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The COVID-19 Crisis and Its Challenges on Social Issues
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The Gender-Differentiated Impacts of the COVID-19 Pandemic on Health and Social Inequalities in the UK

An Exploration of Gendered Themes within Private and Public Discourse and Policy Implications

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Abstract

Recent research has evidenced the gender differentiated impacts of the COVID-19 pandemic on health and socio-economic inequalities in the UK. The impact of the COVID-19 pandemic on gender inequalities particularly regarding the increased burden of unpaid care work, health, education, and gender-based violence have been evidenced in a number of recent studies (O'Donnell *et al.* 2021; Flor *et al.* 2022; Herten-Crabb and Wenham 2022; Dotsikas *et al.* 2023). In particular, gendered inequalities are reflected in gendered themes within caregivers' discourse and reports on patterns among caregivers. This chapter analyses recent empirical evidence relating to the gender-differentiated health, economic and social impacts of the COVID-19 crisis in the UK. The chapter also explores recent research relating to gendered themes within private and public discourse relating to the impact of the COVID-19 pandemic. This is followed by a discussion of the policy implications of private and public discourse relating to the impact of the COVID-19 pandemic on gendered health inequalities in the UK. The main findings of the chapter are that the burden of normative expectations placed on women during the two lockdowns in the UK were overwhelming, with mothers facing extraordinary levels of emotional and psychological stress as they struggled to cope with conflicting demands of domestic work, home schooling, working from home and/or working within health care or social care. Moreover, women and caregivers in general faced extraordinary pressures

in attempting to live up to dominant public narratives of caregivers as stoic and heroic.

Keywords: COVID-19 pandemic; economic inequalities; gender inequalities; health inequalities; policy discourse; private discourse; public discourse; social inequalities.

1. Background and introduction

International research from a range of disciplinary and interdisciplinary fields informs understandings of the direct and indirect impacts of the COVID-19 pandemic on the lives of people of different genders. Here, the World Health Organisation actively encourages the collating, reporting, and analysis of data on confirmed COVID-19 cases and deaths disaggregated by sex, gender, and age. In particular, investment in "quality gender responsive research on the potentially differential adverse health, social and economic impacts of COVID-19 on women and men" is advanced to enable the development of meaningful and responsive policies (WHO 2020).

Recent Studies have revealed the regressive impact of the pandemic on women's employment and unpaid care work, particularly regarding lower household income and food insecurity (Bogotá 2020; Francis-Devine *et al.* 2021; Gottardello and Mazrekaj 2021; de Flor *et al.* 2022; Wielgoszewska *et al.* 2023). In the UK as across societies globally, the COVID-19 pandemic exacerbated the precarious position of women in the labour market. In 2019, women were a third more likely to work in an employment sector that was shut down by coronavirus that men. In particular, mothers were 1.5 times more likely to have been made redundant because of the COVID-19 pandemic (IFS 2020). Moreover, women in the UK were more likely to be in groups disproportionately affected by the pandemic, as 69% of low earners in the UK are women, 54% of women in the UK are on zero-hour contracts and 59% of women in the UK are in part-time self-employment (Women's Budget Group 2020).

A burgeoning body of research evidence has also illuminated gender-differentiated impacts of the COVID-19 crisis. A deeper understanding of these impacts requires recognition of existing and deeply embedded social norms, economic inequalities, and unequal power relations (Oreffice and Quintana-Domeque 2021). Recent evidence has informed understandings of the immediate effects of COVID-19 on gender inequality particularly regarding the increased burden of unpaid care work,

health, education, and gender-based violence (O'Donnell *et al.* 2021; Flor *et al.* 2022; Herten-Crabb and Wenham 2022; Dotsikas *et al.* 2023). Moreover, recent research has identified gendered themes in caregivers' discourse and reports on patterns among caregivers (Ioanna *et al.* 2021; Dotsikas *et al.* 2023). Illustrating this, Oreffice and Quintana-Domeque (2021) found that in the UK women's mental health was worse than men's mental health during the enforced COVID-19 lockdown in 2020. These differences were identified across several dimensions including depression, loneliness, generalized anxiety disorder and panic attacks (Müller *et al.* 2021; Oreffice and Quintana-Domeque 2021). Critically, studies also revealed interconnected vulnerabilities emerging from class, race, and gender during the COVID-19 pandemic (Keys *et al.* 2021; Moore *et al.* 2021) . As Keys *et al.* argue "an intersectional framework for analysis is vital in this COVID-19 moment as it teaches us a lot about enduring multiple and mutually constitutive health and social inequalities related to race, class, age, gender and disability" (Keys *et al.* 2021, 6).

Critically also, systemic, and socio-cultural factors strongly influence how care as an activity and caring roles are conceptualised and valued within distinct societies. Thus, caregivers may also be subjected to long term health impacts irrespective of gender, class, ethnicity, age, or disability. The lived realities of being a formal or informal carer-giver during the COVID-19 pandemic have been evidenced in a number of studies (Dhiman *et al.* 2020; Altieri and Santangelo 2021; Giebel *et al.* 2023; Hansen 2023). The range of recent empirical studies relating to distinct groups illustrates the heterogeneity of caregivers in the UK and across societies globally. Here research studies relating to the impact of caregiving on physical and mental health reveal that existing vulnerabilities and protective factors are strongly related to physical and mental health outcomes endured by informal care givers (Hansen *et al.* 2023; Rippon 2023; Whitley *et al.* 2023). Illustrating this, Whitley *et al.* (2023) found that whilst overall the mental health of home carers deteriorated more during lockdown in the UK, some subgroups of caregivers suffered poorer mental health than others. For example, women had poorer mental health outcomes than men. In addition, caregivers who provide more hours of care and have been caring longer and people who were spousal carers and carers for family members suffered poorer mental health outcomes.

These empirical findings reveal a complex picture regarding the impact of the COVID-19 pandemic on the mental health of caregivers as a heterogeneous group in the UK. Overall, these findings also raise key systemic questions in relation to the care economy in the UK and

across societies globally particularly regarding support provided to formal and informal caregivers as a heterogeneous group within the context of future pandemics. Crucially however research reveals the pre-dominance of women within care-giving populations and the increased burden and intensity of caring responsibilities born by women during the COVID-19 pandemic (Baowen and McMunn 2021; Zsuzsa *et al.* 2021; Phillips *et al.* 2022). These gendered inequalities are exacerbated by entrenched cultural norms and gendered expectations regarding traditional gender roles within the domestic sphere in the UK and across societies globally. Here, a burgeoning body of research has exposed "the second shift problem" that women encounter on a daily basis whereby women who are in paid employment are also expected to do most or all of the caring and domestic work necessary to keep the household functioning (Blair-Loy *et al.* 2015; Brailey and Slatton 2019; Dugan *et al.* 2020; Aldossari and Chaudhry 2021). This situation was exacerbated during the COVID-19 pandemic by the large-scale closure of educational institutions and childcare facilities which meant that parents took on the responsibility for home schooling and unpaid childcare. As a number of empirical studies have shown this work was undertaken more often by women than men due to the continued dominance of traditional gender roles across societies globally and also due to the pre-dominance of women in part-time, low paid and flexible employment (Zhou *et al.* 2020; Cook and Grimshaw 2021; Grasso *et al.* 2021; Powers 2021; Yildirim and Eslen-Ziya 2021). Moreover, women working within the formal care economy often had to balance paid work as health and social care professionals within the front line of the COVID-19 pandemic with domestic, caring, and home-schooling responsibilities (Maryam and Chaudhry 2021; Xue and McMunn 2021). As Kate Powers (2021) observes the burden of these additional demands meant that women were effectively enduring "the third shift problem" during the COVID-19 pandemic across social settings at a global level. A growing body of international epidemiological studies reveal the deleterious health impacts of the "third shift problem" for women. A unifying theme emerging across a number of epidemiological studies relates to the disproportionate impact of the COVID-19 pandemic on the mental health of women due to their increased exposure to stressors relating to caregiving during this period (Wenham 2020; Vloo *et al.* 2021; Wade *et al.* 2021; Del Río-Lozano *et al.* 2022; Garcia *et al.* 2022; Stöckel and Bom 2022).

More broadly, gendered health inequalities generated within the COVID-19 pandemic are closely interconnected within pre-existing gen-

dered socio-economic and labour market inequalities across developed Western democratic societies and societies globally (Yavorsky *et al.* 2021; Phillips *et al.* 2022) . In particular, a substantial body of research reveals that across societies globally women are more likely to occupy precarious low paid jobs than men (United Nations 2020). During the COVID-19 pandemic these types of jobs particularly within the female dominated service sector were more prone to redundancy than jobs within male dominated sectors such as manufacturing and construction (Bădoi 2021; Cook and Grimshaw 2021; Veitch, 2023). As in most Western democratic societies, there is also clear evidence of gendered labour market inequalities arising from the COVID-19 pandemic in the UK. Exemplifying this a major study undertaken by Wielgoszewska *et al.* (2023) revealed that during and after the COVID-19 pandemic women's employment in the UK was more likely to be adversely impacted than men's and that these impacts were more severe for women with a partner and children.

The UK was selected as a case study for this article as it shares key characteristics of a Western democratic societies particularly regarding well-developed health care services, social care services, social protection and childcare provisions and institutions. Critically however, historical variations in levels of health and social care expenditure and subsequent levels of support for women as parents, carers and workers across Western democratic societies have had a significant impact on gendered health inequalities within distinct welfare settings before, during and after the COVID-19 pandemic (Murphy 2019; Bambra *et al.* 2020; Walsh *et al.* 2022; Beck and Gwilym 2023; Veitch 2023). In the UK, the welfare reforms and severe austerity measures that followed the Financial Crises of 2007 to 2008 led to drastic reductions in health, education, and welfare expenditure (Greer Murphy 2017; Haynes 2020; Farnsworth 2021; Jenkins *et al.* 2021; Bray *et al.* 2022; Jupp 2022; Walsh *et al.* 2022; Beck and Gwilym 2023). The resultant impact on gendered health inequalities in the UK has been evidenced by a number of epidemiological studies (Darlington-Pollock and Norman 2019; Demakakos *et al.* 2019; Marmot 2020; McKee *et al.* 2021; Blundell 2022; Walsh 2022). Exemplifying this, a recent major study by the Health Foundation (2022) found that millions of women who live in the most socio-economically deprived areas of England, have a life expectancy of 78.7 years this is approximately 8 years lower than women living in the wealthiest areas of England (The Health Foundation 2022). This represents the lowest average life expectancy for women of all OECD countries apart from Mexico. Further to this a major epidemiological study conducted by Marmot *et al.* in 2020 found

that the life expectancy for the poorest ten per cent of women in England had decreased since 2010 and that austerity measures and welfare reforms enacted over the last decade have contributed significantly to gendered health inequalities in the UK. More broadly, the life expectancy of women in the UK as a whole was ranked lower than 26 OECD countries in 2022 (OECD 2023). Recent studies have found that the severe austerity measures enacted in the UK during the decade prior to the COVID-19 pandemic contributed significantly to these gendered health inequalities, as women are most likely to be on the lowest incomes, be lone parents, or to retire with a lower pension and are thereby disproportionately impacted upon by reduced levels of social security and the withdrawal of public services (Greer-Murphy 2017; Reis 2018; Dabrowski 2020; Walsh *et al.* 2022). This situation is particularly pronounced for disabled women and women from minority ethnic groups living in the UK (Allen 2018; Gibbs 2018; Lisney 2019; Rummery 2019). Whilst these specificities relating to the severity of austerity measures enacted in the UK limit the extent to which research findings from the UK are generalisable, recent international studies provide clear evidence of common themes with regard to the lived experiences of women during the COVID-19 pandemic across Western democratic societies. Core themes emerging from these studies include the impact of increased levels of informal caregiving due to the closure of educational and childcare institutions during lockdown periods on the mental health of women and the regressive impact of the COVID-19 pandemic on women's employment and unpaid care work, particularly regarding lower household income (Almeida *et al.* 2020; Blaskó 2020; Carli 2020; Fortier 2020; Jacques-Aviñó 2020; Power 2020; Rubery and Tavora 2020; Grasso 2021; Zamarro *et al.* 2021; Goldin 2022; Toffolutti *et al.* 2022).

The purpose of this paper is three-fold. Firstly, to analyse recent empirical evidence relating to the gender-differentiated health, economic and social impacts of the COVID-19 crisis in the UK. Secondly, to explore recent research relating to gendered themes within private and public discourse relating to the impact of the COVID-19 pandemic. Thirdly to discuss the policy implications of private and public discourse relating to the impact of the COVID-19 pandemic on gendered health inequalities in the UK.

2. Conceptual approach

A holistic biopsychosocial conceptual approach to health inequalities underpins the theoretical approach adopted within this chapter. This approach was adopted as a result of a critical review of a broad range of empirical and theoretical data and literature relating to the gender differentiated impact of the COVID-19 pandemic on health Inequalities in the UK. Intrinsically this framework proposes that inequalities in the social determinants of health such as employment, work-life balance, and low-income impact significantly on health inequalities (Wenham 2020; Del Río-Lozano *et al.* 2022; Stöckel and Bom 2022). Critically, there is also substantial empirical evidence that psychosocial factors such as stress have a significant impact on health and wellbeing (Etheridge and Spantig 2022; Dotsikas *et al.* 2023; Kourti *et al.* 2023). Here, psychosocial pathways between the social determinants of health and physical and mental health have been evidenced as being strongly related to social roles and gender traits (Etheridge 2022). Previous research has also revealed that women have experienced higher levels of mental diseases across all regions in the world within every age group as a result of the COVID-19 pandemic (WHO 2023). In particular, research evidence has shown that social roles, particularly regarding caring roles have a significant negative impact on levels of stress which acts as a direct pathway to poorer physical and mental health. Here, whilst studies have revealed that women who are in employment have more positive health outcomes (Women's Budget Group 2023), being a caregiver impacts negatively on both physical and mental well-being (Schulz and Sherwood 2007). Here, a number of recent studies have revealed that providing care, especially to family members negatively impacts on physical and mental health (Herten-Crabb and Wenham 2022; Dotsikas *et al.* 2023; Kourti *et al.* 2023). The psychosocial pathways underlying this are complex however, there is clear epidemiological evidence that this is related to the higher levels of stressors impacting on care givers in comparison to non-care givers (Son 2007).

Exposure to strain as a result of these stressors is higher in women than men because women are more often caregivers than men across societies globally (Di Fazio *et al.* 2022) . The COVID-19 pandemic has exacerbated and exposed these gendered health inequalities (Wenham 2020; Del Río-Lozano *et al.* 2022; Stöckel and Bom 2022). A study by Stockel and Born (2022) revealed the "negative mental health effects of informal care provision and show that the effects persist up to four or five years after initial care provision" (Stockel and Born 2022, 12).

The COVID-19 pandemic placed a huge burden on health and social care systems, severely restricting access to formal care, education, and support services across societies at a global level. This led to an exponential increase in the number of people being cared for and educated in the home. The utilisation of a biopsychosocial conceptual approach is appropriate to an exploration of the gender-differentiated impacts of the COVID-19 pandemic on health and social inequalities in the UK as a burgeoning body of empirical research has shown that women bore the largest share of caring responsibilities within the home during the lockdown and associated measures of COVID-19 pandemic in the UK. Moreover, recent epidemiological evidence has revealed that amongst the care-giver population as a whole women had poorer mental health outcomes than men as a result of the COVID-19 pandemic lockdowns and associated measures implemented in the UK and across societies globally (WHO 2023).

3. Methodological approach

The methodological approach is theory driven thematic analysis underpinned by an interpretivist epistemology. Thematic analysis is an appropriate tool for this research in enabling the identification and analysis of patterns of meaning relating to the gendered differentiated impacts of health inequalities emerging from the COVID-19 pandemic in the UK.

The research involves three stages.

1. Literature review. A critical review of a broad range of empirical and theoretical data and literature relating to the gender differentiated impact of the COVID-19 pandemic on health inequalities in the UK.
2. A systematic review of existing qualitative studies focussing on a thematic analysis of gendered themes within public and private discourse relating to health and social inequalities during the COVID-19 pandemic. A deductive approach was adopted. The critical review of literature (stage one) formed the conceptual basis for the theory driven thematic analysis. This approach centred upon the biopsychosocial model of gendered health inequalities. The text was coded line by line to develop descriptive and analytical themes. The descriptive themes were closely aligned to the themes identified in the primary studies; The analytical themes were then interpreted within the conceptual framework developed from stage one of the research.
3. An exploration and discussion of policy implications within the UK.

4. Health inequalities arising from the COVID-19 pandemic

The COVID-19 pandemic continues to have profound impacts on the lives of people globally. Recent epidemiological evidence has underlined the differential impact of the disease on male, female, and non-binary genders. International epidemiological studies have revealed that males have overall increased risk of infection, intensive care unit admission and morbidity than females (Mukherjee and Kalipada 2021; Chaturvedi *et al.* 2022; Demetriou *et al.* 2023). These differences have been found to relate to distinct biological vulnerabilities such as sex-based immunology responses and to gendered differences in negative health behaviours often generated by gendered social norms such as alcohol consumption and smoking (Chaturvedi *et al.* 2022; Demetriou *et al.* 2023). Overall, however, increased vulnerability to the disease has also been shown to correlate closely with socially ascribed roles. Here, being in formal and informal health and social care roles has been shown to significantly increase direct health risks associated with the COVID-19 virus. Within the formal health and social care sectors in the UK, people who identified as females occupied 75% of National Health Service roles and 81% of social care roles during the COVID-19 pandemic (ONS 2020). In terms of the general population in the UK females were thus more exposed to the risks of contracting the disease than males. Underlining this, recent studies have shown that females are much more likely to suffer long COVID than males in the UK (Stroud and Gutman 2021; Pantelic *et al.* 2022; Subramanian *et al.* 2022; Thompson *et al.* 2022). In the UK two forms of long COVID have been categorised. These are ongoing symptomatic COVID which can last for four to twelve weeks and post-COVID Syndrome when symptoms continue for over twelve weeks.

A survey conducted by the Office for National Statistics (UK Government) in January 2022 found that 510,000 women in the UK suffered from forms of long COVID which affected their activities a little compared to 353,000 men (ONS 2022). Critically the survey also revealed that a further 214,000 women suffered long COVID symptoms which seriously affected their daily lives compared to 132,000 men (ONS 2022). Long COVID symptoms include, heart palpitations, difficulty breathing, dizziness, insomnia and depression and anxiety. Deterioration in mental health has been found to be one of the most prevalent direct and indirect consequences of the COVID-19 virus (Chaturvedi *et al.* 2022; Dotsikas *et al.* 2023). The most important gendered effects on deterioration in mental health in women have been revealed as being related to

increased levels of caring responsibilities and domestic duties within the home and increased levels of domestic violence during the COVID-19 pandemic in the UK and across societies globally (Proto and Quintana-Domeque 2021; Xue and McMunn 2021; Herten-Crabb and Wenham 2022; Dotsikas *et al.* 2023; Kourti *et al.* 2023). As in societies globally, the closures of schools and nurseries during the two lockdowns were found to exacerbate these conditions for women. Critically, several research studies have highlighted the lack of psychosocial support for health care workers, 75% of whom were women (Herten-Crabb and Wenham 2022; Kourti *et al.* 2023).

As a result, several studies have emphasised the need for gender responsive interventions in the UK and across societies globally (Hupkau and Petrongolo 2020). There is now clear evidence that women have been disproportionately affected by the COVID-19 pandemic. Women in the UK and beyond have been impacted upon by the disproportionate loss of employment due to the feminized nature of service industries which were impacted upon by the lockdowns. During the initial phase of the COVID-19 pandemic job loss rates were lower for women than for men in the UK. This was because over 75% of health and social care and 70% of education roles were occupied by women (ONS 2020). In addition, women occupied a high proportion of occupations that could be carried out at home. Critically however, studies found that women were more likely to accept the offer of a furlough scheme due to increased caring responsibilities in the home. Moreover, women were found to be more likely to have their paid work interrupted by domestic work and caring responsibilities in the home than men (Andrew *et al.* 2020; Flor *et al.* 2022).

Exemplifying this in 2021, 26% of women compared to 20% of men in the UK reported employment loss. Moreover, women were much more likely to forgo paid employment to care for others in the home than men and by September 2021, women were eight times more likely than men to forgo paid employment to care for others in the home (Flor *et al.* 2022).

In addition, women and girls were twenty-one times more likely than men and boys to report dropping out of school for reasons other than school closures (Flor *et al.* 2022). Finally, women were twenty-three times more likely than men to report that gender-based violence had increased during the pandemic (ONS 2021). In addition, as Alon *et al.* (2020) evidence women were placed under greater strain because of gendered norms underlying social roles related to childcare when nurseries and schools were closed whilst also finding themselves isolated from the support of extended families during lockdown periods.

Public and private discourses may be regarded as both reinforcing and generating socio-cultural, ecological, and systemic environments experienced by formal and informal care givers regardless of their gender identity within distinct societies. From a Feminist perspective however the gendered norms underlying social roles within distinct societal settings have been pivotal in shaping the struggles faced by women within distinct societies as a disproportionate number of primary caregivers were women during the COVID-19 pandemic in the UK and globally (Gilson 2021; Smith *et al.* 2021; Whiley *et al.* 2021).

5. Gendered themes within public and private discourse relating to the impact of the COVID-19 pandemic on women in the UK

5.1. *Descriptive themes within public discourse*

Recent literature has evidenced the continued significance of the media in shaping public discourse and the construction and maintenance of societal norms and values across societal settings (Braun and Gillespie 2011; Saraisky 2016; Zinn and Müller 2022). In contrast to private discourse through which individuals communicate their personal feelings and develop relationships public discourse is often regarded as a central mechanism through which public policies, socio-cultural norms, values, roles and systems are legitimated and reinforced. Here, media institutions ranging from TV and radio media outlets to print media and social media are regarded as playing a pivotal role in shaping public opinion. During the period of the two COVID-19 pandemic lockdowns and related measures between March 2020 and December 2021 UK media institutions and outlets became highly influential in shaping public opinion particularly regarding ensuring compliance with lockdown regulations and related measures.

Exemplifying this, a major study conducted by Sowden *et al.* (2021) found that health care workers were often described in on-line UK newspaper reports as 'heroes' or 'angels' rather than as human beings with fears and needs. Here, the authors found that less homogenous and fear-based coverage of the COVID-19 pandemic in conjunction with clearer information about support available to both formal and informal care givers would have been more helpful to carers in the UK.

6. Selection of data set for analysis

Six qualitative studies were selected for the systematic review. The studies were selected as a representative sample of peer reviewed articles published in international journals. In addition, the research articles are drawn from a range of disciplinary areas including Medicine, Politics, Sociology, Psychology and Nursing Studies.

6.1. *Textual data set*

1. Herten-Crabb, Asha, and Clare Wenham. 2022. "'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". *Social Politics: International Studies in Gender, State & Society* 29 (4): 1213-1235.
2. Adisa, T.A., O. Aiyenitaju, and O.D. Adekoya. 2021. "The Work-Family Balance of British Working Women during the COVID-19 Pandemic". *Journal of Work-Applied Management* 13 (2): 241-260.
3. Mohammed, Shan, Elizabeth Peter, Tieghan Killackey, and Jane Maciver. 2021. "The 'Nurse as Hero' Discourse in the COVID-19 Pandemic: A Poststructural Discourse Analysis". *International Journal of Nursing Studies* 117: 103887.
4. Aughterson, Henry, Alison R. McKinlay, Daisy Fancourt, and Alexandra Burton. 2021. "Psychosocial Impact on Frontline Health and Social Care Professionals in the UK during the COVID-19 Pandemic: A Qualitative Interview Study". *BMJ Open* 11 (2): e047353.
5. Einboden, Rochelle. 2020. "SuperNurse? Troubling the Hero Discourse in COVID Times". *Health* 24 (4): 343-347.
6. Regenold, Nina, and Cecilia Vindrola-Padros. 2021. "Gender Matters: A Gender Analysis of Healthcare Workers' Experiences during the First COVID-19 Pandemic Peak in England". *Social Sciences* 10 (2): 43.

7. Data set analysis

Four common descriptive themes within Public and Private Discourse emerged from across the six studies.

Figure 1 provides a list of these themes with selected textual examples.

FIGURE ONE

Descriptive Theme	Public/ Private Discourse	Quotation	Paper	Code
a) **Care givers exalted for their 'heroism' and 'stoicism' during the lockdown periods and associated measures.**	Private	"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?" (p1224,line 6)	(1)	(a.pr.f)
		"I'm a nurse. For myself, and many of my colleagues, our profession constitutes not just what we do, but who we are. Nurses remain vulnerable to hero discourses because our work is entangled with our identity"(p 344, line 17)	(5)	(a.pr.f)
		"After eight weeks of clapping, I feel completely betrayed and as though what myself and my colleagues went through was just expected of us as our duty". (page 5 line 44)	(3)	(a.pr.f)
		"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." (p1226, line 20)	(1)	(a.pr.i)
	Public	"Health Care Heroes of the COVID-19 Pandemic" (page 344, line 30)	(5)	(a.pu.f)
		"Depictions in the media often drew on religious notions of martyrdom to describe nurses' selflessness in uncertain and, at times, dangerous conditions". (page 4, line 34)	(3)	(a.pu.f)
		"The framed artwork, entitled 'game changer' depicts a young boy kneeling on the floor playing with a brand-new superhero doll. In the background, a waste bin holds two well-known but now discarded superheroes, Batman, and Spiderman. The boy's attention is on his new toy, Supernurse"(p 333, line 10)	(5)	(a.pu.f)
		"The nurse as hero discourse has found public expression through community performances (e.g., singing from balconies, clapping, and banging pots and pans), corporate visibility (e.g., TV commercials, marketing campaigns, and promotional offers to healthcare staff), and governmental displays (e.g., military tributes, politician speeches, and light shows on public buildings)" (page 2, line 32)	(3)	(a.pu.f)
b) **Impact of Covid 19 Pandemic lockdowns and related measures on physical, emotional, and psychological well-being**.	Private	"The demands of paid labour and increases in unpaid labour 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" (page 1226, line 12)	(1)	(b.pr.f)
		"you just become quite tired…it culminated with masks, visors, aprons, hot weather and regulations changing and sometimes you'd come home from a shift and feel you'd been pulled in all directions really" (Page 5, line 38)	(6)	(b.pr.f)
		I was quite anxious about being in the office with COVID I had some colleagues of mine who were able to work from home… I was told that this wasn't possible… it was business as usual. It was a real sense of frustration, not feeling that you're being listened to by my manager and just a sense of feeling overwhelmed and quite helpless about the situation. (page 6, line 46)	(4)	(b.pr.i)
		"Crying at work was most commonly reported by nurses; one nurse described a particularly hard night, "I think everyone that night cried literally every hour on a	(6)	(b.pr.f)

		corner". Nurses in charge also seemed to carry a heavy emotional burden, even though they were less involved in caring for patients. Nurse leads described supporting and carrying their team, which included "sucking up a lot of sadness for the team" (page 6, line 36)		
		the virus messes with your head more than it does your body if you're not hospitalised. That's just down to the media at the end of the day. There's so much media and so much emphasis on death, not so much on recovery (page 6, line 54)	(4)	(b.pr.i)
		"There's been a huge amount of emotional support that we've had to give through anxiety, through grief. All that has been heightened quite greatly really. And a deeper sense of sadness in yourself, that you're trying to support people and having that empathy for them, thinking this is just absolutely horrendous for them" (page 4, line 26)	(4)	(b.pr.f)
c) **Mothers balancing care of children with formal employment**	Private	"It's been difficult. I don't feel like I've been a good teacher in terms of I felt very unable to motivate them in the right way, to do their work in the ways that I would like them to do. It's all seemed a bit futile in places, so draining at home . . . and then quite draining coming to work . . . there's not that much reprieve". (page 9 line 33)	(6)	(c.pr.i)
		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." (p. 1219, Line 5)	(1)	(c.pr.i)
		"My work duties have suddenly been moved to the home, and my domestic duties have increased due to the COVID-19 lockdown. It is really difficult to separate the roles...for example, I will quickly leave a meeting (online) to attend to my children and then rush back to it; sometimes, I will be lost in the conversation because I have missed out on some minutes...it's like a rollercoaster – crazy" (page 250, line, 24)	(2)	(c.pr.i)
		"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." (page 1222, line 8)	(1)	(c.pr.i)
		"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." (p.1219, line, 28)	(1)	(c.pr.i)
		"As we know, women and men perform different familial and domestic roles. Even though we both foot the family bills, my husband doesn't engage in what are termed "women's duties", such as cooking; bathing and caring for the kids; cleaning the house...all of these are considered women's duties. Unfortunately, these duties and work responsibilities have all increased since the lockdown, and I have to attend to all of them" (p250, line 16)	(2)	(c.pr.i)
		"I used to experience role conflict before the lockdown, but it has significantly worsened since the lockdown. My work and domestic duties have increased, and they are both happening in the same place [at home]. Sometimes, I lock myself up in a room to attend to my work duties, which my husband and children are really not happy about...and sometimes, I ignore work duties for a while to attend to my domestic duties...which also affects my work. I can't separate the roles". (p.250, line. 31)	(2)	(c.pr.i)

d) **Culture of Blame Feelings of guilt arising from this.**	Public	"Some also expressed frustration at the 'culture of blame' that they felt permeated the media and public discourse, which can be maladaptive and harmful for one's own mental well-being" (Page 8, line 15)	(4)	(d.pu.f)
		"Will there be an expectation that the "heroes" we are celebrating (and their families) must take on an ever-increasing level of risk? If we can't adequately ramp up capacity, and work conditions become intolerably dangerous, will the public turn on health workers who abandon their posts?" (page, 345, line 6)	(6)	(d.pu.f)
		"Consistent with research from previous pandemics and recent quantitative data during COVID-19, participants also restricted their news intake, particularly as they felt the constant reporting of COVID-19 and the prevalent discourse of blame negatively affected their mental health".	(4)	(d.pu.f)
		The hero discourse often constructed nurses as "model citizens" in a rapidly evolving crisis that required responsibility, action, and, depending on one's political perspective, obeying public authority. Nurses were often depicted as compliant with their role as the "last line of defense" in pandemic management, particularly in the uncertain early phases of the crisis. (page, 4, line 48)	(3)	(d.pu.f)
	Private	"I felt like I didn't deserve that applause because I wasn't on the frontline, and I wasn't doing what I should be doing". (Page, 10. Line 32)	(6)	(d.pr.f)
		"I felt incredibly guilty by the fact that I wasn't helping out on the frontline because I was pregnant. I was just told I'm not allowed to see any patients, by occupational health, and sent home" (page 7, line 22)	(4)	(d.pr.f)
		"Because I'm working, he'll just be watching stuff on his iPad, and so I feel bad about that." (page, 1222, line 5)	(1)	(d.pr.i)
		"I've heard several times . . . 'don't use this now, we're lucky we have PPE, all the trusts and all the hospitals don't have it' and then you just feel guilty because you know that the nurses aren't protected somewhere else". (page 6, line 53)	(6)	(d.pr.f)
		"When I first came off the rota, I just felt really guilty . . . Also, I've spent the last 9 years of my life training for this, and it was like why suddenly am I stepping away from this and it felt like I should be there" (page 10, line 33)	(6)	(d.pr.f)

8. Analytical themes

8.1. *Psycho-social burden of being a care-giver conflicting socio-cultural and normative expectations on women as carers, workers, and citizens*

As illustrated in the descriptive themes above, public discourse in the UK during the COVID-19 lockdowns elevated formal and informal care givers who were predominantly women to the level of 'heroes' and 'angels'. In sharp contrast, private discourse reveals how normative expectations of women, particularly mothers, created daunting levels of emotional and psychological stress. Here women who were also care-givers revealed how they struggled to cope with conflicting demands of domestic work, home schooling, working from home and/or working within health care or social care. Living up to public narratives which often placed caregivers in a heroic light was of itself an often isolating, and physically and emotionally demanding task.

> 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. (p. 1226, line 20) (1)

Private discourse amongst female health care workers also revealed the internal tensions suffered by formal caregivers within the context of heroic narratives perpetuated across the UK media,

> "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?". (p. 1224, line 6) (1)

Tensions between heroic narratives amplified across media outlets and platforms in the UK and the psychological and social demands placed on women who were caregivers during the COVID-19 pandemic also impacted significantly on personal and professional identity as the following quote from a health care worker reveals,

> I'm a nurse. For myself, and many of my colleagues, our profession constitutes not just what we do, but who we are. Nurses remain vulnerable to hero discourses because our work is entangled with our identity. (p. 344, line 17) (5)

The intrinsic link between professional and personal identity experienced by this nurse is clearly evident in her words "its not just what we do, but who we are". Here, feeling vulnerable to hero discourses reveals the extent to which nurses felt under pressure to live up to the heroic public narratives attached to their role by media outlets and platforms. Yet, as has been illustrated the pressures placed on women as formal and informal caregivers in balancing increased demands within the domestic sphere and work sphere placed increased stress on women as caregivers generally. For health and social care workers 'heroism' often entailed trying to ignore the risks associated with inadequate protective equipment or low staffing numbers (Hoernke *et al.* 2021; Kim *et al.* 2021).

> Will there be an expectation that the 'heroes' we are celebrating (and their families) must take on an ever-increasing level of risk? If we can't adequately ramp up capacity, and work conditions become intolerably dangerous, will the public turn on health workers who abandon their posts? (p. 345, line 6) (6)

For those women who attempted to live up to this heroic and stoic narrative increased pressures within both formal and informal care giving was emotionally, mentally, and psychological challenging. Here, women working as informal carers often had to sacrifice paid work in the formal economy leading to a loss of identity. Additional anxieties related to the risks of the COVID-19 virus itself, financial worries and stresses related to home schooling often exacerbated this sense of loss or threats to professional and personal identities. From a biopsychosocial perspective several studies have underlined the relationship between a socially devalued self, perceived discriminations or threatened personal or professional identities and psychological and emotional wellbeing (Haslem *et al.* 2009; Sharma 2010; Garcia 2022; Lunt *et al.* 2022; OECD 2022).

8.2. *Women's sense of powerlessness*

A central analytical theme emerging from across the descriptive themes was the sense of powerless expressed by women within private discourse. Here, feelings of lack of influence over decision making processes led to feelings of powerlessness for both formal and informal caregivers. For informal caregivers a number of recent studies have revealed ways in which the COVID-19 pandemic and particularly the lockdown periods have exacerbated gender differentials within the domestic sphere and across society in the UK. The following extracts clearly indicate the sense

of powerlessness and frustration felt by women who had to balance their role as informal caregivers and paid workers,

> As we know, women and men perform different familial and domestic roles. Even though we both foot the family bills, my husband doesn't engage in what are termed 'women's duties', such as cooking; bathing and caring for the kids; cleaning the house [...] all of these are considered women's duties. Unfortunately, these duties and work responsibilities have all increased since the lockdown, and I have to attend to all of them. (p. 250, line 16) (2)

> I used to experience role conflict before the lockdown, but it has significantly worsened since the lockdown. My work and domestic duties have increased, and they are both happening in the same place [at home]. Sometimes, I lock myself up in a room to attend to my work duties, which my husband and children are really not happy about [...] and sometimes, I ignore work duties for a while to attend to my domestic duties [...] which also affects my work. I can't separate the roles. (p. 250, line 31) (2)

For women juggling unpaid caring duties and paid work feelings of powerlessness and a lack of influence over decision making processes are also clearly evidenced within private discourse.

> I was quite anxious about being in the office with COVID I had some colleagues of mine who were able to work from home [...] I was told that this wasn't possible [...] it was business as usual. It was a real sense of frustration, not feeling that you're being listened to by my manager and just a sense of feeling overwhelmed and quite helpless about the situation. (p. 6, line 46) (4)

The following quotation reveals a clear awareness of culturally defined gendered norms and forms of gendered discrimination underlying social roles in the UK.

> 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. (p. 1219, line 5) (1)

For women within formal care-giving roles feelings of powerlessness were found to spill over into feelings of betrayal and guilt,

> After eight weeks of clapping, I feel completely betrayed and as though what myself and my colleagues went through was just expected of us as our duty. (p. 5, line 44) (3)

A recent study conducted by Mabon *et al.* (2022) revealed the prevalence of feelings of powerlessness experienced by women who were health care workers during the COVID-19 pandemic. Here, women working within health care settings described feeling as if they were "shouting into the ether" if they ever raised issues and concerns related to lack of PPE equipment and this left them feeling powerless.

Within a biopsychosocial conceptual model, feelings of powerlessness to control resources or decision-making processes within the workplace can lead to personal exhaustion and breakdown (Adams 2020; Sonali 2022; Tebbeb 2022; Weinberg and Creed 2022). This is particularly the case during times of crisis. Falcó-Pegueroles *et al.* (2023) found in a recent study that health care practitioners were more likely to focus on the suffering of others during the COVID-19 pandemic than their own well-being particularly regarding exhaustion and mental health issues. Moreover, as previously evidenced frustrations emerging from entrenched gendered norms often eclipsed women from being equally involved in decision making processes in the domestic and employment spheres. Recent international evidence has underlined the impact of the COVID-19 pandemic on the structural limitations and culturally ascribed roles experienced by women and men. For women, "the motherhood penalty" has been found to be particularly significant for women during the COVID-19 pandemic. The motherhood penalty refers to the argument that a woman's capacity to participate in paid work is strongly related to their responsibilities as unpaid caregivers. Similarly, a woman's capacity to take on responsibilities as an unpaid caregiver is strongly related to her participation in paid work (Rathi and Chirantan 2023)

8.3. *Self-blame and guilt within a blame culture during the COVID-19 pandemic in the UK*

Self-pathologizing and feelings of guilt within a blame culture emerged as a linking thread across all the descriptive themes. The tension between public discourse lauding stoicism and heroism and private discourse imbued with feelings of self-blame felt by women struggling to reconcile their identities as carers, workers and citizens was evident across all the descriptive themes. Here, traditional gendered roles became more entrenched during the COVID-19 lockdowns in the UK. For informal carer givers this was particularly acute for mothers who struggling to balance caring for children with the demands of employment.

As one mother expresses,

> It's been difficult. I don't feel like I've been a good teacher in terms of I felt very unable to motivate them in the right way, to do their work in the ways that I would like them to do. It's all seemed a bit futile in places, so draining at home [...] and then quite draining coming to work [...] there's not that much reprieve. (p. 9, line 33) (6)

Echoing these feelings of guilt another mother describes her feelings of guilt when working from home during the pandemic,

> Because I'm working, he'll just be watching stuff on his iPad, and so I feel bad about that. (p. 1222, line 5) (1)

For formal care givers feelings of guilt and self-blame were also evident across all descriptive themes. In particular, the impact of public discourses focussing on heroism and duty on the mental health of formal health care workers was also clearly demonstrated,

> I've heard several times [...] "don't use this now, we're lucky we have PPE, all the trusts and all the hospitals don't have it" and then you just feel guilty because you know that the nurses aren't protected somewhere else. (p. 6, line 53) (6).

For this nurse feelings of guilt emerge from using personal protective equipment as it is in short supply and has been rationed across hospitals and health care centres.

Critically, these findings align closely with a burgeoning body of research evidence which reveals that the discourse of blame which permeated the public sphere in the UK during the COVID-19 lockdowns had a detrimental impact on mental health in general and most particularly on the mental health of health and social care workers generally (Greenburg 2020; Gilleen *et al.* 2021; Neil *et al.* 2021; San *et al.* 2021; Wanigasooriya *et al.* 2021). More broadly, the impact of feelings of self-blame and guilt experienced by women within formal and informal care-giving roles during the pandemic on short-term and long-term mental health has been demonstrated in several recent studies (Qureshi 2022).

There are clear intersections between the three analytical themes proposed in this section. In particular, the psycho-social burden of being a caregiver and conflicting socio-cultural and normative expectations on women as carers, workers and citizens is clearly evidenced as being related to feelings of powerlessness, self-blame, and guilt. Critically however, the relationship between these themes is also mediated by the specificities of cultural settings which generate gendered norms and socially ascribed

roles. As the findings of this chapter have shown, public and private discourse during the COVID-19 pandemic demonstrates how sociocultural factors become entrenched at times of crisis. In particular, the tension between media and news outlets and platforms which perpetuated a public discourse extolling the virtues of heroism and a private discourse characterised by feelings of guilt, powerlessness and self-blame led to internal contradictions for women as carers, workers, and citizens in the UK.

9. Discussion and conclusion

The biopsychosocial pathways underlying the differential impact of the COVID-19 pandemic on the mental health of women and men in the UK are complex. Importantly however, the exploration of private and public discourse relating to the experiences of women who were formal and/or informal caregivers during the pandemic has provided some key insights into these pathways. In particular, the burden of normative expectations placed on women during lockdowns can be overwhelming with mothers facing overwhelming levels of emotional and psychological stress as they struggle to cope with conflicting demands of domestic work, home schooling, working from home and/or working within health care or social care. Moreover, a unifying thread across all three analytical themes was the extraordinary pressure of living up to public narratives of caregivers as stoic and heroic. The impact of the psychological, physical, and social burdens placed on caregivers in general and on women who made up the vast proportion of formal and informal caregivers during the COVID-19 pandemic in the UK has been recently evidenced by a number of epidemiological studies. Here, as has been discussed previously, the COVID-19 pandemic has exposed and exacerbated gendered health inequalities in the UK and across societies at global level (Wenham 2020; Del Río-Lozano *et al.* 2022; Stöckel and Bom 2022).

In recognition of the impact of the COVID-19 pandemic on gendered health inequalities the World Health Organisation has urged investment in "quality gender responsive research on the potentially differential adverse health, social and economic impacts of COVID-19 on women and men" to enable the development of meaningful and responsive policies (WHO 2020). Recent health care policy strategy documents within the UK have endorsed the need to develop meaningful

and responsive policies. Exemplifying this, the *Women's Health Strategy for England* proposes,

> a programme of work to support delivery of the Women's Health Strategy, eradicating deep-seated biases and driving forward the system-level changes needed to close the gender health gap. (*Women's Health Strategy for England* 2022, p. 8)

Within the strategy document a focus on gendered dimensions to mental health literacy is proposed.

> This includes gendered dimensions to mental health literacy, such as improving the visibility of how mental ill health can stem from and interact with health conditions typically experienced by women across their life course. (*Womens Health Strategy for England* 2022, p. 33)

It may be argued that whilst this is a valuable focus in relation to health promotion, from a biopsychosocial perspective pathway which lead to poor mental health outcomes are also socially determined. As this chapter has evidenced it may be argued that the development of meaningful and responsive policies requires a commitment to understanding the complex pathways that lead to health inequalities.

Endorsing this perspective, the *Women's Health Strategy for Scotland* states that,

> The Scottish Government recognises that across most aspects of mental health, outcomes for women and girls are poorer than for men and boys. That is why the Mental Health Transition and Recovery Plan, published in October 2020 in response to the Covid-19 pandemic, commits to making women and girls' mental health a priority. It sets out specific actions to address women and girls' mental health including engaging with women's organizations' to better understand and respond to the gender-related mental health inequalities that have been exacerbated by the Covid-19 pandemic. This includes for example, stressors and trauma experienced by women in key worker jobs and the disproportionate emotional and physical burden on women of caring for relatives of all ages. (*Women's Health Strategy for Scotland* 2022, p. 24)

It may be argued that the private discourses expressing the experience of women as caregivers provided in this chapter underlines the urgent need to engage with, listen to and hear women's voices to "better understand and respond to the gender-related mental health inequalities" and broader health, and socio-economic inequalities, "that have been exacerbated by the Covid-19 pandemic".

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