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Review Article

Workplace harassment and gender inequality among female healthcare workers

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Abstract

Workplace harassment and gender inequality remain pervasive issues across various industries, with female healthcare workers being particularly vulnerable due to systemic challenges and power imbalances. Harassment is characterized by unwelcome behaviors that create hostile work environments, with verbal and sexual harassment being the most prevalent forms. Gender discrimination further exacerbates these challenges, manifesting in unequal pay, limited career advancement opportunities, and micro-aggressions. Studies reveal that nearly half of female healthcare workers experience workplace violence, with nurses being disproportionately affected due to hierarchical dynamics. The psychological and physical toll of harassment includes anxiety, depression, and reduced job satisfaction, significantly impacting victims' mental health and professional efficacy.

Cultural and systemic barriers, such as fear of retaliation and ingrained patriarchal norms, hinder reporting and seeking help. Organizational cultures often perpetuate these issues, failing to provide adequate gender diversity in leadership or effective mechanisms for redress. Existing legal frameworks, such as the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal Act) (POSH), lack specific provisions for healthcare workers, leaving them vulnerable.

Addressing workplace harassment requires implementing anti-harassment policies, promoting awareness programs, and fostering open communication. Future research should focus on evaluating reporting systems and exploring the cultural barriers that sustain harassment. Strengthening legal protections tailored to healthcare workers and ensuring equitable workplace practices are essential steps toward a safer and more inclusive environment. By addressing these systemic issues, the healthcare sector can improve not only the well-being of female professionals but also the quality of care delivered to patients.

Keywords: Harassment, Workplace, Discrimination, Females.

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1. Introduction

Harassment is defined as 'any unwelcome and inappropriate behaviour that is likely to cause someone discomfort, offense, or embarrassment'. It can involve verbal, physical, or behavioural actions that irritate, threaten, insult, degrade, intimidate, belittle, humiliate, or embarrass another person, or that lead to the creation of a hostile or uncomfortable work environment.[1] Women often encounter discrimination from a young age, particularly in societies where there is a strong preference for male offspring.[2] Workplace harassment is receiving heightened attention across all economic sectors, mainly because of the prevalence of negative effects it has on individuals. In healthcare settings, medical workers are more prone to workplace violence than their non-medical counterparts, who also face the risk of physical violence.[3] Furthermore, in the medical arena, the female gender encounters unequal opportunities in career advancement, particularly in areas such as salary promotions, and job prospects. Several expressed that they were significantly underpaid compared to men, leading to feelings of being undervalued. Majority of female healthcare workers encountered different types of gender discrimination from both patients as well as colleagues.[4] Earlier studies documented instances of sexual harassment, micro-aggressions, anticipating motherhood and disparities in

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career advancement, compensation, and workload distribution among female healthcare workers.[4-12] Previous research has indicated that specific forms of discrimination can be tied to particular professions. For instance, female doctors often report being mistaken for nurses, a finding that aligns with results from previous studies.[4,13,14] This narrative review aims to examine the prevalence, forms, and impacts of workplace harassment and gender-based discrimination in healthcare, with a focus on female healthcare workers.

2. Prevalence and Types of Harassment

2.1. Statistical analysis of harassment rates among female healthcare workers

Some systematic review and meta-analysis emphasized gender as a key factor in predicting workplace violence, noting that nurses are at an increased risk as compared to other professions.[15,16] A study conducted by Abdullah et al among female healthcare workers in tertiary care hospital, Saudi Arabia indicated that about 15.5% of female healthcare professionals, primarily nurses, have experienced sexual harassment, with verbal harassment accounting to 46.60% the most frequently cited form.[17] This can be attributed to the power dynamics and hierarchical structure within the healthcare system, where physicians are viewed as superior and nurses as subordinate, making nurses more vulnerable to harassment from both doctors and patients.[16,18]

A study conducted among 465 orthopedic surgeons revealed that women were much more likely to face both gender-based and sexual harassment, with an odds ratio (OR) of 16.2 (95% CI 4.8–54.0) for gender-based harassment and OR of 2.2 (95% CI 1.2–4.0) for sexual harassment.[19] Based on the findings of meta-analytical study including 28 studies from 16 studies, the combined prevalence of workplace violence was estimated to be 45.0% (95% CI 31% to 58%) among female healthcare workers.[20]

2.2. Specific types of harassment (e.g., verbal, physical, sexual)

Common type of violence includes verbal abuse, verbal threats, physical assaults, sexual harassment, mobbing, bullying and discrimination. In a study conducted during the period 2013-2014 among Ghanian nurses, approximately 83% were female nurses and whereas 17% were male nurses who experienced verbal form of harassment. In the same study, females (93.1%) that experienced sexual abuse was greater than their male counterparts which were 6.9%.[21] About 12% of the participants experienced at least one incident of sexual harassment and 52·2% were exposed to verbal abuse. Giglio et al conducted a study among orthopaedic surgeons in 2019 and found that despite the smaller number of female participants, gender-based harassment was more frequently faced among female healthcare workers than males' healthcare workers.[19] Among the participants females were more vulnerable to sexual harassment in comparison to males. Verbal harassment was found to be more prevalent than physical harassment among the different forms of sexual harassment.

3. Discussion

3.1. Impact on mental and physical health

3.1.1. Mental and psychological health

Zeng et al reported that 44.6% of Chinese nurses who experienced harassment developed mental health issues, with 61.26% facing emotional difficulties and 51.79% suffering psychological disturbances.[22] A significant link was found between harassment and women's feelings of depression and hopelessness. A meta-analysis confirmed that harassment victims often develop anxiety, depression, and post-traumatic stress disorder (PTSD). Chaudhuri P described sexual harassment as a traumatic life event, and in Saudi Arabia, female healthcare workers experiencing harassment showed a significant negative correlation between self-esteem and depression levels ($r = -0.357$).[23] An Egyptian study among young physicians showed that sexual harassment was strongly associated with elevated anxiety and depression.[24]

3.1.2. Physical health

Zeng et al also found that 30.19% of nursing staff reported physical health problems following harassment.[22]

3.1.3. Social and emotional well-being

Zeng et al highlighted that 16.02% of victims developed social health issues.[22] In India (Kolkata), harassment was linked to intimidation and anxiety across all categories of healthcare workers.[23] In Pakistan, female trainee nurses reported harassment as significantly associated with low self-esteem and reduced job satisfaction.[26]

3.2. Barriers to reporting and seeking help

3.2.1. Cultural and systemic obstacles to reporting harassment

In professions with patriarchal origins or those historically dominated by men, there is a notable prevalence of competitive individualism, which discourages collective solidarity and makes it difficult for victims to speak out.[27]

3.2.2. Fear of retaliation and impact on career advancement

Concerns about retaliation or punishment deter both victims and bystanders from reporting disruptive behaviors. Fear of being labelled as "difficult" or "uncooperative" also restricts opportunities for feedback that could otherwise correct misconduct, thereby reinforcing silence and complicity.[28,29]

3.2.3. Institutional deficiencies and grievance redressal mechanisms

Despite legal frameworks mandating the creation of grievance redressal mechanisms, institutional deficiencies remain a significant barrier. For instance, in India, the Sexual

Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 (POSH Act) requires the establishment of Internal Complaints Committees (ICCs) in all workplaces. However, evidence shows that many healthcare institutions either do not have functional committees, or if they do, they suffer from poor visibility, lack of awareness among staff, inadequate training of committee members, and minimal trust from employees. This results in underutilization of the system and a continued culture of silence. Similar deficiencies have been observed in grievance mechanisms in academic medical centers globally, where committees may exist formally but fail to provide impartiality, confidentiality, or protection from retaliation. Effective institutional support systems, including accessible grievance redressal, active monitoring of complaints, and visible leadership commitment to zero tolerance, are therefore critical in creating safer workplace environments.

3.2.4. Gender dynamics in healthcare teams and leadership

Healthcare professional associations, organizations, and regulatory bodies need leadership that better reflects gender diversity. A lack of gender-balanced leadership perpetuates decision-making that overlooks the concerns of women healthcare workers and further weakens institutional trust in grievance mechanisms.[31] The barriers to reporting harassment or hindrance in seeking help in professions with patriarchal origins or those that have historically been male-dominated, there is a notable prevalence of competitive individualism.[27]

3.2.5. Organizational culture and gender dynamics

The academic meritocracy and tenure system often perpetuate hierarchies by systematically excluding individuals and concentrating privilege.[27] Although meritocracies are intended to provide opportunities based on accomplishments, talents, or skills, increasing evidence shows that systemic biases and gendered power relations consistently prevent women from advancing equitably in the medical profession.[30,31] Women are more likely to face barriers in promotions, leadership appointments, and access to research opportunities, while men disproportionately occupy senior and decision-making roles. This imbalance not only sustains a male-dominated hierarchy but also limits women's visibility, mentorship opportunities, and influence in shaping institutional policies. Gender dynamics within teams further manifest in women being undervalued, subjected to microaggressions, or relegated to subordinate roles, reinforcing structural inequities and undermining genuine meritocracy.

3.3. Legal and policy framework

The Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redressal) Act of 2013[32] was enacted to ensure a safe working environment for women, regardless of their employment status. Along with implementing measures to prevent workplace sexual harassment, employers are mandated to establish an internal committee to handle and resolve sexual harassment complaints promptly and confidentially. Employers are also mandated to carry out regular training for the employees on the subject. However, the POSH Act has several limitations in the healthcare context. While the Act provides a general framework for addressing workplace harassment, it was not designed with the unique challenges of healthcare settings in mind. For instance, women healthcare professionals frequently interact with patients, attendants, and caregivers who fall outside the formal employer–employee relationship, creating a grey area in the applicability of the Act. Furthermore, studies and audits have shown implementation gaps: many hospitals either do not have a functional ICC, staff are often unaware of its existence, committee members lack proper training, and there is limited monitoring of compliance. In some institutions, hierarchical power dynamics and fear of retaliation discourage women from approaching the ICC. Thus, while the POSH Act establishes an important legal safeguard, its inadequate implementation and limited scope in addressing patient-related harassment leave women healthcare workers vulnerable. To address this gap, there is a need for healthcare-specific legal and institutional mechanisms, including stronger oversight of ICCs, protection against third-party harassment, and sector-focused guidelines for hospitals and medical institutions.

3.4. Best practices for prevention and response

3.4.1. Successful strategies for creating a safer workplace

Ideally, every workplace should naturally be a safe environment for all healthcare workers, without the need for special measures. Unfortunately, that is not the reality, and proactive steps must be taken to ensure safety, particularly for vulnerable groups. Clear anti-harassment policies and regular sensitization workshops are essential in helping healthcare workers recognize, prevent, and respond to harassment, thereby fostering professionalism. Establishing safe environments where female healthcare workers can openly share their experiences, coupled with designating trained leaders or champions to oversee employee behaviour, has been shown to contribute to healthier workplaces. In India, despite the enactment of the Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redressal) Act, 2013, evidence suggests gaps in implementation. Chaudhari P et al[33] highlight that internal complaints committees (ICCs) are often opaque and ineffective, particularly when senior staff are involved. A case study from R.G. Kar Medical College in Kolkata revealed that its ICC was improperly constituted, with members tied to management, undermining neutrality and trust in the system.[34] Similarly, an ICMR-supported study published in the *Indian Journal of Community Medicine* documented a high prevalence of harassment among female healthcare workers with significant psychological impact, while also noting low awareness of POSH provisions.[35]

These examples underscore the gap between legal mandates and practical enforcement in healthcare.

3.4.2. Training programs and awareness initiatives

Training and awareness initiatives are crucial for fostering a culture of accountability. Programs should equip healthcare workers to recognize inappropriate behaviours, understand their consequences, and intervene safely as bystanders using both verbal and non-verbal strategies. Importantly, reporting mechanisms must be well-publicized, with clear instructions for staff on accessing institutional protocols and support systems, including HR and ICCs. Some institutions have begun experimenting with structured awareness drives. For example, workshops in select teaching hospitals have integrated gender-sensitization modules into medical training. However, national-level audits such as those reported by Advotalks, legal tech platform show that junior doctors still often work in unsafe environments, with existing mechanisms—including conciliation under POSH—sometimes diluting accountability instead of empowering victims.[36]

3.5. Gaps and challenges

Despite the existence of policies, many healthcare facilities lack consistent enforcement, with widespread underreporting due to fear of retaliation, power hierarchies, or lack of trust in grievance redressal systems. Evidence from both Indian and global studies demonstrates that legal provisions without effective monitoring and institutional buy-in remain insufficient. There is also a lack of empirical research on healthcare-specific interventions and their outcomes.

3.6. Future directions for research and policy

Future initiatives must incorporate an intersectional perspective, recognizing that women healthcare workers' experiences are shaped not only by gender but also by caste, class, age, ethnicity, and employment status (e.g., contract versus permanent). These intersecting vulnerabilities amplify risks of harassment and reduce access to redressal. Research in India should focus on evaluating the effectiveness of ICCs, institutional grievance redressal systems, and training programs in healthcare-specific contexts. Comparative studies across institutions can identify scalable models and highlight best practices to close the gap between legislation and lived workplace experiences.

4. Conclusion

Research has revealed that female healthcare workers often encounter gender inequality and harassment in their workplaces. This concerning reality highlights the systemic problems within the healthcare industry that disproportionately impact women, hindering their ability to carry out their responsibilities effectively and safely while on duty. These challenges not only influence the mental and emotional well-being of female healthcare workers but also have a negative effect on them. Introducing stricter legislation, such as a Central Protection Act, would establish a clear legal framework that defines harassment, prescribes penalties, and mandates institutional mechanisms for enforcement. Such measures could strengthen accountability, ensure better protection for victims, and reduce the prevalence of harassment.

5. Author Contributions

All authors participated as-

1. Research concept- Alicia Arhana, Avinash Borkar, Namita Deshmukh
2. Research design- Avinash Borkar, Namita Deshmukh
3. Supervision- Namita Deshmukh, Avinash Borkar
4. Materials- Namita Deshmukh, Avinash Borkar
5. Data collection and Interpretation- Alicia Arhana, Avinash Borkar
6. Literature search- Alicia Arhana, Avinash Borkar
7. Writing article- Alicia Arhana, Avinash Borkar
8. Critical review- Avinash Borkar, Namita Deshmukh
9. Article editing- Avinash Borkar, Namita Deshmukh
10. Final approval- Namita Deshmukh, Avinash Borkar, Alicia Arhana

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None.

7. Conflict of Interest

None.

References

1. International Monetary Fund. Policy on Harassment [Internet]. Available from: https://www.un.org/womenwatch/osagi/pdf/IMFpolicysh3.pdf [Accessed 2025 Jan 16]
2. Ulasi I. Gender bias in access to healthcare in Nigeria: A study of end-stage renal disease. *Trop Doct*. 2008;38(1):50–2. https://doi.org/10.1258/td.2007.060160.
3. Yusoff HM, Ahmad H, Ismail H, Reffin N, Chan D, Kusnin F, et al. Contemporary evidence of workplace violence against the primary healthcare workforce worldwide: a systematic review. *Hum Resour Health*. 2023;21(1):82. https://doi.org/10.1186/s12960-023-00868-8
4. Schlick CJR, Ellis RJ, Etkin CD, Greenberg CC, Greenberg JA, Turner PL, et al. Experiences of Gender Discrimination and Sexual Harassment Among Residents in General Surgery Programs Across the US. *JAMA Surg*. 2021;156(10):942–52. https://doi.org/10.1001/jamasurg.2021.3195
5. Anderson N, Lett E, Asabor EN, Hernandez AL, Nguemeni Tiako MJ, Johnson C, et al. The Association of Microaggressions with Depressive Symptoms and Institutional Satisfaction among a National Cohort of Medical Students. *J Gen Intern Med*. 2022;37(2):298–307. https://doi.org/10.1007/s11606-021-06786-6
6. Chow CJ, Millar MM, López AM. Gender discrimination among academic physicians. *Womens Health Rep (New Rochelle)*. 2020;1(1):203–11. https://doi.org/10.1089/whr.2020.0026.
7. Adesoye T, Mangurian C, Choo EK, Girgis C, Sabry-Elnaggar H, Linos E. Perceived discrimination experienced by physician mothers and desired workplace changes: a cross-sectional survey. *JAMA Intern Med*. 2017;177(7):1032–6. https://doi.org/10.1001/jamainternmed.2017.1394.

8. Weaver AC, Wetterneck TB, Whelan CT, Hinami K. A matter of priorities? Exploring the persistent gender pay gap in hospital medicine. *J Hosp Med*. 2015;10(8):486–90. https://doi.org/10.1002/jhm.2393.
9. Muench U, Sindelar J, Busch SH, Buerhaus PI. Salary differences between male and female registered nurses in the United States. *JAMA*. 2015;313(12):1265–7. https://doi.org/10.1001/jama.2015.1487.
10. Lo Sasso AT, Richards MR, Chou C-F, Gerber SE. The $16,819 pay gap for newly trained physicians: the unexplained trend of men earning more than women. *Health Aff*. 2011;30(2):193–201. https://doi.org/10.1377/hlthaff.2010.0597.
11. Richter KP, Clark L, Wick JA, Cruvinel E, Durham D, Shaw P, et al. Women physicians and promotion in academic medicine. *N Engl J Med*. 2020;383(22):2148–57. https://doi.org/10.1056/NEJMsa1916935.
12. Dahlke AR, Johnson JK, Greenberg CC, Love R, Kreutzer L, Hewitt DB, et al. Gender differences in utilization of duty-hour regulations, aspects of burnout, and psychological well-being among general surgery residents in the United States. *Ann Surg*. 2018;268(2):204–11. https://doi.org/10.1097/SLA.0000000000002700.
13. Berwick S, Calev H, Matthews A, Mukhopadhyay A, Poole B, Talan J, et al. Mistaken identity: frequency and effects of gender-based professional misidentification of resident physicians. *Acad Med*. 2021;96(6):869–75. https://doi.org/10.1097/ACM.0000000000004060.
14. Bhandari S, Jha P, Cooper C, Slawski B. Gender-based discrimination and sexual harassment among academic internal medicine hospitalists. *J Hosp Med*. 2021;16(2):84–9. https://doi.org/10.12788/jhm.3532.
15. Kumari A, Ranjan P, Sarkar S, Chopra S, Kaur T, Baitha U, et al. Identifying predictors of Workplace Violence Against Healthcare Professionals: a systematic review. *Indian J Occup Environ Med*. 2022;26(4):207–24. https://doi.org/10.4103/ijoem.ijoem_164_21
16. Ramanathan M, Sukanya R, Sarma S. Survey on sexual harassment in the workplace. *Indian J Med Ethics*. 2016;1:45. https://doi.org/10.20529/IJME.2004.020
17. Aloraier HA, Altamimi RM, Allami EA, Alqahtani RA, Almutairi TS, AlQuaiz AM, et al. Sexual harassment and mental health of female healthcare workers in a tertiary care hospital in Riyadh, Saudi Arabia. *Cureus*. 2022;14(10):e30860. https://doi.org/10.7759/cureus.30860
18. Fallahi Khoshknab M, Oskouie F, Ghazanfari N, Najafi F, Tamizi Z, Afshani S, et al. The frequency, contributing and preventive factors of harassment towards health professionals in Iran. *Int J Community Based Nurs Midwifery*. 2025;3(3):156–64.
19. Giglio V, Schneider P, Bond Z, Madden K, McKay P, Bozzo A, et al. Prevalence of gender-based and sexual harassment within orthopedic surgery in Canada. *Can J Surg*. 2022;65(1):E45–E51. https://doi.org/10.1503/cjs.013120
20. Ajuwa MP, Veyrier CA, Cousin Cabrolier L, Chassany O, Marcellin F, Yaya I, et al. Workplace violence against female healthcare workers: a systematic review and meta-analysis. *BMJ Open*. 2024;14(8):e079396. https://doi.org/10.1136/bmjopen-2023-079396
21. Boafo IM, Hancock P, Gringart E. Sources, incidence and effects of non-physical workplace violence against nurses in Ghana. *Nurs Open*. 2016;3(2):99–109. https://doi.org/10.1002/nop2.43
22. Zeng LN, Zong QQ, Zhang JW, Lu L, An FR, Ng CH, et al. Prevalence of sexual harassment of nurses and nursing students in China: a meta-analysis of observational studies. *Int J Biol Sci*. 2019;15(4):749–56. https://doi.org/10.7150/ijbs.28144
23. Chaudhuri P. Experiences of sexual harassment of women health workers in four hospitals in Kolkata, India. *Reprod Health Matters*. 2007;15(30):221–9. https://doi.org/10.1016/S0968-8080(07)30319-4
24. Duba A, Messiaen M, Boulangeat C, Boucekine M, Bourbon A, Viprey M, et al. Sexual harassment exposure and impaired mental health in medical students: the MESSIAEN national study. *J Affect Disord*. 2020;274:276–81. https://doi.org/10.1016/j.jad.2020.05.100
25. Maghraby RA, Elgibaly O, El-Gazzar AF. Workplace sexual harassment among nurses of a university hospital in Egypt. *Sex Reprod Healthc*. 2020;25:100519. https://doi.org/10.1016/j.srhc.2020.100519
26. Malik NI, Malik S, Qureshi N, Atta M. Sexual harassment as predictor of low self-esteem and job satisfaction among in-training nurses. *FWU J Soc Sci.* 2014;8:107–16.
27. Siad FM, Rabi DM. Harassment in the field of medicine: cultural barriers to psychological safety. *CJC Open*. 2021;3(12 Suppl):S174–9. https://doi.org/10.1016/j.cjco.2021.08.018
28. Broad J, Matheson M, Verrall F, Taylor AK, Zahra D, Alldridge L, et al. Discrimination, harassment and non-reporting in UK medical education. *Med Educ*. 2018;52(4):414–26. https://doi.org/10.1111/medu.13529
29. Colenbrander L, Causer L, Haire B. 'If you can't make it, you're not tough enough to do medicine': a qualitative study of Sydney-based medical students' experiences of bullying and harassment in clinical settings. *BMC Med Educ*. 2020;20:86. https://doi.org/10.1186/s12909-020-02001-y
30. Cropsey KL, Masho SW, Shiang R, Sikka V, Kornstein SG, Hampton CL. Why do faculty leave? Reasons for attrition of women and minority faculty from a medical school: four-year results. *J Womens Health (Larchmt)*. 2008;17(7):1111–8. https://doi.org/10.1089/jwh.2007.0582
31. Golden SH. The perils of intersectionality: racial and sexual harassment in medicine. *J Clin Invest*. 2019;129(9):3465–7. https://doi.org/10.1172/JCI130900
32. Department of Women and Child Development, Government of NCT of Delhi. Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 (SH Act, 2013) [Internet]. Delhi: Government of NCT of Delhi; [cited 2025 Jan]. Available from: https://wcd.delhi.gov.in/wcd/sexual-harassment-women-workplaceprevention-prohibition-and-redressal-act-2013sh-act-2013
33. Chaudhuri P. Experiences of Sexual Harassment of Women Health Workers in Four Hospitals in Kolkata, India. *Reprod Health Matters. 2007;15*(30),221–9.
34. Sain S, Chatterjee A, Nundy S. When trust is betrayed: the horrific rape-murder of a young resident doctor on duty in Kolkata: a call for justice and change. *Curr Med Res Pract*. 2024;14(5):189–91. https://doi.org/10.4103/cmrp.cmrp_142_24
35. Islam F, Alvi Y, Gautam R, Shaikh A, Panda M, Thakur A, et al. Sexual Harassment among Female Healthcare Workers, its Consequences and Barriers in Seeking Help in India's Health Sector. *Indian J Community Med*. 2025;50(5):808–14. https://doi.org/10.4103/ijcm.ijcm_225_24
36. Breaking the Silence: Legal Reckoning for Workplace Harassment in the Wake of RG Kar College. *Advotalks*. 2024. Available from: https://www.advotalks.com/article/breaking-the-silence:-legal-reckoning-for-workplac [Accessed 2025 March 16]

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