

“I Was Facilitating Everybody Else’s Life. And Mine Had Just Ground to a Halt”: The COVID-19 Pandemic and its Impact on Women in the United Kingdom

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A growing body of research has highlighted the disproportionately negative impact of the COVID-19 pandemic on women globally. This article contributes to this work by interrogating the lived realities of sixty-four women in the United Kingdom through semi-structured in-depth interviews, undertaken during the first and second periods of lockdown associated with COVID-19 in 2020. Categorizing the data by subgroup of women and then by theme, this article explores the normative and policy-imposed constraints experienced by women in 2020 with regard to paid and unpaid labor, mental health, access to healthcare services, and government representation and consideration of women. These findings highlight women’s varied and gendered experiences of the COVID-19 pandemic and emphasizes the role that government can proactively play in attending to gender inequalities throughout its COVID-19 response.

Introduction

Infectious disease outbreaks infect and affect men, women, and non-binary genders differently. In the ongoing coronavirus (COVID-19) pandemic, current data suggest that men are infected more than women with a ratio of 1.16:1, and that men suffer more severe symptoms and greater mortality ([Global Health 50/50 2020](#)). However, the downstream effects of COVID-19 are also heavily gendered and affect women disproportionately to men. In this article, we show results from qualitative research with women in the United Kingdom on the socioeconomic effects of non-pharmaceutical

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interventions (NPIs) to stem the spread of the virus. These results complement other quantitative and qualitative studies, highlighting the disproportionate impacts of NPIs on women in the United Kingdom throughout the COVID-19 pandemic (Adams-Prassl et al. 2020; Smith et al. 2021; Xue and McMunn 2020).

The early months of the pandemic witnessed a number of editorials, working papers, and reports warning of the likely impact of COVID-19 on women (e.g. Hupkau and Petrongolo 2020; Peterman et al. 2020; Wenham, Smith, and Morgan 2020). Despite these calls for gender-responsive interventions, primary research from the first months of the pandemic shows that women's lives around the world have been disproportionately negatively affected by COVID-19 and the associated government policy responses. They show COVID-19-related maternal deaths worldwide (Nakamura-Pereira et al. 2020), and the disproportionate loss of jobs for women for two primary reasons: the feminized nature of industries affected by lockdowns (e.g. tourism and hospitality) and the gendered norms related to childcare when schools and nurseries close coupled with restrictions to kinship care (Alon et al. 2020).

Women are disproportionately represented in sectors most impacted by COVID-19 lockdowns, such as hospitality, tourism, and education, while shouldering the brunt of unpaid care duties which have significantly increased due to school and nursery closures (Hupkau and Petrongolo 2020). Women also make up 70 percent of the global health and social care workforce (Manzoor and Thompson 2019). A U.S. study showed that the gender gap in working hours between men and women has increased by 20–50 percent as women have responded to school and nursery closures by decreasing their working hours four to five times more than their male counterparts (Collins et al. 2021). Further studies highlight the particular difficulties in achieving work–life balance during COVID-19 for women with children under five (Del Boca et al. 2020); and mothers saw far greater increases in unpaid work than fathers—however, an increase in paternal unpaid work lead to an overall decrease in the unpaid work time gap between men and women (Craig and Churchill 2021). Decisions to continue in paid employment or undertake unpaid labor within homes form part of routine domestic bargaining in dual-parent households, affected by social gender norms, feminized sectors of the economy, and the gender-pay gap. If a woman is already doing more childcare, already out of work because of lockdown, or earns less, it is likely she will have absorbed the additional unpaid labor during the pandemic. The result of this is stark: in 2020, 5.4 million women in United States lost jobs compared with 4.4 million men (Kurtz 2021).

Significant gendered effects of COVID-19 on mental health have been reported due to increased domestic duties (Ausín et al. 2021; Orefice and Quintana-Domeque 2021; Proto and Quintana-Domeque 2020; Xue and McMunn 2020). Women were more concerned about family and loved ones, while men worried more about society and the economy, highlighting

gendered differences in roles and responsibilities throughout the pandemic (van der Vegt and Kleinberg 2020). A rise in intimate partner violence has also been reported globally (Usher et al. 2020).

We set out to explore the gendered effects of the COVID-19 pandemic in the United Kingdom. The United Kingdom is a reasonably high performer in gender equality globally, being twenty-first in the World Economic Forum's 2020 Global Gender Gap report and sixth in Europe according to the European Institute for Gender Equality's Index. Key challenges to gender equality in the United Kingdom include women's limited representation in parliament (29 percent of ministerial positions), persistent gender gaps in pay and full-time employment, and women's disproportionate unpaid care burden (Barbieri et al. 2020). We sought to understand the effects of the government's COVID-19 response from a bottom-up approach focused on the impact of COVID-19 regulation on everyday women across the United Kingdom.

Recognizing that policy decisions can impact women in a myriad of ways, we employ a framework developed by Morgan et al. (2016) to discuss women's experiences of the UK government's COVID-19 NPIs by evaluating the constitution and negotiation of gendered power relations they experienced. This framework allows us to consider how gendered power relations impact women's lives and agency and how they can be directly addressed and alleviated (or indeed, compounded) at both the individual/household and structural levels.

Methods

Using a gender matrix methodology (Smith et al. 2021), we searched media and gray literature to identify key constituent groups of women at risk of direct or indirect effects of COVID-19. Drawing on the domains of gendered power relations articulated by Morgan et al. (2016), we then developed a thematic interview guide (see Appendix) based on the following questions: "who has what (access to resources); who does what (the division of labor and everyday practices); how values are defined (social norms, ideologies, beliefs, and perceptions), and who decides (rules and decision-making)." Semi-structured interviews were conducted by telephone or Zoom with sixty-four women between April 20 and June 5, 2020. Women came from four constituent groups who were deemed to be most at risk of the downstream effects of the outbreak. This included healthcare workers; parents (particularly of small children); pregnant women/new mothers; and those economically affected (working in industries most affected by lockdown: e.g. recreation, retail, tourism, and hospitality (ONS 2020a)). Recruitment occurred via social media—sharing information about the project with requests for participants to contact us if interested in taking part; and through mailing lists from established

women's organizations in the United Kingdom. Given pandemic working practices, informed consent was obtained verbally at the start of the call. Interviews were recorded and transcribed verbatim. Ethical approval for this study was granted by the London School of Economics and Political Science (LSE) Ethics Committee: 1096. Six months later, we recontacted the same participants by email and asked for a second interview. Thirty-two women participated in follow-up interviews between October 21 and November 20, 2020.

Framework analysis was conducted on the transcripts obtained (Ritchie and Spencer 2002). Two researchers reviewed the transcripts using grounded analysis to identify key trends in the data and creating an iterative coding guide for the remaining transcripts. These trends, grouped into four themes, including how they were conveyed by women generally and along constituent groupings, are reported below under findings. These results are then discussed utilizing the second categorization of the framework by Morgan et al. (2016) based on how power is produced, negotiated, and changed at the individual/people and structural/environmental levels. In our analysis, we have focused the individual/people dimension at the household level specifically, since the interpersonal dynamics of the household remained at the forefront of women's experience due to the nature of the house-bound lockdowns.

Findings

The findings below are grouped according to four themes, established through our grounded analysis of the data: paid and unpaid labor; access to healthcare services; mental health; and government representation and consideration of women. Although we interviewed a diverse group of women representing those reported in the media as most affected by the secondary impacts of COVID-19, some groups were more represented in our interviews than others due to recruitment limitations during the first wave of the pandemic (table 1). As such, the findings below refer to general themes identified across constituent groups. Where members of a constituent group highlighted specific issues within a theme, these have been emphasized.

Paid and Unpaid Labor

There was some variety across the women we interviewed as to how their paid work had been impacted by NPIs. Some women, particularly healthcare workers and those still working in companies that had made redundancies or utilized the government's furlough scheme for other employees, had seen a substantial increase in workload. This contrasted with those women who had been furloughed themselves or who had lost work due to COVID-19-associated closures.

Women's capacity to engage in and/or cope with paid employment changes was directly related to their living situation at home: e.g. financial and

Table 1. Interviewees by constituent group

Constituent group	Number (%)
Pregnant/postnatal	24 (37.5)
Primiparous	15 (23.4)
Multiparous	9 (14.1)
Parent	36 (56.3)
Child(ren) 10 and under ⁽¹⁾	31 (48.4)
Child(ren) 11–18	7 (10.9)
Single parent	5 (7.8)
Healthcare worker	7 (10.9)
Economically affected	6 (9.4)
Total	64 (100.0) ⁽²⁾

Notes.

(1)The age of child categorization is based on Office for National Statistics (ONS) data showing increased childcare burdens for women relative to men, particularly for those with children 10 years and under.

(2)Some women reported belonging to more than one target group and were thus counted more than once.

domestic support from a partner, the opening and closing of schools, the age of children, and whether they were pregnant. Of those we spoke to, the women who had been economically affected through ineligibility for furlough were the most distressed during our interviews. One woman whose husband also happened to be unemployed at the time: “It’s just made me feel worthless, really, just because of my whole work situation. And it’s made me feel like I have absolutely zero control over my life, whereas I’ve always felt I’ve been in control.” These women, along with those who were self-employed, were forced to use their savings to make ends meet while they awaited a return to normal. One pregnant, locum healthcare worker decided to stop taking shifts as she did not feel comfortable continuing to work. This had wider effects: “Obviously not working, not earning. So, I planned to work up until the end of April, beginning of May. So, I’ve probably lost, well, almost two months’ worth of income through not working.”

Other healthcare workers reported substantial increases in paid workload and one even expressed guilt over the many benefits she and others had received: “Financially speaking, we’re the lucky ones, because you know, we’re not going to be out skilled anytime soon, . . . It’s kind of felt almost inappropriate where it’s just like, you can virtually get discounts on anything,” she noted, in comparison to the financial difficulty many of those around her faced.

Most of the women interviewed, and particularly parents, described having assumed more domestic care responsibilities during lockdown: “I do more of

the childcare because he's working a normal working day." For many this meant that paid employment suffered because of the additional childcare responsibilities and home-schooling because of school and nursery closure: "I was close to breakdown because the school was sending in an influx of work, like, you have to do this, you have to do—and you can imagine I've got four children in three different classes . . . and then obviously my work, having to do all these things remotely now from the house . . . everything takes that much longer." The result of this was perceived poor performance in (paid) work: "and I've made some mistakes and I feel I'm not really aware of what my team are up to." Some women had created work and care schedules with their partners, typically resulting in long days and exhaustion: "[We're] tag teaming it, and I typically do teatime and bath routine to let my husband work, and then once the kids were in bed and dinner had happened . . . then from about half-past eight I would be on my laptop until 11 o'clock, midnight some nights." This practice had continued for many women and their partners until schools reopened.

In response, several mothers requested furlough to avoid the necessary balancing act between their paid and unpaid responsibilities, once furlough regulations changed to be permitted for childcare reasons at the discretion of the employer on July 1, 2020 (UK Government 2020c): "I have been furloughed to my great relief, and more or less at my own request, to be honest, it was kind of a mutual thing because after six weeks of having the two at home, and my husband and I both working from home and on emails until midnight, I was running myself into the ground." Another woman noted that this ability to take a pay cut to perform unpaid care duties was tied up with living costs and the need to assume the same income: "Can I afford to go part time, in order to just [survive], which would involve me effectively having to sell my house??"

For some mothers, furlough was not only a relief but acted to further reproduce traditional gender roles and presented a challenge to their identity: "And since then [being furloughed] I've been the Stepford Wife, as I'll call myself, and my husband's working, which has been quite a shock to the system," while others were concerned that furlough would lead to inevitable redundancy, both officially as they effectively tell their employer they are nonessential and in terms of their self-worth. In the face of a second lockdown in November, one furloughed retail worker told us: "I don't feel I've got a purpose, which I kind of got from going to work. So, it's a question of just trying to find something to do." For many mothers six months on, the reopening of schools proved a godsend that allowed them to establish greater balance between both work and family: "Having children back at school has been a massive kind of change and improvement."

One mother reported that her workplace had made substantial accommodations, showing that supportive and gender-responsive workplace policies were possible: "They introduced like a time sheet code that was just a

COVID-19 code that parents and carers could use. And just said, ‘if you can’t work the hours that you’re contracted to work, don’t worry about it.’” However, discrepancies in government policy between shops and schools reopening meant hard choices for women working in retail who were taken off furlough but still had children at home: “They said, you know, we’re not saying, you’ve got to come back to work, but you’ll be on unpaid leave. But I was in a position where I couldn’t go back to work because I had the three children at home. And . . . I thought, actually, you know what this is indirect sex discrimination here, because even though they had taken everybody off [furlough] in a blanket way, the impact really was more on women, because it was women who are generally doing the majority of the childcare and who wouldn’t be able to come back.”

Many mothers considered this distribution of household labor to be a practical response to the circumstances, because of routine gender-pay gap disparities: “There’s no way that [this] would be doable if I was still working . . . because that makes it so much more manageable for him. That is a much less stressful situation for him than it was when I was still working. I have no idea what furlough’s going to mean for me”; and on household decision-making: “It’s not fair to expect him to work and then have to think about what we might want to eat that week. . . . So I’ve been doing all that stuff.” However, several women expressed resentment at the imbalance of their situation yet were unable to extract themselves from it; as one self-employed woman told us: “We’ve been trying to split the day, but . . . He was like I can’t do this anymore. So, I have to backburner my business . . . because my husband’s salaried, and he works full time and that he has to take priority because he’s, you know, we would sink without that money.” Another highlighted how the pandemic has reproduced and enforced gender power relations: “It [the work] hasn’t fallen equally in my house. And we’re both aware of that, but it comes down to how much we earn and who is the breadwinner, which in turn comes down to me having [had] children and time now to look after children.”

In some interviews, we do see men increasing their domestic roles, but these have predominantly fallen into three categories: childcare; supporting those with pregnant partners; and supermarket shopping. Many cohabiting women reported their male partners engaging in more of the childcare; however, the distribution of that labor remained unequal, with women typically taking on more of the additional load, replicating nationwide data (ONS 2020b). Some parents reported that the way they engaged in childcare differed from, and was more time consuming than, their husbands’, highlighting an additional mental load experienced by women with children compared to their male partners: “My husband would be perfectly at ease with plugging them into a tablet or putting something on our projector. . . . I sit there and go, ooh, I must follow a load of things on Instagram and find some sensory play and make some bloody chalk paints.”

Pregnant women reported partners absorbing additional work so they could rest and/or be protected from the outside world (yet we do not know if this is different to how it would have been had they been pregnant in pre-pandemic period). One told us: “I haven’t personally been to the supermarket since the middle of March. My husband’s taken on all of that to make sure that I’m protected.” Several other women reported that their male partners had taken on more of the shopping: “The only thing is obviously my husband is doing, kind of, all the shopping and he’s going and he’s, having to, do everything.” And more than one interviewee warned about the return to (gendered) instincts: “I think that we’re possibly reverting a little bit to male dominance in making decisions and going out in that hunter-gatherer role.”

Our data demonstrated single parents—90 percent of whom are women (ONS 2019)—were some of the most severely challenged by the lockdown measures, having to provide 24/7 childcare, and simultaneously needing to work to pay the bills. This mirrors broader national trends where one-tenth of single parents lost their job and one-third of single parents were furloughed, resulting in increasing poverty among single-headed households (Clery, Dewar, and Papoutsaki 2020). As one parent elaborated: “I did consider asking work if I can be furloughed, because I thought it’s just going to be much easier. But because I’m already working part-time to fit around school hours, I can’t—I just can’t financially afford to take a 20% pay cut. It’s just not possible.”

These realities went unrecognized by government response policies, as elaborated by all single parents interviewed: “[The] implication was that you know, your partner or somebody in your bubble should be doing that. But as a single parent, that isn’t an option for me. I feel like I’ve had to repeatedly perform single motherhood and keep making this, this this point that the realities of parenting during this situation are just not being recognized that way.”

Access to Healthcare

The health system has been distorted as COVID-19 care has been prioritized within hospitals, and because of efforts taken to reduce interaction between individuals (Charlesworth 2020). Many nonessential services have ceased or have changed to online provision. As women are more likely to interact with primary health providers than men (Wang et al. 2013), changes to healthcare provisions have a gendered effect. Several participants from across constituent groups discussed changes to access to routine health issues from both the supply and demand sides. From the demand side, women feared visiting clinical services for fear of transmission, but also because they were following guidance to “stay at home and protect the National Health Service (NHS).” “I changed my contraception [in] February and I’m having a bit of a reaction to that, but I am, again, not doing anything about it until after this has all calmed down. One, because I don’t want to put a strain on my local

doctors, but, two, I also don't want to go there and risk being near sick people, so I'm leaving both of those issues."

Supply-side changes to reproductive health services were particularly acute for pregnant interviewees, who detailed the pregnancy-related healthcare changes. As one stated, antenatal provision was stalled because of the outbreak: "My midwife has phoned check[ed] in on me and—but there is only so much you can do over the phone." Those who were able to access care for check-ups noted the differences in how services were provided: "I went into the hospital and the midwives wouldn't put the devices on my belly, I had to fit them myself while they stood at a distance." Some women expressed concern about the quality of care: "it does make you feel a bit more apprehensive I think, because obviously, you're not getting the same sort of care that you normally get, like urine samples and I haven't taken my blood pressure ... you're meant to have that done every four weeks."

Having to attend antenatal care alone, as per the UK COVID-19 regulation which restricted birth partners in efforts to reduce social contacts, was a particular concern to both primiparous and multiparous women. Notably, this decision was reversed in December 2020 (Bremner 2020). "My 20 week scan I had to do alone, and so if there had been any issues at that point I would've found out by myself. That was a bit scary." Yet the lack of partner's involvement was not just for emotional support during antenatal scanning; some expressed concern as to how their birth partner's absence may affect the quality of care they receive: "I am ... very concerned about my ability to advocate for my own care. I know that, as it stands, if things are very straightforward my husband will be able to be there for the majority of that period of time, but there will definitely be a time after the baby's born when he can't be present. And I am concerned that I'd really be relying on him to know what I want to be done and how I want that, so I am very concerned about that."

Meanwhile, healthcare workers' experiences of work during COVID-19 echoed the difficulties in accessing adequate care highlighted above. For example: "We did do video consults as well, but a lot of our elderly patients weren't able to do that, because they don't have smart phone experience and, you know, you can't do that on a landline. And so, I found it really quite stressful trying to manage everyone over the phone ... I think I found it quite, quite nerve-racking actually, because you feel like you might miss things, ... I'm constantly just kind of second guessing."

Mental Health

The mental health burdens varied between women interviewed but were substantial across all groups. Almost every woman we interviewed referred to some sort of stress or tension. Some were expressly worried about the virus: "[I'm] waking up and finding it really hard to breathe, and being worried is this COVID or whatever, but actually realizing no this is actually just panic

and anxiety in my chest.” Some parents felt guilty or concerned about the impact of the lockdown on their children or their dual burden of paid and unpaid work which have merged because of the lockdown: “I worry about my daughter mostly, because she I think is just missing out on an awful lot at a crucial preschool development stage, you know”; “Because I’m working, he’ll just be watching stuff on his iPad, and so I feel bad about that.” Others are overwhelmed by the sheer load of the paid and unpaid care that they are undertaking and feel as if they have reached their bandwidth for being able to cope. “I just can’t cope, to be honest. Just working and managing children at the same time, indefinitely, it’s so hard. You can’t do anything.”

These mental health concerns were compounded by the lack of the usual support networks that women might utilize as mental and emotional support in their dual roles. “I’m also quite aware, especially with a couple of my friends, where I would ring them up and have a coffee and a chat, I’m aware that they have caring responsibilities at the moment.” This also affected care: “Being a single parent, I’m in a bubble with my parents, but that makes it much more difficult for us to see friends which I think certainly now, you know, we can only meet up outside with other people in a, you know, in a park or outside walk, which during the winter, it’s just not as easy, pouring down, it’s cold.” A number of women reported greater levels of isolation during lockdown and relief when lockdowns ended: “It’s been a lot better since lockdown eased. I think I was really feeling the isolation during lockdown.”

Six months on, women across constituent groups reported high levels of exhaustion and that their mental health had been up and down, with additional lockdowns being a particular concern: “I’m having this malaise where it’s just like, my energy was so like, knowing that another lockdown was coming, knowing that winter was coming, . . . what was coming around the corner next, you just were like, I can’t, can’t do more of this.” This was particularly acute among single parents: “I’ve been exhausted, and I know that everyone around me is exhausted as well. And so, you know that everyone’s in the boat in the same boat, and just experiencing it in different kinds of ways. But yeah, I think I’ve literally just gone into survival mode.”

One mother’s experience echoed other interviews regarding a loss of sense of self: “It did get to a point when I kind of said actually, you know what, I am going back to work because I didn’t feel I just didn’t feel as though I was being particularly valued by anybody. . . . None of the children ever thanked me for my particularly enriching home-schooling lesson that I’d helped facilitate for them. . . . And I think I just felt like I was facilitating everybody else’s life. And mine had just ground to a halt, it was almost like going back to the 1950s.”

Nevertheless, many women highlighted the support they received from their network of friends and support networks: “One of the things that I think is really great for me, is that the women in my life have an amazing kind of network constantly asking each other about mental health. And I think we’re

trained to do that from the baby groups, the teachers are always saying, ‘don’t forget, check in on each other and make sure everyone’s alright’.”

While all pregnant women experienced changes, delays, and cancellations to various aspects of their antenatal care, many expressed concern that their male partners were missing out on the experience of parenthood, highlighting the breadth of mental burdens experienced by pregnant women: “I just think that the effect and the impact on him is probably bigger than even on me, because he isn’t able to participate in anything that’s really important to both of us.”

The mismatch between the expectations of pregnancy and the reality facing women is also important. Women had imagined that they would be able to prepare for becoming a parent—to try out prams, attend antenatal classes, introduce their baby to their family when born, etc.—each part of the ritual of pregnancy and new motherhood (Afflerback et al. 2014) which they were no longer able to enjoy: “More than anything [I’m sad] about missing the fun things that are supposed to happen when you’re pregnant. Like a baby shower, and going shopping for a stroller, and stuff like that. Such minor issues compared to what most people are dealing with, but it’s just you look forward to these things.”

This also extended to social networks which could not be utilized, but which new mothers are reliant on: “Being a first-time mum it’s obviously quite daunting in this, so you need a lot of reassurance, not, not being able to have, say, for example, my mom here and things like that, you’re doing everything over the phone”; “There was all that stuff about like, oh, Mums shouldn’t be gossiping at the school gates as if like, oh, we’re all so silly, and we’re gossiping. But actually, what if that’s the only person that you see all day? What if that’s the only other adult that you get to speak to all day?”

Government Representation and Consideration of Women

Several respondents noted the lack of representation in government decision-making and attributed the lack of recognition of gendered effects of COVID-19-related policy to the fact that there weren’t women “in the room where it happened.” “Almost every night I told my husband, oh, no women on the screen [for the government press conference] . . . I mean, it doesn’t mean that men are bad, obviously, but I think, again, if we only show men in power, what does it say about women?” The concern among participants was that this contributed to unconscious bias whereby women’s concerns were not considered in the development of COVID-19 response policies. Two women from across our sample highlighted: “You’ve got somebody that’s white male and middle-aged telling the nation, predominantly—well, predominantly white male middle-aged—what we should and shouldn’t be doing”; “I just don’t think they think about women because they haven’t got

enough women in them to, you know, they don't have that lived experience. So, it's just it's always an afterthought, isn't it?"

For many interviewees, this lack of women's representation contrasted with the role women were playing on the frontline of the response, highlighting the mismatch between the risks and additional work that these women were doing and their lack of meaningful recognition by the government. "The majority of NHS staff seem to be women and they are considered our heroes, but they don't actually get funded"; "You know, don't go 'oh love,' because it's a bit patronising isn't it, ah, you lovely nurse, you lovely carer, you're going in there to look after the old people . . . and they're potentially going to die on £6 an hour without a mask? Like they don't give a shit about your clapping [Clap for Carers became a weekly activity in the UK during the first months of COVID-19]."

These contrasts also raised questions about how men and women are considered differently in public life and within families. As one respondent posed: "Why are we not witnessing a conversation about men doing more, rather than analysing the suffering of women?" And another exclaimed: "No one's asked Boris [Johnson] what his children are doing or—so I still feel that there's very ingrained . . . roles within society that are very much female rather than male."

Some women felt the government had done their best in a difficult and ever-changing situation. Yet others felt there had been little change in the government's approach to considering and supporting women throughout the pandemic, despite increasing research and public awareness: "I still think that it's expecting women to pick up the strain . . . the Conservative government don't care about women, . . . And I think they've got quite an old-fashioned view, outdated view, that women will just pick up the childcare, the women will pick up the care of elderly parents, they will shoulder the burden of whatever policies are put in place, or decisions that are made, they will just get on with it. And these, I haven't seen anything that makes it easier for women—all I've seen the things that make it more difficult for women."

There was also concern for the longer-term impacts of this perceived gender blindness: "It's always bolted on and I honestly think that the damage this is going to do for you know, women in the workplace. This again, it's going to be really far reaching, it's going to go on for years. I think we'll have to claw it back."

Discussion

Our data show a range of indirect effects on women of COVID-19 and associated NPIs instigated by the UK government. While lockdown can be justified from an epidemiological perspective to reduce disease transmission, due consideration must be given to the gendered secondary effects of this public

health intervention. Our results indicate that government interventions to minimize COVID-19 disease transmission interact with gendered norms at both sites of negotiating and changing gendered power relations—the individual and structural—which in turn influence women’s experiences of the pandemic. Critically, even where women were aware of and frustrated by the gendered inequalities they were experiencing at the individual level, they reported limitations in their ability to affect change at either micro or macro level. These findings highlight the importance of macro-level gender-responsive policy and law in supporting women’s agency as part of a holistic approach to transforming gendered power relations. We write this article for policymakers to understand the gendered downstream effects of their COVID-19 decision-making and the structural obstacles to women’s empowerment and gender equality.

Our data on women’s experiences of the COVID-19 pandemic in the United Kingdom mirror those of other studies quantifying the toll on women’s (reduced) pay (ONS 2020a), unpaid workload during lockdown (ONS 2020b), access to healthcare services and mental health and well-being (ONS 2021). Our research adds women’s voices to these statistics, bringing nuance to the numbers through women’s self-reported feelings and experiences of the pandemic.

At the individual/household level, women’s relationship to paid work varied by sector of employment, the policies of their employers, and their personal circumstances. Healthcare workers shouldered the increased risk of COVID-19 at work, and the need to arrange for care at home, particularly in dual-key worker families, consistent with other interviews conducted with women healthcare workers in England (Regenold and Vindrola-Padros 2021). Workers in lockdown-affected industries were greatly supported by the government’s furlough scheme; however, the pandemic was acutely stressful for those who were not eligible.

Women’s experiences of increased unpaid care work, and mothers’ experiences of increased childcare, were associated with gendered power relations at both the structural and individual/household levels: gender-pay gaps and the need for the higher [male] earner to continue to work—notably at a time where the UK government suspended gender-pay gap reporting for employers (UK Government 2020b)—worked in concert with the exacerbation of existing gendered divisions of labor within households (Adams-Prassl et al. 2020). While men did increase their unpaid care work and childcare during the first lockdown in March–May 2020, by September, their input had shrunk again relative to women (ONS 2021). Our data bring insight into how divisions in labor have emerged and how women understand their paid/unpaid work in relationship to their partners within domestic ideologies of motherhood (Dyck 1990): while some women were happy with a more traditional distribution of labor, many demonstrated individual critical consciousness, feeling that their careers were secondary, and that they needed to give up work,

reduce their hours, or work antisocial hours to facilitate their husband's routine workday.

Indeed, as is well established, women's ability to engage in paid work is dependent on their unpaid care responsibilities, and vice versa (Perrons 2005). In many ways our data show the disproportionate impact of COVID-19 on women as an amplification of the motherhood penalty (Correll, Benard, and Paik 2007), rather than active decision-making by couples. Indeed, it appeared that decision-making was tacit, reflecting gendered norms and indirect household bargaining within families interviewed. Even those women who were frustrated by the gender constraints and intensification of these felt they were unable to change them amid the crisis, reinforcing gendered power differentials within UK households and society.

The demands of paid labor and increases in unpaid labor have taken an emotional and psychological toll on women: whether in a loss of identity having to give up their work, or with more acute mental health concerns as a combined result of the risks of the virus, worry about their children, their financial concerns (or a combination of all of these), and a sense of being at the limit of their emotional bandwidth, unable to take more stresses and trying to juggle these competing demands. The responsibility for keeping life going, and assuming the emotional burden of the family as the sounding board for upset and bored children, also appeared heavily feminized. As one woman summarized: "You've got to be a superhero, you've got to look after your kids, you've got to manage the house, you've got to keep your husband out of the way, and get on with the other life that you normally do, which is working as well, and somehow fit it in."

These impacts were particularly intensified among single mothers who had to juggle paid and unpaid work, and the associated anxiety, but did not have the same physical or emotional support as dual-parent households. While single parents may be accustomed to navigating the additional challenges posed through a range of social networks and established coping strategies (Defrain and Eirick 1981), the pandemic has cut off many sources of support to them through stay-at-home orders and the inability to draw on kinship care. Full-time caring responsibilities have placed some single women in even more precarious financial positions, well documented to lead to greater anxiety (Stack and Meredith 2018), and indeed exacerbated the risk for some single parents of falling into poverty (Cain 2016). The relatively late introduction of 'support bubbles' by the government in June 2020 was a welcome relief to single mothers, and many others, highlighting the mitigating impacts that considered and innovative government policy-making can have.

At the individual/household level, pregnant women were concerned about changes to maternity care resulting from government and institutional (NHS trust) decision-making. While the NHS maintains that safe access to maternity care was not jeopardized by the pandemic (Rimmer and Al Wattar 2020), women's perceptions of being able to access such services may have altered

their interaction with maternity care, causing added anxiety during pregnancy. Indeed, the NHS England information campaign from April 25, 2020 focused on increasing healthcare-seeking behavior specifically included promotions around maternity services which had seen a drop in demand during the first lockdown (Karavadra et al. 2020). Further concerns have been raised about the impact of changes to delivery options and women's decision-making in this process on how women understand and experience pregnancy, which in turn can lead to heightened risk of postpartum depression (Bell and Andersson 2016). Beyond health concerns, women simultaneously grieved the rites of passage of pregnancy that they missed out on because of lockdown. The lack of recognition by government and NHS trusts of the role of birth partners in supporting pregnant women during the perinatal period also had a significant impact on pregnant women's experiences and mental health during COVID. Limits on the presence of birth partners are also likely to have exacerbated expectant fathers' distress and feelings of exclusion regarding maternity.

While some women discussed the distribution of paid and unpaid labor, and the emotional toll in purely practical terms, others recognized the distinct constraints of their increased burdens, and yet appeared to be unable to alter these amid the 'tyranny of the urgent.' Critical consciousness, "the recognition of [one's] reality as an oppressed reality" for the redress of inequalities, comprises both critical thought and critical action (Freire 2005, 174). And yet, of those women who expressed critical thought, their capacity to act accordingly was hamstrung by the magnitude of the crisis, enduring gender norms around household labor, and the lack of supportive policy instruments implemented both prior to and during the pandemic. These include the woman who moved her workstation from the upstairs office to the kitchen table because her unemployed husband was unable to cope with the demands of home schooling two children by himself; the woman who became self-employed following two maternity leaves to facilitate flexibility around childcare and then was forced to put her career on the backburner because it was most financially logical to do so; and the single mother at her wit's end because she could not afford to be furloughed on 80 percent of her already part-time salary but also could not access kinship support before the advent of 'support bubbles.' Critical consciousness in the context of COVID-19 in the United Kingdom is necessary but not (yet) sufficient to create revolutionary change for women.

This highlights the key role that government and other institutions must play in transforming, and at least not exacerbating, gendered power relations. At this structural level, we assume gendered norms held by government representatives, in particular, have led to gender blindness in policy-making and implementation¹ resulting in the disproportionately negative impacts of NPIs on women. Although under the Equality Act (2010) the UK government is required to ensure that all policy produced undergoes an impact assessment, the government has refused to publish its assessments. At the same time as the COVID-19

policies were being developed, the UK government halted the requirement for organizations to report gender-pay gap data, and the Scientific Advisory Group on Emergencies (SAGE) rarely considered gender or women in its advice on NPIs (Wenham and Herten-Crabb 2021). This is reflective of the broader position given to gender issues within the current administration, which has not only reduced capacity and funding to the Government Equalities Office (GEO) within the Cabinet Office (UK Government 2020a), but also saw the merging of the position of the Secretary of State for Women and Equalities with the function of the Minister of International Trade for much of the pandemic, the latter being of much more importance during Brexit negotiations, and thus time commitment to government activities. A review of four European states' economic and social policies during COVID-19 by Cook and Grimshaw (2020) found UK policies to be lacking compared to those in Norway (whose furlough scheme was more generous for low-income earners while the United Kingdom's income replacement rate remained the same), Germany (which gave additional financial support to families with children), and Italy (which, along with Norway, increased parental leave for new parents). Cook and Grimshaw further highlighted the gendered assumptions of UK government policies which "assume a normative (male) worker and leave the gendered division of domestic labour unchallenged." This also needs to be understood within the broader context of Brexit, given that most progress for gender equality and mainstreaming in the United Kingdom was driven by requirements under EU employment, maternity, and childcare directives (Fagan and Rubery 2017).

The COVID-19 pandemic has substantially negatively impacted people of all genders in the UK.² As this article lays out, women are disproportionately and differently impacted by the UK government response to COVID-19. Furthermore, not all women were impacted in the same way, and some women were significantly more affected than others. It is perhaps not surprising that in the process of undertaking this research in the middle of the pandemic we were limited in our ability to reach those women who have been reported as most vulnerable such as women experiencing domestic violence and financially insecure migrants. As such, even those experiences outlined herein represent the views of women who had the time and means to speak to us. Moreover, we recognize that in identifying women solely by their constituent group, we fail to engage with intersecting identities, such as race, location, age, and socioeconomic group. We did not set out to undertake intersectional analysis and thus we do not have comprehensive data on this, but we recognize the limitation of this lacuna.

Per Morgan et al. (2016), we believe it is important to differentiate the gendered effects of the pandemic at the individual/household and structural levels. For example, while decisions around who takes on more paid and unpaid labor may occur largely at the level of household decision-making based on entrenched social norms, there are government policy choices that could mitigate some inequalities, including efforts to reduce the gender-pay gap and

support dual-parent parental leave to overcome the motherhood penalty. Understanding how gendered power relations are negotiated at the level of the individual and household during a pandemic can also reveal the pertinent socioeconomic determinants of health and of government policy more broadly. This allows efforts for change to expand beyond just women as a generic category, which our data highlight has its limitations. Indeed, the increasing engagement of men in childcare and domestic duties, while still less than women during the pandemic, highlights how gains toward gender equality in the realm of unpaid labor can be made during a crisis (but then quickly lost without ongoing policy support) (ONS 2021). Change at the individual (male) and household levels can be further facilitated through government and employer policies that seek to transform gender and workplace norms to support men's engagement (Chung et al. 2021).

While many women noted the absence of women's voices in daily press briefings and decision-making bodies, we know that simply "adding women and stirring" does not inevitably lead to gender-responsive policy (Wenham and Herten-Crabb 2021). It is for this reason that gender mainstreaming initiatives through institutional setups such as the GEO and equality impact assessments (EIAs) are necessary in the development of policy. However, the GEO produced only three documents related to COVID-19 throughout 2020, and the Westminster government has still, at the time of writing in December 2021, refused to publish any of the EIAs it is mandated to undertake through the Equality Act 2010. For example, despite an explicit request by the Women and Equalities Committee for the government to publish its EIAs related to its Coronavirus Job Retention Scheme and Self-Employment Income Support Schemes, the government responded thusly: "While Equality Impact Assessments are part of that process, the Government believes they should not routinely be made public as Ministers need to be able to have full and frank discussions about the potential impacts of their decisions as they make decisions to ensure no one is left behind" (UK Government 2021). The lack of public scrutiny alongside an apparent dearth of input by gender advisors remains concerning.

The evidence herein highlights the disproportionate and different ways that women were impacted by UK government responses to COVID-19 in 2020. Subsequent quantitative data and a parliamentary inquiry into the gendered economic impacts in 2021 suggest that little has changed to reduce women's unpaid care work, or access to mental health services; however, birth partners were allowed to attend maternity appointments and births from December 16, 2021, following considerable advocacy efforts by the But Not Maternity Alliance (Bremner 2020).

As one mother described: "I hold it all—I do hold it all together." We hope the voices herein speak to policy-makers and specifically lead them to ask whether, as the COVID-19 pandemic continues into its third year, the government can do a better job at holding a bit more of "all of it" for women, not least because they are mandated by law to do so.

Appendix

Interview guide.

1. Can you tell us a bit about yourself: job, family set up, other characteristics which you think are important etc.?

Knowledge of COVID + Vulnerability to Infection

2. Do you feel informed about the COVID-19 outbreak?
 - a. When did you first hear about COVID/
 - b. Where do you get your news about the outbreak—from whom?
 - c. Is there information that you need that has not been made available to you?
 - d. Do you feel at risk of infection, and if so, what are you doing to reduce this risk?

Access to Resources

3. How has COVID-19 affected your access to:
 - a. Healthcare services (COVID related/not COVID related)
 - b. SRH Provision
 - c. Finance
 - d. Access to PPE or other mechanisms to protect yourself from COVID

Distribution of Labor

4. How has COVID affected:
 - a. Your work/employment (paid/voluntary)
 - b. Domestic roles and responsibilities (incl childcare, domestic chores, mental load for moving to self-isolation)
 - c. Other aspects of your daily routine

Norms, Values

5. Do you feel a certain expectation to do particular things within the outbreak:
 - a. Care (for sick, children)
 - b. Work (as HCW)
 - c. Volunteer to support response

Policies, Institutions, Public Opinion

6. How have government or local policy and public health responses affected you?
 - a. Have they affected your daily life

- b. What, if any, support/resources have you received? From whom?
 - c. Have you advocated for any COVID-related changes? If so—how—through what channels?
 - d. Do you feel you/your group/workforce has a voice?
7. How do you think women have been considered or presented in this outbreak?
- a. By policymakers
 - b. By media etc

Decision-making

8. How have you arranged new life in COVID?
- a. Decisions for self-isolation and/or continue to work
 - b. Activities at home/outside
 - c. Caring responsibilities

Socio-economic security

9. How has the outbreak affected your:
- a. health and wellbeing
 - b. family
 - c. security (physical, emotional, financial or otherwise)
 - d. other aspects of your life?
10. Do you have any further thoughts on the gendered and/or intersectional impacts of the COVID-19 outbreak?
- a. How do you feel your experience compares to others in this same situation

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Notes

1. We have not interviewed government representatives to interrogate their understanding of gender, but we make this assumption due to the lack of interaction we have seen on these issues, compounded with the comments made by senior government officials when asked about gendered issues within press conferences and media publications.
2. Although there is little research on lesbian, gay, bisexual, transgender and non-binary (LGBT+) peoples' experiences in the United Kingdom during COVID-19 (McGowan, Lowther, and Meads 2021).

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