

Change in women's work burden and gender norms of unpaid care work after the second wave of the COVID-19 pandemic in India

Praheli Dhar Chowdhuri^{a,*}, Kaushik Kundu^a and Suman Meyur^b

^a*Department of Management and Business Administration, Aliah University, West Bengal, Kolkata, India*

^b*Department of Medical Oncology, Saroj Gupta Cancer Center and Research Institute, West Bengal, Chak Thakurani, India*

Received 22 January 2022

Accepted 3 March 2023

Abstract.

BACKGROUND: The COVID-19 pandemic and resultant lockdown has increased the burden of unpaid care work. Hence it is essential to evaluate the crisis response in change of women's work burden and gender norms of their unpaid care work and social status.

OBJECTIVE: To investigate change in women's job roles after second the wave of the COVID-19 pandemic and its effect on physical and psychological burden of work along with identification of common contributors of gendering of care work.

METHOD: Using a structured questionnaire and simple random sampling technique, the study was conducted on married women ($n=691$) in West Bengal, India after the second wave of the COVID-19 pandemic.

RESULTS: Significant job loss ($p=0.014$) occurred during COVID-19. Unpaid care work increased ($p=0.04$) with reduction in rest hours ($p=0.002$). 62.3% women felt increased burden of work. Work burden score increased with age ($p=0.003$), reduction of rest ($p<0.001$) and increased care work ($p=0.022$). Gendering occurred due to male partner's less contribution to care work and respondents' cognitive agreement with expected gender role. Gendering of work is less in urban areas (OR = 0.379, $p=0.008$) and higher income group (OR = 5.37, $p=0.026$). Women faced more gendering in case of job loss (OR = 9.27, $p=0.001$) or if burdened with work (OR = 3.92, $P<0.001$).

CONCLUSION: The impact of employability of women on their work role during the COVID-19 outbreak has highlighted both theoretical and practical significance that opens up the scope of further studies at national and larger ethno-geographic levels.

Keywords: COVID-19, pandemic, household work, gender role, work engagement

1. Introduction

Globally, women perform 76.2% of total unpaid care work. In Asia and Pacific, the amount of women's unpaid work rises to 80%, since men here

share the lowest burden of unpaid care work, with average 1 hrs. 4 minutes per day. This scenario is far worse in India, where on average men spend only 31 minutes a day on unpaid care work [1]. In case of employed women, there are triple spheres of work burden; productive work, reproductive work and community work [2] as the burden of community work, care work or reproductive work does not get reduced for women who are also engaged into some sort of productive work. Such normative gender

*Address for correspondence: Praheli Dhar Chowdhuri, PhD, Research Scholar, Department of Management and Business Administration, Aliah University, West Bengal, Kolkata, India. E-mail: prahelichowdhuri@yahoo.co.in.

roles have been theoretically modelled by different researchers. In their traditional Gender Role Model [3], Parsons and Bales put forward that the nature of duality of gender is based upon the dimensions of instrumentality and expressiveness, the former being more masculine. Eagly's Social Role Theory [4] proposed that gender division of labour actually characteristically establishes the formal gender stereotypes. The Gender and Development approach majorly influenced by Oakley [5] and Rubin [6] also state the same that the social relationship between men and women has established subordinate positions for women. This subordinate position backend by societal gender norms compels women to accept and take up the triple spheres of work burden. For women already engaged in productive work, their unpaid family care work or reproductive work (e.g. childbearing, cleaning, cooking, house upkeep, caring for elderly, sick) generally do not get reduced but add up on and above the productive or paid work. Hence, it is referred as 'second shift' [7]. Along with this dual work burden, women spend a lot of time on 'labor of love', they are the primary person responsible for maintaining social interactions with e.g. neighbors, friends, members of extended family and volunteers groups [8], and spend significant time on development of community resources [9]. This unpaid emotional labour spent on community work, is called 'the third shift' of women [10, 11]. This care work burden is stressful and proves to be more harmful for women engaged to it. In their Caregiver Health Effect Theory, Schulz and Beach [12] argue that women who have only care-giving function have more stressors that could affect their longevity in an adverse way.

1.1. COVID-19 situation and care work burden

Research shows that women's vulnerability surges during disastrous times like flood, natural calamity and war [13, 14]. This happens due to presence of the already existing inequality and lower quality of life women predominantly suffer from, spikes even up during tough times with the additional responsibilities vested upon them. The effect of such escalating burden on women, may prove to be much long-lasting and harmful than the disaster itself [9] and are capable of regressing the civilization beyond thoughts.

The COVID-19 situation is not much different and came up with an unprecedented phenomenon where preventive measures confined human being at

home. Along with the usual unpaid reproductive care work; sanitization, disinfecting and cleaning work have increased heavily. Besides, due to the declaration of a nationwide lockdown in many countries; school, college, offices got completely shut down. Closure of schools, day care centres and crèches naturally increased infant and child care work burden at home and the continuous presence of all family members at home due to office closure and introduction of work from home option, have increased the total care work burden of the family.

In countries like India, managing this care work burden became increasingly difficult. This is because in India, nationwide lockdown was declared on 24th March, 2020, confining all members of a family at home and thus heavily increasing the overall care work burden of the family [14]. In June 2020, the unlockdown process started, initially for essential sectors and later for other non-essential sectors. Unorganized sectors and organized sectors other than software, BPO and those heavily relying on online system started regularising employees' physical presence. However, all schools, colleges and universities remained fully closed in most states of India. After that, when slowly things started getting back to normal, the second wave broke out in India during the middle of March, 2021 and continued until the end of June, 2021. This second wave proved to be much more deadly in India. During April 2021, India was one of the leading countries in terms of number of daily COVID affected cases. States like West Bengal, Maharastra, Kerala, Karnataka, Adhra Pradesh, Delhi, Tamilnadu, Uttar Pradesh had the highest number of active cases [15]. As a result, lockdown was again imposed. For example, in West Bengal, lockdown due to second wave of COVID-19 started during May' 2021 and continued until July, 2021. From August, 2021 workplaces started reopening again. However, during the period of this study, i.e. until September 2021, all schools, colleges and Universities remained fully closed. Such a situation, when schools, colleges and universities remained totally closed with no assurance of reopening date and workplaces remaining open, may have called for a trade-off between women's family life and work life; especially in countries like India, where women are considered to be the primary caregiver of children and family. Or, it might so happen that men have come forward to shoulder care work burden more than earlier, leading to gender equilibrium. Because, previous studies have shown that at some instances, disastrous time have altered gendered role

and have favored women taking opportunity of the same to enter in productive economy [16, 17]. But, if the first option holds true and women actually took over more and more unpaid care work, the burden that arose out of the COVID-19 pandemic will further increase role stereotyping and gendered work burden on women.

Research shows that both men and women equally perceive the importance of doing familial chores, but men usually set it aside for women to perform [18]. Research conducted during the early period of the COVID-19 outbreak in USA shows that in families with dual earning parents, women have been significantly compromised with their professional work time more than men [19]. Studies conducted in Australia [20], Italy [21] and Spain [22] show that whereas the gendered-children care gap has been reduced with increased father's time with children, mother's unpaid work time has increased disproportionately too. However, a study conducted in Italy also showed that in families with both parents working, men spent more time on care work, in case his partner had to commute to the office [21]. Similar findings are observed in Germany in a study conducted from a different angle of cognitive dimension. Here, women remained concerned about family and care work more and men were concerned about labor market and economy; thus enhancing the existing cognitive gendered care burden of women [23].

As reflected from past research on change in women's work during a crisis, the impact of COVID-19 pandemic is presumed to be more negative on women [24]. Most research on changing work situations of women at home after the COVID-19 outbreak concluded that care work done by women has been increased during the pandemic, especially during the lockdown. But this is more important in countries like India where gendering of unpaid work is prominent and a worsening of the situation may toll high, not only on economic outcomes, but also will hinder overall development. Besides, the available research has been done in the early phase of pandemic and as most countries did not face a stepwise 'unlock-down process', the current scenario of work burden on women needs to be explored. Additionally, in most Indian states, educational institutes are still not open, resulting into continuous child care need at home. This study, done in July-September, 2021, i.e. after around one and half years of COVID-19 outbreak will address the situation where work demand at both outside and inside the household is high. The existing studies do not categorically measure if the

burden of work interferes in the quality of life of the women. Also, these existing studies lack a differentiation among the categories of women according to their past and present employment. Hence, how the status of care work changes in women who have become jobless in contrast to those who have newly entered to the job market need to be analysed, along with women with unchanged status of paid work, to understand the new normal of the social norms.

The primary objective of this study is to investigate how job roles of women in form of both paid work and unpaid care work, have changed during COVID scenario. Additionally, this study will measure the change in total work burden on women due to COVID-19 outbreak. Along-with these two major objectives, the study will also focus on gender roles in unpaid care work during COVID-19. Additionally, the study aims to identify the difference of work burden among four work group cohorts- (i) working group (in paid work throughout), (ii) care group (in household care work throughout), (iii) entry group (entered in paid work after the COVID-19 outbreak), (iv) exit group (terminated their paid work upon COVID-19 outbreak). A logistic regression model of work burden among these groups will be formulated using demographic and work-role variables.

2. Methodology

2.1. Sampling

This is a single cross-sectional study, conducted through a questionnaire survey on 691 married women chosen using simple random sampling technique from West Bengal, which is one of the worst affected states in India with COVID-19 pandemic. Samples are chosen from urban, suburban and rural areas of six major and most populated districts of West Bengal, namely-Kolkata, Howrah, Hooghly, Burdwan, South 24 Pargana and North 24 Pargana. These six districts are chosen as a geographical region of interest for having the maximum number of COVID-19 cases in the state of West Bengal. The study was performed between July and September 2021, almost one and a half years after the initial COVID-19 outbreak in India. The survey was done through telephonic conversation, electronic form submission method and distribution of printed questionnaire and recollection.

2.2. Instrument

This study used a quantitative research method, exerted through a structured questionnaire comprising of 31 items, related to the respondent's demographic characteristics, work status and job role; within and outside home and before and after the COVID-19 outbreak. The questionnaire had direct questions about age, education, income [25], residence and whether any family member suffered from COVID-19. Work status and job roles before and after the COVID-19 outbreak, were asked separately. Sixteen Likert scale items were included in the questionnaire to measure the work burden and the gender role of women's work.

2.3. Measurement of work burden and its change

The questionnaire has two sections to measure before and after the COVID-19 work burden situation. In one section of the questionnaire, status, nature and hours of paid and care work are asked. This is an objective way of measuring the level of engagement to either kind of work before pandemic and at present time. However, as many experts emphasize the measurement of impact of work burden in terms of sleep, leisure and personal care [26, 27]; ergonomic impact of work (fatigue, somatic pain) and psychosocial impact of work (stress, leisure, entertainment) has been measured in this study through a 5 point Likert scale items. A total of ten such items were initially included in the questionnaire. Further, with reliability testing and factorization, eight items are taken into account for developing the scale to measure perceived work burden and its change.

2.4. Measurement of gendering of work

The questionnaire has six items related to gender norms of work as perceived by the respondents, chosen according to a mini focus group discussion comprising of five individuals with high level of expertise in gender studies and human resource development [28, 29]. The response of each gender related question was measured using a 5 point Likert scale, where the least possible score (1) has been attributed to absolute non-gendering and the median (3) score has been considered as gender-indifferent situation. A principal component analysis has been conducted to find out main underlying factors of gendering. By applying varimax rotation, the weight of each component under a certain factor has been measured.

The total score of the items under the major factor has been used as a scale of measurement of gendering (continuous data). This is done following ordinal approximation of a continuous variable [30].

A dichotomous scale of gendering (care work gendered vs. not-gendered) has also been derived from the total score under the major gendering factor. This has further been used as the dependent variable of the logistic regression model, in which demographic variables, work dynamics and change in the care work burden are used as predictor (independent) variables. The crude odds ratio has been used for interpretation of the results.

3. Results

3.1. Demographic characteristics of the respondents

The median age of the respondents is 36 years, with minimum age 28 years and maximum age 63 years. Most of the respondents (63%) are graduate or post graduate, followed by high school pass outs (23%). 42% respondents belong to nuclear family. Majority respondents belong to high-middle income group (39%) with family income between 24,001/- to 47,000/- rupees per month, followed by high income group (31%, >47,000/- rupees per month) and middle income group (24%), having family income between 18,001/- to 24,000/- rupees per month. 68% are urban residents, followed by 26% residing at sub-urban area and 6% at rural area (Table 1).

3.2. Work dynamics

COVID-19 has reduced women's engagement in outdoor work (30.4%, $p < .001$). 11.5% respondents have reported loss of paid job ($p < 0.014$). There is no new entrance in the job market. Besides, though paid work hours have been reduced with then COVID-19 outbreak (40.65 ± 1.53 hrs./week to 36.78 ± 2.75 hrs./week), such change is not statistically significant ($p = 0.12$). But, unpaid care work has increased significantly (5.84 ± 0.77 hr/day to 7.07 ± 0.57 hr/day, $p = 0.04$) and a significant decrease in hours of rest taken per day is observed (2.84 ± 0.35 hrs./day to 2.13 ± 0.29 hrs./day, $p = 0.002$) (Table 2).

The scale to measure the change in the work burden is comprised of 8 items with high reliability ($\alpha = 0.883$). This scale has three subparts-one

Table 1
Characteristics of the respondents

| Characteristics of respondents | Frequency (% of total respondents, $n = 691$) |
|--------------------------------------|--|
| Age | |
| < 35yrs. | 39 |
| 35-55 yrs. | 53 |
| >55 yrs. | 8 |
| Education | |
| Professional | 10 |
| Graduate/PG | 63 |
| High school | 23 |
| Primary school | 4 |
| Illiterate | 0 |
| Family type | |
| Nuclear | 42 |
| Joint | 58 |
| Income group | |
| High | 31 |
| High middle | 39 |
| Middle | 24 |
| Low middle | 4 |
| Low | 2 |
| Very low | 0 |
| Residence | |
| Urban | 68 |
| Suburb | 26 |
| Village | 6 |
| Work status | |
| Throughout working | 70 |
| Throughout non-working | 21 |
| Lost job | 9 |
| New entrant in the job market | 0 |
| COVID-19 incidence | |
| Family member suffered from COVID-19 | 18 |
| No incidence | 82 |

physical component, one psychological component of rest and one psychological component of burden as perceived by the respondents (Table 3). The PCA for each of the subpart reveals only one underlying factor, thus validating the component. From the items, a linearly transformed score of change in burden has been calculated with score equal to 50 being no difference in work burden. The mean change of burden score is 60.79. Lower limit of 95% CI being 54.51 (>50, the indifference score), provides high confidence to state that work burden has increased during the COVID-19 pandemic. Also, when the scale was categorized according to an indifference score (24 for 8 items), 62.3% respondents were found to have increased work-burden during the pandemic (Table 3). The work burden score increased in the women who had to leave paid job (mean score 76.67) more than those who had paid jobs throughout (mean score 58.32) but this is less significant ($p = 0.07$).

The logistic regression model shows that women's increasing work burden during this crisis is significantly related to their increased hours of care work ($p = 0.022$) and more so with decreased time to take rest ($p < 0.001$). Also, with the increasing age of the respondents, the burden of work seemed heavier ($p = 0.003$). However, the burden of work was unrelated to the change in paid work (Table 4). These results are concordant to the categorical responses described above.

3.3. Gendering of work

Through principal component analysis, two underline factors are derived. The major factor among these two is taken into account, which consisted of four items with good correlation. The most important component of gendering is "male partner not contributing to care work", with a high median score (4 out of five). The highest component loading is for the item describing conflict between care work and the paid work. The minor factor of gendering is based on the decreased freedom of choosing work by women during the COVID-19 pandemic. However, most of the respondents who have paid work, revealed that they were not expected or pressurized to leave the paid work during this crisis (median score of 1 out of 5, indicating absolute non-gendering of the item). By summing the scores of the items under the major factor, the status of gendering has been dichotomized according to the indifference score (which is 12 out of 20). As per the result, gendering of work during the COVID-19 pandemic was not very obvious as 40.3% women are observed to face gendering in their care work, whereas 59.7% did not report so (Table 5).

The logistic regression model has two continuous predictors; age and family size, both being non-contributory to the gendering of work. However, among categorical demographic variables, women from urban areas faced significantly less gendering (OR = 0.379, 95% CI = 0.185-0.776, $p = 0.008$) and those from high income group families also faced less gendering in care work (OR = 0.177, 95% CI = 0.034-0.917, $p = 0.039$). Work status dynamics during COVID-19 have very significant roles in gendering of care work. Women who had to exit from paid work, faced the major hit, as they were pushed to care work more than their male counterparts with OR of 9.27 (95% CI = 2.49-34.57, $p < 0.001$). On the other hand, women who were only in care work throughout the COVID-19 pandemic also faced gendering of work than those who had

Table 2
Women's work before and after COVID-19 outbreak

| Characters | Before the COVID-19 outbreak (%) | Current (%) | Change statistics (statistically significant) |
|-----------------------------------|----------------------------------|-------------|---|
| Outdoor work engagement (Yes = 1) | 69.7 | 48.5 | Wilcoxon SRT ($z = -3.5, p < 0.001$) |
| Engaged in paid work (Yes = 1) | 78.8 | 69.7 | Wilcoxon SRT ($z = -2.45, p = 0.014$) |
| Paid work hours/week ¹ | | | |
| Mean | 40.65 | 36.78 | Reduction = 3.870 ± 2.47 |
| SE | 1.53 | 2.75 | Paired-t ($t = 1.57, p = 0.12$) |
| Care work hours/day | | | |
| Mean | 5.84 | 7.07 | Increase = 1.23 ± 0.59 |
| SE | 0.77 | 0.57 | Paired-t ($t = -2.1, p = 0.04$) |
| Hours of rest/day | | | |
| Mean | 2.84 | 2.13 | Reduction = 0.71 ± 0.22 |
| SE | 0.36 | 0.29 | Paired-t ($t = -2.1, p = 0.002$) |

¹In women engaged in paid work before COVID-19 outbreak and current time.

Table 3
Scaling of Work burden

| Components of scale | Items | Variance explained | Cronbach alpha |
|--|------------------------------------|--------------------|----------------|
| Physical components (fatigability, sleep duration, bodily pain) | 3 | 69.5% | 0.780 |
| Psychological components of rest (hours of rest, leisure, entertainment) | 3 | 57.0% | 0.802 |
| Psychological components of burden (hours of work, stress) | 2 | 73.5% | 0.629 |
| Total 8 item scale of change in work burden | 8 | | 0.883 |
| Total change in work burden score (min 8, max 40), linearly transformed | Mean=60.79 95% CI = 54.51-67.07 | | |
| Work burden categories | | | |
| Increased burden due to COVID-19 ¹ | 62.3% | | |
| Burden not increased due to COVID-19 ² | 37.7% | | |

¹More than indifferent score = 24 ²Less than indifferent score = 24.

Table 4
Regression model for change in work burden

| Independent variable in model ¹ | Coefficients | 95% confidence interval | | Significance |
|--|--------------|-------------------------|-------------|--------------|
| | | Lower limit | Upper limit | |
| Age | 1.779 | .642 | 2.917 | .003 |
| Family size | -3.979 | -9.495 | 1.537 | .151 |
| Change in hours of rest | -19.982 | -28.981 | -10.984 | .000 |
| Change in hours of care work | 11.474 | 1.764 | 21.184 | .022 |
| Change in hours of paid work | 5.132 | -8.975 | 19.239 | .464 |

¹Adjusted $R^2 = 0.452, p < 0.001$, Model: Change in work burden = $1.02 + 0.431(\text{age}) - 0.61(\text{change in hours of rest}) + 0.33(\text{change in hours of care work})$.

Table 5
Gendering of care-work

| Principal component 1 ¹ | Median score ² | Component loading (with vari-max rotation) |
|--|---------------------------|--|
| Male partner not contributing to care work | 4 | 0.637 |
| Family expecting women to do care work | 3 | 0.691 |
| Respondent's cognitive agreement with expected gender role | 3 | 0.512 |
| Care work interferes with paid work | 3 | 0.742 |
| Principal component 2 ¹ | | |
| Family members expect to leave paid work | 1 | 0.674 |
| Freedom of choosing work decreased | 4 | 0.853 |
| Gendering of care work categories | | |
| Care-work is gendered during COVID-19 ³ | 40.3% | |
| Care-work is not gendered during COVID-19 ³ | 59.7% | |

¹67% variance explained; ²Indifference score = 3, >3 is gendering, ³Indifference score is 12.

Table 6
Logistic regression analysis of gendering of work (OLS method)

| Predictors | Gendering of work roles | | COR | 95% CI | | Significance |
|--------------------------|-------------------------|---------|-------|--------|--------|--------------|
| | No (%) | Yes (%) | | Lower | Upper | |
| Age | – | – | 1.054 | 0.979 | 3.0594 | $p = 0.125$ |
| Residence ¹ | | | | | | |
| Suburban | 18 | 25 | | | | |
| Urban | 76 | 40 | 0.379 | 0.185 | 0.776 | $p = 0.008$ |
| Education | | | | | | |
| School level | 30 | 16 | | | | |
| College/University level | 64 | 59 | 1.729 | 0.856 | 3.489 | $p = 0.126$ |
| Family size | – | – | 1.415 | 0.967 | 3.164 | $p = 0.195$ |
| Income group | | | | | | |
| Low | 2 | 6 | | | | |
| Middle | 13 | 16 | 0.410 | 0.071 | 2.384 | $p = 0.321$ |
| High | 79 | 42 | 0.177 | 0.034 | 0.917 | $p = 0.039$ |
| Work dynamics | | | | | | |
| Throughout in paid work | 77 | 36 | | | | |
| Exit from paid work | 3 | 13 | 9.268 | 2.485 | 34.567 | $p = 0.0009$ |
| Throughout in care work | 12 | 16 | 2.852 | 1.223 | 6.650 | $p = 0.015$ |
| Change in work burden | | | | | | |
| Not increased | 46 | 13 | | | | |
| Increased | 46 | 51 | 3.923 | 1.884 | 8.168 | $p = 0.0003$ |

¹Due to very low rural participants, not included in calculation.

paid work throughout the same period (OR = 2.85, 95% CI = 1.22–6.65, $p = 0.015$). Women who had increased work burden during the period are observed to have faced gendering in their care work (OR = 3.9, 95% CI = 1.88–8.17, $p < 0.001$) (Table 6).

4. Discussion

Most of the previous studies measuring women's work burden were conducted during the early COVID-19 pandemic period where abruptness of the extra-ordinary situation governed the social responses to it. However, universally women were seen to have taken the extra burden of household work [9, 20–22]. Now, the present study is conducted during the “unlock” phase after the second wave outbreak in India and at the time when a lot of damage had already been done, in both economy and public health.

The new normal could have imparted new social norms; since working from home is being practiced by both the genders more frequently than ever before, household work could have gained extra prominence. In contrary to this hypothesis, we observed through this study that women are still overburdened with the care work. Many of them being removed from the paid labor force have felt the extra household work burden, imposing more gender inequality on them. Hence, we fairly conclude, the pandemic has been less fair to women for a long run.

The quality of life has definitely been hampered by the excess work burden that women had to face during the COVID-19 pandemic. We found that this is independent of the work status of women. Even the employment without opportunities of individualistic development can create sufficient stress especially during a pandemic condition like COVID-19 [31]. In the early phase of the pandemic, Di Tella et al. [32] found that post-traumatic stress was greatly increased in women. Interference in women's leisure, sleep and times they enjoy with entertainment and hobbies make them more vulnerable to physical and psychological illnesses unrelated to COVID-19. This might be a “parallel epidemic” situation in the households, where women are having more psychosomatic disorders. Lack of rest has emerged to be the most important psychosomatic scenario in the changing work dynamics of women during the COVID-19 pandemic. This proves that the total work burden of women, especially for those already attached to the paid job were already touching the higher limit and the excess care work burden arising out of the health and economic crisis of the pandemic situation have curtailed their physical and mental wellbeing. The observation that women are facing extra burden of care work, even when their paid work hour is not relaxed, opened up the chance of much feared “fourth shift” (caring while working) for women's work. This will not only be a potential threat for gender equality but also a high toll on women's health [11]. On the other hand, women being faded from paid labor force

shall widen the gender gap of wage and overall female labor force participation, contributing adversely to a country's economy [33].

With qualitative analysis, Chauhan [34] argued that men often declare that they are willing to do household work more often but feel that they are less capable and skilled to do so. This argument is contradicted by the present study, as we see that the women losing their paid jobs experienced more gendering of care work, which contributes to the idea that probably women cannot have less overall work burden in any form, unrelated to what they used to do.

However, social gender norms have not been seen to be strictly followed in the pandemic. A crisis has also been added to the economic crisis in many families. Psychosocial stress of COVID-19 has a direct relation on work related stress [35]. We see that most of the women did not face stringent gendering of their work roles at home. Some workers from the developed countries concluded that during the pandemic both the male and female counterparts of the family has taken extra responsibility, hence neither the patriarchal extreme nor the gender norm reversal has been observed [36]. But it is evident that women from South Asia did not get much help of the male counterparts of the family, to ease their household care work burden and mostly the women counterpart was expected to carry out the extra care work. It was also observed that most of the women also agreed upon such gender norms of care work. Women appeared to take the liability of care upon themselves for the best fit during a crisis and the best way to help their families even if the burden worsens their quality of life. This might be related to the moral dutifulness of women that was ushered by them for generations and is result of social norms. On the other hand, most of the working women had family's support to continue their work, though it added to their overall work burden. This raises another theory that women who earn during a crisis period face less gendering and social gender norms become less evident than economic needs. But that clearly has not proved to be beneficial in terms of health and wellbeing of women, as their burden of care work worsens their quality of life. Moreover, the present study shows that the women who face more work burden fall prey to gender norms even more. This proves taking the extra burden of care work fails to give them sanctuary. Hence the ray of hope, seen by Chauhan [34], seems inadequate in altering gender norms of society even in a crisis such as a global pandemic. McLaren [9] aptly concluded that taking the extra burden may become

the new normal for women so that policymakers and families start to forget the need to acknowledge it.

The major limitation of the study is its limited geographical area of sampling. However; this study has a novel approach to women's work and gender roles in the late phase of the pandemic and found a trend of parameters to be measured. Hence, this study may be taken as an exploratory treatment to the hypothesis raised by the contributors and scope of further study is there.

5. Conclusion

Even after the second wave of the pandemic, the burden of work is observed to have greatly increased for women, mostly due to the excess of care work and significant reduction of hours of rest. Women have significantly disappeared from the paid job market. Women's burden of work increased with age, but not with family size. Most women did not report that they felt gender inequality while doing care work, but this might be due to their relatedness with the expected gender norms. Women were not expected to leave paid job by their families, probably due to the economic crises that emerged out of the pandemic situation. Gendering of care work was less experienced by women of high income families and urban residents. But gendering of care work was found prominent among women who had to exit from paid work and had to take excess work burden.

Ethical approval

Ethical approval was not required as this is a non-interventional study.

Informed consent

Informed consent was taken from all respondents.

Conflict of interest

None to report.

Acknowledgments

Not applicable.

Funding

Not applicable.

References

- [1] Addati L, Cattaneo U, Esquivel V, Valarino I. Care work and care jobs for the future of decent work. *Op. Cit.* 2018.
- [2] Moser C, Planning G. *Development: Theory, Practice and Training.* 1993.
- [3] Parsons T, Bales RF. *Family: socialization and interaction process.* Glencoe: Free Press; 1955.
- [4] Eagly AH, Wood W. Social role theory. In P. A. M. Van Lange, A. W. Kruglanski, & E. T. Higgins (Eds.). *Handbook of theories of social psychology.* CA: SAGE Publications Ltd; 2012, pp. 458-476.
- [5] Oakley A. *Sex, gender and society.* London: Temple Smith; 1972.
- [6] Rubin G. The traffic in women: Notes on the "political economy" of sex. In Rayna R. Reiter (ed.). *Toward an Anthropology of Women.* N.York: Monthly Review Press; 1975, pp. 157-210.
- [7] Hochschild A, Machung A. *Working parents and the revolution at home.* New York: Viking; 1989.
- [8] Gerstel N. The third shift: Gender and care work outside the home. *Qualitative Sociology.* 2000;23(4):467-83.
- [9] McLaren HJ, Wong KR, Nguyen KN, Mahamadachchi KN. Covid-19 and women's triple burden: Vignettes from Sri Lanka, Malaysia, Vietnam and Australia. *Social Sciences.* 2020;9(5):87.
- [10] Chung H. Return of the 1950s housewife? How to stop coronavirus lockdown reinforcing sexist gender roles. *The Conversation.* 2020 Mar 30:1.
- [11] Power K. The COVID-19 pandemic has increased the care burden of women and families. *Sustainability: Science, Practice and Policy.* 2020;16(1):67-73.
- [12] Schulz R, Beach SR. Caregiving as a risk factor for mortality: the Caregiver Health Effects Study. *JAMA.* 1999;282(23):2215-9.
- [13] Bradshaw S, Fordham M. Double disaster: Disaster through a gender lens. In *Hazards, risks and disasters in society 2015 Jan 1* (pp. 233–251). Academic Press.
- [14] Madgavkar A, White O, Krishnan M, Mahajan D, Azcue X. COVID-19 and gender equality: Countering the regressive effects. *McKinsey Global Institute.* 2020 Jul 15; 15.
- [15] Kar S, Ghosh I, Show S, Sen A, Gupta T, Chowdhury P, Chatterjee T, Roy Chowdhury A. Impact of coronavirus (COVID-19) outbreak on society, air quality, and economy in India: A study of three "P" s of sustainability in India. *Sustainability.* 2021;13(5):2873.
- [16] Omona J, Aduo JR. Gender issues during post-conflict recovery: The case of Nwoya district, northern Uganda. *Journal of Gender Studies.* 2013;22(2):119-36.
- [17] Momsen J. *Gender and Development.* Routledge, London; 2019.
- [18] Thébaud S, Kornrich S, Ruppner L. Good housekeeping, great expectations: Gender and housework norms. *Sociological Methods & Research.* 2019;0049124119852395.
- [19] Collins C, Landivar LC, Ruppner L, Scarborough WJ. COVID-19 and the gender gap in work hours. *Gender, Work & Organization.* 2021;28:101-12.
- [20] Craig L, Churchill B. Dual-earner parent couples' work and care during COVID-19. *Gender, Work & Organization.* 2021;28:66-79.
- [21] Del Boca D, Oggero N, Profeta P, Rossi M. Women's and men's work, housework and childcare, before and during COVID-19. *Review of Economics of the Household.* 2020;18(4):1001-17.
- [22] Farré L, Fawaz Y, González L, Graves J. How the COVID-19 lockdown affected gender inequality in paid and unpaid work in Spain.
- [23] Czymara CS, Langenkamp A, Cano T. Cause for concerns: gender inequality in experiencing the COVID-19 lockdown in Germany. *European Societies.* 2021;23(sup1):S68-81.
- [24] Nawaz F, McLaren HJ. Silencing the hardship: Bangladeshi women, microfinance and reproductive work. *Social Alternatives.* 2016;35(1):19-25.
- [25] Saleem SM. Modified Kuppuswamy socioeconomic scale updated for the year 2019. *Indian J Forensic Community Med.* 2019;6(1):1-3.
- [26] Folbre N. Measuring care: Gender, empowerment, and the care economy. *Journal of Human Development.* 2006;7(2):183-99.
- [27] MacDonald M, Phipps S, Lethbridge L. Taking its toll: The influence of paid and unpaid work on women's well-being. *Feminist Economics.* 2005;11(1):63-94.
- [28] Hague PN. *Market research: a guide to planning, methodology & evaluation.* Kogan Page Publishers; 2002.
- [29] Kamberelis G, Dimitriadis G. Focus groups: Strategic articulations of pedagogy, politics, and inquiry. *The Sage handbook of qualitative research* ed. NKDYS Lincoln. 2005.
- [30] Johnson DR, Creech JC. Ordinal measures in multiple indicator models: A simulation study of categorization error. *American Sociological Review.* 1983:398-407.
- [31] Kaur M, Goyal P, Goyal M. Individual, interpersonal and economic challenges of underemployment in the wake of COVID-19. *Work.* 2020;67(1):21-28.
- [32] Di Tella M, Romeo A, Benfante A, Castelli L. Mental health of healthcare workers during the COVID-19 pandemic in Italy. *Journal of Evaluation in Clinical Practice.* 2020;26(6):1583-7.
- [33] Alon T, Doepke M, Olmstead-Rumsey J, Tertilt M. This time it's different: the role of women's employment in a pandemic recession. *National Bureau of Economic Research;* 2020 Aug 10.
- [34] Chauhan P. Gendering COVID-19: impact of the pandemic on women's burden of unpaid work in India. *Gender Issues.* 2020:1-25.
- [35] Yang Q, Huo J, Li J, Jiang Y. Research on the influence of the COVID-19 epidemic on work stress of returning workers in China: A study based on empirical analyses of industrial enterprises. *Work.* 2020;67(1):67-79.
- [36] Hank K, Steinbach A. The virus changed everything, didn't it? Couples' division of housework and childcare before and during the Corona crisis. *Journal of Family Research.* 2021;33(1):99-114.