Gender Bias against Male Nurses in India: A Review of Literature on Stereotyping, Workplace Discrimination, And Barriers to Professional Advancement

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ABSTRACT

Nursing continues to be perceived worldwide as a feminine occupation, and men who enter the profession in India remain a numerical minority who report distinctive workplace challenges. This review synthesises existing published literature on the nature and extent of gender bias experienced by male nurses in India, with the objective of mapping the historical background, the current magnitude of underrepresentation, the forms of stereotyping and workplace discrimination reported, and the implications for nursing administration and health policy. A narrative literature review was conducted using PubMed, ScienceDirect, Google Scholar and SAGE Journals, covering peer-reviewed articles, WHO and government workforce reports, and relevant Indian court proceedings, published largely between 2019 and 2025, using combinations of the terms “male nurses”, “gender bias”, “stereotype”, “workplace discrimination” and “India”. The review found that men constitute roughly one-fifth of the Indian nursing workforce, a figure above the global average of about 10% yet still well short of parity, and that male nurses commonly report being questioned about their competence and motives, being restricted from maternity, gynaecology and paediatric postings, being treated as “muscle” for lifting or restraining patients rather than as full caregivers, and facing delayed promotion and limited institutional support. Statutory and administrative rules restricting nursing roles by sex have also been challenged in Indian courts and remain a live policy dispute: the 80:20 female-to-male reservation applied in AIIMS Nursing Officer recruitment through NORCET, the exclusion of men from the Armed Forces’ Military Nursing Service under a 1943 Ordinance, and admission rules confining undergraduate B.Sc. (Hons) Nursing courses at AIIMS and Delhi-affiliated institutions to female candidates only. At the same time, patient-perception studies suggest attitudes are gradually shifting, with a majority of surveyed patients expressing no explicit gender preference for their nurse. The review concludes that structural and attitudinal bias against male nurses persists in India despite a growing and needed workforce, and that gender-neutral recruitment policy, sensitisation of co-workers and supervisors, and public awareness are needed to support the equitable participation of men in the profession.

Keywords: male nurses; gender bias; nursing profession; workplace discrimination; India

INTRODUCTION

Nursing has historically been constructed as a feminine occupation, and this framing continues to shape workforce composition worldwide. According to the World Health Organization’s State of the World’s Nursing 2020 report, men make up only around 10% of the global nursing workforce (World Health Organization, 2020). India mirrors this global pattern but with somewhat higher male representation: national workforce estimates place male nurses at roughly one-fifth of the total (Karan et al., 2021), and student-population data report a closely similar proportion of about 19.8% (Devi et al., 2022). Men were, in fact, present in organised Indian nursing training as early as the 1930s, yet their numbers have remained persistently below parity with women across nearly a century of professional development (Jayapal & Arulappan, 2020).

The relative scarcity of men in Indian nursing is not simply a matter of individual career choice; a growing body of literature documents that male nurses in India face gender-based stereotyping, workplace

discrimination, and structural barriers to recruitment and advancement. As India continues to face a shortfall in its skilled nursing workforce, and as institutions such as ClearMedi DMH pursue NABH-accredited standards of quality nursing care, understanding and addressing bias against male nurses has direct relevance for workforce planning, staff wellbeing, and equitable human-resource policy in hospitals. This review brings together the available published literature to describe the extent, forms, and consequences of gender bias faced by male nurses in India, and to consider implications for nursing administration.

METHODOLOGY

This paper follows a narrative literature review design. Electronic databases – PubMed, ScienceDirect, Google Scholar, and SAGE Journals – were searched using combinations of the keywords “male nurses”, “men in nursing”, “gender bias”, “gender inequality”, “stereotype”, “workplace discrimination”, and “India”. Peer-reviewed journal articles, WHO and government workforce reports, and relevant Indian court proceedings concerning nursing recruitment policy, published mainly between 2019 and 2025, were included where they addressed the representation, perception, or workplace experience of male nurses in the Indian context; a small number of internationally comparative sources were retained to situate the Indian findings within the broader global pattern. Sources unrelated to nursing workforce gender composition, or focused solely on nursing education pedagogy unconnected to gender, were excluded. Findings are organised thematically below rather than by individual study.

To make the search process more transparent, the databases were queried using Boolean strings combining the population and phenomenon terms, for example (“male nurse*” OR “men in nursing”) AND (India) AND (“gender bias” OR “gender discrimination” OR stereotyp* OR “workplace discrimination”), adapted to the syntax of each database (PubMed, ScienceDirect, Google Scholar, SAGE Journals). Searches were restricted to English-language sources published between January 2019 and June 2025, supplemented by a small number of earlier foundational sources (for example Jayapal & Arulappan, 2020, which draws on early-twentieth-century service records) where these were needed to establish historical context. Titles and abstracts were screened for direct relevance to the representation, perception, recruitment, or workplace experience of male nurses in India, and full texts were retrieved for sources passing this screen; sources addressing nursing education pedagogy without a gender dimension, or unrelated to workforce composition, were excluded. As this is a narrative rather than a systematic review, records were not logged at each stage of identification, screening and exclusion in the manner a formal PRISMA flow diagram would require, and no structured quality-appraisal tool (e.g., CASP, MMAT) was applied to included sources; both points are acknowledged as limitations in the Discussion. Legal developments (court petitions, notices and orders) were identified primarily through contemporaneous legal-affairs reporting (Bar and Bench, LiveLaw, Deccan Herald) rather than through primary law-report databases, and are cited to that reporting accordingly. Formal case numbers and bench details were subsequently verified directly against primary court records for the Karnataka High Court and Supreme Court proceedings discussed below (Sanjay M. Peerapur & Others v. Union of India, W.P. No. 62966 of 2011 (S-RES); Union of India & Ors. v. Ex. Lt. Selina John, Civil Appeal No. 1990 of 2019) and are cited accordingly in the text. A verifiable case or diary number could not be located for the two Delhi High Court public-interest litigations discussed below (the 2018 petition on Military Nursing Service recruitment and the 2023 petition on B.Sc. (Hons) Nursing admission eligibility); these remain cited to contemporaneous news reporting only, and readers requiring an authoritative citation for these two matters are advised to verify the case or diary number against the Delhi High Court cause-list system, SCC Online, or Manupatra before relying on them for citation purposes.

REVIEW OF LITERATURE

Historical background of men in nursing in India

Organised training of male nursing students in India can be traced to the late 1930s in the Madras Presidency, where specific government hospitals were designated to admit and accommodate male nursing trainees under formal service rules (Jayapal & Arulappan, 2020). Despite this early institutional foothold, nursing in India came to be officially and popularly regarded as a woman’s occupation over the twentieth century, a perception

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reinforced by colonial-era religious and missionary nursing traditions and by the broader global feminisation of the profession (Jayapal & Arulappan, 2020).

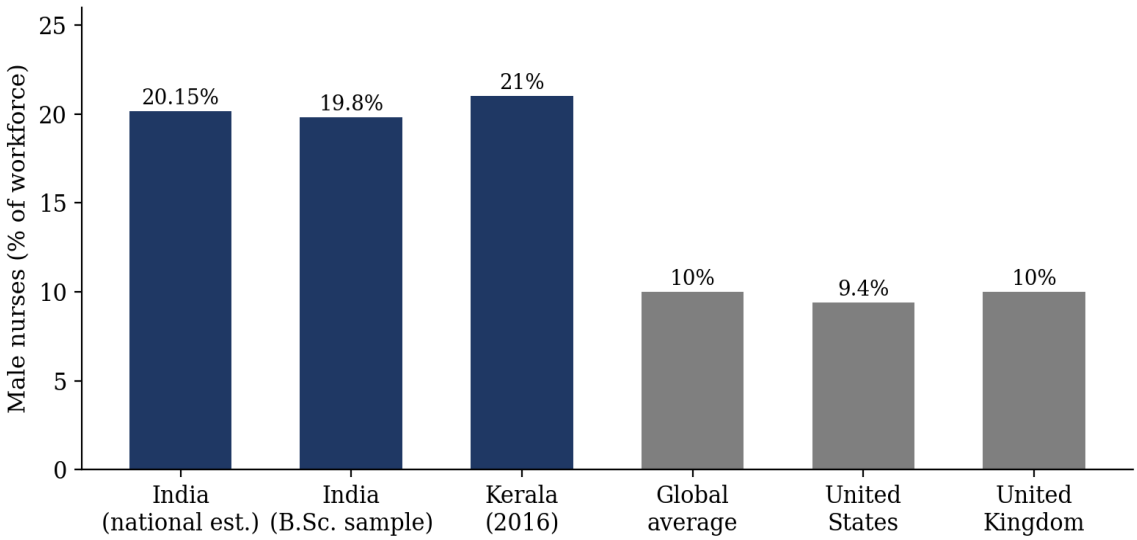
Magnitude of underrepresentation

Current estimates indicate that men account for approximately one-fifth of India's registered nursing workforce (Karan et al., 2021), a figure corroborated by student-level data showing roughly 19.8% male enrolment against 80.2% female enrolment in B.Sc. Nursing programmes (Devi et al., 2022). This is markedly higher than the global average of about 10% reported by the WHO (World Health Organization, 2020) and than figures reported for the United States (~9.4%) and the United Kingdom (~10%), yet it still falls well short of gender parity (see Table 1). State-level data from Kerala similarly show male representation rising from roughly 11% to 21% between 2011 and 2016, reflecting a slow but real increase in participation over time (Jayapal & Arulappan, 2020).

Table 1. Reported Proportion of Male Nurses in India Compared with Selected Countries

Country / Region	Male Nurses (%)	Source
India (national estimate)	~20.15%	Karan et al., 2021
India (B.Sc. Nursing student sample)	~19.8%	Devi et al., 2022
Kerala, India (2016)	~21%	Jayapal & Arulappan, 2020
Global average	~10%	World Health Organization, 2020
United States	~9.4%	NCSBN National Nursing Workforce Survey, 2020
United Kingdom	~10%	Williams, 2017

Figure 1. Male Nurse Representation: India vs. Selected Countries



State-level variation in numbers and reported experience

The picture varies further at sub-national level. Beyond the rise in male nursing representation recorded in Kerala, from roughly 11% to 21% of the workforce between 2011 and 2016 (Jayapal & Arulappan, 2020), Maharashtra Nursing Council registration data show male nurse registrations increasing from 578 in 2007 to over 1,000 by the mid-2010s, and enrolment data from Rajiv Gandhi University of Health Sciences in Karnataka show male B.Sc. Nursing admissions rising several-fold between 2007–08 and 2010–11, alongside

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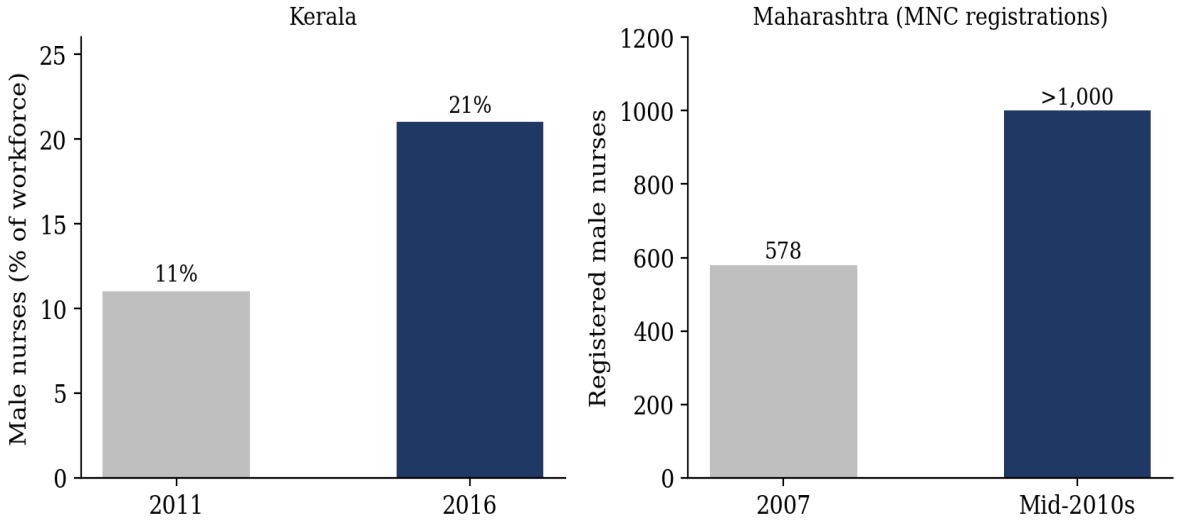
a persistently female-majority intake overall (Jayapal & Arulappan, 2020). This growth has not been matched by uniform movement toward parity in recruitment policy: in February 2021, Maharashtra's Directorate of Health Services introduced its own 90:10 female-to-male recruitment quota for nursing staff in state district hospitals, extending the logic of the AIIMS NORCET ratio beyond the central government sphere (Scroll.in, 2022). Qualitative evidence on male nurses' lived experience beyond Odisha remains limited, but an interview-based study of male nurses across three cities in Kerala similarly found that participants associated the profession with stigma and had their professional legitimacy questioned, and that several viewed nursing chiefly as a route to migration and overseas employment rather than a stable long-term domestic career (George & Bhatti, 2019) — a finding with direct implications for retention within the Indian health system. A 2025 review co-authored by AIIMS nursing faculty similarly found that male nurses across Indian institutions report gender-based reservation in recruitment, gendered role assignment, and barriers to career progression, while noting some countervailing advantages in access to leadership roles in certain settings (Sharma et al., 2025). Taken together, these sources indicate that both the scale of underrepresentation and its lived consequences vary meaningfully by state and sector, though empirical coverage remains concentrated in a small number of states and continues to rest heavily on a single major qualitative study (Karmakar et al., 2025).

Table 4. State-Level Growth in Male Nurse Representation

State / Region	Metric	Earlier	Later
Kerala	% male nursing workforce	~11% (2011)	~21% (2016)
Maharashtra	Registered male nurses (MNC)	578 (2007)	>1,000 (mid-2010s)
Karnataka (RGUHS)	Male B.Sc. Nursing admissions	baseline (2007–08)	several-fold increase (2010–11)

Source: Jayapal & Arulappan, 2020.

Figure 4. State-Level Growth in Male Nurse Representation



Stereotyping and social stigma

Qualitative research among male nursing officers in Odisha found that participants regularly encountered gender bias, occupational injustice and social stigma in their day-to-day work; some reported being treated with disdain by doctors and colleagues who assumed they lacked knowledge or skill, or who viewed nursing as a fallback career for men who "could not succeed" in other medical professions (Karmakar et al., 2025).

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Comparable qualitative findings from Asian clinical settings more broadly describe men being cast primarily as sources of physical "muscle" for lifting or restraining patients, being excluded from maternity, gynaecology and neonatal postings, and being addressed as "the male nurse" rather than simply "nurse" because patients frequently assume men on the ward must be doctors.

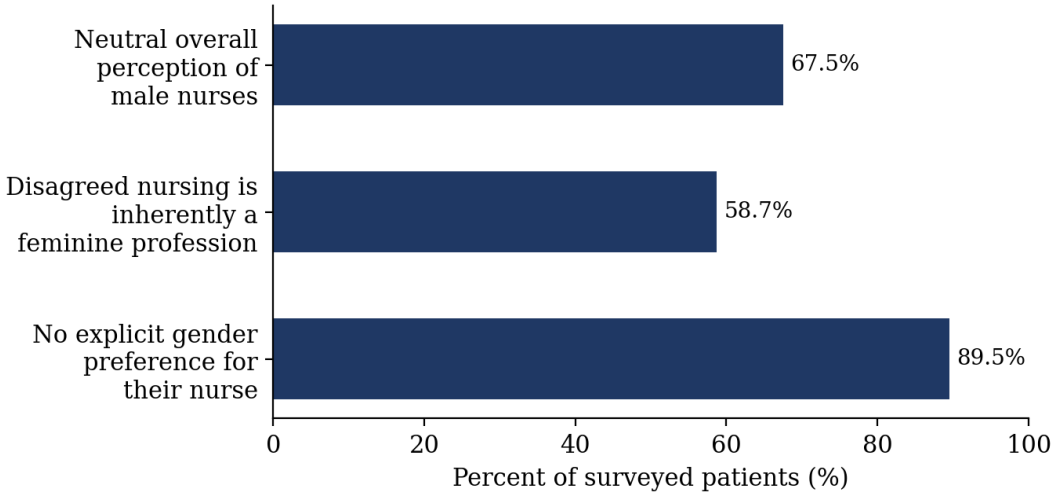
At the same time, patient-facing survey data suggest that direct patient-level bias may be softening. A cross-sectional survey of 400 patients at a tertiary-care hospital in Uttarakhand found that the majority (67.5%) held a neutral overall perception of male nurses, that 58.7% disagreed that nursing is an inherently feminine profession, and that 89.5% expressed no explicit gender preference for the nurse caring for them, with higher patient education level associated with more favourable perception (Sharma et al., 2022). This suggests that bias against male nurses in India may be concentrated more within the profession and its institutions than among patients themselves.

Table 3. Patient Perceptions of Male Nurses (Uttarakhand Tertiary-Care Survey, n = 400)

Indicator	**Result**
Neutral overall perception of male nurses	67.5%
Disagreed that nursing is an inherently feminine profession	58.7%
Expressed no explicit gender preference for their nurse	89.5%

Source: Sharma et al., 2022.

Figure 3. Patient Perceptions of Male Nurses (Uttarakhand, n=400; Sharma et al., 2022)



Workplace discrimination and recruitment barriers

Beyond informal stereotyping, structural barriers to entry and advancement have been documented and, in some cases, formally challenged. Participants in the Odisha study reported prejudice, delayed promotion, and lack of cooperation from higher authorities, and some considered leaving the profession altogether because of low pay, gender bias, and reduced job satisfaction (Karmakar et al., 2025). At a policy level, recruitment rules restricting certain nursing services to women only have drawn legal challenge in India: the Delhi High Court described the Indian Army's practice of admitting only women into its Military Nursing Service as "antiquated", "stereotyped", and a form of gender discrimination, following a public-interest petition brought on behalf of qualified male nurses seeking entry (The Wire, 2022). Admission rules restricting some government-affiliated B.Sc. (Hons) Nursing courses to female candidates only have similarly been challenged as arbitrary and discriminatory given the country's broader nursing shortage. These cases illustrate that gender-

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based restriction of male nurses in India is not confined to informal workplace attitudes but is, in places, embedded in formal service and admission rules.

Formal Recruitment And Admission Quotas Restricting Men: Three Case Studies

The preceding section noted that gender-based restriction of male nurses in India is, in places, embedded in formal service and admission rules rather than confined to informal workplace attitudes. Three current policy disputes illustrate this in detail: the 80:20 female-to-male reservation applied in Nursing Officer recruitment through the Nursing Officer Recruitment Common Eligibility Test (NORCET); the exclusion of men from the Armed Forces' Military Nursing Service (MNS); and rules confining undergraduate B.Sc. (Hons) Nursing admission at AIIMS and affiliated Delhi institutions to female candidates only. Each is examined below with reference to the available primary notifications, litigation record, and recruitment data.

The NORCET 80:20 gender-reservation policy

The Nursing Officer Recruitment Common Eligibility Test (NORCET), conducted by AIIMS New Delhi, is the principal centralised examination for recruitment of Nursing Officers at AIIMS institutes and several central government hospitals. On 27 July 2019, the Central Institute Body (CIB) of AIIMS resolved to reserve 80% of Nursing Officer vacancies for female candidates and 20% for male candidates, a decision reported to have followed internal discussion on the "appropriateness and requirement of female nursing staff" in specialised wards in relation to patient comfort and care (Ambition Nursing Care, 2025; Change.org, 2020). The ratio was first applied in the NORCET 2020 recruitment cycle and has continued through subsequent cycles; the NORCET-10 notification for 2026, covering 2,551 Nursing Officer vacancies across AIIMS and participating central government hospitals, again specifies 80% of seats reserved for female candidates and 20% for male candidates (IndiaJobCentral, 2026).

The scale of the resulting mismatch between qualification and selection is illustrated by the NORCET-4 (2023) result: of 2,668 candidates provisionally declared qualified, 1,051 were male and 1,616 were female — meaning men constituted close to 39% of the qualified candidate pool even though the reservation confines them to at most 20% of posts actually offered (Careers360, 2023). Because selection within each gender category proceeds by merit rank subject to the category ceiling, a substantial number of male candidates who outrank many selected female candidates on the common merit list do not receive AIIMS postings solely on account of the ratio, while lower-ranked female candidates are accommodated within the 80% quota.

This mismatch produced a visible downstream dispute at the North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS), a central institute to which "excess" high-ranking male candidates from the AIIMS-conducted NORCET have at times been posted through a central allocation mechanism. In May 2025, the NEIGRIHMS Director clarified that male Nursing Officers allocated to the institute were not "leftover" or lower-merit candidates but had, in several cases, ranked higher than female candidates selected for AIIMS itself, with the allocation outcome driven by the 80:20 ratio applied at AIIMS rather than by comparative merit (Syllad, 2025). NEIGRIHMS had separately petitioned the Ministry of Health and Family Welfare in July 2024 to permit it to adopt an 80:20 female-to-male ratio in its own recruitment; the Ministry responded in August 2024 that no such provision existed in the applicable Recruitment Rules and advised against adopting the ratio, after which the institute renewed its request in April 2025 (Meghalaya Monitor, 2025).

The policy has drawn organised opposition from male nursing aspirants and professional bodies, who contend that a rigid sex-based reservation of this magnitude is inconsistent with Article 16 of the Constitution, which guarantees equality of opportunity in public employment, and that recruitment should instead proceed strictly by merit (Ambition Nursing Care, 2025). Petitions challenging the ratio have been filed before the Delhi High Court, and news reports from the 2020 NORCET cycle record that counselling and appointment were disrupted while the matter was contested, including an organised counter-petition from sections of the female nursing workforce and the AIIMS Nurses Union defending the reservation as necessary and going on indefinite strike in its support (Change.org, 2020). A related dispute over the ceiling on women's reservation — concerning direct recruitment to the separate post of Nursing Attendant at AIIMS Delhi, where the Central

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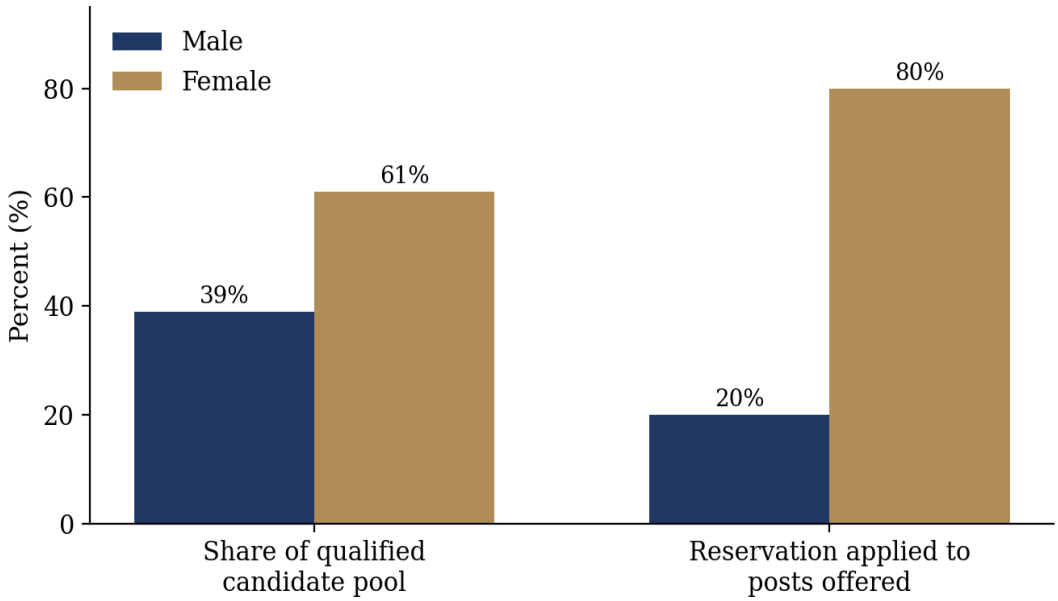
Administrative Tribunal had upheld an 80% women's reservation in Mahipal Singh Jahkar and others v. Union of India — reached the Supreme Court in July 2021; a three-judge bench issued notice on a plea questioning whether more than 50% of posts in a cadre may be reserved for one sex, observing that there was a "divergence of views" on the question in existing case law (LiveLaw, 2021). As of the most recent published recruitment notifications, the 80:20 ratio remains in force for AIIMS Nursing Officer recruitment notwithstanding this ongoing contestation.

Table 2. NORCET-4 (2023) Qualified Candidates by Gender Against the 80:20 Selection Ratio

Category	**Male**	**Female**
Candidates declared qualified (NORCET-4, 2023)	1,051	1,616
Share of qualified pool	≈39%	≈61%
Reservation applied to actual posts offered	20%	80%

Source: Careers360 (2023) for qualified-candidate figures; IndiaJobCentral (2026) and Ambition Nursing Care (2025) for the applicable reservation ratio.

Figure 2. NORCET-4 (2023): Qualified Pool vs. 80:20 Reservation



Exclusion of men from the Military Nursing Service

The Military Nursing Service (MNS), the nursing branch of the Indian Armed Forces, has historically recruited only women. Its governing instruments — the Indian Military Nursing Service Ordinance, 1943 and the Military Nursing Service (India) Rules, 1944 — restrict eligibility for appointment through the words "if a woman", and have been in continuous operation since the Second World War era (The Wire, 2022). The Indian Professional Nurses Association (IPNA) filed a public interest litigation before the Delhi High Court seeking to have this restriction quashed, arguing that thousands of trained and qualified male nurses in India were being denied an avenue of employment and professional advancement, and that the exclusion "stigmatised and ostracised" male nurses as a class (The Wire, 2022).

Hearing this petition on 28–29 May 2018, a Delhi High Court bench of Acting Chief Justice Gita Mittal and Justice C. Hari Shankar described the practice as "very antiquated" and "very stereotyped", asking why an entire nursing branch of the Army had no male members, and issued notice to the Ministry of Defence

(Business Standard/PTI, 2018). On 8 October 2018, a differently constituted bench comprising Chief Justice Rajendra Menon and Justice V.K. Rao went further, terming the all-women recruitment practice "gender discrimination, only the other way round", and directed the Centre to take a decision within a stipulated period, listing the matter for further hearing (India.com/PTI, 2018; Nurseslabs, 2018).

A related but factually distinct challenge was decided by the Karnataka High Court in Sanjay M. Peerapur & Others v. Union of India, Writ Petition No. 62966 of 2011 (S-RES), Karnataka High Court, Dharwad Bench, decided 5 January 2024 (Hegde, J.), which quashed the words "if woman" in Section 6 of the 1943 Ordinance as violative of Articles 14, 16(2) and 21 of the Constitution, holding that the wartime rationale for exclusively recruiting women did not justify a blanket 100% reservation and suggesting that if augmenting the female nursing cadre for deployment needs was the goal, a scheme reserving posts for both men and women in separate units would achieve this without breaching Article 16(2); the court, however, declined to unsettle recruitments already concluded during the pendency of that petition (Deccan Herald, n.d.-a; Karnataka High Court, 2024).

The judiciary's broader scrutiny of gender-based rules within the MNS is not confined to the exclusion of men. In Union of India & Ors. v. Ex. Lt. Selina John, Civil Appeal No. 1990 of 2019, decided 14 February 2024, the Supreme Court (Justices Sanjiv Khanna and Dipankar Datta) upheld the reinstatement of a Permanent Commissioned MNS officer who had been discharged in 1988 solely on the ground of her marriage under a since-withdrawn 1977 Army instruction, describing the rule as "manifestly arbitrary" and a "coarse case of gender discrimination and inequality", and directing payment of ₹60 lakh in compensation (Bar and Bench, 2024; Deccan Herald, n.d.-b). While concerned with a different form of gender-based rule within the same service, this ruling reinforces a consistent judicial position that gender-restrictive service conditions in military nursing — whether excluding men from entry or penalising women for marrying — are constitutionally suspect. Notwithstanding the 2018 High Court observations, published sources available for this review do not record a final, implemented policy change admitting men into the Military Nursing Service; recruitment into the MNS combatant nursing cadre has continued to be reported as restricted to women in subsequent years.

Female-only admission to undergraduate B.Sc. (Hons) Nursing courses

A third and more recent front concerns undergraduate nursing education rather than post-qualification recruitment. The B.Sc. (Hons) Nursing programmes offered by AIIMS New Delhi and its participating AIIMS institutes, and the equivalent B.Sc. (Hons) Nursing courses affiliated with Delhi University (DU) and Guru Gobind Singh Indraprastha University (IPU), admit only female candidates; published AIIMS eligibility criteria for the 2025 and 2026 admission cycles state in terms that the B.Sc. (Hons) Nursing programme is "exclusively for female candidates" and that male candidates are not eligible to apply, a restriction applied uniformly across all participating AIIMS campuses (PW Live, 2025a). The shorter B.Sc. Nursing (Post-Basic) programme, intended for already-qualified nurses, is reported to carry the same female-only eligibility condition (Testbook, 2025).

In November 2023, the Indian Professional Nursing Association (IPNA) filed a public interest litigation before the Delhi High Court challenging the exclusion of men from admission to these B.Sc. (Hons) Nursing courses at AIIMS, DU and IPU, arguing that the underlying premise — that men lack the attributes required to be a nurse — is regressive and that the profession has evolved beyond being one exclusively suited to women (Bar and Bench, 2023). A Division Bench of Acting Chief Justice Manmohan and Justice Mini Pushkarna issued notice to the Central and Delhi governments, AIIMS, DU, IPU and the Indian Nursing Council, and listed the matter for further hearing on 19 February 2024; counsel for the petitioner additionally argued that, given the country's documented nursing shortage, persons of all genders should be permitted to apply to the course (Deccan Herald, n.d.-c).

Based on the most recent published admission notifications available for this review, covering the 2025 and 2026 admission cycles, the female-only eligibility condition for AIIMS B.Sc. (Hons) Nursing remains unchanged and in active application, with the 2026 notification again inviting applications from "female candidates" only across the 19 participating AIIMS institutes offering the course (NursingMitr, 2026). This indicates that, whatever the outcome of the pending litigation, the underlying admission rule had not been

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judicially set aside or administratively withdrawn as of the sources available to this review. Taken together with the NORCET 80:20 reservation and the historical exclusion of men from the Military Nursing Service, the persistence of a female-only gateway at undergraduate entry level suggests that formal, rule-based restriction of men in Indian nursing operates across the full career pipeline — from initial professional education, through post-qualification recruitment, to specific institutional service streams — rather than at any single point.

Implications for career advancement and retention

Taken together, the reviewed literature suggests that male nurses in India face a combination of overlapping barriers: being questioned on competence and motive, being excluded from certain clinical postings, being valued chiefly for physical tasks rather than the full scope of nursing care, encountering slower promotion, and in some services being formally ineligible for recruitment on the basis of sex. These barriers plausibly discourage men from entering or remaining in nursing, which is a relevant concern given India's documented shortfall in its skilled nursing workforce relative to WHO-recommended nurse-to-population ratios (Das & Singh, 2022; Karan et al., 2021).

Economic implications of restricting male nurses' participation

The debate over male representation in nursing cannot be separated from India's broader workforce shortfall. India's nurse-to-population ratio has been estimated at approximately 1.7 to 1.96 nurses per 1,000 population, against a WHO-recommended benchmark of 3 per 1,000, implying a need for well over 4 million additional nurses to meet WHO norms (Business Standard, 2024). Modelling of the investment required to close India's health-workforce gap by 2030 estimated that closing the nurse/midwife shortfall alone would require approximately INR 1,096 billion in additional production investment, with the potential to generate substantial downstream employment and national-income gains if realised (Karan et al., 2023). Within this context, policies that cap male entry into specific recruitment streams — the NORCET 80:20 ratio, the historical all-women Military Nursing Service, and female-only undergraduate admission — restrict the pool of qualified candidates available to fill vacant posts to a subset of the eligible workforce, at a time when national policy otherwise prioritises expanding supply as quickly as possible. The NORCET-4 qualified-candidate data illustrate this concretely: with 1,051 male candidates provisionally qualified against a ceiling admitting at most 20% of posts, several hundred qualified male nurses were, in that cycle alone, unable to take up AIIMS postings despite meeting the same merit threshold applied to their female counterparts (Careers360, 2023). Whether or not this trade-off is judged justified on other grounds, its economic dimension — the foregone deployment of already-trained, already-qualified nursing staff during a documented national shortage — has received little explicit attention in either the policy debate or the litigation record reviewed here.

Figure 5. India's Nurse-to-Population Ratio vs. WHO Benchmark

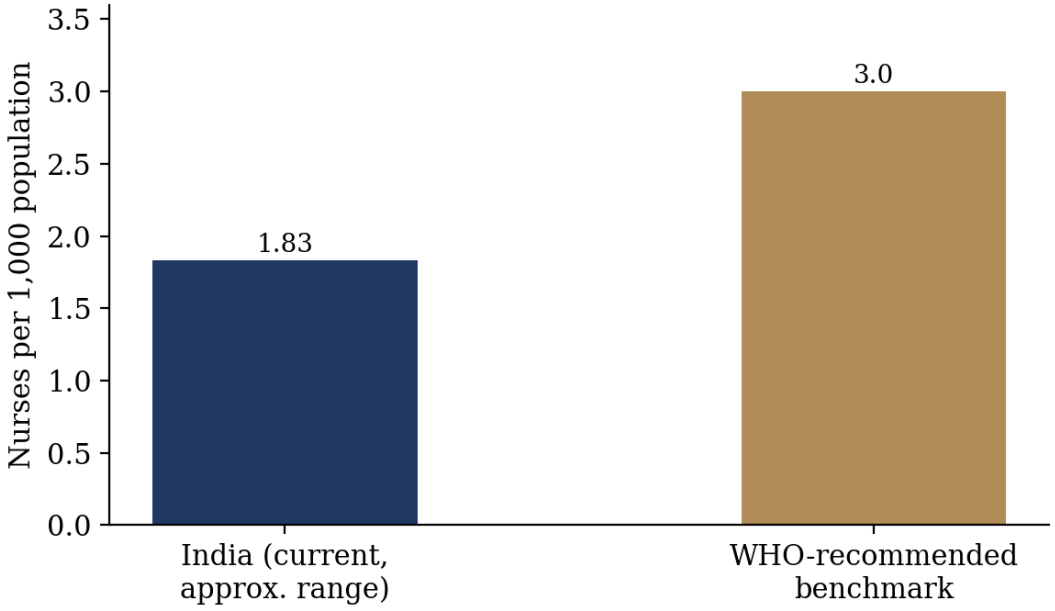

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Figure 5. India's current nurse-to-population ratio (approx. 1.7–1.96 per 1,000, midpoint shown) remains well below the WHO-recommended benchmark of 3 per 1,000 (Business Standard, 2024).

International strategies to increase men's participation in nursing

Several high-income countries facing comparable or more severe male underrepresentation have pursued deliberate strategies rather than relying on gradual change, and these offer possible reference points for India. In the United States, the American Association for Men in Nursing has run a long-standing "20 x 20" campaign explicitly targeting 20% male enrolment in nursing programmes, alongside broader diversity, equity and inclusion frameworks encouraging institutions to track and report male representation by department and seniority (Sharma et al., 2025). In the United Kingdom, universities and the National Health Service have combined targeted outreach with peer-support structures such as the Men in Nursing Together network, alongside the NHS's own "Step Into The NHS" careers campaign aimed at challenging gender stereotypes in healthcare recruitment from school age (Clifton, 2020). A systemised rapid review of the international literature on recruiting and retaining men in pre-registration nursing programmes found that direct contact with, and mentorship from, existing male nurses was one of the most consistently reported facilitators of men's entry into and continuation within the profession, more so than advertising or curriculum change alone (Gavine et al., 2020). None of these campaigns has closed the gender gap in nursing outright — male representation in the UK and US nursing workforce remains below 12% — but they illustrate a set of actions treated as complementary to attitudinal change: institutional target-setting, visible male mentors and role models, and school- and university-level outreach, which current Indian policy responses, centred so far on numerical ceilings restricting rather than encouraging male entry, do not yet employ.

DISCUSSION

The literature reviewed here indicates that gender bias against male nurses in India operates at three broad levels: interpersonal (stereotyping by colleagues, doctors and, to a lesser and apparently diminishing extent, patients), organisational (restricted postings, slower promotion, limited support from supervisors), and structural or legal (sex-restricted recruitment rules in specific services and institutions). This pattern broadly parallels findings reported internationally, where men in nursing are often stereotyped as lacking empathy or as being suited only to technical or physically demanding tasks, even as clinical experience and patient satisfaction tend to erode such assumptions over time. The relatively higher proportion of male nurses in India compared with several high-income countries suggests that numerical underrepresentation alone does not explain the persistence of bias; attitudinal and institutional factors appear to play an independent role.

This apparent paradox — a male nursing share in India (around one-fifth) roughly double the global average, coexisting with some of the most restrictive formal sex-based recruitment rules documented in this review — is not straightforward to resolve from the available literature, but several explanations are plausible and not mutually exclusive. First, a sectoral split may be at work: many of the discriminatory formal rules identified here (the NORCET 80:20 ratio, the historical Military Nursing Service exclusion, AIIMS-affiliated undergraduate admission rules) apply specifically to central government and armed-forces institutions, whereas the private and state-government hospital sector, where a large share of India's nursing workforce is employed, may operate with fewer formal sex-based ceilings, even as informal bias persists there too. Second, regional variation appears real: the rise in male representation in Kerala and the growth in male registrations recorded in Maharashtra and Karnataka (Jayapal & Arulappan, 2020) suggest that numerical underrepresentation is easing unevenly, driven in part by economic push factors — nursing offering a comparatively accessible route to stable government employment or overseas migration for men in some states — rather than by any coordinated shift in institutional attitudes (George & Bhatti, 2019). Third, the timing of the restrictive policies is telling: the NORCET ratio was introduced in 2019, precisely as male qualification rates were rising to the point of qualifying at nearly twice their allotted share of posts (Careers360, 2023), which is consistent with the reservation functioning, in practice if not in stated intent, as a response to increasing male competitiveness for posts rather than a historical relic simply awaiting removal. Under this reading, higher male representation and formal restriction are not contradictory but connected: the restriction may be, in part, a reaction to growing male participation rather than mere inertia.

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A fuller account of this debate also requires engaging with the justification most often advanced for excluding men from maternity, gynaecology and neonatal postings: patient privacy and modesty during intimate examinations and procedures. This concern has genuine grounding in the Indian clinical-ethics literature, which documents that patients — overwhelmingly women in these settings — can experience fear, embarrassment or anger when examined or cared for by an unrelated man, and recommends measures such as chaperoning, explicit consent for intimate procedures, and directly asking patients about privacy preferences (Mahmood, 2018). This literature does not, however, straightforwardly support a blanket exclusion of male nurses from entire specialties or wards: the safeguards it recommends are patient-level and consent-based — chaperone presence, opt-in preference, advance disclosure — rather than categorical bars on male staff, and the same literature notes that men's own modesty concerns during intimate examinations are comparably real but far less institutionally accommodated, with male patients rarely offered a male-attendant option in urology and similar settings. A policy of sex-matched staffing on patient request, applied symmetrically to male and female patients and supported by adequate staffing levels to make such requests practicable, would address the underlying patient-comfort concern without the blanket exclusion that current postings, recruitment quotas and admission rules apply. The literature reviewed here does not indicate that broader exclusion of men from these specialties, as opposed to consent-based accommodation within them, is itself a patient-safety or patient-comfort necessity.

For hospital administrators and nursing leadership, including those responsible for quality and accreditation functions, these findings have practical relevance. Gender-neutral recruitment and posting policies, sensitisation of medical and nursing staff to counter stereotyping, mentorship and fair promotion pathways for male nursing staff, and monitoring of staff-perception indicators could all support a more equitable clinical workforce. Given that patient acceptance of male nurses appears comparatively high, institutional and peer-level attitudes – rather than patient preference – may be the more productive target for intervention. These implications are set out with measurable indicators in the section following the Discussion.

This review has limitations common to narrative reviews: it draws on a purposively rather than systematically identified set of sources, the underlying primary studies vary in design and sample size, and several draw on single-institution or single-state samples that may not generalise nationally. Future research using larger, multi-state, mixed-methods designs would help quantify the relationship between institutional policy, attitudinal bias, and male nurse retention in India.

RECOMMENDATIONS AND INDICATORS FOR NURSING ADMINISTRATION

Building on the discussion above, the following recommendations for nursing administration and hospital leadership are proposed together with measurable indicators that quality and human-resource committees could track over time — an approach consistent with the documented, auditable quality-indicator culture already expected of NABH-accredited institutions.

1. Gender-neutral recruitment and posting policy. Move from sex-based reservation toward merit-based selection, with posting decisions guided by clinical competence and patient preference rather than blanket sex-based exclusion. Indicator: proportion of clinical postings, including maternity, gynaecology and paediatric units, formally open to qualified staff of either sex; ratio of male to female applicants shortlisted relative to the applicant pool.

2. Equitable promotion pathways. Establish transparent, time-bound promotion criteria applied identically regardless of sex. Indicator: median time-to-promotion for male versus female nursing staff at each grade; proportion of male nurses in supervisory and leadership roles relative to their share of the overall nursing workforce.

3. Sensitisation and grievance mechanisms. Provide periodic sensitisation training for medical and nursing staff, supervisors and administrators addressing gender-based stereotyping, alongside a confidential channel for reporting gender-based workplace discrimination. Indicator: number of sensitisation sessions conducted per year and staff attendance rate; number and resolution rate of gender-related grievances logged annually.

4. Consent-based patient-preference accommodation. Where patients express a same-sex staffing preference for intimate procedures, accommodate this through chaperoning or staff reassignment on a consent basis rather than through categorical exclusion of male staff from entire units. Indicator: proportion of patient-preference requests accommodated within a defined time window; patient-satisfaction scores disaggregated, where feasible, by staffing-preference accommodation.

5. Retention and exit monitoring. Track attrition separately by sex and include a standard question on gender-related workplace factors in exit interviews. Indicator: annual attrition rate for male versus female nursing staff; proportion of departing staff citing gender-related factors.

6. Mentorship and role-model visibility. Establish structured mentorship linking newly recruited male nursing staff or students with established male nurses in the institution, drawing on international evidence that peer mentorship is one of the more consistent facilitators of male recruitment and retention (Gavine et al., 2020). Indicator: proportion of new male nursing recruits assigned a mentor within the first month of employment; mentee retention rate at one year.

CONCLUSION

Despite a growing presence of men in Indian nursing, gender bias against male nurses remains evident in stereotyping by colleagues and supervisors, restriction from certain clinical areas, slower career progression, and, in some services and courses, formal recruitment and admission rules — including the AIIMS NORCET 80:20 gender reservation, the historical all-women Military Nursing Service, and female-only undergraduate B.Sc. (Hons) Nursing admission — that exclude or sharply limit men altogether. Patient attitudes appear comparatively more accepting, suggesting that the locus of bias lies substantially within the profession and its institutions rather than with the public. Addressing this bias through gender-neutral recruitment policy, staff sensitisation, and supportive career pathways is important both for the professional equity of male nurses and for strengthening India's overall nursing workforce capacity. International experience suggests that deliberate, target-based strategies and visible male mentorship, rather than numerical ceilings alone, are what other health systems have used to widen participation, and the measurable indicators proposed above offer one practical route for Indian nursing administration to track progress on this front.

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