

LAW'S INVISIBLE WOMEN: THE UNINTENDED GENDERED CONSEQUENCES OF THE COVID-19 LOCKDOWN

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Abstract

This article examines the unintended gendered consequences of lockdown on women's rights, particularly those related to women's work, health and wellbeing. Situating this assessment within wider feminist legal scholarship, which exposes the gendered nature of law and the tendency to legislate in a way that prioritizes a privileged male legal subject, we argue that legislation and subsequent decisions fail to centre women's lived experiences and so deprioritize women's needs. We ultimately argue that lessons need to be learned regarding how post-pandemic responses are implemented to mitigate the impacts on women and ensure gender is mainstreamed within the law-making process.

Keywords: women; Covid-19; flexible working; care; telemedicine; abortion; gender mainstreaming.

[A] INTRODUCTION

This article examines the unintended gendered consequences that the Covid-19 lockdown has had on women's rights, particularly those related to women's work, health and wellbeing. One of the main consequences of lockdown has been the blurring of the traditional boundary between public and private spheres. This is evident in both the widespread move to home-working and the increase in use of telemedical services, both of which have the potential to renegotiate these boundaries with potentially beneficial consequences for women's experiences of work and care and access to women's health. We examine two distinct but related policy areas that have had a significant impact on women, namely the closure of school and childcare settings on women's work and the

expansion of telemedical services to enable women to access abortions at home. We argue that, while challenging the boundaries between public and private spheres in these contexts has the potential to benefit women, the legislative and policy responses to the Covid-19 crisis and subsequent decisions have failed to take adequate account of the impact that such measures would have on women and their inherently gendered needs. Situating this assessment within wider feminist legal scholarship that has exposed the gendered nature of law and the tendency to legislate in a way that prioritizes a privileged male legal subject, we argue that the legislation and subsequent decisions fail to centre women's lived experiences and realities and so deprioritize women's needs. We ultimately argue that lessons need to be learned regarding how post-pandemic responses are implemented in order to mitigate the impacts on women and ensure gender is mainstreamed within the law-making process.

[B] FEMINIST SCHOLARSHIP

Various feminist legal scholars have critiqued the inability of law to properly redress gender inequality due to its promulgation of gender and class hierarchies. Ngaire Naffine and other feminist legal scholars have long argued that the law is centred around an idealized legal subject that is male. In particular, Naffine argues that law is based on a male subject with a male middle-class masculinity (1990: 100), which does not reflect or respond to the lived experiences of women. This is because law reflects liberalism's distinction between the public and private spheres and assigns to women the role of 'holding the two worlds [public and private] together' (Naffine 1990: 149). Similarly, Carol Pateman's (1988) famous feminist critique of the social contract holds that the social contract theory, as espoused by Hobbes, Locke and Rousseau, not only assumes, but is dependent upon women's subordination and relegation to the private sphere. However, it should be noted that this separation of spheres does not necessarily reflect the lived realities of all women. In particular, this distinction is critiqued by Collins who argues that it does not reflect African-American women's experiences of work (Collins 1998: 11-22, especially 21-22; 2000: 45-46; 2002: 47-48). However, this separation between public and private spheres is also evident in the employment context, where Pateman argues that the standard worker model is unburdened from caring responsibilities, reflecting the division between the public sphere of work and the private sphere of family life (1988: 135). James (2016) similarly refers to the unencumbered male worker model in the context of work-family rights, reinforcing the continued focus on the male subject as the standard subject in law. As

Naffine states, '[c]onsequently, the law has imposed on women the roles of child-bearer, child-rearer and domestic servant' (1990: 6). Indeed, even when household labour is contracted out, it is work that is predominantly undertaken by women, usually poorer women and in many cases, women of colour. This reinforces Collins's analysis of African-American women's work. While they have always undertaken paid work, as well as responsibility for familial care, this has traditionally been domestic work. Consequently, their employment has not been in the traditional public sphere, but instead in the private sphere of white women's homes (Collins 1998: 11-22, especially 21-22; 2000: 45-46; 2002: 47-48). Consequently, their experiences of work, and care, are often ignored or rendered invisible (Bargetz 2009). In contrast, the male subject of law is unencumbered from the domestic and family care responsibilities by women in the home (Naffine 1990: 104).

These constructions of the legal subject are underpinned by a specific biological construction of women and femininity in legal regulation that often problematizes them and their bodies (Smart 1992). While Smart was examining the experiences of women during the Victorian period, the constructions of idealized motherhood, and conversely problematized behaviours such as abortion and women's employment and childcare, remain prevalent today (1992: 14, 18-24). However, as Fineman notes, there is no clear delineation between the private and public spheres in practice, with certain institutions being classified as public in some instances and private in others. For instance, Fineman argues that the market is framed as public in comparison with the family, but private when compared with the state (2005: 21-22). Furthermore, as noted above, Collins (1998; 2000; 2002) argues that these distinctions do not reflect the lived realities of all women. Therefore, there is room for uncertainty, given that it is difficult to draw clear boundaries between both spheres in all instances. Even the family, which has more traditionally been classified as private, is subject to significant regulation by the state (Fineman 2005: 21-22). This reinforces that the boundaries are not as fixed as they may appear, and a renegotiation is possible. Nevertheless, doing so requires challenging these idealized constructions of women and motherhood.

As we explore in the subsequent sections, the Covid-19 responses and subsequent decisions have reified these gendered roles within law by failing to acknowledge the impact of certain policies and/or decisions on women. This is evident in research on the Government's response to the pandemic which highlights that: only 38 per cent of women (compared to 50 per cent of men) felt that the government had focused on matters important to them; 43 per cent of women (compared to 50 per cent of

men) felt that the government was acting in their best interests; and 28 per cent of women (and 35 per cent of men) agreed that women's specific needs have been considered and responded to well by the UK Government (UK Women's Budget Group & Ors 2021). Consequently, the impact and potential legacy of the pandemic is a regression in feminist gains in unpicking gendered assumptions and stereotypes within law.

It has reinforced the interrelationship between the spheres and the interdependency required to make work in the public sphere possible, with women continuing to hold 'the two worlds [public and private] together' (Naffine 1990: 149). However, there is also the opportunity to challenge these boundaries and, in doing so, ensure that lessons can be learned from the experiences of the pandemic. For instance, it is already apparent that the traditional notion of work is changing and also that access to telemedicine has become more mainstream. We use these examples to demonstrate how there is an opportunity to escape the gendered law and policymaking that has all too often failed to situate women at its heart and instead has reduced women to stereotypes of mothers and caregivers. Such an escape potentially would help to dismantle the public/private divide. Nevertheless, challenges remain in ensuring that these changes reflect women's lived experiences and do not continue to only benefit specific privileged groups. Thus, we caution that without listening to the voices of women and situating their needs at the heart of the Covid-19 recovery any achievements in dismantling the public/private divide will have been lost.

[C] WOMEN AS WORKING CARERS

Various studies demonstrate that the closure of schools and childcare settings for most children during the pandemic has had a disproportionate impact on working women with caring responsibilities. For instance, the Office for National Statistics (ONS) (2021) research highlights that women were more likely than men: to undertake unpaid childcare (March 2020: 55 per cent more than men; September 2020: 99 per cent more than men); and to be home-schooling (early 2021: 67 per cent women and 52 per cent men) during the pandemic. This is reinforced in research by the Fawcett Society (2020: figure 1, 5) which shows that, in response to the statement, 'I do the majority of work to look after my child/ren while schools and nurseries are closed', 73.8 per cent of mothers working from home agreed with this statement compared with 50.4 per cent of fathers working from home. Furthermore, 48.3 per cent of mothers compared with 39.1 per cent of fathers agreed that they were struggling to balance paid work and care (2020: figure 2, 5-6). Women were also more likely

to report increased pressures on their ‘mental load’ as a consequence of bearing the multiple burdens of work and care during the pandemic (2020: 7). This research underscores that women have shouldered the burden of responsibility for care and home-schooling during the pandemic, with corresponding challenges and consequences for their engagement in paid work. This is true even when both parents are working from home and so are both able, in principle, to provide care. Consequently, the pandemic has exposed both the fragility of women’s labour market engagement and how contingent it is on effective and stable childcare supports, as well as the resilience of gender roles. This reinforces the interdependency of the public and private spheres and the tendency to return to traditional gender roles when this breaks down. In doing so, it highlights either a failure to appreciate the implications of lockdown on women with caring responsibilities, or a wilful disregard for the disproportionate impact it created. Nevertheless, what is key now is how to redress these inequalities in the future.

However, the more recently published 28-country study by the Policy Institute at King’s College London and Ipsos Mori (2021), on which inequalities are viewed as the most pressing in the context of the pandemic, does not reflect these lived experiences and the impact of the pandemic on British women. This research shows that only 23 per cent of Britons thought that gender inequality was a cause for concern, compared with an average of 33 per cent for Europeans. While the authors note that this could be explained by Britain’s relatively high ranking for gender equality overall (20th), other high-ranking countries, such as Sweden (4th) still identified it as an issue (37 per cent). Consequently, the authors suggest that it might instead reflect complacency here. This appears to be in sharp contrast with the research noted above which highlighted the lived experiences of women with caring responsibilities during the pandemic. While this is problematic in itself, as the authors also note, it poses challenges for policymakers, who may prioritize other areas post-pandemic as a consequence (Duffy 2021). If so, women’s experiences and voices will remain invisible in the post-pandemic recovery. Furthermore, initiatives that are aimed at addressing gender inequality may fail to do so anyway because they do not reflect or respond to the specific issues that women have faced during the pandemic. One such response is the focus on flexible working, which has dominated during the pandemic and appears likely to be a key characteristic of post-pandemic employment.

Flexible Work as a Response?

The boundary between the public sphere of work and the private sphere of home and family care has most notably been blurred by the large-scale move to home-working as a key policy both during periods of lockdown and throughout the pandemic. This has resulted in a significant change in the way in which the nature of work has been conceptualized, including, most significantly, where and how some people work and where and how they may work in the future. However, it is important to recognize that, in some sectors, flexibility of working hours and choice of place of work was not an option during the pandemic. For instance, employees in female-dominated sectors such as health and social care and related services were more likely to remain in the workplace and at considerable risk during the pandemic. Furthermore, that it has taken a significant global event such as the pandemic to highlight the potential value of flexible working, not least of all for those with caring responsibilities, reinforces the value that has previously been placed on such forms of work. Nevertheless, there is an opportunity for both employers and government to reflect on the experiences of flexible work and renegotiate the boundaries between work and life and the ways in which people work in the future. This has the potential to have positive implications for working women with caring responsibilities; however, it is important to reflect on the current right to request flexible working, the recommended changes and whether these changes can support this.

It is important to remember that the right to request flexible working is currently enshrined in the Flexible Working Regulations (2014) and has been available to all employees with 26 weeks continuity of employment since 2014 (regulation 3 and section 80F Employment Rights Act 1996 (ERA)), having previously been available only to persons with caring responsibilities (Flexible Working (Eligibility, Complaints and Remedies) Regulations (2002)). Despite this, research by Working Families (2019: 2) shows that 86 per cent of parents want to work flexibly but just under half do so (49 per cent). Their reasons for not working flexibly include: that it is incompatible with their job (40 per cent); that it is not available where they work (37 per cent); and that their manager does not like them working flexibly (10 per cent) (2019: 2). This reinforces the importance of workplace culture and support from employers, as well as the limitations of this right in practice. This can be explained in part by the framework of the legislation itself.

Employees can request a change in the hours, times or place of work (section 80F(1) ERA) and may make one such request in a one-year

period (section 80(4) ERA). However, the requirements are quite onerous since the employee must consider the impact that their request will have and how it can be addressed (section 80F(2)(c) ERA). In contrast, the obligations on the employer are less burdensome. An employer must only deal with the request in a reasonable manner, inform the employee of the decision within three months and can only refuse it on the noted grounds (section 80G(1B) ERA). However, there are various grounds for refusal, making it relatively easy for an employer to do so (section 80G(1) ERA). There is no requirement in the legislation for the employer to offer a right to appeal the decision, but if the employer does, the final decision must also be reached within the three-month timeframe (section 80G(1A) ERA). An application can only be made to the Employment Tribunal if the employer failed to comply with section 80G(1), the decision was based on incorrect facts, or the employer's notification did not satisfy the relevant requirements (section 80H(1) ERA). This does not allow the decision of the employer to be challenged on the grounds that it is unreasonable and/or that the justification is inaccurate, unreasonable or tainted by bias or discrimination, making it difficult for an employee to successfully challenge the decision (James 2006: 276-277). Consequently, the right to request flexible working offers a limited right with limited remedies in practice. Indeed, equality law has provided more effective remedies for those refused such requests. For instance, female employees have previously succeeded in raising claims of indirect sex discrimination relating to flexible work, now under section 19 of the Equality Act 2010 (for example, *Home Office v Holmes* (1984); *London Underground v Edwards (No 2)* (1999); *Lockwood v Crawley Warren Group Ltd* (2000); *Littlejohn v Transport for London* (2007); *Dobson v North Cumbria Integrated Care NHS Foundation Trust* (2021), but compare *XC Trains Ltd v D* (2016)). However, this comes at the price of continuing to frame childcare as undertaken primarily by women and arguing that a provision, criteria or practice to work full time and/or to return to a workplace places women at a particular disadvantage because they are more likely to be responsible for care. While this has undoubtedly been the case during the pandemic, it continues to reify women as carers. Having to rely on discrimination legislation here to assert rights makes this more difficult to challenge and continues to reinforce the resilience of the male subject of law, even in relation to a right aimed (initially at least) at benefitting women as working carers (James 2009: 277-278). This also presents problems for working fathers being recognized as working carers. The Employment Appeal Tribunal in *Walkingshaw v The John Martin Group* (2001) upheld a direct sex discrimination claim brought by a father who had been denied access to flexible working. However, this was in circumstances where it

was clear that a female employee's request would have been approved. It will not always be possible to identify a relevant comparator for fathers to be able to succeed here. This is reinforced in more recent case law on comparators for shared parental leave (SPL) (see *Capita Customer Management Ltd v Ali* (2019) and *Price v Powys County Council* (2021)). Thus, stereotypical views on care continue to be reinforced.

Nevertheless, the pandemic has accelerated support for the normalization of flexible work. In particular, Minister for Women and Equalities Liz Truss MP has noted that there has been a change in mindset about flexible work as a consequence of the pandemic and that:

We should take the opportunity to capitalise on some of those cultural changes that have happened to make it easier for people balancing family and career to work from home, to make it more flexible and to challenge the culture of presenteeism, which has been very alive in business and has also been very alive in politics (Women and Equalities Committee (2020): response to q14).

While the normalization of flexible work is not unwelcome, it is important to consider how this is achieved and supported to enable working women with caring responsibilities, and working carers more generally, to benefit from the renegotiation of the boundaries between work and family life. However, the recommendations relating to flexible work do not go far enough to address this.

The first recommendation follows research undertaken by the government-backed Behavioural Insight Team (BIT) and jobsite Indeed, which reinforces that advertising jobs as available flexibly is more likely to attract interest from both women and men (Londakova & Ors 2021). Furthermore, including flexibility in adverts can normalize flexible work, help increase the availability of quality flexible work and help facilitate the employment of those with caring responsibilities (2021: 7-8). This reflects the proposals consulted upon prior to the pandemic in the 'Good Work Plan: Proposals to Support Families' (HM Government 2019: 50) to increase the visibility and availability of flexible working when advertising jobs. While the normalization of flexible work is to be lauded, it is important to remember that utilization of flexible work has previously been highly gendered, with negative implications for working women and their careers. So, it is necessary to consider what is meant by flexible work in this context and what kind of flexible work has been valued by employers during the pandemic.

The gendered nature of flexible work in practice is highlighted by Chung and van der Lippe (2020: 365, 366 and 369-371) who identify various

studies which show that flexible work often means that women reduce paid work to care and men work additional (at times unpaid) hours to advance their careers. This reflects the traditional division of gender roles, with working women continuing to take primary responsibility for care to the detriment of their engagement in paid work. By contrast, men tend to continue to prioritize paid work, with flexibility being used to work different hours or in different places with the goal of career progression. It is arguably the latter form of flexibility that has been more prevalent during the pandemic, with many employees working flexibly from home, but not necessarily reducing their working hours and men continuing to work more than women. For instance, ONS data shows that during lockdown, fathers spent an average of 45 minutes more per day, across all days, on paid work than mothers (July 2020). This raises concerns if flexible work is viewed as the potential answer to the inequalities that working women with caring responsibilities have experienced during the pandemic. While flexible working will be of benefit to some people with caring responsibilities, it is entirely dependent on what is meant by flexible working in practice and the kind of flexible working that is valued. Many employers have recognized the value of flexible working as a consequence of the pandemic, however this has typically involved employees working from home in much the same way as they did in workplaces. While this nevertheless represents a significant shift in the site of work, it tends to reflect a white collar, middle-class, male model of work rather than the kind of flexibility that is necessary to combine work with care. If the model of flexible work is reflective of this kind of flexibility, then it may further entrench traditional gender roles and reinforce the double burden of work and care that women with caring responsibilities tend to experience.

Furthermore, Chung and van der Lippe (2020: 368-369) also refer to studies that show that flexible work can create more work-family conflict because of competing commitments and blurring of boundaries, particularly when employees are home-working. This has certainly been the case during the pandemic for many employees, most notably women with caring responsibilities as noted above. This suggests that, rather than addressing gender inequalities, the ways in which flexible work operates in practice can instead further entrench traditional gender roles. This is also reinforced in research undertaken by the Working@Home Project (2020) during the pandemic which highlights the emergence of digital presenteeism, which could make home-working more difficult, particularly for those with caring responsibilities. Consequently, the expectation that home-working can challenge ingrained cultural norms and be more responsive to caring obligations may not be borne out in

practice. Instead of the boundaries between the public sphere of work necessarily adapting to accommodate the private sphere of home and family life, the private sphere may actually be contracting for some, with the blurring of these boundaries increasingly resulting in poorer work–life balance. This is particularly likely to be the case where the normalization of flexible work is modelled around the traditional unencumbered male worker model, rather than recognizing and responding effectively to the needs of working women with caring responsibilities. A better response to these challenges is to also redesign the package of work–family rights in the UK to support working carers more effectively and challenge traditional assumptions around care.

The second recommendation—to abolish the 26-week continuity of employment requirement to request flexible work—offers greater potential here (Women and Equalities Committee 2021: 12-13). Similar recommendations were made by the Equality and Human Rights Commission, which recommended extending the right to request flexible working as a day-one right, available at all levels (unless there are genuine business reasons where it is not possible) and to include this when advertising roles (2020: 16). Such a change is a necessary accompaniment to the first recommendation, to ensure that those who wish to work flexibly have the right to do so from the moment they start work. While these recommendations are not unwelcome, they do not address the underlying limitations of the right to request flexible working itself and the different experiences of flexible work for both men and women.

A further challenge within the current legislation is that a successful request will result in a permanent change to the employee's contract of employment. This can make the right less attractive to employees who do not want to make permanent changes to their contracts and can trap employees in decisions that they had to make to respond to particular circumstances. This issue is addressed in Article 9 of the EU Work–Life Balance Directive (2019) (WLBD), which includes the right to request a temporary change and then return to your previous working arrangement (Article 9(3)). Including such a provision in the UK Flexible Working Regulations (2014) could be beneficial in practice and could ensure that carers (primarily women) are not relegated to part-time work.

While flexible working has captured many headlines both during the pandemic and as part of a future renegotiation of the boundaries and sites of work and family life, it is important to bear in mind that the recommendations for change here were not, initially at least, in response to the pandemic itself. Consequently, they do not actually respond to

the lived experiences of working women, and other carers, during the pandemic. Instead, what is necessary is a re-envisioning of the work–family dichotomy to support working carers more generally and challenge traditional gender roles. In doing so, women’s experiences of the pandemic must be more visibly included in the responses and renegotiation of these boundaries, which include making men more visible as working carers.

Revisiting Work–Family Rights

While the relocating of paid work from public workplaces to private homes has limited potential on its own to renegotiate responsibilities of care, a broader revision of work–family rights has far greater potential to do so. While the burden of care and home-schooling has rested on the shoulders of working women throughout the pandemic, there is some evidence of working fathers undertaking a more active role in care during this time (Burgess & Goldman 2021; Margaria 2021). However, as noted above, the focus on redefining work post-pandemic has been on flexible working, with limited attention from policymakers being focused on renegotiating the boundaries between work and care. This approach is unlikely to challenge the division of gender roles because it does not incentivize a sharing of caring responsibilities. Renegotiating the package of work–family rights and related care infrastructures, however, presents a greater opportunity to do so and to genuinely value care, something which has been notably absent in the development of UK work–family rights. This is supported by Mitchell’s (2020) recent analysis of the current framework of rights in the UK, in which she argues that care is not valued. Instead, she argues that the legislation should be based on an ethics of care approach and that a right to care should be developed in the UK. This builds on work by both James (2016) and Busby (2011) in this regard and reinforces the fundamental flaws within the existing framework of rights that continues to be based around a male worker model. There are three ways in which this can, and should, be challenged as part of the post-pandemic recovery. First, by revising rights for working fathers; second, by enacting a right to carers’ leave; and third, by ensuring that the appropriate care infrastructures are in place to provide greater choice for working persons with caring responsibilities.

Fathers’ Rights

While working mothers did undertake the majority of responsibility for care and home-schooling during the pandemic, research also indicates that fathers engaged more in these activities during lockdown than they had previously (Burgess & Goldman 2021). This has been viewed

optimistically by some, who note that the requirement to stay at home and the resultant physical presence at home has enabled fathers to undertake a greater role in care (Margaria 2021: 135). This suggests that the blurring of the boundary between the public and private spheres of work and family life has facilitated a renegotiation of caring roles for some working fathers. This poses the question of whether fathers' work-family rights should now be reviewed and enhanced to capitalize on this.

Subject to various qualifying conditions, fathers currently have the rights to: two weeks' paid paternity leave (Paternity and Adoption Leave Regulations (2002) and Statutory Paternity Pay and Statutory Adoption Pay (General) Regulations (2002)); up to 50 weeks of SPL (Shared Parental Leave Regulations (2014) and Statutory Shared Parental Pay (General) Regulations 2014); and 18 weeks' unpaid parental leave (Maternity and Parental Leave etc Regulations (1999)). However, all these rights are subject to qualifying conditions, and for SPL the mother has to curtail her leave in order for the father to access it. The secondary nature of fathers' rights has been a long-standing criticism of UK work-family rights (James 2006 and 2009; Busby & Weldon-Johns 2019; and, from an EU perspective, Caracciolo di Torella 2015). Redefining fathers' roles in care at the same time as redefining how and where people work provides an opportunity to engage fathers more meaningfully in care and to challenge traditional gender roles (akin to Busby & Weldon-Johns's 2019 'active' fatherhood ideology). Providing fathers with a more clearly defined role in this context is not a new recommendation (see, for instance, Weldon-Johns 2011; Caracciolo di Torella 2015; Atkinson 2017), although strengthening such rights has been recommended as a response to the pandemic (Fawcett Society 2020: section 8; Margaria 2021). Furthermore, the UK Government previously committed to reviewing the right to SPL (HM Government 2019: 4-5), which has not been widely used (just over 1 per cent of those entitled utilized SPL in 2017/291818: Birkett & Forbes 2018). Now would be the opportune moment to do so and to strengthen fathers' rights. While a radical re-envisioning of parental rights, akin to the Nordic style of flexibility where parents each have periods of non-transferable leave, would be welcome (for an overview of rights, see Weldon-Johns 2011; Koslowski & Ors 2020), it is perhaps unlikely in the context of the post-pandemic recovery. Nevertheless, small but meaningful steps forward could make a significant difference. For instance, extending SPL as a day-one right, as recommended by Working Families (2019), would make it more accessible to working fathers. Removing qualification barriers based on the mother's engagement in paid work in the first instance and instead providing fathers with an independent right to leave would also

be a significant improvement (Atkinson 2017; Busby & Weldon-Johns 2019). Enhancing rights to paid leave and facilitating greater flexibility in its utilization would make it more affordable and accessible to working fathers (Atkinson 2017; Busby & Weldon-Johns 2019). Similar changes are evident in the WLBD, which repealed the Parental Leave Directive (2010) and enhanced the right to parental leave, enacted as unpaid parental leave in the UK. Parents are entitled to an individual right to four months' leave, two months of which cannot be transferred (Article 5(1)-(2)). Parents exercising this non-transferable period of leave will be entitled to some form of payment or allowance (Article 8(1)), which 'shall be set in such a way as to facilitate the take-up of parental leave by both parents' (Article 8(3)). The WLBD also requires member states to adopt the necessary measures to ensure that parents can request that it be utilized flexibly (Article 5(6)). These changes mark a greater commitment to working fathers as carers. While they are limited in practice—for instance the payment is unlikely to fully compensate for loss of normal earnings—this is coupled with the right to request that the leave be exercised flexibly, which may mitigate this. These revisions nevertheless represent a positive step forward in recognizing working fathers as carers (Weldon-Johns 2020). Implementing such changes into UK law, either as a revision to the current right to unpaid parental leave or as part of more sweeping reforms to SPL, would signify a significant commitment to recognizing fathers as working carers, and would challenge the continuing focus on mothers as 'child-bearer[s], child-rearer[s] and domestic servant[s]' (Naffine 1990: 6).

Carers' Leave

While the focus in this article has been on working women with childcare responsibilities, those with other caring responsibilities have also been impacted by the pandemic, and this needs to be recognized in the post-pandemic responses. The UK Government consulted on a right to carers leave in 2020 (Department for Business, Energy and Industrial Strategy 2020), which indicates a potentially positive step forward in extending rights to working carers. However, the proposals were limited to five days' unpaid leave per year and contained a narrow definition of carers and the circumstances in which carers' leave could be utilized (ibid: 11-15). Consequently, the proposed right would not cover all of those with caring responsibilities nor all care needs, and seems unlikely to extend to childcare responsibilities. This is in contrast to the Trades Union Congress's (2020) recommendation of a day-one right to 10 days of carers' leave for all parents. Therefore, in much the same way as other work-family rights, the proposals offer little more than another 'sound-bite' addition to the package of work-family rights (Anderson 2003; Weldon-

Johns 2011). In practice, it may offer only a slightly better right to time off than that afforded under the dependent care leave provisions (sections 57A and 57B ERA), which enable employees to take leave to deal with emergency care situations, but otherwise would fail to adequately respond to the needs of working carers. In particular, while it might allow carers to better plan for caring needs rather than only being able to respond in an emergency, the overall length of leave is unlikely to enable working carers to substantially renegotiate the boundaries between work and care on a long-term basis. However, this does reflect the right to carers' leave contained within the WLBD, which introduces a right to five days' unpaid carers' leave (Article 6). It similarly limits the right to traditional familial relationships and only to a person 'who is in need of significant care or support for a serious medical reason' (Article 3(1)(d)). This also fails to capture every relationship of care and all care needs, although it is a tentative first step in recognizing the caring responsibilities of working carers (Weldon-Johns 2020). Nevertheless, a more flexible right to paid carers' leave that is broadly defined would offer greater potential benefits to working carers. This would also challenge the standard male worker norm, the boundaries between paid work and unpaid care, and would recognize that all working persons can be impacted by caring responsibilities at any time.

Childcare Infrastructures

Finally, it is clear that investment in childcare and social care infrastructures is necessary to ensure that working women are able to engage in paid work. The pandemic has underscored the continuing fragility of women's work and the resilience of traditional gender roles when such structures are absent. This reinforces that women's work continues to be viewed as ancillary to men's work, and that women can, and will, revert to the private sphere to fulfil this role when this cannot be provided outside of the home. Indeed, research by Pregnant then Screwed (2020) highlights that 81 per cent of employed mothers who responded to their survey reported that they needed childcare to work. The interdependency of these spheres and their impact on women's work must be recognized. Consequently, the post-pandemic recovery must ensure that there is investment in childcare infrastructure to redress these inequalities and ensure that women can remain in—or return to—paid work (Margaria, 2021; UK Women's Budget Group & Ors 2021; Fawcett Society 2020: section 8). Without this, it is clear that any potential gains made, or lessons learned, during the pandemic in challenging traditional models of work will fail to benefit women in the longer term. These tensions are similarly evident in the experiences of abortion care, the subject to which we now turn.

[D] REPRODUCTIVE HEALTH

Access to abortion has long animated the cause for gender equality and advocating for reproductive autonomy has always been a central strand of feminist advocacy. Access to abortion within mainland Britain is considered a key strand of reproductive health policy with abortions offered by the National Health Service (NHS). However, there are still real barriers preventing many women from accessing appropriate reproductive healthcare, especially disabled women, trans and non-binary people, refugee and migrant women, BAME women, women with abusive partners or families, and women who live rurally (Engender 2016: 7-19). As we argue above, the immediate pandemic law and policymaking by the UK Government demonstrated a dearth of understanding of women's specific needs. It also reified the traditional heteronormative family model, which is premised on a married couple with children. This presupposed a stereotypical family arrangement where the woman either did not work or worked part-time. The regressive gender stereotyping was clear in Government framing that positioned women as mothers and caregivers throughout the pandemic. These same regressive gender stereotypes can be seen in the UK and devolved Governments' approach to women's reproductive health. Here, the pandemic-necessitated move away from in-person service provision has created space for a service that is actually better for many women. Yet, because of the nature of these services—abortion provision—it seems lawmakers are keen to return to the pre-pandemic status quo that is less beneficial to women. This demonstrates that, once again, women's needs and interests are not at the heart of law-making or policymaking.

Thus, similar to the deprioritization of childcare and work-family rights, women's health needs were also deprioritized and the effect of this downplayed (Engender 2020). The initial closure of GP services and many clinics for in-person appointments not only made it difficult for women to manage issues such as pregnancy, contraception, emergency contraception, and gynaecological and sexual health, it also reduced the space available for women to access environments in which they could safely seek help from domestic violence or other abusive behaviours (Scottish Government 2020b: 5). Yet, while the authors agree with the criticisms levelled at the UK Government and devolved administrations for their failure to adopt a gendered assessment in their immediate pandemic response, in this section we highlight how the exceptionalism wrought by the pandemic has provided an opportunity to rethink and redo policy that affects women. We consider the lessons that can be learned from this. This section sets out how the pandemic has in fact provided an

opportunity to change how women and pregnant people access abortion and other reproductive health services and how this has allowed for a more patient-orientated service that is able to better cater for those women who traditionally have faced barriers to accessing abortion. These changes to abortion access were brought about due to the constraints placed on in-person services by the pandemic. As such, these changes to abortion access were made in the absence of the usual criticisms and moralistic debates on abortion that generally accompany any discussion on reform of services and have previously hindered attempts to relax the law. Thus, the pandemic has provided the perfect context to introduce services for which abortion service providers and charities have long been lobbying. However, what is problematic is that governments have made clear that such provisions, even when faced with overwhelming evidence of their success, are merely temporary. This once more demonstrates that women's needs are not at the heart of law-making and that any dismantling of the public/private divide during Covid-19 is not a permanent one. This is problematic because access to reproductive health that allows women to plan when they have children is recognized as being necessary for gender equality (International Planned Parenthood Federation 2015).

Abortion Regulation Pre-pandemic

The passing of the Abortion Act 1967 was heralded as a momentous gain for women's rights and freedoms (Sheldon & Ors 2019). For the first time in Great Britain there was a legal exception to the criminalization of abortion. The 1967 Act does not decriminalize abortion, and those undertaken outwith the terms set out in the Act remain criminal. The Act provides that: 'a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner' and meets certain requirements set out in section 1(a)-(d) (Abortion Act 1967). Such abortions would be criminalized in England and Wales under the Offences Against the Persons Act 1861 and under the common law in Scotland. However, there is debate over whether Scots law has ever criminalized abortion given that pre-1967 jurisprudence allowed for a more liberal regime than in England (Norrie 1985; Brown 2015).

Yet, as Sheldon (1993) has highlighted, the Abortion Act is an incredibly patriarchal and paternalistic framework that merely replaced the criminal justice system as the gatekeeper of women's reproductive rights with medicalization. Indeed, the 1967 Act has been described as a 'curious' piece of legislation 'due to the fact that it does not grant any rights to women that seek to terminate pregnancy' (Brown 2015: 29). It instead

confers a privilege upon doctors. Scott (2015) notes that, far from being a liberal regime, the fact that section 1(1)(a) of the Abortion Act still requires women to gain the permission of two doctors—even in the first trimester—can be read as an obstacle to women’s reproductive autonomy (ibid: 39). Indeed, one of the reasons listed for the requirement for two doctors to be enshrined in law was that it would require the woman to demonstrate a ‘seriousness to terminate’ (House of Commons Science and Technology Committee 2007: 32). Such reasoning reflects the fact that in the 1960s abortion was a surgical procedure and carried risks if not carried out by trained doctors. The lack of legal provision prior to 1967 meant that thousands of women died from complications arising from the unsanitary conditions in which such ‘backstreet abortions’ occurred (Cavadino 1976). However, advancements in medicine mean that the majority of women who undergo an abortion today do so by medical abortion (NHS Information Services Division 2019) and the de-stigmatization of abortion has meant the eradication of ‘backstreet’ secret abortions that were often carried out in unsanitary and dangerous conditions. The development of drugs that can successfully be used for early term abortions means that, for most women, abortion today is a very different and much safer experience than it was in the past (World Health Organization 2018).

However, the moralistic overtones that continue to frame abortion as controversial have remained, and any attempts to reform abortion law are generally met with hyperbolic rhetoric (Mitchell 2021). This has meant that, since 1967, UK lawmakers have only amended the Abortion Act once, in 1990, and remain generally reluctant to revisit abortion legislation. Thus, the overarching criminalization remains, as do the constraints set out in the 1967 Act (Grubb 1990). Yet, this means that the tight restrictions on abortion, which were specifically designed to protect women by allowing abortions only in approved medical settings, now serve as a barrier to women, as many would prefer to self-manage abortions at home when undergoing early medical abortion (Pizzarossa & Nandagiri 2021). Generally, early medical abortion is achieved by administering the drug misoprostol via a single pill and then a day or two later administering the drug mifepristone via a single pill (British Pregnancy Advisory Service (BPAS) 2021). Where previously the Abortion Act’s requirement for abortions to take place in a registered or approved premises was understood to mean a hospital or similar clinical setting in order to prevent private enterprise from seeking to make abortion a profitable business and offering it in private premises, it was also thought that hospital settings would be necessary should anything go wrong. Thus, it is clear that the legislative framework for abortions that mandated they be carried out within clinical premises was

there to protect women from the risks associated with unsafe abortions. That risk no longer exists. As a consequence, women's organizations and abortion charities have long campaigned for a relaxation of the law to allow for self-managed abortion at home.

Despite the evolution in safe early medical abortion, until recently, compliance with the law meant women still had to attend a clinic to take the first pill and then return a day later to take the second pill. This did not provide a better healthcare experience for women, nor make abortions safer (as was claimed by anti-choice organizations), as women generally departed the clinic as soon as they administered the medication in order to complete their abortions at home. However, this resulted in some women, especially those who live rurally, beginning to experience symptoms while travelling home. For some, this even meant beginning to pass the pregnancy while on public transport (Purcell & Ors 2017). It was not until 2017 that lawmakers throughout the UK consented to relax the requirement that mandated women attend clinical settings to administer both pills for medical abortion. Scotland was first in the UK to move to a system that allowed women to take the second pill at home, thus removing the chance that a woman will begin her abortion while travelling home. The Scottish Government used its powers under section 1(3A) Abortion Act 1967 to approve 'the home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy' as a place where an abortion could legally take place.¹ The UK Government and Welsh administration similarly approved women's homes as premises for abortion in England and Wales.²

Any attempt by abortion providers to move to self-managed abortion pre-pandemic was undermined by anti-choice organizations who have challenged what they see as relaxations of the Abortion Act 1967. The amendment to the class of place that allowed for administration of abortion medication at home was challenged in the Scottish courts by the anti-choice group the Society for the Protection of Unborn Children (SPUC) on the grounds that a woman's home was not a suitable premises as envisioned by the Abortion Act. They asked the court to reverse this decision (*Society for the Protection of Unborn Children v Scottish Ministers* (2018)). The Court upheld the Scottish Government's use of these powers at both first instance and on appeal (*SPUC Pro-Life Scotland Ltd v Scottish Ministers* (2019)).

¹ Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2017.

² Abortion Act 1967 (Approval of Place for Treatment for the Termination of Pregnancy) (Wales) 2018; Department of Health and Social Care (2018).

This decision was celebrated by abortion care providers, abortion rights organizations and women's groups. Yet, while this win was a huge vindication for those seeking to offer easier access to abortion, it can also be seen as a procedural compromise. The changes only allowed for the second pill to be taken at home, so still required an in-person visit to administer the first pill on site. While an improvement, this requirement still presents obstacles, and, as several women's groups and abortion rights groups have highlighted, disproportionately affects poorer women, disabled women, women with childcare responsibilities, women in abusive relationships, and women living rurally, as it is generally more difficult for them to organize the time away from work or childcare to travel to a clinic. For other women, this can also be prohibitively expensive, or difficult to ensure privacy (Engender 2016: 7-19). While it is disappointing that abortion providers did not feel able to push for a more radical interpretation of the Abortion Act 1967 that would have negated the need for women to attend in person at all, it is understandable that it was important to first secure this victory to allow women to administer the second pill at home. This was particularly welcomed as it meant that those who had further to travel or could not afford taxis no longer were forced to begin their abortions whilst on public transport. Thus, the relaxations were a welcome step in providing reproductive healthcare that acknowledged the pain, suffering and indignity that the two-day in-person attendance placed on many women.

Pandemic Opportunities in Reproductive Healthcare?

The pandemic actually provided the impetus for the radical revision of abortion provision in mainland Britain that seems unlikely to have been implemented otherwise. The necessity of reducing non-urgent in-person medical consultations meant that many patients were being offered telephone or internet consultations with their medical teams. This is known as telemedicine. To ensure staff and patient safety, and also free up NHS resources to fight Covid-19, it made sense that abortion services be offered in the same way. It generally involves a patient having a telephone or internet consultation and then being prescribed both abortion pills to take at home and bypasses the need to attend the clinic. Since this is how abortion is provided in many other jurisdictions and is known to be safe (Aiken & Ors 2021a; 2021b), it would appear that pandemic necessity forced a move to a service that is actually more appropriate for many patients. It allows for a quicker and more efficient service for abortion and also does not require women to travel. The Scottish Government allowed for telemedical abortion through issuing revised guidance to abortion providers (Scottish Government Chief Medical Officer 2020).

The guidance was put forward by the Scottish Abortion Care Providers Network (2020). What is curious is that the move to telemedical abortion required only a minimal change to the law.³ Indeed, it was clear from the earlier court judgments that it would have been within the power of the Scottish Government to allow for telemedical abortions back in 2017 when it amended the law to list the woman's home as a suitable place for an abortion. If her home was suitable to administer the second pill, then it stands to reason it would be suitable to administer both pills.⁴

While the availability of telemedicine during the pandemic has actually been an opportunity for women's health services to reorganize service provision around the actual needs and wants of patients, it has taken the lockdown, and the necessary move away from in-person services to prevent Covid-19 transmission, to actually facilitate this. Indeed, at the start of the national lockdown in 2020, in England the Department of Health (DOH) issued guidance to allow for full telemedical abortion in England in March 2020 (Department of Health and Social Care 2020b). Yet, when this was reported in the media and attracted backlash from anti-choice groups, the guidance was withdrawn and the DOH claimed it had been published by mistake (Ford 2020). It was only following media pressure by women's groups that the guidance was reinstated and telemedical abortion made available in England during the pandemic. Despite recent changes to the law to provide for abortion provision in Northern Ireland, no telemedical services were made available by the NHS there. Northern Irish women seeking abortion continued to travel to Britain, even at the height of the pandemic. This situation was roundly criticized as being both damaging to the individual woman and also to attempts to reduce the spread of Covid-19 (Bracke 2021; McManus 2021; see also Todd-Gher & Shah 2021).

Yet, despite the success of telemedical abortion, both the Scottish and UK Governments have made clear that such provision is only a temporary state of affairs. Despite evidence reported by patients and service providers that telemedicine offers a better service (Prandini & Larrea 2020), the English,⁵ Scottish⁶ and Welsh⁷ Governments all launched

³ The Scottish Government again used its powers to approve a pregnant woman's home as a class of place for the termination of a pregnancy. This time the legislation allowed for both pills to be taken at home after an online or telephone consultation. See the Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2020.

⁴ However, Taylor and Wilson (2019) argue that the first instance case is wrongly decided.

⁵ Department of Health and Social Care (2020a) and Scottish Government (2020a).

⁶ Scottish Government (2021).

⁷ Welsh Government (2020).

public consultations on the future of telemedical abortion provision. As women's organizations and abortion rights charities highlighted, no other healthcare decisions are made on the basis of public opinion. The fact that governments would choose to consult the public on the future of abortion services, rather than use an evidence-based approach from both patients and the experts, suggests once more that women's needs and realities are not placed at the centre of law or policymaking. Instead, they are subordinate to wider influences. This again demonstrates that women's needs are conditional on overcoming hidden barriers rather than be taken as read, meaning law and policy actually reinforce harmful patriarchal gendered stereotypes. In the case of reproductive healthcare, law and policy changes that would provide a more patient-oriented service are too often 'balanced' against moralistic objections voiced by anti-choice groups. In labelling the provision of telemedicine temporary, and subjecting its future to public consultation, the governments are once again subordinating women's needs and wants to the wishes of anti-choice and anti-women influences. Any potentiality offered by the pandemic seems set to be lost in the return to mandatory in-person abortion services.

What Has the Pandemic Highlighted?

Thus, it is clear that the exceptionalism and necessity wrought by the pandemic has allowed for a streamlined approach to relaxing the guidance on abortion provision. This is a change that has benefitted women and has been welcomed by abortion service providers (BPAS 2020). However, it has once again shone a light on the fact that, in regular times, simple changes in, or relaxations of, abortion guidance are difficult to achieve due to the residual moralistic framing that remains. For too long, women's particular healthcare needs have been classed as 'controversial', which has meant unnecessary medical oversight, placing a burden on individual women and creating barriers to access (Purcell & Ors 2014).

Nevertheless, the necessity for people to remain at home has meant the widespread adoption of telemedical abortion has allowed women to access healthcare from their own homes. This has allowed for a patient-centric service that has generally been welcomed by both service users and service providers, and has generally meant women are having abortions earlier and therefore more safely (BPAS 2020).

The fact that telemedical services have been so successful suggests that they should continue as an option for women. The reluctance of the English, Scottish and Welsh administrations to commit to continuing this

successful model post-pandemic suggests that they are not committed to women-centric services that place the individual patient's needs at the centre. Indeed, while this section has used reproductive rights and abortion services in general as a case study for viewing emancipatory potential for female-centric law and policymaking, it recognizes that the exceptionalism narrative deployed to justify lockdown law-making means that, post-pandemic, politicians seem likely to return to framing women's reproductive healthcare as controversial. This will mean the continuation of moralistic balancing exercises, despite evidence that telemedical abortion is successful and more appropriate for many women. This seems a needlessly regressive step.

[E] CONCLUSION

We have argued that the lack of gender sensitivity at the beginning of the Covid-19 lockdown produced both unintended harsh consequences for women, but also the space to envision emancipatory possibilities. We explored the distinct but related examples of home-working and reproductive health to demonstrate a lack of awareness about women's lived reality in legislating and policy around Covid-19. While the Government eventually amended its initial lockdown policies and law to allow for some children to remain in childcare or education (where necessary to allow parents to work) and called on employers to embrace flexible working, it only did so after much criticism by women. In the same way, abortion guidance was only relaxed to allow for self-managed abortion at home after it was highlighted that abortion is a time-critical and necessary health service, and that lack of provision would result in serious consequences for women's mental and physical health. In this way, accommodations were made that acknowledged women's specific needs. These accommodations, if enshrined further in law, have the potential to benefit women and contribute to lasting gender equality. However, we have demonstrated that such potentiality needs to be harnessed and embedded in law and policy in order to further and not hinder gender equality. The fact that flexible working and revisions to work-family rights are not guaranteed, and that provisions allowing for home abortions may not be continued, point to a short-sightedness and a stubbornness on the part of the law-makers in upholding and reifying the public/private divide.

We caution against such a regressive approach as the Covid-19 recovery plan will only succeed if it centres women's actual needs at its heart. Without these measures entrenched, inequality will be further cemented by the pandemic. Ultimately, women-focused law-making must take

account of women's lived reality in order to ensure that gender equality is not set back a generation.

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