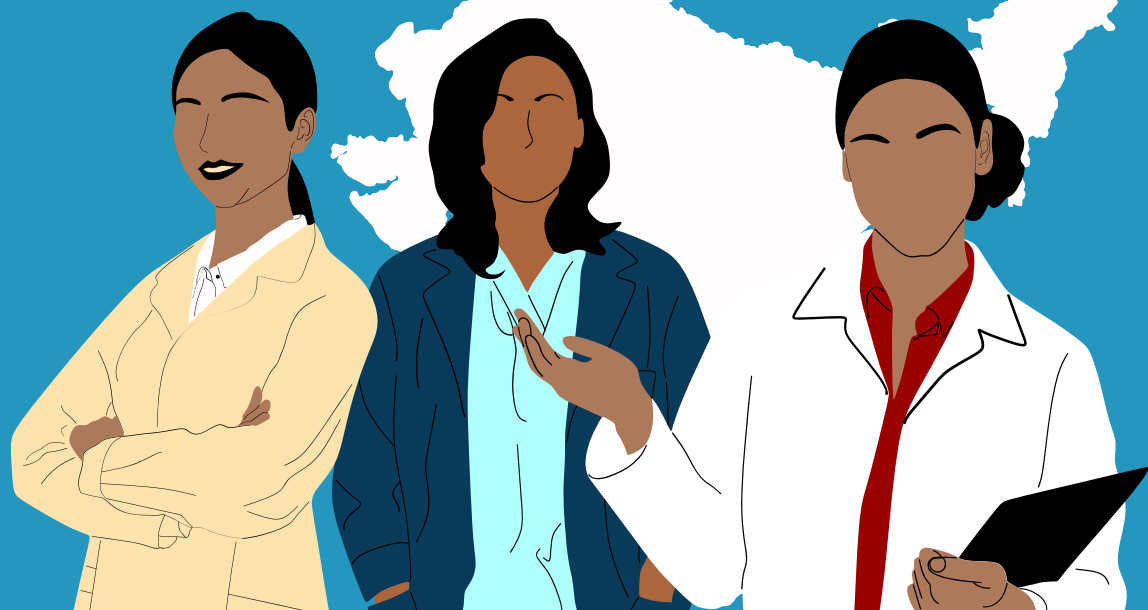


# STAKEHOLDER ANALYSIS REPORT:

# INDIA

March 2023



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## Table of Contents

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Acronyms	1
Executive Summary	1
Introduction	3
<b>Study Design</b>	<b>3</b>
<b>Methodology</b>	<b>4</b>
<b>Analysis</b>	<b>5</b>
<b>Limitations</b>	<b>6</b>
<b>Literature Review</b>	<b>7</b>
<b>Findings</b>	<b>13</b>
<b>RQ1: What are the barriers and opportunities around women’s leadership in public/global health to address in the program design?</b>	<b>13</b>
<b>RQ2: What are current efforts that foster women’s leadership, diversity and inclusion within organisations?</b>	<b>26</b>
<b>RQ3: What are the various ways organisations and the WomenLift program may work together?</b>	<b>31</b>
Recommendations	33
Annex 1: Key Informant Summary Data	36
Annex 2: Semi-structured Interview Guide	37
Annex 3: Works Cited	39

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## Acronyms

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ANM -	Auxiliary Nurse-Midwives
ASHA -	Accredited Social Health Activists
AWW -	Anganwadi workers
CEO -	Chief Executive Officer
CHC -	Community Health Centres
CIO -	Chief Information Officer
CISO -	Chief Information Security Officer
COO -	Chief Operations Officer
CTO -	Chief Technical Officer
DEI -	Diversity, Equity and Inclusion
HMIS -	Health Management Information System
IAS -	Indian Administrative Services
ILO -	International Labour Organisation
MoHFW -	Ministry of Health and Family Welfare
MPHW-M -	Multipurpose Health Worker- Male
NGO -	Non- Governmental Organisation
NHWA -	National Health Workforce Accounts
NSSO -	National Sample Survey Organisation
PHC -	Primary Health Centre
POSH -	Prevention of Sexual Harassment
UN CEDAW -	United Nations Convention on the Elimination of All Forms of Discrimination Against Women
WFH -	Work from Home
WHO -	World Health Organisation

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## Executive Summary

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Established in 2019, WomenLift Health is committed to expanding the power and influence of talented women in global health and catalyzing systemic change to achieve gender equality in health leadership. With Hubs in East Africa, North America, South Asia, Southern Africa, and with plans for further expansion into other regions, WomenLift Health envisions a world where diverse, accomplished leaders collectively transform health outcomes. As an effort to launch their program in India, WomenLift Health undertook a stakeholder analysis in partnership with LEAD at Krea University. The study aimed to understand the barriers and opportunities existing within the institutional landscape in India for enabling women's leadership in health.

The study involved a landscape analysis, secondary data review, and key informant interviews with 40 men and women leaders and executive level representatives of health organisations from across seven stakeholder categories in India. The stakeholder categories identified were as follows: international non-governmental organisations (INGOs), local NGOs, government institutions, universities, private sector entities, philanthropy organisations, and multilateral organisations.

Purposive sampling was used to identify influential organisations in each stakeholder category and semi-structured interviews were conducted with leaders in these organisations, covering aspects pertaining to women's leadership in the health sector within the country, as well as within their organisation.

The stakeholder analysis identified institutional opportunities for women to grow into leadership positions. Essential to these is the provision of a strong Diversity, Equity and Inclusion (DEI) policy within organisations, and devising mechanisms to measure the impact of these policies. Organisations with global DEI policies underpinning their operations in India, highlighted the inclusion of members of the LGBTQIA+ community as an important indicator of diversity in hiring mechanisms. Other organisational efforts include supporting women through formal as well as unstructured mentoring, which is considered vital to promote women to leadership positions. It was also widely acknowledged that the COVID-19 pandemic made Work from Home (WFH) models an occupational reality, and that it has largely been beneficial for both the employer and the employee. The flexible options reportedly provide women with autonomy over time, which holds significant importance for women in managerial positions within organisations. Lastly, gender-friendly laws and measures for promoting women's participation in the workforce such as Prevention of Sexual Harassment of Women at Workplace Act (PoSH), setting up of Internal Committee to enable a harassment free working environment, and

parental leaves are other provisions that contribute to women's growth in leadership level roles.

Gender stereotyping and gendered care work are identified as major barriers to women's growth in leadership roles, as around three-quarters of the women leaders interviewed reported that women have to shoulder various care responsibilities within their household. This has repercussions on their careers. Other barriers include imposter syndrome and the lack of safety that adversely impacts women's mobility. Prevalence of '*old boys' networks*' and glass ceilings was identified as yet another crucial factor hindering women's growth in the healthcare sector.

In light of the barriers, current efforts and opportunities identified during the stakeholder analysis, this report highlights recommendations from participants to strengthen women's participation and representation in leadership roles. Throughout the study, a recurring theme was the need for sensitising men and for considering them as companions rather than opponents to the cause of promoting women's leadership. Additionally, policy-level reforms that provide support for child care, both at the national level and within organisations, can encourage women to continue working in the sector, thereby reducing attrition rates among mid-career professionals and ultimately improving the representation of women in global and public health leadership.

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## Introduction

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Established in 2019, WomenLift Health is committed to expanding the power and influence of talented women in global health and catalyzing systemic change to achieve gender equality in health leadership. With Hubs in East Africa, North America, South Asia, Southern Africa, and with plans for further expansion into other regions, WomenLift Health envisions a world where diverse, accomplished leaders collectively transform health outcomes. WomenLift Health believes that it is essential to contribute to transformative institutional and societal level change by raising awareness about the value of women's leadership and catalysing change through a portfolio of scaled interventions.

WomenLift Health implements a portfolio of interventions that reinforce transformative change and that ripple out to reach an increasing number of women and men. One core intervention is the 'Leadership Journey', which is designed to give talented women leaders the tools – confidence, networks, understanding of barriers – along with peer, mentor and coach support, to successfully use their voice, expertise and leadership skills for health impact.

To inform the expansion of the Leadership Journey program, WomenLift Health partnered with LEAD at Krea University to undertake a stakeholder analysis in India to ensure the inclusion of local voices into its program design.

The findings and recommendations from this analysis will inform WomenLift's key priorities and program strategy for future cohorts of the Leadership Journey program.

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## Study Design

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WomenLift Health, in partnership with LEAD at Krea University conducted the Stakeholder Analysis for India. The objectives of the Stakeholder Analysis are to:

1. Conduct a desk review and analysis of existing data on women's representation in India's health sector.
2. Identify and establish relationships with the individuals and organisations that are influential in the public and global health space in India.
3. Draw upon their collective experiences to identify barriers and opportunities around women's leadership in public/global health.
4. Understand current efforts to foster women's leadership, diversity and inclusion within organisations.
5. Understand various ways organisations and the WomenLift program may work together.

In the findings, we will primarily focus on the last three research questions which are:



**RQ1:** What are the barriers and opportunities around women’s leadership in public/global health to address in the program design?



**RQ2:** What are current efforts that foster women’s leadership, diversity and inclusion within organisations in the health sector?



**RQ3:** What are the various ways organisations and the WomenLift program may work together?

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## Methodology

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We conducted this stakeholder analysis by identifying the leading organisations in public health in India. In-depth interviews were conducted with senior leaders or executives within these organisations, focusing on women’s leadership in the health sector within the country, as well as within their organisation.

**A literature review** was conducted covering secondary sources available in the form of articles and publicly available data covering women’s participation in the health workforce. The qualitative insights are supplemented with gender-disaggregated data pertaining to the health workforce where available through national surveys and public databases. The available information was collated to inform the landscape analysis for this study. However, the scant data available around leadership in public health, especially gender disaggregated data, resulted in a limited scope of quantitative inquiry.

**Key Informant Interviews:** The research team conducted 40 key informant interviews with leaders and executive-level representatives of organisations from across seven stakeholder categories working in the public health sector in India.

Sector as per RFP	Interviews Conducted
INGOs	8
NGOs/NPOs	6
Government	8
University	3
Private	8
Philanthropy	5
Multi-laterals	2

Table 1: Details of interviews conducted

Purposive method was used to identify the entire population eligible for the sampling frame; seven stakeholder categories were created within this population for ease of sampling and analysis. From within this sampling frame, the research team aimed to attain a maximum variation in terms of organisations in the final sample.

Leading organisations in each stakeholder category through internet searches and snowball sampling from professional networks of the research team and the WomenLift Health India team. As the data collection process progressed, snowball sampling was further applied to identify new organisations in each category based on the suggestions provided by the respondents. 76 organisations were shortlisted for the interviews, and 121 individuals were contacted via email to request appointments for key informant interviews. Two follow-up emails were sent to each potential respondent, with a gap of one week between each email. Some individuals redirected the research team to other colleagues and/or other organisations, while respondents themselves also identified relevant potential key informants: all such suggestions were also contacted via snowball sampling. This process was followed until theoretical saturation was attained. Throughout the data collection process, low response rate was a key challenge, especially among multilateral organisations and universities. In total, only 31% of key informants contacted spoke to us for this analysis.

**Interview guide:** A semi-structured interview guide was prepared (see Annexure 2), which was thematically divided into questions around organisational policies and processes, current trends and gaps in the health sector in India and on a global level, and potential areas of collaboration that organisations were interested in exploring with WomenLift Health. The interviews typically lasted around 45-60 minutes, and were conducted virtually based on the respondents' availability and convenience. Quality assurance was carried out through frequent backchecks, weekly team reviews, and random checks of recorded interviews by the technical partner. Based on the feedback, the interview process was modified as required.

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## Analysis

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Each interview was recorded and transcribed as a first step in the data analysis process. The research team used the qualitative analysis software NVivo (Release 1.7) to open code a select number of transcripts. After conducting an inter-rater reliability exercise, a common codebook was arrived upon, based on which the rest of the transcripts were indexed and charted into an analysis framework. Based on this framework, major themes were identified and analysed. Summary notes were used to inform the analysis where required, and relevant quotes were extracted to be included to support the findings. The team followed the framework method of analysis for this project (Gale et al, 2013; Srivastava and Thomson, 2009) .



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## Limitations

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The sample used for this assessment is not statistically representative of the public health sector in India; rather, the study targeted respondents that serve as heads of select influential organisations in the field. While the team tried to cover equal numbers of respondents in each of the seven stakeholder categories, the low response rate, especially from the Multilaterals and universities, resulted in a skewed sample. The research team tried to use snowball and convenience sampling strategies to reach out to a larger number of individuals through personal and professional networks and increase response rates.

Due to the low response rates, the research team supplemented the primary data collection with a review of secondary data around women’s participation in the health workforce in the health sector where available, as discussed in the preceding sections. Government stakeholders had the lowest response rates, and thus the team added more NGOs working in the health sector at a district level or higher in India for their insights. Some leaders, especially male leaders, redirected us to their deputies or junior female colleagues. While suggested candidates were interviewed wherever possible, requests for interviews with the male leaders for their insights were also made.

Limitation	Mitigation
Purposive sampling reduces representativeness of the sample	Maximum variation sampling, multiple stakeholder categories included
Low response rates	Supplementary review of secondary data available in public domain around women’s workforce participation in India
Redirection by senior leaders to female colleagues/subordinates	Interviews conducted with suggested candidates as well as requests made for the leaders’ time

Table 2: Limitations and mitigations strategies for the evaluation

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## Literature Review

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### 1. Background

Women's awareness of the gender pay gap, access to career advancement opportunities, work-life balance, and access to leadership roles have been identified as crucial to realising their full potential as well as in ensuring that they are represented fairly in the decision making processes. Worldwide, the concern of women's equal representation in civil, political, economic and social domains first gained recognition via the UN Convention on the Elimination of All Forms of Discrimination Against Women (UN CEDAW) that was adopted in 1979. The Beijing Platform for Action that was adopted during the UN Fourth World Conference on Women in 1995 made it clear that a gap remained and women remained under-represented due to the discriminatory attitudes and practices and unequal power relations. Women's empowerment was thus envisaged in a manner that enhanced their ability to think critically and foster capabilities to take initiatives naturally (Nanivadekar, 2010). Moreover, the Sustainable Development Goal 5: Achieving Gender Equality and Empower all Women and Girls further reiterates the significance of ensuring equal opportunities for leadership at all levels of decision making in political, economic and public life .

Even though women make up 71% of the worldwide health care workforce (Mousa et al., 2021), they are disproportionately underrepresented in top leadership positions in the industry. Their involvement in senior and executive leadership varies by nation, location and employment in the public or private sectors. The World Economic Forum estimates that just 35% of leadership positions in the international healthcare sector are held by women (Schwab et al., 2017). According to a review, only 20% of organisations have gender parity in their governing bodies and only 25% of global health organisations have gender parity at senior management levels (Betron et al., 2019). Moreover, globally women comprise only 21% of the top leadership positions such as CIOs, CTOs and CISOs, across sectors, as per the Boardroom Insiders' 2021 report (Mehta, 2022). Taking into account both skilled and low-skilled health cadres<sup>1</sup>, women constitute nearly 50% of all health professionals in India (Rao et al., 2011). However, we see a pyramid-shaped trend wherein the grassroots- level workforce is predominantly female, while more senior positions are held by men.

This trend is reflected in the National Health Workforce Accounts (NHWA) data estimates, collated below:

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<sup>1</sup> The difference between qualified and unqualified health workforce depends on the available information on technical education (degree, certificate/diploma) of the participants of the National Sample Survey self reported survey.

Health workforce by skill level	NHW estimate	
	Male	Female
Medical Doctors	86%	14%
Pharmacists	90%	10%
Nursing and Midwifery Professionals	19%	81%

Table 3: Gender-disaggregated health workforce estimates by skill level. *Source: NHWA - 2018<sup>2</sup>*

Low representation of women in the skilled health workforce, especially among medical health professionals, has implications for women’s access to healthcare in the country. States such as Gujarat, Rajasthan, Haryana, Himachal Pradesh, Uttaranchal, Uttar Pradesh, Madhya Pradesh, Bihar, Jharkhand, Chhattisgarh, West Bengal, Orissa, and Assam have only two female doctors per 10,000 women (Rao et al. 2011). Women in the health workforce are estimated to earn 34% less than their male counterparts (ILO, 2018a, 2018b). They are also five times more likely to experience setbacks, even while experiencing similar early career advancements as men (Taylor, 2009). A similar pyramid-shaped trend is seen among women in leadership positions in the public health sector. Frontline community health initiatives are primarily led and implemented by a cadre-based female workforce: the Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwife (ANMs), Anganwadi workers (AWWs) in the rural areas (Chokshi et al., 2016). Even though they comprise a significant part of community health delivery, they continue to work for low wages with limited scope for climbing the ladder to executive positions.

Hierarchy	Category	Male	Female
Senior positions in Health department	Principal Secretary of States	30	6
	Deputy Secretaries	13	3
	Joint Secretaries	6	4
	Director (Central health portfolios)	10	3
	Mission Director	28	8
Cadre workers	ANM/MPHW-M workers at sub centres	52,978	187,557
	Health Assistants at PHCs	13,446	13,786

Table 4: Absolute numbers of male and female workers in India’s public health workforce. *Source: MoHFW -2023<sup>3</sup>; RHS 2020-21<sup>4</sup>*

<sup>2</sup> “NHW Web Portal,” accessed February 28, 2023, <https://apps.who.int/nhwportal/Home/Index>.

<sup>3</sup> “MoHFW Directory\_7.Pdf,” accessed February 28, 2023, [https://main.mohfw.gov.in/sites/default/files/MoHFW%20Directory\\_7.pdf](https://main.mohfw.gov.in/sites/default/files/MoHFW%20Directory_7.pdf).

<sup>4</sup> “Rural Health Statistics 2020-21 | Ministry of Health and Family Welfare | GOI,” accessed February 28, 2023, <https://main.mohfw.gov.in/newshighlights-90>.

Global estimates also suggest that women workers/employees are paid roughly 22% less than men in the healthcare sector. Moreover, the gender pay gap at entry level and mid-career can widen over time and impact on retention, especially during mid-career, according to a report by the IFC (IFC, 2019). Additionally, women continue to be generally excluded from higher-status and higher-paying positions in the health sector: men are overwhelmingly at the helm or in charge of global health organisations, with 80% of board chairpersons and 69% of global health organisations' leaders being men (World Health Organization, 2019). Even for highly underrepresented female doctors, pay disparity still exists among medical staff such as doctors globally. It is argued that female doctors earn 20–29% less than their male counterparts globally (Boesveld, 2020).

In the absence of national-level data that can be used to identify trends around leadership in the health sector, the research team attempted to capture trends in the gender ratio across 50 influential organisations across all seven stakeholder categories identified for the study. We surveyed data available in the public domain regarding who occupied leadership and Board positions in these organisations (as of February 2023)<sup>5</sup>; here as well, we found that not all organisations had this data in the public domain, and thus the sample is limited (n=32). This further highlights the need for organisations to collect and publicly display gender-disaggregated data on leadership. While this snapshot is not nationally or sectorally representative, this exercise is meant to indicate that even within the health sector, progress with gender parity in leadership roles varies significantly:

Sector	Number of Male Leaders	Number of Female Leaders
NGO	31	50
INGO	104	68
Government	8	2
Private	107	75
Philanthropy	32	28
University	1	5
Multilaterals	1	1

Table 5: Sector wise breakup of male and female employees in leadership roles

It is well known that women's leadership plays a significant role in improving health policies as they are able to emphasise on the need for pro-women policies (Adams and Ferreira, 2009; Erhardt, Werbel, and Shrader, 2003)--thereby making the case for having more women representation at the top level leadership in the healthcare sector. It is observed that family-friendly laws and incentives have been found to help women balance work and family, especially in areas such as recruitment, retention, and career satisfaction

<sup>5</sup> The number of men and women in board positions and top level leadership for organisations across the stakeholder categories were obtained by reviewing information available on their websites. Hierarchies and leadership roles may vary based on the stakeholder category and organisation size and structure.

(Villablanca et al., 2010). Furthermore, it was found that women's professional progression took place via flexible work rules and "soft" regulations such as a code of conduct (e.g., parental leave, duty flexibility). In India, some of the legal provisions that enable women's participation in the workforce include:

- Maternity leave enables a woman to take time off from work after giving birth to a child. The national Maternity Benefit Act of 1961 specified the amount of maternity leave that female employees could take up to 12 weeks. However, the length was extended to 26 weeks by the Maternity Benefit Amendment Act of 2017.
- Furthermore, the Maternity Benefit Amendment Act in India forbids discrimination against pregnant women and safeguards their right to employment. Additionally, the law mandates that businesses with 50 or more workers should provide childcare facilities close to the workplace.
- The PoSH Act aims to ensure safety of women at workplaces and prevent sexual harassment within the workspace. The employer is entrusted with the duty of filing a complaint, assisting the employee if they experience sexual harassment, spread awareness via conducting workshops on women's safety in addition to making it imperative for organisations to set up a complaint redressal committee.
- A Health, Safety and Welfare Committee must now be established by employers with 100 or more employees. If the firm employs women, at least a "sufficient number" of the committee members must be women. The committee's duties and responsibilities include a survey of the property to identify any danger zones or hazardous objects, repairing them, holding annual health and wellness camps to raise awareness of any infectious diseases or epidemics, holding annual recreational events, and planning social and educational awareness campaigns.

## 2. Defining Women's Leadership

The public health sector in India is largely driven by the "triple-A" cadre at the grassroots-*Anganwadi* workers (AWW), Accredited Social Health Activists (ASHA), and Auxiliary Nurse-Midwives (ANM). These constitute an important part of the health workforce, although they remain outside the scope of this stakeholder analysis. For the purposes of this assessment, leadership in healthcare is understood in the broader sense of governance and administrative roles that women may take up in healthcare organisations and businesses, such as the position of CEO, COO, Director, etc. (Lantz, 2008).

## 3. Barriers faced by Women in Global Health

A study by the International Female Leadership Council (2019) highlights that there are still too few women in leadership positions in the medical and organisational leadership fields who can influence, inspire, and serve as role models for other women in the field. No matter their position within the firm, an absence of women in leadership positions has repercussions for all women in a particular ecosystem (IMT, 2022). Several reasons have been identified to act as barriers to women aspiring and rising to top level leadership

positions within the healthcare industry. These can broadly be clubbed under the following categories:

- **Societal Norms:** female employees face greater challenges than their male colleagues due to the conflict between work and home obligations. This is supported by broader scholarship around time poverty and the double burden faced by women globally as well as in India (Nambiar et al., 2022) and (Hagiwara et al., 2018). Career advancement for male and female doctors was found to be comparable albeit women experience job interruption five times more than their male counterparts owing to family obligations. This is found to have an adverse impact on the manner in which their career advances (Pololi, 2016). Discrimination and violence against women, especially in workplaces is yet another factor.
- **Organisational Barriers:** A lack of support from the organisation and institutional leaders at large hinders women's progression into leadership positions. This is manifest in poor implementation of policies ensuring women's safety in workspace or its lack thereof. Overt and covert gender discrimination at the workplace practised by leaders is also another factor impeding women from advancing to senior leadership roles. Furthermore, lack of mentorship and upskilling of women in organisations is known to undermine women's confidence and opportunities for career advancement. A certain degree of "imposter syndrome" has resulted among women (IFC, 2019). Women's underestimation of their own skills and abilities was mentioned by 71% of the women as their biggest obstacle to career advancement, followed by a lack of confidence (55%) in a survey conducted by RockHealth (Tecco & Huang, 2018).

#### 4. Opportunities for Women Global Health Leaders

Leadership development programs have the ability to raise the fundamental capabilities, competencies, and skills of people in leadership positions in the healthcare industry, while reinforcing the significance of organisational culture in promoting gender parity (Smith et al., 2019). This can be done by supporting women through formal, structured mentorship as well as informal, unstructured mentoring that increases their chances of obtaining senior positions across all industries, including the healthcare industry (Pololi, 2016). Educating people about bias and how to combat it can be a crucial first step in eradicating it and, eventually, encouraging institutional change, notably the advancement of women in the field of public health (Girod et al., 2016). Organisational leadership training and development programs that are centred on maximising capability have shown both short- and long-term benefits for the progress of women in leadership, especially in the healthcare industry (Chang, 2006).

Considering women are underrepresented in executive-level management positions, healthcare organisations would substantially benefit from diversifying their top leadership talent to incorporate contributions from women nursing staff and doctors since they act as the backbone of the healthcare workforce (McDonagh & Paris, 2013). Inclusion of women in executive-level healthcare teams has advantages, such as democratic decision making processes, innovative, empathetic leadership that is believed to enhance

collaboration and improve communications (McDonagh et al., 2014; Mehta, 2022). Women leaders entering the healthcare sector would create a case for better mentorship possibilities, network effects, and eventually establish a sense of sharing information that bears the potential of improving the quality of care (Onie, Farmer, & Behforouz, 2012; Venkateswaran, 2021). Moreover, the impacts of group mentorship programs among women working in the medical/healthcare field are known to enhance women's competence, skills and productivity. It also has the potential to provide networking, mentoring and research possibilities, especially to the junior female faculty and trainees (Gaetke-Udager et al., 2018).

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## Findings

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### RQ1: What are the barriers and opportunities around women's leadership in public/global health to address in the program design?

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#### Barrier 1:

##### **Restrictive Societal Norms**

Gender stereotypes and the resulting discrimination has been widely discussed in scholarship pertaining to women leadership. The link between the cultural norms and the economic outcomes such as reduced female labour force participation is established clearly in the literature (Alesina, Giuliano, and Nunn 2011). While the expectations manifest as allocation of roles, gender norms exert their influence through negative sanctions such as restriction or scolding which has proved to further restrict women's participation in full-time employment (Cislaghi et al, 2022). Respondents in our study talked extensively about how the existing gender norms in Indian society have restricted women from actively seeking senior leadership positions. These norms relegate women to the sphere of the household and attribute caregiving roles as essential to their existence.



*Women, right from the day they're born, they're told: don't talk, don't talk loudly, sit properly, make yourselves small, don't act overconfident. I think in the social context in India, women are made to discourage themselves, and that comes through across all areas of their life, including when and where they work. So that fundamentally is a huge barrier.*

—Senior Woman Leader from  
the NGO Sector

*"I found that children were given certain things that you imagine a firefighter, surgeon, cancer specialist, homemaker, teacher - then a majority of those kids who were around ten years or eight years of age - they identified a firefighter as a man, pilot as a man, surgeon or doctor as a man. And homemaker, teacher, musician - those kinds of things were for women. So this stereotyping comes in very early. And perhaps we need to work there, change their environment, tell the children it's really not true."*

- Senior Woman Leader in Government sector



*"A girl child is relegated to roles 'inferior to' those of her siblings or peers who are male - leading to the regular trajectory of her focus and the family's focus being marriage, post which she is again relegated to a social role where she is primarily the care provider and accesses health services the last - and therefore that cycle & that conditioning is so ingrained in a majority of the population that it is often glorified."*

- Senior Woman Leader from NGO sector

Related to the aspect of upbringing, many female respondents shared how men in the workplace often bring their patriarchal notions and thoughts and exhibit them when interacting with female colleagues. They expressed a strong need to "sensitise men"- that should begin at an early age - to respect women leaders and accept women colleague's existence and their ascent to leadership as a reward for their skill set and not because of gender.

*"We have one Board with 10-12 people on it, for which the office bearers were being selected. A couple of positions were finalised, and they were all men. And then they [the men] said, [pointing at the women] "Accha inme se bhi to kisi ko bana do na" [sic] (Give one of these women some position or another, too). These are esteemed, high-level educated people. So it was pretty obvious what they're thinking. So it's a mindset, I think it's an issue of the mindset."*

- Senior Female Consultant in the Private sector

## **Barrier 2:**

### ***Gendered Division of Care Work***

Closely related to restrictive norms is the barrier of gendered division of care work, as around three-quarters of the women leaders interviewed reported that women have to shoulder various care responsibilities within their household, which leads to repercussions on their careers. The responsibilities are not only restricted to child rearing but also taking care of family members like looking after an aged in-laws and relatives. While the inherent attitude to expect women to take major responsibility of child rearing was reported to be predominant, several women leaders also highlighted how this creates a double burden on women to excel at both family management and professional lives. Feminist scholarship has a well-defined theory supporting the concept of double burden, and how this can often cause role



*The expectations of society—that women will take on the house rearing and child rearing roles and take primary responsibility for these—acts as a disadvantage [to their leadership journey].*

—Senior Male Leader from  
Private Sector

overload leading to burnout and sickness in women in the workforce (Bratberg et al, 2002).

*“Women mostly bear the burden as they are seen as support systems within their families, community support as well as at the organisations they work. Even as a child in a family, the boy is given more opportunities, while the girl takes care of household work. There is that unconscious bias which exists. And a lot of these biases are picked up by the people themselves because they see their parents behaving in a certain way. So those in leadership positions actually demand a lot of (an employee’s personal) quality time, which then becomes a barrier for young women leaders.”*

- Senior Woman Leader in a Multilateral organisation.

At the organisational level, there is reportedly little room for women to express this double burden, and the lack of consideration has effects on their mental well being. The respondents shared how women are expected to be “superhumans” managing both household and work, and in turn divert their human capital more into child rearing and allied activities, hampering career progression. Few respondents also talked about the guilt included by these norms that women experience when they have to leave a baby in a childcare facility. Few respondents also shared how these gendered societal norms are not always explicit, but could be implicit in certain expectations. For example, adjustments related to relocation or child rearing are mostly expected to be made by women, irrespective of career position and potential advancement in their current position.

*“It continues to be the woman (who makes these adjustments) - but it’s just that a person who has worked for a five-to-seven year period, may not be able to continue (in the workforce)--despite wanting to--because she follows the husband post-marriage to wherever the husband works. And this is so even if she draws a higher salary in comparison to the husband. So, I would think it’s more a cultural factor.”*

- Senior Woman Leader from the NGO sector

At the organisational level, gendered care work expectations and the resulting career gap has reportedly impacted many women from reaching leadership positions.

### **Barrier 3:**

#### ***Career Gaps/Breaks***

The role accumulation theory proposed by Sieber (1974) postulates that the accretion of different roles such as mother, wife and employee often leads to limitation or restriction of one of the roles, usually that of the role of employee. Wiggins (1995) also explores how parenthood can lead to ‘role conflict’ which in turn leads to discord for most of the professional women. This sentiment was strongly reflected by the respondents

interviewed, where many leaders talked about women's "career clock coinciding with their biological clock", often leading to conflict and in turn breaks in the career.

A senior woman leader shared how she has observed her younger colleagues being pressured to get married and bear children, and later become demotivated to enter the workforce due to a long career gap. Another woman leader shared the conflict that arises between care responsibilities and career progression for women of child-bearing age:

*"At a certain point of time, the woman is poised to become a leader, go high in her career. Coincidentally it is the same time when she needs to think about the family and that's so tragic in a sense, it is very conflicting for a woman because you have only so much time and then you need to do both. Women cannot marry so young, bear kids and then come back. I sit here today saying, we should be doing it. But in my heart, when I had my daughter, there were thoughts such as: is it okay that I just leave her and come to the office?"*

- Senior Woman Leader in the Private sector

While the government mandated maternity leave offered by organisations is mostly seen by respondents in a positive light, women, especially those aspiring to become leaders, consider such a gap as a setback in career progression. It was reported that such a break sets women back in terms of their career progression by a few years, as their male counterparts continue to reach senior leadership roles. A study of female healthcare managers found out that many highly successful women were either single or divorced and bear fewer children than male counterparts at the same senior leadership level (Wiggins, 1994).

One of the women leaders from the private healthcare sector pointed to how organisations typically offer lesser compensation for a woman who is trying to re-enter the workforce after a maternity or child rearing break. Although the qualifications of the female candidate are at par with her male counterparts, some organisations may try to 'leverage' the reduced opportunities that these women have access to in the job market and offer lower compensation to them. Another woman leader acknowledged that despite being a woman herself, she and other female colleagues who were on promotion boards had taken into consideration the career breaks that younger women subordinates may take in the future have to take due to marriage and childbirth as potential hindrances to organisational timelines.

#### **Barrier 4:**

## **“Old Boys’ Networks”**

The concept of a glass ceiling as mentioned in various gender studies refers to the “existence of artificial barriers that inhibits the advancement of women and minority groups (Cotter et al. 2001).” Intrinsically linked to the concept of favourable promotions, various literature has also pointed out how such promotion decisions to top positions depend greatly on the individuals present at such levels, leading to “similar-to-me” effect (Powell and Butterfield 1994). This specific effect brings out the behavioural event, where the people in top positions tend

to prefer to work with individuals that are similar to themselves. In our sample, although there was not an explicit mention of glass ceiling, the term “old boys’ network” that is closely associated with this concept was reiterated by several respondents.



*I think the milieu that you come from (matters). Especially for men, if they have seen women being encouraged and respected, they would provide that kind of support to their colleagues too. But if it becomes a boys’ club, then it becomes difficult for women (to progress in such a situation).*

—Senior Female Leader from the International NGO Sector

*“There has been a very strong old boys’ network that has been functioning in India for a long time and that disadvantages not only female (leaders), but also people from outside that network, there may be men also and belonging to different communities, etc. So that’s something that needs to change. It’s been a lazy device by even those entities that should make sure that these situations change, because they continue to go back and rely on these same old people for their various advisory roles or decision making process of other types.”*

- Senior Male Leader from the Private sector

The presence of an ‘old boys’ club’, which can be understood in this situation as men occupying senior leadership positions for a long time through their closed network of social and professional connections, is acknowledged as one of the important barriers for women climbing the leadership ladder by both men and women. Such a network or group of male leaders is acknowledged at the country level as the spill-over effects of patriarchy and a system based hierarchical structure. One respondent attempted to explain this through a gender essentialist lens:

*“Many of my female colleagues have told me that there is a problem of ganging up. And what happens is that a large majority of men outnumber the women in such positions. And then because of biology, our hormones, we’re different. So women are different in a similar kind of situation - even if men and women are of the same skills, same qualifications and at the same position. Then also their reactions would differ because we’re different. And so the aggressiveness is less, the assertiveness is relatively less.*

*They don't fight back so often. So these things add up and the men become more privileged."*

- Senior Woman Leader from Government sector

However, the concept holds more relevance at the organisational level, as several women respondents talked about how organisational culture sometimes perpetuates the existence of the old boys' network and the network in turn reinforces toxic work culture for women aspiring to become leaders. Interestingly, the viewpoint was put forth not just by women but also many male respondents during the study. As one of the senior Board member in an International NGO noted:

*"In one of my stints, we saw women were promoted a lot. However, there came a time where the old male crocodiles (sic) came back, where they stopped women from developing in (in their careers). Not all the men are bad or the old crocodiles are bad. But actually, you must identify some of the better old crocodiles. You must use them as leads, because then the old crocodiles sometimes have political weight. And if they only bring in the political weight that you can launch such processes that can help (women become leaders)."*

- Senior Male Leader from an International NGO

Although it seems like a positive sign that senior male leaders have talked about the phenomenon, many female respondents felt that the prevalence of such an issue has been acknowledged only in the past five years. It was also noted that the gender composition at senior levels have far reaching effects, as one of the respondents quoted above. The minority status of women at senior leadership positions is reported to bring such privilege bias inherently, and hence more efforts are needed at organisational level to address this barrier.

## **Barrier 5:**

### **Imposter Syndrome**

Several mid-career women professionals as well as senior leaders talked about how women exhibit imposter syndrome in leadership roles or when they are offered such roles. Among the many descriptions, words like 'insecurity', 'lack of self-confidence', 'not believing in themselves' were predominantly used. Literature also supports this gendered phenomenon: the term '*imposter phenomenon*' was first recorded in a study on high achieving women, and the authors defined it as an experience of "intellectual phoniness" (Clance and Imes, 1978). The study also reveals that gender stereotypes and cultural norms have led to symptoms such as lack of self-confidence and attributing success to factors such as luck instead of one's own capabilities is quite prevalent.

Additionally, in the context of societal pressure on women, words such as ‘upbringing’, ‘inherent values’, ‘lack of assertion’ were frequently alluded to. A female medical practitioner running a non-profit organisation noted how these values are ingrained in girls during their childhood:

*“Right from the day a girl is born, she is told to ‘don't talk, don't talk loudly, sit properly, make yourselves small, don't act overconfident’, and so I think in the social context in India, women are discouraged to flaunt their achievements, and that come through across all areas of your life, including when and where you work so I think that fundamentally the lack of internal confidence that is, little bit down right from the first day, is I think, one huge barrier.”*

- Senior Woman Leader from the NGO sector

## **Barrier 6:**

### **Mobility and Safety:**

In the Indian context, many respondents talked about how mobility emerges as a major barrier for women in the formal workforce. This barrier however was not just specific to women leaders, but working women in general – especially those working in the public health sector and in the grassroots development sector. Some respondents pointed out that even until a decade ago, women were not permitted by their families to travel long distances for work due to safety concerns, which impeded their access to professional opportunities. Although it was acknowledged that the situation has since improved, many women leaders discussed how their female subordinates have refused to relocate or travel for work, which resulted in their organisation having to make many provisions to enable women to travel.

*“I had a young colleague, I remember when she came on board, she told me very clearly that her father and her family won't let her go out of the home. So I think there are such barriers around mobility. Even when you interview for a job, the people who are mostly likely to relocate are men! Because they can drag the family with them, but women can't move away from families.”*

- Senior Woman Leader from NGO sector.

While many women face pressures from their kin, lack of access to childcare also poses a mobility barrier at the organisational level, it is essential to note that the mobility barrier was largely intertwined with the issue of women's safety. Although reported as a peripheral issue, it was implied that the issue of mobility is an occupational hazard since most of the areas where public health programs are implemented are in the interior regions with poor connectivity. The prominent connotation of safety was barriers to women's mobility, and this emerged as a significant barrier for women's career progression and subsequent access to leadership roles.

## Opportunities

The discussion around the barriers to women's leadership in the health sector led to the respondents highlighting certain opportunities for promoting women's leadership in the health sector. As discussed in the literature review, existing women leaders have made a case for better opportunities such as mentorship, networking possibilities, thereby providing pathways for women in leadership roles (McDonagh et al. 2014). In light of the barriers discussed in the previous section, it is imperative to assess, devise and recalibrate the opportunities to fix the *'leaky pipeline'* that women encounter in their professional journey and growth in leadership roles in the healthcare sector.

### Opportunity 1:

#### Strengthening Institutional Policies

Policies catering to leaves, especially maternal and child care leaves, teleworking and flexible work timings can address some of the barriers highlighted in the previous section. A senior female leader from the government sector notes:

*"There are some organisations where women are scared to ask for leaves because they are worried about being seen as not committed to the job. So, leaves in my opinion are very important, whether or not you use them. But it's important and crucial to put them in the policy. The other issue which is not possible in government—but nowadays some NGOs are doing it—is work from home. There are days when you could, let's say, want a hybrid kind of model, right? For example, if your child is sick some day and you need to look after him or her, although you don't need to look after them for eight hours a day, working from home could help you a lot in these situations. Sometimes women need flexible work hours: I might be working for the same amount of time, but not at that particular time".*

- Senior Woman Leader from Government Sector

In a similar vein, well-functioning child care facilities in the vicinity of the workplace were identified by some respondents as an important support structure for women with child rearing responsibilities in order to retain them in the workforce:

*"It should be something at the policy level: to have a good child care facility within, say two kilometres (of the workplace). I think the largest dropouts in women (employees) happen at mid level to upper mid level due to the lack of a social support system, or the right child care facility. I have seen this across both profit and non-profit organisations. If there is a functioning child care facility, there would be no dropout."*

- Mid-career woman from philanthropy sector

In organisations with a more traditional administrative system such as public universities and government institutions, stakeholders shared that bureaucratic processes and documentation requirements may make it more difficult for women to avail institutional policies that can aid their career progression. This can be addressed by ensuring transparency in and simplification of the management and administrative processes, which in turn can increase the uptake of such initiatives and policies by women.

*“Wherever they can be cut down—what you call bureaucracy and red tape-ism (sic)--have to be cut down so that women feel more encouraged to do [apply for programs and initiatives meant for their career growth]. Because of these barriers only women don't want to venture into it at all, thinking: ‘Why should I get into that at all?’.”*

- Senior Woman Professor in a University

Further, government regulations and donor requirements are two arenas that provide ample opportunities for organisations to improve their efforts vis-a-vis promoting women's leadership. Among government regulations, The Companies Act 2013 that mandates all listed companies to have at least one woman on their boards was considered a warrantable policy having far reaching effects on women leadership. Many respondents in our sample also quoted the need for enhancing government regulation for policies on education of the girl child, especially encouraging them to take up a career in Science, Technology, Medicine and Engineering (STEM) can go a long way in promoting their leadership opportunities in the healthcare sector.

*“Literacy rates can determine to a great extent if women will be given opportunities or not to rise up in the leadership level roles. This is one of the reasons for the discrepancy one sees between how different states in India perform.”*

- Senior Male Leader in the Government Sector

Strengthening institutional accountability for gender mainstreaming as part of corporate and development reporting frameworks can be an important enabler to ensure that women are supported into leadership positions, especially for the non-profit and the philanthropy sector. One of the senior women leaders from the philanthropy sector shared how during the proposal writing process, the donors ask for numbers on Board composition, and there is a pressure on organisations to answer such concerns satisfactorily from a gender ratio perspective.

*“There is also a lot of push from the donor. To some extent, we have to respond because they are funding our operations. They are asking us to give gender disaggregated data about our leadership. I've had a donor tell me that if we did not fix the gender disparity in the leadership team, we might stop giving you money.”*

- Senior Male leader from International NGO sector



## Opportunity 2:

### Male allyship

As the feminist movement gained momentum in the late 1900s, calls for ‘men as allies’ in supporting and championing the movement were evident. Michael Kimmel has pointed out: “We cannot fully empower women and girls without also engaging men and boys, and when we do, we find out that gender equality is a good thing for men as well as women” (Kimmel, 2005).



*Men can play a very important role [in building allyship] which is both positive, as well as not being negative. The latter is a duty in terms of language,*

In our analysis, participants primarily referred to male allyship as a future prospect, where certain changes in attitude and behaviour of men were needed to ensure gender parity. These expectations fall under major sub-themes such as ‘promoting and championing women’, ‘listening to women’ and ‘informal support’. It is important to note that many female respondents talked about how there is a perceived difference in having a male manager or boss as a mentor, as opposed to male colleagues providing support as well. While the former was commonly witnessed by many female respondents, having a male colleague at the same hierarchical level championing and supporting a female colleague was not reported.

*“I still feel Indian men tend to treat women more lightly. Those issues have to be taken care of. How you talk to them, how you refer to them, kind of remarks you make, not maybe directly to a person, but in general refer to women. I think those are the issues which have to be and they have to be made much more cognizant of the fact that the respect is there, the attitude those issues need to be taken care of, I think, important at the workplace”.*

- Senior Woman Leader from the International NGO Sector.

An interesting theme brought up by many participants regarding male allyship was the need for male colleagues to listen to their women counterparts. Phrases such as ‘passing the mic’, ‘giving up power’, ‘flagging when women are cut off in workplace discussions’ distinctly stood out in the examples respondents provided of how male colleagues can support women in the workplace in everyday professional settings.

*"Having internal democracy is the critical element and particularly when women speak up, when they complain or when they offer contrarian views to what is the conventional wisdom of the boss. You must have the ability to listen and say okay, perhaps you're right and let's discuss this further; and it may turn out quite often they may be right. "*

- Senior Male Leader from Private Sector

Under the theme of male allyship, 'male mentors' evolved as a sub-theme in our analysis, where a majority of the respondents talked about the importance of men and their role in promoting women leaders. Many female participants also quoted personal examples, where the male mentors or bosses have been allies in the leadership team.

*"There is a male employee in the organisation. In his capacity he doesn't actually have to give time. But every week, he makes it a point to spend thirty minutes with a female colleague to guide her, support her, give her all the time and technical capability, so that she is able to do well in the initiative. And I think that unless people take that as our own ownership & responsibility, it is difficult to bring about a change."*

- Senior Male Leader from the Philanthropy Sector

Mentorship by male colleagues took different forms, where some males were seen as bosses who had mentored their subordinates, while instances of male colleagues who went out of their way to help female colleagues, although few, also found mention. In the case of the former, the male respondents in the sample referred to mentoring women in their own capacity. For example, a senior male leader from the philanthropy sector talked about being a "pillar" for his women subordinates and gave them confidence. However, at present these efforts are in an individual capacity, and do not necessarily reflect sector-wide trends. The impact of gender in the mentorship process has been widely discussed in the literature and having a female leader mentor to a female employee seems to be more favoured in such discussion (Lin et al.,2021). Although the participants did not specifically stress on the importance of female mentors, few respondents talked about the positive impact of having female leadership in the organisation as well as women role models at the global level. Furthermore, in organisations that had a majority of women, having a female CEO is seen as an important factor in attracting female talent.

### **Opportunity 3:**

#### **Building Leadership Capacity for Mid-Career Professionals**

An important opportunity outlined by several respondents was the support organisations can provide to their female employees to build technical skills and professional capacities to be able to advance in their careers. To advance in the health sector, there is a requirement to build on one's technical skills as well as soft skills—both are vital in preparing women to take on leadership roles in their organisations and sectors. However, many respondents shared that women often lack access to on-the-job training opportunities and mentorship that can help build these skills. As one respondent pointed

out, a lack of these technical and soft skills can actively hinder women's career trajectories, especially in the public health sector where stakeholder management is key to the success of interventions and the employees' growth as leaders:

*“Women in the public health sector need to possess managerial and technical skills because most of the operations are implemented through programs. They often don't have the required skill set and often shy away from taking on these roles because they hesitate. They feel they aren't well-adept at dealing with bureaucrats and politicians and will not be able to undertake administrative roles so they become complacent with what they know they can do well”.*

- Senior Female Leader from the Government sector

However, some organisations have identified a role as facilitators to help build capacity among women in the health sector, which in turn can help equip them with the skills required to be considered for leadership roles. As one leader in the private sector pointed out, organisations can play a key role in addressing this lack of access to such training and mentorship:

*“We have quite a few examples of us identifying and making sure that some of our female researchers—who have not been able to, let's say, do their PhDs—get an opportunity through their PhD. So we identify them, we provide them with support in putting together a high quality PhD application to a good PhD program and support them through the process and help them succeed. And at the same time, we also identify female colleagues who are in non research roles and help them grow in their non research career paths as well, by again identifying and making sure that they are aware of [leadership development programs] and then facilitating their ability to benefit from these opportunities”.*

- Senior Male Leader from the Private sector

Fostering mentor-mentee relationships within and outside of the organisation was also identified as an opportunity that employers can tap into for promoting women's leadership. Such capacity building efforts, when designed to be diverse and inclusive, enhance women's technical and soft skills through peer engagement and cross-vertical learning, ultimately equipping them with the skills required to grow into leadership positions. As one respondent highlighted, such opportunities can truly build leadership within the organisation, aiding junior-level staff to move higher up in the organisation as well:

*“I would say that a lot of these [skill development courses] are available both to men and women. We've had, you know, leadership coaching and there are cohorts that have been put together, and these are deliberately kept diverse. We've had sort of global colleagues coming together to work on some leadership, team courses, leadership development support and that is actually, interestingly, not just available to you if you're a program person. It goes all the way down even to program assistants who are for example, executive assistants. And people have really moved from the most basic of roles by skilling themselves.”*

- Senior Female Leader from the Philanthropy sector



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## RQ2: What are current efforts that foster women's leadership, diversity and inclusion within organisations in the health sector?

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Across various studies on advancing women's leadership, the role of the organisation in designing effective interventions in supporting sustainable increase of women's participation is widely discussed. There is also multi-sector evidence to support gender equity interventions at the organisational level (Mousa et al. 2022). Prime amongst these is the concept of Diversity, Equity and Inclusion (DEI) that aims at creating an equal opportunity workspace, thereby ensuring fairness and respect to people hailing from diverse backgrounds. Given that India has a very diverse population in terms of caste, class, region, and religion, the role of DEI becomes even more important as organisations attempt to be representative and inclusive. Current efforts by organisations are largely guided by DEI policies. The findings under this section provide details of such policies and subsequently discuss closely associated schemes and programs.



*“There is a lot of emphasis on DEI, and over the years, this whole movement has expanded beyond gender diversity to also looking at different sensibilities: whether it comes to sexual orientation, to disabilities, or to millennials and their expectations. And in all of this*

### **Current Effort 1:**

#### **Organisational DEI policies**

DEI policies are reportedly considered a top priority for various sectors, and are especially crucial in ensuring an effective recruiting and hiring process (Barney, 2018). In the case of organisations, DEI is seen in the context of human resource management enabling equity stakes in careers especially for historically marginalised populations (Ferraro et.al., 2022). Organisational behaviour, which encompasses several other themes such as inclusive workplace environment, safety as well as accommodating diverse perspectives, also has immense significance for women professionals in the workplace. About 70% of all the respondents in our sample mentioned that some form of DEI policies exist at their organisation. In many instances, such DEI policies were an extension of the global directives adapted to the country context: this is true for stakeholder categories such as multi-laterals or international NGOs with headquarters in other parts of the world. However, few (only four) respondents discussed monitoring and evaluation practices in

place to measure the outcomes of DEI initiatives. Monitoring and evaluation is necessary to ensure the ethos of DEI policies translates into appropriate action.

The adoption of policies does not necessarily translate into tangible action and the execution may vary depending on the sector. For example, some organisations that mentioned existing DEI policies also reported the lack of process to execute them; this was observed in organisations that have a more traditional setup, such as government departments and research organisations. The phrases used by respondents such as 'difficulty in translating to action', 'action more important than document', 'implementation depends on leadership' highlight gaps in DEI efforts compared with the intended goals of the organisational policies. While probing such issues, a major sub-theme that evolved was the prevalence of informal DEI initiatives.

As a female senior leader from the international NGO sector noted:

*"We have taken the conversations to the sub-grantee level where we are talking about issues of safeguarding, child protection, inclusion and equity. Also, there are training packages for staff around actually respecting and practising inclusivity in the organisation that is regularly updated. We have hired an external expert on equity and inclusion and included what definitely needs to be avoided or not done in professional spaces if one has to truly incorporate these ideals."*

Another male senior leader from the private healthcare sector shared:

*"In terms of affirmative action, it is implicit rather than explicitly stated in any policy document. But again, we do try and see that, for example, if there are any committees that are being constituted, whether for selection committees or any other committees like research committees that are being constituted, we definitely pay attention to gender representation."*

Among organisations that do not have a global directive for DEI policies, representatives reported an organic approach in designing such policies in-house through dialogue and experiential learning, instead of hiring consultants or external stakeholders. As a senior male leader from the private healthcare sector notes:

*"During the whole DEI drafting process, we have learned a lot from our female colleagues and female leaders and so their contribution should be placed on record appropriately. It is not like the men in the organisation have come up with all of this on their own."*

## Current Effort 2:

### Hiring mechanisms

According to estimates by the Periodic Labour Force Survey, female labour force participation (FLFP) in India was a mere 32.8% in 2021, as compared to the male labour force participation rate of 77.2% (NSSO, 2023). Economists attribute this gender gap in unemployment to ‘explained’ and ‘unexplained’ factors. While factors such as gendered differences in education and occupation choice explain this trend to an extent, other factors that are not easily apparent, such as unconscious biases, can lead to unequal hiring and promotion of women in the workforce as compared to their male counterparts (Levenson and O’Kane, 2019). Against this backdrop, there is a need for robust hiring processes that reduce bias and increase gender inclusion. Nearly all respondents reported that their organisation was an “equal opportunity employer”; there was also a focus on merit and performance as an important criteria for selection. However, few participants mention that they specifically encourage women and candidates from marginalised groups to apply for positions, and look for women specifically for certain positions to ensure diversity.

*“You have to look at the leadership and move into the position like a pyramid, so your base as women, you have to increase that base. And I think gradually, perhaps I mean in the next 10-20 years, I’m sure that we’ll be able to see many more women in areas of leadership.”*

- Senior Woman leader from the Government Sector

Respondents also reported that hiring mechanisms in their organisations are primarily guided by the DEI policies, which focus on hiring candidates from different ethnic backgrounds, caste groups, and genders. These organisations, especially ones with global DEI policies underpinning their operations in India, highlighted the inclusion of members of the LGBTQIA+ community as one of the important indicators of diversity in hiring mechanisms.

*“We are an organisation providing equal employment opportunities. We have a diversity, equity, inclusion strategic plan as well. It also involves creating platforms for learning and engaging or really hiring persons from a very diverse background. So here, whether it’s equally qualified women candidates, equally qualified people from minority communities, from diverse backgrounds, the LGBTQ community—they are also given a preference.”*

- Senior Woman leader from Multilateral Sector

### **Current Effort 3:**

#### **Mentorship**

Among the many organisational efforts supporting women, both formal and unstructured, mentoring is considered vital to promote women into leadership positions (Pololi et al., 2016). Mentoring can help women in upgrading technical skills, improving confidence and other soft skills. House et.al (2021) in their work on the influence of mentorship establish that the effects of mentorship is visible at individual levels, but at the organisational level it leads to increased retention and involvement of under-represented communities.

In our study sample, the overwhelming majority of respondents talked about various mentorship programs and skill building efforts done as part of their organisational protocol. Of particular importance is the nature of such mentorship programs and the range of skills that are covered through these programs. While some organisations have mentorship programs in terms of capacity building for technical skills, some have mentorship specific to leadership training targeted at mid-career professionals.

Furthermore, some of the mentorship programs are informal and do not follow structured frameworks. For example, a senior woman leader from the NGO sector shared how she has assisted a few women in the public health sector with their PhD applications. In another instance, a senior male leader mentioned bringing successful women leaders from outside the organisation to have informal conversations and share knowledge and experience with their female staff. It is interesting to note that mentorship programs are mostly gender neutral and are targeted at specific organisational-level candidates to ensure succession planning or general promotions.

*“We have the leadership development program, for mid level managers, and every year you are selected, it's all global. So, from various countries, people are selected, and women are encouraged to apply for those positions. And, I think, now, more women are coming into these positions.”*

- Senior Woman leader from international NGO sector

### **Current Effort 4:**

#### **Flexible Work & Work From Home**

The literature review establishes that family-friendly initiatives have helped women's professional progression. Among many such “soft rules”, flexible work and especially Work from Home (WFH) options found major prominence, across all sectors in the health workforce. More than half the participants, especially those with childcare responsibilities, highlighted that the availability of flexible work options is an incentive for better work and mental health. It was also widely acknowledged that the COVID-19 pandemic made WFH models an occupational reality, and that it has largely been beneficial for both the employer and the employee. The presence of such flexible options has been found to



provide women with autonomy over time, which holds immense significance for women in managerial positions within organisations (Tremblay,2002).

*“Some bit of flexibility, as people will need it, is there... we were very rigid, and I think we went into a very ‘hundred percent must be there all the time’ mode, for a few months, and then realised, that also there is value in respecting that some people may have some individual constraints, and it’s okay as long as the work is getting done.”*

- Woman Leader from the Philanthropy Sector

It was also reported that these flexible work options have worked out very well for organisations in the NGO, philanthropy and the multilateral sector. However, a few respondents, especially in the government sector, have reported about the difficulties in having WFH options while working directly with the public, especially at the community health level.

## **Current Effort 5**

### **Legal provisions:**

In terms of the presence of family-friendly laws promoting women’s participation in the workforce, the most prevalent legal mandates include paid maternity leave for 26 weeks (six months) for female employees and the requirement to have a Prevention of Sexual Harassment (PoSH) committees at all workplaces employing more than ten employees. More than two-thirds of the participants responded positively to the existence of maternity leave regulations and non-discrimination against pregnant women at work. Further, it was established that organizations have ‘zero tolerance policy’ of violence against women and presence of ‘Prevention of Sexual Harassment’ (POSH) policies at workplace as mandated by the Indian government. A few organisations also reported child protection policies at the organisational level. This provides evidence towards the influence of legislation on organisational interventions for advancing women in leadership roles (Mousa et al. 2022).

*“We have maternity policies in place that are in line with legal requirements of the country. I was very happy when the government of India said that one of the boards had to be women or some representation had to be women. That is probably how we need to go. This becomes a catalyst in the beginning. When the government mandates something, organisations will try their best to follow or fix the issue.”*

- Senior Male Leader from International NGO sector



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## RQ3: What are the various ways organisations and the WomenLift program may work together?

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### Potential Collaboration 1:

#### Sensitisation of men:

Despite the progress made in the global conversations around gender parity, research has discovered that there is still a need for change in attitudes of men toward women in the workplace. The studies also discovered that given many of the C-suite roles are occupied by men, a delay in attitude change would restrict women ascending to senior leadership positions, further perpetuating gender discrimination (Bentley University, 2017). This sentiment was largely reflected in our study too. 82% of the participants reported the immediate need for sensitising men as an important actionable step for promoting women leadership both at country and organisational levels.

*“(Attitudes of) men are also a reflection of how they are at home. It comes in a patriarchal system of society where men are used to being in power. So, at work when someone else comes into power, they feel intimidated. By sensitising men to the concept of equality at the workplace, women can feel more at ease.”*

- Senior Woman leader from the Government Sector.

Based on the findings, WomenLift Health can collaborate with organisations on providing sensitisation workshops and trainings specifically targeted for men. While few participants talked about ‘respectful workplace training’ for all members of the organisation, trainings specifically tailored for sensitising men emerged as a potential collaboration.

### Potential Collaboration 2:

#### Nominate women for training

Lack of technical and soft skills, or limited skill set was cited as one of the important barriers for women in being promoted to leadership positions. Given the organisational mandate of WomenLift Health, several respondents were open to the idea of nominating women from their own organisations to be a part of the upcoming cohorts. The participants also stressed on frontline workers in India, and the need for them to be part of the ambit of leadership training and skill building offerings as well. As one respondent highlighted:

*“Who is focusing on the women who are in leadership roles at the civil society level, and building & nurturing their leadership? Because these (programs) are addressing people*

*who are already educated - they are highly empowered - already in leadership positions. I would be very happy if WomenLift Health really starts thinking of women-led civil society organisations and frontline workers, building their leadership - so designing courses which are aligned to the more to less privileged women - but who are in leadership roles (at the grassroots level).”*

- Senior Woman leader from international NGO sector

However, two-thirds of the respondents needed more information about the program and the nature of potential partnerships before committing to nominate women from their own organisations. Interestingly, some of the mid-career women who were part of the sample, had already been part of the previous cohort and highly recommended the training. Having peer support and a community of aspiring women leaders were quoted as some of the positive outcomes of the training.

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## Recommendations

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The recommendations listed below include suggestions by respondents on ways to promote women's leadership in the health sector. The recommendations can be divided into two segments: 1) for strengthening WomenLift Health's program, and 2) addressing broader socio-cultural factors that prevent women's participation in health leadership, which WomenLift Health can potentially work to address in collaboration with partner organisations in the future:

### **Recommendations for WomenLift Health**

#### **Recommendation #1: Engage with men in the workplace**

The need for sensitising men and for considering them as allies rather than opponents to the cause of nurturing more women leaders was a recurring theme in the study. Further, the positive impact of having male mentors to support the progression of women in leadership positions is also established. Hence, having a balanced participation of male and female mentors in the program to make the perspectives more diverse and inclusive, thereby also fostering more gender-equal mentorship support, was recommended as an action point for WomenLift Health.

#### **Recommendation #2: Include frontline workers**

The majority of the participants, especially those working in the field of community health, stressed the importance of frontline workers such as ANMs and ASHAs for the last-mile delivery of health services, and the leadership qualities already exhibited by them. Providing leadership training or organised mentorship programs for these frontline workers and women leaders from grassroots organisations or collectives was highlighted as a gap currently existing in the focus of the program—one that remains vital if the aim is to address the landscape of the health sector in India in a more holistic manner overtime.

### **Recommendations for Collaborating Organisations**

#### **Recommendation #3: Provide support for care work**

The gendered nature care work emerged as one of the significant barriers in our findings, and the lack of child care facilities was reported to augment its negative impacts on women's participation in the workforce and their promotion to leadership in the sector as a whole. Policy-level reforms that provide support for child care, both at national level and organisational level, were highlighted as ways to encourage women to continue working in the sector, and thereby reducing attrition rates in mid-career women professionals. Further, improvements to

infrastructure in the form of creches within the organisational premises can prove to be extremely beneficial.

#### **Recommendation #4: Focus on actionable DEI policies**

Although DEI efforts were fairly varied among the organisations of the stakeholders interviewed, the common consensus was that having diversity and inclusion as a focus in the organisation's vision and mission does ultimately help translate into concrete measures. Some sectors (such as the INGO and multilateral sector) have made more progress with the application of these principles through equal sourcing of resumes, actively searching for diverse candidates, and providing intensive mentoring and return-to-work programs for women in the organisation. However, even in organisations where the focus on DEI is more in spirit than in letter, respondents shared informal mentoring, aiding women by increasing their exposure to leadership opportunities by 'passing the mic', and setting internal targets to have gender-equal decision-making groups and committees. Providing flexible work options to women serve as examples of how organisations are able to take steps to encourage and empower women to become equal stakeholders in the workplace. In either case, the commitment of the leadership team towards diversity and inclusion was identified as being of utmost importance to ensure that DEI and more specifically gender parity is embedded in the organisation's DNA.

#### **Recommendation #5: Create monitoring and evaluation mechanisms for DEI efforts**

Although the importance of measuring the impact of DEI initiatives was highlighted by several respondents, very few organisations reported having such mechanisms in place. As reported, the impact of informal DEI efforts often remains unmeasured, which hinders organisational efforts to translate policy into meaningful action. Establishing robust, evidence-backed monitoring and evaluation mechanisms of DEI efforts within organisations can help collaborating organisations in addressing this gap, and WLH can provide strategic support in the process.

#### **Recommendation #6: Address safety and mobility related concerns**

Among the various reasons attributed to reduced female labour force participation, restrictions in mobility emerged as a major factor affecting women from mid-career to senior levels. In India, the lack of safety while travelling for work emerged as an important contributing factor. While instilling safety infrastructure and women safety laws is beyond the scope of the WomenLift Health program activities, organisations can provide arrangements such as drop-off facilities that can bolster women's safety and address some concerns around travelling for work and mobility. Shared parental leaves and making provisions for women to undertake work-related travel with children if required can help in retaining women in the workforce by addressing mobility barriers in the short-term, while long-term policy measures are needed to address the gendered nature of care work in society that hinders women's representation in the workforce in general and leadership roles in particular.

***Additional recommendation for governments: Record gender-disaggregated data***

Overall, the study would have greatly benefited from gender disaggregated data on the healthcare workforce, especially at the leadership positions at national and state government level. Robust, representative, and gender-disaggregated data on leadership at all hierarchical levels of the public and private health sector is the need of the hour. Existing surveys such as the Periodic Labour Force Survey, Rural Health Statistics reports, and the Health Management Information System databases available in the public domain can collect data on leadership positions to help address this gap. Such data can, over time, help identify gaps in country-wide and sector wise trends in leadership and tailor better programs to address these gaps.

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## Annex 1: Key Informant Summary Data

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	Number of interviews conducted
Total	40
Sector	
INGOs	8
Local NGOs	6
Government	8
Universities	3
Private sector	8
Philanthropy	5
Multilateral institutions	2

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## Annex 2: Semi-structured Interview Guide

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Please tell us about your experience in the health sector in brief - Number of years in the sector, how long you have been in the current organisation and designation.

Based on your experience, do you think that women's participation in leadership has grown in the last five years in the sector in India? How so and why?

### Section 1: Related Specifically to your Organisation

1. Does your organisation have any efforts or policies promoting diversity, equity and equality within its staff? Please describe.

[Probes: recruitment/promotion, mentoring/social support, retention mechanisms, challenges faced by organisation when implementing these processes].

- a. Did you/your Board have external consultants to support you in designing your DEI strategies and /or in coaching /mentoring leaders? (*Focus on gender within DEI strategies*)
  - b. Looking back, how successful do you think these initiatives were?
  - c. Are there some changes that you will make to make them more effective?
  - d. In your opinion, which are the organisations (national or global) that have implemented DEI strategies with success? Please share key strategies that can be learnt from them. (*Focus on gender within DEI strategies*)
2. Tell me how your organisation supports women specifically to grow as leaders or into leadership positions?
    1. Can you share how this is done?
    2. What have been the successes associated with these efforts?
    3. What have been challenges associated with these efforts?
    4. Do you feel like there are any challenges for women to grow into leadership positions in your organisation specifically?
    5. What more do you think your organisation could do to address women's leadership/equity issues?

### Section 2: Related to Global Health and the Health Sector in India

3. Data show that men comprise about 30% of the health workforce, but occupy 75% of leadership positions and 95% of CEO or head of agency positions. In your view, what are some key reasons for this discrepancy?
  - a. From your experience, how could more women be supported to get into leadership positions? Can you speak about the current gaps that may prevent women from reaching senior leadership?



4. What role do or could men specifically play in promoting/supporting women into leadership roles within public health? How can they be allies?
  - a. Do you have examples or situations when you have seen men playing a role promoting women into leadership roles in your organisation?
5. Finally, what enabling systems and policies currently exist for women to become leaders in the public/health sector?

*Probe: Are there formal or informal supports or communities of practice? (An example may be paid parental leave)*

### **Section 3: Related to Future Collaboration**

6. Would your organisation be interested in working with WomenLift Health in the future?
  - a. What possible areas of collaboration do you see with WomenLift Health?
  - b. If they answer in the affirmative, ask: Would you like to be contacted by someone to discuss ways to collaborate further?
7. Are there other organisations that you feel are doing well to promote women's leadership? Can you describe what they are doing?

That is the end of the interview. Is there anything else you would like to tell us?

Thank you for your time.

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