



Gender Inequality and COVID-19 and employment pattern changes : The Case Of Indian People

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Abstract :

Gender inequality is defined as disparity between men and women in different economical, social, political, cultural and legal aspects. The advent of the COVID-19 pandemic and the resultant lockdown in India brought to light the gender inequality issue with a new meaning. The study aims at examining gender inequalities across many characteristics since April 2020, when lockdown was ushered in the country. Under the present study, primary data employing a sample of 120 participants has been undertaken to find the effect of the pandemic on various issues like gender inequality's relation to mental health etc. The results clearly portray that women's mental health has been found worse than that of men, and women folks have seen the infection as more prevalent and fatal than men. Additionally, women are more likely to anticipate a new lockdown or viral outbreak by the end of 2020 and are more pessimistic about the Indian economy's current and future state, as indicated by their anticipation of future unemployment rates.

Index Terms - Gender inequality, COVID-19, Mental health, Women

INTRODUCTION:

Gender inequality is considered as a persistent problem in the way of development. It is generally defined as the disparity between men and women in different economical, social, political, cultural and legal spheres. Nobel laureate Amartya Sen had highlighted that gender inequality is a major cause of worry across countries worldwide, whether developed, developing or underdeveloped. He said that gender inequality could take seven different forms including special opportunity inequality, professional inequality, mortality inequality, natality inequality, basic facility inequality, ownership inequality and household inequality. In India, gender inequalities have been deep rooted and embedded in the patriarchal scenario.

With its outbreak in December 2019 in China, the Corona virus has spread across the globe like wildfire. A public health emergency, a socio-economic disaster, the novel Coronavirus has proved fatal to the world economy as a whole claiming millions of lives. In India, nationwide lockdown was imposed to combat the invisible enemy that brutally affected millions of lives.

The study aims at examining gender inequalities across many characteristics since April 2020, when lockdown was ushered in the country. Various reports have highlighted the gender inequality question during the pandemic like the World Economic Forum's Global Gender Gap Report 2021 which stated that India has slipped 28 places to rank 140th among 156 countries, becoming the third-worst performer in South Asia. Women are disproportionately impacted negatively by a number of socio economic hardships globally (Pearce, 1978; Assassi, 2009; Gill & Roberts, 2011; Langer et al., 2015), many of which COVID-19

exacerbates (Ewing-Nelson, 2020). There is grounds to believe that the epidemic will have a disastrous effect on gender equality, and notably on women's well-being. Alon et al. (2020) clearly show that, while men's work has historically been more at risk during economic crises, numerous unique characteristics of this epidemic make women's employment more vulnerable. In practise, women have historically lost the bulk of jobs as a result of COVID-19 (IWPR, 2020). In Canada, for example, 5% of women between the ages of 25 and 54 have lost their careers owing to Coronavirus, compared to only 2% of men of the same age (Johnson, 2020). The notion of political responsibility based on social connections is particularly well-suited to addressing gender disparity, notably the inequality aggravated by COVID-19. To begin, there is little doubt that, even in the best of circumstances, we are all inextricably linked to women as a social group through systematic interdependence and hence all are bound to strive toward resolving structural inequities based on gender (Rai et al., 2014). As feminist and gender-conscious theorists have long emphasised, while women's domestic, reproductive, and care work is largely unpaid and unrecognized, it is absolutely necessary for a healthy (global and national) economy (Aatay & Zler, 1995; Budlender, 2007; Heckmann & Masterov, 2007; Heckman, 2008; Harper et al., 2009; for examples of how policymakers overlook the importance of women's work, see Hey We all rely on women's unacknowledged labour, both domestically and globally.

The research aims at understanding a firsthand account from nearly 120 participants about various aspects relating to the pandemic to decode the gender inequality problem. Primary data on mental health, COVID-19-related health and economic worries, time allocation to market and household production, protective actions, and donations have been acquired via a survey of 120 respondents. Respondents were chosen to be representative of the Indian population by age, sex, and ethnicity if they agreed to participate in the survey.

The study's major findings can be classified into various categories. The first aspect considered was that of the mental health status of men and women in mid-June across multiple disciplines including generalized anxiety disorder (GAD), despair, panic attacks and loneliness. Although not directly comparable, Banks and Xu (2020) demonstrated that women's mental health status in India in April 2020, as measured by changes in the General Health Questionnaire (GHQ) in the India Household Longitudinal Study, deteriorated significantly more than men's when pre- and post-COVID-19 pandemic data was compared. Secondly, anxiety and stressed among both genders in relation to questions regarding contracting and spreading of the COVID-19 virus was analysed which is consistent with Galasso et al (2020). The aspect holds relevance for analysis as women account for more than half of infected individuals in European countries [Lewandowski et al. (2020)], and where women participate more fully in the labour market, they may be more susceptible to COVID-19 infection than men. Thirdly, questions in regards to anticipation of new lock down or viral outbreak by the end of 2020 were analysed. This has been consistent with previous studies (Andrew et al., 2020; Sevilla and Smith 2020). Analysis was also made to account for the weekly time spent on child care and house work as done by Hupkau and Petrongolo's findings (2020).

The next part discusses the review of literature, followed by how we collected our primary data, how it compares to a nationally representative dataset, and the primary characteristics of our respondents. Our methodology is described in Section 3. Section 4 summarizes and discusses our uncorrected and adjusted gender disparities. Section 5 concludes the study.

REVIEW OF LITERATURE :

In comparison to previous epidemics or pandemics, the majority of governments' public health initiatives to combat COVID transmission have had unintended and uneven effects on women. Internationally, shelter in place or stay at home orders have been implemented. These orders resulted in the closure of non-essential companies, restrictions on movement, and restrictions on social connections. These initiatives had the greatest impact on industries with a high number of female workers (Moore, Beebe, & Bakhiet, 2020). Additionally, the closure of schools and childcare services increased caregiver responsibilities, with women shouldering a greater share of care giving tasks than men (Darmody, Smyth, & Russell, 2020; Moore et al., 2020; Reichelt, Makovi, & Sargsyan, 2020). In the United States, studies indicate that men were less likely than mothers to cut back on work hours during the pandemic, reaffirming the already established allocation of childcare responsibilities in the majority of couples (Reichelt et al., 2020). The United Nations (UN) acknowledges that families' inability to access institutional and communal childcare during the lockdown increased the strain on women, limiting their ability to work (Power, 2020).

Not only are women laid off at a larger rate than males, they are also sacrificing jobs at a higher rate to satisfy rising childcare duties. As schools and daycares close, childcare jobs transition from the paid to the unpaid sector. Women already perform significantly more unpaid care work (of both children and adults) and have significantly less free time than men (Mattingly & Bianchi, 2003; Sayer, 2005; Bettio et al., 2006; Esquivel et al., 2008; Budlender, 2010; Schoonbroodt, 2018), and any increase in care needs will be borne disproportionately by women (Alon et al., 2020). Women bear the brunt of this shift both because of social norms regarding who takes on caregiver roles (Floro et al., 2009; Signorelli et al., 2012; Wenham et al., 2020) and because women's jobs are often given less priority because they are more likely to work part-time, earn less, and have less bargaining power than men in almost all economies (Kim, 2000; Truong, 2000; Carr & Alter-Chen, 2002; Antonopoulos, 2008; Dejardin & Owens, 2009; Floro et al., 2009; Sirimanne, 2009; Boniol et al., 2019; Johnson, 2020). Additionally, low-wage workers are less likely to have adequate health insurance, sick leave, childcare, and other advantages that protect higher-wage workers against COVID-19 exposures (Poteat et al., 2020). Intersectional oppressions should not be overlooked in this instance: For example, black Americans are more likely to work in low-wage vital service jobs, increasing their chance of catching COVID-19 and dying from it (Yancy, 2020). Or, for example, because homeless people live in communal living environments, both formally (in shelters) and informally (in encampments and abandoned structures), and among people who may lack access to basic hygiene supplies, they are more prone to develop coronavirus (Tsai & Wilson, 2020).

Consider also a study by Kizilirmak and Memis (2009), which demonstrates that women's (and not men's) duties for care work (and, therefore, any growth in care work needs) intensify in lockstep with their poverty level. The most vulnerable members of our societies are those who face the greatest danger. Increased unpaid care work is one of the most direct and indirect ways in which this crisis will damage women. Assuming a disproportionate share of the burden of unpaid care work generated by our answers to COVID-19 directly hurts women due to its effect on mental health. Without a doubt, excessive role duties (whether at home, at work, or both) have a deleterious influence on psychological well-being (Fox & Nickols, 1983; Gore & Mangione, 1983; Lowe and Northcott 1988; Nelson & Burke, 2002). Caregiving responsibilities, in particular, have been linked to an increase in psychological discomfort (Anthony-Bergstone et al., 1988; George & Gwyther, 1986; Hoyert & Seltzer, 1992; Schulz & Williamson, 1991; Strawbridge et al., 1997; Pinguart & Sørensen, 2003). Additionally, women endure more psychological anguish in their jobs as caretakers than males do (Miller & Cafasso, 1992; Yee & Schulz, 2000).

OBJECTIVES:

- To study and compare mental health of the Men and Women during Covid19 pandemic.
- To analyse variations in the income loss by gender due to Covid19.
- To study the consequences of gender inequality perspective in India during the pandemic.

DATABASE AND RESEARCH METHODOLOGY:

- **RESEARCH DESIGN:**

Research design is defined as a set of advance decisions that make up the master plan specify the methods and procedures for collecting, analyzing and interpreting the required data (Makwembere, 2014) . In the present study, an attempt has been made to analyse the effect of COVID-19 by accounting for the gender perspective on various parameters . Our empirical study paints a striking picture three months after the COVID-19 pandemic began. To emphasize the importance of the gender dimension of COVID-19 to policymakers and to ask for additional gender-related COVID-19 research and analysis.

• METHODOLOGY:

The study is based on primary data based on the convenience sampling in India of over 120 respondents through a survey . A total of 150 questionnaires were sent through Google forms and using the offline method but only 120 valid responses were received from both the sources and kept for the final analysis and this was our targeted sample size (120).

Time period of the study:

The time period of the study pertained to a period from April 2020 to January 2021. This marked the advent of the pandemic in the country and the resultant lockdowns.

Linear regression has been prepared and considered for the study are as follows:

$$y_i = a^s + b^s F_i + e_i^s$$

$$y_i = a^l + b^l F_i + c X_i + e_i^l$$

Where,

$$b^s = \text{Unadjusted}$$

$$b^l = \text{adjusted}$$

y_i = Outcome of the respondent i

F_i = Female indicator

X_i = Vector of standard socio-demographic control variable

HYPOTHESIS 1

H₀: Mental health of women was same as that of men

H₁: Mental health of women was worse than that of men

HYPOTHESIS 2

H₀: There is no significant difference between income loss and gender during COVID-19.

H₁: There is a significant difference between income loss and gender during COVID-19.

ANALYSIS AND INTERPRETATION:

Mental and physical health related concern

This subsection is concerned with the aspect of mental health of men and women during COVID-19. Table 1 examined gender disparities in mental health measures—GAD, To begin, women's average GAD anxiety score was 5.32, 1.07 units higher (or 25% more) than men's. The SD difference in GAD is 0.22, compared to a gap of around 0.28 SD among respondents to the Covid-19 study's June wave.

Second, the average female indicator of feeling sad, depressed, or hopeless—ranging from 0 (never) to 3 (almost every day)—was 0.86, 0.16 units (0.19 SD) greater than the average male indicator (or 22 percent higher). Third, 25.8 percent of women reported

having experienced an anxiety attack (sudden feelings of fear or panic), compared to 14.2 percent of men. As a result, women were 11.6 percentage points (81%) more likely than males to have experienced an anxiety episode. Finally, women appear to experience loneliness more frequently than men, scoring 0.09 units (0.14 SD) higher (or 6% more) in the loneliness scale than males. If anything, this difference is less than the 0.17 unit gender disparity observed in the Covid-19 study's June wave: 1.57 (among women) vs. 1.40 (among males), p -value 0.001. Correlation coefficients between GAD and depression indicators are 0.75 (p -value = 0.000), anxiety indicators are 0.54 (p -value = 0.000), and loneliness indicators are 0.47 (p -value = 0.000).

The gender disparities persist after correcting for conventional sociodemographic control variables such as ethnic origin, age, education, living with a spouse or others, log of income in 2019, current employment status, rural/urban domicile, and geographic location of habitation. Three statistically significant and sizable disparities related obesity, alcohol consumption, and socializing shine out when standard sociodemographic factors are adjusted for. To begin, women's obesity rate was assessed to be 26.3 percent, while men's obesity rate was estimated to be 18.8 percent, implying that women were 7.5 percentage points (40 percent) more likely than men to be obese (body mass index 30). While the result for women is 2.7 percentage points lower than the figure for males from the 2018 Health Survey for India, the figure for men is more than 10 percentage points lower than the 26 percent. A portion of this variance could be accounted for by reporting difficulties.

	GAD	Depression	Anxiety	Loneliness
Mean for Men	4.257	0.707	0.142	1.532
N for Men	52	52	52	52
Mean for Women	5.322	0.863	0.258	1.616
N for Women	68	68	68	68
Mean difference	1.065	0.155	0.116	0.093
% Mean difference	25.0%	21.9%	81.3%	6.1%
p -value mean difference	0.000	0.000	0.000	0.008

Adjusted Gender gap

The preceding section documented gender disparities in a variety of areas, including mental health, COVID-19-related health and economic concerns, market and home production time allocation, and charitable giving. Many of these disparities cannot be explained by ethnic origin, age, education, living with a spouse or other household members, income in 2019, current work status, residing in a rural (vs. urban) area, or geographic location. In this section, we take it a step further and add the following controls to the previous list:

Children & seniors living in the house:

Number of children by age category (number of children aged 0–5, number of children aged 6–15, number of children 16–18)

Number of individuals aged 60 and above

Employment characteristics:

Working full-time vs. part-time

Being a healthcare worker

Employment shocks:

Having being furloughed because of COVID-19

Having lost their job because of COVID-19

While none of these variables is a perfect substitute for a direct measure of risk aversion, we believe they help bring risk attitudes under control. As a result, we believe they are effective for accounting for potential differences in risk aversion between men and women when assessing the gender gap in COVID-19-related concerns.

Table 2 examines gender disparities in labour market hours and income loss among employed individuals aged 18–64 in January–February 2020. When children, seniors, and employment type factors are included, the gender gap shrinks from 6.95 (SE

= 1.95) to 4.42 (SE = 1.95) hours. These additional controls account for 36% of the gender disparity when corrected for standard controls.

	Hours of work	Hours of work before COVID 19	Change in hours of work	income loss
A Standard Controls	-6.952*** (1.949)	-4.061** (1.718)	-2.891 (1.595)	0.014 (0.033)
B A+ Children & seniors Employment type	-4.419 (1.946)	-1.444 (1.712)	-2.975 (1.678)	-0.009 (0.033)
C B+ Employment shocks	-3.365 (1.854)	-1.464 (1.696)	-1.901 (1.546)	-0.033 (0.031)

Indication: **p value<0.5, ***p value <0.01

When job shock indicators are included, the gender difference narrows even more to 3.37 (SE = 1.85) to account for more than half of the disparity. While not explicitly stated in the table, the new controls that are statistically significant and attract the highest coefficients in the final row (full specification) are being furloughed due to COVID-19 (21.06, SE = 2.01), having a full-time job (16.1, SE = 1.97), and having lost a job due to COVID-19. The second column indicates that 64% of the adjusted gender wage disparity early in the year preceding the pandemic can be accounted for by having full-time employment (18.0, SE = 1.87) and having a household with children aged 16–18 (6.83, SE = 3.06). The third column indicates that 34% of the gender disparity in change in hours of work can be attributed to being furloughed and losing a job. Finally, the final column establishes that there is no statistically significant evidence that income loss is gender-specific.

FINDINGS AND CONCLUSION :

Our findings indicate significant gender differences in pandemic vulnerability and the importance of gender-sensitive pandemic-related health policies, as well as the need for the government to develop stimulus policies that take into account women's difficulties and avenues for improving their mental and economic well-being. Having said that, it is critical for studies to determine the extent to which the gender disparities observed in this article persist over time. Both hypotheses are supported by the above study, as women's conditions are worse than men's, while income loss has no effect on gender.

A summary of the results has been started as follows. To begin with, women's mental health was worse than men's in mid-June across multiple dimensions: generalized anxiety disorder (GAD), despair, panic attacks, and loneliness. The relative gender disparities in mental health disorders were significant, ranging from 81% having experienced an anxiety attack to 22% feeling depressed.

Second, women expressed greater anxiety about contracting and spreading the virus (12 and 8% higher, respectively). Additionally, we discovered that women viewed the infection as more widespread and dangerous than males (31 percent and 39 percent higher than men, respectively).

Third, women's estimates for a new lockdown or viral breakout by the end of 2020 were 0.18–0.20 SD greater than men's. Women were more negative about the Indian economy's current and future situation, continuously forecasting an increase in unemployment in June 2020, December 2020, and June 2021.

Fourth, between early 2020 and June 2020, women increased their weekly time spent on childcare, between 3.4 and 3.9 hours,

and housework, between 2.3 and 2.8 hours.

We find no statistically significant gender differences in changes in hours worked or in the incidence of job loss or furloughing. Fifth, the COVID-19 pandemic is expected to have an effect on people's donations due to changes in government policy and increased uncertainty about future health/economic effects.

In this regard, we discover that women donated 5 out of every 50 pennies (31 percent or 0.31 standard deviation) more to food banks than males. Finally, neither the gender disparities in COVID-19-related health and economic concerns nor the gender disparities in increased hours of childcare and housework can be explained by a diverse set of control variables, including the number of children living in the house (by age category), the number of "seniors" living in the house (individuals aged 60 or over), the number of full-time workers, and employment shocks (having being furloughed due to the corona-virus pandemic, having suffered a job loss due to corona-virus pandemic). Rather than that, we discover that the gender disparity in mental health can be explained in part by the disparity in COVID-19-related health worries between men and women, but not by disparities in economic concerns associated to the pandemic.

STRENGTHS AND LIMITATIONS OF THE STUDY :

Our study has some significant strengths. To begin, we took a holistic approach to gender inequality, examining many factors ranging from mental health to charitable giving, which enables us to paint a comprehensive picture of the situation in India. A second advantage is that an explicit question regarding the number of hours allocated to market and household production was asked before the onset of the Coronavirus pandemic in early 2020, ensuring that the documented changes are in comparison to the circumstances immediately before the outbreak. Third, data has been gathered from original sources in order to replicate and extend the study beyond the scope of this paper.

There are also limitations . To begin with , while the holistic method enables reporting on novel and previously unrecorded COVID-19 gendered features, we occasionally lack the material necessary to analyse specific themes in detail, such as furloughing, which is extensively explored in other studies. Second, we must recognise that by asking retrospective time allocation questions, there is a possibility of reporting with measurement inaccuracy caused by recollection bias. Finally, the data comes from prolific responders who may be identical or unlike, as demonstrated in this study, from a representative sample of randomly selected Indians.

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