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Women and care ethics during the COVID-19 pandemic: Who *cares* for the care-givers?

Elias Konyana
Senior Research Associate: African Centre for Epistemology and Philosophy of Science
University of Johannesburg, South Africa
Email: ekonyana@gzu.ac.zw
ORCID: https://www.orcid.org/0000-0003-3690-6616

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Abstract

Caring is a general ethical responsibility that makes human existence worthwhile and fulfilling. Whenever society is distressed be it by a famine, war, poverty or a pandemic, the impact falls hard on women, children and people living with disability. We all need to be cared for and we owe the same obligation to others, especially those who care for us. However, during crises, the ethics of care becomes integral and, more often, men are not readily available to offer it. Arguably, the duty to care is one of the most compelling obligations that make human and non-human beings survive any form of distress. However, it is unfortunate that women face more of the brunt of the requirements of the duty to care than their male counterparts, particularly in the home front. This was most evident during the COVID-19 pandemic, when most ill persons were kept in the home because healthcare institutions were overwhelmed with numbers of infected persons scrambling for limited and non-existent resources. The pressure was not only on scarce resources, but COVID-19 also brought into sharp focus the need for better care for those who care for the sick in the home, especially during times of national distress. This article is a critical reflection on the impact of COVID-19 on women healthcare providers (HCPs) caring for the sick in the home. It particularly focuses on the caring burden created by COVID-19 and how it impacted on women's mental health acknowledging that, currently, there is limited feminist analysis of moral distress among women healthcare providers in rural communities and healthcare institutions. Through the ethics of care theory and the feminist political economy lens, the article further explores the care challenges faced by women during the COVID-19 lockdown period. The article employs in-depth interviews and focused group discussions as the methods of data collection. It also proffers interventionist strategies that could be employed to lessen the burden of care on women. The findings show that more women healthcare givers suffered a lot of pressure from the impact of COVID-19 since they received little recognition and appreciation from both patients and the healthcare institutions they worked for.

Keywords: COVID-19, ethics of care, healthcare providers, mental health, moral distress, women

Introduction

The COVID-19 pandemic posed unprecedented challenges to healthcare providers (HCPs), including heightened moral distress, the experience in which one knows the ethically right action to take but is systemically constrained from taking it. Indeed, the COVID-19 pandemic heightened moral distress among HCPs in general and women HCPs in particular. Despite evidence of the gendered differences in experiences, there is limited feminist analysis of moral distress among women healthcare providers. Hossain (2021:187-192) writes, "During this era of COVID-19, front liners from every part of the world are facing moral distress. Moral distress occurs while delivering care, allocating resources and

maintaining professional integrity." Examples of COVID-19 related moral distress include not being able to provide quality care due to lack of time, resource constraints and COVID-19 restrictions (Morley, et al 2020). This study explores experiences of COVID-19 related moral distress among women HCPs in selected rural healthcare centres in Chipinge, Manicaland province between December 2020 and March 2021 at the height of lockdown restrictions in Zimbabwe. It attempts to do basically three things, namely: (i) to identify types of moral distress among women HCPs during the COVID-19 pandemic; (ii) to explore how feminist political economy might be integrated into the study of moral distress; and (iii) to argue that women HCPs suffer the most from moral distress and thus require not only recognition but also protection and the kind of care they render to others.

This research draws on interviews and focus groups, the transcripts of which were analysed using the care ethics framework analysis. Forty (40) women healthcare providers, based at Chibuwe, Rimbi and St. Peters (Checheche) rural healthcare centres in Chipinge district of Manicaland, participated. The outcome of this research shows that COVID-19 has led to new and heightened experiences of moral distress among healthcare providers in response to paid and unpaid care work. While many of the experiences of moral distress at work were not explicitly gendered, implicit gender norms were evidently structured in moral care decisions. Women HCPs had to take it upon themselves to organize, seek out resources and resist moral residue during the course of discharging their duties. A feminist political economy lens illuminates how women healthcare providers faced and resisted a double layering of moral distress during the pandemic. At home, women experienced moral constraints related to inability to support children's education and the wellbeing of sick relatives. Moral conflicts related to lack of flexible work environments and moral dilemmas developed between unpaid care responsibilities in the rural healthcare institutions and COVID-19 risks during paid care at the workplaces. Women HCPs resisted moral residue and structural constraints by organising for better working conditions, childcare and access to personal protective equipment (PPE), engaging mental health support and drawing on professional pride. Not only did moral distress contribute to a mental health crisis among HCPs during the COVID-19 pandemic, but the relationship between moral distress and work burnout threatened and actually exacerbated the already troubled human resource shortages in the healthcare sector in Zimbabwe, leading to high levels of brain-drain.

Background

The concept of moral distress originally developed in the nursing literature and has increasingly been applied to understand the experiences of other HCPs. While there are varying definitions of this concept, in this paper I use Morley *et al.*'s (2019) definition, which says,

> Moral distress is the combination of (1) the experience of a moral event, (2) the experience of 'psychological distress', and (3) a direct causal relation between (1) and (2).

Morley *et al.* (2019) identify multiple types of moral events, arguing that this broadening of legitimate events often leads to moral distress which, in the long run, support the development of preventive and responsive interventions to mitigate the problem. A number of studies indicate higher levels of moral distress among women HCPs compared to men. Such differences may reflect the gendered structures of healthcare systems, wherein more women than men fill positions requiring close contact with patients, but have less access to decision-making, and/ or reflect dominant gender norms within which women are expected to seek personal development by caring for others first before they care about themselves. Psychological studies have also established that women have higher levels of moral sensitivity, potentially making them more vulnerable to moral distress. Gender differences may also reflect norms which encourage women to foster and express emotional sensitivity and discourage men from doing so, potentially biasing the necessary responses. However, beyond these suppositions, there are

few critical inquiries into the determinants of unequal experiences of moral distress between women and men HCPs.

Greater engagement within feminist approaches has the potential to rectify this gap. Peter and Liaschenko (2013:24) argue that "feminist ethics share a number of common features that can inform the recognition of the work-life elements that lead to moral distress," noting that the care ethics theory offers a "richer explanation" of both the individual and institutional components of moral distress. Morley *et al.* (2019) apply feminist phenomenology to analyse and classify experiences of moral distress among nurses, but do not analyse the gendered nature of these experiences. Brassolotto *et al*. (2017) apply feminist political economy (FPE) perspective to analyze moral distress among private care aids, emphasizing how the structural feminization of the care sector creates conditions of moral distress. They further point out the majority of research documents, and argue that FPE provides a framework for analysis of determinants of moral distress. In this way, the FPE positions moral distress as an organizational problem experienced on an individual level (Armstrong-Esther *et al.*, 2008). This article draws on these approaches, while adding to them in two ways.

First, FPE offers a further opportunity to deepen the study of moral distress, particularly in the context of COVID-19, as it emphasizes the need to include unpaid care work in health system analysis (Waylen, 2013). Unpaid care, also termed reproductive labour or the care economy, refers to the work of cooking, cleaning, caring for dependents and the ill, as well as other tasks that are essential to the social and economic development of the family. FPE researchers have documented how this work is primarily performed by women and, while rarely acknowledged, is essential to all other economic and social activity (Lokot and Bhatia, 2020). Scholarship during COVID-19 has particularly exposed the relationship between gender inequality at work and the crisis in unpaid care at home, resulting from school and service interruptions. Recognizing women's multiple roles, an FPE lens poses the possibility of moral distress in response to unpaid care, as well as paid care responsibilities, illuminating the often-ignored impacts of unpaid care burdens on women's wellbeing.

Second, a common critique of moral distress scholarship is that it denies HCPs agency, positioning them as helpless or not responsible in situations where patient care suffers (McCarthy and Gastmans, 2015). Such positioning denies HCPs power to resist constraints and obscures their resilience. FPE provides an approach that both analyzes the structural constraints that create the conditions of moral distress and resistance to them. It positions healthcare systems and social care sectors as sites of struggle within which women, among other equity deserving groups, continue to resist inequality. As feminist theorists have argued, it is crucial to document these struggles, even those that have not yet affected change, to better understand persistent structures of oppression, and inform ongoing resistance (Robinson, 2015).

Contextualizing the research

In general, moral distress occurs in a context shaped by political and economic forces, and in this case, policy decisions in response to a crisis (Shrma and Smith, 2021). It has been observed that, in Zimbabwe, women remain the primary care providers within households and families, doing two to three times more unpaid care work than men, as gender norms continue to position unpaid care as women's responsibility. This is drawn from the fact that most of the patients believe that women provide the best caring services. Elsewhere, unpaid care responsibilities forced a disproportionate number of women out of paid work during the first year of the pandemic, particularly during the initial lockdown from mid-March to mid-June 2020, when most schools and childcare facilities were closed (Faraday, 2020). Subsequent temporary closures and isolation periods have continued to impose heightened care burdens on women, with impacts on their paid work and wellbeing.

Participants

Between December 2020 and March 2021, the researcher purposely sampled 10 Focus Groups with 40 participants and 20 key informant interviewees drawn from rural health care centres and the surrounding communities (*n = 60*). **Table 1** shows a range of HCPs selected based on gender composition (all women), and having close contact with patients, residents or clients. Twenty (20) participants worked in the rural health institutions drawn from the three healthcare centres mentioned above while twenty (20) participants were drawn from the general community and ten (10) were home care givers.

Table 1. Research Participants.

Participants	Focus Groups	FG Participants	Interviews
Community Healthcare	4	20	4
Midwives	3	9	4
Nurses	3	11	2
Key Informants		-	10
Total	**10**	**40**	**20**

Key to abbreviations from the table:
FGCHC- Focus Group Community Healthcare; FGMW- Focus Group Midwife;
FGN- Focus Group Nurse; KI- Key Informant

Participants were recruited purposefully through social media. Inclusion criteria included identifying as a woman and currently working in one of the professions listed. Focus groups and interviews were held virtually through Zoom and WhatsApp, lasting approximately one hour and were audio recorded. Both were semi-structured with questions related to women's experiences at home and work during the pandemic, participation in decision-making, and recommendations for strengthening the health workforce. Key informant interviews, also held virtually, addressed similar themes, plus aimed to clarify contextual and policy questions.

The initial research was conducted from a broad gender-based analysis lens that recognized gender as a social construct and sought to better understand how its structures interacted with women HCPs' experiences and wellbeing (Ssali *et al.,* 2016). The idea was to analyze effects at the individual, household/ family, and healthcare system level, applying framework analysis to transcriptions coding content based on these categories (Cameron, 2013).

Findings

Moral constraint at work
Moral constraint refers to the inability to carry out one's preferred moral requirement due to external or internal constraints (Ives *et al.,* 2020). Participants spoke about how lack of adequate staffing led to moral constraints related to poor quality of healthcare. They noted that staffing shortages forced them to reduce care to patients, with one explaining that:

> *Nguva zhinji varwere havagezi. Vanokwanisa kuita mwedzi wese vasina kugeza zvakakwana. Kana zvadai, mwedzi wapera kudai murwere asina kugeza zvakanaka, ini semushandi uye munhukadzi, ndinorwadziwa nazvo nekuti ava varwere vanhuwo uye ikodzero yavo kuwana rubatsiro*

> *rwakaringana.* (Multiple times patients do not bath. They may spend a month without getting a proper bath. When it happens like this where patients do not bath well, I as a caregiver and a woman, feel bad about it because these patients are also human and it is their right to get adequate help or support. (07-FGN).

Midwives experienced moral constraints related to their inability to ensure parent and infant safety. Designated as allied HCPs, as opposed to essential workers, midwives were not eligible to access PPE from the government supply chain and so had to source their own, which was challenging during the initial months of the pandemic due to shortages. Midwives described sewing their own masks and washing out gloves to be re-used. One midwife described her experiences thus: "*Zvakatiomera kubatanidza kutya kwangu kubatira COVID-19 uye kutya kurasikirwa nehupenyu hwamai nemwana avo vandinofanira kuchengetedza.* (It is hard to balance my fears of contracting COVID-19 and thinking of the woman and baby I have to save." (02-FGMW).

Another described having two homebirths in one night with only enough PPE for one. Lack of PPE for midwives, resulted in increased risks for families, which in turn increased moral distress among midwives.

Moral constraints at home

All participants noted that they, as women, were the ones primarily responsible for unpaid care work in their families and that unpaid care work had increased dramatically due to COVID-19 related childcare, schooling and service interruptions, as well as due to the increased needs of vulnerable family members, especially the elderly and those living with disabilities. These perceptions are supported by earlier research indicating that, while men took on more care responsibilities during the initial COVID-19 related lockdown than previously, women continued to do the majority of unpaid care work (Scheibling *et al*., 2020). Participants who were mothers described increased unpaid care as not only adding to their work burden, but also to experiences of moral constraints over their perceived inability to adequately support their children's wellbeing and education. A Key Informant explained that:

> *Zvinoshungurudza, kunyanya patanga COVID-19 zvikoro zvavharwa. Unorwadziwa mupfungwa nekuti vana havachaendi kuchikoro, havachakwanisi kubuda kundotamba nevamwe uye vavakushuwira kuenda kuchikoro saka waakusungirwa kuverenga navo uye kutamba navo nekuti havasikufarawo nekuda kweCOVID-19 uye hazvikwanisiki kuti uite zvese.* (You always feel bad, especially at the beginning of the pandemic when there was no school. You're constantly feeling guilty because children don't have friends to play with, they're missing school, you should be reading with them, you should play with them because they're upset too over COVID-19, and it's just not possible to do it all (01-KI).

Increased paid work reduced parents' time to provide unpaid care, just as those demands also increased. Another Key Informant had this to say, that:

> *Ndave kupedza nguva yakawanda ndirikure nevana vangu nekuda kwebasa rawanda rekuchenesa kubasa uye varwere vekundoona vawanda. Saka unogara uchiita basa zhinji kudarika zvaunofanira kuita.* (And then I'm spending more time away from my kids because of a lot of cleaning work, and spread out your appointments. So you're just pulled away so much more than you would like (02-KI).

A nurse who contracted COVID-19 at work felt guilty about the impact it had on her children. She said:

> *Ndakabatwa neCOVID-19 ndikaiswa kwangu mumba mangu ndega, kure nevamwe. Hapana aiziva kuti ndirikunzwa sei. Saka vana vangu vaingofunganya kuti ndichararama here.* (I was in isolation. They didn't know how I was doing. So they were super stressed, anxious around whether mom is going to be OK (08-FGN).

At the peak of the COVID-19 pandemic, paid work burdens and risks-imposed constraints on unpaid care work, which led to mothers' distress, caused feelings of frustration, powerlessness and guilt. One nurse admittedly remarked by saying:

> *Kana hupenyu hwako hwepamba hwaoma seizvi, usina vanhu vako vanokutsigira, unoshaya chinokutsigira, woomerwa mupfungwa, wobva wati regai ndimboti imwei waini ndibvise kuomerwa uku uchifunga kuti zvinhu zvese zvichangonaka zvega.* (When your home life is hard like this and you don't have your support people, you don't have things to put back into your emotional bank, then you decide to take wine to reduce stress, hoping that all things will just be okay (03-FGN).

In actual fact, many of the respondents in this research felt that lack of care infrastructure exacerbated moral constraints. Most of them described childcare as a nightmare and impossible.

Moral conflict at home

Healthcare providers experienced moral conflict when they identified opportunities to adapt paid care work to better meet unpaid care responsibilities but were denied permission to do so. One nurse's request to partially work from home (which she felt was possible with her responsibilities) was denied and she was told to 'figure out childcare or take leave' (07-FGN). A community health worker who had taken time off due to childcare closures described receiving "threats from my employer that if I didn't get back to work then what? Not an overt threat but there was always the threat of 'You need to get back to work and figure this out.' So I felt like I was drowning every single day" (13-FGCHC).These conflicts reflect the assumption that women should be able to manage both paid and unpaid labour, even when unpaid work increases due to exceptional circumstances such as a pandemic.

Moral dilemma at work

Moral dilemmas result from having to choose between two or more non-negotiable moral requirements (Ives, *et al.,* 2020). Most of the employed participants interviewed described moral dilemmas over their inability to both provide an ethical standard of care and maintain COVID-19 prevention protocols. A nurse at Rimbi Clinic described her being unable to get into a patients' ward on time to incubate them due to the need to put on PPE properly first. She said:

> *Zvinonetsa chaizvo nekuti panedzimwe nguva ndaitadza kupfeka nhumbi dzekuzvidivirira pabasa nenguva. Panguva imwechete, murwere aikungochema, apa ndisingakwanisi kuenda kwaari ndisina kuzvidzivirira. Murwere akabva ashaya ndakatarisa, ndikashushikana kwazvo. Nekuda kweizvi, ndakatsvaga rubatsiro kuti ndisanzwa ndiine mhosva yekurega murwere achifa.* (It's upsetting because there's a few moments where I couldn't get to put on PPE on time. Meanwhile, the patient was groaning in pain and I just couldn't get to help the patient without putting on PPE. The patient died in my eyes and I got worried. For that reason, I went for counseling so I couldn't feel the guilty" (03-FGN).

Moral dilemmas were acute when respondents had to enforce COVID-19 protocols which they recognized as negatively impacting patients'/ residents' emotional wellbeing. A Sister-in-Charge at Chibuwe Clinic described the burden of having to prevent family from visiting patients with COVID-19 saying:

> *Kushungurudzika mupfungwa kunovepo nekuti unenge uchiziva kuti murwere anoda hama dzake pedyo asi hadzikwanisi kuuya kuzomuona.* (You get moral distress from knowing that a patient needs his/ her relatives close-by but they are not allowed to visit (05-FGN).

The isolation of patients/ residents created a further layering of moral dilemma whereby healthcare providers felt they should increase the comfort they provided but remained restricted by COVID-19 protocols. Nurses described situations whereby they were being instructed to spend as little time as possible with patients, to reduce risk of transmission, and yet at the same time, patients needed greater emotional support because they had no family present. Midwives described physical/ social distancing as

conflicting with "the essence of midwifery care" (01-FGMW), which is based on building relationships and providing holistic support, during a time expectant mothers needed additional reassurance due to fears around COVID-19 and inability to access other support networks.

Moral dilemma at home

In the home front, moral dilemmas emerged around balancing occupational risks and responsibilities for dependents' wellbeing. While all participants spoke of anxiety around the possibility of transmitting COVID-19 from work to home, those with elderly care responsibilities were particularly conflicted, describing high levels of guilt when they decided against caring for their elders out of concern for their safety and anxiety when they had to continue to provide care due to lack of alternatives. Participants noted that moral dilemmas over how to reduce COVID-19 risks for those they provided both unpaid and paid care to affected relationships with family members

Resisting conditions of moral distress

While sources of moral distress directly related to the pandemic, such as physical distancing policies and information uncertainty, were recognized as beyond their control, participants shared instances of moral distress and other constraints, and the efforts to overcome moral residue. Midwives successfully advocated for access to government supplied PPE by working with the Chipinge District and Mission hospitals.

In order to address the long-term effects of moral distress, such as moral residue, some participants either increased their counseling sessions or began therapy during the pandemic. Midwives were the only HCPs who did not have access to employer provided mental health supports or extended benefits. Consequently, one midwife explained that:

> *Ndakatowedzera nguva dzangu dzekubatsirwa kugadzikana mupfungwa nekuti, sekuziva kwenyu, handizvikwanisi, asizve handikwanisi kurega kuzviita. Saka tirikungopinda muzvikwereti nekuti tinofanira kutongotaura neumwe munhu nekuti zvinhu zvacho zvakanyanya.* (I also have increased my counseling time in the last few months because I'm like, you know what, we can't afford it, but I also can't afford not to do it. So, we just go into debt and I'm putting it all on my credit card because I need to speak to someone because it's just too much (01-FGMW).

In this case, committing to self-care generated new vulnerabilities where healthcare providers get exposed to accruing debts in order to care for themselves.

Respondents also spoke of how they resisted moral residue by drawing on professional pride and fulfillment. A midwife explained by saying that:

> *…tinoramba tichishanda munguva yeCOVID-19, tichingoshanda sevashandi vasingakosheswi nenharaunda yedu uye zvipatara zvedu, asi tinongoramba tichishanda nekuti tinofarira zvatinoita.* (We will keep working in the pandemic and we'll keep working as underpaid people, we'll keep being undervalued by our communities, our hospital, and we'll keep doing it because we love what we do (09-FGMW).

Similarly, a nurse explained that she was willing and able to go to work in her completely broken state because she was a nurse and that was what nurses were trained and expected to do. While such expressions convey the continued exploitation of the essential work these women provide, they also express a recognition of its value beyond its commodification, and a determination to continue to strive for the ethical standards of care they deem essential.

Discussion

The onslaught of the COVID-19 pandemic created new and heightened experiences of moral distress among HCPs. Findings from this research confirm experiences that identify physical distancing policies, isolation and moral uncertainty as sources of moral distress during the COVID-19 pandemic (Anderson-Shaw *et al.,* 2020). Results suggest that lack of adequate staffing and access to PPE contributed to moral constraints, while lack of consultation between decision-makers and healthcare providers led to moral conflict. Uniquely, the argument is that health-care and social-care workers experienced moral distress in response to both paid and unpaid care work. Participants described moral distress in response to their inability to provide quality care to dependents and education to children, as well as from fear of passing the virus from work to their family, or vice versa. While the structure of feminist economic analysis has separated moral distress in response to paid (at work) and unpaid care work (in the home), participants in this study did not experience two separate forms of moral distress. Women HCPs returned from overtime shifts exhausted due to staff shortages to feel further guilt when faced with demands from children in their homes. Those with elder care responsibilities lived with the fear of passing the virus to the people they cared for both at work and at home.

While many of the experiences of moral distress at work were not explicitly gendered, and therefore, may be experienced by HCPs of all genders, implicit gender norms structured these events. How care, as a feminised act, is valued, both as paid labour and an often invisible contribution to social relations, is reflected in inadequate staffing policies and expectations that those providing care will continue to do so despite lack of resources, including basic supplies such as PPE and infrastructure such as childcare (Gilligan, 2016). Women's own recognition of the importance of the care they provide, despite lack of formal recognition and support, compelled guilt when care burdens became impossible to manage (Held, 2006). The distress women felt when they could not have meaningful relationships with those they provide care to, due to physical distancing, reflect the relational aspects of moral decision-making often associated with women.

The feminist political economy (FPE) lens applied in this research not only enables the gender analysis of health systems and the inclusion of unpaid care but offers a framework for understanding relationships between individual experiences and structural constraints of moral distress (Brassolotto, *et al.,* 2017). This approach bridges FPE literature, which demonstrates that when institutional investments in care are inadequate, women bear the costs individually. In turn, the moral distress analysis adds to the FPE literature on the care economy, demonstrating that the costs of unpaid care borne by women during COVID-19 are not only material in terms of lost wages and opportunities, as has been demonstrated elsewhere, (Oveisi, *et al.,* 2022) but also psychological in terms of the long-term effects of moral distress. Such findings suggest further potential for the application of FPE to moral distress research questions and vice versa.

The feminist political economy theory further highlights the agency of women by considering how they sought to resist constraints (Rai *et al,* 2013). Notably, women had to take it upon themselves to organise, seek out resources and resist moral residue. Whatever external support systems were provided, such as access to counseling services, were not only unequally available, but responded to the individual effects of moral distress such as anxiety and trauma, as opposed to the structural determinants such as lack of staffing and equipment. Despite moral distress being increasingly documented as a collective experience among HCPs, particularly during COVID-19, very little attention has been put on how HCPs can be assisted to avoid moral distress. It is clear that the COVID-19 pandemic exacerbated existing gender inequalities, as women disproportionately took on increased caregiving responsibilities both in the home and in healthcare settings. Many women had to balance working from home, homeschooling children and

providing care for the elderly or vulnerable family members- all while healthcare workers, were on the frontlines of the pandemic. Care ethics, a feminist philosophical approach that emphasizes the moral significance of caring relationships and attentiveness to context and particularity, has been especially relevant during this time. This research shows that care ethics highlights the crucial yet often undervalued work of caregiving and the ways in which this labour falls disproportionately on women.

From the participants' responses, it is clear that the pandemic illuminated a bright light on the ways in which social institutions and systems have failed to adequately support and care for caregivers, particularly women. Issues such as the lack of paid family leave, inadequate childcare options and insufficient mental health resources for healthcare workers in homes and healthcare institutions, have made the situation even more challenging. Addressing these problems require a multifaceted approach. There is need for policy changes that recognise and value caregiving work, expand social safety nets and provide more comprehensive support systems for both institutional and familial caregivers. It also requires a broader cultural shift in how caregiving responsibilities are conceptualised and distributed. The responses from the institutional healthcare participants pointed out that one of the key aspects of the COVID-19 pandemic's impact on women caregivers has been the increased burden of unpaid domestic care work. With school and daycare closures, many women had to take on the full-time role of homeschooling and childcare, in addition to their regular paid work responsibilities. It immerged that the extra baggage of unpaid labour placed tremendous strain on women's physical and mental wellbeing.

Furthermore, women have comprised a significant majority of the healthcare workforce, often working long hours in high-stress environments. These frontline workers have faced increased risk of infection, lack of personal protective equipment, and immense emotional toll from caring for critically ill patients. Yet, their needs for rest, respite, and mental health support have often been overlooked. Ultimately, the COVID-19 pandemic highlighted the pressing need to rethink how a society cares for those who care for others when they fall ill. By focusing on the experiences and needs of women caregivers, society can work towards a more equitable and sustainable system of care that extends to cover for the needs of the caregivers as well. A more just, resilient and caring society- one that recognises the fundamental importance of care work and provides the necessary support systems, has become an imperative to cushion all health care givers from the adverse impact of pandemics. This is essential not only for weathering crises such as the COVID-19 pandemic, but for building a more equitable and thriving future.

Conclusion

Considering the well-documented effects of moral distress on healthcare providers' mental health and the burnout they suffer, and the attendant secondary effects on human resources in the healthcare sector, it is imperative to investigate and address the moral distress experienced by women healthcare providers in the context of the COVID-19 pandemic. Responses must go beyond short-term mental health interventions, to address the underlying constraints, many of which pre-date COVID-19 and are notably gendered, around working conditions and investments in the care economy. The COVID-19 pandemic has shone a spotlight on the critical role that women play as caregivers, both in formal healthcare settings and in informal, unpaid caregiving within families and communities.

Women have disproportionately borne the burdens of care work during the pandemic, juggling paid employment, childcare, eldercare and other domestic responsibilities. This has taken a significant physical and emotional toll on women caregivers, many of whom have experienced increased stress, burnout and mental health challenges. Yet, the needs and experiences of these caregivers have often been overlooked, with insufficient support and resources provided to help sustain them in their vital caregiving roles. Moving forward, it would be crucial to develop robust care infrastructure and policies that recognise and value the essential work of women caregivers. This could include expanding access to affordable childcare and eldercare services, providing paid family and medical leave, ensuring fair

wages and benefits for formal and informal care workers, and offering mental health support and respite care for unpaid caregivers.

Additionally, care ethics- an approach that emphasises empathy, interdependence and the moral primacy of care relations- should be more deeply integrated into policymaking, organizational practices and societal norms. By interrogating the experiences and needs of caregivers, especially women, this article has highlighted the need to work towards a more equitable, resilient and humane post-pandemic world. Ultimately, caring for the care-givers is not only a moral imperative, but a practical necessity if humanity were to navigate future crises and build a more just and inclusive society.

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