Care economy during the COVID-19 pandemic and measures for its prevention in Serbia

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LIST OF ABBREVIATIONS

LFS	Labour Force Survey
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
EU	European Union
ILO	International Labour Organization
RS	Republic of Serbia
SORS	Statistical Office of the Republic of Serbia
SIPRU	Social Inclusion and Poverty Reduction Unit
WHO	World Health Organization

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SUMMARY

The report "Care economy during the COVID- 19 pandemic and measures for its prevention in Serbia" was drafted by the SeConS in partnership with UN Women. The report is part of the project *Key Steps to Gender Equality* that UN Women conducted with the financial support of the European Commission (EC). The report was created after the state of emergency introduced due to the pandemic caused by the COVID-19 virus, and based on researches which were conducted in mid-April and mid-June.

The research covered several aspects:

- Influence on the position, working conditions, the workload of employees in sectors that belong to the care economy (health care, social protection, education) and what were the gender-specific effects;
- Influence on the care economy from the perspective of individuals and families who used the commercially available care economy services;
- Forms of the division of unpaid housework and family care in the significantly changed conditions in everyday lives due to the closure of kindergartens, schools, public social support services, and similar.

The research was conducted through two components: Survey telephone research conducted in mid-April, using a standardised questionnaire on a representative sample of 1603 men and women who were employed[1]in February 2020, before the declaration of a pandemic and introduction of the state of emergency, and a survey conducted in mid-June on a representative sample of 1925 adult citizens of Serbia. The qualitative component included 11 semi-structured interviews with women who are formally or informally employed in the care economy occupations.

Impact of the pandemic on the workforce employed in the formal and informal care economy sector. A contingent of employees in the formal and informal care economy sector are employed in occupations of direct and indirect care in the *sector of education* (preschool/school teachers, professors, pedagogists, psychologists, cleaners, cooks, etc.), *in the health care sector* (medical staff, pharmacists, cleaners, cooks, etc.), *in the social protection sector* (social workers, psychologists, pedagogists, counsellors, medical staff, caregivers, medical staff in residential institutions, cleaners, cooks, etc.) and *the persons providing services to households for compensation* (cleaning, child care, care for elderly or ill).[2]

[1] The surveyed respondents had to meet the definition of employment, used by the Statistical Office of the Republic of Serbia in the Labour Force Survey, which is harmonised with the international methodology of the ILO and Eurostat. According to this definition, employed persons are persons who have, during at least one hour in the reference week, performed paid job (in cash or in kind), and persons who have a job but were absent from it during that week (with a guarantee of returning to it) (Statistical Office of the Republic of Serbia. *Labour Force Survey, methodological guide.* Available at https://publikacije.stat.gov.rs/G2017/Pdf/G20177069.pdf)

[2] These criteria follow the methodology applied in the global study of ILO. (2018). *Care Work and Care Jobs. For the Future of Decent Work.* ILO. Geneva.

According to the data from the research in April, predominant workforce in the care economy sector are women (78.7%). Formally employed persons in this sector were less likely to lose their jobs (4.3%) than those who were employed in other sectors (9.1%). This is not surprising, given that there was increased demand for occupations in the health care sector which was at the forefront of the pandemic response. Pandemic and the state of emergency have had a differentiated impact on sectors that are in the care economy: employees in education and social protection have mostly switched to working from home, while medical staff continued to perform primarily their tasks at their workplace in the front line of the pandemic response and were exposed to increased health risks.

Also within the same sector, there was the polarisation for those employed in the field of education who were exposed to greater workload (20%) as results of digital teaching and those who cited the reduced workload (18%). Not only was there a change in workload, but the new working conditions launched new challenges which people who switched to working from the home had to face. One number of the employees did not have appropriate working conditions, either because of lack of space to work or technology for work. Additional difficulties are connected to the intrusion of work on the privacy of the family and/or a load of family responsibilities because of which they could not fully commit to work. This was an additional source of frustration with a significant number of employees who switched to working from their homes. On the other hand, the employees who continued to carry out their work in normal workplaces (mainly employees in the health sector) faced serious health risks, increased workloads, which were additionally made difficult by the organisation of transport to work due to the suspension of public transport and suspension of work of educational institutions. When it comes to protective equipment, most of the employees in the care economy cited that they had adequate personal protective equipment (94%), a smaller number of them said that they did not have adequate protection or have not used it.

Impact of the pandemic on the beneficiaries of the care economy. The picture of the situation regarding the needs for care services in households and the way they were met during the pandemic was obtained based on the research conducted mid-June in Serbia within the UNFPA and UN Women regional study of the impact of the COVID-19 pandemic on the empowerment of women and men. According to the findings of this survey, about a quarter of the surveyed sample households had needs in the different types of care economy services, such as care for small children (15.2%), care for the elderly with limited mobility in the household (6.9%), for severe chronic patients (5.2%), for children with disabilities (0.7%) and adults with disabilities (3.1%).

Before pandemic for household members in need of nursing care, the care was most often provided exclusively within the household, no matter what the health problem was. In a somewhat smaller number of cases, the needs were met either by hiring persons from outside the household (either paid or unpaid) or through a combination of hiring persons from outside the household and internal resources. The outbreak of the pandemic led to lower reliance on the support of institutions and involvement of people outside the household, and care for the ill was to an even greater extent transferred to the resources from the households, which increased the workload of the household members. However, the burden of care in the household was not evenly distributed, but its distribution was primarily gender-specific and depended on the age of the person in need of support. Women bear the greater burden of this care for all the household members in need of support. They bear the greatest burden when it comes to small children and people with disabilities. The level of involvement of men depends on the age of the household member who needs care, they are more likely to be engaged in the care of older people with chronic illness and elderly people with disabilities, than other people,

but even in these cases, the greater burden is on women than on men. Changes in the modalities of providing care are determined by movement restrictions, suspension of the institutions/organizations that provide services, and the fear of both service providers and beneficiaries of exposure to health risks. After the state of emergency was lifted, most households returned to the service-providing modality used before the pandemic outbreak.

Care economy as reproductive economy. Activities such as meal preparation, baby feeding, household maintenance, patient care when provided within the household are classified as "reproductive", or those whose function is the reproduction of the family, individuals. At the same time, their value for the reproduction of the workforce and the entire society is completely neglected. It is this unpaid housework and family care that represent the area of very pronounced gender inequalities in Serbia, which was confirmed by the research conducted in April.

According to the findings of that research, before the outbreak of the pandemic, in most households in Serbia, women still had predominant responsibility for doing unpaid everyday housework such as cooking, washing the dishes, laundry, ironing, cleaning. When it comes to caring for the elderly and children, the gender gap in the division of responsibilities is somewhat narrower than in other household activities, especially when it comes to caring for the elderly. Although men are somewhat more involved in the care for the elderly and care for small children, they do so in a modality of performing it together with the women. Caring for school children is usually the sole responsibility of women in the household.

The outbreak of the pandemic was accompanied by the introduction of a state of emergency when kindergartens and schools were closed and people over the age of 65 were not allowed to go out, which caused even greater burden on household members. The research findings show that the pandemic did not lead to significant changes in the patterns of division of labour and responsibilities in direct and indirect household care activities. Some kind of change was reported by less than a third of households, and this change usually meant only an additional burden on women who normally carried the main burden of these activities, because it was necessary to prepare more meals, supply the elderly, keep track of schoolwork of children who were attending school from home or caring for children who could not go to kindergarten. In a smaller number of households, there were changes in terms of greater involvement of the partner or other household members "to help women", which indicates that there were actually no significant changes in the perception and practice of responsibility in sharing household care. Only in a very small number of households, the main responsibility shifted from women to men, mainly in the households where women had to go to work, and men switched to working from home or did not work at all.

1. INTRODUCTION

This report was written during the period after the state of emergency introduced due to the COVID-19 virus pandemic, which hit Serbia in the spring months of 2020. The research was conducted at the end of June and the beginning of July, first covering the period of relaxation, when the pandemic seemed to have weakened and when the very restrictive Government measures were abolished, but then also the period of the new increase in the number of cases and announcements of new restrictive Government measures. It is important to keep this in mind because some indicators of status, and also perceptions, are marked by the described conditions.

The care economy in those conditions was one of the most important pillars of the system in the response to the pandemic, both the formal response, in the health care sector, and informal response in the sphere of private, informal family care. Care economy is an area where women make up the majority, whether we are talking about its market or non-market segment, so the situation observed in this area marked the professional and private everyday lives of women to the largest extent.

This report is one of four separate analyses of the impact of the COVID-19 pandemic conducted by SeConS in partnership with UN Women in the period April-July 2020 as part of the Gender Equality Facility Project funded by the European Commission (EC):

1) analysis of the impact of the pandemic on employment and working conditions of women and men who were employed in the month before the pandemic was declared;
2) analysis of the impact of the pandemic in the field of the formal and informal care economy;
3) analysis of the impact of the pandemic on women's entrepreneurship;
4) analysis of the impact of the pandemic on the labour activities and position of rural women, with the focus on their involvement in agricultural production.

OBJECTIVES

The aim of the analysis is to show how the COVID-19 pandemic reflected on the care economy in three aspects:

- How it affected the position, working conditions, the workload of employees in sectors that belong to the care economy (health care, social protection, education) and what were the gender-specific effects;
- How it affected the care economy from the perspective of individuals and families who used the commercially available care economy services;
- How it affected the division of responsibilities in the sphere of informal, private care economy in households and families whose everyday lives significantly changed in the conditions of interrupted work of institutions, availability of services, movement restrictions, increased health risks and other conditions related to the pandemic and the Government measures in response to it.

Having in mind that employment in the care economy activities is associated with less favourable working conditions than employment in some other activities (shift work, emotionally stressful work associated with caring for other people's well-being, low salaries, often poor physical working conditions and lack of adequate equipment) and that in the sphere of informal family care it also involves a large emotional investment through the so-called “reproductive” unpaid (both economically and socially

inadequately valued) work, these unfavourable conditions and effects of the pandemic are particularly reflected on the position and well-being of women who make up the majority of employees in the market segments of the care economy and bear most of the responsibilities in the informal household and family care economy. Therefore, the aim of this analysis is not only to shed more light on gender inequalities expressed through the care economy in the pandemic conditions, but also to recommend short-term interventions and also long-term, structural changes that should eliminate inequalities and enable a more equal and socially equitable distribution of the care economy, both in the sphere of market services and in the sphere of division of labour in the household and family care.

RESEARCH METHODS AND SAMPLE

The research methodology contained two main components: survey research and qualitative research conducted in the form of interviews. The quantitative component is based on rapid assessment, which means that the survey had to be conducted in a short period, and given the limitations of movement, physical distancing, it could not be conducted with a face-to-face survey, but with a telephone survey, which limits the scope in terms of the number of topics that could be examined. The analysis was conducted on the data of two surveys implemented in two periods – one in April during the state of emergency, and the other in June. The first survey was conducted at the peak of the pandemic and the state of emergency, from 11 to 23 April 2020, on a sample of 1603 women and men who were employed in February 2020, before the pandemic and the state of emergency were declared.[3] The second survey was conducted from 13 to 25 June 2020, on a sample of 1925 women and men older than 18, regardless of their employment status, i.e. whether they are employed or not.

The sample for both surveys was stratified by regions and by the type of settlement and representative quotas by sex and age within the regions. The two stages for ensuring the randomness of the sample were the selection of the household through a simple random household selection and the selection of the respondents from the selected household. Phone numbers were selected from the database of all landline phone numbers belonging to the territory of Serbia, using a generator that randomly selects the phone number to call. At the last level of selection, within households, if several people in the same household corresponded to the target population, the interview was conducted with only one person, and the selection criterion was the date of birth (the interview was conducted with the person whose birthday was first in line from the date of the survey).

The detailed structure of the sample for both surveys is given in the annex to this report.

[3] The surveyed respondents had to meet the definition of employment, used by the Statistical Office of the Republic of Serbia in the Labour Force Survey, which is harmonized with the international methodology of the ILO and Eurostat. According to this definition, employed persons are persons who have, during at least one hour in the reference week, performed paid job (in cash or in kind), and persons who have a job but were absent from it during that week (with a guarantee of returning to it) (Statistical Office of the Republic of Serbia. *Labour Force Survey, methodological guide.* Available at https://publikacije.stat.gov.rs/G2017/Pdf/G20177069.pdf).

In addition to the survey questionnaire, qualitative research was conducted with the aim of getting a deeper insight into the effects of the pandemic on employees in the care economy occupations. Within this component, 11 in-depth interviews were conducted with women who are both formally and informally employed in the care economy occupations. Four interviews were conducted with health workers, one interview each with women employed as social workers, caregivers of the elderly, babysitters, cleaners, pharmacists, preschool teachers and personal assistants for people with special needs. The interviews were conducted over the phone because it was necessary to ensure physical distancing. The interviews were conducted using semi-structured questionnaires by researchers with many years of experience.

2. CARE ECONOMY – CONCEPTUAL FRAMEWORK

Care economy can be defined as "the part of human activity, both material and social, that is concerned with the process of caring for the present and future labour force, and the human population as a whole, including the domestic provisioning of food, clothing and shelter."[4] It intersects the areas of the market and non-market economy, formal and informal, paid and unpaid, "productive" and "reproductive" labour, including:

1) Segments of the market economy, where care services are provided to individuals and families either through:
    a. Formal sector of education, health care and social protection services,
    b. Informal sector of services where support services for the household, children, the elderly in households or household maintenance are most often provided by informally engaged domestic workers;
2) The non-market care economy includes all activities of care for family members and household by household members / other persons from informal support networks.

It is necessary to point out the differences compared to the category of unpaid work. Unpaid work may also involve other forms of work other than the care economy, such as the work on a family farm or in another family business.

According to the definition of the International Labour Organization (ILO), the work in the care economy includes two types of activities: direct care activities, such as feeding a baby or nursing a sick partner and indirect care activities such as cooking, cleaning, etc.[5] The ILO considers unpaid work in the care economy as work in the full sense and a crucial dimension of the overall world of work. Actually, it is pointed out that the "unpaid care work–paid work–paid care work" circle influences gender inequalities in paid work outside the care economy, and has implications for gender inequalities within the household, i.e. the ability of women and men to perform unpaid care activities. Therefore, the issue of paid and unpaid work in the care economy is an important part of the ILO's decent work agenda.
Changes in family structures, a higher share of the dependent population in relation to the working population, changed needs for care due to the population ageing, but also due to new standards of social inclusion (which, for example, imply greater support for people with disabilities or health problems so they can be adequately included in the society), combined with increasing employment of women who mainly perform care activities and reducing the size of families (which reduces the capacity of families to provide adequate support to their family members), increased the demand for care services and the importance of the care economy in general. According to the ILO estimates in 2015, 2.1 billion people worldwide needed care services, and by 2030, that number will reach 2.3 billion.

[4] Alexander, P., and Baden, S. (2000). *Glossary on Macroeconomics from a Gender Perspective*. Bridge Institute of Development Studies.
[5] ILO. (2018). *Care Work and Care Jobs. For the Future of Decent Work*. ILO. Geneva.

According to estimates based on time use surveys from 64 countries, the equivalent of full employment (8 hours a day) of two billion people is spent every day in the unpaid care economy. If such services were valued according to labour market standards, i.e. if they were paid in the amount of the minimum hourly wage, these activities would have a share of 9% in the global GDP. According to the same sources, women do three-quarters of this work globally, and there is not a single country where men do this work more than women. According to the findings of the study on the economic value of unpaid care work in the Republic of Serbia,[6] women spend an average of 5.07 hours on unpaid jobs and men spend 2.58 hours, which is 40% less time. Additionally, over 5 years, the average time they spend caring for their own minor children and other family members increased by 2.5 hours per day. The total annual value of unpaid housework in Serbia is estimated at 21.5% of the GDP, which is significantly higher than the global average.

The ILO points out that unpaid care work contributes significantly to economies but also to the well-being of individuals and societies. Despite that, it remains invisible, unrecognised and is not taken into account in decision-making. Transformative policies and policies promoting decent work are crucial for promoting gender equality, and they must be based on the principles of social justice. To make bigger progress in providing decent work conditions within the care economy, the ILO estimates that it will require twice as much investment in the care economy on the global level, which could include 475 million jobs by 2030, out of which 269 million would be new jobs.

The importance of care economy became much more visible during the COVID-19 pandemic, primarily due to the role that the health care sector played in the response to the pandemic, but also due to the heavy burden that was placed upon the informal, non-market care economy, not only due to increased health care needs for ill family members, but also because various elements of the market care economy were transferred to the family due to the closure of kindergartens and schools, the transition to distance learning which required the provision of additional support to children, due to the suspension of the market social care services for the elderly, persons with disabilities, as well as due to interrupted practices of hiring informal paid assistance to support the household and family. The following chapters aim to describe how these changes manifested and how they affected the workload, everyday life and well-being of women and men, and whether they strengthened or initiated changes in gender relations and regimes? [7]

[6] UN Women (2020) *Economic Value of Unpaid Care Work in the Republic of Serbia. Gender Analysis,* UN Women, Government of the Republic of Serbia, Coordination Body for Gender Equality, British Embassy in Belgrade.

[7] Gender regimes are understood to mean "relatively structured relations between men and women, masculinity and femininity, in the institutional and non-institutional environment, at the level of discourse and at the level of practice. This structuring is materialized in different gender roles, different gender identities and different gender representations...". (Blagojević, M. (2002) "Women and men in Serbia 1990-2000: gendering the price of chaos", in Bolčić, S, Milić, A. (ed.) Srbija krajem milenijuma: razaranje društva, promene i svakodnevni život" [Serbia at the end of the millennium: destruction of society, changes and everyday life], ISIFF, Belgrade: 283-314).

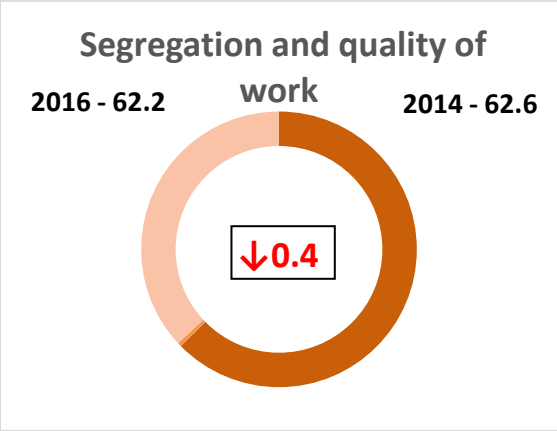
3. SERBIA IN THE GLOBAL PANDEMIC FLOWS AND THE LABYRINTH OF GENDER INEQUALITIES

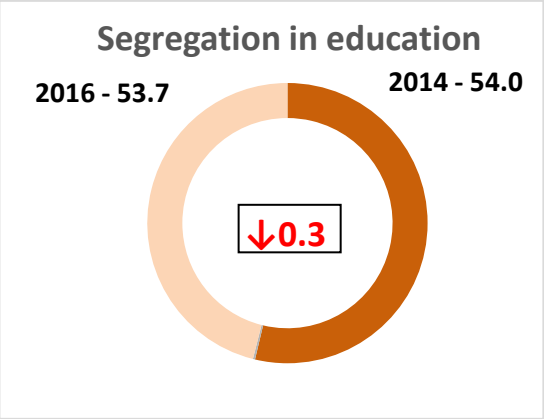
The research findings need to be considered in the context of long-term, structural processes and gender relations, i.e. gender regimes in Serbia, but also the direct circumstances that arose under the impact of the pandemic and the Government measures in response to it, which made the characteristics of these long-term processes form distinctive everyday practices that were gender-specific and made the activities, risks, burdens of women and men not only different but also strengthened the already existing inequalities that always conceal unequal power balance.

It is well known that Serbia is characterized by pronounced gender inequalities. They have been proven and described by numerous scientific and applied studies, and since recently have also been monitored by the Gender Equality Index, a tool used in the EU and candidate countries, which measures the level of achievement and the gender gap in six main policy domains: work, money, time, knowledge, power and health, as well as in two satellite domains – intersecting inequalities and violence against women.[8] According to the latest Gender Equality Index from 2018, Serbia was still a country of pronounced gender inequalities in all domains. These inequalities were significantly more pronounced compared to the EU average, and progress has been made (compared to 2016), although very small. One of the main axes of inequality noted by the Index refers to gender segregation, which is established during education and continues later in the labour market, and precisely this axis of inequality is one of the fundamental ones for understanding the results of this research.

[8] SIPRU (2018) *Gender Equality Index in the Republic of Serbia. Measuring gender equality in the Republic of Serbia 2016,* Belgrade.

Chart 1: Gender Equality Index for Serbia, 2018, for the domain of work, sub-domain of segregation and quality of work and domain of knowledge, sub-domain of segregation in education





Source: SIPRU, Gender Equality Index in the Republic of Serbia 2018.

Inequalities are also present in the domain of power, where despite the progress in the representation of women in the sphere of political participation, there has been little or no progress in the domain of distribution of economic and social power. Inequalities are also visible in the domain of money, because women have lower income than men, and certain groups of women are also exposed to higher risks of poverty. Inequalities in the domain of time show how much time and work women spend in the household and family care, i.e. doing unpaid housework, which is the time usually taken away from their free activities (very important for well-being and personal development), as indicated by the Time Use Survey.[9]

Neither the pandemic nor the Government measures had a positive effect on reducing gender inequalities. On the contrary, they became more prominent in the specific context characterized by high risks of infection, especially among those who cared for the infected or had to perform other jobs with high risks of infection. They also became more prominent in a situation where numerous social services such as education, childcare, care for the elderly, people with disabilities, the ill, were transferred to the family, where these duties are extremely unequally distributed between women and men.

A brief history of the pandemic and response to it

First registered case in the world: China, 7 January 2020[10]
First registered case in Europe: France, 24 January 2020[11]

[9] SORS (2016) *Time Use in the Republic of Serbia in 2010 and 2015,* Belgrade, available at https://rodnaravnopravnost.gov.rs/sites/default/files/2017-01/Kori%C5%A1%C4%87enje%20vremena%20u%20Republici%20Srbiji_0.pdf

[10] World Health Organization (WHO), Coronavirus disease (COVID-19) outbreak. Available at: http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov

[11] World Health Organization (WHO), 2019-nCoV outbreak: first cases confirmed in Europe. Available at: http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/01/2019-ncov-outbreak-first-cases-confirmed-in-europe

WHO declares the pandemic: 11 March 2020[12]
First registered case in Serbia: Subotica, 6 March 2020[13]
State of emergency declared: 15 March 2020[14]
Number of cases and deaths on 11 April 2020 (start date of the first quantitative research): total number of cases is 3,380, and total number of deaths is 74.[15]
Number of cases and deaths on 23 April 2020 (end date of the first quantitative research): total number of cases is 7,276, and total number of deaths is 139.[16]
Number of cases and deaths on 13 June 2020 (start date of the second quantitative and qualitative research): total number of cases is 12,251, and total number of deaths is 253.[17]
Number of cases and deaths on 25 June 2020 (end date of the second quantitative and qualitative research): total number of cases is 13,372, and total number of deaths is 264.[18]

The response to the pandemic in Serbia followed the "restrictive model", which included a package of measures such as closing the borders, suspension of public transport to reduce the mobility of people, relatively strict restrictions on movement with periods of curfew and lockdowns lasting for several days. Measures also included the closing of all stores except stores selling food, relocation of work from offices to homes of employees, except in cases when it is not possible or when it is necessary to provide basic services, closing of educational institutions at all levels, abolition of public and social services in direct contact with citizens, etc.

This led to a significant reduction in business volume for most companies, while fewer came under pressure from increased work and increased demand, such as medical institutions, protective equipment and medical device factories and pharmaceutical distribution, but also delivery companies,

[12] World Health Organization (WHO), Health emergencies, available at: http://www.euro.who.int/en/health-topics/health-emergencies

[13] Information from the official website of the Ministry of Health of the Republic of Serbia and the Institute of Public Health. Available at: https://covid19.rs/%d0%bf%d0%be%d1%82%d0%b2%d1%80%d1%92%d0%b5%d0%bd-%d0%bf%d1%80%d0%b2%d0%b8-%d1%81%d0%bb%d1%83%d1%87%d0%b0%d1%98-%d0%ba%d0%be%d1%80%d0%be%d0%bd%d0%b0%d0%b2%d0%b8%d1%80%d1%83%d1%81%d0%b0-%d1%83-%d1%81/

[14] ING- PRO, Decision on declaring the state of emergency, available at: https://www.propisi.net/odluka-o-proglasenju-vanrednog-stanja/

[15] Information from the official website of the Ministry of Health of the Republic of Serbia and the Institute of Public Health. Available at: https://covid19.rs/%d0%b8%d0%bd%d1%84%d0%be%d1%80%d0%bc%d0%b0%d1%86%d0%b8%d1%98%d0%b5-%d0%be-%d0%ba%d0%be%d1%80%d0%be%d0%bd%d0%b0-%d0%b2%d0%b8%d1%80%d1%83%d1%81%d1%83-covid-19-11-04-2020-%d1%83-15-%d1%87%d0%b0%d1%81/

[16] Information from the official website of the Ministry of Health of the Republic of Serbia and the Institute of Public Health, available at: https://covid19.rs/%d0%b8%d0%bd%d1%84%d0%be%d1%80%d0%bc%d0%b0%d1%86%d0%b8%d1%98%d0%b5-%d0%be-%d0%ba%d0%be%d1%80%d0%be%d0%bd%d0%b0-%d0%b2%d0%b8%d1%80%d1%83%d1%81%d1%83-covid-19-23-04-2020-%d1%83-15-%d1%87%d0%b0%d1%81/

[17] Information from the official website of the Ministry of Health of the Republic of Serbia and the Institute of Public Health, available at: https://www.zdravlje.gov.rs/vest/347976/informacija-o-novom-korona-virusu-na-dan-5-jun-2020-godine-u-15-casova.php

[18] Information from the official website of the Ministry of Health of the Republic of Serbia and the Institute of Public Health. Available at: https://www.zdravlje.gov.rs/vest/348169/informacija-o-novom-korona-virusu-na-dan-15-jun-2020-godine-u-15-casova.php

platforms for online communication, etc. These changes affected the level of activity and employment, but also the quality of employment and working conditions.

The media report numerous analyses of economic effects of the pandemic and predictions of economic and social consequences. The truth is that they cannot be fully predicted at the moment. In the Monitor of global labour market developments during the COVID-19 pandemic from 29 April 2020, the International Labour Organization (ILO) estimates that the number of working hours globally decreased by 4.5% in Q1 of 2020, which is the equivalent of 130 million full-time jobs. The number of global working hours is expected to be 10.5% lower in Q2 of 2020 than in the pre-crisis quarter, which is equivalent to 305 million full-time jobs. The largest losses in this regard are projected for North, Central and South America (12.4%), as well as for Europe and Central Asia (11.8%) (ILO, 2020: 1). Vulnerable categories in the labour market are particularly at risk. This primarily includes informal employees, with their number in the world being 1.6 billion according to ILO estimates. It is estimated that the relative poverty rate in this category will increase by 34%. (ILO, 2020: 2).

4. CARE ECONOMY IN THE SERVICES MARKET DURING THE PANDEMIC

4.1 Impact of the pandemic on the workforce employed in the formal and informal care economy sector

When the focus is on the market care economy, it includes the education, health care and social protection sectors, as well as domestic assistance activities provided with formal or informal cash or in-kind compensation. However, not all employees in these sectors are care workers. For example, administrative staff in health care cannot be considered care workers and although they work in the care economy sector, their status and job characteristics are significantly different. That is why the contingent of employees in the care economy in this analysis is defined based on occupations and sectors, so that it includes only those who perform care work (direct or indirect care) in sectors belonging to the care economy (education, health care, social protection and domestic assistance). Thus, for example, psychologists in schools and health services are included in the group of care workers, and psychologists in marketing are excluded from this contingent. It is important to note that cleaners, cooks, i.e. persons performing indirect care activities, are included in the contingent of care workers only if they work in the sectors of the care economy. So, for example, cleaners in health care are included, and those who work in finance are excluded from the care economy. We should have it in mind that occupations that provide direct care also have an additional dimension of emotional engagement, which doesn't necessarily exist in occupations providing indirect care. Nevertheless, it was decided that those providing indirect care in the sectors of the care economy should be included in the contingent of care workers.

These criteria follow the methodology applied in the ILO global study[19] on care economy employees. Accordingly, the contingent of employees in the market sector of the care economy included the following categories of employees (formally or informally employed):

1) Employees in occupations of direct or indirect care in the education sector (preschool/school teachers, professors, pedagogists, psychologists, cleaners, cooks, etc.);
2) Employees in occupations of direct or indirect care in the health care sector (medical staff, pharmacists, cleaners, cooks, etc.);
3) Employees in occupations of direct or indirect care in the social protection sector (social workers, psychologists, pedagogists, counsellors, medical staff, caregivers, medical staff in residential institutions, cleaners, cooks, etc.);
4) Persons providing services to households for compensation (cleaning, child care, care for the elderly, the ill).

According to the data from the research on the impact of the COVID-19 pandemic on employment in Serbia[20], the contingent of employees in the sample that includes the four mentioned categories

[19] ILO (2018) *Care Work and Care Jobs. For the Future of Decent Work*. ILO, Geneva.

accounted for almost 18% of all employees in the non-agricultural sector (17.6%).[21] More than half (52.1%) were employed in education, while 41.9% were employed in the health care and social protection sector. It is a predominantly female workforce, which makes up 78.7% of employees in the care economy.

Employees in the care economy were significantly less affected by job losses due to the pandemic and the declared state of emergency. According to the data from the same research, in April 2020, during the most restrictive measures, 4.3% of employees in this sector lost their jobs, while the job loss rate among other employees was 9.1%.[22] This is not surprising, given that this is precisely the workforce in the sectors that were at the forefront of the pandemic response, especially when it comes to the health care sector in which the labour needs were even increased.

Given the small number of persons in the sample who were employed in the care economy sector and who lost their jobs in April (only 12), it is not statistically reliable to study the characteristics of this group in greater detail. The most common reason for losing the job is, as in the general sample, being laid off because the company suspended its activities due to Government measures in response to the pandemic, followed by the expiration of a short-term contract, with a new contract not being offered.

Employees in the care economy are by no means a homogeneous group. There are significant differences in the labour market status between those employed in the education, health care and social protection sectors and those who perform mostly informal work for private households[23]. However, there were also very pronounced differences between the employees in the first three sectors in the pandemic conditions. A large share of employees in the care economy switched to working from home during the pandemic and state of emergency, and these are mainly employees in the education and social protection sectors, while health workers continued to perform their work at their workplace, just like before the pandemic. One in five employees worked shorter hours or had a reduced number of shifts, while 10.7% worked longer hours than usual or had a larger number of shifts. One part of the employees was reassigned to another job, to another facility (Chart 2).

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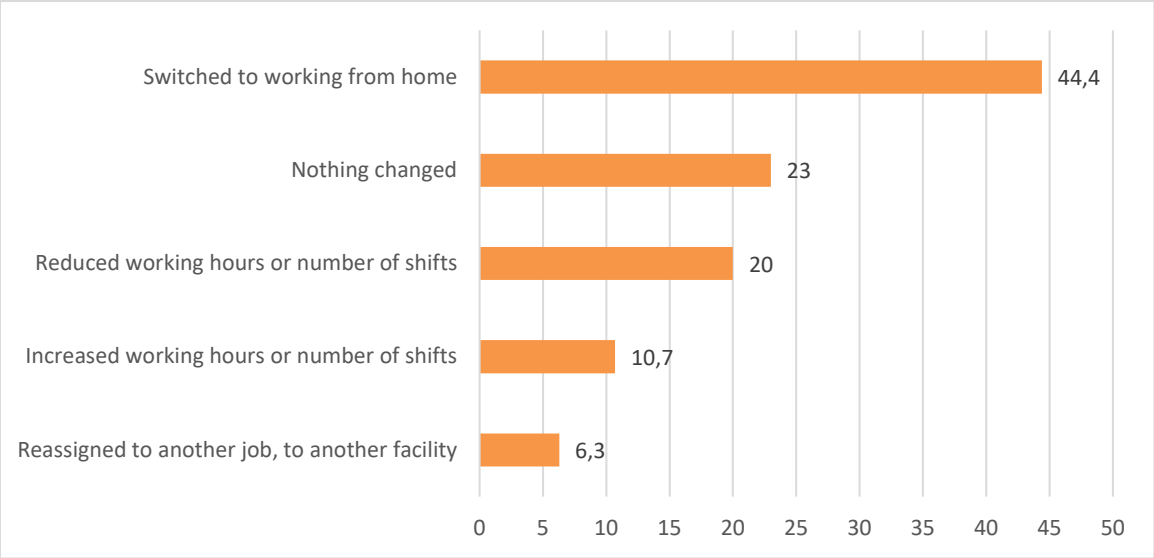
[20] SeConS (2020) *Impact of the COVID-19 pandemic and measures for its prevention on employment and working conditions of women and men in Serbia*, UN Women, Belgrade.

[21] It is a sub-sample of 282 people employed in these sectors.

[22] "Employed persons are persons who have, during at least one hour in the reference week, performed paid job (in cash or in kind), and persons who have a job but were absent from it during that week. Employed people, in addition to people who have established employment and work in a company, institution or another type of organization or work as private entrepreneurs, include individual farmers, assisting household members, as well as persons who have performed some work they independently found and contracted (orally or in writing) without formal employment and for whom that work represented the only source of livelihoods. Therefore, the Survey does not take into account the formal status of the person being interviewed, but the employment status of that person is determined based on the real activity they performed in the reference week." (SORS, LFS methodological guide, p. 2, accessed on 30 May, 2019 at https://publikacije.stat.gov.rs/G2017/Doc/G201720107.docx)

[23] There were very few such persons in the sample for the analysis to be conducted, only 7 cases.

Chart 2: Changes in the working conditions of employees in the care economy



Source: SeConS, FES, UN Women, Research on the impact of the COVID-19 pandemic on employment of women and men in Serbia, April 2020.

When it comes to those who switched to working from home, in 46.2% of cases the respondents said that they had an equal amount of work at home as in the workplace. One in five (20%) said that they worked more because there was more work, and it was mostly the teaching staff who had to adapt to the new, digital class conditions. On the other hand, 17.6% worked less than usual because they had less work, and again, those are mostly employees in education. While 5% of respondents said that they managed to do more at home than at the workplace because they were more efficient, 13.4% said that they managed to do less than usual because they were less efficient. Almost one in four of those who switched to working from home (24.4%) did not have a suitable place in the living space where they could adequately commit to work, and 5% did not have the appropriate technology, such as a computer, laptop, the internet, etc. Nearly 40% worked more often at night to be able to finish the work or to be able to work in peace. Nearly one in three (31.9%) felt frustrated because the work intruded on their privacy, disrupted family life, and 16.8% felt frustrated because family members interfered with their work.

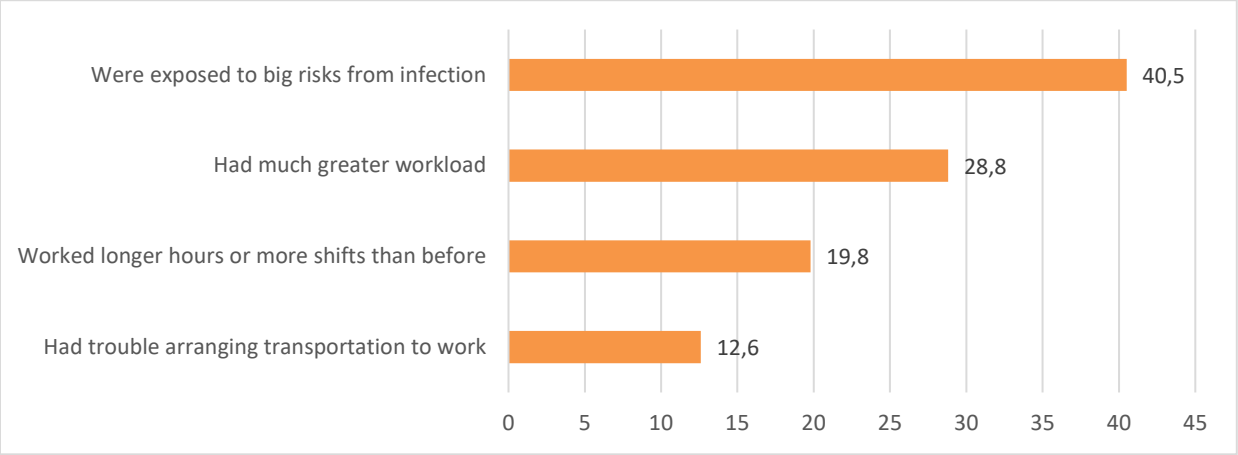
The findings from the in-depth interviews showed that employees who switched to working from home during the pandemic faced difficulties in doing their job that they have not had before. Employees in kindergartens pointed out that it was demanding to design daily activities concerning childcare and to communicate them to parents. They had the obligation to design creative exercises for the development of children's motor and cognitive abilities, which were communicated to parents through a Viber group. The condition was that these activities be more complex than drawing and ordinary play, they were not mandatory for the parents and there was no supervision over their implementation and results, but the employees had the obligation to design them regularly. Respondents said that this type of activity in the changed work environment was a source of stress and frustration.

Throughout the day, you are preoccupied with what you can come up with that is interesting enough and can be done at home. Somehow you feel like the work is always there.

Preschool teacher in Belgrade, 50 years old

Employees who continued to work at their workplace outside their home faced increased health risks, but also difficulties in arranging transportation to work when public transport was suspended, as well as difficulties in organizing family life if they had small children, due to the closure of kindergartens and schools. There is a significant share of those who were exposed to high risks of infection, and those are most often health workers. More than one in four had a far greater workload, almost one in five worked longer hours or had more shifts than usual, and there is a significant number of those who had difficulties arranging transportation to and from work (Chart 3).

Chart 3: Some working conditions of employees who continued working at their workplace



Source: SeConS, FES, UN Women, Research on the impact of the COVID-19 pandemic on employment of women and men in Serbia, April 2020.

In-depth interviews with women employed in the care economy showed that working conditions changed significantly. Medical workers, i.e. nurses and doctors, continued doing their jobs, but the shifts were extended and they were required to use the full protective equipment at all times. Such working conditions led to employees being under stress and in fear, caused mostly by uncertainty regarding the general health situation.

"We didn't know what was going on exactly, what type of respiratory infection it was and how one can contract it. In my work, I have encountered many similar cases, but this was different."

General practitioner from Kraljevo, 51 years old

"It was uncomfortable when they came to test us, it was very stressful. No matter how careful we were, you never know it if everything is okay. I was stressed, but I tried to keep it to myself and protect all the people around me. I was not angry and dissatisfied, but there was fear. I tried to be calm, not to panic... We were afraid because we didn't know where it was coming from and what it actually was. "

Nurse in a nursing home for the elderly from Belgrade, 28 years old

In the vast majority of cases (94%), employees in sectors included in the care economy said that the employer had provided them with adequate personal protective equipment, such as masks, face shields and gloves. In 26.2% of cases, the employer redistributed the work in shifts for safety reasons, and in 7.1% of cases, the employer reorganized the work so that employees can work at a safe distance from one another in the same space. However, 7.1% said that they did not have enough protective equipment. The vast majority of respondents always used protective equipment (93%), while 7% used it sometimes, but not always.

Key findings

- The care economy in its market segment includes social services in the education, health care and social protection sectors, as well as the most common informal but paid services provided to households.
- The care economy is a segment of the economy that predominantly employs female workforce.
- In the context of the pandemic and the state of emergency measures, the heterogeneity of the sector was expressed, with polarized effects: in the sector of education and social protection, the working conditions changed so that employees mostly switched to working from home and were more protected from health risks, while employees in the health care sector were at the front line of the pandemic response and exposed to increased health risks.
- Among the employees in education, there is a noticeable polarization between those who were exposed to a higher workload due to the transition to new, digital forms of work, and those who reported a reduced workload due to less work. Obviously, the transition to digital and remote forms of education did not equally affect all employees in the education sector, i.e. all teachers.
- Working from home did not suit everyone, some employees did not have the adequate working conditions, either due to the lack of workspace, work technology or difficulties related to the work intruding on the family privacy or the burden of family obligations which made work suffer. In any case, these challenges created frustrations for a significant share of employees who switched to working from home.
- The work that employees continued to perform at their usual workplaces was associated with high health risks and increased workload, and the difficulties associated with organizing transport to work due to the suspension of public transport and organizing child care with the closure of kindergartens and schools additionally contributed to the stress.
- Most employees had protective equipment provided, but a small number reported that they did not have completely adequate protection or that they did not use it regularly.
- In a broader perspective of the effects of the pandemic on employment, the burden of the response to the pandemic was borne especially by women employed in the health care sector segment of the care economy. Employees in this sector, along with employees in other occupations that were at the forefront of health risks, such as supermarkets, which are also dominated by women, endured the greatest workload in the adverse working conditions during the state of emergency.

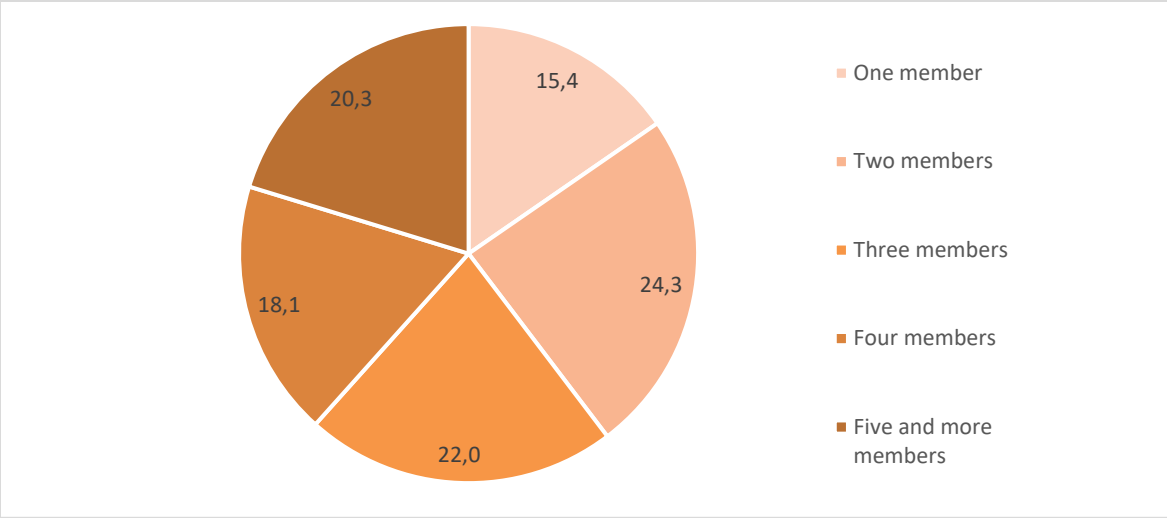
4.2 Impact of the pandemic on the beneficiaries of the care economy

The picture of the situation regarding the needs for care services in households and the way they were met during the pandemic was obtained based on the research conducted in Serbia within the UNFPA and UN Women regional study of the impact of the COVID-19 pandemic on empowerment of women and men. Women and men from the sample live in households with an average size of 3.2 members,

which is slightly above the average for Serbia according to the last population census[24]. Around 15% of respondents live alone. They are mostly elderly people: more than half (54.7%) are older than 65, 15.9% are between 55 and 64 years old, and 29.3% belong to the younger and older population (29.4%). This age structure of single households reflects the situation indicated by numerous sociological researches[25], according to which single households are most often households of the elderly people and not young people who are starting their independent life. Due to the difficulties related to the employment of young people and ensuring housing, young people delay independence and live in households with their parents longer than their peers in some other European countries. However, from the point of view of the needs for care economy services, this age structure of single households indicates a significant need for these services outside the household (either from the service market or from other households of informal support networks), due to the lack of potential to provide care within the household.

Almost one in four respondents lives in a household with two members. In this case, too, the share of the elderly population living in this type of household is high: 36.4% are older than 65, 27% are aged between 55 and 64, while there is only 12.8% of younger people (18-34) living in such households, and the remaining 13.8% are middle-aged people (35-54). On the other hand, middle-aged people most often live in medium-sized (3-4 members) or larger households (5 or more members). For example, in the group of households with 3-4 members, the share of persons aged 65-54 is 46.5%, and in the group of households with 5 or more members, they make up 43.9%.

Chart 4: Respondents' households, by the number of members, in %



[24] According to the population census from 2011 in Serbia, the average household size was 2.88 (SORS. (2011), Census data – Excel spreadsheets. Available at https://www.stat.gov.rs/media/3761/2_domacinstva-prema-broju-clanova-po-naseljima.xls)

[25] SORS. (2017). Women and men in the Republic of Serbia, Belgrade, Available at https://publikacije.stat.gov.rs/G2017/Pdf/G20176008.pdf

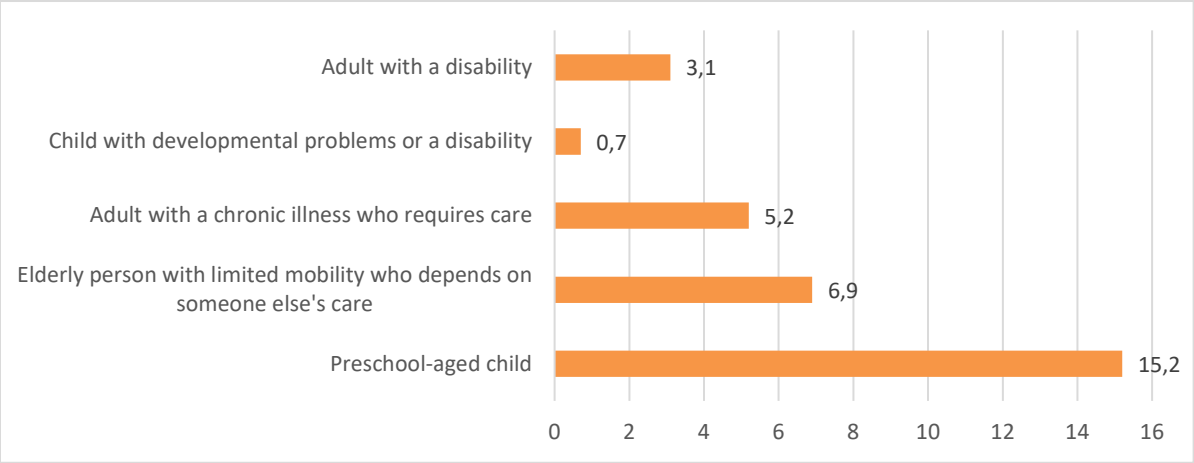
Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

The needs for care services among the households in the sample are conditioned by whether there are young children, the elderly who need support, people with disabilities or ill people in the household. When we take into account both the needs for care of preschool children and the needs for special care of household members who need it for various reasons, the sample includes a total of 25.9% of households that needed care economy services only in the domain direct care services for children, the elderly, the ill, people with disabilities, or health care and social protection services during the pandemic.

In the survey sample, households with small children (0-6) make up 15.2%, and households with children aged 7-17 make up 19.3% of all households. In 29.3% of households, there is at least one person aged 65+. Of course, this does not mean that all households with elderly people have needs for care services. On the contrary, younger elderly people (65-74) are often a significant source of social support to the family, rather than care recipients.

The sample identified 12.5% of households in need of some form of special care, either because they have an elderly or disabled person who depends on someone else's care (6.9%), or a person with a severe chronic illness that requires someone else's care (5.2%), a child with a disability (0.7%) or an adult with a disability (3.1%).

Chart 5: **Households according to the presence of members with special needs for care**



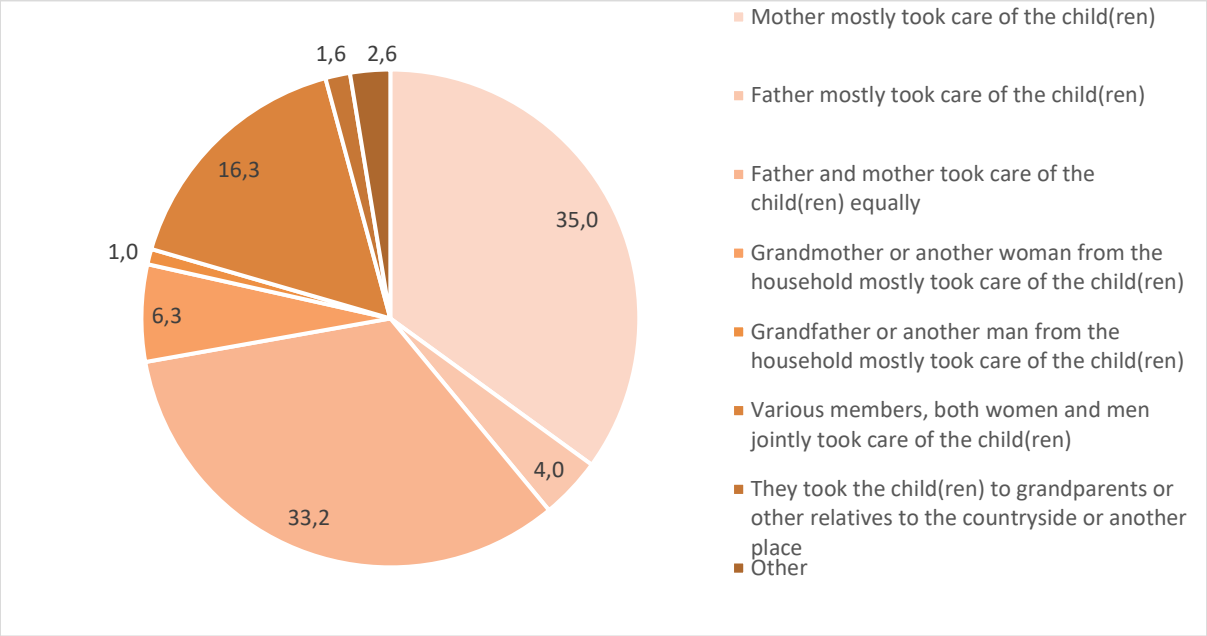
Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

Care for young children

Before the pandemic and the declaration of the state of emergency when all kindergartens and schools were closed, 60.3% of children aged 0-6 went to kindergarten or attended compulsory preschool education. With the outbreak of the pandemic, the care of young children was completely transferred to the family, but it was not equally distributed among the parents, and in some cases, the care was mainly the responsibility of grandparents or other persons in the household (Chart 6). In more than one in three of the households, the mother took care of the young children the most, in one in three cases the mother and father did it together, followed by joint care shared by different members of the household,

including women and men. Fathers taking over the care was an extremely rare modality among the households from the sample.

Chart 6: Division of responsibility for the care of children aged 0-6 during the state of emergency, in %



Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

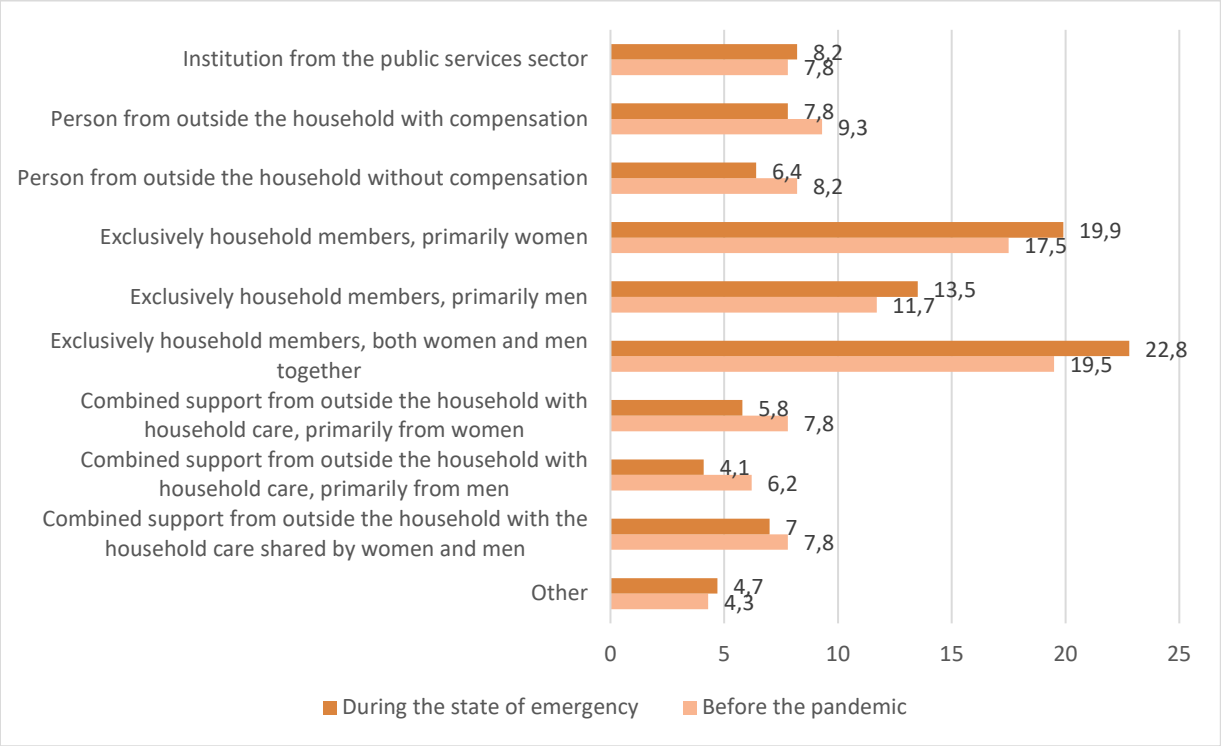
Care for the elderly with limited mobility

Before the outbreak of the pandemic and the introduction of the state of emergency, support for the elderly with limited mobility was most often provided exclusively within the household – in 48.7% of cases. Reliance on institutions and organizations in the provision of care was recorded only in a small number of households (7.8%), a person from outside the household was hired in 9.3% of cases with compensation and in 8.2% of cases without compensation, and in slightly more than one in five households (21.8%), care for the elderly was organized through a combination of persons from inside and outside of the household (Chart 7). Research data indicate that the effect of the pandemic and the state of emergency was manifested primarily in the lower reliance on external support and greater reliance on own resources in the household, except in the case of institutional support (the number of households that resorted to institutional solutions after the outbreak of the pandemic increased slightly, but the difference is very small, 0.4%). All other modalities involving reliance on persons from outside the household showed a decline. So, while 39.3% of households were hiring a person from outside the household before the pandemic, either as the main way of organizing care or in combination with care provided by household members, 31.1% of households were still doing it after the outbreak of the pandemic and the declaration of a state of emergency. At the same time, the share of households that exclusively provide care for the elderly within the household increased from 48.7% to 56.2%.

The findings of this research are consistent with earlier findings from various studies that examined the division of responsibilities in the household in the care economy. According to these studies, there are clear gender, long-term patterns of division of responsibilities, which indicate that women provide care for young children significantly more than men, while the gender imbalance in the care for the elderly is

less pronounced, i.e. men are more involved in the care for the elderly, who are often their parents. The normative and value background of such patterns has not been examined in greater detail so far, but it can be assumed that the care for parents is more readily accepted by men than child care, because the responsibility for parents is more individualized (not shared, according to the principle that everyone has the largest share of responsibility for their own parents), while the child care, which should be shared, is easily transferred through the patriarchal normative and value system to become the primary responsibility of women.

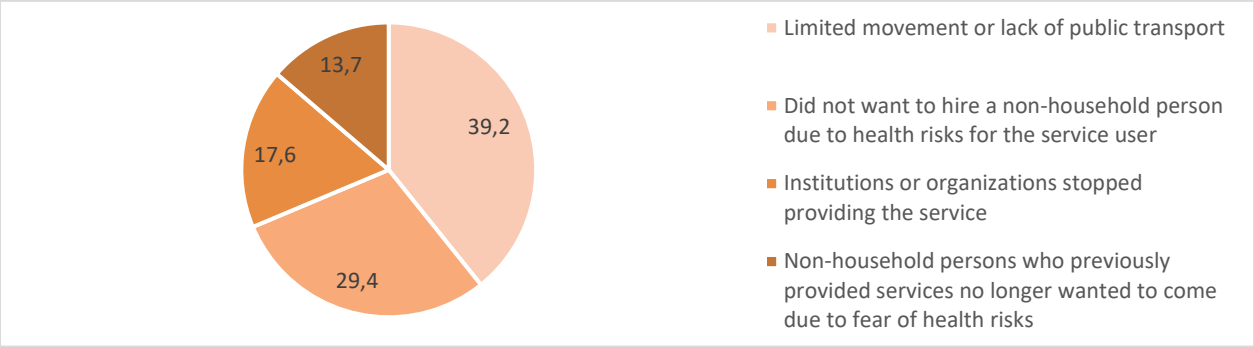
Chart 7: Modalities of care for the elderly with limited mobility in the household, who depend on someone else's care, before and after the outbreak of the pandemic, in %



Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

The reason for changes in the provision of care for the elderly with limited mobility in the household was most often that persons who provided services from outside the household were no longer able to do so due to limited movement or lack of public transport (39.2%), because household members no longer wanted to hire a non-household person due to health risks for the service user (29.4%), because institutions or organizations did not provide services during the state of emergency (17.6%), or because non-household persons who previously provided services no longer wanted to provide services due to fear of health risks (13.7%).

Chart 8: Reasons for changes in the modalities of providing care for the elderly with limited mobility in the household after the outbreak of the pandemic, in %



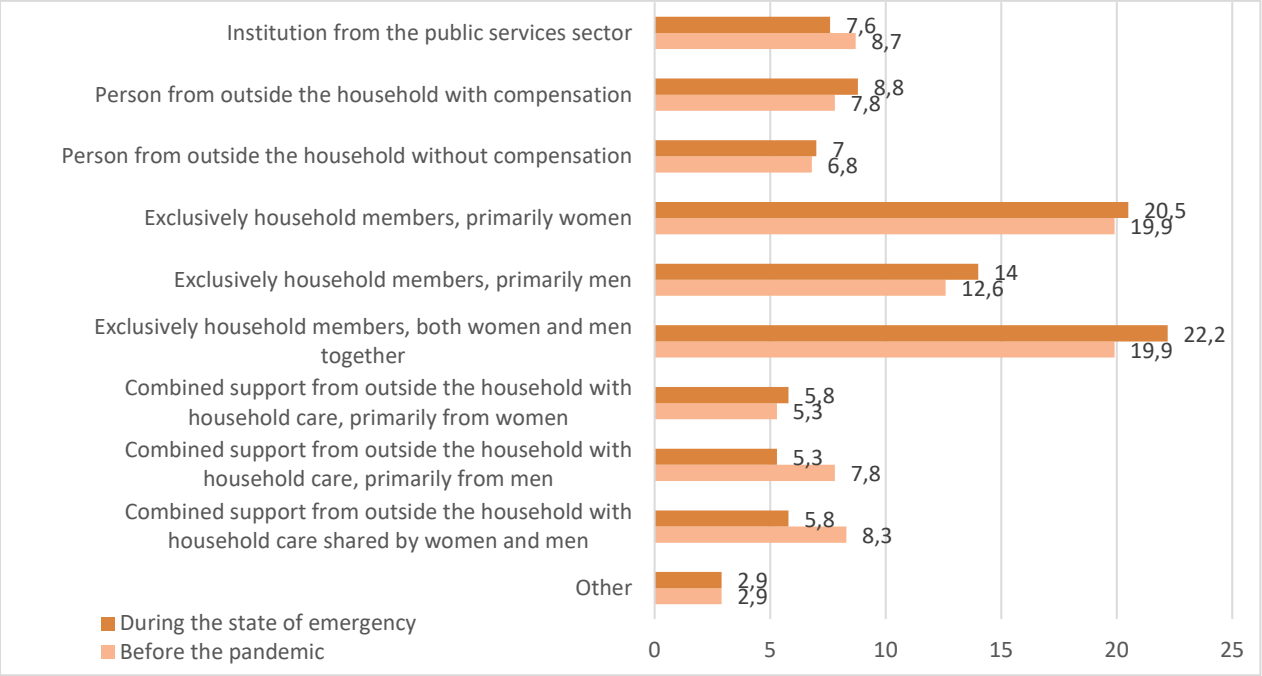
Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

In more than half of the cases, the described changes in the provision of care for the elderly with limited mobility increased the workload of household members, but equally for men and women (52.9%). In 29.4% of cases, women were more burdened in the household, and in 17.6% of cases, the burden on men was increased. After the state of emergency was lifted, most households (83.5%) returned to the way they used to meet the needs of caring for the elderly before the pandemic. A smaller share of households, however, kept the patterns of care from the state of emergency.

Care for adults with severe chronic illness

Patterns of care for chronically ill adults who require someone else's care are very similar to patterns of care for the elderly (Chart 9). In this case, too, the care before the pandemic was most often provided exclusively within the household (in 52.4% of cases). 8.7% of households relied on the support of institutions from the public services sector, 14.6% of households relied on the support of persons from outside the household with or without compensation, and 21.4% relied on combined support from outside and within the household. With the outbreak of the pandemic, the share of households that relied on institutional support decreased by 1.1 percentage points, the share of households that hired people from outside the household in any modality decreased from 36% to 32.7%, although the trend is not consistent for all modalities. The share of households that relied exclusively on the support of persons from outside the household, whether with or without compensation, increased slightly, so did the share of households that practised this in combination with care provided by women within the household, while there was a decrease in the share of households that combined the care of an externally hired person with the care provided by men within the household or several people together. This indicates that men in the household have taken on somewhat greater responsibility in caring for chronically ill members. At the same time, the share of households that provide care for the chronically ill only with their own resources increased from 52.4% to 56.7%, and again, this increase is mostly reflected in the modality of care provided mainly by men, or women and men from household together (Chart 9).

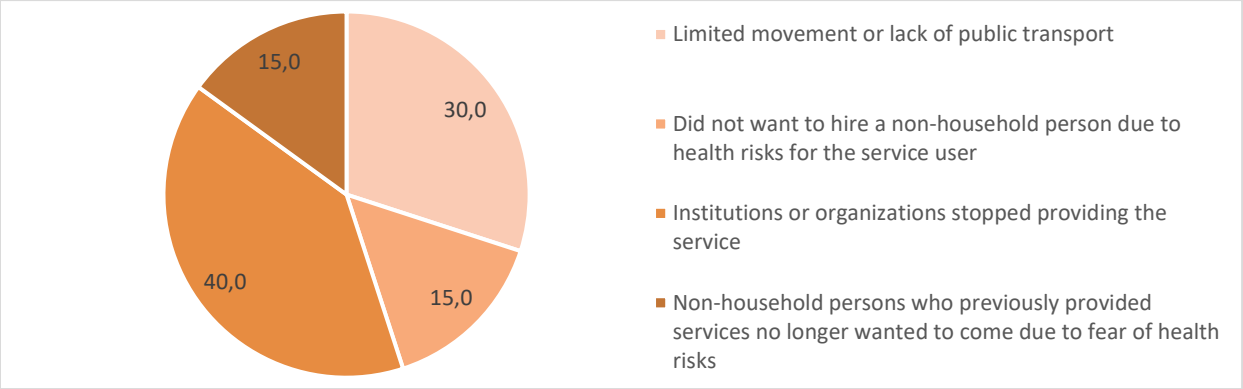
Chart 9: Care for adults with a severe chronic illness that require someone else's care according to who provided care before the pandemic and during the state of emergency, in %



Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

In this case, the most common reason for changes in the modalities of providing care is the suspension of work of institutions that were providing the service, followed by movement restrictions and the suspension of public transport, and then unwillingness of households or hired persons to expose themselves to health risks, in equal proportion (Chart 10).

Chart 10: Reasons for changes in the modalities of providing care for people with a severe chronic illness in the household after the outbreak of the pandemic, in %



Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

Changes in the modalities of care, according to the respondents, most often burdened women and men in the household equally (42.5%), but they also burdened women (30%) somewhat more often than men (27.5%). In 90.1% of cases, they returned to the earlier way of providing care after the state of emergency was lifted.

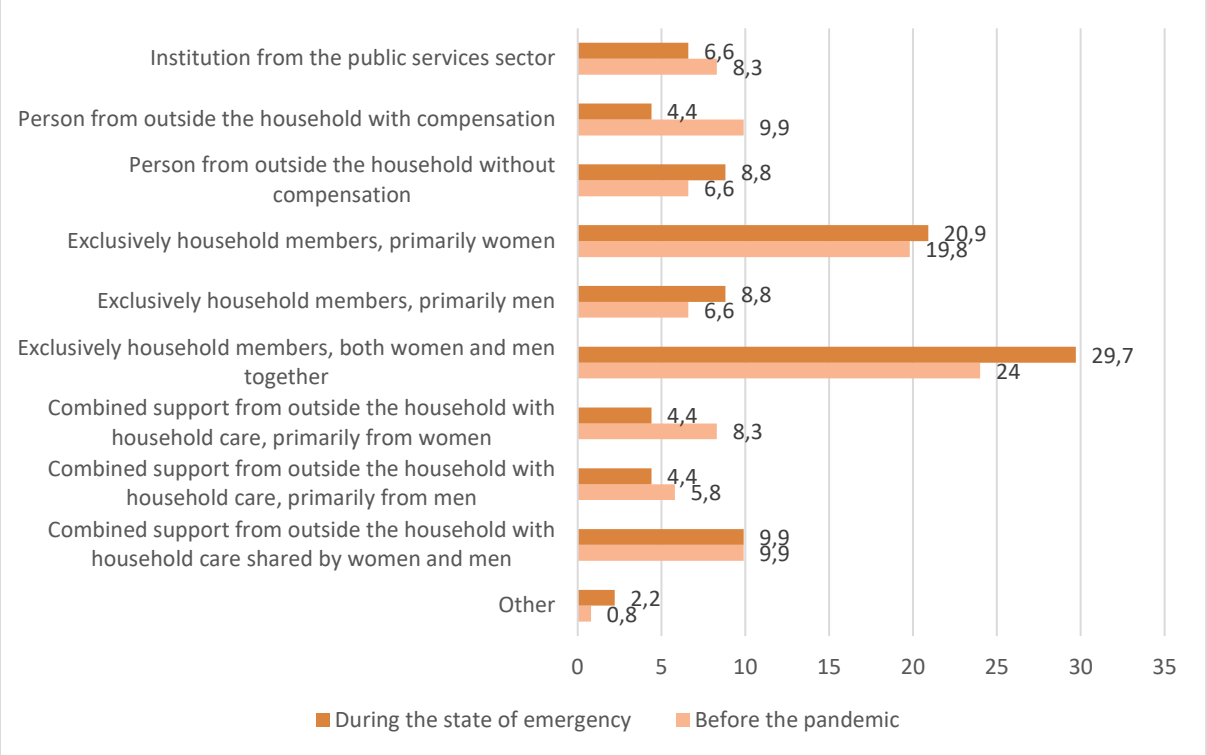
Care for children with disabilities

Due to the small number of cases that reported the need for care for children with disabilities (only 14 cases), it is not possible to conduct an analysis like for other forms of care. The basic, qualitative insights into these data, which do not allow statistical generalization, indicate that before the pandemic, care was provided mainly within the household or in combination with a person hired from outside the household, and that during the pandemic, care was almost completely transferred to households. The burden was mainly on women.

Care for adults with disabilities

Before the pandemic, care for adults with disabilities was most often provided exclusively within the household (50.4%). 8.3% of households relied on the support of public services, 16.5% of households relied on the predominant support of persons from outside the household, and in 24% of households, the care was being provided through a combination of internal and external resources. With the outbreak of the pandemic, the share of households that rely on institutional support and paid assistance from outside the household decreases and the share of households that provide support exclusively with internal resources increases (from 50.4% to 59.4%), along with reliance on persons from outside the household, but those providing non-market support (from 6.6% to 8.8%), without compensation (Chart 11).

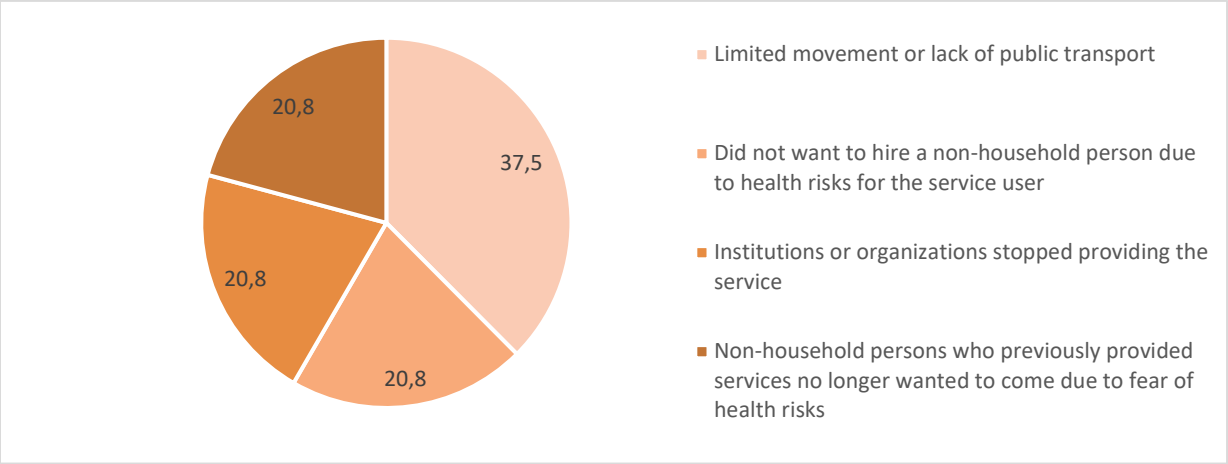
Chart 11: Care for adults with disabilities before the pandemic and during the state of emergency, in %



Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

The most common reasons for changes in the modalities of providing care were movement limitations during the state of emergency as a result of the curfew and the suspension of public transport, while the other reasons were equally represented – closure of institutions, fear of health risks among both the service users and providers (Chart 12).

Chart 12: Reasons for changes in the modalities of providing care for adults with disabilities in the household after the outbreak of the pandemic, in %



Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women

Shifting the focus to the household in the care for persons with disabilities most often increased the burden on women in the household (in 37.5% of cases), somewhat less often the burden was equally increased for women and men in the household (29.2%) and the burden was the least for men (25%). After the state of emergency was lifted, most households (88.3%) returned to the modalities of providing care from before the outbreak of the pandemic

Key findings

- Around one in four households in the sample needed various services of care economy in the period before and after the outbreak of the pandemic, such as care for preschool children, care for elderly people with limited mobility in the household, severely chronically ill people, children with disabilities and adults with disabilities.
- The modalities of meeting the care needs are very similar when it comes to people with various health problems in the household: care is usually provided exclusively within the household, and in a somewhat smaller number of cases, the needs are met either by hiring persons from outside the household (either paid or unpaid) or through a combination of hiring persons from outside the household and internal resources.
- The pandemic led to lower reliance on external services and higher reliance on the household's own resources in providing care, thus increasing the burden on household members.
- The increased burden within the household is not distributed equally and in summary, the findings show that when it comes to small children and people with disabilities, women undoubtedly bear greater burdens. Men are somewhat more involved in the care for the elderly and chronically ill, which results in burden being shared between women and men, i.e. the gap in the burden is somewhat smaller, although we should not neglect the fact that the burden is systematically higher for women than men in these cases.

- The reasons for changes in care modalities are related to movement restrictions, suspension of work of public sector institutions/organizations that provide services, and fear of health risks among both service users and providers.
- Most households went back to the “old” modalities of service provision after the state of emergency was lifted, but the “new”, “pandemic” modality of care provision was retained in a minority of households.

5. CARE ECONOMY AS REPRODUCTIVE ECONOMY

Although some forms of work involve the same activities, they are classified in "productive" or "reproductive" economy depending on where and under what conditions they are performed. Meal preparation, baby feeding, patient care, when provided in the sector of market services (whether public or private services) are classified as "productive" economy and their value is calculated in national accounts. When the same activities are provided within the household, their value is not recognized and visible, because these activities are classified as "reproductive", i.e. as those whose function is the reproduction of the family, individuals. At the same time, their value for the reproduction of the workforce and the entire society is completely neglected. These activities are not covered by national accounts. Even after the revision of the methodology for national accounts which expanded the scope of activities whose value is calculated in the gross domestic product in order to also include non-market-oriented household production activities, the area of services provided in the household, which includes direct and indirect care services, still remained excluded from the calculation of national accounts.[26] However, we also should not neglect the fact that the work in the market segment of the care economy is undervalued, wages are relatively low despite difficult working conditions and great responsibilities. The average monthly salary in the health care and social protection sector in February 2020 amounted to 61,044 dinars, while in the education sector it was 59,683 dinars. The average salary in both sectors is only slightly higher than the average for all salaries in Serbia, which for the same period amounted to 58,132 dinars, and is as much as two times lower than in the sector of computer programming and consulting (137,898 dinars), although the educational structure of employees in all three sectors very similar.[27] But while the care economy employs mainly women, the computer programming and consulting sectors employ mostly men, indicating that sectors in which women make up the majority of employees are less valued in the labour market. In primary health care, the net monthly salary for nurses with 4 years of secondary education in February 2020 amounted to 39,727 dinars[28], and for nurses with additional 5th year of training it amounted to 45,375 dinars[29], while in secondary and tertiary health care for employees with 4 years of secondary education it amounted to 42,819.18 dinars[30], and for those with undergraduate degrees, salaries were slightly higher, 48,341.18 dinars[31], which is much lower than the average salary in Serbia in February 2020, which amounted to 58,132 dinars.[32]

It is this unpaid housework and family care that represent the area of very pronounced gender inequalities in Serbia. Various studies have pointed to these inequalities and shown that changes in this

[26] More about it in Babović, M. (2020) *Who pays the price of unpaid housework and how the European and national left treat this issue?, Antropologija,* (in preparation).
[27] SORS. (2020), *Earnings statistics,* (2020). Available at: http://data.stat.gov.rs/Home/Result/2403040102?languageCode=sr-Cyrl
[28] Istinomer. Salaries of nurses. Available at https://www.istinomer.rs/izjava/plate-medicinskih-sestara-od-50-000-do-54-000-dinara/
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] SORS. (2020), *Earnings statistics,* (2020). Available at: http://data.stat.gov.rs/Home/Result/2403040102?languageCode=sr-Cyrl

aspect of gender roles are extremely slow and that women mostly bear responsibilities and burdens of doing housework, but also caring for children, while in the care for the elderly, the burden is somewhat less disproportionate. The pandemic and the state of emergency abruptly and significantly changed the everyday lives of households. According to the findings of the research on the impact of the COVID-19 pandemic on employment from April 2020, one in four of all employees (24.7%) switched to working from home[33] where it was necessary to find a new way to reconcile work with family care, in the conditions when all family members, including minor children, were at home all the time. For those who continued going to work, challenges arose in terms of the organization of care for children and the elderly, which was fully transferred to the family, as they needed care during working hours. However, judging by the findings of the same research, even such drastic changes in work and family life mostly did not manage to start changing the very strong, long-lasting patterns of division of housework and care for family members.

Data on the division of unpaid housework (indirect care activities), before the outbreak of the pandemic, show that in most households in Serbia women still have the predominant responsibility for doing this everyday housework, such as cooking, washing the dishes, laundry, ironing, cleaning. We should have it in mind that households in which these jobs are predominantly performed by men are actually mostly single households of men or households of single fathers with children, and a very small percentage are households such as married couples with children, without children or multifamily households. So, in most cases, men take on the responsibility and the greatest burden only when there are no women in the household. Also, there is a minority option in which women and men from the household equally share responsibilities and burdens for performing these tasks, and this mainly varies depending on the task, so, for example, men are less involved in ironing, cooking and doing laundry than washing the dishes and cleaning.

When it comes to caring for the elderly and children (direct care activities), it can be observed that the gender gap in the division of responsibilities is somewhat narrower when it comes to caring for the elderly than caring for children. So, men are somewhat more involved in the care of the elderly, but in the modality of performing this care together with women, rather than in taking on main responsibility. Care for young children in more than half of households is equally divided between men and women, but still, in as many as 42.7% of households women have the predominant responsibility. Women in the household are usually predominately responsible for taking care of children's schoolwork.

[33] SeConS (2020), *COVID-19 and employment in Serbia*: *impact of the pandemic and measures for its prevention on employment and working conditions,* available at: https://www.secons.net/files/publications/113-publication.pdf

Table 1: Who usually performs activities of housework and care for the elderly and children in households, in %

Activity	One or more women	One or more men	Women and men equally	Woman from outside the household for compensation	Man from outside the household for compensation	Nobody/other
Cooking	73.0	7.6	18.2	0.4	0.3	0.5
Washing dishes	66.9	8.4	23.3	0.3	0.2	0.8
Washing clothes	79.0	7.0	12.9	0.5	0.2	0.3
Ironing	77.8	6.6	11.7	0.7	0.2	3.0
Cleaning, tidying up	65.2	8.4	24.8	1.2	0.2	0.1
Care for the elderly	32.0	24.0	40.0	-	-	4.0
Care for young children	42.7	2.6	54.3	0.4	-	-
Controlling children's school work	55.6	7.1	34.8	0.3	-	-

Source: SeConS, FES, UN Women, Research on the impact of the COVID-19 pandemic on employment of women and men in Serbia, April 2020.

Findings of the qualitative research confirm that the gender gap is narrower when it comes to the division of activities related to child care. Although men are somewhat more often involved in these activities, it is noticeable that the care of small children was shared with women, rather than men mostly doing it on their own. Respondents who participated in the qualitative research point out that child care is distributed depending on the job obligations of the partner.

"When it comes to extracurricular activities, my husband mainly deals with that, while I'm in charge of the school work. Going to the doctor – whoever can go, either one of our older children or one of us"

Housekeeper, from Belgrade, 51 years old

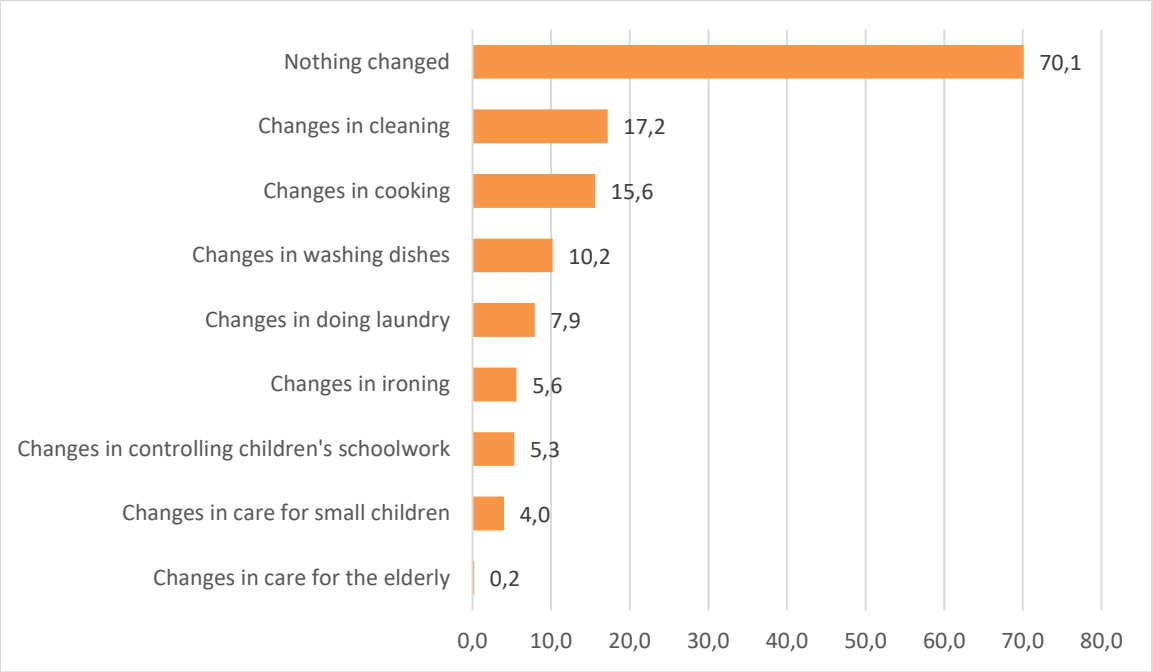
"We both take care of the children, depending on who is available since we work in shifts. I try to sync my shifts at the pharmacy with children's school shifts, so it's easier for me to keep track of everything, particularly the extracurricular activities. "

Pharmacist, from Belgrade, 50 years old

The changed everyday life during the state of emergency due to the COVID-19 pandemic affected the changes in the patterns of division of labour in household care only in 30% of cases. Among the households that introduced changes, they were most often related to the cleaning activities, tidying up

the living space, cooking, washing the dishes, doing laundry and much less often to ironing, controlling children's schoolwork and caring for young children (Chart 13).

Chart 13: Households according to whether something changed in the division of housework and family care



Source: SeConS, FES, UN Women, Research on the impact of the COVID-19 pandemic on employment of women and men in Serbia, April 2020.

However, when the changes are considered from the perspective of changes in the responsibilities and burdens of household members, research data indicate that they actually most often manifested as an additional women's burden with housework, that they performed anyway even before the pandemic. Somewhat less frequently, these changes manifested in terms of greater involvement of partners or other household members with the intention of "helping the woman" with housework (Chart 14).

In addition to the above, a different distribution of responsibilities was observed in activities related to grocery shopping. Although grocery shopping is an activity in which men are more often involved in regular circumstances, the findings of the qualitative research show that men were involved in grocery shopping activities more often than usual during the state of emergency. The main reason given for that is that grocery shopping during the state of emergency was less frequent due to the duration of the curfew, but much more extensive.

Patterns of change vary depending on the type of activity. So, doing laundry proved to be the activity most resistant to change, because in 70% of cases, it was an activity where the burden on women only increased. In almost half of the households, women, who usually cook, were even more burdened with this work because all the household members were together. In more than one in three households, women who usually used to wash the dishes now had to wash even more dishes, and in almost 40% of households, women, who were usually doing the ironing, had to iron even more. The patterns are

similar for cleaning, tidying up the living space. Also, when it comes to direct care activities, there is a noticeably increased burden of women with care for the schoolwork of children in more than one in three households, which can be explained by the fact that children did not go to school and needed additional support with the transition to the new distance education forms.

When it comes to the modality of involvement of other household members in activities to "help the woman", this happened more often for washing the dishes, then for cleaning, tidying up the living space, then cooking, caring for small children, ironing and controlling the schoolwork of children. In a small percentage, the predominant responsibility for performing these activities moved from women to men – in about 13% of cases for the care of small children, in 10% of cases for cooking and washing the dishes, but much less often for other activities. Data from the qualitative survey also show that other female members of the household (daughters) are more often involved in the housework in multi-member households to help the woman. A different distribution of responsibilities manifested mainly in households where women had to continue working at their usual workplace during the pandemic and men stayed at home more because they switched to working from home.

"Everything stayed the same during the pandemic, only my daughter was more involved than before – she started helping more, washing the dishes and vacuuming."

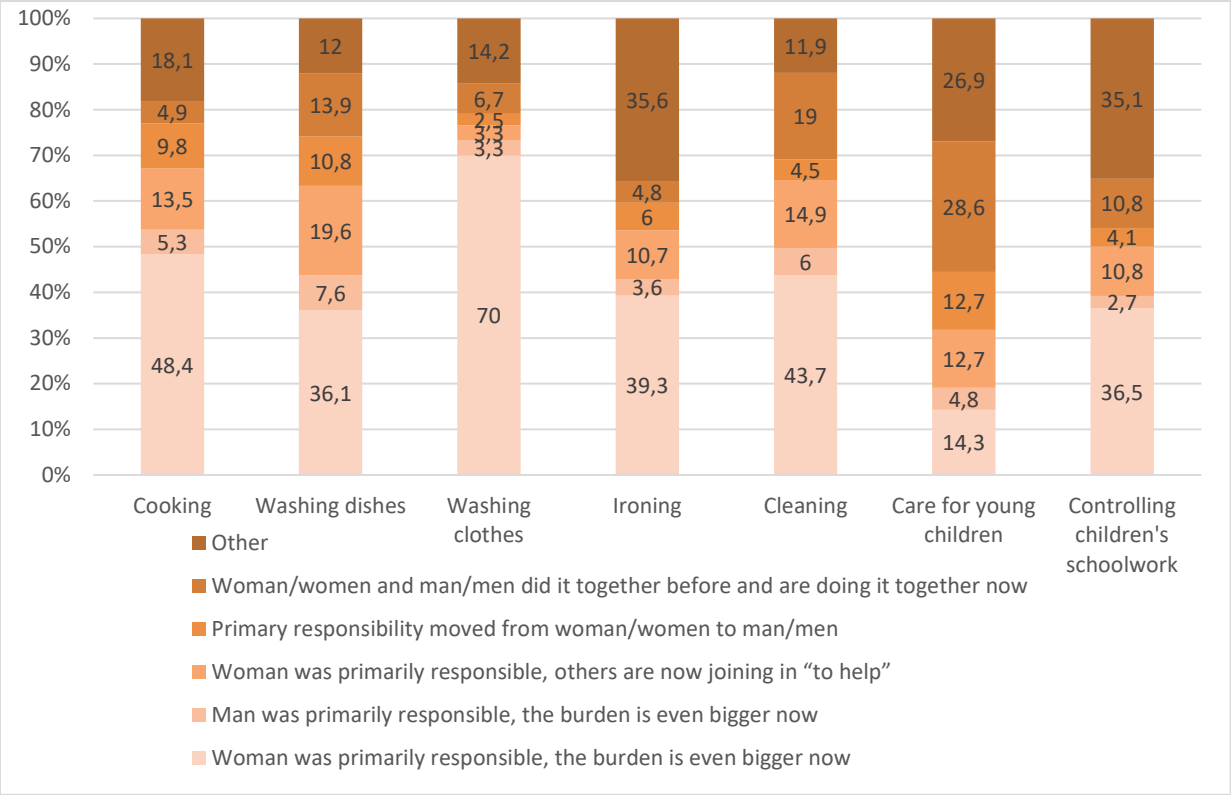
Social worker, from Belgrade, 48 years old

"My fiancé took over most of the housework during the pandemic, because I had to work."

Nurse, from Belgrade, 28 years old

A certain per cent of households experienced a change, although both before and during the pandemic women and men performed these activities together. These are households in which most of the work was done by the main couple before the pandemic and other members joined in during the pandemic, or vice versa, previously it was done equally by other women and men (usually grandparents), and now the main couple in the household is more involved (parents). In any case, these are multi-generational or multi-family households. However, these patterns are the most present in the care of small children and then in cleaning, and less in the domain of other activities.

Chart 14: Changes in responsibilities for various housework and child care activities



Source: SeConS, FES, UN Women, Research on the impact of the COVID-19 pandemic on employment of women and men in Serbia, April 2020.

Key findings:

- In the conditions of the pandemic and the state of emergency when kindergartens and schools were closed and people over the age of 65 were not allowed to go out, a significant part of the work related to direct or indirect family care was transferred to households.
- The pandemic did not lead to significant changes in the patterns of division of labour and responsibilities in the activities of direct and indirect care of the household and household members, which are traditionally mostly performed by women. Some form of change was reported by less than a third of households, and this change usually meant only an additional burden on women who usually carried the main burden of these activities, because it was necessary to prepare more meals, supply the elderly or keep track of schoolwork of children who switched to complex forms of distance education.
- In a smaller number of households, there were changes in terms of greater involvement of the partner or other household members "to help the woman", which indicates that there were actually no significant changes in the perception and practice of responsibility in sharing the household care.
- Only in a small percentage was there a shift of the main responsibility from women to men, mainly in households where women had to go to work and men switched to working from home or did not work at all.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The COVID-19 pandemic and the Government measures in response to it particularly affected various segments of the care economy – both those belonging to the sphere of market economy and "productive labour" and those classified as "reproductive labour", associated with direct and indirect activities of caring for the household and family members. Since women make up the majority in both the market and non-market segment, i.e. that they bear the main responsibilities and burdens, the effects of the pandemic also had a pronounced gender dimension. The pandemic only highlighted the existing structural gender inequalities, both in the labour market and in the economy, as well as in the sphere of household and family reproduction.

The effects of the pandemic on the market segments of the care economy manifested as a bifurcated impact on a part of employees (primarily in the education and social protection sectors), who mostly switched to working from home. They were more protected from the health risks of the pandemic, but were not spared the various challenges associated with working from home, especially in conditions where children and other household members did not go to school or work, when there was no adequate space or technology for work, and when it was not easy to separate the business and private life, professional and family life, which lead to many feeling frustrated. On the other hand, the army of the predominantly female workforce continued to go to work in the aggravated conditions, with high health risks of infection, with increased workloads and difficult conditions for organizing transportation to work and caring for children and families, which was completely transferred to households.

From the perspective of the reverse side of the market care economy and the needs for its services, households faced challenges in providing care to its members, such as caring for young children, the elderly, people with severe and chronic illnesses, people with disabilities and children with disabilities. Although this care was in most cases organized exclusively within the household even before the pandemic, there was limited access to external services during the pandemic, whether it was the services of public sector institutions or paid persons who provided these services outside the household. The reasons for the transfer of care from the market to the household were most often the suspension of work of institutions that provided services, difficulties related to movement restrictions, suspension of public transport, but also the fear of infection among both the service users and providers. Gender patterns are also observed in the distribution of these burdens shaped by the pandemic conditions. The burden is most often increased equally for both women and men in the case of care for the elderly and the chronically ill. Women's burden is, however, particularly increased when it comes to caring for young children and people with disabilities. Although most households returned to the old, pre-pandemic care modalities after the state of emergency was lifted, which once again increased the reliance on the market mechanisms, the number of households that continued to provide care in the way they did during the pandemic is not negligible. This also means that the burden is still on the household members, and in the case of small children and persons with disabilities, the burden is on women and it continues to increase.

Finally, when it comes to the “reproductive” care economy, which includes unpaid housework and care for family members, the pandemic failed to “soften” the persistent patterns of division of labour and

responsibilities which primarily burdened women. It was only in a small number of households that some kind of change took place, and even in those households, it was usually just an increased burden on women who had to increase their activities in conditions when all the household members were at home all the time and the children needed additional support due to the transition to distance learning, along with the support to the elderly due to the movement restriction. Some tendencies of reducing the gender gap were manifested only in certain activities, through the somewhat greater involvement of partners or other family members "to help the woman". This does not actually indicate any substantial changes in perceptions and practices of the division of responsibilities and work in direct and indirect care activities in households.

6.2 Recommendations

Short-term

- Due to the increased workload in the health sector in the pandemic conditions, it is necessary to preserve the established practice of hiring additional staff in the health care sector. Thereby, it is necessary to guarantee basic labour-based rights for the duration of the engagement. When hiring additional workforce, men should be especially encouraged to apply for these positions in order to reduce the gender gap.
- If possible, courses for procedures during the epidemic should also be organized for citizens to regularly attend them on a voluntary basis, thus gaining knowledge useful in the event of an epidemic, and they could be hired as an auxiliary workforce in the health care system or the systems serving, supplying and supporting the health care system. As in the previous case, it is necessary to take care not to reproduce or increase the gender gap, and to stimulate the engagement of members of the less represented gender.
- It is also necessary to support civic volunteer initiatives in such periods, which provide important forms of support to various groups of citizens, such as supply, meal preparation, information dissemination, etc. In this case, too, it is necessary to take the gender gap into account.
- Examine the needs for hiring educational assistants due to the transition to distance learning and with regard to the technological requirements and, if necessary, hire additional workforce while respecting labour-based rights during the engagement and respecting the principles of gender equality and equal representation.
- In case of kindergartens and schools closure due to the pandemic, it is necessary for companies, that are able to do so, to introduce measures that would primarily help employed parents who have to come to work and do not have another family member to take care of the children. This is primarily the case with single parents, most of whom are mothers. Along with the work shift flexibility, which would be necessary whenever the type of work allows it, companies should be encouraged to develop some alternative models of childcare while parents are at work. For example, for parents who have to come to work and don't have anyone to leave their children with, a special service could be developed within the company that would include organizing child care on a one-on-one basis – one person looks after one or several children, but only if they are from the same family (the service does not have to be physically provided in the company if there are no conditions for that). For childcare needs of employees, companies could hire a part of persons (mostly women) who informally provide these services in households in normal circumstances, and who were almost completely unable to work during the pandemic. Introduction of such a support measure should be subsidized by the state and help establish a system of linking companies and persons providing childcare services.

- Unavailable or inadequate transportation is one of the important barriers to going to work in the pandemic conditions, especially for the female workforce that relies more on public transportation. That is why it is important for the state and employers in care economy to provide appropriate transport options for people who have to come to work, having in mind the type of settlement in which the employees live (urban or rural area). Health care institutions should, first of all, provide collective transport (bus, van, etc.) for employees who are not able to come to work in any other way. Also, instead of suspending public transport lines, additional lines should be introduced during the pandemic and the frequency of buses should be increased, which would at the same time reduce the number of passengers in individual vehicles and enable adhering to the recommended physical distance.
- Since it has been shown that people with job insecurity, especially those informally employed as domestic workers, are particularly vulnerable in a pandemic, measures need to be designed to cover these particularly vulnerable categories. Instead of linear distribution of the same amount of money to all adult citizens, cash benefits should be distributed more fairly and directed to those who need help the most. One of the categories that need special support is people engaged as domestic workers or people who provide care for the elderly, children, people with disabilities or the ill in households through informal arrangements, who remain without income in such conditions.
- It is necessary to urge employers to consult their employees when organizing work from home, in order to take into account their needs and to enable them to better harmonize their professional and family obligations. For example, more modalities should be developed and offered to employees, whenever possible, to choose the one that would suit them the most (for example, flexible working hours, fixed working hours, split shifts, etc.).
- It is important to design measures and activities that would encourage redistribution of housework and childcare work during the pandemic, when the amount of household work additionally increases. For example, it is possible to promote examples of good practice through the media or organize campaigns to reduce gender inequalities in housework and childcare activities (for example, moms go shopping on certain days and dads cook, and vice versa on other days). Also, if online parent-teacher meetings are organized, homeroom teachers should require equal presence of both parents (except in cases of single-parent families), i.e. that dads and moms attend alternately.

Medium and long-term recommendations

- It is necessary to redesign the time-use research methodology in order to be able to measure and evaluate work in the care economy more accurately, including paid, market work, volunteer work and housework.
- It is necessary to adequately take into account the care economy with all different forms of work in national accounts, macroeconomic analyses and all measures and policies related to macroeconomics. In doing so, gender aspects of the care economy and the values of different forms of work should be taken into account.
- It is necessary to invest in quality care services, including the necessary infrastructure, such as kindergartens, day-care centres for the elderly, children with mental disabilities, children and adults with disabilities, etc.
- It is important to work continuously on eliminating gender inequalities both in the area of education and in the labour market, because these two areas are linked very closely. Special attention should be paid to encouraging young men to enrol in both secondary schools and faculties that provide the

knowledge and competencies needed to perform jobs in the field of care economy (in health care, education, etc.), and girls to enter professions traditionally and predominantly performed by men, such as engineering, ICT, etc.

- It is necessary to conduct intensive and comprehensive campaigns to change awareness and attitudes about the sharing of parental responsibilities in child care, with particular emphasis on the importance of involving fathers in raising children from the start.
- It is necessary to improve the legal framework to give women the opportunity to return to work as easily as possible and to commit not only to the family but also to professional duties, as well as to enable fathers to take their share of responsibility in raising a child and get the opportunity to develop a good relationship with the child. Although the current Labour Law allows fathers to take parental leave, the leave is not non-transferable, and analyses have shown that "soft" measures of awareness-raising and promoting greater use of parental leave by fathers have not yielded good results so far. Therefore, it is necessary to harmonize the legal framework with the standards of the EU Work-life Balance Directive, which envisages at least ten (work) days leave for fathers immediately after the birth of a child, as well as two months of non-transferable parental leave for fathers. The so-called "father quota" was introduced as a model that gave very good results in the Nordic countries. It would also be good to look up to good practices in the region. In Slovenia, for example, fathers are entitled by law to half of the parental leave (130 calendar days). They can transfer one part of that leave to the mother, but 90 days of leave are non-transferable.[34]
- Having in mind that there is still a far smaller number of women in Serbia who have a driver's license compared to men, various campaigns and incentives (discounts in driving schools, etc.) should try to motivate women to acquire this important competence and fulfil the first condition for using a car. This would also reduce the number of women depending on other drivers in the household and would be a significant step towards achieving gender equality in this aspect.
- It is important to work on fostering the digital competencies of women engaged in the care economy, especially those employed in education who are expected to keep pace with technological innovations in teaching. It is no less important to raise the competencies of women employed in social protection because part of these services has also moved to digital communication channels, which need to be further developed so that beneficiaries of social protection services can also access these services during the interruption of physical admission to social protection institutions.
- It is necessary to systematically improve the accessibility of childcare facilities, which enables more adequate support to families and especially women, who now have the primary responsibilities in child care, and thus create better opportunities for their employment or easier reconciliation of professional and family responsibilities. All children should have the right to kindergarten, regardless of their parents' employment status.

[34] European Commission (2018) *Thirty days of (fully) compensated paternity leave in Slovenia from January 2018,* ESPN Flash Report 2018/7, https://www.google.com/search?q=fathers+parental+leave+in+slovenia&rlz=1C1CHBF_enRS747RS747&oq=fathers+parental+leave+in+slovenia&aqs=chrome..69i57j33.5726j0j7&sourceid=chrome&ie=UTF-8

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APPENDIX 1: RESEARCH SAMPLE STRUCTURE

Table 2: Socio-demographic characteristics of respondents in the survey conducted in April, in %

	Socio-demographic characteristics of respondents	%
Region	Belgrade	25.8
	Vojvodina	26.3
	Šumadija and Western Serbia	27.6
	Southern and Eastern Serbia	20.2
Type of settlement	City	60.3
	Village	39.7
Sex	Male	46.8
	Female	53.2
Age	18-29	15.8
	30-39	29.9
	40-49	26.8
	50-59	20.5
	60+	7
	Primary school and lower	1.4
	Secondary vocational school and gymnasium	47.0
	University education (college, faculty and post-graduate studies)	51.6

SeConS, FES, UN Women, Research on the impact of the COVID-19 pandemic on employment of women and men in Serbia, April 2020.

Table 3: Socio-demographic characteristics of respondents in the survey conducted in June, in %

	Socio-demographic characteristics of respondents	%
Region	Belgrade	22.9
	Vojvodina	27.6
	Šumadija and Western Serbia	28.0
	Southern and Eastern Serbia	21.6
Type of settlement	City	61.0
	Village	39.0
Sex	Male	48.1
	Female	51.9
Age	18-34	23.7
	35-44	16.9
	45-54	17.2
	55-64	18.3
	65+	23.9
Highest education attained	Primary school and lower	8.5
	Secondary vocational school and gymnasium	55.3
	University education (college, faculty and post-graduate studies)	36.2

Source: Study on the impact of COVID-19 on empowerment of women and men, UNFPA, UN Women, June 2020