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# DISCRIMINATION AND ITS EFFECTS ON SOCIAL AND GENDER-BASED PERCEPTIONS IN POST-PANDEMIC SITUATIONS (2020-2024) (EMPHASIS ON WESTERN AND ASIAN REGION, EXAMPLE: INDIA, UK)

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**Abstract**

This article demonstrates that social inequalities worsened during the COVID-19 period, particularly amongst disadvantageous groups in both India and the UK. The pandemic not only enlarged pre-existing inequalities associated with caste, race and gender, but also delivered less visible harms, such as damage to mental well-being, in terms of anxiety, depression and social isolation. In India, for example, Dalits and Adivasis had their rights to health and social economic support routinely denied under systemic caste discrimination, similarly to how BAME groups were subject to worse health outcomes along with overt racial backlash, witnessed in the UK. In this paper, we have shown the significant need at all levels to make a response to these inequalities, particularly requiring policies on gender equality, increasing social inclusion, alongside more mental health provisions designed for disadvantaged populations. Most of all we have argued for an understanding of inclusion and equity as key to recovery and resilience in the post-pandemic context.

**Keywords** - Discrimination, COVID-19, Marginalized Communities, Mental Health, Social Inequality, Gender Equality.

## Introduction

The crisis destroyed healthcare systems and economies from 2020 to 2024 and brought to light some critical socioeconomic and gender inequities (Silveira et al., 2024). The coronavirus pandemic aggravated the existing gender-based oppression and social exclusion while fundamentally altering perspectives and experiences of inequity across society with respect to gender and socio-economic inequities. Women, in particular, and people from underrepresented socio-economic categories faced disproportionate challenges: working from home alongside family responsibilities, work-related complications, and unanticipated barriers to sites providing essential health care support services. This research will explore the repercussions and psychological stressors inflicted by pandemic pertinent to gender and social inequity and how the pandemic exacerbates and manifested inequities in a post-corona world. The methodology would include examples from both India and the UK-providing examples from different socioeconomic and cultural contexts. The investigation intends to address the inequities expanded by the question of the pandemic will have substantial and ongoing implications for gender roles, mental health and social relationships. The study intends to explore how inequity has metamorphosed for this generation, assess the indefinite and emerging deficits in a post-pandemic context, and to present alternative frameworks to counter inequities.

## Background and Global Context

The COVID-19 pandemic had a widespread global impact in 2020. The virus not only affected public health around the world, it also disrupted society, disrupted the economy, and irrevocably changed gender relations in the world (Otenyo and Hardy, 2021). While the virus itself did not discriminate, its consequences were certainly affected by pre-existing structural inequalities across gender and socioeconomic hierarchies. In general, the crisis exacerbated gender discrimination, which is defined as discriminatory attitudes and behavior based on gender. Women encountered institutional exclusion in aspects of employment, health, and domestic work, since they continued to be the primary carers and were disproportionately covered under low-paid sectors (Cole, 2022).

The pandemic sustained intersectionality theory principles, which relate to how intersecting identities such as class, caste, race, and ethnicity produce cumulative disadvantage. Entrenched inequalities were exacerbated, exposing marginalised people in both industrial and developing countries to increased health risks, economic vulnerabilities, and reduced access to basic services. Social discrimination, accordingly, moved beyond gender to broader unequal access to opportunities based on social position and identity.

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Women everywhere were at multiple levels of disadvantage. Three out of four health care workers are women, meaning that they were more likely positioned on the front line of the pandemic and incurred greater exposure to health risks (Elkholy et al., 2021). The closing of schools and daycares reinforced traditional gender roles in entrenching women's unpaid caring roles and limited access to paid labour. There were embers of economic disadvantage, as women lost their livelihoods 1.8 times more than men, and incidences of domestic violence escalated during lockdowns. There is correlating evidence of gendered vulnerabilities during moments of crisis. The pandemic laid bare structural divergences against a minority ethnic group and other populations that are further marginalized. BAME communities in the UK have faced higher levels of illness and death and, overall, this is at least an indication of pre-existing structural inequities (Cheshmehzangi, 2022). Caste hierarchies in India have continued to deny Dalits and other marginalized communities' entry into healthcare and public services.

The pandemic showed deep social inequalities and gendered inequalities which were still in support of theoretical representations of structural inequality. It illustrated that crises amplify social gaps, while reinforcing the scale of the task of closing those gaps at the recovery phase.

**Gender Discrimination During the Pandemic**
**Methodology**

The study uses a comparative qualitative design to explore how pre-existing socioeconomic and gender inequalities interacted during COVID-19, and the post-COVID-19 recovery, with a focus on India and the UK. Secondary data were collected from peer-reviewed articles as well as governmental and organizational reports conducted in 2020-2024, including qualitative reviews of engagement in the labor market, access to healthcare, persisting mental health conditions; and accounts of caste- and race-based discrimination. The research utilized a theoretical framework informed by feminist theory, social reproduction theory, intersectionality, and critical race theory to help understand them as interconnected systems of oppression (gender, caste/class, race) and to consider what feelings of exclusion were experienced as a result. Data were thematically coded so persistent patterns of disparity could be identified in relation to employment, healthcare, unpaid domestic responsibilities, and psychosocial outcomes. The research takes a cross-national perspective to consider the contextual- and structural-level experiences of discrimination in order to illustrate the emergence and persistence of systemic conditions of disparity, differences, convergences and divergences in India and the UK during post-pandemic recovery.

**India**

The already pre-imbalanced socioeconomic conditions in the country and patriarchal practices in India emboldened gender discrimination there, during the epidemic. "Gender imbalances at work exist through inequities in the work economy, inequities in healthcare institutions, and remaining home responsibilities throughout the epidemic."

**Labor Market Inequities**

India's labor market is characterized by extreme informality with millions of women working in industries seriously affected by lockout measures. The informal sector comprises a large population of women employed as domestic workers, artists, street vendors, and small businessmen. The sectors have been worst affected by the recession since the lockdown and social distancing measures reduced the demand for their services and hindered them from performing efficiently. It was 1.8 times more likely to impact women's employment as against men in the world at large and with a huge chasm in India, said the ILO.

Many low-wage and informal sector women workers were thus caught off guard when firms went under or downsized operations. For example, female domestic workers suffered enormous loss of employment as houses were reluctant to hire outside help because they feared infection. Women working on small-scale manufacturing or as artists likewise suffered loss of jobs when their marketplaces and supply systems were hit. A survey by Azim Premji University reports that as many as 47% of the female victims who were laid off during the epidemic period did not return to their jobs, while 7% of the males (Nath et al., 2023).

In addition, men had dominated sectors that were stronger or easily transitioned to remote work, which includes technology and finance. In this respect, the pandemic increased employment disparities between men and women. Apart from the vulnerability of women in the informal economy during the pandemic, it still amplified the job inequalities already prevalent based on gender.

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**The unpaid care burden**

Apart from loss of employment, the lockout also placed an unequal burden of unpaid care work on women. School and daycare center closures and rising home health needs forced women to take on secondary care responsibilities. Based on a study conducted by Oxfam India in 2021, women contributed 3.6 times more hours towards unpaid care work than men during the pandemic (Abraham et al., 2022). These included childcare, care of elderly dependents, and general household work that could not be outsourced due to lockdown. The additional workload precluded women's participation in paid work and professional training drills, leading to many falling out of the market and enduring long setbacks in economic liberation and career advancement. The National Commission for Women (NCW) reported rising reports of domestic violence in 2020–21, as lockdown isolated women in violent relationships and locked out protection services (Times of India, 2021).

Healthcare inequalities also rose significantly. India's stretched health care system diverted resources largely towards COVID-19 treatment, leaving women's reproductive and maternal health needs at the bottom of the priority list. Limitations on travel and lack of employment restricted safe abortion, contraceptive, and maternity care services for tribal, Dalit, and rural women (Thapa et al., 2021).

The UNFPA (2020) estimated that if India limits service disruption, 2.3 million unplanned pregnancies will occur. Men's health is seen as important in cultural norms that make women a secondary or inferior choice, and many have turned to home remedies as they cannot afford not to do so. This compromised existing gender hierarchies in family-level health decision-making, adding an extra layer of structural devaluation to women's health requirements.

| Issue | Statistic / Evidence | Source |
|---|---|---|
| Unpaid care work | Women spent 3.6x more hours than men in unpaid care | Oxfam India Report, cited in Abraham et al., 2022 |
| Workforce withdrawal | 47% of women who lost jobs during the pandemic did not return to work | Azim Premji University, 2021 |
| Domestic violence | NCW recorded 2.5x increase in complaints during lockdown | Times of India, 2021 |
| Maternal health disruption | Maternity care interruptions led to increased maternal risks | Thapa et al., 2021 |
| Reproductive health services | Service disruptions could cause 2.3 million unintended pregnancies in India | UNFPA, 2020 |
| Healthcare prioritization bias | Men's healthcare prioritized; women often resorted to home remedies | Thapa et al., 2021 |

**United Kingdom**

While a developed economy, it is clear that the United Kingdom saw the worsening of gender inequalities due to the pandemic, particularly in terms of the labor market, unpaid domestic labor, and health care. The gender inequalities were similar to those of India but shaped by particular socio-economic and ethnic trends specific to those countries.

**Disparities in the Labor Market**

They were disproportionately clustered in industries like hospitality, retail, and health care that faced the most economic impacts during the lockdowns. As of May 2020, 30% of women were on furlough as compared to 25% of men, indicating a disparity in job security (Hopson and Wilkinson, 2021) according to the UK's Office for National Statistics. Women workers representing minority groups, precariously situated in terms of job status and protection, saw the most significant impact (Nath et al., 2023).

**Expanded Household Burden**

Just as in India, British women also carried an unequal burden of unpaid care work in the pandemic. Mothers spent a significantly longer time on childcare and homeschooling compared to fathers even when working from home, Cambridge University research discovered (Kallitsoglou and Topalli, 2024). This disproportionate allocation continued to sustain traditional gender roles, adding to the psychological suffering of women and limiting their access to entry paid work. According to the Institute for Fiscal Studies, British women were 47% more likely than men to leave the workforce entirely during the epidemic. This is an Oxfam India conclusion that unpaid feminine work and labor force dropout greatly inhibited their long-term economic autonomy (Abraham et al., 2022).

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**Healthcare Access and Racial Disparities**

The UK had tremendous gender and racial disparities in healthcare. Women's healthcare services were extremely reported to be postponed due to resource reallocation towards treating COVID-19 (Hoernke et al., 2021).

BAME women were most hit by the crisis since research has indicated elevated infection and death rates among them relative to white women. The Royal College of Obstetricians and Gynaecologists noted that expectant BAME women were more likely to be hospitalized due to severe COVID-19 symptoms than their white counterparts. This is reflected in India, where tribal and Dalit women have structural barriers to healthcare access (Thapa et al., 2021). In both cases, structural inequalities—either race or caste-based—are intersecting with gender to produce enhanced vulnerability.

**Comparative Analysis**

India and the UK cases reflect divergence and convergence. In India, patriarchy, caste, and informality contributed to the marginalization of women, while in the UK, sectoral concentration and racial inequalities revealed women's, particularly minorities', weaknesses.

Both cases demonstrate how, when we look at gender at the intersections of caste (or race, or class) there are layers of disadvantage. In both contexts, women bore the brunt of job loss, unpaid care work, and inequities in healthcare. This comparator approach gives credence to the idea that discriminatory forms differ based on contexts but the structural nature of gender discrepancies in a crisis are universal.

| Dimension | India | United Kingdom | Comparative Insight |
|---|---|---|---|
| Labor Market | Women concentrated in the informal sector (domestic work, street vending, small-scale industries). 47% of women who lost jobs during the pandemic did not return (Azim Premji University, 2021; Nath et al., 2023). | Women overrepresented in hospitality, retail, and health care — sectors hit hardest by lockdowns. 30% of women furloughed vs 25% of men (Hopson & Wilkinson, 2021). | Both contexts show women concentrated in vulnerable sectors with higher job loss risk, but India's informality vs the UK's precarious service sector marks a structural difference. |
| Unpaid Care Work | Women spent 3.6x more hours than men on unpaid care (Abraham et al., 2022). Closure of schools forced many women to quit jobs entirely. Domestic violence cases surged 2.5x (Times of India, 2021). | Mothers took on majority of childcare and homeschooling, even when both parents worked (Kallitsoglou & Topalli, 2024). Women were 47% more likely to leave workforce permanently (IFS, 2021). | In both countries, women disproportionately bore unpaid care work. India's burden compounded by domestic violence and caste-based vulnerabilities, UK's by workforce exit and childcare imbalance. |
| Healthcare Access | Dalit and tribal women faced systemic barriers; maternal and reproductive health services disrupted (Thapa et al., 2021). 2.3M unintended pregnancies projected due to service gaps (UNFPA, 2020). | Women faced delays in healthcare treatments as services were redirected to COVID-19 (Hoernke et al., 2021). Pregnant BAME women more likely hospitalized with severe symptoms (RCOG, 2021). | Both contexts show gendered healthcare inequities. In India, caste + rural disadvantage amplified exclusion; in the UK, race + poverty deepened disparities. |
| Intersectionality | Gender inequality intertwined with caste, class, and rural marginalization. | Gender inequality intertwined with race, ethnicity, and migrant status. | Intersectionality central to both cases; caste in India and race in the UK shaped distinct but structurally similar exclusions. |

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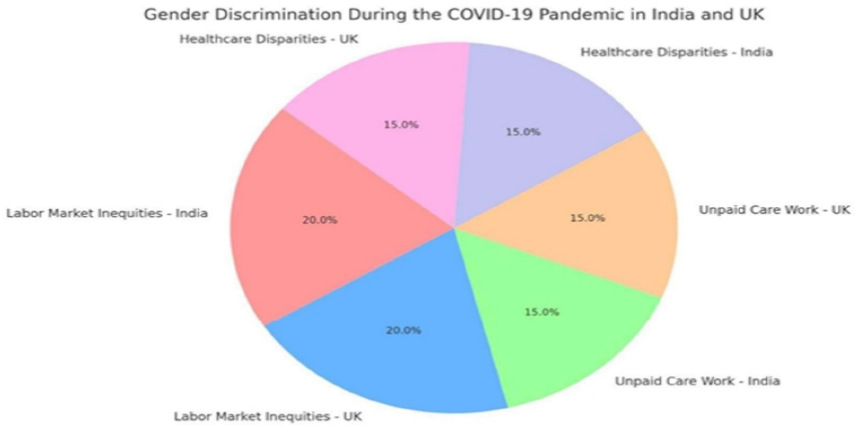


**Figure 1: Gender based Discrimination in UK/India during Pandemic**

**Social Discrimination and Psychosocial Impacts During the Pandemic**

It fueled prevalent social discrimination based on caste, race, and ethnicity. The victims of the crisis in both India and the United Kingdom undoubtedly were marginalized. A juxtaposition of social discrimination and economic vulnerability enhanced the psychological effects of the situation on the vulnerable groups. Actually, mental health issues such as anxiety, depression, and social withdrawal rose in such categories.

**India**

Rigid social structures in India, primarily the caste system, had fundamentally influenced the resources supplied and treatments during the epidemic. Though it is officially derecognized, the caste system continues to impart their effect on the social, economic, and political trends. The discrimination towards Dalits, Adivasis, and other oppressed classes remains well- entrenched. These biases intensified over the course of the epidemic, confining access to healthcare, relief works, and jobs.

**Caste Discrimination**

The caste system also remains one of the factors fragmenting Indian society, and the pandemic unevenly affects the Dalits and Adivasis. Dalits form a sizable section of India's sanitation workers who led the response operations at the forefront of the pandemic. Overall, there were reports of discriminative measures by sections of people against the Dalit sanitation workers. Several were denied protective gear and social isolation due to disease fear. According to a paper prepared by the National Campaign for Dalit Human Rights, in broader terms, the life of the sanitation workers has been directly or indirectly affected by the health and economic effects of the pandemic, which was barred from relief and public services. Facts to be noted are that there is no PPE equipment available for Dalit workers, and they attend to high-risk sanitation chores in hospitals, quarantine facilities, and also urban areas.

Another broad fact is related to discrimination against many Dalits and Adivasis while receiving healthcare treatments. Interestingly, as per a survey conducted by Oxfam India in the year 2021, 22% of the Dalits and 12% of the Adivasis were denied medical care treatment during the epidemic (Roy, 2024). These facts indicate how rampant bias was prevalent in rural districts where healthcare services were rare and poor people would often be refused or post- dated treatment in such regions. It was only in urban areas that the Dalit and Adivasi population, largely in low-wage risky jobs, caught the virus more easily but were not treated enough.

Even the governmental humanitarian response could not reach most at risk. According to the study of SWAN

(Stranded Workers Action Network), a network of migrant worker activists, many lower caste migrant workers could not find food or even shelter in the lockout. Similarly, as SWAN's own research showed, at the end of the very first shutdown in 2020, a whopping 64% of questioned workers had less than ₹100, and over 90% did not receive government aid, in turn making this caste and class exclusivity in relief very apparent (Adhikari et al., 2020).

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**Psychosocial Effects on Marginalized Communities**

The mental impact of the epidemic through caste inequality was important. Already a vulnerable lot because of economic insecurity, these groups were now beset by greater worry and desperation and social isolation. It indeed does seem that in India, economic insecurity, social isolation, and risks to health all conjoin to contribute to a popular sense of impotence in such communities.

A survey done by the Indian Psychiatric Society in the year 2021 reports that levels of anxiety and depression increased over the course of the epidemic, especially among the poorer and other deprived sections (Das, 2020). According to NIMHANS, the number of patients seeking mental health care from deprived areas increased during the epidemic. However, access to mental health care remained very low. Available services were mainly concentrated in urban areas so little help reached the rural groups, and certainly, very little help reached the Adivasi communities.

The epidemic further gave a push to the marital violence perpetrated against women, mainly from the lower classes. According to the National Commission for Women (NCW), reports of domestic abuse increased 2.5 times during India's lockdown periods (Maity, 2022). This was heart-wrenching to underprivileged women primarily because they had to go through the economic crisis as well along with domestic abuse. Majorities of the lower-caste women who faced both gender and social inequality had lousy access to services and hence aggravated their vulnerability.

**Impact on Migrant Workers**

The worst victims of this pandemic in India are the migrant laborers from lower castes and deprived sections of society. When the Indian government declared an undiscriminating lockdown throughout the country in March of 2020, millions of these migrant workers found themselves jobless, penniless, and stranded in places far from their own. The sudden loss of livelihood drove people to run on foot to their respective towns since public transport was not available. According to the Ministry of Labour and Employment, during the first shutdown nearly 10 million migrant workers returned to their respective home states, and there are documented cases of harassment and humiliation.

This mass migration has deep mental implications. Many of these migrant workers feel orphaned and helpless and at the end desperate while fighting for food, shelter, and medical treatment amidst the lockdown. The lack of government support and discriminatory attitudes from employers and local authorities only further stressed their mental health problems. To that end, they were worried by the uncertainty of future job prospects that would be available. Many of the workers feared losing any opportunities they might have had to return to the metropolitan districts once the lockdowns were released.

**United Kingdom**

Social discrimination against BAME groups was the highest in the United Kingdom during the pandemic. Their cases of infections and deaths were also the highest during the epidemic: figures spoke about growing socioeconomic inequalities and structural prejudice within British society. The emotional price of these disparities was high as this contributed to growing mental health issues within the minority ethnic groups who also confronted a sharp increase in racial discrimination and hate crimes throughout the epidemic.

**Racial Disparities in COVID-19's Impact**

Early on in the epidemic, the disproportionate impact that COVID-19 appeared to have at least initially on BAME populations in the UK became noted. According to a report from Public Health England (PHE), people from Black, South Asian, and other minority ethnic origins were more likely than others to contract the virus and suffer grave consequences, including death (Darko, 2021). According to the report, those of Black ethnicity were four times more likely to die from COVID-19 compared to the Whites and those of South Asian origin, three times more likely.

These disparities, concluded the report, were attributed to a number of socioeconomic factors and factors such as overcrowded housing; higher prevalence of pre-existing health conditions, including diabetes and heart disease; and an overrepresentation of BAME people in frontline employment. According to a Runnymede Trust analysis published in 2021, more BAME workers are found working in key sectors, including healthcare, public transportation and the retail industries, where the risk of COVID-19 exposure is much higher (Wiśniowski et al., 2023). These populations' economic weakness coupled with systematic prejudice made them more susceptible to health effects from the pandemic.

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**Increased Racial Discrimination and Hate Crimes**

Besides these direct health impacts, BAME communities in the UK faced a rise in racial hate and hate crimes during the whole epidemic period. EHRC identified that there was a significant rise in racist incidents, focusing on Chinese and Southeast Asian individuals. False information and xenophobic emotions enhanced by the fact that the virus came from China fueled increased anti-Asian hate crimes across the globe, including within the United Kingdom.

The mental impact of this rise in racial prejudice was huge. Most people from Asian communities reported that they felt unsafe when venturing out into public places. Few individuals stopped going outdoors at all, fearing harassment or assault. The Chinese Welfare Trust survey found that 79% of Britain's Chinese had to put up with racial discrimination during the pandemic, and most of them experienced more anxiety, fear, and social exclusion (Wiśniowski et al., 2023).

Racial differences in testing for COVID-19 compounded feelings of injustice and lack of satisfaction for black and South Asian populations. There were also many people in the regions who believed themselves to be disproportionately exposed to the virus because they worked in key services and had been neglected by the healthcare system. This increased mental health difficulties as research demonstrated the rates of anxiety, depression, and PTSD were higher throughout the pandemic in BAME individuals.

**Psychosocial Effect on Ethnic Minorities**

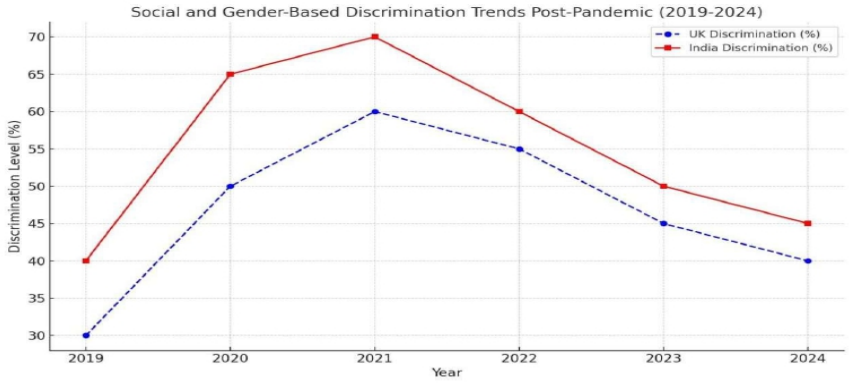
The psychological effects of these inequalities were tremendous. According to a research by University of Manchester, 2021, "BAME participants were more likely to report mental health problems including anxiety, depression, and feelings of hopelessness when it comes to the pandemic". The findings also suggested that women in BAME reported more psychological distress linked with racism and sexism.

Furthermore, culturally insensitive mental health care in the UK resulted in little to no access for most BAME individuals. The NHS Confederation's BAME Network noted that the concerns of minority ethnic groups regarding their mental health were largely neglected in the wake of the pandemic as many felt that their affairs were being handled poorly by professionals in health care. The outcome in this respect further exacerbated psychological impacts of the pandemic to these communities.

Disparities in Mental Health Treatments The epidemic period found BAME groups in the UK facing significant disparities in mental health treatments. This is because long studies had been found to indicate that the BAME were less likely to seek any treatment for mental health due to stigma, cultural hurdles, and distrust of the healthcare system. Such hurdles became even more compounding during the epidemic period as mental health services went unbearably crowded while healthcare's attention focused on handling the immediate crisis.

A leading British mental health charity, Mind, showed that BAME adults received insufficient effective care for their mental health during the pandemic. A few reported unreasonably long intervals between referral and treatment or counseling, and others experienced the phenomenon of doctors, nurses, or other medical staff ignoring some of their most critical mental health issues. The study also brought to the point that adequate mental health services for communities from a different culture need to be developed, focusing on the specific needs of BAME populations.

**Figure 2: Social and Gender based Discrimination (UK/India), Source: Author Generated**



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**Long-Term Effects on Social and Gender-Based Perceptions**

Long-term effects of the pandemic on social and gender attitudes are yet to be determined, but some major tendencies are emerging. Pandemic has indeed entrenched traditional gender roles in both states: India and the United Kingdom, where women become an increasingly disproportionate contributor to unpaid care work. This discourages gender equality most particularly in the workplace, whereby women face more significant obstacles when returning to the same as men.

Socially, the pandemic has further fueled the racial, ethnic, and economic inequalities, thus causing more friction and strain among states. Already a difficult demographic difference was cast-cum-religious; in India, it has become worse; in the United Kingdom, the structural disadvantage of the minority ethnic populations has been exposed by the epidemic. Such inequalities are going to take their long-term impact as they have destroyed faith in institutions and widened social gaps.

The epidemic has been worse psychologically to the victims of discrimination and exclusion. Anxiety, despair, and stress-related illnesses rose universally owing to long periods of isolation combined with economic uncertainty and a health concern. Many women drastically suffered while working, taking care of their families, and performing personal care.

**Addressing Post-Pandemic Discrimination**

Ending the effects of social and gender discrimination in society after the pandemic requires a multi-dimensional approach through change in legislation, participatory approach by the community, and direct support to those affected. Because the epidemic has exacerbated existing disparities, governments, institutions, and civil society must emphasize programs that promote gender equality and social inclusion and ensure fair access to health, education, and economic opportunities for excluded groups.

**India** does need massive reform efforts in general, and particularly in the caste system's social systems, targeting the welfare of vulnerable people. Providing wider social security schemes for women and the vulnerable sectors in society is mandatory. Such schemes may be in the direct transfer of cash benefits, retraining, and placement programs tailored to the needs of those sectors. The government must make efforts in the infrastructure area so that more people can afford the health-care services, mainly in the rural areas, where health facilities are fewer in number. The state could offer support to the disadvantaged communities so they can also gain some requisite access to essential services and resources to overcome their socioeconomic barriers.

There should also be representation of the marginalized groups in the decision-making process in the local government institution. This participatory approach ensures that there are policies guided by the experiences of those suffering from prejudice, hence delivering more effective and representative policies. Grassroots activism and community organization could be a useful approach to championing the interests of the marginalized and building collective action in overcoming prejudice.

Tackling issues of racial inequity in matters of health and employment would be of extreme importance in the **UK's** post-pandemic recovery. The government has to introduce targeted interventions indicating the challenges for the BAME populations. This will include health outcomes by ethnicity, improvements in data collection to underpin public health efforts and will make sure that BAME people will have equal access to jobs, especially in areas affected severely by the epidemic. Hiring should be encouraged through diversity and inclusion programs that support fair hiring practices and encourage healthier climates at work.

Psychologically, there is a great need for increasing mental care toward women and vulnerable groups, who have been severely affected by the pandemic situation. Public awareness should be taken to the grassroots level to eradicate stigma related to mental health, and community- based support programs should be established that enhance networking and resilience. Mental health services should be culturally competent and attentive to the various issues diverse communities face so people feel safe and supported when seeking care.

Examining the complex effects of gender and social discrimination in the post-COVID environment requires a comprehensive and evidence-based policy that includes legislative reform, community involvement and targeted interventions for at-risk groups. Evidence indicates that women's employment was impacted more than males; Indian women, for example, were 1.8 times more likely to be unemployed than males and many did not return to work (Nath et al., 2023; Abraham et al., 2022). In the UK, there were 30% of total females that were furloughed and compared to 25% of males (Hopson & Wilkinson, 2021). To address these disparities, governments should improve social security

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and retraining programs for women and other genders and invest in subsidized childcare, given that women took on 3.6 times the amount of caregiving responsibilities while working from home during the pandemic (Abraham et al., 2022; Kallitsoglou & Topalli, 2024). Caste-based institutional discrimination in India restricted nearly all Dalit and tribal women from accessing maternity and reproductive health services (Thapa et al., 2021), whereas BAME women experienced increased hospitalization during pregnancy in the UK (Cheshmehzangi, 2022).

The enhancement of rural health infrastructure, culturally relevant use of maternal services, and grassroots engagement are essential for ensuring equity. Mental health interventions must be instituted in light of increasing anxiety and depression among at-risk groups (Das, 2020; Wiśniowski et al., 2023) and the escalating protective measures for women, since lockdowns have led to unprecedented reports of domestic abuse (Times of India, 2021). Ultimately, sustained investment in universal healthcare, job stability, and mental health—driven by the marginalized voices—will be essential for recovery from the epidemic (Otenyo & Hardy, 2021).

| Area of Inequality | Key Evidence from Sources | Actionable Implications |
|---|---|---|
| Employment & Labor | Indian women 1.8× more likely than men to lose jobs; 47% did not return (Nath et al., 2023; Abraham et al., 2022). In UK, 30% of women furloughed vs. 25% of men (Hopson & Wilkinson, 2021). | Expand retraining, social security, and re-employment programs; mandate gender-inclusive job recovery schemes. |
| Unpaid Care Work | Women in India performed 3.6× more unpaid care hours than men (Abraham et al., 2022). UK mothers carried disproportionate childcare and homeschooling burdens (Kallitsoglou & Topalli, 2024). | Provide affordable childcare, flexible work policies, and community-based care infrastructure. |
| Healthcare Access | Dalit and tribal women in India denied maternity/reproductive care (Thapa et al., 2021). BAME women in UK more likely hospitalized during pregnancy (Cheshmehzangi, 2022). | Expand rural health infrastructure in India; implement culturally sensitive maternity programs in UK. |
| Mental Health | Rising anxiety and depression among vulnerable groups in both countries (Das, 2020; Wiśniowski et al., 2023). | Invest in culturally competent mental health services; embed counseling in primary care; reduce stigma. |
| Gender-Based Violence | Domestic violence complaints in India spiked 2.5× during lockdowns (Times of India, 2021). | Strengthen helplines, safe housing, and integrate screening for domestic violence in health systems. |
| Structural Inequality | COVID-19 exacerbated systemic inequities globally (Otenyo & Hardy, 2021). | Institutionalize intersectional data collection (gender × caste × race); ensure participatory policymaking. |

**Conclusion**

The COVID-19 pandemic used the structure of many disparities and demonstrated the great impact that gender, social and cultural hierarchies have on people's ability to cope during times of crises. Women, for example in India and the UK, experienced significant challenges related to job loss by being disproportionate, being unpaid caregivers, gaps in access to healthcare, and heightened assault vulnerability. Marginalized populations such as Dalits and Adivasis in India, and BAME people in the UK experienced dramatically compounded challenges because of entrenched caste and racially based systems that excluded them from critical services and opportunities. Psychosocially, challenges in these manners are related to stress, anxiety, and isolation began to highlight a need for critical action. The recovery effort must be far more than a temporary effort and must include inclusive job markets, accessible healthcare, mental health supports, and equitable representation in government. As we move forward with fairness and equity, we have a moral and ethical obligation to create a society that is able to bounce back from future catastrophic events.

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