Women on the frontline: exploring the gendered experience for Pacific healthcare workers during the COVID-19 pandemic

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Summary

Background Women comprise 90% of patient-facing global healthcare workers (HCWs), yet remain underpaid, undervalued, and under-represented in leadership and decision-making positions, particularly across the Pacific region. The COVID-19 pandemic has exacerbated these health workplace inequalities. We sought to understand Pacific women HCWs experience from the COVID-19 frontline to contribute to policies aimed at addressing gendered gaps in regional health systems.

Methods Our interpretative phenomenological study used critical feminist and social theory, and a gendered health systems analytical framework. Data were collected using online focus groups and in-depth interviews with 36 Pacific regional participants between March 2020 and July 2021. Gender-specific content and women's voices were privileged for inductive analysis by Pacific and Australian women researchers with COVID-19 frontline lived experience.

Findings Pacific women HCWs have authority and responsibility resulting from their familial, biological, and cultural status, but are often subordinate to men. They were emancipatory leaders during COVID-19, and as HCWs demonstrated compassion, situational awareness, and concern for staff welfare. Pacific women HCWs also faced ethical challenges to prioritise family or work responsibilities, safely negotiate childbearing, and maintain economic security.

Interpretation Despite enhanced gendered power differentials during COVID-19, Pacific women HCWs used their symbolic capital to positively influence health system performance. Gender-transformative policies are urgently required to address disproportionate clinical and community care burdens and to protect and support the Pacific female health workforce.

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Introduction

Since March 2020, the COVID-19 pandemic has disrupted health, socio-economic, and political systems globally, and exacerbated known inequalities across gender, race, and disability in every resource context.[1] Sex and gender differences in direct health effects

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Research in context

Evidence before this study

Gendered inequality within health systems has been exacerbated by the COVID-19 pandemic, whereby women healthcare workers (HCWs) have disproportionally experienced occupational health and safety risks, increased mental ill-health, higher workloads, and reduced access to leadership and decision-making opportunities. Furthermore, women HCWs have faced a double burden both professionally and in the personal domain where they have shouldered most caregiving responsibilities for children, families, and communities.

We searched Medline (OVID and PubMed), Embase (OVID), Google Scholar, the Cochrane Library, WHO resources, Pacific and grey literature using search terms 'COVID-19/pandemic/surge events', 'emergency care', 'emergency medicine', 'gender', 'gender analysis', 'women healthcare workers', 'critical feminist methodology', 'women', 'Pacific Islands/region' and related terms. We found that Pacific regional healthcare systems also comprised a high majority female workforce, consistent with global patterns. During the COVID-19 pandemic, Pacific emergency care clinicians demonstrated leadership and resilience, strengthened by cultural relationships and innovation. COVID-19 created increased barriers for Pacific women's sexual and reproductive healthcare, but little is known about the specific gendered experience of women HCWs at the frontline of the pandemic response across the Pacific region. Momentum is increasing globally for improved health system policies that understand and address gendered inequity, particularly to sustain the feminised workforce.

Added value of this study

This is the first study to deeply explore Pacific women HCW's experience at the coalface of the COVID-19 response across the region. Although Pacific women HCWs faced similar ethical challenges in negotiating professional and personal caregiving responsibilities to their global female colleagues, we also found unique cultural strengths and threats. The COVID-19 pandemic reinforced power differentials between Pacific men and women HCWs, particularly enhancing occupational segregation in emotional labour, and lack of access to high-stakes decision-making. Our feminist and social theoretical approach enabled an understanding of how Pacific women can use their symbolic capital to positively influence health systems by demonstrating emancipatory leadership, situational awareness, and loving care.

Implications of all the available evidence

Effective gender-transformative health system policies are urgently required to protect and uphold the Pacific female workforce, who face disproportionate risks and responsibilities enhanced by the COVID-19 experience. Unique to the Pacific context, policies and practices that recognise Pacific women HCWs cultural strengths and symbolic capital will enable participatory leadership and enhance team performance. Elevating and sustaining Pacific women in decision-making, leadership, and advocacy roles will likely increase stakeholder trust in Pacific health systems and positively contribute to regional aspirations for Healthy Islands and Universal Health Coverage.

have been well researched,[2] but in broader measurements of well-being that include health access, socio-economic, and safety indicators, it is clear that women have been substantially more negatively impacted by the COVID-19 pandemic than men.[3] Women and girls have been more likely to lose employment, drop out of education, become a carer, or experience gender-based violence; effects that are also influenced by regional and cultural contexts.[3] Understanding how socio-cultural, environmental, political, and resource dynamics influence the sex and gendered impacts of COVID-19 can lead to nuanced and context-specific policies and practices that are more likely to successfully address gender disparities and inequity.[4]

Women healthcare workers (HCWs) comprise more than 70% of the global health workforce and 90% of health workers in patient facing roles.[5,6] Despite their critical role to uphold health systems, women HCWs remain underpaid, undervalued, and under-represented in leadership and decision-making positions.[7,8] The COVID-19 pandemic has exacerbated these inequalities, where women HCWs have been disadvantaged by ill-fitting personal protective equipment (PPE), increased care burdens, unsafe rostering, and mental health challenges.[9–12]

Women also comprise the majority of the health workforce across the Pacific region, again in lower paid and in less leadership positions.[13] Although we can assume they have faced similar gendered challenges and inequalities documented in other global health contexts, we know little about the specific experiences of Pacific women HCWs and emergency care (EC) stakeholders during COVID-19. Despite disparate geographies and populations, the 22 Pacific Island Countries and Territories (PICTs) that comprise the Pacific region share common historical, colonising, language, and socio-cultural experiences,[14] including the lowest level of women's political representation globally.[15] Connected by the Blue Pacific Continent, PICT peoples place high value on natural resource stewardship, community inclusion and consensus, cultural practice, and traditional knowledge.[16] Although most PICTs are low- and middle-income countries (LMICs) with significant health resource challenges, regional strengths characterised by strong relationships, past surge event experience, and adaptability[17]

may have influenced how Pacific HCWs have experienced the COVID-19 pandemic across all genders.

In this context, we aim to explore the gendered experience of the COVID-19 pandemic for frontline HCWs and EC stakeholders across the Pacific region, using a critical feminist theoretical framework.

Methods

Study design, setting, participants, and data collection

We conducted an interpretive phenomenological study, seeking to explore and understand the COVID-19 experience of participants from their lived experience using in-depth interviews supplemented by focus group discussions.[18,19] We understand the ubiquitous impact of gender as a social construct on all aspects of health systems,[20] but also that individuals experience sex and gender differences uniquely. Our hermeneutic phenomenological approach enables us to appreciate the '*lifeworld*' context of our participants, but also to incorporate our own understanding and gendered experience of COVID-19 into the interpretive process.[21]

This study is a subset of a larger prospective, qualitative research collaboration which has been described at length previously.[22,23] Data were collected from 116 consenting HCWs and other stakeholders from at least 15 different PICTs using online platforms between March 2020 and July 2021. All data were recorded, transcribed, and de-identified. Key informant interview and focus group discussion guides incorporated gender and feminist theoretical framing, which enabled us to code data for gender-specific content. For this study, we inductively analysed data from 36 participants: the complete transcripts of interviews with all seven women key informants (2 doctors, 4 nurses, 1 regional health program manager), transcripts of two focus group discussions (a total of 23 participants of both genders) and gender-specific content extracted from transcripts of interviews with six male key informants. PICTs represented through the seven women's in-depth interviews included Fiji, Kiribati, Palau, Papua New Guinea, Samoa, Solomon Islands and Tonga, while all recognised geographical Pacific regions (Melanesia, Micronesia, and Polynesia[24]) were represented in focus group discussions and the remaining key informant interviews.

Theoretical framing

We applied critical feminist theory to expose and resist conventional health system research approaches that maintain knowledge structures and practices rooted in patriarchal systems of power.[25] Our study adopted deliberate women-centred approaches reflecting the five suggested methodological considerations for critical feminist research: how/why questions are asked, attention to language, reflexivity, representation, and research for social transformation.[26] We believe a critical feminist approach is required when exploring issues of gender in healthcare systems, particularly in the Pacific region, where women's voices are underrepresented and health outcomes inequitable.[27]

Consistent with our critical feminist approach, we specifically privileged and elevated women's voices by focusing on women key informants. However, recognising that gendered experiences in health systems research are about differential power relations, gender-specific data from all participants were included for analysis. To assist with interpretation, we used the gender framework developed by Morgan et al.,[20] which focuses on power as a driver of inequity within health systems and uses four key questions to explore the attainment and use of power: *who has what, who does what, how values are defined*, and *who decides*. Examining gender as a power relation also enables an intersectional lens that may incorporate other social stratifiers such as education, class, ethnicity, race, age, sexuality, and geographical location, all of which may interact to influence how power and vulnerability is experienced by Pacific women HCWs.[20]

Finally, we use the theory and concept of 'capital' from French social philosopher Pierre Bourdieu to guide data interpretation. Bourdieu introduces symbolic capital to describe power derived from all forms of assets, beyond mere mercantile economics.[28] People accrue, transform, and exchange forms of capital that encompass cultural, social, political, educational, scientific, and other fields in which they operate. When analysing how gender influences and informs power relations within health systems, Bourdieu's concept of symbolic capital helps to reveal less obvious forms of women's power and can expose how women may exchange their accrued capital to attain influence. In Pacific contexts, the dynamic use of symbolic capital has been used to illuminate how women have accessed political power in masculinised fields.[29]

Data analysis, researcher characteristics and reflexivity

The principal researcher (GP) has been trained in qualitative research methods and led the interpretative, reflexive thematic analysis as outlined by Braun and Clarke,[30,31] assisted primarily by co-researcher MK, and in collaboration with women research team members. Data were open-coded, subsequently collated into subthemes, and finally analysed to identify key themes through an iterative, robust process of deep reading, thinking, and discussion. Results and interpretation were presented to the entire research team for feedback on clarity and veracity.

Our research team comprised clinicians and EC stakeholders from Australia and the Pacific region, prioritising women co-researchers for data interpretation. Principal co-authors (GP and MK) have their own lived experience of working as EC clinicians on the frontline, including through sex-specific and gendered events during the pandemic, ranging from pregnancy and childbirth,

through to menopause. Because many participants were known to the research team as regional colleagues, great care was taken with confidentiality and reflexive practice consistent with our hermeneutic phenomenological methods.

Ethics

Ethics approval was provided by The University of Sydney Human Research Ethics Committee (Reference 2020/480) and registered with Monash University Human Research Ethics Committee (Reference 28325). Research protocols for Phases 1 and 2A of the previous research project were also reviewed by the World Health Organization's AdHoc COVID-19 Research Ethics Review Committee (Protocol ID CERC.0077) and declared exempt. Reporting of study data adheres to Enhancing the Quality and Transparency of Health Research (EQUATOR)[32] and Standards for Reporting Qualitative Research (SRQR)[33] guidelines.

Role of the funding source

There was no specific funding for this study. Funders of the original research[22] had no role in study design, data collection, data analysis, interpretation, nor writing of the manuscript.

Results

We identified four core themes encapsulating the diverse experience of Pacific women HCWs at the frontline of the COVID-19 response:

1. Women's emancipatory leadership;
2. Women's bodies and responsibilities;
3. Women as workers; and
4. Women in Pacific culture.

Although presented independently, these themes intersect and complement each other through the fundamental identity of Pacific women, who hold authority, responsibility, and prowess by virtue of their cultural, biological, and familial status. These attributes inform women HCWs' leadership and shape how they work; bringing great strength but also tension as they individually and collectively negotiated ethical care obligations in the early phases of the COVID-19 pandemic. Women's testimonies and observations are elevated in this analysis rather than presented as if in opposition to male HCWs, who themselves may have both unique and shared pandemic frontline experiences. Each theme is explored and illuminated with participant quotes in the following subsections (using women's voices, unless otherwise specified). However, the thematic findings are to be read and contextualised in the patriarchal milieu that Pacific women navigate and work within, where even women of very high power and status endure gendered inequality and face discriminatory practices:

> "When I talk about women, and work, I feel a lot of pain, because we see it every day in our workplaces. I see it on TV, played out with our female parliamentarians, by their male counterparts, I just find it so disgusting. And that trickles right down. So if people up in leadership position face that, how much more a person towards the bottom of the ladder? How much more do they face, and they don't have a voice."
>
> [Key Informant (KI)9]

Theme 1: Women's emancipatory leadership

Participants observed women health clinicians in leadership positions demonstrating a strong, inclusive leadership style, which was also described by participating women leaders themselves. They empowered and united their colleagues to feel confident and work together in navigating the workplace unease and pressures ushered in by the COVID-19 pandemic:

> "I think for this pandemic, all of us females here are managing the situation. So I think with our director, also a female – we have a strong leader as a female – so it also helps us that we work together as a team and we [are] able to manage our situation here in [our country]"
>
> [Focus Group (FG)1, Participant (P)13]

> "For the good of your staff. And staff meaning from the doctors right down to the cleaners, they all come under you. And they have families whom you have to consider, so their safety is of paramount importance. Even the clerks too. So yeah, that's how I see it, you kind of take care of everybody who's working in your department, with regards to COVID-19…"
>
> [KI10]

By taking on leadership, women became role models for other female staff. Participants observed women leaders building the capacity of their colleagues by sharing information, exemplifying expertise, and engaging them in complex problem solving:

> "… She has all the other colleagues, other medical staff and the nurses, the doctors, the lab technicians, even the ambulance drivers, from the very menial staff to the top ranking ones, they all get together, they plan and they try and develop and implement the results that she has found out."
>
> [FG2,P16]

As adept communicators in the healthcare field, women HCWs allayed fears and enabled their co-workers to feel positive and efficacious, thereby demonstrating a distributive and emancipatory style of leadership:

> "…myself, in my chief operation, as much as you want to also take time off you kind of really have to be

there for everybody else ... you have to do a lot of mental distressing, and talking to people."

[KI11]

"So I try during the times that we're on shift, and we have some free time, I try to talk to them, to brief them. And even run through a scenario or two, just to, you know, just to get them to open up... You talk to them until they feel so good, and so confident, that they could probably do this and that. And then when they see their colleagues perform and do well, they want to be a part of that as well."

[KI12]

Talking skills became a form of altruistic and powerful advocacy from mature women leaders, who demonstrated courage, audacity, and perseverance to ensure their staff were protected and patient care was maintained:

"So, you just have to talk and talk. If one door is shut there's some other option you can go to, you cannot just say 'Okay, just leave it like that', no. You have to just keep on talking, talking, talking until you find a way around to get what you want, for the good of everybody.... I had to approach the Director of Medical Services who is a male, even the CEO himself, I had to [go] all the way to them. It's just how you talk and how you frame your words properly and give it to them. You must be somebody who can really convince them to get what you want, yes. So yeah, that's the game I played. [Laughs]"

[KI10]

"I argue with the doctors on a regular basis 'cause I'm fighting for my nurses"

[KI11]

Formidable female leadership in the workplace derived from some women's authority status within families and the community. This style and recognition of leadership intersects with Pacific women's cultural strengths (Theme 4), and was particularly effective at the height of COVID-19 pandemic preparations:

"A lot of our work as well is affected by how we work in our families, there's like this invisible hierarchy of importance. Some people come with their crowns from home, so. It's recognised in the workplace, and people really use it. I like it when they use it for the good things in the emergency department."

[KI12]

For younger women attempting to assert their expertise and step into leadership roles within strongly patriarchal contexts, persistence and endurance were critical to overcoming seemingly hostile barriers and garnering respect:

"So in [my town], where I practice, it is a very male-dominant society and I am not from there, and I'm a woman, and I'm a young consultant. So I think one of the challenges for me as a woman was getting people to sit up and listen. And it really just got to a point where they didn't really have a choice because all the senior management was in quarantine or in isolation so there was no leadership on the ground, and there were only [X] consultants on the ground and I was one of them. So people didn't really have a choice but to listen. But it was really difficult, just pushing and pushing until something had to give."

[FG1,P1]

This consistent demonstration of female professionalism, reliable presence, and courage was supported and validated by the presence of other women colleagues, and access to trustworthy and reputable resources:

"I didn't find that too much of a challenge because we reported to the emergency operation centre, and we were familiar with the people in [there] and there's a lot of females as well in the emergency operation centre... If I disagreed with something I was able to say it. And what also helped was because I was able to get evidence from the ACEM group and also from the network of emergency physicians, I was able to ask them what they thought as well, to ensure that whatever I said in the meeting had some background basis and it wasn't just my opinion."

[KI5]

Theme 2: Women's bodies and responsibilities

Pacific women's bodies—their fertility, their nutritional source (breastmilk), their physical size and capabilities—were inextricably entwined with women's personal and professional experience as HCWs at the COVID-19 frontline. Commonly, male staff were simply referred to as men or doctors (and infrequently but notably 'male nurses'). Women at work, by contrast, frequently became 'mothers', 'breastfeeding mothers', or 'expecting mothers'. Although we can assume that male staff were equally likely to be 'fathers', this parental role was never used as a critical identity signifier for men in the workplace:

"Gender inequality. So we've got – one, two, three, four – I think four or five boys, five male nurses, and then the rest are female. And most of them are mothers."

[KI13]

Women's fertility exposed and restricted them in the workplace. Breastfeeding female staff with newborns were fearful of COVID-19 exposure. Women's fecundity

became public knowledge, and ensured decisions were made about them and on their behalf. Such decisions were often made with good intentions to 'protect' pregnant women, but simultaneously denied them autonomy.

> "...like for the pregnant staff, we made it clear that if any staff did find out they were pregnant they need to let us know early, so that appropriate protection would be given to them... when the outbreak started we have a few of our staff who are pregnant, so they were put in the non-COVID side. And as soon as our hospital started having increasing cases we've just asked them to stay home and look after themselves, rather than coming and getting exposed."
>
> [KI8, male]

Maternity was also an additional cause of stress in the workplace—as a contributor to reduced staff and cause of future recruitment difficulties, exacerbated by the pandemic:

> "Well even now, it's been a constant issue with staffing, especially nurses. It's like we're always short in staff... And now with COVID, we will all be stretched, with our limited staff that we have now and – yes I think the conflict, the internal conflict, that nurses will face, whether to stay at home or to come to work, will also affect our staffing... And we're already stretched, and if someone calls in sick or someone goes on maternity leave, the remaining staff who is on day off will be called back..."
>
> [KI13]

> "...we will be burning out very fast if we don't have enough staff on the ground to do the work. So yes, we do have issues about female staff coming to work for the COVID team."
>
> [FG1,P9]

As mothers, daughters, and wives, women HCWs were bound by their family as the determinant of all decisions. The conflict between duty to work and responsibilities at home provoked ethical challenges, borne almost exclusively by women frontline clinicians:

> "Yes, I think the female staff were impacted greatly, especially those who are married with kids, with children, those who were expecting mothers. They had concerns over their obligation or their duty to their family versus their duty to work, to patients. So that was an ethical decision that they had to make, a really hard one. I've had a few talks with a few of my fellow nurses who say to me, if COVID does come she feels like she's deciding not to come to work, because she feels more obligated to take care of her family and her role as a Mum, as a wife, as a daughter as well."
>
> [KI13]

Women HCWs in our sample were prepared to expose themselves to the risks of COVID-19, despite concerns about adequate PPE, but also adapted their practice according to physical and gendered experiences of comfort and safety:

> "I was a female with the COVID team and there was more males, ... And [we] went down to the ships. I had to climb the mothership to do the screening. I went down two times and then after that I discussed with the [female] director; I think it is much better if the male doctors do the screening on the ships ... I went into quarantine, and our director also asks us who they would like to partner with ..., so I chose another female doctor to go into the quarantine, because I felt comfortable you know."
>
> [FG2,P19]

Theme 3: women as workers

Women clinicians brought compassion, empathy, and love to the workplace—for their patients and for each other. When describing their roles, women participants commonly used words of care and support:

> "So as an emergency care nurse, I deliver emergency assessment, stabilise, providing ongoing management. Also as a caregiver, I get to provide palliative tender loving care to terminal elderly that comes over to ED... And as a counsellor, I also provide emotional and spiritual support. Lastly, I am an advocate as well. I act as a medium between doctors and patients and friends, voicing their needs and requests, etc."
>
> [KI13]

> "We need to support our staff as well. So when the plane comes with our repatriates we have to be present at the airport to give them support as well, that we are there for them."
>
> [KI7]

In contrast to their male colleagues, some women HCWs identified that they paid attention to detail and demonstrated a wide awareness of multiple perspectives influencing patient care and workplace function. Professionally, women perceived the many stressors facing colleagues and were mindful to support staff wellbeing and prevent burnout. Women worked their way strategically around issues to prioritise patients:

> "About a female perspective and male perspective? Well, we have to strategise and compromise with a male prior to doing something, to take care of patients. So it's a challenge. Sometimes males are

straightforward. They don't think about some little, little things that will be a distraction to how we do the care or how we facilitate everything."

[FG1,P12]

Women were at the frontline of the COVID-19 response—in multiple roles and greater numbers than men, and often at the forefront of exposure and risk:

"But they do most of the work! They're out there, doing all the work in the background. Who goes to the, does contact tracing? I see here, in [my country], on the news all the time – who's in the front? A woman carrying a bag, all donned up and walking around the neighbourhood to do contact tracing. Then they come back and they're in the forefront giving vaccination. And then they're back into the hospital. So, yes, I think women do a lot more out there."

[KI9]

"And then there was another added responsibility where, like, I didn't have my senior medical officers on the ground, so I had to play that role of senior person to liaise between the staff and the management with regards to all kinds of things happening in the ED. Deaths of patients, moving patients, transporting things here and there, pushing for enough PPE to be on the ground for staff to use and work, so that was like an added thing on to what I'd already been doing,..."

[KI10]

Often women HCWs were the first to put themselves forward, although not necessarily gaining attention or recognition for their work. This preparedness to step up intersects with Theme 1, demonstrating how some Pacific women HCWs empowered colleagues through role-modelling and inclusive, positive leadership:

"In other words, it's a bit different; male and female. The males, even though they know a lot and they put all their support into things, it's the females that do most of the work... the females actually volunteered and then over time we have the males stepping in."

[FG2,P16]

"Initially when the first suspected case came through, I remember at that time there was a lot of apprehension as to 'Who is going to do it?'. I remember I came to two of the senior [female] nurses and I said 'We have to do the first case, we have to set the example – we need to go in and swab that patient because if we are scared to do it then everyone else is going to be scared in our team. So we need to show them that its okay'. I had to make sure that I understood, that I was clear in my mind, about how to don and doff, and what was the risk."

[KI5]

Economic imperatives to provide for the family were a strong motivator for women HCWs, who faced the ongoing dilemma of duty to patient care and responsibilities at home, as identified in Theme 2. Financial incentives and expected rewards for overtime shift work and pandemic risk allowances were specifically removed in many PICTs, which disproportionally targeted the largely female nursing workforce:

"COVID has, well see, for example – there's no more overtime. And who does overtime? Nurses. Nurses do overtime to, a lot of them find doing overtime is more attractive, because they get additional money to support their low salaries, to be able to support their family."

[KI9]

Female staff were concerned about the potential risks and impact of COVID-19 on health and wellbeing not only personally, but also on their families. Serious threats to their occupational health and safety had equally serious implications for others who relied on women HCWs in their personal roles as carers.

"Another of my colleagues has got elderly parents who [have] other non-communicable diseases as well. She's like, 'If I die or if I contract this virus, there's no one else to take care of my parents 'cause all my brothers are married and moved away, so I'm the only one responsible for my parents'."

[KI13]

Theme 4: Women in Pacific culture

Women are the centre of families and community life in the Pacific. For women frontline clinicians, COVID-19 healthcare duties seriously threatened their cultural expectations and economic responsibilities:

"[In my country], and I heard nurses in [another PICT] do it when they go into, when there's a new lot – they care for these people for 14 days and then they quarantine for 14 days! That's one whole month away from your children, from your family, from your husband. Women in the Pacific, they're the ones that hold their families together. Most of them are, quite a lot of them are, breadwinners for the family. So they just have no option. So they still are disadvantaged."

[KI9]

Despite their critical professional and personal roles, women often had to seek permission from superiors

and garner male approval before they could speak or act publicly. Male relatives sometimes refused to allow women their professional autonomy:

> "...it is cultural ... as we have the three Fs – so family, faith and food. So family is, 'cause we exist in a community, we exist in families. So we can't make decisions without consulting our elders or, we don't think for ourselves, we put our family first before ourselves..."
>
> [KI13]

> "So our female staff, we have this cultural thing – so some of the female staff are unable to come to work because the husbands will not allow them to come to work due to fear and so many things. So that's one challenge because not every female staff are allowed to come to work by their spouses..."
>
> [FG1,P9]

As within the home, women HCWs relied on men's power to recognise their workplace leadership—which was not always visible to male counterparts. In some contexts where men could not see women's strengths, women's voices were silenced:

> "Not providing that platform that women can come out and speak freely, a platform that looks at nurses as leaders in their units, as family members, as children with children."
>
> [KI9]

> "No, I have not been offered or had the opportunity to talk to, yeah, those guys with authorities. [Laughs] I'm just like looking..."
>
> [KI13]

The patriarchal structure of Pacific societies ensured male voices were heard and male leadership was magnified, even if women HCWs had more experience or provided most of the healthcare service:

> "Pacific society yeah. Male-dominated. You can see that even with sessions that we have out there, you have all the male counterparts speaking out, in the forefront, giving information that, talking on behalf of everybody... And females, women, don't speak out. In the Pacific 70% of the workforce is females. Over 60% are nurses and nurses are predominantly female. But how many leaders out there are women? And in the forefront? Just a handful. So that speaks volumes."
>
> [KI9]

In some PICTs, the pandemic provided an opportunity to elevate and embed women's cultural attributes in a way that enhanced health workplace and team function:

> "It shows that culture is also been instilled in the workplace, where normally we have, I'm not sure how I can say it in English, but in [my country] the females are mostly "(local word)" .... it means to be nosey and investigative. We are very fortunate because this COVID-19 has pushed our culture as females to actually wanting to know more. We are thankful that we have our male colleagues in the back supporting us in whatever we find, we actually pushed back to them."
>
> [FG2, P16]

Pacific women bring many cultural strengths to the healthcare workforce. Their centrality within families and communities, and demonstrations of love and empathy, motivated and inspired their colleagues during the COVID-19 experience:

> "... a lot of our culture comes through in our work. Like, working together, the cultural concepts like patriotism. It's not really patriotism, it's like love of country, love of people."
>
> [KI12]

Discussion

This is the first study to illuminate the COVID-19 experience of Pacific women frontline HCWs using a critical feminist approach and an analytical gender framework. We found that Pacific women's multiple roles across home and work are both a burden and a source of strength and skill. As pivotal carers and breadwinners within Pacific families, women possess particular work attributes of care, empathy, compassion, multi-tasking, attention to detail, and emotional intelligence for effective leadership and pastoral care. Authority conferred by Pacific cultural, church, and community status—the 'crowns from home'—enables some women to step into leadership roles and demonstrate empowering, distributive management styles. However, this doesn't work for all women or all the time. There is tension between women having authority and women being subordinate to men, senior family, or community members. Furthermore, Pacific women's identity and status are sources of additional stress and introduce complex ethical challenges and moral distress[34] to prioritise work over family (or visa-versa), meet financial demands, and balance occupational health and safety risks.

Our findings align with the known gendered maldistribution of the healthcare workforce.[5–8,35] Our participants' lived experience of shouldering the burden of the pandemic response across the population and community level, as well as at the forefront of clinical service, reinforces the urgent need to develop and implement

gender-responsive global health security policies.[36] Future initiatives should incorporate greater female representation in decision-making leadership, better protection for women HCWs, recognition of women's unpaid work, gender-sensitive data handling, and more expansive support for civil society women's organisations during ongoing and future health emergencies.[36]

Pacific women HCWs are likely to be in their peak reproductive years. During COVID-19, pregnancy and maternal activities were segregated and pathologised as high-risk (perhaps by both men and women), becoming signifiers for how staff were identified (women as mothers, men as men) and confirming expectations around motherhood found in other contexts.[11] This had serious implications for rostering and recruitment of women, and a potential impact on morale and emotional fortitude for Pacific women HCWs who did experience pregnancy, childbirth, and/or breastfeeding during the pandemic. Evidence before COVID-19 highlighted the serious risks of systemic structural gender discrimination and inequality to global strategies towards building and maintaining Human Resources for Health.[37] Our findings reinforce global evidence that the pandemic has exacerbated these risks.[38] Without addressing women's recruitment, support, embodied needs, and pay equity with gender-transformative policies and practice, the Pacific region may face critical future workforce shortages that threaten Healthy Islands[39] and Universal Health Coverage aspirations.[40] Although current WHO Western Pacific Region strategic planning priorities lack sufficient attention to this issue,[41] recognition of the need to protect and invest in the global healthcare workforce is gaining political and intersectoral traction.[42]

Pacific women HCW's caring attributes and situational awareness skills induced their additional role as custodians of workplace wellbeing. In the pandemic context, this sensitivity, perception, and responsiveness to the mental health landscape at work elevated the importance of women HCWs in the Pacific region. However, it also reinforced social gender ideologies of 'women's emotional work'[43] that contribute to occupational segregation.[44] Women were also highly effective communicators who were not afraid to speak out to those in authority for the benefit of their colleagues and patients, but who were denied platforms to speak or make decisions in higher-stakes contexts. This further illustrated occupational segregation in Pacific health workplaces[6]; but it also demonstrated mechanisms some women HCWs used to resist conditions that contributed to moral distress at the frontline.[34] Pandemic contexts where Pacific women HCWs were able to model highly efficacious leadership and participatory decision-making were enabled through the supportive presence of other women.[45]

Using the social theory of Bourdieu, our findings can be understood as transactions of symbolic capital. When Pacific women's social and cultural capital (their 'crowns from home') are recognised and valued in society, they can convert this symbolic capital to gain access to professional or political capital in the workplace. This transcends previous understandings of social relationships as sources of support and/or stress during pandemic events,[46] to a unique Pacific understanding of some social connections (for example, 'family and faith') as sources of strength and power. Using their legitimised symbolic capital to 'play the game' in the professional sphere enabled Pacific women HCWs to assert power and influence decisions and practice.[29] In addition to symbolic capital conferred by their centrality within families, Pacific women accrue substantial emotional capital through their caring duties within the community and (for some) maternal roles.[47] Unfortunately during COVID-19 they were also required to expend disproportionate amounts of emotional capital on both patients and highly stressed staff in the workplace, without commensurate professional or political capital gain. Recognising and valuing the different forms of Pacific women's capital, and how it may be amassed and exchanged to allow for increased access to power and decision-making, may assist in future policy interventions aimed at improving women's health leadership.

Applying a 'health services research' gender framework to our findings enhances an understanding of how power relations influence Pacific women HCWs' COVID-19 experience. Viewing gendered inequalities through the lens of power differentials can also lead to focused policy interventions aimed at restructuring how power is distributed in health systems. We therefore briefly re-order our findings in Table 1, according to the following key domains of gendered power relations: who has what; who does what; how values are defined; and who decides.[20]

In everyday health systems, these gendered power domains are dynamically maintained through shifting policies, practices, and attitudes. Our findings emphasise how the COVID-19 pandemic reinforced power differentials between men and women HCWs (particularly around occupational segregation), but also demonstrated the potential for Pacific women HCWs to reshape power inequalities through their symbolic capital and to positively influence health system performance. This is particularly salient for transformational leadership in health, whereby Pacific women HCWs' qualities of emotional intelligence, situational awareness, and loving care could substantially enhance team function if recognised as essential for formal health leadership roles during surge events.[8,48,49] Furthermore, placing a higher value on Pacific women's effective advocacy for patient and staff safety may contribute to altruistic health governance that engenders trust among all stakeholders,[50] and meets post-pandemic calls to elevate nursing and midwifery leadership to achieve Universal Health Coverage across the Pacific.[51]

Key domain questions	Women	Men, institutions, structures, other/unknown bodies
Who has what?	Specific and highly desirable workplace skills (communication, situational awareness, emotional intelligence, persistence, and endurance) Networks to access information Emancipatory leadership skills Social and cultural capital	Power over work conditions, pay and other benefits. Control over women's access to work and/or other activities (women required to seek permission, or denied permission to work) Demands on women's time, social and cultural capital (family and community caring responsibilities and expectations) Access to knowledge
Who does what?	Most of the patient-facing, clinical work (service-provision, frontline, professional roles), including working overtime Look out for staff; care and protect staff Family and community caring (personal roles) Pregnancy, breastfeeding, maternal care Role modelling for other female staff Effective, 'on-the ground' advocacy Take risks and put themselves forward	Higher-level, management work Provide support for some women in some PICTs in leadership roles May or may not recognise women's work and women's leadership Speak on behalf of women
How values are defined	Women shape and confirm values using their social and emotional capital: Women HCWs perceive themselves as well (possibly better) suited to patient-facing roles by virtue of their attention to detail and loving care provision Some PICTs elevated women's cultural capital ('crowns from home'), and accepted social norms of women's assertiveness ('being nosey and investigative') which enabled courageous advocacy and frank speaking from women Women's solidarity assisted with leadership, safety in the workplace and pandemic planning	Common Pacific cultural values (from our data): - Patriarchy (men as head of the family and community) - Respect for elders/hierarchies - Women's domestic centrality - Communitarian Assumption of male leadership and of male speaking opportunities and platforms Women's leadership qualities of inclusivity, persuasion and empowerment not necessarily valued or recognised High value on maternity/motherhood resulting in identification and protection of pregnant HCWs
Who decides?	Group decision-making when in formal leadership roles Informally—women HCWs withdraw their labour if they feel unsafe or the risk/benefit ratio falls towards the family/community rather than the workplace Can enter decision-making roles by default through persistence and advocacy	Men make decisions and speak out on behalf of women or may actively exclude the female voice by nature of male-only leadership Political (almost exclusively male) decisions about pay, overtime allowances and pandemic benefits Institutional decision-making for pregnant HCWs (potentially denying women's autonomy)

Table 1: **Pacific HCW experience of gendered power relations during COVID-19.**

Power was disproportionally used against women HCWs by the almost exclusively male Parliaments of some PICTs through decisions about financial benefits and overtime pandemic pay. Although our data did not demonstrate the additional advocacy efforts that economically disenfranchised Pacific women HCWs undertook to realise their rights,[52] we assume this magnified their ethical challenges and emotional labour at the height of the pandemic and may have contributed to increased stress and burnout.[12] Similarly, none of our participants specifically discussed gendered experiences of PPE, despite the known impact of ill-fitting and poorly designed PPE for frontline women clinicians.[9] Gender-based violence (GBV) was mentioned briefly in reference to barriers created by pandemic restrictions for women victims seeking refuge. Although physical and/or sexual violence against women is known be highly prevalent in many PICTs,[53] and statistically very likely to affect Pacific women HCWs, our data did not link this issue with the COVID-19 frontline clinical experience. We are unlikely to learn more without targeted and appropriately conducted research focused on women's pandemic experience of GBV, and instead should proactively focus on rights-based responses and recommendations.[54]

Limitations of the broader project have been described at length elsewhere, including measures taken to address potential gender, role, and cultural barriers to open participation by Pacific stakeholders.[22] In terms of this paper's focus on gender, our findings are limited by our small sample size and constraint of few gender-specific questions embedded within interview and focus group discussions that covered a large topic field. These factors may have restricted data depth and nuance, and potentially contributed to the gaps identified earlier. However, participatory engagement of Pacific women as co-researchers in data analysis and interpretation provides additional acuity and validity to our findings.

This study has highlighted the substantial contribution of Pacific women HCWs during the COVID-19 pandemic as frontline clinicians, emancipatory leaders, role models, advocates, staff welfare champions, and insightful care providers both in the public and personal realm. To perform all these roles, Pacific women ethically negotiate their moral responsibilities to their families, communities, patients, and colleagues, and strive to overcome cultural and structured gendered inequalities that privilege men's power. By making visible this women's work, we hope to positively encourage our Pacific colleagues who uphold their health systems. Further, our findings endorse the urgent need to protect and support the female healthcare workforce through

gender-transformative policies across the Pacific region and beyond.

Contributors

GP was responsible for this study design. GP and MK performed data coding, analysis, and interpretation, with LMH and SK performing initial transcription and gender-specific content extraction. All authors contributed to final data interpretation, with MK and SM providing essential regional input and contextual advice. GP developed the first draft of this manuscript. The final version was reviewed and approved by all authors.

For the original project design MC, GP, CEB, SK (along with Rob Mitchell and Gerard O'Reilly) were primarily responsible. MC and SK coordinated funding acquisition and project administration. MK (along with Deepak Sharma, Berlin Kafoa and Penisimani Poloniati) provided regional perspectives and contextual advice. Study materials were developed by LMH, MC, GP, SK and CEB (along with Rob Mitchell and Gerard O'Reilly). All original authors engaged in data collection through online support forums, interviews or focus group discussions.

Data sharing statement

De-identified and coded interview transcript data used to support the results in this article may be made available to interested stakeholders after careful consideration by the research project team and upon receipt of a written request to the corresponding author.

Declaration of interests

GP and MC declare they are recipients of International Development Fund Grants from the Australasian College for Emergency Medicine (ACEM) Foundation and are members of ACEM. SK declares past employment at ACEM, CEB former ACEM committee membership, and LMH past contract payment from ACEM. GP reports visiting Faculty status at the University of Papua New Guinea and Fiji National University.

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References

1 Wenham C, Smith J, Morgan R. COVID-19: the gendered impacts of the outbreak. *Lancet*. 2020;395:846–848.
2 Jin J-M, Bai P, He W, et al. Gender differences in patients with COVID-19: focus on severity and mortality. *Front Public Health*. 2020;8:152. https://doi.org/10.3389/fpubh.2020.00152.
3 Flor LS, Friedman J, Spencer CN, et al. Quantifying the effects of the COVID-19 pandemic on gender equality on health, social, and economic indicators: a comprehensive review of data from March, 2020, to September, 2021. *Lancet*. 2022;399:2381–2397.
4 Morgan R, Pimenta DN, Rashid S. Gender equality and COVID-19: act now before it is too late. *Lancet*. 2022;399:2327–2329.
5 Women in Global Health. *Subsidizing global health: women's unpaid work in health systems*; 2022. https://womeningh.org/resources/policy-report-subsidizing-global-health-womens-unpaid-work-in-health-systems/. Accessed July 19, 2023.
6 World Health Organisation. *Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. WHO Human Resources for Health Observer Series No. 24*. Geneva; 2019. Contract No.: Licence: CC BY-NC-SA 3.0 IGO https://apps.who.int/iris/bitstream/handle/10665/311322/9789241515467-eng.pdf. Accessed July 19, 2023.
7 World Health Organisation. *Closing the leadership gap: gender equity and leadership in the global health and care workforce*. Geneva; 2021. Licence: CC BY-NC-SA 3.0 IGO https://apps.who.int/iris/bitstream/handle/10665/341636/9789240025905-eng.pdf. Accessed July 19, 2023.
8 Women in Global Health. *The state of women and leadership in global health*; 2023. https://womeningh.org/wp-content/uploads/2023/03/The-State-of-Women-and-Leadership-in-Global-Health.pdf. Accessed July 19, 2023.
9 Regenold N, Vindrola-Padros C. Gender matters: a gender analysis of healthcare workers' experiences during the first COVID-19 pandemic peak in England. *Soc Sci*. 2021;10(2):43. https://doi.org/10.3390/socsci10020043.
10 Lotta G, Fernandez M, Pimenta D, Wenham C. Gender, race, and health workers in the COVID-19 pandemic. *Lancet*. 2021;397:1264.
11 Hennein R, Gorman H, Chung V, Lowe SR. Gender discrimination among women healthcare workers during the COVID-19 pandemic: findings from a mixed methods study. *PLoS One*. 2023;18(2):e0281367. https://doi.org/10.1371/journal.pone.0281367.
12 Sriharan A, Ratnapalan S, Tricco AC, Lupea D. Women in healthcare experiencing occupational stress and burnout during COVID-19: a rapid review. *BMJ Open*. 2021;11(4):e048861. https://doi.org/10.1136/bmjopen-2021-048861.
13 Boniol M, McIsaac M, Xu L, Wuliji T, Diallo K, Campbell J. *Gender equity in the health workforce: analysis of 104 countries. Working paper 1*. Geneva: World Health Organization; 2019 (WHO/HIS/HWF/Gender/WP1/2019.1).Licence: CC BY-NC-SA 3.0 IGO https://apps.who.int/iris/handle/10665/311314. Accessed July 19, 2023.
14 Pacific Islands Forum Secretariat. *The framework for Pacific regionalism*. Fiji: Suva; 2014. https://www.forumsec.org/wp-content/uploads/2017/09/Framework-for-Pacific-Regionalism.pdf. Accessed July 19, 2023.
15 Pacific Women. *Leadership and decision-making for women and girls in the Pacific. Pacific women shaping Pacific development (Australian aid)*; 2021. https://pacificwomen.org/wp-content/uploads/2021/05/Thematic-Brief_Pacific-Women-Leadership.pdf. Accessed September 19, 2023.
16 Pacific Islands Forum Secretariat (PIFS). *2050 Strategy for the Blue Pacific continent*. PIFS, Suva, Fiji; 2022. https://www.forumsec.org/wp-content/uploads/2022/08/PIFS-2050-Strategy-Blue-Pacific-Continent-WEB-5Aug2022.pdf. Accessed September 19, 2023.
17 Woodruff IG, Mitchell RD, Phillips G, et al. COVID-19 and the Indo-Pacific: implications for resource-limited emergency departments. *Med J Aust*. 2020;213(8):345–349.e1.
18 Van Manen M. But is it phenomenology? *Qual Health Res*. 2017;27(6):775–779.
19 Reiners GM. Understanding the differences between husserl's (Descriptive) and heidegger's (interpretive) phenomenological research. *J Nurs Care*. 2012;1(5). https://doi.org/10.4172/2167-1168.1000119.
20 Morgan R, George A, Ssali S, Hawkins K, Molyneux S, Theobald S. How to do (or not to do)... gender analysis in health systems research. *Health Policy Plan*. 2016;31(8):1069–1078.
21 Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. *Perspect Med Educ*. 2019;8(2):90–97.
22 Cox M, Phillips G, Mitchell R, et al. Lessons from the frontline: documenting the experiences of Pacific emergency care clinicians responding to the COVID-19 pandemic. *Lancet Reg Health West Pac*. 2022;25:100517. https://doi.org/10.1016/j.lanwpc.2022.100517.
23 Herron LM, Phillips G, Brolan CE, et al. "When all else fails you have to come to the emergency department": overarching lessons about emergency care resilience from frontline clinicians in Pacific Island countries and territories during the COVID-19 pandemic.

Lancet Reg Health West Pac. 2022;25:100519. https://doi.org/10.1016/j.lanwpc.2022.100519.
24 D'arcy P. Cultural divisions and island environments since the time of dumont d'Urville. *J Pacific History*. 2003;38(2):217–235.
25 Nowatzki N, Grant KR. Sex is not enough: the need for gender-based analysis in health research. *Health Care Women Int*. 2011;32(4):263–277.
26 Lafrance MN, Wigginton B. Doing critical feminist research: a Feminism & Psychology reader. *Fem Psychol*. 2019;29(4):534–552.
27 Kennedy E, Binder G, Humphries-Waa K, et al. Gender inequalities in health and wellbeing across the first two decades of life: an analysis of 40 low-income and middle-income countries in the Asia-Pacific region. *Lancet Glob Health*. 2020;8(12):e1473–e1488.
28 Grenfell MJ. *Pierre Bourdieu: key concepts*. London: Routledge; 2014.
29 Spark C, Cox J, Corbett J. Gender, political representation and symbolic capital: how some women politicians succeed. *Third World Q*. 2019;40(7):1227–1245.
30 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101.
31 Braun V, Clarke V. One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qual Res Psychol*. 2021;18(3):328–352.
32 Equator Network. *Enhancing the quality and transparency of health research*; 2021. https://www.equator-network.org/. Accessed July 19, 2023.
33 O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245–1251.
34 Smith J, Korzuchowski A, Memmott C, Oveisi N, Tan HL, Morgan R. Double distress: women healthcare providers and moral distress during COVID-19. *Nurs Ethics*. 2023;30(1):46–57.
35 Ayaz B, Martimianakis MA, Muntaner C, Nelson S. Participation of women in the health workforce in the fragile and conflict-affected countries: a scoping review. *Hum Resour Health*. 2021;19(1):94. https://doi.org/10.1186/s12960-021-00635-7.
36 Women in Global Health. *Gender equity in health emergency preparedness and response*; 2023. https://womeningh.org/gender-equity-in-ppr/. Accessed July 19, 2023.
37 Newman C, Nayebare A, Gacko NMNN, et al. Systemic structural gender discrimination and inequality in the health workforce: theoretical lenses for gender analysis, multi-country evidence and implications for implementation and HRH policy. *Hum Resour Health*. 2023;21(1):37. https://doi.org/10.1186/s12960-023-00813-9.
38 Morgan R, Tan HL, Oveisi N, et al. Women healthcare workers' experiences during COVID-19 and other crises: a scoping review. *Int J Nurs Stud Adv*. 2022;4:100066. https://doi.org/10.1016/j.ijnsa.2022.100066.
39 World Health Organisation Western Pacific Region. Healthy Islands 2023. https://www.who.int/westernpacific/about/how-we-work/pacific-support/healthy-islands. Accessed July 19, 2023.
40 World Health Organisation. *Universal health coverage: moving towards better health – action framework for the western Pacific region*; 2016. https://www.who.int/westernpacific/publications-detail/9789290617563. Accessed July 19, 2023.
41 World Health Organisation Western Pacific Region. *For the future, towards the healthiest and safest region: a vision for WHO work with member states and partners in the Western Pacific*; 2020. https://www.who.int/publications/i/item/WPR-2020-RDO-001. Accessed July 19, 2023.
42 Agyeman-Manu K, Ghebreyesus TA, Maait M, et al. Prioritising the health and care workforce shortage: protect, invest, together. *Lancet Glob Health*. 2023;11(8):e1162–e1164. https://doi.org/10.1016/S2214-109X(23)00224-3.
43 Tong R. The ethics of care: a feminist virtue ethics of care for healthcare practitioners. *J Med Philos*. 1998;23(2):131–152.
44 Newman CJ, Fogarty L, Makoae LN, Reavely E. Occupational segregation, gender essentialism and male primacy as major barriers to equity in HIV/AIDS caregiving: findings from Lesotho. *Int J Equity Health*. 2011;10:1–13.
45 Govindasamy LS. Supporting each other: Pacific emergency care clinicians navigate COVID-19 pandemic challenges through collaboration. *Lancet Reg Health West Pac*. 2022;25:100535. https://doi.org/10.1016/j.lanwpc.2022.100535.
46 Billings J, Ching BCF, Gkofa V, Greene T, Bloomfield M. Experiences of frontline healthcare workers and their views about support during COVID-19 and previous pandemics: a systematic review and qualitative meta-synthesis. *BMC Health Serv Res*. 2021;21(1):923. https://doi.org/10.1186/s12913-021-06917-z.
47 Reay D. Gendering Bourdieu's concepts of capitals? Emotional capital, women and social class. *Sociol Rev*. 2004;52(2_suppl):57–74.
48 Mousa M, Garth B, Boyle JA, Riach K, Teede HJ. Experiences of organizational practices that advance women in health care leadership. *JAMA Netw Open*. 2023;6(3):e233532. https://doi.org/10.1001/jamanetworkopen.2023.3532.
49 Howard E. Effective support for women's leadership in the Pacific: lessons from the evidence. Australian National University Department of Pacific Affairs. Discussion Paper 2019/1 https://dpa.bellschool.anu.edu.au/sites/default/files/publications/attachments/2019-04/dpa_dp20191_howard_revised.pdf. Accessed July 19, 2023.
50 Phillips G, Kendino M, Brolan CE, et al. Lessons from the frontline: leadership and governance experiences in the COVID-19 pandemic response across the Pacific region. *Lancet Reg Health West Pac*. 2022;25:100518. https://doi.org/10.1016/j.lanwpc.2022.100518.
51 Rumsey M, Leong M, Brown D, Larui M, Capelle M, Rodrigues N. Achieving universal health care in the Pacific: the need for nursing and midwifery leadership. Review paper. *Lancet Reg Health West Pac*. 2022;19:100340. https://doi.org/10.1016/j.lanwpc.2021.100340.
52 Fanasia A. *Nurses' strike looms. Solomon Star*. Honiara; 2020. https://www.solomonstarnews.com/nurses-strike-looms/. Accessed July 19, 2023.
53 Pacific Women. *Ending violence against women. Pacific women shaping Pacific development (Australian aid)*; 2020. https://pacificwomen.org/our-work/focus-areas/ending-violence-against-women/. Accessed July 19, 2023.
54 Dawson A, Ekeroma A, Rokoduru A, Wilson D, Tran NT, Bateson D. The COVID-19 pandemic and sexual and reproductive health and rights in the Pacific. *Asia Pac J Public Health*. 2021;33(6-7):777–779.