Gender segregation as a benefit – a qualitative study from Pakistan

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Aim To explore the possibility of exploiting gender segregation as a benefit for registered female nurses.
Background Nursing is a highly gendered profession in Pakistan with 95% of nurses comprising females who suffer from low professional status, negative identity and unfavourable work environments.
Methods A qualitative research design was used to interview 12 nurses in management positions through purposive sampling. Face-to-face in-depth interviews were conducted to explore the views of female nurses on the benefits, if any, of gender segregation in the nursing profession.
Results Content analysis identified three major categories of benefits of gender segregation for female nurses including: (1) demand for female nurses compared with demand for males, (2) resilience of female nurses in the face of difficult work environments and (3) comfort and safety of female co-workers in a male-dominated setting.
Conclusion Realising the benefits of gender segregation could mobilise nurse teamwork and union efforts in order to improve nurse identity, professional status and work environments.
Implications for nurse management The present study highlights the nurse manager role in advancing knowledge of gender segregation benefits, team-building for gender solidarity, control of nurse supply, union mobilization and raising community awareness for women's health development.

Keywords: benefit, female nurse, gender segregation, nurse manager, Pakistan

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Introduction

Gendered professions are described by literature as a consistent pattern of gender segregation in the reproduction of roles, identity and occupations (Acker 2006). When societies do not accept men in feminized occupations the profession is known to suffer negative status (Hollup 2013). Nursing is a highly gendered profession with characteristics of care provision, nurturing and emotional support contributing to its 'feminisation' (England 2005). Female nurses are commonly known to suffer from low pay, lack of employee benefits, bad work structures and high rates of violence (Pudney & Shields 2000, Walani 2013),

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with problems remaining unsolved because of lack of funding and acceptance of stereotypical female subjugation (Kane & Thomas 2000). South Asia and other developing nations have consistent reporting of females dominating the nursing profession and evidence of elevated gender inequality in the workplace (Lee & Saeed 2001, Piper 2005).

Developed nations have encouraged men to enter into the nursing profession in attempt to solve nurse shortage problems (Whittock & Leonard 2003, Buerhaus *et al.* 2004). Research shows that male nurses entering into the nursing profession create gender inequality through their ability to 'ride the glass elevator' and secure higher pay and promotions for themselves while relegating their female counterparts to minority status (Kvande 2002, Simpson 2004). This systematic advantage of male nurses is secured by dominance of men in top administrative positions (Snyder & Green 2008) along with the inaction of female nurses (Elwér *et al.* 2012). Research from patriarchal societies suggest that entrance of men into the nursing profession only reaffirms female nurse subjugation because of the acceptance of cultural norms and the presence of male-dominated hierarchies (Herdman & Badir 2008).

In the last decade there has been more recognition that existence of gender segregation in an occupation does not always necessitate gender inequality (Blackburn & Jarman 2006). Studies have acknowledged that there is a patriarchal dividend of gender segregation (Connell 2005, Herdman & Badir 2008), with benefits of providing societies and organisations with stability, cohesiveness and horizontal segregation (Bettio 2002, Blackburn 2009). Horizontal segregation is deemed a benefit because the segregated gender would not have to compete for promotions and seniority. Some developed economies have attained relative equality in earnings between male and female nurses through union mobilization (Catalano 2000, Apesoa-Varano & Varano 2004, Tourangeau & Cranley 2006, Vecchio *et al.* 2013). In addition, female teamwork has shown positive association with advancement of professional status and increase in job satisfaction for female nurses (Bryant-Lukosius *et al.* 2004, Jaruseviciene *et al.* 2013).

Interactionist sociological philosophy asserts that social reality is a process of individual interaction and perceived interpretation (Aksan *et al.* 2009). In other words it is not society or structures which dictate actions but individuals. Nursing practice has been recognized as an action-based and reflexive profession which can alter its own realities through individual and managerial efforts (Allen 2001). The gender perspective for this study is guided by the 'difference' perspective, which implies that men and women are different and equality can be created through recognition of differences and valuing of equality between the genders (Verloo & Lombardo 2007).

Background

Of the 76 244 nurses in Pakistan an overwhelming 95% are female (World Health Organisation 2012). Desperate nurse shortages exist with the ratio of nurses at only 5.8 per 10 000 population (World Health Organisation 2012). Nurses in the country are plagued by unfavourable work environments, high rates of violence, negative professional identity and inadequate structural benefits (Lee & Saeed 2001, Somani 2012). Nursing unions exist but they have been ineffective in improving public image and constitutional rights for female nurses (Khan & Khan 2011). The gender gap index ranks Pakistan 134 out of 135 countries (Hausmann 2012), which has implications for the sustaining of female inequality in areas of educational access, legal rights, political participation and employability. Low female labour participation, at 15.9%, and relegation of females to feminised professions play a significant role in the social construction of gender inequality (Khan 2007). The problems of working women in Pakistan, and especially nurses, have their roots in deeply patriarchal sociocultural values and male-dominated work structures (Lee & Saeed 2001, Hussain 2008). Cultural patterns prohibit men from entering into feminized professions such as nursing, which is seen as an extension of the female domestic housewife role. Men's entry into nursing in Pakistan is minimal and this pattern will be slow to change because of a lack of investment in male nursing programmes, a lack of policy initiatives and traditional 'masculinity' barriers to entry (French *et al.* 1994).

Gender-based violence in the workplace for female nurses is suspected to be extremely high as there is an inability to ascertain overall statistics because of the lack of a reporting culture (Lee & Saeed 2001). The presence of physical, verbal and sexual assault at the workplace is fortified by male supremacy in administrative positions and a lack of constitutional laws supporting female safety at work (Weiss 2003, Newman *et al.* 2011a). Female nurses in developing nations bear burdens of role-delivery at work and at home without structural support or community and family relief (Newman *et al.* 2011b). The female Paki-

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stani nurse has additional burdens of home care from joint family living arrangements and pressures from in-laws and extended family (Jejeebhoy & Sathar 2001). Even though dependence on female nurses for care provision is high (Marks 2001, Ahmad & Alasad 2007), nurses in Muslim societies are highly stigmatised for interacting with male patients and male colleagues who are not their male relatives (Padela & Del Pozo 2011). Inadequate work environments for female nurses has encouraged high rates of immigration from countries such as India, Pakistan, the Philippines, Zimbabwe and sub-Saharan Africa to the developed world (Iredale 2001, Aiken *et al.* 2004, Ball 2004, Brush *et al.* 2004). A dire need exists for developing nations to prevent nurse brain-drain and nurse shortages through immigration to developed nations (Aiken *et al.* 2004).

Scope and aim of study

There is an absence of research from the Muslim world about exploration of sociocultural solutions for gender problems and nurse gender inequalities (Hollup 2013). International research suggests that it is important to identify the benefits, if any, of gender segregation in the nursing profession (Kane & Thomas 2000), reap the patriarchal dividends of gender segregation through exploitation of female nurse majority (Hollup 2013) and encourage female nurse managers to assume a progressive role for female nurse equality in the workplace (Elwér *et al.* 2012). Further scope for this study is rooted in the current national need to identify possible solutions for nurses to improve professional status, work structures, recruitment and retention. Empowering the nursing profession would secure optimal nurse care-provision, patient safety and progressive balance for the health sector (Armstrong & Laschinger 2006). The aim of the study is to explore nurses' own views on the possibility of exploiting gender segregation as a benefit within the nursing profession in Pakistan. This study is relevant for other developing, Muslim, conservative and patriarchal societies that have female-dominated nursing professions. It is hoped that nurse mobilisation for equality and autonomy in the workplace will also have benefits for other working and non-working women in Pakistan (Kabeer 2005).

Methodology

A qualitative design using a content-analysis method was used for this study. Content analysis is recurrently used in nursing research and enables the researcher to inductively and systematically describe phenomena through meaningful categories (Graneheim & Lundman 2004). This approach was suitable for the exploratory nature of the study which aimed to explore and describe nurse managers experiences of the possible benefits from gender segregation (Elo & Kyngäs 2008). The in-depth interviews were conducted by the first author through semi-structured interview questions. The main question asked was: Could you identify any benefits of gender segregation for females in the nursing profession? Probing questions were used to clarify responses and decipher conversion of the benefits in an active and practical manner. These questions were, for example: How may what you have referred to as a benefit be converted to an active benefit in working life? Audio tapes were not used to encourage nurse managers to talk openly and freely about sensitive topics related to workplace and work colleagues.

Participants

The selection criteria for recruiting participants for this study was registered and practicing nurse managers with more than a decade of management experience. Nurse managers were considered suitable for interviewing because of their competency and knowledge, rich work experience in supervision and training of nursing staff, and information-rich interactions within hospital settings (Profetto-McGrath *et al.* 2009, Casida & Parker 2011). Pakistan public sector hospitals have three groups of nurse managers: nurse supervisor, nurse clinical instructor and ward head-nurse. Participants were recruited based on purposive sampling from Hospital A and Hospital B in Lahore with quota sampling used within subpopulations of nurse supervisor, instructor and ward head-nurse. Both institutes are large tertiary-care public sector hospitals and teaching hospitals for student nurses in Pakistan. Both institutes have a combined total of 84 nurse managers including: one nurse supervisor each, 10–12 nurse instructors and 24–36 ward head-nurses.

In total, both the nurse supervisors, five nurse instructors and eight ward head-nurses were requested for permission to be interviewed and all 15 gave their consent. Interviews were continued with 12 participants until saturation or until no new information was forthcoming and no new theme was emerging from respondents. The final participants of nurse managers for this study included two nurse supervisors, four instructors and six ward head-nurses (Table 1). Interviews were carried out across a 6-week period

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Table 1
Purposive sampling breakdown of nurse managers (n = 12)

	Hospital A (n = 6)	*Hospital B* (n = 6)
Nurse supervisors	1	1
Nurse instructors	2	2
Ward head-nurses	3	3

from April 2013 to June 2013 as a part of the qualitative data collection process for the PhD thesis of the first author. Each participant was interviewed only once and the interviews lasted between 45 minutes and 60 minutes.

Data collection

Ethical approval was received from the Institutional Review Board, University of the Punjab. Before the start of each interview informed written consent was given by all the participants. Participants were assured confidentiality, anonymity and freedom to end the interview at any time. All participants were female, aged between 40 years and 55 years and with over 15 years of working experience as registered nurses. All nurse managers had studied and worked exclusively in Pakistan; two had attained highest degree of Master of Science (MSc) in nursing, three had attained an undergraduate Bachelor of Science (BSc) in nursing and seven had attained a 4-year diploma in nursing. The interviews were carried out in a semi-structured and conversation style to invite valued data and additional information of relevance. The first author and assistant note-taker took copious notes during interviews, which were transcribed for analysis.

Data analysis

Conventional content analysis was used in which codes are inductively derived from data during data collection and coded according to relevance and similarity (Graneheim & Lundman 2004, Hsieh & Shannon 2005, Elo & Kyngäs 2008). Although content analysis is commonly used in nursing research, less has been written about how to apply it methodologically (Elo & Kyngäs 2008). It has been shown that content analysis is not linear, straightforward or a standardised process; instead, it is flexible and highly dependent on researcher style and skill (Hsieh & Shannon 2005).

This study has been guided by Graneheim and Lundman's (2004) eight concepts of qualitative content analysis, which include: identification of manifest and latent content of text, unit of analysis, development of meaning unit, condensation, abstraction, content area, coding and categorisation. The unit of analysis for this study was interview text that referred to 'the benefits of gender segregation for female nurses'. Graneheim and Lundman (2004), suggest that the research question is a suitable unit of analysis as it is large enough to keep in mind reflection of the context and its meaning developed by researchers. Microsoft word was used to transcribe and code interviews. The data analysis process included: (1) grouping of text that was related to each other into meaning units, (2) condensing meaning units in size while retaining meaning, (3) abstracting and labelling condensed meaning units with codes and (4) grouping common content into subcategories. The process of data analysis is presented in Table 2 using the example of subcategory development of 'preference of male and female patients'. Categories with similarity were grouped together after interviews with respondents 1, 2 and 3. Subsequent interviews with respondents 4, 5, 6, 7, 8, 9 and 10 confirmed coding and categorisation. At this point, categories for benefits of gender segregation were being repeated and no new categories had emerged. A final two interviews with respondents 11 and 12 were conducted to confirm saturation point.

Table 2
Examples of meaning units, condensed meaning units and codes for subcategory of 'preference of male and female patients'

Meaning unit	*Condensed meaning unit*	*Code*	*Subcategory*
When patients, male or female, ask for the nurse, they expect motherly and sisterly care provision from a female nurse not male nurse. Nurses are called 'sister' or 'mother' and not 'nurse'	Both male and female patients prefer and expect care provision to be provided from female nurses and not male nurses	Male and female patients prefer and expect female nurse	Preference of male and female patients
Male nurses will not be allowed to provide services to women in our society owing to not being 'mahram' (unmarriageable kin) and inviting cultural and religious restrictions or censure	Male nurses cannot be allocated to female patients owing to socio-cultural and religious taboos	Male nurses cannot be allocated to female patients	

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Trustworthiness of data

To ensure the trustworthiness of data analysis, coding and categorisation the interview transcripts were reviewed independently by first author and research assistant (Graneheim & Lundman 2004). All authors met regularly to ensure accuracy and consistency during the process of data collection and analysis. In this way, the refinement of categories was carried out. Debriefing sessions were held frequently with senior researchers about consistency and dependability of data analysis and coding (Shenton 2004). Final transcripts were shared with nurse manager participants with the intention of identifying discrepancies or misreporting of information. Findings and categories were confirmed by nurse manager participants without indication of misrepresentation.

Findings

In the present study, all 12 nurse managers agreed for the need to discuss the possible benefits of gender segregation for females in the nursing profession because of problems related to violence, low professional status and negative nurse identity. All 12 participants confirmed that female nurses dominated the nursing profession in Pakistan and that this female majority would be a long-term situation in the Pakistan health-care sector because of sociocultural values prohibiting male entry and the scarcity of nursing schools for males.

Table 3 describes three broad categories and subcategories of the perceived benefits of gender segregation described by nurse managers. The three categories of the benefits of gender segregation included: 'demand for female nurses', 'resilience of female nurse' and 'comfort and safety of female co-workers'. The first category of 'demand for female nurses' included subcategories of: (1) preference for female nurses over male nurses, (2) the acceptance of female nurses by all types of patients and (3) the monopoly of care-instinct and emotional support by female nurses. The second category of 'resilience of female nurse' included subcategories of: (1) enrolment in nursing schools despite negative nurse image, (2) retention despite bad work structures and violence, and (3) front-line exposure to social and health problems of female patients. The third category of 'comfort and safety of female co-workers' included subcategories of: (1) sharing emotional burdens, (2) relief in work burden and shift scheduling, (3) respectability of female work-colleagues (in a conservative community) and (4) safety of female work colleagues in highly aggressive and violent work environments.

Table 3
Categories and subcategories of the perceived benefits of gender segregation described by nurse managers

Categories	*Sub-categories*
1. Demand for female nurses	Preference of male and female patients
	Acceptable for all
	Monopoly of care-instinct and emotional support
2. Resilience of female nurses	Enrolment in nursing schools despite negative nurse image
	Retention despite bad work structures and violence
	Front-line exposure to social and health problems of female patients
3. Comfort and safety of female co-workers	Sharing emotional burdens
	Relief in work burden and shift scheduling
	Respectability of female work-colleagues (in conservative community)
	Safety of female work-colleagues in highly aggressive and violent work environments

Demand for female nurses

All participants described male and female patients as having an exclusive preference for female nurses. Discussions portrayed general social expectations in society of female nurses being more acceptable care providers. Participants mentioned that the female nurse has an advantage of being 'acceptable to all', whereas the male nurse is comparatively 'inferior' and less in demand by patients and health institute. A ward head-nurse from orthopaedics with 18 years of working experience predicted:

> 'If we (female nurses) stop services or go on strike, the hospital would close down! Our health-care sector is dependent on female nurses. We must understand our strengths to build our confidence and unity'. (Participant 6)

Almost all of the participants held the view that, in hospital settings, unlike male nurses, female nurses were in high and exclusive demand. It was suggested that to convert demand for female nurses into an active benefit, nurses would have to recognise their majority strength and control their supply in order to change their workplace environment. These changes were detailed by nurse managers in terms of need for better child-care centres, maternity breaks with pay, gap years, part-time work and flexible working hours.

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Participants also emphasised that health-care administration, patients and attendants expected care provision and emotional support from female nurses rather than from male nurses. A nurse instructor from Hospital A, with 15 years of experience in training nurse students summarised:

> 'Female nurses monopolize care instincts. Care provision is an innate feature which we (female nurses) do not require training for. When patients are admitted for long periods of time they turn to female nurses for care provision and when relatives are dealing with the loss of a patient they depend on female nurses for emotional support. No male staff member can provide this necessary service in hospital settings'. (Participant 3)

Resilience of female nurses

The majority of the participants described the resilience of female nurses while working in male-dominated and adverse work environments. This was highlighted in terms of females enrolling in nursing schools and remaining in the profession despite the difficulties of work strain and negative nurse image in the country. It was expressed that that resilience to enter nursing profession and stay in the profession are both strong indicators of high professional commitment of female nurses. An important finding from nurse manager participants was the unanimous proposition that the shortage of nurses in Pakistan was caused by a lack of graduate enrolment but a lack of government hiring after nurse student graduation. A nurse supervisor at Hospital A, with past experience as a nurse principal, stated that:

> 'Despite work strain and frequent violence, nurses are still entering and remaining in the profession. I see nurses underpaid and overworked year after year – yet still not leaving the profession'. (Participant 1)

It was suggested that nurse commitment should be channelled toward professional status development through stronger union mobilization. The main requirements from a strong union mentioned were an increase in work autonomy, respect for the profession, legal improvements and investment in education and training. Legal improvements were specified by participants in terms of proper implementation of laws against harassment and violence at the workplace, minimum wages, maternity benefits and adequate nurse staffing ratios per ward. A nurse supervisor from Hospital B with 25 years of working experience commented:

> 'We have a nursing union (Young Nurses Association). But it is mostly involved in protests and has not been able to influence operational changes in medical policies, nurse contracts or legislation. Our union needs to combat state and health sector failure by expanding initiatives aggressively to gain nurse autonomy, safety and training'. (Participant 2)

It was also agreed by the majority of participants that the nursing union should be used as a platform to raise awareness for general social problems related to women's inequality and oppression in society. The nurse manager participants expressed an opinion that female nurses have significant knowledge of sociocultural problems and difficulties faced by female patients because of their front-line exposure. For example, a nurse ward-head in gynaecology and maternity department with 18 years of working experience commented:

> 'Female patients delivering newborns at hospital have common and highly prevalent problems of… closely spaced births, inadequate nutritional consumption, lack of awareness about immunization requirements for newborn and experiencing violence from husbands and in-laws. Our nursing union should include advocacy for women's health and rights'. (Participant 9)

Comfort and safety of female co-workers

All participants recognised that having female co-workers gave female nurses the advantage of sharing emotional burdens and supported a 'sisterhood'. Female nurses were described as being able to discuss domestic pressures, share duties and swap shifts with each other. In addition, participants elaborated the advantages of having female nurse co-workers while working late hours, earning low pay, and bearing high stress from multiple sources, including patients, attendants, hospital co-workers and conservative families. A nurse supervisor from Hospital A commented:

> 'Female co-workers understand the pressures of juggling workload with husband, children, in-laws and home-care. We (female nurse colleagues) are able to cover for each other when home crises occur. Men can never understand

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> baby-sitting problems or difficulties of living with unaccommodating in-laws'. (Participant 1)

In the context of the conservative culture of Pakistan, the majority of nurse managers described that there is great comfort for female nurses in sharing rest-rooms, lunch breaks, sleeping area and non-work leisure activities with female co-workers. It was also mentioned that there is safety in the presence of female co-workers because of fears from a male-dominated and violent environment. A nurse instructor with 21 years of working experience and 12 years of skill in training nurse students added:

> 'Violence, sexual overtures and inappropriate behaviour is commonplace for female nurses. We teach our students to maintain the invisible code of never leaving each other alone with aggressive and volatile patients or with male physicians and doctors who have bad reputations. Like they say, there is safety in numbers'! (Participant 5)

Discussion

Despite the chains of patriarchy and illiteracy, and regressive movements against women by the Taliban (Hirschkind & Mahmood 2002, Gardezi 2008), there is a demand for female employment and female nurses want to stay in Pakistan. International research has emerged in the last decade to support the benefits of gendered professions, but with recommendations for contextual and regional evidence (Bettio 2002, Blackburn & Jarman 2006, Blackburn 2009). Nearly all the nurses in Pakistan are female and there is an urgent need to exploit current demographic characteristics to counter dire circumstances related to nurse shortages, unsafe work environments and unfair work structures (Kane & Thomas 2000, Lee & Saeed 2001, Somani 2012). Studies suggest that female nurses must use their segregation as a benefit and exploit their strengths on the basis of gender differences (Verloo & Lombardo 2007), with the most vital role played by nurse managers (Elwér *et al.* 2012). The present study attempted to describe nurse manager views on the possibility of using gender segregation as an impetus for developing active benefits for the profession.

Demand for female nurses was the first category that emerged from findings, with both male and female patients exclusively preferring female nurses. Feminist theories suggest that even in the most patriarchal and conservative societies, men are known to fulfil their needs through the use of female labour (Gardiner 2005). Our findings confirm that majority of female nurses in a male-dominated society can benefit from the high dependency on, and exclusive demand for female nurses. Other Muslim and conservative societies also have a preference for female nurses (Chur-Hansen 2002, Vidyasagar & Rea 2004, Ahmad & Alasad 2007). Findings show that nurses have the power to control their supply and consequently create formidable gender solidarity to combat community barriers against women's autonomy and professional advancement (Khan 2007). Nurse solidarity in the developed world has been found to be successful in gaining nurse workplace benefits and role expansion (Wade 1999, Bryant-Lukosius *et al.* 2004, Cresswell *et al.* 2010).

Findings revealed that another monopoly of female nurses was the universal bias in assuming that they would provide better care, emotional support and healing. Women have, across time, predominantly assumed the role of care provision at home for the elderly and for children (England 2005) because of their inherent care instinct and stereotypical role casting (Marks 2001). It is this exclusive care instinct which gives female nurses power to control their work environments and employment benefits if they are mobilised and united. In addition, nurses play not just a 'care'-providing role but a 'cure'-providing role for patients (Aiken *et al.* 1994). By controlling their supply in terms of either revoking their services completely or by low-quality nursing care-provision, nurses have the power to dictate their supply terms and conditions. International evidence of reduced mortality rates through better care provision by nurses (Needleman *et al.* 2002) can also be used to demand improved work benefits and structures for nurses in Pakistan.

Findings under the resilience of female nurse category indicate the strong commitment of nurses who are driven to enter into and remain in the profession despite known problems of low pay, high levels of work strain and lack of safety. It was suggested that with gender solidarity and stronger union mobilisation nurse commitment could easily be transferred to improvement in professional status of nursing. International studies show a positive correlation between nurse commitment and development in nurse work structures, education and legislation (Catalano 2000, Apesoa-Varano & Varano 2004, Tourangeau & Cranley 2006, Vecchio *et al.* 2013). Findings determined that union mobilisation should target constitutional changes and improvement in work structures for female workers, including higher wages, maternity

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benefits, part-time work options and child-care centres. Nurse union mobilisation must also be geared toward legislative improvements for women's legal protection at the workplace and at home (Ellsberg 2006) in order to counter the common problem of violence against women in Pakistan (Lee & Saeed 2001, Somani 2012). It is agreed that without legislative improvements and change in community norms female-dominated nursing professions cannot improve (Herdman & Badir 2008). Improvements in nurse professional status and work structures will assist in preventing immigration and brain-drain of nurses from developing nations (Aiken *et al.* 2004, Brush *et al.* 2004).

Although nurse shortages have been recognised in Pakistan (World Health Organisation 2012), our findings imply that the shortage is not caused by low graduate enrolment and retention, as expected (Khowaja *et al.* 2005), but by a lack of government hiring. Reasons for this may include extremely a low budget allocation for the health-care sector in Pakistan and corrupt misallocation of funds which favour investment for medical practitioners over nurses (Ahmed & Shaikh 2008, Vian 2008). Another substantial finding is that female nurses who have high interaction with, and knowledge of female patients could, through stronger union efforts, raise awareness for gender issues such as maternal health and domestic violence in Pakistan. This is a substantial finding given that women's access to health care and awareness of nutritional needs for self and children are unfavourably low in Pakistan (Mumtaz & Salway 2005). Gender health inequality problems are sustained by high rates of illiteracy, female unemployment, rural residence and social immobility. In lieu of all this there is need for urgent broadcast of women's health needs through nursing union communication, media campaigns and non-governmental organisations (NGOs). Local literature indicates an absence of, and need for, collaboration between media and civilian bodies for holistic women's development (Khan & Khan 2004, Donelan *et al.* 2008).

The final category, comfort and safety of female co-workers, yielded data about the social cohesion between female nurses in terms of joining together to defend each other, swapping duties, providing emotional support and affording protection in an aggressive work environment. Literature supports the advantages of working women supporting each other in the workplace and helping sustain a work–family balance (Cranford 2012, Jaruseviciene *et al.* 2013). It has also been reported that to maintain care provision and relieve emotional burdens of home and work, it is important for female nurses to be able to have caring and understanding co-workers (Lambert & Lambert 2008). In addition, female co-workers are a benefit for female nurses in Pakistan, where sociocultural values would not approve of or allow overt friendship and rapport-building with male co-workers (Jejeebhoy & Sathar 2001, Roomi & Parrott 2008, Padela & Del Pozo 2011). As gender segregation is socially constructed and theologically validated in Muslim societies it follows that the benefits of gender segregation would garner more support in such communities (Khan 2007, Herdman & Badir 2008, Hussain 2008). It is implied that female camaraderie and wellbeing in the workplace would help nurses to maintain the vital care instinct needed for optimal role delivery and ensure nurse job satisfaction (Armstrong & Laschinger 2006).

Limitations and further research

Limitations of study findings include that they are specific to Pakistan health-care set-up and are highly dependent on the opinions of participants. A need exists to test these findings through other studies in wider settings and in other regions. There is a need to recognise that Pakistan's sociocultural values toward working women control the extent to which nurse managers can influence change. Longitudinal research is recommended to ascertain the effect of nurse managers' ability to convert the benefits into a positive advantage for the nursing profession.

Conclusions

The present study identifies the need for critical expansion of the nurse manager role in Pakistan. Nurse managers must use their position to safeguard subordinate nurses in violent work environments and provide emotional stability in inadequate work structures. More importantly, there is need for long-term fostering of gender solidarity among nurses and mobilisation of unions to convert the gender segregation into a positive benefit and an advantage for professional advancement, work benefits, nurse identity, constitutional rights and workplace safety.

Implications for nurse management

It is recommended that nurse supervisors hold regular meetings with nurse managers for discussion about and awareness of gender benefits of female

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domination in nursing, including the exclusive demand for female nurses, resilience of female nurses and comfort and safety of female co-workers. Nurse managers must in turn become leaders of change for their nurse subordinates and mobilise improvements in the current practice through: (1) team-building initiatives (e.g. customized training, initiation of buddy systems, frequent communication and extracurricular activities like group yoga); (2) control of supply of nursing services (e.g. through strikes and implementation of nurse care-plans in hospital organisations); (3) union mobilization for work benefits, legal rights and protection laws; and (4) raising of community awareness through unions, media and other facilitating bodies.

Gains by nurse managers are highly dependent on authorized facilitating bodies, including provincial and national nursing unions, the Pakistan Nursing Council and the Ministry for Women. The health-care sector and hospital administrations must support nurse managers by arranging periodic formal workshops and programmes for nurses to advance their profession and identity. From a wider community perspective, nurse managers must play a leadership role in collaborating with the media, non-governmental organisations, development lobbies and civil society groups for community awareness toward positive social change for nurse professional advancement and women's holistic health development.

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