. The course syllabi identified 187 gender-related topics, which are mainly concentrated in public health and obstetrics and gynecology courses, without evidence of cross-cutting integration throughout the curricula. This distribution suggests a fragmented incorporation, concentrated in specific areas (Table 3) and without cross-cutting integration, which is consistent with the perceptions of faculty and students, who indicate that its presence depends primarily on individual initiatives. From the perspective of gender mainstreaming, these findings correspond to an initial level of integration, characterized by the presence of content in specific areas without longitudinal articulation or structural coherence in the curriculum.

3.2 Conceptual understanding and implementation methods:

The perceptions of the academic community revealed a heterogeneous understanding of the gender perspective. While some participants interpret it as an analytical tool for addressing health inequities, others associate it with more limited aspects, such as the use of inclusive language or gender parity. Some examples:

- *"For me, the gender approach is like an approach, a paradigm from which we can analyze situations…"*
- *"I have a question… does it refer only to the male/female issue or to any gender?"*

This diversity of interpretations translates into equally heterogeneous forms of implementation, characterized by the absence of common criteria and by a non-systematic incorporation into the curriculum. Likewise, a gap was identified between the graduate profile and its realization in educational experiences, reinforcing the perception of a more declarative than operational integration. This heterogeneity can be interpreted as an expression of an incipient mainstreaming process, in which there is no shared conceptual framework to guide the integration of the approach into educational processes.

3.3. Barriers and facilitators for curricular integration:

The analysis made it possible to identify factors that condition the incorporation of the gender perspective, grouped into barriers, facilitators and opportunities.

Among the main barriers highlighted were the lack of teacher training on the subject, the absence of clear institutional guidelines, and the persistence of traditional teaching practices. Students also mentioned generational resistance and the difficulty of modifying previously established models. For example:

- *"One barrier is that we don't have the tools… it's difficult to convey something in which one has no formal training."*
- *"It is very difficult to go against what our teachers were taught."*

Furthermore, relevant facilitators were identified, such as the commitment of motivated teachers and the existence of an ongoing institutional dialogue. These initiatives, although still in their early stages, have generated significant experiences that could be scaled up to the curricular level.

- *"Many teachers are willing to learn more… that's an opportunity."*

Taken together, these findings reveal a scenario characterized by partial progress, where the incorporation of a gender perspective depends on individual efforts and lacks a consolidated

institutional structure. In terms of mainstreaming, these factors reflect institutional conditions that are still insufficient to sustain a systematic integration of the approach.

Table 3. Gender-related terms in the analyzed study programs.

Career	Number of findings	Terms found
Nursing	21	Social Determinants of Health (4), Women (4)
Kinesiology (2016-2021)	7	Sexual (3), Woman (3), Diversity (1)
Kinesiology (2022)	11	Equity (3), Inequality (1), Social Determinants of Health (6), Sexual (1), Diversity (1)
Nutrition	4	Social Determinants of Health (4)
Speech therapy	15	Diversity (5), Determinants (3), Man (2), Woman (2)
Occupational Therapy	24	Social Determinants of Health (6), Identity (5), Gender (5), Sexual (6), Female (1), Male (1)
Dentistry	2	Man (1), Diversity (1)
Medicine	103	Sexuality (9), Female (18), Male (16), Gender (9), Determinants (8)

Table 4. Dimensions identified from interviews with authorities and focus groups.

Dimension	Teachers	Students
Conceptual perception	- "For me, the gender approach is like an approach, a paradigm from which we can analyze situations… different from gender equality… I admit I'm not very knowledgeable, but I see it as a tool or approach to analyze and prevent disparities." - "I understand that the gender approach is about reducing barriers or inequalities associated with gender… in health care or health education."	- "I have a question first. Regarding the gender perspective, does it refer only to the male/female issue or to any gender?" - "I don't know, maybe I'm not understanding the gender perspective... if you had an example it could help me form a better opinion."
Partial and informal presence of gender issues	- "These topics ultimately arise more from the professors themselves, from the teaching staff or academics, more from within the program itself… But it is not something that arises from the administration, from the head of the program."	- "I don't know which teachers are prepared, not because I feel that most of them keep their opinions to themselves… in the five years there was only one, during March 8th… only then did the teachers give their opinion about the day."
Gaps and lack of institutional structure	- "I don't know if the University as a whole has a policy or any document… I think it would be super useful to have a general opinion from the Faculty of Medicine on this issue… I feel like we are accepting it more than discussing it."	- "I think the main barriers are a systemic issue, how things have always been done… I think it's very difficult to go against what, for example, our teachers were taught."
	- "I believe that many teachers are	- "I think there are teachers who are

Opportunities arising from teacher commitment	willing to learn more about this, to teach it, and to know how to approach it with students."	also willing… they don't close themselves off, and that's an opportunity… maybe not everyone needs to do it, but there are some who already do."
Challenges, facilitators and barriers	- "The challenge is to make it a systematic thing… so that it doesn't depend on a teacher wanting it, but is part of the structure itself." - "I think the facilitators are that there is already a certain openness, people talk more… before, nothing was said about this, now it is… so there is fertile ground." - "One barrier is that we don't have the tools, we haven't had any training in gender issues, so it's difficult to convey something in which one has no formal preparation."	- "I think the main barriers are a systemic issue, how things have always been done… I think it's very difficult to go against what, for example, our teachers were taught." - "I think there is also a generational resistance… as if the older teachers see it as something exaggerated or unnecessary." - "The facilitators are when a teacher takes a chance, like you see that they are interested and incorporate it, even if it is not in the curriculum."

4. Discussion

This study shows that the incorporation of a gender perspective into the training of health professionals at the analyzed faculty is partial, heterogeneous, and unsystematic. Based on the integration of document analysis and the perceptions of the academic community, the findings identify three central aspects: a fragmented curricular integration, a diverse and non-consensual conceptual understanding, and the presence of structural barriers alongside emerging facilitators.

Regarding curricular integration, the results show that gender-related content is concentrated in specific areas, such as public health and obstetrics and gynecology, without cross-curricular integration throughout the curriculum. This pattern suggests a fragmented incorporation, more linked to disciplinary logics than to a planned educational strategy. Consistently, the perceptions of both teachers and students reinforce this interpretation, indicating that the inclusion of this content depends largely on individual initiatives. From the perspective of gender mainstreaming, this finding can be interpreted as a low-level integration, characterized by the sporadic presence of content without longitudinal or structural articulation within the curriculum.

Regarding conceptual understanding, there is significant heterogeneity in how the gender perspective is understood, ranging from its association with inclusive language or parity to its recognition as a social determinant of health. This diversity translates into equally heterogeneous implementation, characterized by a lack of common criteria and unsystematic integration into the curriculum. Furthermore, a gap is identified between graduate profiles, which incorporate general principles of equity, and their concrete application in educational experiences. This conceptual heterogeneity not only reflects individual differences but can also be understood as an indicator of a lack of effective mainstreaming, given the absence of a shared framework to guide its curricular integration.

Finally, the findings show that the incorporation of a gender perspective is conditioned by multiple factors. Among the main barriers are the lack of teacher training, the absence of clear institutional guidelines, and the persistence of traditional training models. In contrast, the commitment of motivated teachers and the existence of an emerging institutional dialogue are significant facilitators, although still insufficient to sustain structural change. In terms of mainstreaming, these elements indicate a process in its early stages, where the institutional conditions necessary for systematic integration are not yet fully developed.

Furthermore, the heterogeneity in the understanding of the concept can be interpreted as an expression of the absence of a shared conceptual framework, which hinders its operationalization in the educational field. In this context, the hidden curriculum acquires a relevant role, since practices, discourses, and omissions can contribute to the reproduction of gender biases, even in the presence of advances in the explicit curriculum. Thus, gender education is not limited to the inclusion of content, but also involves addressing the cultural and structural dimensions that shape the educational experience.

These findings are consistent with the international literature, which describes the incorporation of a gender perspective into medical education as a heterogeneous and frequently fragmented process, sustained in many cases by individual initiatives rather than consolidated institutional strategies (14-16). Several studies have shown that, when there is formal and progressive curriculum planning, it is possible to achieve a more transversal and evaluable integration of the gender approach, with an impact on professional competencies (8, 17).

In Latin America, the available evidence is still limited and mainly focuses on local experiences or specific qualitative studies, reflecting an incipient process of institutionalization (18-20). In the Chilean context, previous research has shown the limited presence of a gender perspective in health training programs and the persistence of gaps between stated principles and their effective implementation (18, 21, 23). In this sense, the results of the present study align with previously described trends, providing evidence from an integrated analysis that combines curriculum review and perceptions of the academic community.

In this context, and in dialogue with the framework of gender mainstreaming, the findings allow us to propose a preliminary conceptualization of levels of integration of the gender perspective in health education. A first level corresponds to incipient or fragmented integration, characterized by the occasional presence of content in specific subjects, without longitudinal articulation or structural coherence in the curriculum. A second level corresponds to partial integration, in which there are more systematic efforts at incorporation, but these are still limited by the absence of clear institutional guidelines, heterogeneous teacher training, and the lack of a shared conceptual framework. Finally, an advanced level would correspond to structural mainstreaming, in which the gender perspective is integrated coherently and longitudinally into the curriculum, is articulated with pedagogical practices and the hidden curriculum, and is supported by institutional policies, teacher training, and evaluation mechanisms.

From this perspective, the results of this study suggest that the institution analyzed is primarily at an incipient level of integration, with some emerging elements that could facilitate the transition to more advanced levels. This approach can contribute to guiding the design of curricular strategies and monitoring their implementation in different educational contexts.

5. Conclusions

- This study analyzed the integration of a gender perspective into the training of health professionals at a Chilean faculty, revealing a partial, heterogeneous, and unsystematic approach. The findings show that this integration is characterized by a fragmented presence

in the curriculum, diverse conceptual understandings, and the existence of structural barriers that limit its implementation.

- Based on these results, relevant guidelines are identified for advancing towards a more coherent and sustainable integration of the gender perspective in health education. These include: the development of a shared conceptual framework to guide its curricular incorporation; the training of faculty in gender-related content and pedagogical strategies; the progressive and coordinated integration of this content into curriculum redesign processes; and the strengthening of institutional guidelines and spaces for academic dialogue to ensure its sustained implementation over time.
- Taken together, these elements can contribute to training that is more sensitive to gender inequalities and better prepared to respond to the needs of a diverse population, in line with the current challenges of health education.

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Regarding the use of AI: For this work, AI was only used in the drafting and translation of the English abstract in order to use more scientific language. This version was subsequently reviewed by the corresponding author.

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