

UNDERSTANDING THE EMPLOYMENT
STATUS OF WOMEN AND
PERSONS WITH DISABILITIES
IN ALLIED HEALTHCARE PROFESSIONS



FOREWORD BY CEO



We at Tech Mahindra Foundation work towards spearheading skill development, educational and employment opportunities for today's youth. The foundation provides a platform to the young men and women that enables skill enhancement and opportunities, to help them become 'job-ready' skilled professionals. In addition to their pragmatic high-quality domain knowledge, students are also given training in English, soft skills and IT. This helps them get absorbed in a variety of job markets

and remain versatile in their approach. While the main focus of the Foundation is to empower the youth of India and provide them with respectable jobs, our work also puts a special focus on the empowerment of women and persons with disabilities. We wish to work towards an economy that grows with the contribution of everyone in the society and ensures that nobody is left behind from the benefits of the economic growth that the country is preparing for.

From that perspective, as a part of our mandate, we have taken conscious decisions to identify the key vulnerable groups who need to be empowered and break through the constraints that stem from the fundamental social problems, historical inequities, attitudinal problems, and therefore the inherent disempowerment that is ingrained in the social fabric.

The healthcare sector is one of the fastest growing sectors in our economy. As India witnesses an increase in disease burden, it has resulted in a huge demand for healthcare workers. India, right now, is facing a serious shortage of skilled paramedical and other allied healthcare professionals. This has created a potential for increased job opportunities for skilled and qualified allied healthcare workers.

Tech Mahindra Foundation understands this demand gap and has taken a step forward through this current research. The healthcare sector has a high potential for absorbing women and persons with disabilities as allied healthcare professionals. Yet the data shows that their representation is not healthy. Hence, the purpose of this research is to understand the current contribution of women and persons with disabilities engaged as allied healthcare professionals. It also aims to identify the status of employment, retention in services, and the requirement of skilling. The findings will help to chart out the trajectory to build the next phase of action to empower women and persons with disabilities in the healthcare sector.

Rakesh Soni

CEO. Tech Mahindra Foundation

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Personal details of the respondents have been kept confidential and maintained anonymity for the purpose of this study

Disclaimer: This report is based on data collected by Tech Mahindra Foundation from HR representatives, medical professionals and health experts of different private and government healthcare centres, and from data available in secondary literature which includes state and central government reports as on 20th November 2019. The data has subsequently been reviewed by the internal team at Tech Mahindra Foundation. All surveys and recommendations made in the report are made in good faith and on the basis of the information available to the research team at the time. The information contained in this report is believed to be true and every attempt has been made to ensure the correctness of data. However, no representation or warranty is given (expressed or implied) as to its accuracy, completeness or correctness.

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List of Abbreviations:

AHP Allied Healthcare Professional

CAGR Compound Annual Growth Rate

CHC Community Health Centre

DGHS Director General of Health Services

ECG Electrocardiogram

FLFP Female Labour Force Participation

GDA General Duty Assistant

GDP Gross Domestic Product

IHDS India Human Development Survey

LFPR Labour Force Participation Rate

MCI Medical Council of India

MSJE Ministry of Social Justice and Empowerment

NCD Non-Communicable Disease

NEET National Eligibility cum Entrance Test

NSSO National Sample Survey Office

OECD Organisation for Economic Co-operation and Development

OT Operation Theatre

PFHI Public Health Foundation of India

PHC Primary Health Centre

PIL Public Interest Litigation

PwD Persons with Disabilities

SDGs Sustainable Development Goals

UN United Nations

UNCRPD United Nations Convention on the Rights of Persons with Disabilities

U.S.G Ultrasonography

WHO World Health Organisation



BACKGROUND OF THE STUDY

The government of India has actively introduced labour market policies to increase the participation of females and persons with disabilities in the economy. These policies have been pursued via reservations, educational scholarships and capacity building via skills training initiatives. However, the gaps in effective implementation along with the deep-rooted societal construct have not let these policies be as impactful as imagined. India's economic growth can be compromised and undermined if discriminatory barriers to employment and skilling of the large section of the population and lack of equity in the job market continue to prevail. Social exclusion is a serious challenge that not only negatively affects access to education and jobs, but also has an enormous impact on the standard of living and quality of life of the vulnerable groups.

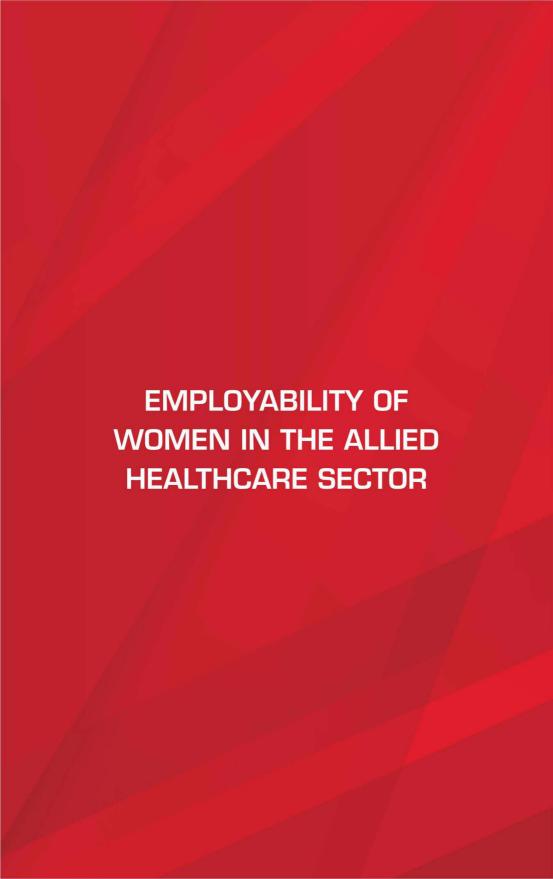
This is of serious concern as social and economic factors exclude groups, particularly women and persons with disabilities from the labour market and employment opportunities. Even though the reasons for their exclusion vary and both the groups require insight into unique factors affecting their vulnerability, broadly, historical social conditioning, stereotypes, and prejudice influence their options. As a result of this, large population segments are getting excluded from the labour market and their expectations in terms of jobs and income level are not optimised. This exclusion and the suboptimal use of the large segment of the population's potential has an adverse impact on the economy. Studies have shown that inclusion can increase GDP growth in India.

It is therefore important to understand the reasons for this exclusion and also the solutions needed to address this challenge. While there are some factors that are generic in nature, solutions to the problem will have to be customised according to the imperatives of different sectors. This white paper focuses on the barriers and solutions to the employability of women and Persons with Disabilities in the health care sector. This sector has enormous potential to create employment, educational and skilling opportunities for these target groups.

While the demand in India is to have 100 million skilled workers by 2022, the real picture for the skilled individuals to getting absorbed in the Indian workforce shows a different picture. The Deen Dayal Upadhayay Grameen Kaushalya Yojana, a central government initiative skilled around 160,000 individuals in 2016-17, but only half of those individuals received jobs (Garg & Shahi, 2018).

This picture should also be understood in the context of India, which has a huge labour force (after China). Yet, when we look at the absolute percentage of individuals trained, we find that 90% of them are not formally trained, as compared to 47% in China. The government of India has taken initiatives through its Skill Development Programmes which are implemented by 22 ministries and central government departments. The New Education Policy of 2016 in its draft also proposes to integrate skill development programs into the curriculum of schools and higher education institutes (Garg & Shahi, 2018). More proactive steps have to be taken to reduce the gap between skilling and employability.





EMPLOYABILITY OF WOMEN IN THE HEALTHCARE SECTOR

OVERVIEW OF THE CURRENT STATUS OF EMPLOYABILITY OF WOMEN IN THE HEALTHCARE SECTOR

The issue of skilling and empowering women for the healthcare sector will have to be understood within the larger context of women's participation in the Indian labour force that has always been quite dismal. India stands at the 120th position out of 131 countries when it comes to female LFPR. While 48 per cent of the total population comprises of females, only 27 per cent are a part of the Indian labour force. This is seen as the lowest amongst the BRICS countries, and the G-20 countries according to an IndiaSpend article. The current statistics in India show that female LFPR is 50 per cent lower than male LFPR along with the fact that 95 per cent of the females (195 million) are engaged in the informal unorganised sector of the economy (Deloitte, 2018).

Estimations show that if an additional 235 million female workers join the workforce, it can lead to greater economic and income stability, productivity and growth. This will also lead to women empowerment in terms of making them financially independent, an increase in their disposable income, significant contributory members in the society and hence not remain dependent members anymore. This is supported by a recent IMF report which said if women's participation in the workforce increases to the level of the participation rate of men, the GDP of the country can be estimated to increase by 27 per cent [Deloitte, 2018].

Moreover, according to the Deloitte report titled Empowering Women & Girls in India for the Fourth Industrial Revolution, female labour force participation in India has fallen to 26 per cent in 2018 from 36.7 per cent in 2005, amid lack of access to quality education and underlying social, economic barriers limiting the opportunities for women. About 95 percent or 195 million women are employed in the unorganised sector or unpaid work. Specifically, in the India context, the female labour force participation has had a decadal fall from 36.7 per cent in 2005 to 26 per cent in 2018, with 95 percent (195 million) women employed in the unorganised sector or in unpaid work. The range of factors that influence this includes lack of education, access to quality education, digital divide, which limits them from gaining employable skill sets and entering the workforce or establishing an enterprise (Press Trust of India, 2019).

However, when talking about the need for an increase in female participation in the labour force, one should not conceptualise the situation by numerically looking at the percentage of females residing in India and the percentage actually engaged in economic activities. It's important to assess the underlying reasonings for the wide gap in the two estimates. The major reason for such a discrepancy is the lack of skills and the kind of social norms that are practiced in India.

A research conducted by IndiaSpend in collaboration with Harvard Evidence for Policy Design reflects on the same: The research concluded that an increased number of Indian women are willing to participate in the labour force. However, this gets restricted by their lack of skills and social norms which put a constraint on their mobility. Typically, women who are not engaged in agricultural activities find themselves in the informal sector which includes household work activities. This however may not be aligned with their preferred employment choice. This brings our attention to the structural factors that restrict a woman from pursuing employment opportunities outside her home. A pilot survey conducted by IndiaSpend with the rural youth of Bhopal and Sehore showed that 91 percent of female respondents aged between 18-25 and who fall in the BPL category feel that they should work outside their homes. This number then cuts down to nearly 21 per cent who were actually employed in the previous year in contrast to nearly 70 per cent who remained unemployed (Pande, Johnson, & Dodge, 2016).

The cultural attitudes, lack of infrastructure and question of safety that exists in India often contribute to mobility constraints for women. Two rounds of the IHDS was used by IndiaSpend and estimates showed 79.9 per cent of women required prior permission of their husbands or other family members to visit a healthcare centre. The 2012 data reflected the inability of 33 per cent of women to go alone and seek medical care. A national survey conducted by IHDS showed 51.7 per cent women believing that it is usual for a husband to beat up his wife if she leaves home without his knowledge. This data however shows the restrictions that come due to the cultural attitudes that are still prevalent in different regions of the country, but there are still other factors that come into play and contribute to mobility restrictions for women. These factors include: distance between work and home, lack of road infrastructures, lack of public transport, safety concerns, amongst others. A Skill India participant sample showed that while 60 percent of women showed willingness to migrate for work, 70 per cent reported that they will feel unsafe if they work away from home (Pande et al., 2016).

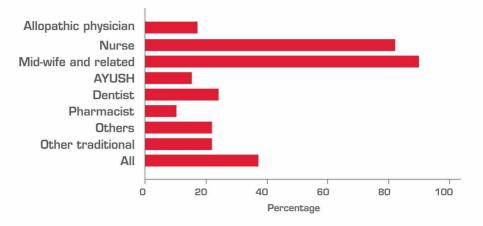
IndiaSpend, April 9, 2016.

STATE OF FEMALE HEALTHCARE WORKFORCE PARTICIPATION

A key finding of a WHO 2019 report which analysed the gender equity in the healthcare sector after analysing 104 countries showed that women contribute 67 per cent of employment share in the healthcare force and the social sector. However, the distribution of women across occupations was disproportionate. Most of the countries showed a higher participation of males when it came to being physicians, dentists and pharmacists and female workers were more in number when it came to being midwives or nurses (Boniol et al., 2019).

The 2013 PFHI report estimated that India has 7 female health workers per 10,000 population. This means that women comprise of one third of the total health workforce in the country. Most of the females (about 70 per cent) are seen as nurses, community health workers and midwives. Due to which the share of female doctors comes down to only 17 per cent of the total doctors (see Figure 1: Distribution of women as healthcare workers in India).

Figure 1: Distribution of Women as healthcare workers in India



Other = Dietician & nutritionist, optician, dental assistant, physiotherapist medical assistant & technician and other hospital staff

Other Traditional = Traditional medicine practitioner, faith healer

Source: Kao KD, Bhatnagar A, Berman P (2009)

India has witnessed the establishment of hospitals by female physicians – such as Christian Medical Colleges in Vellore and Ludhiana. Some of these advocated hospitals also function in remote areas in order to provide healthcare services to the poor. Jamkhed, Deen Bandhu of Pachod in Maharashtra has seen women health workers residing in villages improving the status of healthcare in their community with a special focus on maternal and child health. This shows that if the government can provide support and encouragement to impart healthcare skills, especially to female workers then there can be considerable improvements in community healthcare (such as nursing personnel in villages).









DEMAND FOR ALLIED HEALTHCARE PROFESSIONALS

DEMAND FOR HEALTHCARE PROFESSIONALS

STATUS OF DEMAND FOR HEALTHCARE PROFESSIONALS

There is a special reason to assess the scope of increased female participation in the healthcare sector. Demand for healthcare services is exploding in India due to an increase in disease burden. India is undergoing a dramatic health risk transition that has huge implications for the healthcare system and delivery. The overall disease burden is expected to increase significantly in India and be pushed by several factors. These include ageing of population due to increased life expectancy that requires more geriatric care; poor nutritional levels and related underlying diseases, especially amongst the economically weaker sections of society; lifestyle pressures and wrong diet patterns of the growing middle class; and the growing environmental risks due to polluted water, air and soil and toxic contamination. While the global burden of diseases is increasing, the current healthcare infrastructure is not well equipped to address this national emergency.

Moreover, with economic growth, India is facing a unique epidemiological transition. While the traditional disease burden associated with a communicable disease is reducing, it is still prevalent. At the same time, the NCD's is also rising rapidly. This leads to the situation of a double burden of diseases. With the increase in population coupled with an increase in disease burden, the demand for healthcare is also increasing. This also calls for systemic responses for equal access to affordable and accessible healthcare for all.

Whether or not the country is ready to meet with this increase in demand with its supply of healthcare workforce is questionable because currently there is a huge gap between the two. There is a shortage of health workforce, both in India and globally. Along with this, there also lies a wide urban and rural disparity when it comes to female health workforce in India. The urban areas have 5 times more density of female healthcare workforce as compared to the rural areas. When it comes to female doctors, they are 17 per cent in total but they are only 6 per cent in rural areas. The nurses and midwives don't have a significant disparity but still the disparity is four times higher in urban areas, as compared to rural counterparts. There is also a disproportional distribution of health workers in different levels of healthcare, i.e., primary, secondary and tertiary. This implies enormous scope and opportunity for jobs and livelihood in the healthcare sector.



MEDICAL TOURISM IN INDIA: DOES INDIA HAVE ENOUGH MEDICAL PROFESSIONALS?

Apart from the growing need for health workers due to an increase in disease burden, India is also coming up as one of the most sought-after countries for medical and allied healthcare treatments. Medical tourism in India is growing at a fast pace. This can be corroborated by the estimates given by the Tourism Minister of India. It shows that India declared nearly INR 1,35,193 crores in 2015 which gradually increased to INR 1,77,874 crore in 2017. India is also expected to grow at a CAGR of 15 per cent and the global market share is predicted to reach 20 per cent by 2020 (Tour My India, 2018).

The major reasons as to why people are flocking towards India for medical treatment is due to the availability of cost effective and accredited treatments. This calls for the need to increase human resources in the allied medical professions. If we compare the available approved posts along with the availability of skilled medical specialists in local CHC's, we see a dismal picture. There is a shortfall of 56 per cent of obstetricians and gynecologists, 67 per cent of pediatricians, 56 per cent of surgeons and 59 per cent of medical specialists (Satpathy & Venkatesh, 2006). This also increases the scope of involving female health workers in the industry.

HOW PARTICIPATION OF WOMEN IN THE HEALTHCARE WORKFORCE CAN HELP INDIA ACHIEVE ITS SDG'S

The dearth of human resources as mentioned above increases the scope of employing a greater number of women in the healthcare workforce. This actually makes women the key to solving the problem. Investing in females to join the health workforce will improve women's participation, without which achieving the SDG's by 2030 will be difficult. Goal number 5 (or SDG 5) talks about gender equality. Investing in the healthcare workforce will not only improve gender equality but will also contribute to quality of education (SDG 4) and decent work and inclusive growth (SDG 8). The recommendations given by the UN Commission of Health Employment and Economic Growth (HEEG) highlights the same: It calls for increased investments, especially for women and youth in the healthcare sector along with providing the required skills training through quality education. If India follows this, it can also contribute to the global healthcare workforce which is expected to have a shortage of 18 million healthcare workers by the year 2030.







JOB PROFILE OF WOMEN IN THE HEALTHCARE SECTOR: OVERVIEW AND CONSTRAINTS

OVERVIEW OF THE JOB PROFILES FOR WOMEN IN THE HEALTHCARE SECTOR

According to a 2016 WHO report, 38.0 per cent of the total health workforce comprised of female members. The male – female ratio was estimated at 1.6 of doctors and 0.2 of midwives and nurses. However, an interesting find is that when it came to medical qualifications, higher number of female doctors had medical degrees as compared to male doctors. It was also found that a higher proportion of female healthcare workers received education above the secondary level as compared to their male counterparts in every health category except the ancillary healthcare services (Anand & Fan, 2016).

When it came to educational qualifications, data shows that women were more in number as compared to men. It was found that 67.2 per cent of female allopathic doctors had medical qualifications as compared to 37.7 per cent of male allopathic doctors. 11.3 per cent of female nurses and midwives had medical qualifications as compared to 2.6 per cent of males (Anand & Fan, 2016). Even though we find that women have more qualifications, there still remains a shortage of 10,112 female health workers in PHC's, 11,712 female health assistants and at least 6,1000 female health workers and auxiliary nurse midwives at sub-centres, as per data until March 31st, 2017 (Maurya & Gosami, 2017).

Increased opportunities reside in the larger allied health professions that is facing a huge demand shortage of professionals who can work as technicians at medical laboratories, radiographers or work as radiologists, physiotherapists, speech therapists and audiologists, dialysis therapists, emergency technicians, emergency care practitioners, perfusion technicians etc. With diagnostic and therapeutic technology becoming more complex there is a need for quality medical facilities and allied healthcare professionals. This has generated high skilled jobs. If women get more access to these skills, they can get absorbed in these job roles that will help in their empowerment and upliftment.

The range of allied healthcare professional work is extremely diverse. It includes medical lab technology, operation theatre technology, physiotherapy and occupational therapy, cardiac perfusion technology, dialysis, renal dialysis technology, orthotic and prosthetic technology, optometry, pharmacy, nursing, radiography, radiotherapy, hospital administration, management medical records administration, dental hygiene and dental mechanic, dental ceramic technology apart from health or sanitary inspector and many more (MoHFW, n.d.).

CONSTRAINTS FACED BY WOMEN IN THE HEALTHCARE SECTOR: WHY IS THE RETENTION RATE LOW?

If we look at the statistics in India there are 50 million females who haven't received education or employment. This is coupled with the high drop-out rate of girls that stands at 63.5 per cent during adolescence (Amy, 2018). The NSSO data for 2017-18 reportedly shows female participation in the workforce has declined further to 23.3 per cent. A lot of these challenges get further aggravated due to the basic socio-economic disadvantages and gender-based inequality in society.

Major reasons as to why women find it hard to remain in the health workforce is because either they receive limited training, have low paid or unpaid roles, face sexual harassment in their work place, lack of education, poor understanding of job opportunities amongst others. D Y Patil University cited two studies – the first study conducted in New Delhi, which was based on at least 150 interviews found that the nurses reported using their time in indulging in unskilled, menial and administrative work. A study conducted in Kolkata showed that more than 50 per cent of female healthcare workers complained to have faced sexual harassment at work (D.Y Patil, 2015).

According to the UN, the burden family care that includes child care and care for elderly fall disproportionately on women and women undertake three times more unpaid work than men and spend about half as much time in paid work. Women have to resort to less productive jobs and are more likely to do part-time and temporary jobs with fewer avenues for advancement. This creates enormous gender disparity.

It was also found that on average, 66 percent of the work done by Indian women is unpaid, compared to 12 percent of men. In India, according to the OECD, women spend on average 352 minutes a day on unpaid work against 52 minutes among men. Women in India spend on average 297 minutes a day on tasks such as taking care of children, the elderly and the sick; in comparison, men spend 31 minutes a day.





EMPLOYABILITY OF PERSONS WITH DISABILITIES IN THE ALLIED HEALTHCARE SECTOR

EMPLOYABILITY OF PERSONS WITH DISABILITIES IN THE HEALTHCARE SECTOR

STATUS OF EMPLOYABILITY OF PERSONS WITH DISABILITIES

The information on the employability and employment of persons with disabilities (PwDs) is not as extensive as that for women. In fact, this information with regard to the PwD employment in the health sector in India is miniscule. It is therefore, important to note the generic challenges that PwDs face across sectors due to their disability. Full and productive employment is eluding them despite the UN charter on persons with disabilities. A world Bank report identifies that excluding PWDs from the economy can lead to a loss of 5-7% of the country's GDP. It has not been possible to ensure their equal access to all levels of education, vocational training and job opportunities.

People, particularly youth with disabilities are looking for employment opportunities, but face serious barriers both before and after employment. Available studies show that workplaces are not always accessible and sensitive to the needs of PwDs. This leads to high attrition. PwDs are more likely to be unemployed and also earn lesser income as compared to their counterparts.

According to the 2011 Census, there are 26.8 million PwDs. That is 2.2 percent of the total population. This in fact is considered an underestimation – given the average levels globally. Twenty-one disabilities have officially been identified in India – hearing, speech, movement, mental retardation, mental illness, multiple disabilities, and any other. Government of India has come up with a policy for reservation in jobs. PwDs with over 40 per cent disability are eligible for such reserved jobs.

The scenario is very different in the private and corporate sectors. Very few companies have explicit recruitment policies that include provisions for employment of PwDs. This is very nascent in India. It is said that some companies have started to show interest in such recruitment – mainly disability related to orthopedic and hearing – to combat high attrition. However, as the technology aid for several disabilities are becoming more accessible, the opportunities are opening up. But it is quite clear that there is still a strong reluctance among the employer to recruit PwDs as they are not willing to make the right investments for workplace solutions and improvement customised for PwDs. This includes infrastructure in terms of accessible washrooms, elevators, technology aids and software etc.

Physical access to and within the worksite is among the strong concerns of the PwDs. Studies have pointed out that majority of PwDs perceive that communication, attitude of people, discrimination, harassment at work place, and information are some of the critical barriers. Very few employers are aware and very few institutions have a written policy on employing persons with disabilities.

There is little information available on the absorption of PwDs in the healthcare sector. Some documentation that has been carried out by the organisations like the America India Foundation, shows that some hospitals have adopted PwD related human resource practices. The jobs offered are largely related to housekeeping, cleaning of the premises and equipment, laundry, stacking uniform, record keeping, operation of washing machine, and cylindrical ironing machines. They also deal with backend console handling, masseurs and reflexology. As their performance in these areas has been found to be satisfactory it has created opportunities for them.

There is a range of ancillary jobs in the healthcare sector that can absorb PwDs. For this, educational and vocational training needs to be strengthened for PwDs. They need to be equipped with stronger communication skills and skills to negotiate and ask for workplace accommodations after employment, along with training in the basic sector-specific content. Training providers also need to advocate for PwDs and emphasize on the financial sense of inclusion and diversity in the workforce to potential employers to ensure that their employment is not sympathy-based and is more sustainable.





ASSESSMENT
OF EMPLOYMENT
OPPORTUNITIES FOR
PERSONS WITH DISABILITIES
AND WOMEN IN THE
ALLIED HEALTHCARE
PROFESSIONS

ASSESSMENT OF EMPLOYMENT OPPORTUNITIES FOR PERSONS WITH DISABILITIES AND WOMEN IN THE ALLIED HEALTHCARE PROFESSIONS

ABOUT THE STUDY

In order to understand the ground realities of the employment status of women and Persons with Disabilities (PwDs) in allied healthcare professions (AHP) in India, Tech Mahindra Foundation has undertaken a study in 2019. This report captures the findings of that investigation. This has been compiled on the basis of primary research covering 56 respondents from private and government healthcare organisations, hospitals and training institutes for pesons with disabilities. The research has been conducted in four major cities of India-New Delhi, Mumbai, Mohali and Hyderabad.

The research team interviewed the respondents based on a brief questionnaire. The researchers held interviews with human resource (HR) departments, or top management of the different hospitals, healthcare institutions and training institutions to collect first-hand information through one-on-one interviews, supplemented by secondary research. The summary of the findings is as follows.

Through conversations with the concerned HR representatives and top management of different hospitals - both government and private set ups, the report summarises the findings and the analysis.









FINDINGS AND ANALYSIS UNDERSTANDING
PERSONS WITH DISABILITIES
(PwDS)
IN ALLIED HEALTHCARE
PROFESSIONS

FINDINGS AND ANALYSIS - UNDERSTANDING PERSONS WITH DISABILITIES (PWDS) IN ALLIED HEALTHCARE PROFESSIONS

More PwD candidates in government healthcare sectors than private sectors: The data collected from respondents from both government hospitals and private hospitals has given a larger picture of how there are more PwD candidates in the government sector as compared to private sectors.

- Presence of a government mandate to promote inclusivity: As per the provisions of Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, 3% of all vacancies in government jobs in group A, B, C and D, filled via direct recruitment are reserved for PwD candidates. The Act of 1995 was then replaced by the Rights of Persons with Disabilities Act, 2016 (RPwD Act, also known as Divyangjan Adhikaar Kanoon 2016). Under the 2016 Act, the following changes were made²:
- The reservation in government jobs increased from 3% to 4%
- Disability in definition is seen as an evolving and dynamic concept. Hence, the types of disabilities increased from 7 to 21 (Please refer to annexure 2) also leaving space for the Central Government to add more to the list.

The presence of such a mandate in the government sector has promoted inclusivity in terms of providing an accessible environment for PwDs, and an overall framework for supporting their welfare. It has also contributed to finding a greater number of employees with disabilities in the government healthcare institutions.

"In the government sector, finding PwD AHP professionals is easier than finding them in private enterprises, primarily due to the reservations. Absence of a mandate in the private sectors may act as a deterrent to employing PwD's in professional job roles said a government hospital representative.

• Absence of a government mandate in the private sector: Unlike the government sector, the private sector doesn't have any such mandate in place. Given how there is an absence of such a mandate, it was interesting to analyse whether private hospitals have any provisions in their recruitment policy that may give preference to hiring PwD candidates (refer to figure 2).

Following are the responses

- 75% of the HR respondents of private healthcare institutions said no.
- 20% of the HR respondents said that they do.

Figure 2: Is there any provision in the recruitment policy that incentivises hiring of PwD candidates

20% 75%

of respondents have provisions in their recruitment policy of respondents don't have provisions in their recruitment policy

Source: Internal Survey, Tech Mahindra Foundation, 2019.

^{*5%} of respondents chose can't say.

²See Right of Persons with Disabilities Act, 2016 for more information on the Act.

Effect of recruitment policies and government incentives on the distribution of PwD employees in AHP workforce

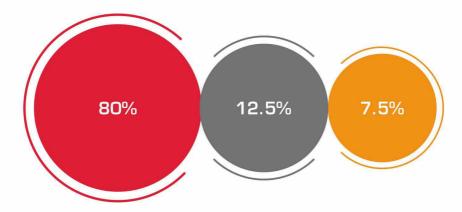
The following data was collated and analysed through the interviews -

a) Lack of knowledge of private employers about government incentives to help absorb PwD candidates in their healthcare institutions

The Government of India in 2016 announced incentive schemes available for private employers to promote workplace inclusivity (more information in section – 'Incentive schemes available for private employers').

The interviewers sought to understand whether private healthcare providers are aware of such incentive schemes or not. Following is the data captured through survey:

Figure 3: Are you aware of government incentive schemes for private employers to help absorb PwD candidates in the private sector?



of HR respondents from private healthcare sector said they are not aware of any such government incentive scheme of HR respondents from private healthcare sector said they are aware of HR respondents did not answer

Further analysis was done to understand whether the knowledge of government policies for private employers has anyway contributed towards formulating internal recruitment policies to facilitate the absorption of PwD candidates in private hospitals (refer to figure 4).

- Amongst the 12.5% of hospitals that have knowledge about such government incentives, there are 5% who still don't have an internal recruitment policy in place, while 7.5% do.
- Amongst the 80% of respondents who don't have the knowledge of the government incentive, 62.5% don't have an internal recruitment policy favouring PwD candidates, but 12.5% do. Rest 5% did not respond.

Figure 4: Does the knowledge of government policies for private employers to incentivise PwD employment contribute to more inclusive internal recruitment policies in private hospitals?



Source: Internal Survey, Tech Mahindra Foundation, 2019.

or nospitals who are not aware about government incentive schemes for PwD absorption

This analysis shows that even though majority of the hospitals don't know about the existing government incentives for the absorption of PwDs in their hospitals (80%), there are a few (12.5%) who have still formulated and taken steps forward for better inclusivity.

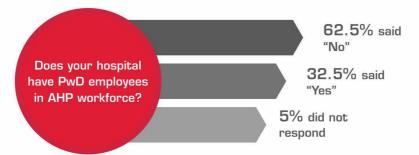
Whereas, amongst the hospitals that have the knowledge about the government incentives (12.5%), comparatively a larger percentage of hospitals (7.5% of hospitals out of the total 12.5%) have incorporated inclusivity provisions in their internal recruitment policies and 5% still haven't. This shows that inclusivity steps in HR policies still haven't been incorporated, even though the cohort hospitals are aware of the existence of government incentives for hiring PwD candidates.

HR policies of private employers often do not have clearly defined hiring policies in the context of PwDs (Shenoy, n.d.). The knowledge about government policy may help private employers formulate more strategic policy frameworks.

When asked if there are any key AHP job roles that can be best suited for PwD candidates, an HR representative of a private hospital said, "I feel as we are a patient service provider industry, I don't think there are any AHP job roles that may have a high potential for recruiting PwD's."

The Negative attitude that stems from ignorance, stereotyping, fear and misunderstanding can also inhibit PwDs from being absorbed in the job market, especially the healthcare sector. The employers and the employees that are engaged in the institution themselves have certain thoughts and ideas about employees with disabilities that may often also reflect in their decisions towards absorbing them. There is also an assumption from the side of the employers that hiring PwDs may result in a negative reaction from their able-bodied counterparts (Shenoy, n.d.).

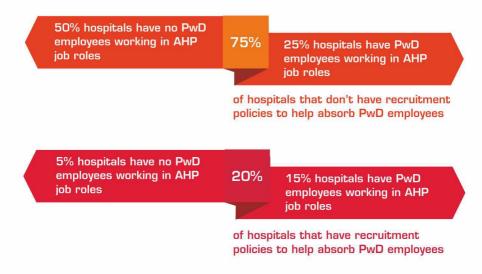
When respondents were asked if their hospitals have PwD employees in AHP job roles, the following responses were captured:





c) Does the presence of a recruitment policy which incentivises absorption of PwD candidates contribute to an increased number of PwD employees?

- Amongst the 75% of hospitals that don't have any internal recruitment policy preferring PwD candidates, 50% don't have any PwD candidates in AHP job roles. However, 25% still have.
- Amongst the 20% of hospitals that have recruitment policies for PwD candidates, 5% still don't have any PwD candidates in their AHP job posts, but 15% do.



Source: Internal Survey, Tech Mahindra Foundation, 2019.

This shows that having a formal channel in place in terms of incentives, provisions and policies for the PwD candidates helps in better inclusion. The reasons cited by the respondents who don't have PwDs in AHP job roles, despite having a policy that provides incentives for their absorption is that they don't feel that PwDs are well suited for professional healthcare job roles, or that they don't find candidates who have the right skill set and knowledge for these jobs.

Most believe pwd candidates are not suited for AHP job roles

As given in figure 6:

- 57.5% of respondents said that they don't think PwD's are suited for professional AHP job roles. They identified backend, front desk (data entry, handling online appointments), hospitality job roles, guard supervision, camera monitoring, as job roles in the hospitals that PwD candidates can be best suited for.
- 20% of respondents identified job roles in CSSD, lab technician, X-Ray Technician, OT technicians, counsellors, sterilisation jobs, reviewing MRI's, CAT scans and other medical visualisations and writing up of summary as roles suitable for PwD employees.

The only challenge they said is to find individuals who have a disability that will not interfere with the job requirements.

"But a person with lower limb disability can still be an efficient lab technician. Even to be an OT technician, the candidate can work efficiently if they have vision and hearing abilities", said a cardiologist from a private healthcare centre.

Figure 6: Are there any key allied healthcare professions that have high potential for recruiting PwD candidates?



*22.5% of respondents did not answer

Source: Internal Survey, Tech Mahindra Foundation, 2019.

Lack of training and skill development institutes for PwD candidates

While 30% of respondents said that there aren't adequate training institutions for PwD candidates to be job ready, 55% responded with a 'maybe'. They elaborated by saying that while on paper there may be a lot of institutes who claim to train PwDs in skill development and other bridge courses in becoming job ready, the quality of services provided is questionable, as explained by a private hospital representative (refer to figure 7).

Figure 7: Are there adequate institutions and courses to train PwD candidates in allied healthcare professions?

May be	55%	
No	30%	
Yes	10%	
Not Answered	5%	

Respondents also explained that due to the lack of quality institutes, they also don't understand where to approach PwD candidates, if they wish to expand and diversify their workforce. They elaborated by saying that they don't mind hiring PwD's if they have the required skill sets.

A respondent from a private hospital said, "we give more importance to productivity than inclusivity. If we find a candidate with the right skill set and a disability that will not hinder the work profile, we will readily hire him/her. However, we haven't come across any such individual."

Another respondent said that PwD-centric training institutes are nearly negligible in India. Most of the institutes have a greater number of able-bodied individuals and a scarce number of disabled students. Due to this the campus placements also don't find qualified PwD candidates to apply for the healthcare job roles. The argument is supported by a representative who runs an institution that trains and empowers deaf children and also works towards placing them in the job sphere.

"You cannot put able-bodied students and disabled students in the same classroom and expect them to learn at the same pace as everyone. Lack of inclusivity in classrooms act as a major hindrance for PwD candidates to expand their skill development and be job ready", said the respondent.

Another response gathered from a personal interview is given by an HR representative from a private hospital.

"There are instances where PwDs themselves may not be willing to engage in training in the existing institutions. Due to the various pension and government schemes available for disabled individuals and the lack of support that most of them face at home, it demotivates them from getting a job or to join a vocational training institute to make themselves job ready and look for opportunities."

Literature review shows that only a few institutes exist as of today that directly deals with PwDs. The Ali Yavar Jung National Institute for the Hearing Handicapped has been established for manpower development, research, clinical and therapeutic services, outreach and extension services for persons with hearing disabilities. Swami Vivekanda National Institute of Rehabilitation, Training and Research in Cuttack undertakes vocational training, placement and rehabilitation of the physically handicapped. National Institute for the Orthopaedically Handicapped was established in Kolkata to develop human resources for providing rehabilitation services to persons with locomotor disabilities, providing services in rehabilitation, restorative surgery, aids/appliances etc. National Institute of Visually Handicapped in Dehradun has been upgraded as National Institute for Visually Handicapped for education and rehabilitation of persons with visual disabilities.

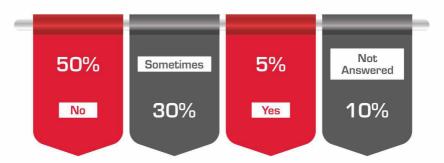
National Institute of Mentally Handicapped in Secundrabad delivers services through quality models of rehabilitation and promotes human resource development to work with mentally handicapped persons. Pandit Deen Dayal Upadhyaya Institute for the Physically Handicapped in New Delhi develops trained manpower for the rehabilitation of persons with orthopedically disabled persons. Composite Regional Centres for Persons with Disabilities in Srinagar, Sundernagar, Lucknow, Bhopal, Guwahati, Patna, Ahmedabad and Kozhikode to provide both preventive and promotional aspects of rehabilitation like education, health, employment and vocational training, research and manpower development, rehabilitation for persons with disabilities (Department of Empowerment of Persons with Disabilities, 2018).

However, given the scale of the challenge, more capacity will have to be developed in the country.

a) Lack of educational qualification and skills act as a constraint for PwD's to be absorbed in ahp job roles

- \bullet 50% of respondents said if and when PwD candidates apply for job posts, they don't find PwD candidates with adequate skill sets and educational qualifications.
- 30% responded that they sometimes find such candidates.
- 5% said they do find PwD candidates who have the required skill set and knowledge for the job role. Rest 5% did not respond.

Figure 8: Do you find enough number of PwD applicants who are trained in specific allied health professional skills and techniques?



Source: Internal Survey, Tech Mahindra Foundation, 2019.

The respondents further elaborate the dearth in the right kind of schools for PwDs that leads to a huge drop out of the said students.

Speaking about deaf students, a respondent who runs an institution for deaf children said "they either haven't received formal education or even if they have gone to school, they end up dropping out in the 8th grade. A usual school may have 1 or 2 deaf students but yet the primary methodology of teaching is still oral. This doesn't make any sense because at the end of the day the deaf student still cannot hear and process the information."

This finding is similar to what is identified in a disability employment report released by TRRAIN. Out of the 6-10 crore PwDs who reside in India, an approximate of 1.23 crore of them are uneducated. There is also a huge mismatch in the demand for trained and skilled PwD candidates and the supply of the same. There is a lack of the right kind of schools that can equip the special needs of PwD's, unavailability of special instructors and lack of family support to help facilitate the integration of PwD candidates in employment (Karayamparambil, 2019).

Lack of work place accommodations and integration processes to absorb PwD candidates

While government hospitals identified having adequate infrastructure to accommodate the mobility of PwD candidates, most of the private healthcare facilities interviewed reported to not have the required infrastructures yet. This was also added as a reason as to why they don't feel encouraged to hire PwD candidates.

- 75% of hospitals reported that they don't have any sensitising workshops or processes to help PwD candidates get familiarised or help them settle down better with their peers.
- 12.5% said that they do.

Figure 9: Does your hospital have any policy to socially integrate PwD employees?

75%

of hospitals don't have policies to socially integrate PwD employees 12.5%

of hospitals have policies to socially integrate PwD employees

*12.5% did not answer

Source: Internal Survey, Tech Mahindra Foundation, 2019.

A respondent who works and provides training and education to visually impaired youth said, "contrary to the popular belief, PwDs don't require any special infrastructural support that can be deemed as a costly affair for the employers. They just require a simple guidance to help them get familiarised with the new infrastructure. It can almost be seen as an excuse used by the private employers to say that due to lack of infrastructural support and money for the same that they feel discouraged to hire PwDs."

Literature reinstates the fact that employing PwDs does not require expensive or extra efforts to invest in the infrastructure. Almost 60% of PwDs can suffice with an informal familiarisation with their workplace environment and don't need any special support for their everyday activities. The adaptations that may be required are in terms of better mobility for them – their travel and communication challenges. These also can be resolved through cost-effective solutions that are practical in nature (Bhattacharya, Agrawal, & Shenoy, 2015).

Few respondents also said they don't feel there is a requirement to hold separate sensitising workshops as the office culture isn't such that would consciously or sub-consciously discriminate against PwD's in their offices.

Another representative said that while they don't have regular sensitising workshops and being a private entity, they aren't mandated by any government regulations, they still provide time relaxation to PwD candidates.

The respondent elaborated and said, "our office has extremely strict time policies. We start at sharp 8:00 AM in the morning and end at 5:30 PM. However, for the PwD candidates we have given time relaxation because they are completely dependent on public transport. So, while we do not accept others to walk in at 8:05, 8:10, for PwDs we make an exception."

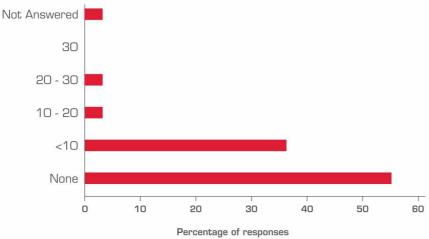
Literature suggests that PwDs often feel misplaced or shunned in their organisation due to the lack of an effective integration process. The underlined perceptions and attitudes of their co-workers often dissuade employees with disabilities to excel in their capabilities due to their perceived shortcomings. This is coupled with the situation where PwDs also find themselves at a stage where their disability inhibits them from undertaking complex assignments and responsibilities. This leads to PwDs experiencing what the literature terms as the 'lost opportunity effect', i.e. when the opportunity to improve is lost due to the absence of effective feedback for the improvement of their performance (Shenoy, n.d.).

Distribution of PwD employees in the interviewed hospitals

From the data collated from the survey responses, the following is the result -

- Maximum number of respondents (55%) said they don't have an employee with a disability and none of the hospitals have more than 30 employees with disabilities.
- 37.5% said that they have less than 10 employees with disability.
- 2.5% of hospitals reported having either 10-20 or 20-30 employees with disabilities.

Figure 10: How many employees does your hospital have with some kind of disability?

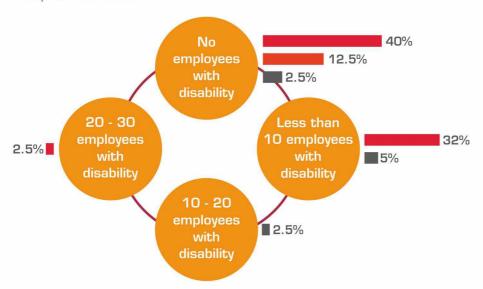


The data shows that the total strength of employees with disabilities in the interviewed hospitals is not strong. Very few hospitals reported having a strength of 20-30 employees with the second highest strength reported as less than 10 employees with disabilities. Maximum hospitals don't have any PwD employees.

Distribution of PwD employees in hospitals and the availability of integration and sensitisation processes

In order to understand the impact of having institutional frameworks and policies that help in facilitating mobility and integration of PwD employees, the following results came from our analysis:

Figure 11: Availability of integration and sensitisation processes in the hospitals interviewed



Source: Internal Survey, Tech Mahindra Foundation, 2019.

Figure 11 shows that in hospitals which have no PwD employees, 40% have no sensitising or integration processes, while 12.5% said that they do have provisions.

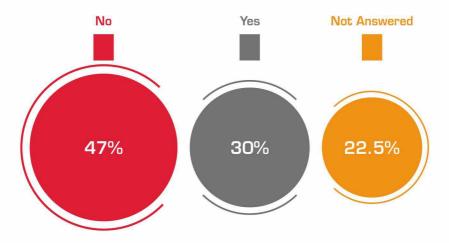
Respondent from one such hospital said "earlier we had 2-3 employees with disabilities in backend jobs. However, due to personal reasons, two of them are not working with us anymore and we couldn't afford to keep the third employee due to lack of punctuality and inefficiency in their work."

In hospitals with less than 10 employees with disabilities, 32.5% reported having no provisions for integration while the rest did not respond. All hospitals with 20-30 employees with disabilities reported having no integration processes.

Fewer respondents reported having re-skilling provisions for employees, especially PwD employees in their hospitals

47.5% of respondents said that they don't have up-skilling provisions in their hospitals for employees, especially for PwD candidates, while 30% said that they do. Re skilling provisions as identified by respondents are: mandatory trainings in every six months in different departments and soft skills, excel and other IT related skill trainings, community engagement training, etc.

Figure 12: Is there a provision for re-skilling or in-skilling for candidates, especially for PwD candidates in your organisation/hospital?



Source: Internal Survey, Tech Mahindra Foundation, 2019.

Lack of workplace readiness also deters $\mbox{PwD}\mbox{'s}$ from being absorbed in the AHP job roles

From the experiences of respondents who have conducted training workshops and employers who have employed PwD candidates, a respondent shared,

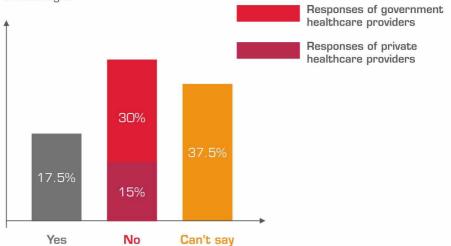
"PwD candidates need to be told that they got the job not because of their disability, but because of the skill set they have acquired. AHP job roles, or any healthcare job role require punctuality, professionalism along with the ability to provide quality service. PwD candidates lack in skills that make them job ready., Most of the times they don't understand that they have to work for certain hours, reach on time and not take an off for no reason at all. If these actions are repeated then it's only natural for their employers to complain and not have enough reasons to retain them."

Employers should also not be asked to take the full responsibility of being the reason for why there aren't enough number of PwD candidates in the AHP job roles.

Lower retention rate for PwD candidates in private hospitals: Government hospital respondents have reported having a higher retention rate of PwD candidates and have not cited it to be a challenge to do the same, as compared to private hospital representatives. According to figure 13:

- \bullet 45% of the total respondents said it is not a challenge. From this, 30% were government hospital representatives and 15% were private hospital representatives.
- 17.5% of private hospitals said that it is.
- 37.5% said that they don't have adequate comparative data to say whether it has been a challenge or not. (These respondents are a mix of government and private healthcare providers.)





Source: Internal Survey, Tech Mahindra Foundation, 2019.

Lack of productivity and societal pressures have been identified as the major reasons by private hospitals as to why it's a challenge for them to retain PwD candidates. A private hospital representative said,

"Government hospitals provide benefits such as leaves and travel incentive allowances to PwD candidates along with the mandate of recruiting PwD for a certain percentage of seats. This provides the PwD's with a job security and they may find PwD's with adequate skills as per the job requirement. The same facilities are not available in private enterprises."

Respondent also sees employing PwD's as a social cause due to which they don't find the retention rate to be lower as explained by a respondent from a private hospital, "if we have PwD candidates as employees in our hospital, we usually retain them for long as they are needy." This explores the thought process of the employers who employ PwD candidates, not on the basis of their skill set but due to other reasons.

Lack of family support, education, skill development and inadequate acceptance of the healthcare employment result in low employability of PwD candidates in AHP job roles: Interviews discussing the major constraints faced by PwD candidates in getting employed in AHP job roles brought out that due to the lack of investment a family would make towards a person who has disabilities, hinders him/her to realise their own potential and develop skills and attain education that may help them secure a job role in the healthcare sector.

"The family support is usually either extremely overprotective or misguided. They have issues regarding distance, travel, work timings and a disbelief that their kid can actually do the job role that they otherwise may be qualified for. For females its tougher. This leads to a sense of demotivation amongst the disabled individuals", said a respondent who runs a training institution for the visually impaired.

"But comparing the placement rates in other sectors as compared to the healthcare sector, the health sector has absorbed very few PwD candidates. And as per my knowledge, none of them are engaged in any hard core AHP job roles. Like I said, its mainly back end work" said another respondent, who runs a school for deaf children and works towards empowering and providing employment to PwD candidates.

More scope to absorb PwD candidates in healthcare sectors which already have initiatives that work towards empowering them: Through the interviews with healthcare sector employers, it was understood that the probability of having more PwD employees in private health sectors occurs if the organisation already has facilities to empower the target group.

A respondent who is a part of the vision health sector said, "we have 10-12 employees in our organisation. Our recruitment is sensitive towards employing PwD candidates so we either hire them through external sources or internally we absorb them. We have a vision rehabilitation department where we train people with low or no vision. The training is provided in learning computer skills and absorb them in the same job role."

UNDERSTANDING OF PWD'S IN AHP JOB ROLES: A SUMMARY

- 1.Government mandate of reservation encourages government sector to have morePwD employee as compared to the private healthcare sector.
- 2. Maximum respondents of the private sector aren't aware about government incentives available to help absorb PwD's in the private sector.
- 3. General sentiment that PwD candidates aren't the right fit for professional PwD roles.
- 4. There is a lack of skill training institutes for PwD candidates.
- 5. Major constraints for PwD's include lack of educational qualification, not being job ready, lack of skills, family support and societal demotivation.
- Most of the hospitals lack in work place accommodations and sensitizing workshops to help PwDs transition in the formal work space.
- 7. Very few respondents reported to have re-skilling and in-training provisions for PwD employees in their hospitals.
- 8. Low retention rate of PwD's in private hospitals as compared to government hospitals.





FINDINGS AND ANALYSIS - UNDERSTANDING WOMEN EMPLOYMENT IN ALLIED HEALTHCARE PROFESSIONS

BACKGROUND PROFILE FOR HOSPITALS

Respondents were asked whether they get enough applications to close vacant posts in allied healthcare job posts and whether they see a dearth in the required skills in the market.

- \bullet Close to 70% of the respondents said that they do get an adequate number of applications to fill the AHP job posts. The rest have either said no (17%) or are uncertain (15%).
- However, 27.5% of respondents feel that there is a dearth of required skills in the market. While 20% do not agree, the rest are uncertain [52.5%].

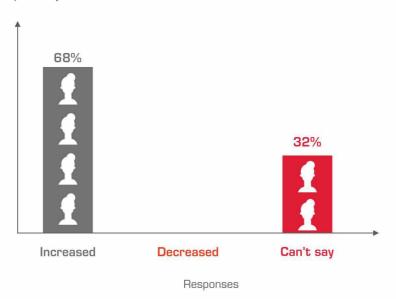
The availability of skills overall is a concern in the sector. The respondents comprise of HR representatives and medical representatives of the interviewed hospitals.



TRENDS IN WOMEN EMPLOYMENT

An encouraging percentage of respondents (68%) have said that the employment trend in their respective institutions shows that the employment of women is on the rise (refer to figure 14).

Figure 14: What is the trend of intake of women employees in the past 3 years?



Source: Internal Survey, Tech Mahindra Foundation, 2019.

Need for greater gender parity across AHP job roles

Hospital representatives acknowledged that while a greater number of women are applying and joining the AHP job posts, there is still a long way to go to achieve a 50-50 gender balance. Interviewers probed further to understand why gender balance has remained below the 50-50 ratio.

- About 7.5% of respondents said that they feel women are less suitable for professional AHP job roles.
- Maximum respondents (85%) said that they don't think women are less suitable but when it comes to the actual number of applicants and post holders, there is an existing trend in a lot of hospitals where the number of women is comparatively lesser.

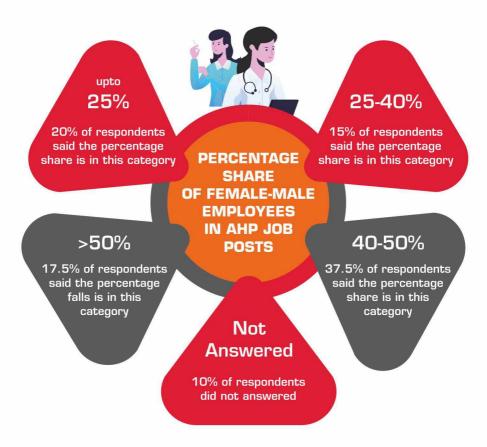
A respondent from a private healthcare centre said, "in most hospitals you will find the percentage of women in AHP job roles to be lesser than the percentage of men. Our hospital also has lesser women compared to the men in the job posts. While we don't consider women to be less suitable for the job requirements, reasons such as distance from their home, job timings, other family responsibilities have been some major reasons as to why we couldn't hire or retain women."

When further asked what is the percentage breakup that can be given to the distribution of females-male AHP employees in their hospital (also given in figure 15), the following were the results:

- 37.5% said it is between 40%-50%
- 17.5% said its more than 50 %.

This shows that less than 20% of hospitals have stronger gender distribution in their AHP job profiles.

Figure 15: What is the percentage share of female – male employees amongst the allied healthcare professions



Source: Internal Survey, Tech Mahindra Foundation, 2019.

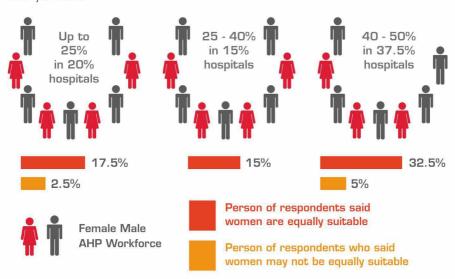
It is also interesting to analyse any gaps between the thought process and the actual implementation of – when respondents said that women are equally suitable for AHP job roles, whether this understanding reflects in the percentage share of female-male employees in their hospitals.

Figure 16 tells us the following:

- •17.5% of respondents, from the 20% of hospitals that reported a lower gender balance in their existing AHP workforce (up to 25% females) said females are equally suitable for AHP job posts as compared to their male counterparts. This is compared to the 2.5% of respondents who said that women may not be suitable.
- 15% of respondents, from the 15% of hospitals that reported a 25-40% female-male distribution in their AHP workforce said they don't see women and men at different levels of competencies when it comes to the requirements of an AHP job role.
- 37.5% of hospitals that reported a gender balance of 40-50% to have 32.5% of respondents answering that women are equally suitable as men while 5% responded that they may not always consider women to be equally suitable if they have to choose between a male candidate and a female candidate for an AHP job role.

Hence, the analysis shows that hospitals which that higher number of respondents saying that women are equally suitable and competent for the AHP job roles however have a lower gender balance (Less than 50% of females) in their existing workforce.

Figure 16: Comparison between the distribution of female to male employees in AHP jobs and whether respondents feel that women are less suitable for AHP job roles



Source: Internal Survey, Tech Mahindra Foundation, 2019.

When asked why the gender parity is still not as strong, the respondents cited certain reasons.

A respondent from a Delhi based government hospital said

"Even though we say that women and men are equally suitable for the job roles, there still exists a hidden discrimination from the side of the employer while they have to choose from a candidate pool that has a mix of males and females all equally competent..."

While the respondent did not acknowledge to have seen anything like this in their hospital, they spoke about the hesitance that other employers may feel while hiring a woman in terms of her maternity or childcare leave. The employer views it as a risk due to her possible absence for 6 months and not being able to fulfil her job requirements. AHP job roles, according to the respondent in the government hospitals are usually on a contractual basis.

"...If I require a Radiographer or an OT Technician, I will be inclined to keeping them on a one-year contractual basis. If the contractual job is for a year and if within that year a woman ends up on maternity leave for 6 months, it acts as a loss to the resources of the employer."

Another part of the argument that was expressed by a private healthcare representative was understood in terms of having a male-dominated candidate pool when the recruitment happens on a referral basis. A respondent from the vision health sector said:

"Our candidate pool is not always balanced. We have seen a trend where a male employee/candidate is referring another male candidate only..."

It was also understood from the interview conducted with the private healthcare representative that campus placements find more females as potential candidates to hire. However, having said that, according to the experience of the respondent, female candidates often don't follow up about the job offer as compared to male candidates recruited from campus placements.

"...this has remained a major cause as to why we find more male candidates than female candidates after campus recruitment. When we filter our candidates, even though we find an overwhelming number of potential female candidates during the time of recruitment, we find it hard to track them again as we can't get through their contact. This leaves us with more male candidates."

Shortage of women in AHP job roles: When the HR representatives of the different hospitals were interviewed, they identified certain AHP job roles (as shown in figure 18) where there is a shortage of women.

A respondent from a private healthcare facility said the following:

"Women don't lack in the skillset that is required for the roles. If they have the education and degree, that qualifies them for the job. But whether or not they are present in the existing workforce for those job roles or why the retention may be low may not always be because they didn't have the skills. From our experience we have seen reasons like job timings, travel requirements, the expectation of being readily available for responding to emergencies (e.g., ambulance requirements) as some major causes for lesser female applicants and lower retention in the identified AHP roles." When the HR respondents were asked during the interview if they think there is a shortage of women with the right skills for some departments of AHP professions, 55% said that they don't feel women are short on skills.

However, 35% of HR representatives said that they feel women may not have the required skills for the job roles and that can be a contributing factor for having lesser women in the job roles (refer to figure 17).

Figure 17: Is there a shortage of women with the right skills for some departments of AHP professions?

55% 35%

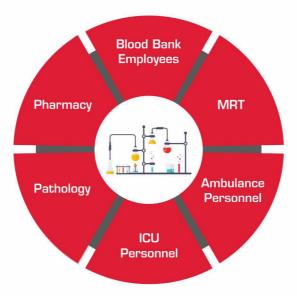
Agreed that women have the required skills for any AHP job role

*10% of respondents remained neutral.

Think that women are short on skills for certain AHP job roles

Source: Internal Survey, Tech Mahindra Foundation, 2019.

Figure 18: AHP job roles that have shortage of women



Source: Internal Survey, Tech Mahindra Foundation, 2019.

Analysis also shows that when data is compared to the total number of hospitals reporting gender parity in their total workforce vs the gender parity in their allied healthcare professional job roles, the number for the latter reduces. The analysis is further explained under the section 'Effect of Recruitment Policies on the Gender Distribution in the Hospitals'.



Key AHP job roles that have a high potential for recruiting women: Respondents were asked if they think there are certain key AHP job roles which have a higher potential for absorbing female candidates.

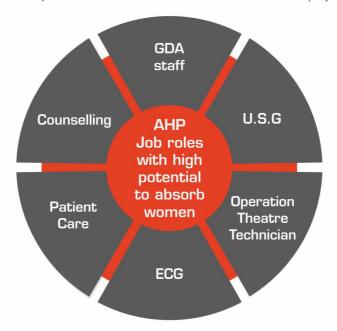
- 35% of the respondents said yes, that there are certain job roles which have a high potential for recruiting female candidates. The respondents identified job roles as well (as given in figure 20).
- 65% of the respondents however said that all AHP job roles have the equal potential for absorbing female candidates. Respondents expressed that women are suitable for all AHP job roles, and decision making between male and female candidates comes based on their skill set and educational qualification as per the job requirement.

Figure 19: Are there key allied healthcare professions that have high potential for recruiting women candidates?



Source: Internal Survey, Tech Mahindra Foundation, 2019.

Figure 20: AHP job roles that can absorb maximum female employees



Effect of Recruitment Policies on the Gender Distribution in the Hospitals: The following data was collated through survey interviews:

a) Percentage distribution of total employees in the hospital (gender-wise):



or nospitals
reported to have
more than
50% of females
in their total
workforce.

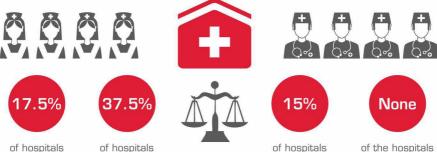
of hospitals have a distribution of 40 - 50% of females to males.

of hospitals have 25 - 40% of distribution. of the hospitals reported to have up to 25% of females in their total workforce.

Source: Internal Survey, Tech Mahindra Foundation, 2019.

• None of the respondents interviewed reported to have a distribution of females to be lesser than 25% of the total workforce.

b) Percentage distribution of total employees in the AHP workforce (gender-wise):



of hospitals more than 50% of females working in their AHP job roles. of hospitals have a distribution of 40 - 50% of female to male employees in their AHP job roles.

of hospitals have 25 - 40% distribution of female to male employees. have up to or less than 25% of females in AHP job roles.

*30% of respondents responded as can't say.

Source: Internal Survey, Tech Mahindra Foundation, 2019.

The above two figures bring out an interesting analysis: While a greater number of respondents reported having better gender parity in their total workforce, when asked about the distribution of females in their allied healthcare job roles, the number reduced.

 \bullet 60% of hospitals that reported to have more than 50% of females in their total workforce in the hospitals have only 17.5% of females as compared to males when it comes to their AHP job roles

C) Preference to hire women candidates within the recruitment policy of the hospitals: While 55% of hospital representatives have said that they don't have an explicit policy to hire women candidates and choose purely on the basis of qualifications and calibre, 37.5 percent of representatives have said they have provisions in their recruitment policy that encourages hiring of women.

Figure 21: Is there a recruitment policy to encourage and promote women employees?

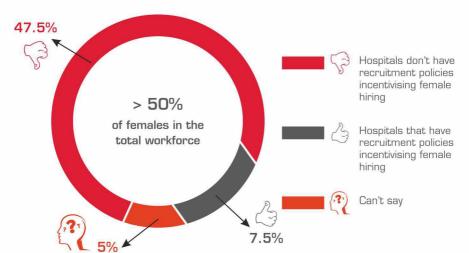


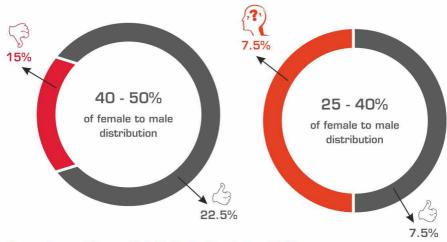
Source: Internal Survey, Tech Mahindra Foundation, 2019.

A respondent from a nursing home said, "we also try and give preference to women candidates while recruiting fresh employees as we want to work towards a better gender ratio in the hospital".

Gender distribution of employees in hospitals with and without recruitment policy that incentivises absorbing female candidates: Interviews show the following analysis -

Figure 22: Relationship between the total work force gender distribution of female to male employees to incentives in recruitment policies for women





Source: Internal Survey, Tech Mahindra Foundation, 2019.

- Hospitals that have better gender distribution amongst its total employees (more than 50% of women in their total workforce) reported to not have a policy that incentivises the recruitment of female employees: 47.5% of respondents reported they don't have any such recruitment policy, while only 7.5% said that they do have a policy that prefers hiring female employees.
- Hospitals with poorer gender distribution (less than 50% of women in their total work force) reported to have recruitment policies incentivising female recruitment: 7.5% of respondents with a female to male employee distribution of 25-40% and 22.5% of employees with a female to male distribution of 40-50% reported to have policies in their recruitment that prefers hiring female employees.

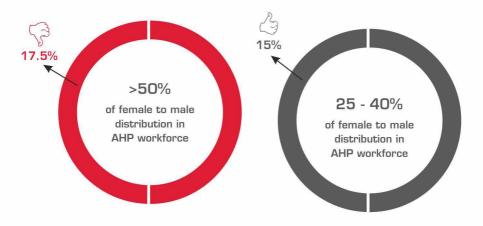
Therefore, the majority of hospitals with a healthy gender distribution don't have recruitment policies that give preference to hiring female candidates. Whereas the majority of hospitals with less than 50% of female employees do have recruitment policies incentivising female recruitment.



A similar analysis came up when we analysed the impact of recruitment policies that incentivise female recruitment on the gender distribution in the allied health profession (AHP) workforce in the hospitals (as given in figure 23).

- Hospitals that have a better gender balance (more than 50% of women in the AHP workforce) reported to not have any recruitment policy that gives preference to hiring women candidates. All of them (17.5%) said no, they don't have a recruitment policy that gives preference to women.
- Hospitals with a poorer gender balance (25-40% of females to males in the AHP workforce), all the respondents, i.e., 15% said they have provisions in their recruitment policies that give preference to hiring women employees.

Figure 23: Relationship between the AHP work force gender distribution of female to male employees to incentives in recruitment policies for women



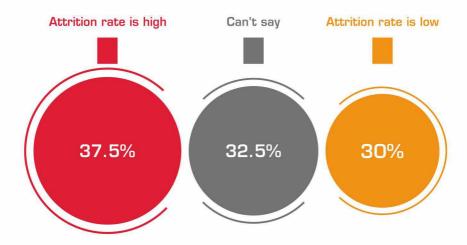
Source: Internal Survey, Tech Mahindra Foundation, 2019.

Societal and safety concerns inhibiting women from taking up field-based work: Interviewees also mentioned that due to the issues of safety, travel requirements and fluctuating distance from home, women employees feel discouraged to take up jobs that include field-based work.

A respondent from a vision healthcare centre said: "On the field, we have 150 workers. This includes a coordinator, a counsellor and an optometrist. Given how this is a travelling job with our camps constantly moving to remote locations and rural communities, out of the 150 field workers, very few are females."

Maximum respondents reported a higher attrition rate for women: 37.5% of respondents reported high attrition rates for women in their hospitals, while 30% reported lower attrition rates. Family issues, night shifts, emergency type job roles have been noted as the major reasons as to why employers have found the attrition rates to be higher for women in their hospitals.

Figure 24: Is the attrition rate for women higher in your hospital?



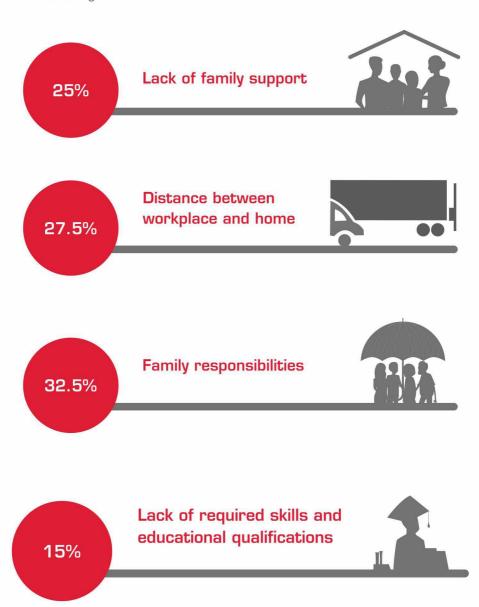
Source: Internal Survey, Tech Mahindra Foundation, 2019.

Constraints faced by women in approaching AHP job roles include lack of family support, distance and family responsibilities: The respondents have identified how women still face constraints in applying for jobs, including jobs in the healthcare sector. These constraints stem from socio-economic factors.

A representative from a private hospital said, "even though the healthcare sector has maximum potential for employing women, there still exist constraints and societal issues that make the absorption of females in this particular sector a challenge. These constraints include: lack of support from their families or challenges in managing the distance between work and home. Women don't feel determined enough to either apply or to remain in their jobs for long"

A pediatrician from a government hospital said, "there are instances where women leave their jobs midway at the hospital due to reasons such as the husband earning a higher income. This happens even if the woman was previously earning a stable salary subjected to increments."

Four major constraints as identified by the respondents can be grouped in the following manner:



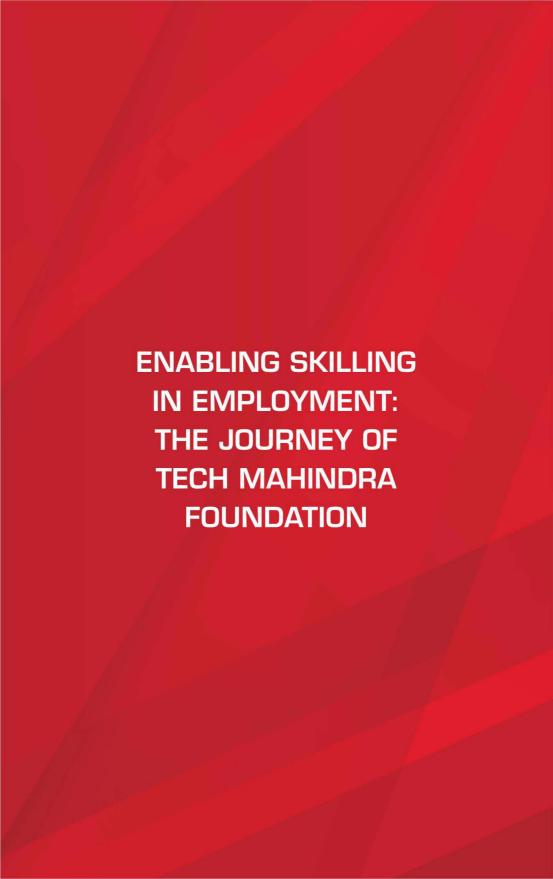
These constraints also need to be contextualised in terms of regional variations. These variations come in the form of the urban and rural divide, the state's relative position in employment among women (married or unmarried), their cash holding status and the autonomy in making household decisions. Studies show that when these factors come into the picture, southern and northeastern states fared comparatively better than northern states (Jain, 2018).

UNDERSTANDING OF WOMEN'S EMPLOYMENT IN ALLIED HEALTHCARE PROFESSIONAL JOB ROLES: SUMMARY

- 1. Need for greater gender parity across AHP job roles.
- 2. Safety and traditional societal constraints inhibit women from taking up field-work based job roles.
- 3. Job roles such as pathology, pharmacies, emergency personnel don't find adequate women with the required skills applying.
- 4. High attrition rate for women in hospitals.







ENABLING SKILLING IN EMPLOYMENT: THE JOURNEY OF TECH MAHINDRA FOUNDATION

INITIATIVES OF TECH MAHINDRA FOUNDATION TO PROMOTE EMPLOYABILITY IN THE ALLIED HEALTHCARE SECTOR

Tech Mahindra Foundation has taken the lead to reduce the skill-gap challenge by facilitating a platform where it provides skill development and education in the allied healthcare domain. Through its flagship employability programme - Skills for Market Training (SMART), the Foundation works towards its vision – "Empowerment through Education" by training youth in its SMART Academy for Healthcare. The Academies impart advanced level training in allied healthcare courses and the chain of SMART Academies across cities have taken roots in 2016.

The Academies not only impart skill development but also help the trained youth in receiving jobs in the industry. Tech Mahindra foundation understands the gap between acquiring education and then utilising the skillset developed in the workforce and hence, supports its students in receiving placements. Overall, the SMART Healthcare Academies have a healthy placement rate of over 70%.

Currently, Tech Mahindra SMART Healthcare Academies are located in Delhi, Mohali, and Mumbai. These academies aim at skilling the youth both in theory and through practical modules that are a part of its holistic curriculum. Along with providing skill development in allied healthcare courses, the curriculum is also designed to improve both skills and employability potential amongst the youth. Hence, students hone their soft skill development, IT skills, English language proficiency and personal growth alongside gaining expertise in allied healthcare courses.

The courses are taught in the well-equipped state of the art facilities by faculty who themselves are domain experts. To help students hone the skills they have acquired and learned through their training, the Academies also provide with internship exposure by providing channels to work at hospitals, clinics, laboratories and nursing homes as allied healthcare professionals. This also helps students realise their utmost potential to work in real work environments and learn to overcome challenges that may come their way and prepare themselves better for the time when they actually step into the job market. At the end of their course, a dedicated placement committee at the Academies help students secure stable job roles and start their career path.

Giving importance to the idea of bringing in more female participation in the sector, the SMART Academy situated in Mumbai provides paramedical and allied healthcare training for women only.

TRENDS IN ENROLMENT AND JOB OUTCOMES AT TECH MAHINDRA SMART HEALTHCARE ACADEMIES FOR HEALTHCARE

Over the years, the number of women who are enrolling in the education system and availing quality education in India has seen improved numbers. Data also reports that a greater number of women are successfully passing class 10th exams as compared to their male counterparts. However, the numbers are dwindling when we look at their participation in the labour force. Women are either marrying and settling down, not looking for jobs or not finding any jobs (Salve, 2016).

According to a 2015 study by the International Monetary Fund, the enrolment of girls in higher education saw a rise to 46% from 39% between 2007 and 2014. However, the participation of females in the labour force saw a dip to 27% in 2014 from 34% in 1999. This is seen to be below the global average that is around 50% and the East Asian average of 63% (Das, Chandra, Kochhar, & Kumar, 2015). Similarly, the rate of female labour force participation (FLFP) in India fell from 36% in 2005-06 to 24% in 2015-16 as reported in the Economic Survey of India 2017-18.

The societal fabric of India has been deeply woven for decades that has significantly contributed to the different stereotypes and biases against women and their contribution to the economy. One of the biggest biases that most women still fight against is the idea of getting married at an early stage in life. Hence, marriage remains as the biggest constraint between women and them acquiring jobs. Other challenges as identified through studies are mobility concerns and fluctuating working hours (Bhandare, 2017).

Another challenge that India faces, unlike the western countries, is to retain women in science-related careers. According to a 2015 report, there is a healthy number of women science teachers in colleges and schools of India. However, the gap exists when they transition from completing their degrees to pursuing careers in science (The Association of Academies and Societies of Sciences in Asia (AASSA), 2015).

The analysis of data on enrolment, admission, pass and employment of girls trained in SMART Academies in Delhi, Mohali and Mumbai provide a good insight. Annual data is available for three consecutive years - from 2016-17, 2017-18, and 2018-19.

Delhi Academy became operational in 2016-17 and since then it witnessed a mixed trend. It's not necessary that the total number of students who enrol will also be given admission into the healthcare academies. While Tech Mahindra Foundation provides the infrastructure required to train young professionals in various allied healthcare professions, immense importance is also given to the quality of students. The skillset required to join the healthcare sector requires quality training as these professionals' train themselves to take care of other people's lives in the future.

It is encouraging to see that those passing out of the Academy are also finding jobs. Out of the total admissions of 350+ students since 2016, about 43% have joined work.

Mohali Academy became operational in 2017-18. The total number of enrolment of girls increased from 59 in 2017-18 to 98 in 2018-19 but dropped again to 52 in 2019-2020. The Academy maintains an admission rate of almost 85% and a placement rate of nearly 80%.

Mumbai Academy became operational in 2018-19. The Academy has only female students. The total capacity of girls in the Mumbai Academy is 400. The Academy also maintains a healthy percentage of enrolment, which is close to 90%.















INCLUSIVITY OF PwDS IN MEDICAL INSTITUTIONS

INCLUSIVITY OF PwDS IN MEDICAL INSTITUTIONS OVERVIEW OF MEDICAL BODIES IN THE SPHERE OF INCLUSIVITY

Currently the healthcare system is not inclusive as far as PwDs are concerned. The Parliament in 2016 passed the Rights of Persons with Disabilities Act (RPwD Act). This became necessary after India ratified United Nation Convention of the Rights of Persons with Disabilities (UNCRPD) in 2007. The Act becomes important to harmonise the existing legislation with the provision of the Convention. This legislation is considered progressive because it has replaced charity-based approach to right based approach to protect the human rights of the PwDs. The government also increased the number of disabilities

from 7 to 21 with space to add more.

According to the Act, any person with a benchmark disability and a minimum of 40% of a specified disability, is entitled to avail all the benefits and accommodations provided in the Act. This includes 5% reservation in higher education as well. Taking this as a point of reference, the Medical Council of India (MCI) amended its rules for its post graduate courses, to make candidates with any of the 21 disabilities listed in the RPwD Act as eligible in 2018.

This encouraged candidates with disabilities to seek admission in medical courses under disability quota and write the National Eligibility cum Entrance Test (NEET). But the experience with admission in 2018 showed that several students with a range of disabilities were declared ineligible. It was reported that in 2018, the Directorate of Medical Education, Mumbai declared 8 out of the 110 students selected under the disability quota as ineligible. These students had learning disabilities (Gaikwad, 2018). Similar incidents started getting reported from across the country soon after where candidates with low vision, dyslexia, dwarfism, upper limb disability, hemophilia were being denied admission.

These decisions were the result of the then admission guidelines devised by an Expanded Committee on Disability formed under the MCI. The guidelines noted that even though the candidates may have benchmark disabilities in visual impairment, autism, specific learning disabilities and hearing impairment, they will still be ineligible for the disability quota. Upper caps were specified – 60% for non-dominant upper limb disability and spine involvement and 80% for disabilities due to chronic neurological disorders, haematological and lower limb disabilities.

Guidelines were framed by The Ministry of Social Justice and Empowerment (MSJE) for the evaluation and certification process of the different specified disabilities. These were then finalised and notified on January 4, 2018 in the Gazette by the Central Government. An expert committee was then constituted by MSJE that further created eight sub-committees that would take charge of deliberations on "developmental disorders" and "mental illness." Even though these channels were available, the MCI depended on only one psychiatrist to take decisions on developmental disabilities and said that this discriminates against people with learning disabilities. When cases like this come up – that may have varied interpretations in classifications and become controversial in nature, the Director-General of Health Services (DGHS) has the final authority to take decisions. However, the MCI did not consult the DGHS (Singh, 2019).

According to the Assessment Guidelines, no reassessment is required after 18 years of age and that the certificate can be valid for life time. This recognises that the coping strategy of dyslexics and their learnings are established by the time students are eligible for higher education. But MCI insisted on reevaluation. This makes it discriminatory.

MCI had disallowed five categories of PwDs from taking admission in MBBS degree courses. These included those suffering from dysgraphia, one hand amputation, chronic neurological conditions, blood disorders and locomotor disability - all with 80 per cent or more impact. This was challenged in the court of law. A PIL was filed by disability rights campaigner and member of Doctors with Disabilities: Agents of Change. This was filed against a notification of MCI that barred PwDs with more than 80% disability from pursuing MBBS courses (February 4th notification). The response of the director in the Department of Empowerment of Persons with Disabilities supported the decision of MCI and said, "the medical practitioners are supposed to meet the minimum standards of patient care keeping in view the needs of patient at large" and "the protocol of treatment of patients demands ensuring safety of the patients." (Bhatnagar, 2019). It also stated that "patient care and safety of the patient needs to be kept in mind while deciding the criteria for admission to such courses" and added that "Indian Medical Council and Union Ministry of Health and Family Welfare are competent authorities to justify their stand." (Bhatnagar, 2019).

The unlawful nature of the MCl guidelines is evident in the fact that the Delhi High Court on July 31, 2018, granted relief to a hearing-impaired candidate who cleared the NEET examination but was denied admission. This was done on the ground that the MCl guidelines stated that candidates with hearing disabilities are not eligible for admission into the medical course in the disability quota. But the court gave permission and upheld the principles of non-discrimination and equal opportunity enshrined in UNCRPD.



NEED FOR A CENTRAL REGULATORY FRAMEWORK FOR ALLIED HEALTHCARE PROFESSIONALS

India currently does not have an effective regulatory authority in place that can help in monitoring of the plethora of health workers engaged as AHPs and establishing educational and quality standards for the recruitment of the job roles under it. There is an increased need to have a framework in place with an effective implementation that can help in enumeration, standardisation and regulation of AHP professions. Due to the absence of a regulatory authority, the problems of unskilled or unqualified AHP's in different allied departments has increased. This also affects the efficient working of the said professionals. With modernisation of the healthcare system, the approach towards patient care has also changed. The systems are progressing towards a model called 'teambased healthcare delivery' (Baker, Day, & Salas, 2006; Wagner, 2000).

Medical teams are considered as 'action teams' and have a mix of doctors, nurses and allied health professionals. The idea is to have an interdisciplinary framework to meet the medical needs of patients and provide optimum results. Team based approach can help provide cost-effective operations, quicker medical emergency responses, faster decision-making processes and safe patient results.

The absence of a regulatory authority for allied health professionals and its courses in India has divided the professionals into smaller groups. This gives an impression of them being regulated separately by different independent bodies at the central and state level. Due to this there aren't any unified rules and regulations for professionals to refer from. Due to which the rules governing the better organised groups of physiotherapists, optometrists, audiology professionals and speech therapists are different from the lesser organised groups of room technicians and radiation therapists.

A step forward in this matter was taken when the Allied Healthcare and Professions Bill was passed in the Rajya Sabha in 2018 (PRS India, 2018). However, the bill still awaits recommendations from a standing committee that it has been referred to further.







INCENTIVE SCHEMES
AND POLICIES OF THE
CENTRAL GOVERNMENT
ON INCLUSIVITY OF
PERSONS WITH DISABILITIES
IN THE INDIAN WORKFORCE

INCENTIVE SCHEMES AND POLICIES OF THE CENTRAL GOVERNMENT ON INCLUSIVITY OF PERSONS WITH DISABILITIES IN THE INDIAN WORKFORCE

INCENTIVE SCHEMES AVAILABLE FOR PRIVATE EMPLOYERS

The Financial Year of 2007-08 announced a scheme of incentives that will be provided to the private sector in order to encourage and provide employability to PwD candidates. Following the announcement, the Ministry of Social Justice and Empowerment launched a scheme for the private sector Employers. A revised scheme for the same was then introduced in 2012 and effective from April 1st, 2016. Following are the different schemes that were introduced:

Policy: Incentive Scheme for Providing Employment to Persons with Disabilities (PwDs) in the Private Sector, Appendix IV³.

Contribution of EPF/ESI for PwD employees: Private employers who employee PwD candidates in their organisation are exempted from depositing the EPF/ESI contributions for their PWD employees. This responsibility will be taken by the government (DEPwD) who will make advance payments to the EPFO/ESIC. The employers need to intimate the EPFO/ESIC departments about the inclusion of PwD employees so that they can initiate the employer's contribution and deposit it to the respective PwD employees accounts. This scheme can be availed by any PwD candidate employed in the private sector regardless of their salary or wage ceiling for 10 years.

Payment of Gratuity: The employers are expected to pay one-third of the gratuity amount to PwD employees as per the Gratuity Act. As a part of the incentive scheme, this amount shall also be borne by the DEPwD.

Payment of Stipend amount: In the case of a PwD candidate being employed as an apprentice by a private employer for an apprenticeship, the stipend money after the completion of the apprenticeship period will be borne by the DEPwD.

Women

With regard to women, the Government of India has special schemes like maternity benefits which is also available for private employers.

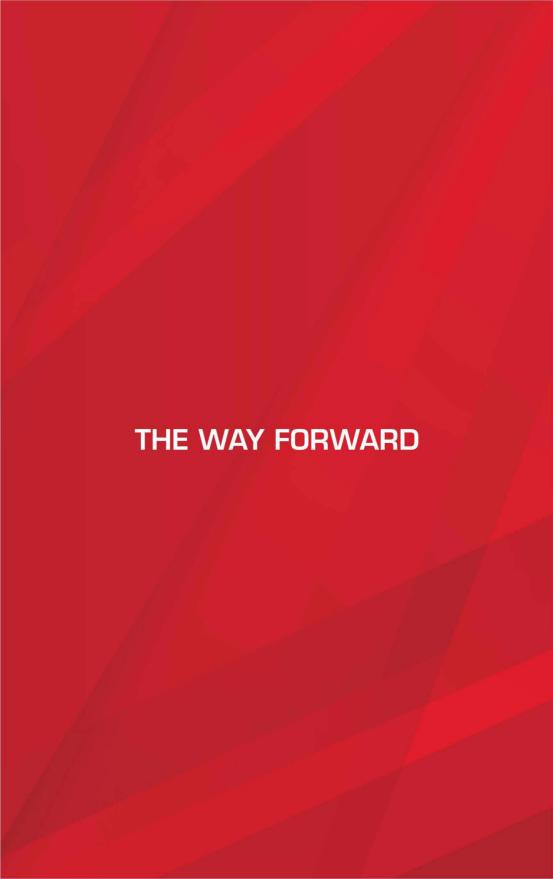
³See Incentive Scheme for Private Employers, Ministry of Social Justice and Empowerment, Government of India, 2018:

http://disabilityaffairs.gov.in/upload/uploadfiles/files/Incentive%20Scheme%20under%20SIPDA.pdf









THE WAY FORWARD

RECOMMENDATIONS

The Government of India has several policies for PwD and women. Overall affirmative action in terms of legislation and policy can help to create broad mandate. Global good practice shows that financial support in terms of tax benefits, or workplace modifications, targeted training and orientation, etc, for both the target groups has helped substantially.

The investigation has also explored the possibility of promoting the employment of women and PwDs in the private health care sector. But the private sector will also require a conscious and explicit recruitment policy to give preference to women and PwDs in allied health care professions. More concerted efforts are needed to build policies and initiatives.

Enabling policies for vulnerable groups - Women and PwDs

- 1. Need well defined corporate policy on recruitment for incentivised hiring of women and PwD candidates: Overall there is a need for explicit recruitment policies at the institutional and corporate level to ensure gender parity and equitous an approach to PwDs. There is a requirement to imbibe the hire, train and deploy approach to attract and retain talent with disability. This will allow a more responsive ecosystem in the workplace. For better gender parity, the HR hiring policies should take into consideration the current workforce status of the employees and if the ratio of male to female is not balanced, then create provisions to include a healthy balance of the same.
- 2. Need recruitment guidelines for recruiters and recruitment agencies: Detailed guidelines will have to be developed for the recruiters so that appropriate methods are adopted for interviewing PwDs with different types and levels of disability and more gender sensitive approaches for women. Recruiters will have to be trained and oriented towards training needs of the prospective candidates and their level of skilling.
- 3. Motivation of the top management is critical in this initiative: Such an approach is possible only if the top management of the institutions are sensitised and take the lead in policy reforms. This will require sensitisation workshops.
- **4.** Develop supportive policies to make the working ecosystem amenable: Human resource (HR) policy and workplace design need to be more sensitive towards the unique and specific needs of women and PwDs. Women will require gender sensitive environment and policies to help them balance their responsibilities related to childcare, sexual harassment policies etc.
- **5.** Disable friendly workplace: PwDs will require design changes and technology aids in workplaces. Hospitals and other healthcare institutions need to be wheelchair friendly; require sign language interpreters; accessible restrooms and ramps; more appropriate visual signs; and allow barrier free movement. Campuses will require accessible footpaths with tactile pavers, proper design to address level differences. The work stations can be modified by the introduction of Braille writing and videos with subtitles. The entire ecosystem will have to be disable-friendly. Even internal communication within the institutions will require inclusive digital design.

- **6.** Look for partnerships with NGO's and other initiatives: Identification and partnership with other initiatives that can help hospitals to bridge the gaps and promote effective communication with PwDs, strengthen their employees with disabilities and identify different areas where PwDs can be employed.
- 7. Leverage CSR to build infrastructure for skilling and training for capacity building: There is considerable scope for setting up capacity building and training centres for targeted training and education. Corporate Social Responsibility is an important opportunity to leverage resources to build and harness talent among the target groups. CSR bodies and training institutes can identify the healthcare providers who already have engaged PwDs in their AHP job roles and outsource its customised training modules and experience to the employees with disabilities. CSR bodies can also identify those healthcare providers who may be aware of government incentives but still have a weak representation of PwDs in their workforce. They can help them device strategies and policy frameworks for better inclusivity.

8. Central Regulatory Body to Streamline the Allied Healthcare Professions:

The Allied and Healthcare Professions Bill, 2018 has established the Allied and Healthcare Council of India. The council will consist of 48 representative members from Centre, State and medical experts. The functions of the council would be to frame regulatory policies influencing education and allied practices. They will also maintain a central register with up to date information of all allied healthcare professionals. It will also organise and monitor a uniform common entrance and exit examinations. This bill can be an important step towards not only an efficient functioning of the healthcare system, but also a motivation for aspiring medical students by incentivising them to look at these various allied professions — such as physiotherapy, lab technologist, a mental health professional, etc and build a satisfying career in the same.

The health sector of a country does not suffice just on doctors, but is a collaborative effort of doctors and allied healthcare professionals. If the United Nations predicts a shortage of 18 million healthcare workforce by 2030, perhaps with this bill, India can help invest in the health workforce.

9. Systematic studies and pilots of success stories of healthcare industries that have successfully engaged persons with disabilities in professional allied healthcare job roles and individuals with disabilities who have been absorbed in the industry: Many healthcare providers have the attitude mindset that PwDs can only be useful in narrow job roles (backend, frontend, hospitality jobs) in the healthcare sector. Patient care services are typically understood to be efficiently done by their male-bodied counterparts. PwDs are often only assessed based on their disabilities but not the skillset and aptitude that they come with. Having proof-of concept success stories can go a long way in helping the stakeholders understand that they too can become an equal-opportunity employer.





Swati Kalra
Eye Donation Counsellor

One such success story comes from Swati Kalra.

"It feels wonderful to work here now, because at one point in time I used to come here as a patient" chuckled Swati.

Swati is an eye donation counsellor, also known as a grief counsellor currently working with Dr. Shroff's Charity Eye Hospital. As a grief counsellor, Swati becomes the liaison between the eye bank and the donor family. She helps in generating awareness about eye donation, motivates the donor family and on agreement takes their consent for the donation.

After completing her under-graduation with distinction, Swati had to discontinue her studies after a retinal detachment surgery. As she now sits in her office, walking us through her work space, Swati shares her experiences as a person with a visual impairment finding her way around the job market in India. "We say we live in a liberalised economy and yet our thought process is so backward. We are not ready for acceptance or inclusivity" says Swati. She currently works at the Eye Bank Department of Dr Shroff's, as a part of a 12 member team. Swati also has a long-standing association with Silver Linings, an organisation that works towards inclusive education for blind children. Swati has been a part of Silver Linings family since the inception of the organisation. Having found a mentor and a guide in Ms Preeti Monga, who is the Founder and CEO of the organisation has also contributed to her wholesome development.

"I've worked with Ms Preeti for two years and now I complete three years at Dr Shroff's. My association with this place has been very positive because the people who make my work environment are so accepting and courteous", she says. However the journey has not been a smooth one for her. She lost her vision in the right eye when she was born due to medical complications at birth. However, this did not stop her unstoppable yearning to learn and succeed in life. While she can read fonts big in size and can function without any assistive gear, she uses her magnifier to read fine print. She not only works out of the office, but also travels when there is field work.

Prior to working at Dr Shroff's, Swati explored different options in the healthcare sector and other sectors as well. The challenge lay while exploring job opportunities in the private sector. "It's easier to get through government jobs because they have reservations, but government jobs may not be everyone's choice. It's disheartening to be left with limited opportunities." Swati recollects her interview process at one of the leading healthcare sector chains where her disability became the deciding factor for whether to take her on board or not. "The healthcare sector is not very open to employing people with disabilities. They will not say no to you directly, but will give reasons which often sound unconvincing." From her experience, even though her skill set and qualifications were compatible with the job requirements and her disability was not a deterrent to working efficiently, the opportunity still fell through. "This becomes very demotivating because we have invested in ourselves by studying and achieving a good skill set but our evaluation does not go beyond our disability. The private sector needs to become more proactive about inclusivity", she exclaims.

Ms Preeti Monga says, "Swati has been fortunate to have had an upbringing in an environment with a strong family foundation and great educators. She also had an excellent opportunity to study in a mainstream school since childhood and being exposed to a set of people who helped her and her parents to receive all the quality inputs, including a wholesome education. This has empowered her to reach a place of quality and high standards. I feel that every child should be given this right to have an equal platform for them to succeed. If this is taken care of then there should not be any constraint towards generating employment as individuals will be job ready with the required skills and qualifications." Grief counsellors form a cohort within the umbrella of mental health support workers, which is a recognised allied healthcare profession (refer to annexure 1).

While the road to success has been a bumpy one for Swati, she is still proving the society wrong about people with disabilities being any different from their peers. They just execute their tasks differently, but the results always lie in the efforts and perseverance. Dr Shroff's Charity Eye Hospital, being one of the leading eye and ENT care hospitals in India, has captured what it is to have a workforce that is equitable and inclusive. With the support of Dr Shroff's, Swati too sets an example for her peers and continues to prove that you don't need a perfect sight to have a vision in life.

*Grief counsellors form a cohort within the umbrella of mental health support workers, which is a recognised allied healthcare profession (refer to annexure 1).



Annexure 1

An indicative list of Allied and Healthcare Professionals

- 1. Advance Care Paramedic
- 2. Anaesthesia Assistants and Technologist
- 3. Anatomy (Non-clinical)
- 4. Assistant Behaviour Analyst
- 5. Behaviour Analyst
- 6. Biochemistry
- 7. Biomedical Engineer
- 8. Biotechnologist
- 9. Burn Care Technologist
- 10. Cardiovascular Technologist
- 11. Cell Geneticist
- 12. Clinical Coder
- 13. Clinical Social Worker (other than Counsellors)
- 14. Critical Care or Intensive Care Unit (ICU) Technologist
- 15. Cytogenetics
- 16. Cytotechnologist
- 17. Diagnostic Medical Radiographer
- 18. Diagnostic Medical Sonographer
- 19. Dialysis Therapy Technologist
- 20. Dietician including Clinical Dietician, Food Service Dietician
- 21. Ecologist
- 22. Electrocardiogram (ECG) Technologist or Echocardiogram (ECHO) Technologist
- 23. Electroencephalogram (EEG) or Electroneurodiagnostic (END) or Electromyography (EMG) Technologist or Neuro Lab Technologist
- 24. Emergency Medical Technologist (Paramedic) or Emergency Medical Technician Basic
- 25. Endoscopy and Laparoscopy Technologist
- 26. Environment Protection Officer
- 27. Forensic Science Technologist
- 28. Health Educator including Disease Counsellors, Diabetes Educators, Lactation Consultants
- Health Information Management Assistant, Medical Secretary,
 Transcription (Including Medical Record Technician or Medical Records Analyst)
- 30. Health Information Management Technologist
- 31. Hemato-technologist
- 32. Histo-technologist
- 33. Human Immunodeficiency Virus (HIV) Counsellors or Family Planning Counsellors
- 34. Integrated Behavioural Health Counsellors
- 35. Medical Equipment Technologist
- 36. Medical Laboratory Technologist
- 37. Mental Health Support Workers
- 38. Microbiologist (non-clinical)
- 39. Molecular Biologist (non-clinical)
- 40. Molecular Geneticist
- Movement Therapist including Art, Dance and Movement Therapist or Recreational Therapist
- 42. Nuclear Medicine Technologist
- 43. Nutritionist including Public Health Nutritionist, Sports Nutritionist
- 44. Occupational Health and Safety Officer
- 45. Occupational Therapist

- 46. Operation Theatre (OT) Technologist
- 47. Ophthalmic Assistant
- 48. Optometrist
- 49. Perfusionist50. Physician Associate and Assistant
- 51. Physiology (Non-clinical)
- 52. Physiotherapist including Geriatric Physical Therapist, Orthopaedic Physical Therapist, Pediatric Physical Therapist
- 53. Podiatrist
- 54. Psychology (Non-Clinical)
- Radiology and Imaging Technologist or Assistants (Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Mamographer)
- 56. Radiotherapy Technologist
- 57. Respiratory Technologist
- 58. Sleep Lab Technologist
- 59. Other

Annexure 2

Below is the official list of 21 disabilities as identified by the Government of India under The Rights of Persons with Disabilities Bill - 2016¹. These disabilities will be recognised within the scope of the study conducted by Tech Mahindra Foundation which aims to understand the status of participation of women and persons with disabilities engaged in allied healthcare professions in India. The 21 disabilities are given below:

- 1. Blindness
- 2. Low-vision
- 3. Leprosy Cured persons
- 4. Hearing Impairment (deaf and hard of hearing)
- 5. Locomotor Disability
- 6. Dwarfism
- 7. Intellectual Disability
- 8. Mental Illness
- 9. Autism Spectrum Disorder
- 10. Cerebral Palsy
- 11. Muscular Dystrophy
- 12. Chronic Neurological conditions
- 13. Specific Learning Disabilities
- 14. Multiple Sclerosis
- 15. Speech and Language disability
- 16. Thalassemia
- 17. Hemophilia
- 18. Sickle Cell disease
- 19. Multiple Disabilities including deaf-blindness
- 20. Acid Attack victim
- 21. Parkinson's disease

The official list of allied healthcare professions as recognised by the Ministry of Health and Family Welfare.

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Tech Mahindra Foundation commits itself to a vision of a more equitable and inclusive India, and the values of good corporate governance, ethical practices, and dignity of the individuals. In order to achieve sustainable transformation, it supports and creates opportunities that nurture talent and enable the socially disadvantaged to utilize their potential. Founded in 2007, it operates across eleven locations in India and has established itself as a prominent CSR player within the Mahindra Group as well as a leading social organisation at the national level.

The Foundation is committed to the idea of empowering, nurturing and expanding the employability and learning opportunities for the youth, with special focus on women and persons with disabilities. The vision is envisaged and steered forward by Tech Mahindra Foundation's flagship employability program - SMART (Skills for Market Training). The program provides a platform for the youth, with special focus on women to hone their employability skills in the different sectors of the economy - including the healthcare sector. The Foundation also works towards empowering Persons with Disabilities and invests in their skill development through its SMART+ (Skills-for Market Training for Persons with Disabilities) program. SMART + aims at training persons with disabilities in different skillsets that can help them become job ready and proactive in the job market. The Foundation continues to build a cadre of young professionals and has a mandate to have 50% of its beneficiaries as women and 10% as persons with disabilities. Tech Mahindra Foundation runs more than 100 centres providing skill development in 11 cities. In addition, 7 Tech Mahindra SMART Academies for Healthcare, Logistics and Digital Technologies. Over the years, SMART has successfully trained 85,000 + young men and women, with a placement rate of over 75%. Its robust processes, stringent monitoring system and industry-led approach has created a model for scaling up skill development while maintaining high training standards.

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