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The Gendered Politics of Care: Structural Inequalities Facing Indian Women Caregivers

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Abstract: Caregiving is an essential yet undervalued labour, disproportionately shouldered on women across the globe. In India, female caregivers in familial, community or institutional contexts, bear the overwhelming burden of unpaid or underpaid care work, often under conditions of chronic stress, economic insecurity and social invisibility. While public discourse on gender equality has grown in recent years, the abuse, discrimination and exploitation faced by female caregivers remains a severely under-researched area. This paper addresses this critical gap by examining the multidimensional challenges faced by women in caregiving roles, focusing on the human rights violations they endure, and outlining policy measures to safeguard their safety, dignity and wellbeing.

The primary objective of this paper is to analyze how systemic neglect in policy frameworks perpetuate gender-based inequality in caregiving labour, and to propose actionable, rights-based policy interventions. In doing so, it emphasizes the urgent need for comprehensive legislation, social protection mechanisms and mental health support tailored to female caregivers. This paper also explores the intersection of caregiving, revealing how marginalized women are at greater risk of physical abuse, emotional neglect and economic deprivation in caregiving contexts. The study is anchored in feminist theoretical framework, which examines the gendered division of labour, and sociological theories to understand how the meanings attached to caregiving roles shapes women's identities and perpetuates power imbalances.

Using a mixed method approach based on secondary sources, the research evaluates qualitative accounts from case studies in existing literature to explore the lived realities of female caregivers. By bridging empirical evidence with theoretical insights, the paper calls for a shift from welfare-based to rights-based policy frameworks, positioning caregiving as a matter of social justice, gender equality and human rights.

Index Terms - Female caregivers, caregiving abuse, human rights, gendered expectations, SDG Goals, India.

I. INTRODUCTION

As older adults are living longer lives, end-of-life care facilities are becoming increasingly crucial. A lot of advancements have been made in palliative care, end-of-life care and hospice, yet the family members of cancer patients continue to worry about the expenses, lack of dignity and compassion, pain and discomfort, distorted care and the fear of the dying process. In instances where the family members are directly involved in their own family member's caregiving, they basically go through the prolonged and more painful process of dying (Given & Reinhard, 2017). As the disease progresses, the victim becomes more dependent on their caregivers and their involvement in caregiving increases. Yet there is a paucity of attention towards the family members and the role of the caregivers during this entire journey. Often caregivers are thrust upon the responsibilities without support or training on physical care of the patients. With little or no preparation for this role, the caregivers end up with feelings of incompetence and low confidence while providing care, resulting in caregiver distress. Additionally, family caregivers become very anxious about unmanaged pain, they remain very concerned about giving too little or too much medication. They might also misunderstand the side effects of medication and fear the chances of addiction.

These caregiving roles and the consequent challenges might result in their physical and psychological morbidity. Although their responses depend on the complexity of the patient's care, the caregiver's grief, depression, burden and distress are often increased by family conflict over decision making and providing quality care to their loved ones (Given & Reinhard, 2017). What the caregivers need is proper counselling and guidance prior to getting this responsibility, but in the Indian context, they are not receiving proper and

formal support. The healthcare needs of the caregivers should be assessed regularly by the healthcare professionals, as they tend to ignore their own health and wellbeing while performing caregiving duties. This is important so that they can continue caregiving without struggling with health problems. Another significant challenge is that caregivers often face a financial toll when their families suffer from out-of-pocket expenses for equipment and services at the end of life.

This paper's main goal is to examine how gender-based inequality in caring labour is sustained by systemic neglect in policy frameworks and to suggest practical, rights-based policy solutions. By doing this, it highlights how urgently comprehensive laws, social safety nets, and mental health services catered to female caregivers are needed. The nexus of caring is also examined in this research paper, demonstrating how underprivileged women are more likely to experience economic hardship, emotional neglect, and physical abuse when providing care. The study is grounded in Sociological theories to comprehend how the meanings associated with caregiving roles influence women's identities and sustain power disparities, as well as feminist theoretical frameworks that analyze the gendered division of labour.

II. Literature Review

Women make up 60% of caretakers nationwide. Nearly 70% of caretakers for individuals with dementia are women. A woman is typically taking care of herself when she is a caregiver. She lacks a partner to lean on for support. Because of this, providing care for others takes up a lot more time for women and lasts throughout the duration of their lives. Gender norms and the general expectation that women should provide care are the cause of this (Strategic Communication, 2023).

Informal caregivers of patients with chronic illness are described as the "invisible backbone" of the long-term healthcare system, providing about 80-90% of assistance to the family member suffering from chronic health issues (Barbic et al., 2014). They provide unpaid health care to their loved ones, but in return several social, emotional and physical demands are entrusted upon them, as they keep coping-up with the new responsibilities and roles. One report finds out that 50% of the informal caregivers suffer from burnout, as their services continue to remain uncompensated (Galiatsatos et al., 2017).

In order to provide effective and appropriate interventions to reduce caregiver burden, especially among individuals caring for cancer patients at home, it is important to understand the different forms of burden they experience and the factors responsible for these burdens. The studies should explore larger groups of people from multiple institutions and geographic regions, and also among multiple socio-economic groups. Personal caregiving and the greater duration of caregiving not only has psychological and emotional burden, but it results in greater unmet needs of the caregiver themselves (Halpern et al., 2017). These burdens can be coupled with the lack of support from friends and relatives. This might result in productivity loss and reduced participation. Family caregiving is becoming more stressful and time consuming as the needs of the loved one's increase. Although demographic changes are taking place, the number of personal caregivers is not keeping pace with it. But the most concerning fact is that without a personal caregiver, the health and wellbeing of the victims would be worse, and the expense would be higher (Kendall & Lampert, 2017). For caregivers, emotional stress levels are higher if they are dealing with individuals with mental health issues like dementia or Alzheimer's, where they find difficulty coordinating caregiving for three or more health conditions at once (Kendall & Lampert, 2017). This is not only limited to taking care of older adults, but those caring for their loved ones belonging to any age group.

Many caregivers show concerns about a burden on their time management, as they have to adjust their schedules and depart from their personal involvements. Family caregivers are expected to provide care, operate sophisticated medical equipment, do critical decision-making, with or without the support or instructions of the healthcare system. Due to their low rates of preparedness, or limited knowledge and skills, their stress levels might increase. This difficult phase makes them ill due to the increased demands against their limited capacities and resources. With little or no preparation or training for this role, the caregivers suffer from low confidence and feel incompetent in their ability to caregiving, which increases their caregiving distress (Given & Reinhard, 2017). They constantly need to adapt to the changing conditions of the patients; they need to become more educated and trained about symptom management and other trajectories of pain and illness. The situation becomes more difficult when the caregivers themselves are older individuals with chronic diseases like hypertension, diabetes, etc. which might escalate. The

physical health of elderly caregivers needs monitoring as well because they might suffer from health risks like sleep deprivation, fatigue, gastrointestinal disorders, weight loss, and loss of physical strength. To make it worse, the financial stress and economic burden of medicines, equipment, and services will be an additional cause of stress (Given & Reinhard, 2017).

The caregiver's perspective of the influence that caregiving has on their lives is referred to as caregiver burden. There are two types of caregiver burden: perceived and tangible. Perceived burden is the degree to which the caregiver is distressed or disturbed while giving care, whereas tangible burden is related to the expenses and efforts involved in caring for the receiver. The diversity of roles and gendered expectations may further add to the difficulty faced by Indian women caregivers. The care receiver's reciprocal support exchanges and other family members' support contributions, on the other hand, have the potential to lessen the caregiver's perceived burden, which has been found to be connected to perceived reciprocity in the caregiver-care receiver relationship. Stories of women who are left behind reveal how gender affects caring responsibilities for senior citizens. Even though these choices were frequently not their own, staying behind to care for elderly people or going back to their homes to do so became significant choices for women. The gendered nature of caring responsibilities, cultural expectations for daughter-in-law's care, and young women's attempts to defy these expectations are all existing factors in India. Despite giving more time, effort and support than men, women were less likely to feel that the support they got was reciprocated. Since, defying the patriarchal system would have denied them access to property and financial resources, women were forced to play the roles that were given to them (Ugargol & Bailey).

Women make up the majority of both formal and informal health care providers, and health labour, whether paid or domestic, has a strong gender identity (Glazer 1990, 1993). All around the world, women are in charge of their own children's and family's health, they tend to the aged family members and provide and oversee the care of the sick and disabled. Even in fulltime jobs, women handle the majority of daily healthcare tasks for themselves and other family members. Both the low-paid labour of women health workers and the unpaid family healthcare work of women have been exploited and marginalized by the contemporary, market-driven medical business (Hilfinger Messias et al., 1997).

Nobody is born with the ability to provide care. Like anything else, we learn it. It's no secret, though, that women tend to be the primary caregivers, starting at an early age, and contributing more. Furthermore, data and testimonies from all around the world demonstrate that women who work as informal caregivers make less or no money, have less free time, experience greater loneliness, and become ill more frequently. The vast majority of women who provide care for a loved one and are that person's sole source of assistance during times of illness, disability, or emergency are referred to as female informal caregivers. Without education, information, or professional or social safety, they carry out this essential duty for their families and communities, they remain unseen, they stumble, fail, and try again (Lorenzo, 2023).

When it comes to offering elders physical care for activities of daily living (ADL), women outnumbered men, according to a June 2019 HelpAge India survey on the "Roll of Family in Caregiving" conducted in 20 cities in India. Frequently, the daughter or the daughter-in-law is the one who does it. According to the survey, between 28 and 68% of daughters-in-law nationwide assist with Instrumental Activities of Daily Living (IADL), such as meal preparation, cleaning and call assistance, medication administration, and money management. The percentage of sons who received such care ranged from 10% to 51%. Additionally, the majority of emotional assistance for older people with issues like loneliness, anxiety and fear of reliance is provided by female caregivers (56% to 59%). The statistics that favour female caretakers are not unique to India. According to the National Alliance for Caregiving, 60-70% of Alzheimer's patients in the US receive informal care from women. According to Anupama Dutta, Head, Policy Research and Advocacy, HelpAge India, as individuals live longer, women are also bearing a greater duty of care. Life expectancy was significantly lower in the past, but as people live longer, care is needed for longer periods of time. The question arises, could it result in elder abuse? The most frequent forms of abuse we encounter are neglect, verbal abuse and disrespect. This may occasionally have to do with care because long-term caregivers do want recognition, which is rarely given. Though abuse cannot be tolerated under any circumstances, the caregiver may also be getting older herself, and it may be difficult for her. However, neglecting the gender perspective on care and caregiver stress may be the underlying causes (Is Caregiving Mainly A Woman's Job?, 2019). In India, conversations on mental health do not often address the mental health of the caregiver, even if it ought to. Research has indicated that caregivers of individuals with

dementia may experience anxiety and depression frequently. Burnout among caregivers may result from a decline in physical health as well. Such data is difficult to find in India. It's also occasionally difficult to determine whether a change is occurring in the absence of additional surveys on gender in caregiving and its implications.

It has been noted in several contexts that women are more likely to be caregivers for people with impairments. The role of the father is typically that of someone who is present but does not share equally in providing care. Given these findings, it's intriguing to observe that women make up the majority of the beneficiaries of a state program that offers financial aid to caregivers. Even when a male family member has been identified as the caregiver, the care was actually given by a woman. When asked why the female member was the caregiver rather than the male, the majority of the answers mirrored those of Reena and Maya:

Reena: "The money is being handled by my husband. Being at home and looking after the children was the least I could do. Since we have two PWDs at home, his name is on the scheme receipt list."

Maya: "I do this work for free. Why spend money that could be used for other purposes?"

Caregiving is seen as a territory of the female sex due to stereotypes of "mothering" that link women with qualities of tenderness and caring. Males only participate in caring when it is a paid job because of the strong feminine connotations associated with the concept of care. Women, not males, are compelled to perform unpaid caregiving because of the silent logic of natural provision of care. Nearly every home responded negatively when asked if any additional assistance had been employed with caregiving duties. In reference to unpaid and unrecorded labour that women perform at home, caregivers said that there is not enough money to cover the costs, particularly when the woman of the household could perform the same task for free (Abraham, 2021).

For family members who are chronically ill, caregivers carry out a variety of nursing and medical duties, such as administering medication, healing wounds, feeding and conducting routine hospital appointments. However, their work is not included in the official health workforce. Women who provide care must juggle unpaid caregiving and other responsibilities such as parenting and household chores like cooking and cleaning. Due to time poverty brought on by women's caregiving responsibilities, educational and employment prospects are lost. It is crucial to acknowledge that in addition to the strain of providing care, women are at risk for maternal health issues due to their reproductive obligations. Elderly women caregivers deal with stress and exploitation in addition to the way their communities perceive aging (Ngwira et al., 2024).

Women caregivers are often frontline workers who put their health and safety at risk to provide care during health emergencies such as COVID-19, HIV/AIDS outbreaks, and Ebola. Despite providing the majority of the care during these outbreaks, official initiatives typically ignored the efforts of women. Women who provided care have been disproportionately affected by COVID-19, despite the fact that their vital role in caring for the sick and preventing future transmission is occasionally disregarded. Gender stereotypes, a lack of political resources, and the undervaluation of women's involvement in community politics are the reasons for the underrepresentation and disrespect for the contributions of female caregivers (Ngwira et al., 2024).

During the last two decades, social scientists have researched the relationship between women providing informal care and women's employment. They have discovered that providing care decreased married women's career prospects, while it had no effect on the employment of male caregivers. There are additional concerns regarding the connection between women's elder caregiving and their future financial security given the negative impact that caregiving has on their income. For instance, what impact does providing care have on women's retirement earnings? Informal caregiving may have an impact on married women's employment prospects and future poverty risks if social insurance and pensions are mostly based on earning (Wakabayashi & Donato, 2006).

Understanding the ramifications of care labour also requires taking into account studies that found differences in association between health and caregiving during the caregiving career and among various health characteristics. Previous studies offer more proof that the emotional wellbeing of the caregiver is most frequently impacted by caregiving, and that these impacts worsen throughout longer caregiving durations. However, shifting to different sources of care is not prompted by rising psychological distress levels. Less frequently, physical restrictions increase, but when they do, they usually happen sooner and may require seeking care from other sources. These trends point to the necessity of paying more attention to both aspects of the caregiver's health and investigating additional support systems that could mitigate these negative health impacts (Pavalko & Woodbury, 2000).

III. RESEARCH METHODOLOGY

This study uses a mixed-methods approach based on secondary data to analyze the challenges faced by female caregivers in India. Both quantitative and qualitative insights are drawn from national datasets, scholarly works, and policy reports. The literature review highlights the disproportionate caregiving burden on women and the absence of adequate support structures. The analysis combines statistical patterns and thematic examination of socio-cultural barriers and policy gaps. The theoretical framework integrates feminist standpoint theory, which centres women's lived experiences, and social reproduction theory, which frames caregiving as undervalued labour sustaining both households and economies. Anchored within SDG 3 and SDG 5 (UN, 2015) and WHO's assistive care agenda (WHO, 2016), the methodology provides a comprehensive basis for policy-oriented inquiry.

IV. THEORETICAL FRAMEWORK

The challenges faced by women caregivers in India can be best understood through Feminist Political Economy and the Ethic of Care Theory. Feminist Political Economy underscores how unpaid and undervalued caregiving labour is structurally embedded in patriarchal and capitalist systems, reinforcing women's subordination both in households and in the labour market (Bakker & Gill, 2003). Similarly, Carol Gilligan's Ethic of Care (1982) emphasizes caregiving as a relational and moral practice, but when situated in India's patriarchal society, it reveals how women's labour is invisibilized, normalized, and exploited. Building on this, Indian feminist scholars such as Nivedita Menon (2012) highlight how patriarchy intersects with caste and class, creating layered vulnerabilities for women caregivers, while Sharmila Rege (1998) emphasizes the role of caste and gendered division of labour in shaping the unequal burden of caregiving. Together, these perspectives illuminate how socio-cultural norms, caste hierarchies, and economic structures perpetuate systemic inequalities for women caregivers. Therefore, caregiving must be reframed not as a private duty but as a matter of social justice, human rights, and gender equality requiring policy transformation.

V. POLICY GAPS AND CHALLENGES – CURRENT FRAMEWORKS AND THEIR LIMITATIONS

In India, caregiving policies remain fragmented, largely subsumed under general social welfare or health schemes, without specific legal recognition or protections for female caregivers. Existing frameworks like the National Policy for Senior Citizens (2011) and National Health Policy (2017) focus on beneficiaries rather than the rights or wellbeing of caregivers, leaving gaps in financial support, mental health services and workplace accommodations. Social stigma and gender norms exacerbate invisibility in policymaking. There are additional concerns regarding the connection between caregiving and their future financial security given the negative impact that caregiving has on their income. What impact, for instance, does providing care have on women's retirement earnings? Informal caregiving is likely to have an impact on women's future poverty risks if social insurance and pensions are mostly based on earnings (Wakabayashi & Donato, 2006).

VI. PROPOSED POLICY INTERVENTIONS

A comprehensive policy framework for women caregivers in India must adopt a right-based approach that legally recognizes caregiving as a valuable work, ensuring entitlements such as fair financial compensation, pension benefits and health insurance. Welfare measures should include accessible respite care services, mental health support and skill development programs to enhance economic opportunities. Legal protections must address workplace discrimination, provide flexible working arrangements and safeguard

against abuse within caregiving environments. Embedding these interventions within national health and social protection policies, aligned with SDG 5 (Gender Equality) and SDG 3 (Good Health and Well-being) will ensure the dignity, safety and wellbeing of women caregivers.

Women are much more likely than men to be primary caregivers, be 65 years of age or older, be married, have higher levels of education, be unemployed, and provide more intensive and complex care; struggle to balance caregiving with other family and work obligations; experience poorer emotional health as a result of caregiving; and deal with caregiving responsibilities by either skipping respite or blaming oneself for being selfish (Navaie-Waliser et al., 2002).

However, there are some limitations to the existing data, which points to a number of potential avenues for further study and data gathering. In order to comprehend all stages of the caregiving career, but particularly the changes that take place when people begin providing care, longitudinal studies of both caregivers and non-caregivers are essential. Therefore, it is crucial that questions about caregiving and other forms of unpaid labour be included in the expanding list of longitudinal, nationally representative data collections across several survey waves. These surveys' nationwide reach serves as a valuable supplement to the more in-depth data offered by smaller, less representative caregiver samples. Second, comprehensive information on the timing of role transitions is necessary for a more thorough understanding of the reciprocal links between health and caring (Pavalko & Woodbury, 2000).

Women in particular are under a lot of pressure to offer a lot of care with minimal assistance from formal caregivers. Policymakers, program designers, and formal caregivers must collaborate to offer creative, reasonably priced, and easily accessible programs and support services in India, that lessen the burden of family caregiving.

VII. DISCUSSION

The challenges faced by women caregivers in India are multidimensional, deeply entrenched in social and cultural expectations that normalize caregiving as a woman's duty. Empirical studies show that caregiving for the elderly, dementia patients, and those requiring palliative support creates immense physical, psychological, and financial strain, particularly for women who often lack institutional or community support. Urban research, such as work conducted in Mumbai, highlights how women struggle to balance paid work with household and caregiving responsibilities, leading to significant stress and role conflict. In rural contexts, studies point to financial insecurity, poor access to healthcare facilities, and limited awareness of supportive services, thereby exacerbating the vulnerabilities of women caregivers.

The literature on dementia and mental health caregiving consistently points to the invisibility of women's unpaid labour in both academic discourse and policy design. This invisibility has serious consequences. Caregivers report higher levels of depression, anxiety, and poor self-rated health compared to non-caregivers. Yet, India's National Health Policy (2017) and related frameworks such as WHO Global Strategy on Ageing and Health (2016), which emphasize the importance of supporting informal caregivers. Furthermore, the Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality), call for reducing gender inequalities in healthcare and recognizing unpaid care work as a critical component of equity.

Policy-oriented analyses argue that India's health system continues to prioritise maternal and child health, overlooking the long-term demands of chronic illness, elderly care, and mental health where women's caregiving roles are most pronounced. The lack of financial incentives, legal protections, or structured respite care creates significant policy gaps. Thus, this paper strongly advocates for interventions that not only recognize unpaid care work but also create financial, psychological, and infrastructural support systems for women caregivers. This includes integrating gender-sensitive measures into healthcare policy, legal recognition of caregiving labour, and alignment with international frameworks as the SDGs and WHO caregiving guidelines.

VIII. Conclusion

Women caregivers in India remain an invisible yet indispensable backbone of the health system, particularly in elderly, dementia, and palliative care. Literature shows that their caregiving labour is undervalued, unrecognized, and often accompanied by financial hardship, emotional stress, and health deterioration. Despite the clear alignment with SDG 3 (Health and Well-being) and SDG 5 (Gender Equality), current Indian health policies, including National Health Policy (2017), largely overlook the rights and welfare of caregivers. To address these gaps, it is essential to move beyond welfare-oriented perspectives towards a rights-based framework that recognizes, protects, and supports caregiving as a critical component of public health. Strengthening legal protections, financial support, and community-based respite care will not only improve caregiver well-being but also ensure more equitable healthcare delivery in India.

The study underscores that caregiving in India is deeply embedded within structures of gender, caste, and class, making female caregivers disproportionately vulnerable to exploitation and neglect. From a sociological standpoint, caregiving is not only a private responsibility but also a form of social reproduction that sustains households and economies while remaining invisible and undervalued. The normalization of unpaid or underpaid female caregiving reflects patriarchal arrangements that reinforce women's subordination in both domestic and public spheres. Viewing this issue through a human rights framework highlights the urgent need to recognize caregiving as a matter of justice, not charity. International commitments such as the UN SDGs (2015) and India's constitutional provisions for equality and dignity place a moral and legal obligation on the state to safeguard the rights of women caregivers. Ensuring their access to healthcare, financial support, and legal protection is not only critical for advancing gender equity but also for strengthening the foundations of social justice and human rights in India.

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