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BREAKING BARRIERS

WOMEN'S EMPLOYMENT IN HEALTH IN THE EASTERN MEDITERRANEAN REGION

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EXECUTIVE SUMMARY

Women are the face of the global health workforce, constituting an average of 67 percent of those employed in the health and social care sector globally.[1] However, this global average often conceals significant regional and national differences, particularly in terms of labor force participation, employment and gender equality.

The World Health Organization (WHO) Eastern Mediterranean Region (EMR) is a region where, on average, men form the majority of those with paid employment in the health and care sector.[2] These regional and national differences in women's participation in labor markets, especially in the health sector, indicate a need for context-specific policies explicitly linked to women's economic empowerment. This policy paper aims to examine women's employment in health in the EMR to expand the evidence base and understand the factors influencing women's representation in the health workforce. Section 1 provides an overview of women's participation in the health workforce.

Limited evidence exists on the drivers of women's employment in health in the Eastern Mediterranean Region. Section 2 examines what drives and the factors that constrain women's participation. The report analyzes data through a gender lens to explore the relationship between overall female labor force participation and employment in health. It also investigates differentials in working conditions, such as pay for women and men in the health and care sectors.

Three detailed case studies examine how political, cultural and social norms influence women's engagement in the health labor market. This combined evidence identifies policy opportunities to enhance women's participation and economic empowerment across the sector.

The report underscores significant regional variations in women's participation in the health workforce. Section 3 concludes with lessons learned and the policy implications. Despite challenges, the report concludes that employment in health in the Eastern Mediterranean remains appealing for women, even in countries with low overall female labor force participation. Targeted actions can catalyze women's empowerment in these contexts.

Key policy actions for the Eastern Mediterranean Region

1. Collect gender-disaggregated data and conduct intersectional gender analyses of the health labor market.
2. Implement gender-responsive health workforce policies specific to the national context.
3. Improve working conditions for all forms of health work, especially for highly feminized occupations.
4. Engage in collaborative and multisectoral solutions to increase women's participation and representation in the health workforce.

INTRODUCTION

The health and social sector* is a large and rapidly growing economic area. Women make up 67 percent of those in paid employment in the health and care sector.[3,4] However, variations exist across countries and regions due to social and cultural norms that shape acceptable roles, available opportunities and, ultimately, choices and behaviors.

While data show that the global health and care workforce predominantly consists of women, there are examples of regions and countries where men represent a greater share of the workforce. This includes WHO EMR which includes 22 countries and territories, diverse in their demographic and sociopolitical contexts, income levels, health system maturity and norms and cultures. On average, men make up the majority of those in paid employment across the health and care sector in EMR. In 2020, men accounted for 57 percent of all workers employed in the health and care sector in Eastern Mediterranean countries, with; 55 percent in low- and middle-income and 58 percent in high-income roles within the region.[5]

In 2020, men accounted for 57 percent of all workers employed in the health and care sector in Eastern Mediterranean countries.

The lack of comprehensive health workforce data, particularly disaggregated by gender, presents a significant challenge for many countries in the EMR to obtain an accurate and up-to-date understanding of women's participation in the health workforce. However, some available literature offers valuable insights into the current situation. A study in Saudi Arabia showed low representation of women in various health professions, with only 37 percent of pharmacists, 36 percent of dentists, 36 percent of physicians, 24 percent of allied health personnel, and 62 percent of nurses being women.[6] In Yemen, women make up about 22 percent of the health workforce, mostly in nursing and midwifery roles. However, they are scarcely represented in senior medical and administrative positions, with less than 10 percent of leadership roles held by women.[7,8] In Afghanistan, women's participation in the labor force remains extremely low at an estimated 5 percent in 2023. Women accounted for 29 percent of nurses, 48 percent of community health workers, and 24 percent of doctors that year.[9] Overall, there is a a paucity of information on women's involvement in paid health roles in the region. This highlights the need to examine factors influencing their participation, which is something explored in this report.

Countries with high female participation in the labor force and in the health workforce offer women the chance for economic empowerment through policies such as those addressing pay gaps and working conditions. Conversely, in the EMR, where women's labor force participation is relatively low, health employment plays a vital role in attracting women to paid employment and increasing female

* While the report focuses on health employment, data is derived from various global reports and sources, many of which do not differentiate between employment in the health versus social care sectors. The report therefore refers to the 'health and care sector' as well as the 'health sector', depending on the data.

labor force participation rates. Recognizing this context is essential for developing gender-responsive policies. This policy paper examines women's employment in health in the EMR and identifies factors influencing their participation in paid health employment. It uses several data sources, including primary data, alongside national reports, gender-disaggregated labor force statistics from the health and care sector, WHO's National Health Workforce Accounts, Ministry of Health reports, and case studies from Afghanistan, Pakistan and Qatar.

SECTION 1. OVERVIEW OF WOMEN'S PARTICIPATION AND EMPLOYMENT IN THE HEALTH LABOR MARKET

This policy paper presents and analyzes data adopting an intersectional gender lens, guided by WHO's recommended approach for gender analysis of the health labor market.[10] This section focuses on the questions of 'who has what?' (access to education and training) and 'who does what?' (participation in the health labor market).

ACCESS TO EDUCATION AND TRAINING

Women's education and training in health in the EMR varies across countries, reflecting progress as well as challenges. Many countries have seen an increase in women's participation in education for the health professions, despite social and political obstacles.

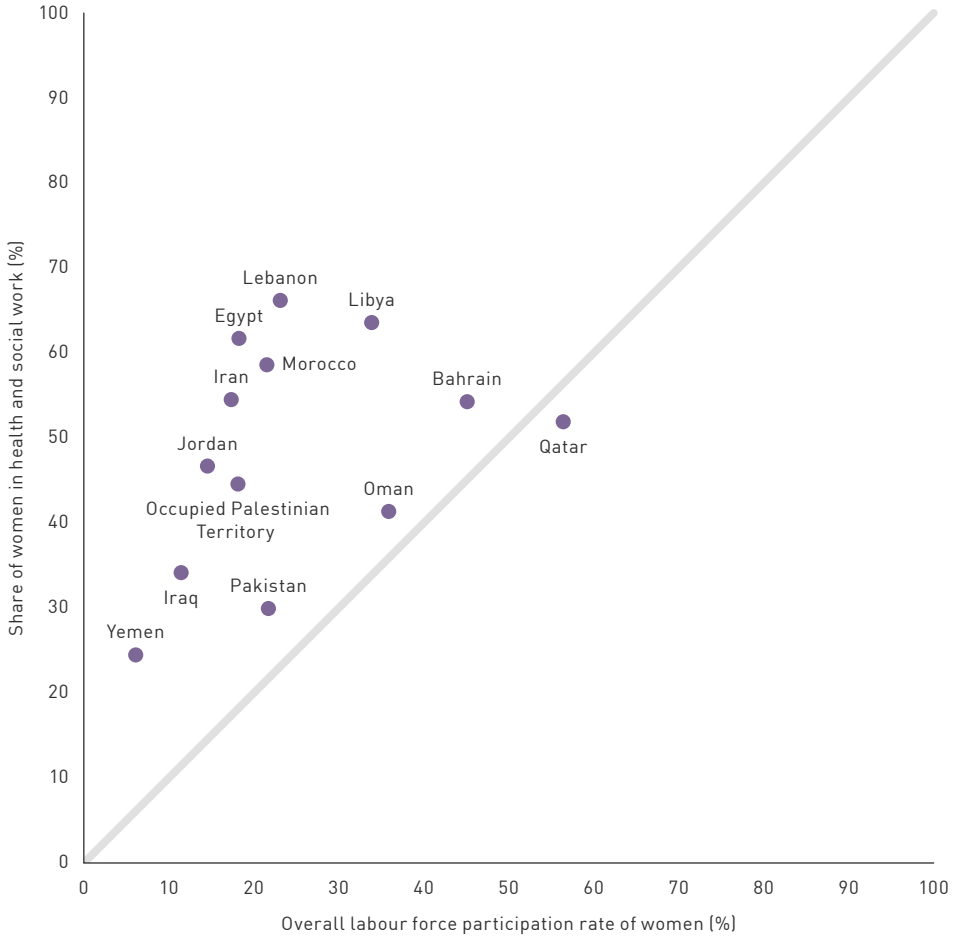
Many countries in the EMR have seen an increase in women's participation in education for the health professions.

For example, Jordan saw women comprising 70 percent of all healthcare graduates in 2022, with strong representation in nursing (71 percent), midwifery (98 percent) and pharmacy (77 percent).[11] Pakistan also saw a rise in women enrolling in medical colleges between 2010 and 2020, to numbers that outnumbered student that were men.[12] In addition, gender parity among faculty in medical colleges improved in Pakistan over the past decade. Afghanistan presents a contrasting scenario where sociopolitical restrictions have severely affected women's enrollment in education and training for the health professions (see Case studies 2 and 3).

PARTICIPATION IN THE HEALTH LABOR MARKET

In terms of access to employment, the relatively low proportion of women employed in the health and care sector in the EMR reflects women's overall lower labor force participation. The following figure shows that women's participation in the health and care sector is generally higher than their overall participation rate in labor markets. This is a signal that health and care is an important employment sector for women across the region.

Women's participation in the health and care sector in EMR in relation to their overall participation rate in the labor market, 2020



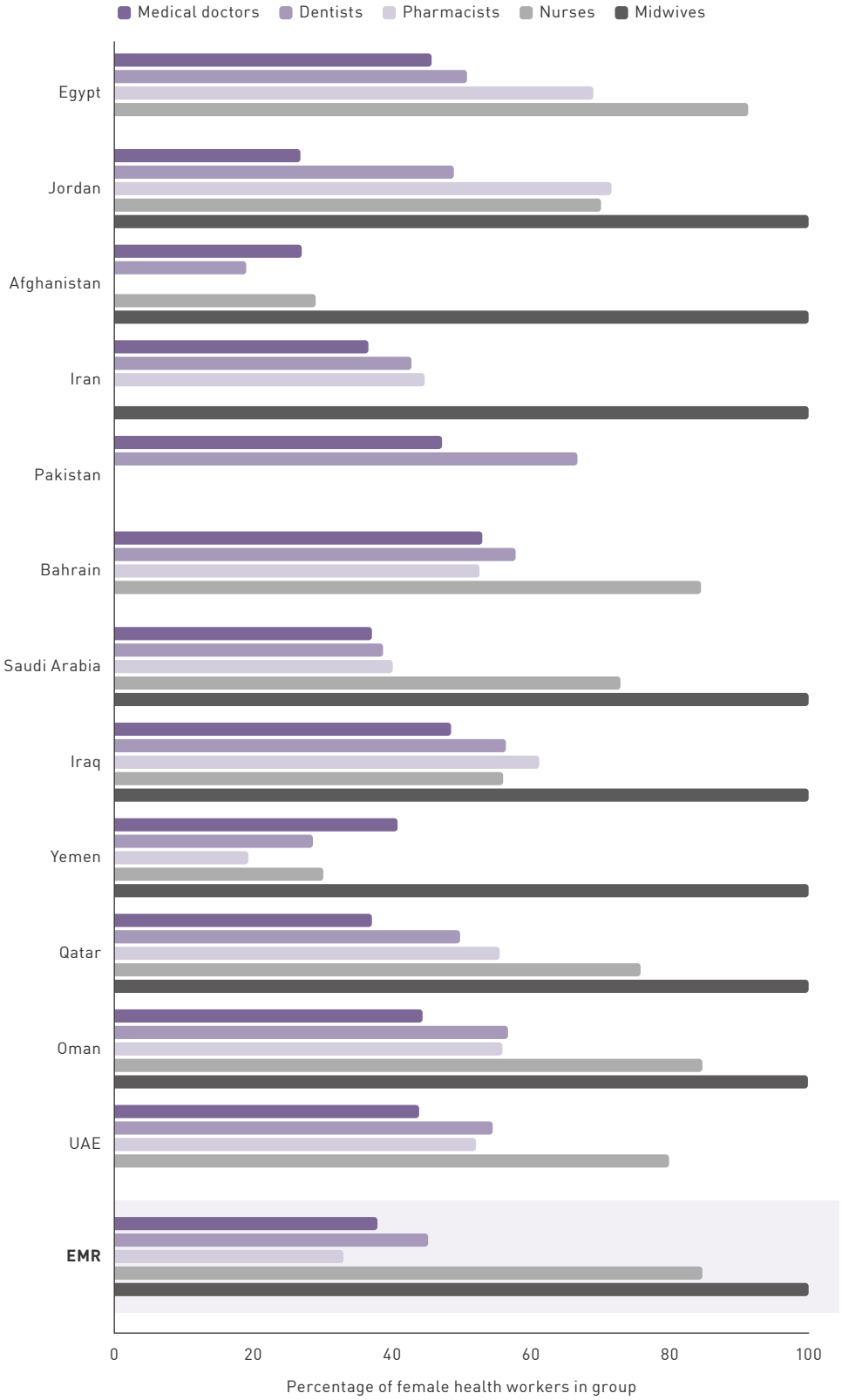
Source: Adapted from WHO and ILO (2022)[13]

Certain occupations – such as midwifery and nursing – have a high representation of women, while others – such as medicine and pharmacy – show important disparities among EMR countries.

In 2023, only 27 percent of doctors and 29 percent of nurses were women in Afghanistan, this is well below the EMR average of 38 percent and 85 percent, respectively.

In 2023, data reveal that Afghanistan had the lowest representation of women in the health workforce in the EMR, with only 27 percent of doctors and 29 percent of nurses being women, well below the EMR average of 38 percent and 85 percent, respectively.[14] Yemen also exhibits a low representation of women in the health workforce, with women representing 19 percent of pharmacists and 30 percent of nurses[15] (see figure on the following page).

Women's representation in the health workforce across the EMR

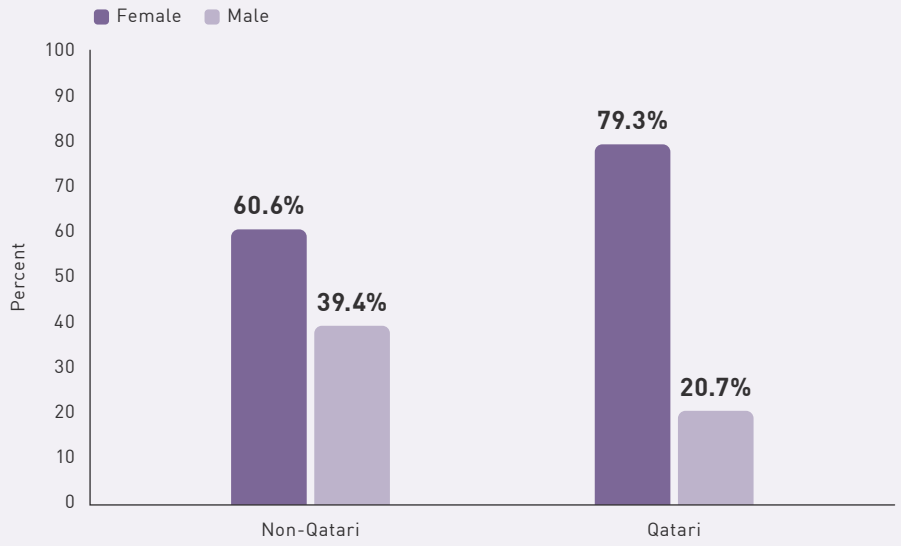


Sources: WHO (2022);[16] WHO (2024);[17] Ministry of National Health Services, Regulation and Coordination (2024);[18] Iraq Ministry of Health (2020);[19] Jordan Ministry of Health (2023);[20] Saudi Arabia Ministry of Health (2022);[21] Sultanate of Oman Ministry of Health (2022);[22] United Arab Emirates (2022);[23] Yemen Ministry of Health and Population (2021);[24] Planning and Statistics Authority (2022).[25]

CASE STUDY 1. MIGRANT WORKERS' AND WOMEN'S PARTICIPATION IN THE HEALTH LABOR MARKET IN QATAR

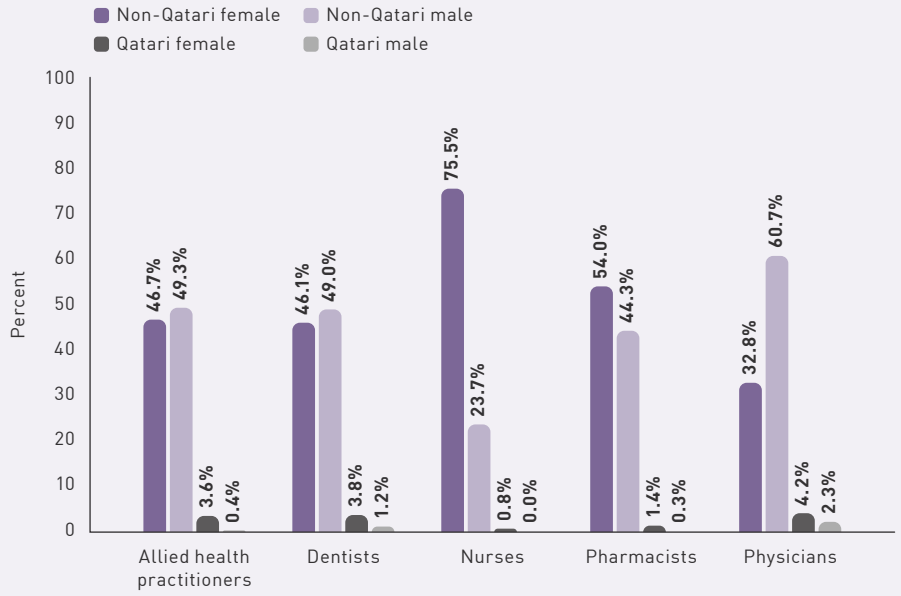
The health and care sector is the largest employer of women in Qatar.[26] Data indicate that the total number of registered health workers in Qatar is 52,979, and 61 percent are women.[27] In Qatar, women are highly represented in nursing roles (76 percent) but less well represented as medical doctors (37 percent). More women work as pharmacists and in allied health professions compared to men. However, it is important to note that migrant workers are a major force in Qatar's labor, and studies suggest that migrant workers constitute 95 percent of the total Qatari workforce. Of the 300,000 migrant workers engaged in domestic labor, most are women.[28] The figure below suggests that, while women form the majority of the national and non-national health workforce, women are more highly represented in the pool of Qatari national health workers.[29]

Registered health workers in Qatar by gender and nationality



The following figure shows that most nurses in Qatar are non-Qatari, and the vast majority are non-Qatari women. In contrast, dentists and allied health professions exhibit a more balanced gender distribution, with a notable presence of non-Qatari men. Across all occupations presented in the figure on the following page, Qatari women have a larger representation in the workforce compared to Qatari men. However, Qatari nationals are still underrepresented compared to the non-Qatari in the health workforce, indicating a high reliance on expatriate health and care workers. This segregation based on gender and nationality is influenced by broader socioeconomic and cultural factors, with Qatari women more likely to work in administrative or supervisory roles due to higher education and socioeconomic status.[30]

Registered health workers in Qatar by sex, nationality and occupation

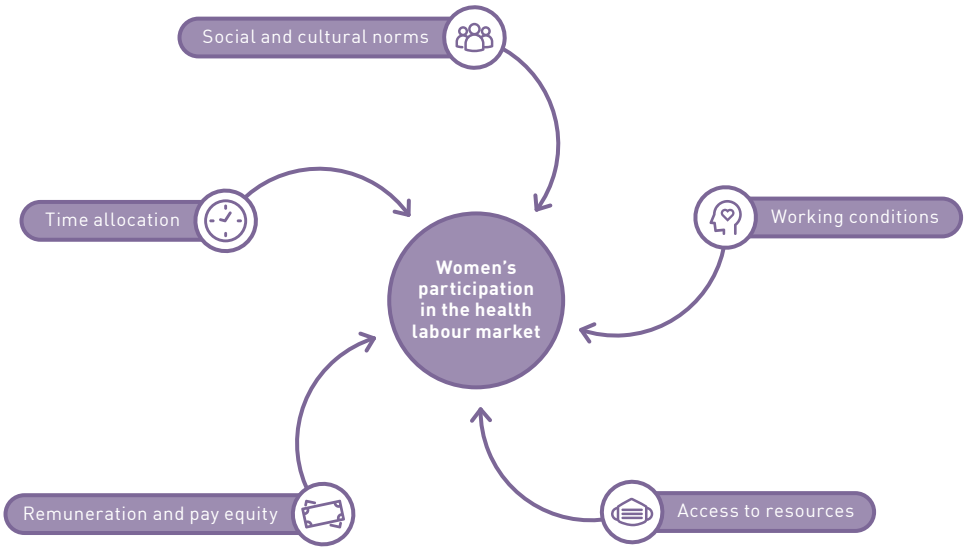


This case study highlights the importance of an intersectional approach, demonstrating how gender, nationality, and occupation intersect to shape distinct experiences for health workers in Qatar.

Flexible working arrangements can be a significant factor for promoting women's employment. Unlike many countries where part-time employment is much more common, especially for women, data show that there are almost no part-time workers in Egypt and Jordan in the health and care sector.[31] This absence of part-time work may be hindering women's ability to participate in the labor force, as they often carry more unpaid care responsibilities than men globally.[32–34] There is also a noticeable difference in the distribution of public and private sector employment between women and men in Egypt and Jordan, with women more likely to work in the private sector.[35] Working conditions often vary between the public and private sectors, and therefore men and women who are participating at different rates in the public and private sectors may be experiencing different working conditions.

SECTION 2. INFLUENCES ON WOMEN'S PARTICIPATION IN THE HEALTH LABOR MARKET

There is limited evidence on what drives and constrains women's participation in the health workforce in the EMR. This section is guided by the gender analysis approach recommended in WHO's *Health Labour Market Analysis Guidebook*.[36] This section adapts this approach to analyze gender power relations within the categories of 'who has what?' (access to education and training; renumeration and equal pay); 'who does what?' (the division of labor, roles and working conditions; time (allocated to different activities, such as unpaid care; and balancing career with family responsibilities); and how values are defined (social and cultural norms) (see figure below) to examine the factors influencing women's participation in the health labor market. Case studies from Afghanistan and Pakistan are also presented to explore these dynamics further.



ACCESS TO EDUCATION AND TRAINING

In certain EMR countries, such as Afghanistan and Yemen, women face barriers to accessing education and training for health occupations.[37] Early marriage, societal expectations and economic constraints can further limit women's educational opportunities, reducing their qualifications for health employment.

Education and training in health professions can empower women economically. Initiatives such as scholarships, mentorship programs and vocational training are essential to increase women's participation in the paid health workforce.[38] Studies in Lebanon show that women's career progress is influenced by a complex mix

of societal and organizational factors. Despite facing a range of obstacles, studies suggest that women nevertheless leveraged persistence, education and personal traits to advance in management roles.[39]

Mentorship and guidance from visible role models can encourage and motivate women in health.[40] Gender disparity, particularly in leadership positions, reflects the challenges in career progression and the lack of leadership opportunities for women, as indicated in one study from Pakistan.[41] Creating more inclusive and supportive work environments, along with implementing leadership development programs tailored for women, and facilitating networking opportunities with mentors and peers, can play an important role in work satisfaction and motivation. In Saudi Arabia, a study on job satisfaction among women health workers highlighted teamwork, positivity and equitable professional development opportunities as key factors in job satisfaction. Collaborative teamwork, where women work on an equal footing with men, was a key motivator for women's empowerment.[42]

WORKING CONDITIONS

Discriminatory practices, such as gender bias in hiring, promotions and salary decisions,[43] have a significant impact on women's career progression and job satisfaction. Studies show that limited access to leadership positions and opportunities for professional development, and disparities in pay contribute to work discrimination.[44–46] In Saudi Arabia, 52 percent of women trainee physicians experienced gender discrimination, leading to severe outcomes such as depression and thoughts of suicide.[47] Only about 16 percent of Saudi women physicians are satisfied with their work-life balance.[48] Women in healthcare often face harassment and safety concerns. Verbal and moral abuse were the most prevalent type of harassment reported in studies from Morocco, Pakistan, Iran and Saudi Arabia,[49–53] with sexual harassment – particularly toward young unmarried women health workers – causing high levels of depression, anxiety and stress.[54, 55]

Limited maternity leave and childcare support, along with demanding working conditions, create significant barriers in the health sector. Balancing work and family responsibilities is challenging, leading to higher attrition rates.[56] The lack of family-friendly policies means that women often need to choose between their careers and their families. In Egypt, studies have highlighted difficulties in balancing career and family responsibilities such as child-rearing and housekeeping.[57]

Supportive policies and gender-responsive measures, such as equal pay, anti-discrimination laws and maternity leave, are essential in creating a more inclusive working environment.[58] Government initiatives promoting gender equality could encourage more women to enter and remain in the health workforce. Offering flexible work arrangements such as part-time work, telecommuting and job-sharing can help women balance work and family, reduce attrition rates, and keep more women in the health workforce.[59] Allowing working mothers and caregivers to work to flexible schedules could also enhance retention and job satisfaction. Establishing a safe workplace for women in health is important for retention. Anti-harassment policies, support systems and safety measures can address the challenges that women encounter in the workplace.[60] Health organizations must have protocols for reporting and addressing harassment, as well as resources such as counseling and legal support.

REMUNERATION AND EQUAL PAY

Another important factor for increased labor force participation is potential earnings. Gender pay gaps can hinder women's entry into the workforce and affect their bargaining power within the household. Pay gaps can also serve as a key indicator of broader gender equality in the workplace. A 2022 report by the International Labour Organization (ILO) and WHO examined gender pay gaps in the health and care sector, revealing significant variations between countries. Those countries that have implemented proactive measures to address the problem generally have lower gender pay gaps.

Women are under-represented in the highest-paid roles in the health workforce.

Jordanian labor law prohibits gender-based wage discrimination in the workplace. Despite some challenges with oversight on implementing the law, the health and care sector in Jordan has lower pay gaps compared to the global average, with hourly pay differentials between men and women below 10 percent.[61,62] In Qatar, data show a gender pay gap of 10 percent in 2021.[63] Gender pay gaps have also been documented in Saudi Arabia.[64] Despite women making up a large portion of the health workforce, they are under-represented in the highest-paid roles.[65] Efforts to address these inequalities, including tackling cultural barriers, are essential for promoting an equitable workforce and increasing women's participation in the EMR.[66,67]

TIME ALLOCATION: BALANCING CAREER AND DOMESTIC RESPONSIBILITIES

The challenges that women health workers face are different from those faced by men. Also, women are often juggling unpaid caregiving roles with their paid employment. This can lead to career adjustments such as breaks, or part-time work,[68,69] or parental leave impacting their advancement opportunities. Women are less likely to return to full-time work after part-time roles,[70] facing biases that impact their career pathways, such as limited promotions and training opportunities.[71,72] This limits professional growth outside of the home.[73] Due to such norms, families may discourage women from pursuing their educational and career aspirations, further limiting their employment opportunities in the health labor market.

INFLUENCE OF SOCIAL AND CULTURAL NORMS

Cultural and developmental barriers significantly hinder women's career advancement in health. Societal norms and institutional challenges maintain gender inequalities, and so demand tailored solutions.[74] A study from Lebanon demonstrated how cultural values and gender roles in the EMR hinder women's progress. These norms create significant barriers within societal and organizational contexts, affecting women's professional growth.[75] Research on Lebanese organizations confirms the structural and attitudinal obstacles that women face in managerial roles.[76] Women health workers, including physicians and nurses, encounter workplace gender discrimination; they struggle with limited family-friendly policies and organizational support, including insufficient training opportunities; biased recruitment and promotion practices favoring candidates who were men, and faster career progression for men than women.[77–81]

CASE STUDY 2. EXAMINING HOW SOCIETAL NORMS INFLUENCE DECISIONS ABOUT ENTERING THE HEALTH LABOR MARKET IN PAKISTAN

Despite high enrollment of women in medical colleges – 70 percent, according to the Pakistan Medical and Dental Council – half of these graduates either do not practice, or they exit the labor market early.[82] Medicine is seen as a respectable profession, one that could potentially improve marriage prospects and serve as a safety net for women. However, the higher enrollment in medical education has not led to a corresponding increase in women practicing medicine.

Medical education in Pakistan's public sector is heavily subsidized by the government, costing about $3,600 compared to $18,000 in the private universities. In Pakistan, 35 percent of women doctors are not employed – particularly those trained in public institutions. This high inactivity rate has raised concerns over effective public investment, closing the health workforce shortage, and meeting health needs.[83]

The Labour Force Survey 2020–2021 shows that one in five women medical graduates chose to remain out of the labor force; 76 percent of them were married. Employment opportunities for women doctors vary by location, with rural areas offering fewer jobs and exhibiting a higher unemployment rate (31 percent in rural areas versus 9 percent in urban areas). Conversely, more women in urban areas are choosing not to work (21 percent in urban areas versus 17 percent in rural areas). Sociocultural factors such as traditional gender roles and stigma against working can be harmful to women doctors professionally and personally. Delays in recruitment, discrimination, biased interviews, and restrictive job placements further obstruct women's career advancement as doctors. Women also face workplace issues related to working conditions such as remuneration, workload, discrimination and harassment.[84,85]

Addressing these issues requires policies that support a work-life balance – such as flexible hours and childcare – to help married women maintain their medical careers. By overcoming societal barriers, Pakistan can better use its medical graduates, improving the health workforce and overall health services. The systemic barriers to women's equality in the workforce are extensive, surpassing cultural norms to manifest as significant disparities in opportunities within the job market. These disparities adversely affect the income and social standing of those marginalized or subordinated in the labor market, and also compromise the integrity of the sociopolitical system.

CASE STUDY 3. WOMEN'S LEGAL RIGHT TO WORK IN THE HEALTH SECTOR IN AFGHANISTAN

In Afghanistan, women's labor force participation remains extremely low at less than 5 percent in 2023.[86] Health is one of the few areas where women are legally allowed to work amid recent restrictions. In 2023, 29 percent of nurses, 48 percent of community health workers, and 24 percent of doctors were women. Women predominantly work in roles focused on women and children, for example making up 89 percent of nutrition counselors and 69 percent of obstetrician/gynecologist specialists in Afghanistan.[87] Cultural norms require that women patients are attended by women health workers. The lack of women represented in health occupations means that women could face challenges in accessing all forms of healthcare.

Recent restrictions on education for women and girls led to zero women's enrollments in key programs such as curative medicine in 2023. Midwifery was the only program that permitted women's enrollment in 2023.[88] Currently, nursing education for women in Afghanistan is restricted to the Institute of Health Sciences under the Ministry of Public Health. Ongoing restriction on girls' education beyond sixth grade raises serious concerns about the future of education in the health professions, and the overall health workforce pipeline. Policy measures are necessary to improve access to health education, training, and jobs for women, especially in rural areas.

WHO strategies advocate for increasing economic recognition of care work, and promoting pro-equality policies to improve women's financial positions, and foster a more inclusive global health environment.[89] Focused interventions in the EMR aim to boost women's participation in paid employment and address regional disparities, emphasizing women's potential to drive change and equality in the health workforce. Policymakers must address these inequalities to achieve a more balanced health service.

EMR countries have an opportunity to achieve a more effective and inclusive health workforce by addressing barriers and leveraging enablers so that the health workforce can act as a catalyst for gender equality.

SECTION 3. CONCLUSIONS, LESSONS LEARNED AND POLICY IMPLICATIONS

This policy paper demonstrates that, although women's participation in the health workforce in the EMR lags behind the global average, this is more a reflection on women's low labor force participation rates across the region than a sector-specific issue. The report shows that the health and care sector remains a comparatively attractive employment sector for women in the EMR. Policies to expand the supply of health services in countries with high unmet health needs could provide countries in the region with an opportunity to attract more women into the labor market.

There are many examples of effective policy action, under the responsibility of different government agencies, that can advance the agenda of women's empowerment and participation in the labor market.[90] As outlined above, despite men accounting for 57 percent of all workers employed in the health and care sector in Eastern Mediterranean countries, it remains a relatively attractive employment sector for women, especially in countries where overall labor force participation of women is low. The sector can, with targeted action, play a role in encouraging the empowerment of women and girls.

KEY POLICY ACTIONS FOR THE EMR

1. **Strengthen data collection and analysis:** In EMR countries, gender-disaggregated data on the health workforce should be collected, and intersectional gender analyses should be conducted. Strengthening the collection, availability, accessibility and use of gender-disaggregated health workforce data is important for public accountability mechanisms, gender-responsive monitoring and evaluation, and identifying evidence gaps.

2. **Implement gender-responsive health workforce policies specific to the national context:** Developing gender policies tailored to the specific national contexts of EMR countries requires leveraging evidence. In this report, barriers and enablers that can influence women's participation in health employment vary greatly from country to country. Therefore, policies aimed at promoting gender equality in the health workforce need to be tailored to the context. The workplace can be made more inclusive by ensuring gender equality, which attracts more women to the workforce, and also inspires them to stay and flourish there as well. It is imperative to take this approach to build a robust health system that maximizes its workforce's potential.

3. **Improve working conditions for all forms of health work, especially for highly feminized health occupations:** There is an urgent need to audit and improve working conditions in all forms of health work in countries in the EMR, particularly women's professions. Policies such as family leave, flexible working arrangements, strengthened labor rights, and enforced antidiscrimination laws are essential. The health sector must strengthen women's leadership and participation in decision-making, guarantee decent jobs for all, prevent violence and harassment, and provide mental health

support to health workers. By implementing these measures, a more equitable and supportive work environment can be created in the region to improve the quality and sustainability of health services.

4. **Foster collaborative and multisectoral solutions:** By collaborating with governments, non-governmental organizations and the private sector, a comprehensive support system for women's employment can be developed, with resources mobilized in EMR countries. To enhance resource allocation and policy implementation, education, finance, gender, and labor ministries (or equivalent) must participate in a multisectoral approach.

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The authors alone are responsible for the views expressed in this report, and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated. Any errors or omissions remain the responsibility of the authors.

ABBREVIATIONS

EMR	Eastern Mediterranean Region
WHO	World Health Organization
ILO	International Labor Organization

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