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# Differences in the Pandemic? Qualitative Study of Gender as a Social Determinant

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## Abstract

Life history factors have a significant role in disease development and coping, but have been given little consideration in the response to the COVID-19 pandemic. Based on a thorough analysis of oral history interviews from the initial phase of the pandemic, an investigation of the effects of COVID-19 on individual areas of life is carried out and subjective coping patterns are considered The mental stresses experienced due to the pandemic situation relate primarily to the social environment, the job and society.

In particular, the aspect of reconciling professional and private obligations makes it clear that the challenges perceived here affected women with small children and single parents in particular. The results illustrate the importance of gender and life situation for the individual experience of the pandemic.

***Keywords:*** *Oral history, COVID-19, Pandemic, Compatibility, Gender gap, Diversity*

## Background

The year 2020 was supposed to be groundbreaking for gender equality. Instead, the spread of the COVID 19 pandemic threatens to undo even the limited gains of recent decades. The pandemic deepened already existing inequalities and exposed vulnerabilities in the social, political and economic systems, which in turn amplified the impact of the pandemic [54].

Life history factors have a considerable share in the development and management of disease, but were given little consideration in the measures taken in the pandemic - both nationally and internationally [25,31,41,45]. This contradicts WHO health goals and is also gradually entering public awareness, but so far without effect [33]. At the same time, studies make it clear that the effects significantly influence inequalities: for example, socially disadvantaged people have a higher risk of infection with COVID-19 and a more severe course of the disease [6,13], the possibility of mobile working is unequally given [1], and low-income workers experience above-average income losses [24]. Relevant social determinants of the individual risk of infection are cramped living conditions, poor housing quality, low income, low education and a disadvantaged socio-economic situation [23]. Occupations with a potentially increased risk of exposure are those that are characterised by interpersonal contact and cannot be easily practised from home, such as retail, health or rescue workers [23].

Women more often experience additional care work and reconciliation conflicts [19,27,40], they are more affected by infection worries [21,39] due to different living environments and are exposed to different influences and health resources, which are expressed in different ways of dealing with complaints [58]. Wandschneider [57] points out that a large proportion of health care workers are female [13], that women take on the majority of care work [32,59] and that they suffer more frequently from domestic violence [55].

Taking into account the social determinants of health [10,11,53,60] can already lead to better planning in preparedness plans and contribute to successful pandemic management on several levels [26]. The current COVID 19 pandemic has once again highlighted the drifting apart of opportunity structures.

At the same time, the gender category influences numerous areas of social life and, according to Gamper et al. [15], plays a significant role as a category of social order and social positioning [5,43]. In the area of health, numerous studies have shown a strong difference between the sexes (morbidity, mortality, development and course of diseases, health behaviour) [28,42]. Furthermore, social and cultural factors have an impact on health care and are expressed in partly significant gender differences [15,28].

Qualitative observations of the connections between the pandemic situation, gender and inequality deal with different focal points. The Federal Conference of Women's and Gender Equality Representatives pointed out early on that there has been increased structural discrimination against women scientists and other experts since the beginning of the COVID pandemic [9]. Several studies point to a stronger disadvantage of female students [3] and scientists [12,16,46,56] in the pandemic situation. Haag and Gamper point to a new urgency in the situation for women in science, which has intensified with the onset of the COVID 19 pandemic [16].

With the aim of recording the perception and interpretation patterns of the pandemic situation on an individual biographical level,

the perspective was expanded to include further social aspects. Based on life history interviews, this article explores the question of which life-world effects women in western industrialised countries perceived in the context of the COVID 19 pandemic and the containment measures they experienced and formulated in oral history interviews.

## Research Approach: Secondary Analysis of Oral History Projects

### Data Collection

This paper captures this phenomenon on an individual-biographical level. To this end, it looks at the individual perception and coping with the measures from the perspective of women. Methodologically, access is gained through a systematic secondary analysis of several oral history projects on experiences during the COVID 19 pandemic in 2020-22, which made their documented records available to the public and for further use. In addition, aspects of the interaction of collective memory are considered as well as organisational structures and subjective coping patterns that helped shape the handling of the measures ordered and thus the crisis community.

A systematically collected sample of oral history interviews with women from western industrialised countries on their experiences in the early phase of the COVID pandemic, which were collected in various projects and made available for use, serves as the source basis. The interviews recorded between March 2020 and October 2021 were subjected to secondary analysis [48,49]. For this purpose, the transcripts of the included interviews on the work situation, perceived risk of infection and expressed or recognisable psychosocial stress were searched [36]. The interviews conducted in other projects were not specifically concerned with these aspects, so they were not always the focus of the interviews, but many interviewees did address these aspects.

This paper is based on a secondary analysis of qualitative data from four different qualitative surveys on experiences with the pandemic situation. The understanding of secondary analysis refers to the analysis of empirical material along a research question that deviates from the epistemological interest of the primary projects included [29,35,44,47]. As explained below, the secondary analysis was carried out methodologically as a qualitative content analysis.

The research design presented here is not fully suitable for the study of individual experiences with the pandemic and restrictive measures. For better comparability, more comparable data sets and questions would have to be available, which was not feasible within the framework of this analysis. Nevertheless, the research presented here can provide initial indications of subjective perceptions and interrelationships. At the same time, it can only be understood as an empirically based, hypothesis-generating preliminary investigation; a hypothesis-testing investigation is therefore still pending.

The interviews included are from published and widely available oral history projects on COVID-19 from Columbia University in New York, Sacred Heart University in Fairfield, Texas A&M University San Antonio and the Historic New Orleans Collection. Even though the recordings are available to the public, the interviews have been effectively anonymised to protect the personality of the people speaking out.

Explanation of the projects included:

- New York. Students in Prof. Ana Paulina Lee's Contemporary Civilization II course at Columbia University in New York conducted oral history interviews in April and May 2020, shortly after the pandemic hit New York City and Columbia University courses switched from in-person to online. As such, the interviews provide a snapshot of understanding of COVID-19 and its social impact in the early days of the pandemic. From this project, 10 interviews were included in the analysis [29].
- Fairfield: The oral histories archived there are the result of student research in courses taught by Dr Charlotte Gradie (HI203 Medicine, Disease and History) and Dr Gerald Reid (SO201 Poverty and Inequality in the US) at Sacred Heart University in Fairfield, Connecticut. From the documented records, all accessible interviews with women, 28 in total, were included in the study [30].
- Texas: The COVID-19 Oral History Project began in September 2021 at Texas A&M University, San Antonio and is currently ongoing. From the recordings accessible in the Student Works Collection "History 1302", 21 videos on female perspectives were included in the analysis [31].
- New Orleans: The oral history project "From the Front Line. Narratives of the COVID-19 Pandemic in New Orleans" began in May 2020 and has collected audio interviews with nurses, doctors, paramedics, epidemiologists, public officials, undertakers, spiritual leaders, business people and artists through the end of 2021. The interviews, which have been catalogued and archived, form one of the most comprehensive resources on the social history of the pandemic in New Orleans. From this series, selected interviewees are featured in a series of short videos in an exhibition and on social media. From this project, 6 recordings were included in the analysis [32].

### Data Collection

The included interviews provide an exciting foil for comparison with the perspectives in the literature and the other recorded memories. The series of interviews collected between spring 2020 and autumn 2021 address individual perspectives on the pandemic situation. The following diagrams show the composition of the surveyed sample (n=65):

The article uses Daniel Oesch's class-analytical model to capture and interconnect the multiple effects of the COVID 19 pandemic [37]. This combines a horizontal axis of inequality research (level of education) with a vertical differentiation according to dominant work logics (administrative, interpersonal, technical, independent) (Figures 1-4).

According to Fessler et al. [20] in the administrative logic the work process is determined by bureaucratic rules, in the interpersonal work logic direct human interaction plays a central role, in the technical logic the work processes are concentrated on technical artefacts and machines and in the independent work logic the processes are subject to the control mechanisms of autonomy. According to Holst et al. [21,22]. women are clearly overrepresented in the four interpersonal employment classes and in the two lower classes of the administrative work logic, while men dominate above all the technical employment classes and the upper administrative as well as independent employment classes. The gender ratio observed by Holst et al. is also reflected in part in the interview sample. Accordingly, the statements refer primarily to the perspective of representatives of interpersonal work logics with a higher level of education, but other perspectives are also represented (Figure 5).

## Data Analysis

The topic-centred interviews serve as a starting point to reconstruct women's perspectives on their situation in the pandemic and, more importantly, the perceived impact of the interventions [7]. Topics addressed in the interviews include: Personal background (social and local origin, education and occupation), Recollection of becoming aware of the pandemic situation, Perception of the risk of infection as well as the impact on everyday life, occupation and social environment, Abandoned activities, Comparable drastic experiences, Classification of government coping measures as well as their impact, Personal lessons and consequences from the situation. The recorded interviews give the interviewees, to varying degrees, the opportunity to set their own priorities and formulate their interpretations of the situation. Depending on the interview, interviewees also address the perceived social inequality that is felt to be intensified in the pandemic situation.

The data was analysed using the MaxQDA analysis software. A coding method based on qualitative content analysis according to Mayring served as the evaluation method [34]. Qualitative content analysis according to Mayring involves the ordering, categorisation and structuring of manifest and latent contents and the development of systematic and intersubjectively verifiable results.

The coding was done in two steps; first, all categories were created theory-based (according to Holst et al.) [21]. In order to obtain a balanced code system, the interviews, which were initially coded inductively, were recoded deductively in a second step. The strength of this deductive-inductive approach lies in "not only being able to analyse objects, contexts and processes, but ... to imagine them in a re-experiencing way" [34].

## Findings

This paper examines women's perceptions of the impact of COVID-19 on their lives in Western industrialised countries in the context of the COVID-19 pandemic and the associated restrictive measures. The perceived impact of COVID-19 on women's everyday lives is examined below using three topics as examples. These also play an essential role in the public discourse on coping with the pandemic [21]. The following sections are first devoted to the reconciliation of gainful employment and care work; then perceived risks of infection are considered; after that, the aspect of psychosocial stress is examined. For each topic area, typical subjective patterns of experience are reconstructed from the perspective of women.

**Figure 1:** Distribution by age.

| Under 20 | 21-30 | 31-40 | 41-50 | 51-60 | 61-70 | 71-80 | over 81 |
|---|---|---|---|---|---|---|---|
| 4 | 26 | 6 | 9 | 14 | 3 | 1 | 2 |

**Figure 2:** Distribution by survey period.

| Q II/20 | Q III/20 | Q IV/20 | Q I/21 | Q II/21 |
|---|---|---|---|---|
| 10 | 0 | 34 | 19 | 2 |

**Figure 3:** Distribution by family background.

| | |
|---|---|
| No children: 44 | Children: 21 (of which single: 3) |
| No migration background: 53 | Migration background: 12 |

**Figure 4:** Distribution according to education level.

| Apprenticeship | Training profession | Semi-Profession | Academic Profession | Unknown |
|---|---|---|---|---|
| **8** | **16** | **18** | **21** | **2** |

**Figure 5:** Distribution according to work logic and employment class (according to Oesch):

| Administrative | Interpersonal | Technical | Independent | Unknown |
|---|---|---|---|---|
| Upper Management: 3 | Sociocultural Expert: 7 | Technical Expert: 0 | Independent Professional: 3 | |
| Lower Management: 8 | Sociocultural Semi-Profession: 9 | Technical Semi-Profession: 1 | Entrepreneur: 1 | |
| Skilled Office Worker: 0 | Skilled Service Worker: 7 | Skilled Worker: 1 | Small Business with employees: 0 | Training: 10 |
| Routine Office Worker: 2 | Routine Service Worker: 6 | Routine Worker: 0 | Small Business without employees: 5 | Unknown: 2 |
| **Total: 13** | **Total: 29** | **Total: 2** | **Total: 9** | **Total: 12** |

## Reconciling Gainful Employment and Care Work

The following section looks at how the respondents perceive the changed working conditions with regard to the reconciliation of gainful employment and care work in the pandemic situation. In order to get closer to an answer, changes in professional activity and the associated coping patterns and reconciliation conflicts are considered. The majority of the interviewees work in the interpersonal field, i.e. professions that, according to Oesch [37], are mainly occupied by women.

One of the most significant changes in connection with the pandemic situation was to reconcile gainful employment and care work under the new circumstances [27]. While there is no question that this was the sole responsibility of the interviewees, the main responsibility for balancing lay with the interviewees who were confronted with the changed living and working conditions.

## Changes in Gainful Employment

Perceivable changes took place especially in the conditions of gainful employment. The interviewees perceived many developments that affected their everyday work. The changes described include, above all, the rules of conduct and hygiene that the interviewees not only had to observe in their work, but also demand from their clients.

- "We're wearing double face mask, we have gloves, we wash our hands constantly, we make sure that we take care of our customers and make sure that they're are practicing social distance." (TX_I67)
- "Several interviews referred to the closures and layoffs that accompanied the changed economic situation as very drastic. This changed not only earning but also training opportunities, especially in the interpersonal sphere:
- "I gave up my graduation, ... things that I have been looking forward to, me and my family." (NY_I39)
- Also, especially in the interpersonal field of work, learning content could not always be adequately conveyed in education and training.
- "I was worried that I wasn't having in person (at the practice). ... I was worried I wasn't going to be caught up with everything that I need to know by the time I graduate and that I wasn't going to be up to the par of the therapist before me." (CO_I20)

Another measure perceived as very relevant is the transfer or placement of professional activities into the virtual realm. This did not only affect women entering the profession:

- "So this is actually my first full year teaching. ... I taught for three months. And then we ... went into lockdown, and I haven't had ... a normal experience, if you may have teaching." (TX_I49)
- "Many of the interviewees reported the transition to mobile workplaces and the changes in their working conditions that came with it. Many of the changes affected all family members in home-based work, members of all genders regardless of whether they were raising children at home or not:
- "So we had to rethink everything that we've done." (CO_I13, with Care Commitment)
- "Because the whole country somehow shutdown, everyone was working online." (NY_I41, with Care commitment). One problem that many affected people perceived was the difficult differentiation of professional and private areas and times:
- "Work and life, work and personal life, you know, in the same house, you know, your living room is your working room, and your bedroom is next to your working room. So it's very confusing how to separate your life--personal life and work." (NY_I38)
- "At first I was having a hard time separating my work from my personal life but eventually I learned how to live with it." (TX_I50). This spatial overlap and accompanying availability was perceived as a compression and increase in workload:
- "I feel like I'm working a lot more especially when we were full-time working from home. Because I didn't have to drive to work. ... I didn't have to, you know, do anything to leave my house. I was working, you know, sometimes 7:45 in the morning until like, 6:17 at night ...So I feel like I've been working longer hours and putting different effort in." (CO_I27)
- "Seems like we're working at all hours of the day in different increments instead of going to work for 8 hours a day." (TX_I63, with care commitment)

## Changes in Care Work

The interviews suggest that people in precarious jobs, people in the low-wage sector or who depend on part-time work are particularly affected by the more difficult conditions in care work. At the same time, the majority of care work is done by women and women are more likely to be in precarious or low-paid jobs. This means that women in particular have greater difficulties in reconciling their professional activities or training with the pandemic measures [38]. The interviews also reveal that already existing multiple burdens are now even more difficult to cope with. Numerous interview sequences make it clear that in particular the lack of supervision of children, the expectation to take on educational tasks and the constant workload have led to reconciliation conflicts.

- "So the work stuff was tricky because obviously exacerbated by the fact that then like, my kids were home. So that was really it was a dark time" (CO_I6, with care commitment). It is clear that single parents in particular found few ways to compensate for the extra workload and lack of resources.
- "In the beginning it was a very rough transition, as a single mom having two young boys and having to learn how to work from home and homeschool them it was a rough transition." (TX_I58, with care commitment). Some interviews also make it clear that administrative institutions, employers and decision-makers are not always able to empathise with the situation of employees or those who qualify themselves and perceive their needs and possibilities.

- "I noticed, I think a lot of my colleagues assume that our students are sort of 20 years old, like sitting alone in a room with a private office, doing their work like totally uninterrupted. But what I actually saw was that I'll pay some of my students are also parents, so it's the same time as my kids were home from school. Their kids are home from school and even ... students who ... were responsible for their siblings." (CO_I6, with care commitment). The interviews also make clear that traditional, stereotypical role models have been reinforced or hardened in the changed working and living conditions. For example, some interviewees report perceived expectations and inequalities within their relationship that have manifested themselves with the pandemic situation:
- "I was expected to cook a whole heck of a lot more. I really didn't like that. ... But like, you know, I think that it was just, I felt drained at the end of the day." (CO_I13, with care commitment)
- "I have been kicked out of my office. So he is taking over my office and there are times where and he's loud. He runs all these meetings and stuff and it and I'm upstairs over it and I'm trying to run my class..." (CO_I16, with care commitment). At the same time, some interview sequences make it clear that the role models were also internalised by the female side and thus handed down. For example, it was reported as a matter of course that the man gets the quieter room and the woman felt responsible for supervising the children while she was at work.
- "You know, one another world people with the kind of, it was basically my (partner) working upstairs in the office cuz he could shut the door and then me working downstairs because I didn't want to leave the kids like unsupervised and me taking a meeting with the kids like three feet away from me." (CO_I6, with care commitment)
- "Even just figuring out like where do you know, especially for my two daughters ... While I was also having to have classes, while my husband was needing to access introduce them calls for work." (CO_I25, with care commitment). Some female interviewees were critical of the internalised unequal distribution of work of others involved:
- "I'm … remember standing on the surgery unit talking to the nurse and she was like, completely exhaust braided. She says: 'I'm going to leave here and I have to go home and, you know, do homework with my kids' and I'm like: 'where's your husband?' ... I mean she was completely exasperated." (CO_I24, with care commitment)

## Compatibility Conflicts

In addition to the described changes in gainful employment and care work, the accompanying conflicts of reconciliation, the perceived burden and also attempts at compensation are addressed.

In one conversation, it becomes clear that the multiply burdened women burdened themselves with self-reproaches of neglecting their children.

- "Because I became a bad parent because I was always trying to work while I was with my kids which is not good for them ... and I just thinking about it all the time." (CO_I6, with care commitment)

### Coping Patterns

Several interviews refer to coping patterns to compensate for the stressful situation. Among the approaches mentioned were better structuring or reorganisation as well as support from other family members. In the case of a solution found, a thoroughly positive attitude towards the changes is evident.

- "I feel like it has made me a little bit better at making a schedule, planning things." (TX_I58, with care commitment)
- "I'm ... very lucky to have our aunt living with me and doing a lot of the housework and the cleaning, and just running errands and being a godsend." (NY_I45)
- "But the reality of it is is that happening to (my husband) was the greatest thing that could have happened. Because ... him being able to be home and do what he did and ... with a level of comfort that I may not have had had we both been working" (CO_I24, with care commitment)

### Possibility of Infection during the Pandemic

Another aspect that is relevant in the context of women's perspectives on the influences of COVID-19 and the accompanying measures is the risk of infection. How did the interviewees perceive their own risks of infection and those of their environment? For this purpose, both the objective and subjective risks of infection were considered. It can be seen that interviewees with children speak more extensively about perceived risks.

A comparison of the fields of work to which the respondents (n=65) are assigned shows that the majority work in the interpersonal field (administrative: 13, interpersonal: 29, technical: 2, independent: 9, unknown: 12). Activities in this field of work often involve direct contact with people, which means that the objective risk of infection is also higher than in other occupational classes. The question here is to what extent an assumed objectively higher risk of infection is also reflected in the perception of the respondents (subjective risk of infection).

### Subjective Risk of Infection

The perceived risk of infection becomes clear through several aspects: classification of the general situation, desire for more knowledge, existing fears, perceived risks of specific groups (young childhood, age, occupation, social class, big city), corresponding protective measures.

Several interviews show that the pandemic situation and the possibility of self-disease were classified differently in phases and individually. Public and social media as well as conversations with other people played a major role in the classification of the situation.

- "I saw more people getting infected, more patients (coming) to the hospitals, and that's when I said: this is serious." (NY_I47).

- "I didn't think it would impact our life here. ... So we didn't expect it will hit us that hard." (NY_I38). Individual conversations point to a desire for more knowledge in order to be able to classify the situation:
- "At that time there wasn't a lot of research or knowledge about the pandemic. So you had to take the most cautions most forgotten that you could." (CO_I7)
- "So I started reading every book I could about an epidemic. And then I read a book on (the major outbrerakt of Spanish Flu) in (the city) ." (NO_I34)

Along with this, different fears were expressed, especially at the beginning of the pandemic when infection routes, courses and effects were perceived as difficult to assess:

- "You know in the beginning it was really scary. I'd personally felt like the world was ending. I didn't know what was going to happen like, ... Really like scared me ... So I would say the hardest part was the beginning and I guess like the lack of information and the uncertainty and the unknown." (CO_I4)
- "People were very afraid. ... I was really afraid. ...I remember, this funeral home from Brooklyn, was on the news and they have so many dead bodies that they would just piling up in a truck outside" (CO_I11)
- "So with COVID-19 at first I didn't want to go to the store, I was afraid.... For maybe a few months I was just using curbside so I would just order through (a delivery service). I've never sanitized my hands so much." (TX_I63, with care commitment)
- "So my life started to change. I was living a different life. I lived with the fear of going out on the streets. I was afraid of everything that would happen. ... I thought that every step I took would infect me. I thought everything was already infected ... Then everything changed inside me. ... Before, I lived a free life, ... I went out on the street without worrying. ... When I go out, I have to remember to take care of myself. I have to go out with a mask, I have to take disinfectant, I have to think about who I approach because for me everyone is infected" (NY_I47).

There are no statements about fears due to inadequate protective measures in the private or work sphere. It can be assumed that comparable positions can be found in a gender-independent consideration. The concerns are based, among other things, on a non-knowledge or a non-controllability and a resulting feeling of powerlessness.

- "We all want on this (situation) is that was at least one thing I could control ... You have no control in this whole thing." (CO_I24, with care commitment)

## Objective Risk of Infection

It also becomes clear in the interviews that objectively known risks of infection were known and perceived in the interviewees' environment. The extent to which this affected the living and working conditions of the interviewees is shown in the following sequences.

One risk that was formulated in the interviews is the perceived risk of infection of newborns and children:

- "My sister has a baby and she's been taking it very easy to because she's doesn't know how, you know, this would affect the virus would affect the baby of his age." (CO_I20)
- "I am concerned that (my son) going to you know he does socialized with this local kids that go to school ... I chose to go remote again." (CO_I29, with care commitment)

The perceived objective risk of infection of older people in the environment did come up more frequently:

- "With my family is all here in (X-City) so my parents are 75 ... That age, you can easily contracted this disease. So ...at the beginning ... I stayed away for quite some time." (CO_I14, with care commitment)
- "Especially like my elderly family members. I've been really concerned about them... just because they're their immune systems are as strong as they once were. So it's a lot of stress on me." (CO_I8)
- "Whenever I go visit my grandmother, like, I never hug her anymore and it's just, like, it's really sad." (CO_I8)

The perception of risk of infection in the context of vulnerable groups is probably related to involvement in care work. It can be assumed that comparable concerns were expressed by all people involved in this field. If there is a higher proportion of women here, this is probably related to the higher involvement of women in care work overall.

In addition to the likelihood of infection of people in the environment, the perception of one's own risk as an older person was also addressed:

- "At the beginning I thought it was something unimportant, but then I saw the situation was somewhat serious. I saw how people were already getting infected very quickly - and that worried me. Firstly, because I am 60 years old ... At my age, my immune system is already weakened, which means it's a danger for me." (NY_I47).

Besides age, social and economic class were perceived as objective risk factors, but this was rather rarely addressed:

- "Because of their low salary, (some) cannot afford to buy healthy and nutritious food. So they eat poorly. If they eat poorly, they will be more easily affected by the virus. They will die faster because their immune system is weakened." (NY_I47).

Very often, respondents raised the perceived risk of infection in relation to their job:

- "But in my situation with my current job as a sales associate at (a big super market), I am not able to work from home. So, I always have to go in, in-person for my shift and interact with other customers and um people who may potentially carry the virus." (" (TX_I65)

Summary Table of People Involved.

| Interview | Project | Age | Care Obligation | Single Parent | Migration | Working Class | Working Logic | Level of Education |
|---|---|---|---|---|---|---|---|---|
| 2 | Connecticut | Up to 20 | no | no | yes | Routine Service Worker | interpersonal | Apprenticeship |
| 3 | Connecticut | 31-40 | yes | no | no | Sociocultural expert | interpersonal | Academic Profession |
| 4 | Connecticut | 21-30 | no | no | no | Lower management | administrative | Semi-Profession |
| 5 | Connecticut | 21-30 | no | no | no | Lower management | administrative | Semi-Profession |
| 6 | Connecticut | 31-40 | yes | no | no | Sociocultural expert | interpersonal | Academic Profession |
| 7 | Connecticut | 21-30 | no | no | yes | Independent Professional | independent | Academic Profession |
| 8 | Connecticut | 21-30 | no | no | no | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 9 | Connecticut | 31-40 | no | no | no | Lower management | administrative | Semi-Profession |
| 10 | Connecticut | 21-30 | no | no | no | Lower management | administrative | Semi-Profession |
| 11 | Connecticut | 51-60 | no | no | no | Sociocultural expert | interpersonal | Academic Profession |
| 12 | Connecticut | 21-30 | no | no | no | Lower management | administrative | Semi-Profession |
| 13 | Connecticut | 51-60 | yes | no | no | Lower management | administrative | Semi-Profession |
| 14 | Connecticut | 51-60 | yes | no | no | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 15 | Connecticut | 21-30 | no | no | no | Skilled Service Worker | interpersonal | Training Profession |
| 16 | Connecticut | 41-50 | yes | no | no | Sociocultural expert | interpersonal | Academic Profession |
| 17 | Connecticut | 21-30 | no | no | no | Skilled Service Worker | interpersonal | Training Profession |
| 18 | Connecticut | Up to 20 | no | no | no | Training | interpersonal | Academic Profession |
| 19 | Connecticut | 21-30 | no | no | no | Training | interpersonal | Academic Profession |
| 20 | Connecticut | 21-30 | no | no | no | Skilled Service Worker | interpersonal | Training Profession |
| 21 | Connecticut | 21-30 | no | no | no | Skilled Service Worker | interpersonal | Training Profession |
| 22 | Connecticut | 21-30 | no | no | no | Sociocultural expert | interpersonal | Academic Profession |
| 23 | Connecticut | 21-30 | no | no | no | Routine Service Worker | interpersonal | Apprenticeship |
| 24 | Connecticut | 51-60 | yes | no | no | Skilled Service Worker | interpersonal | Training Profession |
| 25 | Connecticut | 51-60 | yes | no | no | Sociocultural expert | interpersonal | Academic Profession |
| 26 | Connecticut | 21-30 | no | no | no | Sociocultural expert | administrative | Academic Profession |
| 27 | Connecticut | 51-60 | no | no | no | Sociocultural expert | interpersonal | Academic Profession |
| 28 | Connecticut | 51-60 | no | no | no | Entrepreneur | independent | Academic Profession |
| 29 | Connecticut | 31-40 | yes | yes | no | Lower management | administrative | Semi-Profession |
| 32 | New Orleans | 51-60 | yes | yes | no | Upper management | administrative | Academic Profession |
| 33 | New Orleans | 41-50 | yes | no | no | Independent Professional | independent | Academic Profession |
| 34 | New Orleans | 41-50 | no | no | no | Upper management | administrative | Academic Profession |
| 35 | New Orleans | 51-60 | no | no | yes | Independent Professional | independent | Academic Profession |
| 36 | New Orleans | 41-50 | yes | no | no | Upper management | administrative | Academic Profession |
| 37 | New Orleans | 41-50 | no | no | no | Skilled Service Worker | interpersonal | Training Profession |
| 38 | New York | 51-60 | no | no | yes | Small Business without employees | independent | Training Profession |
| 39 | New York | 21-30 | no | no | no | Training | unknown | Training Profession |
| 40 | New York | 51-60 | no | yes | no | Technicale Semi-Profession | technical | Semi-Profession |
| 41 | New York | 51-60 | yes | no | no | Unknown | unknown | Unknown |
| 42 | New York | 61-70 | no | no | no | Routine Service Worker | interpersonal | Apprenticeship |
| 43 | New York | 51-60 | no | no | no | Small Business without employees | independent | Training Profession |
| 44 | New York | 21-30 | no | no | no | Training | administrative | Academic Profession |
| 45 | New York | Over 81 | no | no | no | Unknown | unknown | Unknown |
| 46 | New York | 71-80 | no | no | yes | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 47 | New York | 61-70 | no | no | yes | Routine Service Worker | interpersonal | Apprenticeship |
| 48 | Texas | 31-40 | yes | no | no | Sociocultural Semi-Profession | interpersonal | Semi-Profession |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 49 | Texas | 21-30 | yes | no | no | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 50 | Texas | 21-30 | no | no | yes | Small Business without employees | independent | Training Profession |
| 51 | Texas | 21-30 | no | no | no | Small Business without employees | independent | Training Profession |
| 52 | Texas | Up to 20 | no | no | no | Training | unknown | Academic Profession |
| 53 | Texas | 21-30 | no | no | no | Routine Office Worker | interpersonal | Apprenticeship |
| 54 | Texas | 21-30 | yes | no | no | Lower management | administrative | Semi-Profession |
| 55 | Texas | 21-30 | no | no | no | Training | unknown | Academic Profession |
| 56 | Texas | 41-50 | yes | no | no | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 57 | Texas | 51-60 | no | no | yes | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 58 | Texas | 31-40 | yes | no | no | Facharbeit | technical | Training Profession |
| 59 | Texas | 41-50 | yes | no | yes | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 60 | Texas | Up to 20 | no | no | no | Training | unknown | Training Profession |
| 61 | Texas | 31-40 | yes | no | yes | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 62 | Texas | 51-60 | yes | no | yes | Sociocultural Semi-Profession | interpersonal | Semi-Profession |
| 63 | Texas | 41-50 | yes | no | no | Skilled Service Worker | interpersonal | Training Profession |
| 64 | Texas | 21-30 | no | no | no | Training | unknown | Academic Profession |
| 65 | Texas | 21-30 | no | no | no | Routine Service Worker | interpersonal | Apprenticeship |
| 66 | Texas | 21-30 | no | no | no | Routine Service Worker | interpersonal | Apprenticeship |
| 67 | Texas | Up to 20 | no | no | no | Routine Office Worker | interpersonal | Apprenticeship |

Urban space and cramped situations as a possible risk factor for contracting COVID-19 and how this affects one's situation was also mentioned several times:

- "I feel like (the big city) is the worst place that you could be right now, knowing how many people are dying there every day." (NY_I40)
- "The populations is insane. ... it's definitely it was definitely very different cuz here I anytime I just need to ... put my mask on. ... I have to be extremely careful." (CO_I23)

In particular, interviewees from the interpersonal work sector, for whom working from home was not possible and close human contact was part of the job description, reflected on the risk of infection they perceived and described the impact on their work and life situation.

- "Because being in the medical field, I'm very aware of germs, and I'm an avid handwasher" (NY_I40)
- "I was worried that I would bring something home and get them sick. ... I bring my hand sanitizer everywhere. I wash my hands all the time." (CO_I9)
- "So coming home we had the standard procedure where he would have me in the back porch and I would take off my shoes. He would Lysol my shoes and then he would take my clothes deposit them in a separate bucket and then wash them in hot water to make sure that nothing was coming in the house wasn't contaminated. And then, I would go right into the shower." (CO_I24, with Care commitment)
- "My mom ... was working directly with COVID patients because her floor that she work at the hospital was the COVID 4 and that was during the peak of the pandemic. So, you know, she would come home and we couldn't, you know, we couldn't interact with her … She was literally wiping herself down with (a desinfection) that's just what it took for her to have that piece of mind that she's not bringing anything home." (CO_I7)

### Psychosocial Stress and Borderline Experiences

Among the most far-reaching influences in the context of the pandemic situation and the restrictive measures are the psychosocial stresses that the interviewees perceived and expressed directly or implied indirectly. These had an impact on the living and working environment of the interviewees. The statements on this concentrated mainly on three areas: Stresses or borderline experiences in the social environment, at work and in society.

### Stresses and Strains in the Social Environment

The central burdens and borderline experiences mentioned are those in the social environment; here above all: the restriction of social contacts, the restriction of freedom of movement, isolation (own, others), lack of social support, fear of self-infection, infecting others as well as experiences of illness and death.

Most of the statements on restrictions of family and general social contacts concern the environment of extended family and friends. It is observed that normalities, bonds and dynamics shift greatly as a result:

- "I'm with my mom and dad. I'm an only child. So, it's just us. You miss interacting with other people." (NY_I44)
- "I would spend more time actually with my immediate family um but less time with my extended family ... and that would kind of affect um our dynamic." (TX_I65)

- "So it was hard because my family ... hasn't even met (my newborn son) and that's like insane, you know ... but it's just really affected like how he's growing up." (CO_I20)
- "Haven't had much of a social life in the last, you know, since pandemic started." (CO-I4)

Some interviewees perceive the restrictions on freedom of movement and leisure life as burdensome:

- "We had to stay quarantined. It was really tough cause there wasn't much to do but, I had to cope with it cause I'm an outdoor person. It was hard." (TX_I67)
- "We're never going to be able to go anywhere ever again because of all this you know I mean like I want to go to Italy again. I've been saying that you know forever and I'm sitting here going to get to Italy before that or die." (CO_I24, with care commitment)
- "So I'm afraid to go outside, so much so that I don't want to go outside at all. ...I have to disinfect all the products I buy, I have to disinfect myself. I have to be careful not to bring the virus into my house... In other words, it is a drastic change. For me, my life has stopped. It has stopped. ...In other words, my life is no longer my life." (NY_I47).

Non-voluntary isolation measures when ill are perceived as a very strong burden. Respondents describe feelings of being locked up and a fear of loneliness:

- "It was just a toll mentally just not being able to really do anything … and like kind of felt like you were in a box. … I think a lot of people felt that way." (CO_I21)
- "That's really scary. And there was nobody like, not a soul, which really like made it even more extreme. But it was like I was really, really alone. And it did have a fax on like my mental state and my moods every day and it was just like, upsetting because I will talk to people and I would be happy and I'm going to have to hang up and then I was back being alone and it was just really upsetting and it wasn't didn't feel the same as going back into the quarantine." (CO_I18)

The isolation imposed on sick and dying people is perceived as equally overwhelming, regardless of whether the respondents were directly affected by it or not. This situation also put a strain on caregivers, as shown below:

- "I do have a friend who's father passed away, …Well he had detected, or was, he found out that he had this Coronavirus. And they took her home, they wheeled her out, she waved goodbye, and that was the last she saw of him and two days later he died. And I think, I think with this virus, the sad part of it all is, is, you know, they end life alone. So I think it's kind of like a lonely disease and death." (NY_I42). One thing that the interviewees express as a very intense burden is the experience of illness and death in their immediate and extended environment:
- "It's been such hard year, hard for us. First of all, my family got infected, all my kids got infected, my husband got infected, I got infected ... it was such a bad time. And it is crazy because I always tried to protect my family by not taking them nowhere, just stay home and we still got infected, this is crazy ... I always try be safe and take care that way we don't get the virus but we still got it." (TX_I59, with care commitment)
- "When I tested positive, my first thought was I'm going to be alone for 2 weeks, which I was really scared." (CO_I18)
- "Well, it affected me deeply. I nearly lost my life to coronavirus" (TX_I61, with Care Commitment).
- "It was difficult. It was sad. It was heart wrenching. We lost family members. All of a sudden, I lost a very good friend and coach. … So that hurts my heart." (TX_I62, with care commitment)

**Stress at Work**

Another area to which the perceived stress related is the occupation. Aspects cited included excessive workload, the possible far-reaching consequences of professional actions, job insecurity, and borderline experiences in professional activities. Several interviews address the perceived time pressure and increased workload due to the urgency of the situation:

- "But it was just like all the sudden we had one day to, you know, figure it all out." (CO_I11)
- "Covid made us have to work very, very quickly. I mean, there were weeks where we were working here. Um, we were running around frantically for, for weeks at a time. You know, this was like a every day was just, um, like a frantic day. And we were getting used to working like that when your adrenaline just at such a high level and it just never let up. I feel like we never even could take a breath to just kind of regroup and say, oh my goodness, it just, it never stopped." (NO_I32, with care commitment). Another perceived burden was the possible far-reaching consequences of professional actions in combination with the urgency required, existing ignorance or existing overload.
- "And there was so much that we did not know about this virus and we were making decisions on the fly with presumptions about what this virus might become. This is scary." (NO_I33, with Care Commitment)
- "The hardest decisions came around the increasing number of deaths … and recognizing that, um, there was a point when there would be, um, multiple cardiac arrest and we did not have enough employees to respond to the other calls. We also had to look at our medical, um, responses and decide how likely is survival after a certain period of time. … We did have to modify our protocols and that was hard." (NO_I33, with care commitment)

For several interviewees who worked in precarious or semi-skilled jobs, another aspect that was perceived as very stressful was the perceived pressure of impending dismissal and unemployment:

- "Last year I was working as a waitress, I couldn't even work at that moment because all the restaurants and bars were closed, and it was bad, really bad." (TX_I59, with Care Commitment).
- "I believe it was May that entire office actually, with us, for offices, with investing company and all four offices laid off their stuff. So that was I think probably the most impactful way that the coronavirus has affected me and my job. So that was really hard to take." (CO_I7)
- Existential borderline experiences resulting from the professional activity, such as accompanying dying people and their relatives, appear to be particularly drastic:
- "And these people would call ... the hospital and know, their family members are dying and the only time that you would be able to come in as if they were making a decision to take somebody off life support, they let you come in and say goodbye to the person." (CO_I24, with Care Commitment)
- "I got the iPad out, and I (asked my colleagues, to) work for me, so that I could (speak) with the family. ... And I said to (the patient): 'You know, you hear your family.' ... I just tried to allay their fears and let them know that I was doing everything I could to make sure that she was peaceful so they could have peace." (CO_I24, with care commitment)

### Burdens on Society

In addition to the perceived stresses in the social and professional environment, psychosocial stresses were also formulated in relation to society. The aspects addressed include: unforeseen changes, the experience of social boundaries as well as the experience of social division.

Several interviewees mentioned that the suddenly changed circumstances and the experience of uncertainty were stressful for them.

- "I'm… everyday I'm kinda panicked too because I don't know how long I have to work at home." (NY_I38)
- "So everyone was kind of uprooted for sure. And fast like everyone had to kind of figure out what to do right away." (CO_I9). Likewise, the changing public discourse and the experienced social division were among the challenges mentioned:
- "If I was to compare this to anything, it would be like another civil war, because Americans are fighting with each other over human rights, and they're on either side of the spectrum." (TX_I51)
- "Another stressful factor mentioned was the experience of the limits of the social system:
- "This pandemic also show our country does have weakness, too. The system--it's not as effective as we thought. We're not as strong as we thought." (NY_I38)
- "So like, we are in a new normal." (CO_I20)
- "I would tell future generations about this pandemic to not trust everything you may have read on social media and to listen reliability to credible sources ... I think when history writes about COVID, it is going to write.... about as us as a society and as a global entity how we failed a little bit in our responses and how ill prepared we were." (TX_I56, with care commitment)

## Discussion and Reflection

The COVID 19 pandemic had a far-reaching social impact, not only in its early phase. This paper explored the impact of the pandemic situation and coping measures on individual lives, looking at the perspectives of women in the United States. In order to capture female perspectives, the effects of COVID-19 and coping measures on women's everyday lives were examined using three aspects as examples: the reconciliation of gainful employment and care work, perceptions of the risk of infection, and psychosocial stress and borderline experiences.

Based on a secondary analysis of topic-related interviews from four oral history projects, the perceived lifeworld effects of the COVID 19 pandemic were recorded and analysed. For a networked view of the multiple effects of the COVID 19 pandemic, this paper draws on Oesch's class analytic model [37]. It shows that an overwhelming proportion of interviewees work in the interpersonal sector, i.e. professions that, according to Oesch [37], are mainly occupied by women.

According to Holst et al. [21,22], women are significantly overrepresented in the four interpersonal labour force classes and in the two lower administrative labour force classes; men, on the other hand, dominated mainly the technical labour force classes and the upper administrative as well as independent labour force classes. These factors were given little consideration in the pandemic mitigation measures [23,25,31,41,45]. The associated effects become clear in the individual experience of the respondents.

For example, the lockdown of almost all social sectors that were not considered relevant to the system - such as crèches, kindergartens, schools, cultural offerings - and the simultaneous working from home made it difficult to reconcile gainful employment and care work. Many respondents, especially single parents or mothers of small children experienced the situation as precarious

According to Bukof, the difficulties that arise in the pandemic situation manifest themselves in a multiple burden on women of all social status groups with children due to simultaneous home schooling, hardly sufficient emergency care, rarely partnership-based solutions and the privatisation of the care problem [9].

Suphan's research also points to these problems. The following were cited as burdensome: Childcare closures and homeschooling, the need for childcare while working, a constant sense of insecurity, a perceived disadvantage at work due to parental responsibilities. Suphan states a decreased possibility for women to combine gainful employment and care work [52].

These aspects are also reflected in the interviews analysed. With regard to the question of reconciling life-supporting and caring tasks,

the interviewees describe above all perceived changes in behaviour and hygiene rules, dismissals or training discontinuations due to the pandemic, effects on employees in the low-wage sector and in part-time jobs, the transfer or placement of professional activities in the virtual sphere, the dissolution of work boundaries, experienced externally expected and internalised role models, non-reconciliation of family and work and the associated reactions.

Several interviewees describe how the impact of COVID-19 directly affects their precarious employment status. Several interviewees also report on dismissals and leaves of absence, the resulting consequences and the pressure that arises from the threat of dismissal alone. In the interpretation, however, it must be taken into account that all people, regardless of gender, suffer from precarious employment and living conditions when they are affected by them.

On the question of reconciling care and gainful employment, Holst et al. point out that the gender and age of the children (and thus of the parents) are relevant. Thus, women, regardless of their socio-economic position, have a significantly higher risk of experiencing conflicts between gainful employment and care work. Holst et al. describe social inequalities in the management of reconciliation conflicts: For example, the lower interpersonal and technical classes could hardly work from home and were more dependent on people from the social network to organise the care of their children in times of closed childcare facilities [21,22].

Current research notes that mobile working can increase inequality [30]. Arndt et al. describe a general increased burden due to, among other things, the simultaneity of private and professional life, heterogeneous individual starting points and technical infrastructures [4].

Bukof describes an associated potential for disadvantage and discrimination in several areas. For example, women often have poorer equipment and access, and students and employees in lower wage groups are also at a disadvantage [9]. Access to information and the dissolution of boundaries between private space and work are also described.

Suphan notes changes in working hours, the place of work and work processes [52]. For example, the journey to the workplace would be saved, but mobile working would significantly increase the difference between contractually fixed and actual working time. Thus, home office increases the spatial and temporal dissolution of boundaries through constant presence. Communication is strongly objectified with a simultaneous lack of personal contact.

Similar results can also be seen in the oral history interviews. In the qualitative interviews analysed here, it becomes apparent that mobile working has ambivalent effects from the perspective of the interviewees. Although this offered protection against infection and significantly reduced commuting, several affected persons describe experienced problems (dissociation, permanent accessibility) depending on their housing and living situation and their technical resources. Respondents in lower income brackets seemed to be more affected by the resulting social inequalities, and they also saw less scope to implement alternative family role models. In particular, working mothers of younger children, single parents and women in cramped living conditions found it difficult to achieve an improved work-life balance through mobile working. It was pointed out several times that working from home and childcare, and parallel homeschooling, are difficult to reconcile. In some cases, support from the social network was able to compensate for major challenges, but the experienced situation often brought parents of young children to the brink of overload. In this context, it should be further investigated to what extent effects related to mobile working had an additional influence on the pandemic experience.

Another aspect that was considered was the perceived risks of infection. In general, it can be said that individual perceptions differ less according to the level of education and more according to social environment and work logics. The perceived risk of infection could be examined through several aspects: Understanding of the seriousness of the situation, level of information, existing fears, classification of infection risks in young childhood, age, depending on occupation, social class, living environment and enabled protective measures.

The qualitative interviews indicate that a broad awareness of pandemic-related health risks was raised by people from the interpersonal work environment. There were hardly any statements about the lack of protective measures at the workplace. In addition to people from the interpersonal work sector, interviewees living in urban areas in particular commented on their perceived increased risk of infection due to the sometimes cramped situations in public spaces in large cities.

In addition to the aspect of the risk of infection, the psychosocial burden associated with the pandemic and the restrictive measures was considered. In the area of health, Bukof notes an increase in physical and psychological stress, the emergence of fundamental fears as well as the very different recognition of risk patient status [9]. In the area of organisational processes, Bukof points to a perceived low level of problem awareness at management level, non-transparent decisions and processes, and a lack of anchoring and implementation of equal opportunities measures [9]. The oral history interviews focused on the following areas in particular: social environment, profession and society.

The stressful aspects in the social environment mentioned in the interviews seem to be less gender-specific. The frequently mentioned burdens include the restriction of social contacts, the restriction of freedom of movement, isolation (own, others), lack of social support, fear of self-infection, infecting others as well as experiences of illness and death. The experience of domestic violence was not directly discussed in the interviews; this may be due to the fact that the problem is generally not dealt with openly and at the same time was not directly asked about. In order to obtain reliable data on this, the interviews studied so far would have to be supplemented in the analysis with written sources from violence protection outpatient clinics.

According to Holst, the pandemic-related health risks found their focus in the interpersonal work logic, the economic burdens of the pandemic measures mainly affected the self-employed and technical classes and the pandemic-related mobile work mainly affected the administrative area [21]. The interviews reflect Holst's

horizontally differentiated distribution of work-related burdens and risks. The psychosocial burdens formulated here, which related to the job, dealt with excessive workload, far-reaching consequences of professional actions, job insecurity as **well** as borderline experiences in professional activities. Since the interviewees work to a large extent in the interpersonal field, there were several women in caring, therapeutic and medical professions among the interviewees who were very stressed by the pandemic situation.

Psychosocial stress in relation to society included, in particular, stress due to unforeseen changes, the experience of social boundaries and the experience of social division.

The captured memories of individual experiences in the COVID 19 pandemic show how the pandemic and the implemented containment measures were perceived. Most of the interviews were conducted between the second quarter of 2020 and the first quarter of 2021, i.e. in a phase in which restrictive measures were very topical and recently implemented, depending on the region, and further developments were not foreseeable. The interviews thus depict perceptions that arose from this situation. On the one hand, this means that the memories of the events and processes are still very present. On the other hand, it also means that some measures and the problems associated with them might have been understood differently over time, that an inner distance from some situations would be more likely and that relativization or even glorification could also occur. This must be taken into account when interpreting the statements.

Because the selection of interviews for the secondary analysis is not based on random sampling, it cannot be guaranteed to be representative of all women in the United States. Nevertheless, the author is convinced that the present dataset can show clear trends.

The oral history projects included here differ not only in terms of the researchers, target groups and scientific interests, but also in their questions. In addition, different project designs were implemented. For these reasons, the interviews are not directly comparable, but they can provide an overarching perspective and illuminate specific focuses. This was used in such a way that the various interviews can complement each other. When classifying the interview sequences, it must therefore be taken into account that the statements were made in the context of different projects and the interviewees answered questions on the topic considered here less directly. At the same time, the sample offers a rich fundus that allows insights into the personal perspectives of women on experiencing the pandemic and the changes it has brought about.

The present analysis is only a cautious approximation. It became clear that those surveyed perceived the early phase of the pandemic as a collective experience: the uncertainty about the future and their own dismay from a possible infection made their personal socio-economic situation clear to those affected.

## Conclusion

The analysis of the perceived life-world effects has shown that the changes caused by the pandemic have had a far-reaching influence. They affected personal contact with one another, the conditions of gainful employment and care work and, in the case of compatibility conflicts, became a factor that increased inequalities. Based on a secondary analysis of oral history interviews, the perceived impact of the COVID-19 pandemic on everyday life was recorded and the assumed relevance of gender and pandemic experience was discussed. A better understanding of the situation can serve as a basis for needs-based support and necessary political measures in the further course of the pandemic under consideration and future epidemic events. Even if it can only be verified in a long-term study, it can be assumed that the pandemic situation has made it more difficult for women to reconcile gainful employment and care work and career paths [12].

The differentiation of the pandemic effects according to Oesch's class scheme offers an extended approach to understanding pandemic inequalities. The results also show the analytical benefit of the qualitative approach of oral history to determine individual perspectives on pandemic experiences. The qualitative interviews allow a direct insight into the individual perceptions and classifications. The utterances contain different levels of reflection – some sequences refer to personal experiences, others anticipate other experiences and others reflect on a meta-level. Access via the oral history shows the extent to which COVID-19 and the coping measures associated with the pandemic affected practically all areas of life of the interviewees included in the study. In particular, the aspects of the compatibility of paid work and care work, perceived risks of infection and experienced psychosocial stress made it clear that people who perform care work were particularly affected by the pandemic situation and the associated restrictive measures. It seems that the pandemic and the restrictive measures that have accompanied it have increased social inequalities. In order to be able to name the multiple, intertwined dimensions of inequality more clearly in this context and to be able to make meaningful recommendations for future pandemic plans, it is important that future research looks for alternative approaches to analyze the problems perceived by the interviewees. The long-term consequences can also only be mapped out at a later point in time, but it is already clear how far-reaching the pandemic experience is affecting gender inequality.

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