Care work during Covid-19: Impacts on women's wellbeing in the Middle East and North Africa

1. Background

The gendered division of care work is a critical but understudied manifestation of economic inequality. Based on data from 64 countries, the ILO[1] estimates that three-quarters of the estimated 16.4 billion hours that are spent providing unpaid care daily are performed by women and girls. Women's care work reduces their time available for activities such as paid work, education, leisure and self-care[2]. The ongoing Covid-19 pandemic has brought new attention to the issue of care work and the longstanding gender and socioeconomic inequalities in who performs this labor across societies[3,4]. Emerging evidence indicates that the pandemic has led to increased time spent in unpaid care work due to factors including school and nursery closures, disruption of home-based care giving arrangements and disruption of labor-substituting services such as restaurants and paid domestic work[4]. The disproportionate impact of this additional care work on women will influence gendered labor market, health and education outcomes for years to come.

The empirical literature on how the pandemic has impacted care work has thus far focused on high-income countries and particularly Europe, with mixed findings in terms of the gendered effects of the pandemic on care giving. In Germany, both fathers and mothers were found to increase their time spent in childcare during the first lockdown in Spring 2020, but the equalizing effect of the lockdowns attenuated over time[5]. In the UK, women increased their care work time more during the pandemic but there was an 18-percentage-point increase in the number of men who reported being primary caregivers for their children[6]. Another study in the UK found that increased time spent in unpaid care and adapting work patterns during the pandemic were associated with higher levels of poor mental health[7].

European countries generally had much more egalitarian divisions of care work prior to the pandemic than other world regions,[1] which may contribute to more equal distribution of added care responsibilities during the pandemic. The Middle East and North Africa (MENA), by contrast, had the highest female-to-male ratio of time spent on unpaid care work of any world region, with women spending on average 4.7 times more time on unpaid care than men prior to the pandemic[1]. Countries in the region have experienced widespread school closures and total lockdowns as a result of Covid-19, yet to date, no studies have examined the impact of the Covid-19 pandemic on care work in MENA.

In this paper we analyze the impact of the Covid-19 pandemic on women's subjective wellbeing in MENA via the pathway of changes in time spent in unpaid care work. Given the already highly gendered division of unpaid care labor in the region, we hypothesize that (1) additional unpaid care responsibilities during the pandemic are likely to have fallen on women, increasing their total time spent in care work; (2) women who spend more time in unpaid care work experience lower subjective wellbeing, particularly among women who also engage in paid work outside the home; (3) increases in unpaid care work during the pandemic lead to poor subjective wellbeing among women; (4) closures of schools and nurseries are key drivers of increases in unpaid care work and decreased subjective wellbeing among women.

2. Data and Methods

2.1 Data sources

We utilize data from the Covid-19 MENA Monitor panel surveys that are being conducted by the Economic Research Forum in Egypt. The MENA Monitor is a collection of nationally representative, longitudinal surveys that aim to track the economic impact of Covid-19 in the MENA region. The surveys are being conducted by phone over the course of four waves from November 2020 to July 2021 in Egypt, Jordan, Morocco, Sudan and Tunisia. The universe for the individual survey is mobile phone users aged 18-64. Random digit dialing is being used to select the sample. Samples are stratified by the market shares of mobile operators in each

country. The initial wave in each country includes a sample of 2,000 individuals, who will be tracked over time through Wave 4. A refresher sample is being added as needed to combat attrition and attrition is incorporated into the survey weights.

2.2 Measures

A standard questionnaire is used in all five countries, allowing for cross-national comparability of the analyses. Our outcome, subjective wellbeing, is measured through the World Health Organization Well-Being Index (WHO-5). Respondents are posed five, positively-phrased statements about their life over the past two weeks (e.g. "I have felt calm and relaxed", "my daily life has been filled with things that interest me") for which the response choices range from five (all the time) to zero (none of the time). The raw score of 0-25 is multiplied by four to convert to a scale that ranges from zero (minimal wellbeing) to 100 (maximum wellbeing). A cutoff score of 50 or below is commonly used to indicate low wellbeing [8].

The key predictors of interest consist of time use measures that were collected for all women respondents of the survey. Due to the limitations of the phone survey format, these measures were collected as aggregates rather than as detailed time use data. Respondents were asked how many hours they spent on childcare in a typical day during the past week, and likewise for housework, as well as how this amount of time compared to how much time they spent on these activities in February 2020 (before Covid-19). Respondents were also asked about which care work activities they engaged in, including indirect care activities (e.g. housework) and direct care for children age 5 and under, tutoring or caring for children aged 6-17, and caring for ill or dependent adult household members. Additional covariates incorporated into the multivariate models include marital status, employment status (current and as of February 2020), education, age, number of household members and presence of children in the household (age 6 and under; school age).

The effects of the pandemic on care work may be driven in large part by school and nursery closures increasing time spent on childcare[9]. We therefore also compile a dataset that tracks nursery, primary and secondary school closures in the study countries for the entire MENA Monitor data collection period on a weekly basis. The dataset of school and nursery closures will then be linked to the Monitor survey data based on the date a particular respondent was contacted for the multivariate analyses.

2.3 Analysis

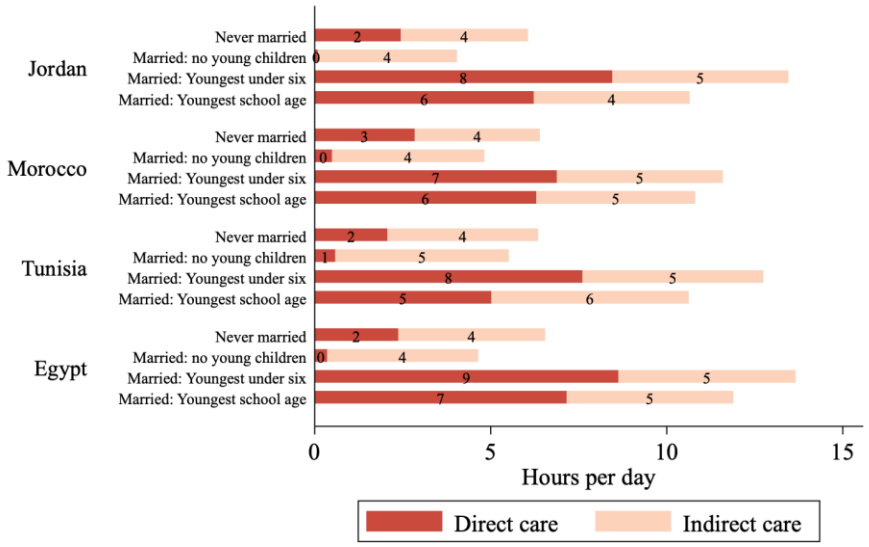
We conduct descriptive analysis of the evolution of women's time in unpaid care work over the study period and compare with retrospective measures about time use prior to the pandemic. Regression analysis is used to analyze the association between time spent in direct and indirect care work at baseline and women's subjective wellbeing to address hypothesis (2). A regression model with individual and country fixed effects will be used on the panel data to estimate the impact of changes in time use on changes in women's wellbeing to address hypothesis (3). The model will then control for the time-varying factor of school and nursery closures to test hypothesis (4). Including individual fixed effects helps to control for bias caused by unobserved characteristics that are constant over time (e.g. genetics, history of previous mental illness) and thus allows for stronger causal claims regarding the impact of time use and child care availability changes on wellbeing.

3. Preliminary Findings

We classified women by household composition and marital status as never married, married with no young (< age 6) children, married with the youngest child under six, and married with the youngest child school age. Figure 1 shows the average hours per day of direct and indirect care work in the week preceding the survey by country and household composition/marital status for the February 2021 wave. As expected, married women with the youngest child under six performed the highest number of hours per day of unpaid care work

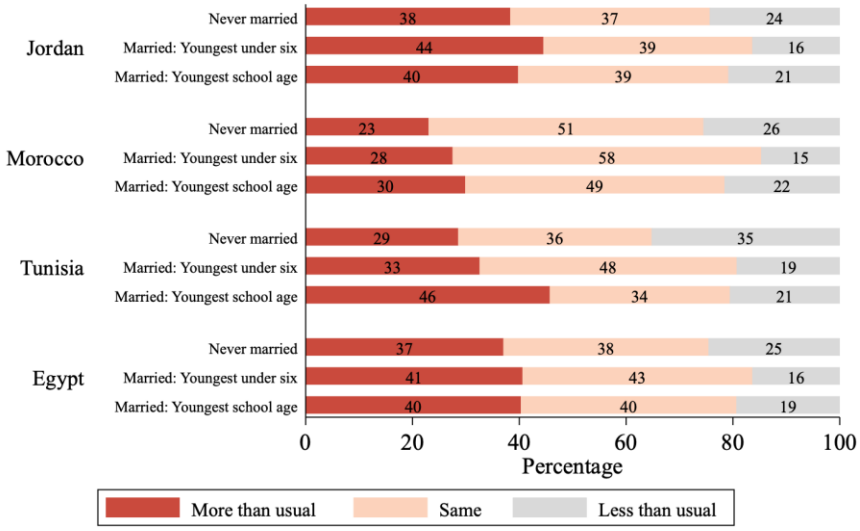
(14 hours in Egypt, 13 hours in Jordan and Tunisia, and 12 hours in Morocco). This is primarily due to their greater responsibilities of direct care work. In sum, the daily time spent in unpaid care work for women with children is comparable to a daily paid work shift in the labor market.

Figure 1. Hours per day of direct and indirect care work (average over week preceding survey interview), by household composition/marital status and country.



Source: Authors' calculations based on COVID-19 MENA Monitor February 2021 wave.

Figure 2. Hours spent caring for children the past week versus February 2020 (percentage), by household composition/marital status and country.



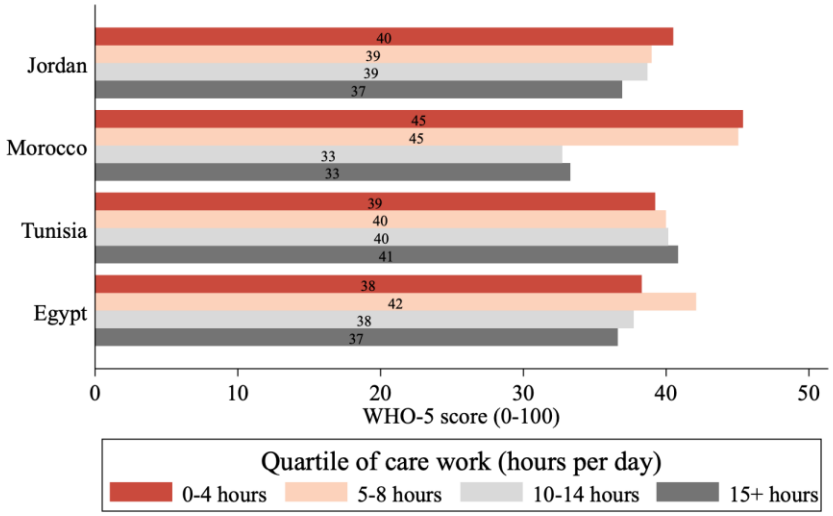
Source: Authors' calculations based on COVID-19 MENA Monitor February 2021 wave.

Figure 2 shows how the time spent caring for children changed between February 2020 (before Covid-19) and the reference week in February 2021 (during Covid-19). Egypt and Jordan exhibit similar patterns in the evolution of hours spent on caring for children. Regardless of their marital status, women in Egypt and Jordan were more likely to spend more time than usual in direct care activities for children than women in Morocco and Tunisia. Moreover,

married women with the youngest child under six were more likely to spend more than usual in caring for children than married women with the youngest child in school age or never married women. By contrast, in Morocco and Tunisia, married women with the youngest child of school age were more likely to report an increase in their time spent in caring for children. Multivariate analyses will explore the role of school and nursery closures in these divergent results.

Turning to subjective wellbeing by quartiles of time spent in unpaid care work, Figure 3 shows that overall, women in the four countries suffer from low wellbeing (below 50). Yet, it is clear that women in the two highest quartiles of unpaid care work (10-14 and 15 + hours daily), who are more likely to suffer from time poverty, have much lower wellbeing than those who perform less care work. The only exception to this pattern is Tunisia, where the wellbeing score slightly increases with quartiles of unpaid care work, possibly reflecting greater gender equity and more care-supportive institutions.

Figure 3. Mean WHO-5 score, by quartile of care work (direct + indirect) and country



Source: Authors' calculations based on COVID-19 MENA Monitor February 2021 wave.

References

1. ILO. Care work and care jobs for the future of decent work. Geneva: International Labour Organization; 2018.
2. UN Women. Progress of the World's Women 2019-2020: Families in a changing world. New York: UN Women; 2019.
3. Thomason B, Macias-Alonso I. COVID-19 and raising the value of care. Gender, Work & Organization. 2020;27(5):705–708.
4. United Nations. Policy Brief: The Impact of COVID-19 on Women. New York: United Nations; 2020.
5. Hipp L, Bünning M. Parenthood as a driver of increased gender inequality during COVID-19? Exploratory evidence from Germany. European Societies. 2020:1–16.
6. Hupkau C, Petrongolo B. Work, Care and Gender during the COVID-19 Crisis. Fiscal Studies. 2020;41(3):623–651.
7. Xue B, McMunn A. Gender differences in unpaid care work and psychological distress in the UK Covid-19 lockdown. PloS one. 2021;16(3):e0247959.
8. Topp CW, Østergaard SD, Søndergaard S, Bech P. The WHO-5 Well-Being Index: a systematic review of the literature. Psychotherapy and Psychosomatics. 2015;84(3):167–176.
9. Petts RJ, Carlson DL, Pepin JR. A gendered pandemic: Childcare, homeschooling, and parents' employment during COVID-19. Gender, Work & Organization. 2020;27(5).