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Original Research Article

"Study on Gender Disparities in the Nursing Workforce: Challenges and Opportunities"

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Abstract

Background: Gender inequality in the nursing workforce is still a big issue, especially in rural areas such as Osmanabad, Maharashtra. Even though nursing is a profession dominated by women, women are still confronting systemic obstacles to leadership, to pay equity, and to a safe workplace. These differences are exacerbated by cultural standards, restricted institutional assistance, and a lack of resources in rural health care facilities. ***Objectives:*** Considering the background, this study is planned to look into the magnitude of gender inequality of nurses in the district of Osmanabad. More specifically, these aims will: identify gender differences in recruiting, role assignment, and career advancement; measure acts of violence and the effect of perceptions of unsafe work settings; provide practical strategies to move toward gender equity within rural nursing. ***Methods:*** The present study was conducted using a mixed methods approach with both quantitative and qualitative data generation. Stratified purposive sampling was employed to select a sample of 60 registered nurses working at PHCs, CHCs, and the District Hospital, Osmanabad. Information was collected using questionnaires, semi-structured interviews, and focus group discussions. The quantitative data were processed with SPSS, and the qualitative data were subjected to thematic analysis. ***Results:*** Female nurses were predominantly represented, although not in leadership roles, and female nurses were significantly underpaid compared with their male colleagues. Women experienced workplace violence more often compared to night shifts. Emotional exhaustion, professional inertia, and a wish for change were depicted in qualitative accounts. ***Conclusions:*** Sex disparities in the nursing workforce existed in Osmanabad and are indicative of wider systemic imbalances in rural health care. Overcoming these inequalities through enabling policies, mentorship programs, and community engagement is crucial in strengthening nursing and healthcare. The report highlights the requirement for gender transformative interventions suitable for rural areas.

Keywords: Gender equity, nursing workforce, rural healthcare, workplace safety, leadership gap, career advancement, Osmanabad.

1. INTRODUCTION

1.1 Background

Nursing is widely acknowledged to be a feminized occupation that includes the majority of women, 80% or more in numerous countries, including Indian [1]. Yet, even with this superabundance, gender disparities still exist in such key aspects as leadership, pay equity, and workplace safety. In rural hinterlands such as Osmanabad (Maharashtra), disparities are steepened due to structural constraints such as paucity of resources, patriarchal values, and inadequate institutional support.

1.2 Contextual Relevance to Osmanabad

Osmanabad, in the arid Marathwada region, is perennially short of health workers, including nurses. The district's health infrastructure, made of PHCs, CHCs, and a district hospital, depends immensely on the presence of nursing personnel for front-line service. At the same time, however, circulating hearsay also indicates that female nurses in Osmanabad face more than their male colleagues' obstacles to career advancement, safety, and recognition [2].

1.3 Problem Statement

Though nursing is considered to be a female-dominated profession, the paradox is that women are underrepresented in positions in which decisions are

made, but overrepresented in domains of care that are less valued. In Osmanabad, the rural seclusion and regressive sociocultural demands, along with the absence of 'gender sensitive policy instruments', further compound the gender imbalance. Male nurses tend to be a minority in the profession but are more likely to hold supervisory positions and be given more desirable postings, which reproduces implicit bias in workforce management [3].

1.4 Rationale

But it is important for two reasons that we 'see' how gender inequality is playing out in the nursing workforce in Osmanabad: one is because understanding this offers clues about how the rural healthcare system continues to generate inequalities, and the other is because it is the basis for making interventions within such an environment that will benefit both the morale of the nursing workforce and patient care. Closing these gaps satisfies national aspirations of equal access to healthcare and global pledges of gender equity in health systems [4].

1.5 Objectives

- To study gender wise variation in recruitment, job allocation, and career advancement among nurses in Osmanabad.
- To explore the prevalence and effect of workplace violence and the safety perception of female nurses in China.
- To suggest practical measures for advancing gender equity in rural nursing.

2. REVIEW OF LITERATURE

2.1 Global Gender Disparities in Nursing

Internationally, nursing continues to be one of the most sex-segregated professions, with more than 80% of the workforce being female [1]. Even so, women are still a minority in the leadership sector, and they do encounter obstacles that are rooted in the system. Gauci *et al.,* [5] note that discrimination at work is an issue not only for male nurses but also for female nurses, though women are particularly stifled in career opportunities and terms of safety.

2.2 Gender Inequity in Indian Healthcare

gender discrimination is so deeply ingrained in the health system [6]. reported that female health care practitioners experience restricted occupational mobility, wage discrimination, and social prejudice. Dasra's sectoral analysis found that women make up 80% of nursing staff, yet hold only 18% of leadership positions, and earn 34% less than their male counterparts [3]. These differences are more glaring in rural areas such as Osmanabad, where patriarchal attitudes and lack of resources widen the divides.

2.3 Rural Workforce Dynamics and Gendered Roles

Rural healthcare systems often rely on female nurses for frontline care, yet their contributions are undervalued [7]. argue that the feminization of India's health workforce has led to occupational segregation, with women concentrated in lower-paid, high-burden roles. This is compounded by caste and class dynamics, which further marginalize female nurses in rural settings.

2.4 Workplace Violence and Safety Concerns

Workplace violence is a serious problem that affects female nurses, particularly in remote rural postings. [8] report instances of verbal abuse, physical threats, and inadequate institutional support. These are factors that lead to burnout, dropout, and poor patient care. The lack of mechanisms of grievance redressal in districts such as Osmanabad adds to the vulnerability.

2.5 Gender Bias in Recruitment and Promotion

Recruitment and career changes may be influenced by gender stereotypes. Oluwatayo [6] has pointed out that structural and cultural impediments exist that deny women access to leadership positions even where they have equal qualifications. In nursing, men are preferentially fast-tracked into supervisory roles, while women are forced into care-based roles without upward mobility.

2.6 Perceptions of Gender Roles Among Nursing Students

Prosen investigated how nursing students internalize their sex-defined roles [7]. They concluded that while male students associate technical and leadership advancement, female students associate nursing with altruism and caring. These perceptions serve to fuel occupational segregation and shape long-term career pathways.

3. RESEARCH METHODOLOGY

3.1 Study Design

This research design is mixed-methods, combining quantitative and qualitative analytical methods to provide a holistic view of the nursing workforce as it relates to gender disparities. The design permits triangulation, which would enhance the credibility and richness of results.

3.2 Study Area

The study was carried out in the Osmanabad district of Marathwada, Maharashtra, India. The district primarily has a rural setting and a limited health care infrastructure, and a large demand for public health services. Nurses in this area are essential primary health care providers who work in resource-limited and culturally complex settings.

3.3 Study Population

The sample population consisted of 60 registered nurses working in different health care centres of Osmanabad:

- Primary Health Centres (PHCs)
- Community Health Centres (CHCs)
- District Hospital
- Sub-centres and mobile health units

Participants were male and female nurses from different years of experience, levels of education, and positions within the healthcare system.

3.4 Sampling Technique

Stratified purposive sampling procedures were applied to the heterogeneous sample for the representation of various types of facilities and gender. The patients were further stratified into the following three groups:

- 20 nurses from PHCs
- 20 nurses from CHCs
- 20 nurses (half from DH and half from sub-centres of the district)

Participants were invited to interviews according to the criteria of availability, willingness to participate in the interviews, and diversity of profession within the different strata.

3.5 Data Collection Methods

3.5.1 Quantitative Component

- A standard questionnaire was filled out by the 60 subjects.
- The data recorded in the instrument included demographics, job descriptors, history of promotion, salary scale, and exposure to violence at work.
- Items were rated on a Likert scale to measure perceptions of gender bias, career satisfaction, and safety.

3.5.2 Qualitative Component

- Semi-structured interviews were used to collect data from 15 nurses (10 female, 5 male) describing lived experiences of gender bias.
- Focus group discussions (FGDs) were conducted with two nurse groups (one all-female, one mixed-gender) to explore shared histories and community-wide processes.
- ITWs and FGDs were held in Marathi or English as per the willingness of the participants, and sessions were audio recorded with permission.

3.6 Data Analysis

Quantitative Analysis: The quantitative data were managed with SPSS version 26. Results were presented through descriptive statistics (mean, severity, percentage). Chi-square analyses were used to determine differences between gender and career outcomes.

Qualitative data were recorded verbatim and were subjected to thematic analysis. Codes were coded inductively, and themes emerged over multiple readings.

3.7 Ethical Considerations

- Written consent was obtained from all patients.
- Anonymity and confidentiality were preserved during the data collection period.
- Participants were informed that they were at liberty to withdraw from the study at any time without penalty.

4. RESULTS AND ANALYSIS

4.1 Overview

This section of the report describes the findings from quantitative and qualitative data collected from 60 nurses working in the PHCs, CHCs, and the District Hospital of Osmanabad. Analysis exposes gender contrasts in leadership, pay, safety, and roles. The data are presented in thematic sub-sections, annotated with tables and concise descriptions.

4.2 Gender Composition and Leadership Representation

Table 1: Gender Composition and Leadership Representation

Facility Type	% Female Nurses	% Male Nurses	% Leadership Roles Held by Women
PHCs	83%	17%	10%
CHCs	78%	22%	8%
District Hospital	80%	20%	12%

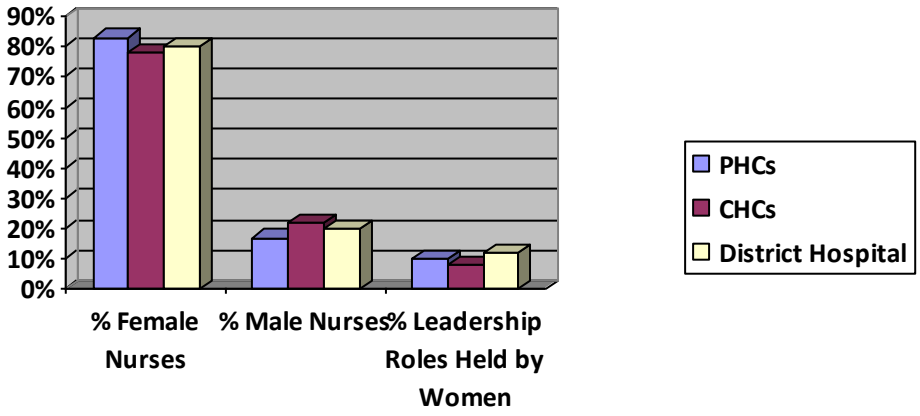

Figure 1: Gender Composition and Leadership Representation

Although women comprise the majority of the nursing workforce, their presence as leaders is disproportionately low. The number of male nurses is relatively small, but they are likely to be assigned to a supervising position.

4.3 Career Advancement and Promotion Trends

Table 2: Career Advancement and Promotion Trends

Gender	% Received Promotion in Last 5 Years	% Expressed Dissatisfaction with Career Growth
Female	22%	68%
Male	45%	32%

Female nurses experienced fewer promotions and more dissatisfaction with career development. Cultural norms and the absence of mentorship were identified as major obstacles.

4.4 Pay Equity and Role Allocation

Table 3: Pay Equity and Role Allocation

Gender	Avg. Monthly Salary (INR)	Common Posting Areas
Female	₹28,500	MCH, immunization, OPD
Male	₹32,700	Emergency, ICU, and administrative

Male nurses worked in high-stakes or technical units more frequently and were paid an average of ₹4,200 more per month.

4.5 Workplace Safety and Violence Exposure

Table 4: Workplace Safety and Violence Exposure

Gender	% Experienced Verbal Abuse	% Experienced Physical Threats	% Felt Unsafe During Night Shifts
Female	62%	28%	74%
Male	35%	10%	38%

Female nurses were significantly more exposed to workplace violence, particularly during night shifts and in remote areas. Many did not have access to recourse mechanisms.

4.6 Qualitative Themes from Interviews and FGDs

- **Theme 1:** Invisible Leadership - female nurses felt no inclusion in the decision-making mechanisms, even though they have years of working experience.
- **Theme 2**: Gendered expectations –Women were "naturally caring" and so were allocated to maternal and child health.
- **Theme 3:** Insecurity as Silent Suffering- Several female nurses experienced threats and bullying to be normalised, as no institutional support**.**
- **Theme 4:** Aspirations – reality discrepancy: Younger female nurses reported high ambitions but anticipated that structural obstacles would negatively affect their career development.

These stories capture the human and professional costs to women of gender disparities. They also shed light on the resilience and reformist ambitions of female nurses.

5. DISCUSSION

5.1 Interpretation of Key Findings

The findings from Osmanabad emphasise the continuing irony; despite women outnumbering men in the field of nursing, it is the women who are few in the higher cadre and technical jobs. This mirrors wider trends in India, given that women's professional opportunities are stunted by occupational segregation and gendered expectations [11]. The female-dominant distribution of nurses in the MCH does not prevent the disqualification of these women from participating in decision-making, yet reinforces dominant systems and their inherent inequities.

5.2 Workplace Violence and Safety

The female nurses in Osmanabad reported a high frequency of verbal abuse and physical threats, with a higher severity during night shifts. This is consistent with national figures that indicate >75% of healthcare workers in India have been subjected to workplace violence, women more than men [9]. The emotional impact is compounded by a lack of institutional support and grievance protocols, adding to burnout and exits.

5.3 Cultural and Structural Barriers

This kind of passive-aggressive hatred is all pervasive in rural Maharashtra, and it shows why very few women can take leadership roles in them. Nursing's history as a feminine profession, based on caregiving stereotypes, affects the division of roles and expectations in professional nursing practice [10]. Male nurses, however few, serve in roles including emergencies and management while leaving checks on gender hierarchy untouched.

5.4 Policy and Institutional Gaps

Although in India there have been declarations about gender equity at the national level, we find, at the local system level in Osmanabad, gender-transformative health policies are missing. There is little transparency in recruitment and promotion, and there is almost no female nurse leadership development. To address these gaps, gender equity indicators should be incorporated into district health planning and workforce development [11,12].

5.5 Opportunities for Reform

There is great scope for reform via inclusive policy making, mentorship programmes, and community involvement. Evidence from other rural schools has shown that focused interventions, such as bias training, clear promotion criteria, and safety audits, can enhance retention and job satisfaction [13]. The promotion of female nurses is not only a justice concern, but is also strategically needed for rural health development [14].

5.6 Implications for Rural Health Equity

Sex-based inequalities in the workforce in Osmanabad are indicative of wider systemic problems in rural healthcare. Doing so may result in more sustainable health systems, improved patient outcomes, and a more motivated workforce. Incorporation of gender equity in policy and practice is critical to achieve sustainable health reform [15].

6. CONCLUSION

The present study highlights the complicated and long-standing problem of gender inequalities that prevail in the nursing workforce in Osmanabad. Although a significant majority of nursing staff are females, they are least represented in managerial ranks, technical fields, and decision-making bodies. Nurses in sexualised societies: gendered perceptions of risk of exposure to bloodborne viruses Although there are relatively few data on occupational risk among nursing staff in the Middle East, we note in a recent review (Kermode, Jolley & Turner 2007) that the situation for many professional health care workers in the region mirrors their global experience: cultural norms, dangerous workplaces and gendered inequality have a significant impact on the opportunities and well-being of female nurses.

Mixed-methods findings highlighted statistical trends and lived experiences to portray an occupationally segregated workforce of undervalued and underpaid, yet overly victimised, workers. Nursing sisters, especially in the rural postings, suffer from institutional negligence in everything from professional safety, identity, to career opportunities. These inequities not only limit one's potential but also undermine the health care system in underserved areas such as Osmanabad.

But the research also points to some clear opportunities for reform. Gender-sensitive hiring, clear avenues for promotion, and inclusive policy development can promote equity and enhance retention. Community involvement and cultural sensitivity training can help eradicate stereotypes and gain public confidence in nursing as a gender non-specific profession.

There is more at stake here than mere representation in rural areas; it's strategic to building rural health care. Equipping women in nursing with leadership development, safety policy, and equal pay can turn Osmanabad into a model for economic workforce growth. Future interventions will need to be context-responsive, evidence-based, and ethically justifiable to support enduring change.

In summary, gender equity in nursing is a moral and operational imperative. Osmanabad can be the beginning of a more equitable and resilient healthcare

future by centering the voices of nurses and breaking down structural obstacles.

7. Conflicts of Interest

The author has no conflicts of interest related to this study. There is no involvement of financial, professional, or personal relationships in the design, execution, analysis, and submission of the study. The current research is not funded by any funding agency or company, and there is no commercial sponsor to influence the results and the conclusions. Ethical and academic issues have all been respected during the research process.

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