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# Identifying Women Caregivers: Gendered Informal Care Burden in Himachal Pradesh

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**Abstract**

*This paper examines the gendered nature of informal caregiving of chronic physiological as well as psychiatric diseases in Himachal Pradesh, whereby tertiary health care located in Shimla serves to compound the burden on the household. The study, based on six detailed qualitative case studies carried out at the Indira Gandhi Medical College (IGMC) and the State Mental Health Hospital (SMHH), addresses the issues of long-distance commute, out-of-pocket expenses, and institutional support as these issues are encountered by rural women. It has been found that caregivers incur a particular penalty of centralisation: poverty of time, drainage of financial resources, and even compelled withdrawal of productive work, which frequently results in distress financing. There arises an illness asymmetry whereby physiological caregiving comes with physical fatigue and economic cost, psychiatric caregiving comes with social stigma and secrecy, which results in the creation of two levels of isolation: geographical and cultural, which leads to further loss of support. The protracted role strain causes most women to abandon themselves and become secondary patients in the healthcare system. The role strain in the healthcare system is seen as a structural gap and not a personal responsibility. Policy action must concentrate on decentralised satellite care, systematic discharge planning, regular health screenings of the caregivers, and protracted psychosocial interventions like Family Focused Therapy, whereby this mostly invisible but most needed workforce can be given due credit and attention.*

**Keywords**

Unpaid Care Work, Gendered Caregiving, Informal Care, Women Caregivers, Care Burden, Himachal Pradesh.

## Introduction

### On the Structural Imperative and the Feminisation of Care

Voluntary assistance in the form of informal caregiving of the chronically ill, disabled or weak by families is a significant scaffold. With no long-term care funded by the state, the households end up being the first line of offering long-term care. This is more acute in Low- and Middle-Income Countries (LMICs) such as India, where demographic changes (longer life expectancy, increase in non-communicable diseases) enlarge the care demands, but institutional reactions to the situation are small. Dependency ratios are decreasing; that is, the number of working-age individuals is decreasing and has to support an increasing number of the dependent population. This care deficit in practice is incorporated into households, usually by women, where it is a collective duty, but it has become a survival tactic.

### The Invisible Work and The Gender Differentiator.

The distribution of care is uneven in India. Ingrained patriarchal values place women in a two-fold role. Caring and mothering, on one hand, and keeping the home on the other hand, and thus, the scholars refer to the *dual ledger of survival*; that is, she needs to take care of the health of the patient on one hand at the cost of her own life opportunities. India Gender Report 2024 indicates that India has the lowest rate of women in the labour force in the G20 countries. One is that much of the work women do is not taken into consideration as formal employment and is counted as unpaid family work. Estimates given in the Care Economy Report (PB35) show that women spend 4.33 out of the 24 hours in unpaid care every day, more than men, and that more women than men are involved in unpaid domestic services, 81.08 per cent of women versus 26 per cent of men. This invisible contribution is valued in monetary terms to the tune of 22.7 lakh crore, almost 7.5 per cent of the GDP of India. However, its awareness is not present in policy frameworks. This invisibility does not just wear statistical status- it gets converted into the

limitation of education, loss of skills acquisition, and continued inability to work in the labor market. These gender expectations in Himachal Pradesh additionally drive caregivers into unpaid and unacknowledged jobs in a state that has rugged terrain and centralised hospitals that already restrict the mobility of women.

**The Implications: Strain and the Development of the Secondary Patient**

Extensive caregiving puts physical, emotional and financial strain cumulatively. Higher rates of stress, depression and anxiety are reported more by women, and this fact is supported by the results of working women caregivers, where high burden is demonstrated as compared to homemakers. This constant stress over time turns caregivers into what has been described as *"secondary patients"* because their health also suffers as they are under the burden of responsibility. High strain is associated with disruption of self-care, unhealthy diet, and failure to attend medical check-ups. This crisis is aggravated by monetary cost. Cancer treatment, as an example, causes families to go into disastrous spending on health of more than rupees 80,000 on average per inpatient stay, which can result in distress financing, such as loans and the sale of assets. Psychiatric caregiving is an added burden of stigma and isolation, where many women have to hide their plight. The comparative evidence of the Kerala-based Arogyakeralam Project gives an example that even in the state where the palliative care framework is more prevalent, the caregivers remain susceptible to lacking special respite care, counselling, and support groups of their kind. Women bear this burden in Himachal Pradesh, which is a mountainous geography where the access barriers are aggravated and have minimal institutional safety nets.

**The Situational Issue: Himachal Pradesh and Amplified Burden**

Unpaid caregiving, as a crisis that is already deeply rooted in gender inequality, as well as in the state's underinvestments, obtains a more acute form in the mountainous landscape of Himachal

Pradesh. In this case, the small-scale rural households are facing not only the emotional and physical cost of sickness but also the geographical fact of distance. In Shimla, tertiary services are centralised in the Indira Gandhi Medical College (IGMC) and the State Mental Health Hospital (SMHH) meaning that they are the only lifeline to the rest of the state. To the caregivers who are mostly women, this centralisation makes every consultation a voyage not only in kilometres but also in the lost earnings, borrowed cash and fatigued physiques. The geography makes this economics complex. Indirect costs of long bus travels, frequent journeys, and staying overnight at Shimla only increase the already high out-of-pocket expenses. In Himachal, where the overrepresentation of women in unpaid family work is prevalent, the need for long-term care can easily mean that the relevant women have to give up productive work altogether. Their work is an undisclosed subsidy to the health sector, and their families fall deeper into precarity, a process which the Care Economy report also predicts, even stating that unpaid work is both perpetuating and impoverishing families. The picture is even more complicated by the nature of the illness. There are predictable but crushing financial costs of physiological illnesses such as cancer. Strain is, however, overlaid with the stigma of psychiatric illnesses. Family members of bipolar or schizophrenic patients tend to keep quiet to avoid gossip and family stigma. This creates a kind of two-fold isolation, physical alienation of resources in the city and social alienation within the village population. The caregivers of Himachal are alone. The communal role previously played by local groups such as self-help and Devta committees is now often absorbed by the national or state level, and at most, they assist in a long-term and close work level of illness care.

Caregiving in Himachal is thus identified in this paper as a compounded crisis: a geographical, infrastructural and cultural clash that increasingly raises the hidden cost of care. Through a

juxtaposition of physiological and psychiatric caregiving experience, it seeks to generate context-specific evidence to introduce these invisible pressures into sociological and policy gaze.

**Theoretical Framework: Integration towards a Framework**

In order to sociologically examine the gendered burden of informal care in Himachal Pradesh, this research takes an integrated approach that combines Social Exchange Theory (SET), Feminist Care Theory, and Role Theory. These views, drawn interpretively from the lived strains of caregivers like Ritu Devi's endless Shimla treks and Sunita Thakur's village silences, reposition women caregivers' suffering not as isolated endurance but as a structural extraction embedded in the state's mountainous geography and centralized health setup.

**Major Analytical Prism: Social Exchange Theory (SET)**

**George Homans** and **Peter Blau's** Social Exchange Theory considers human interaction a balancing process between costs and rewards. Applied to Himachal's caregiving ledger—skewed by Shimla commutes that drain funds and bodies even before treatment begins—this exposes why women persist amid indefatigable strain. For Ritu Devi, costs mount as physical labor, out-of-pocket disasters, and productive withdrawal; yet non-material rewards like family decency and stigma prevention bind her, rendering exit a social non-option. In psychiatric cases like Sunita's bipolar care, the exchange weakens further: stigma obscures rewards, tilting persistence into entrapment, where moral compulsion overrides rational calculus.

**Narrative Supplement 1: Feminist Care Theory**

Developed from **Carol Gilligan's ethics of care and Joan Tronto's political theory**, Feminist Care Theory reveals caregiving as a social construct, not individual ethic. In patriarchal Himachal, women's default status naturalizes their labor as shadow subsidy to the health system—unseen in records yet vital, as Gayatri Sharma's untrained discharge ordeals illustrate. Gilligan's relational responsibility and Tronto's care politics highlight how this devalues women:

hours more unpaid than men impoverish households, curtailing education and labor entry, while centralization extracts their mobility as unpaid transit for the state.

**Narrative Supplement 2: Role Strain and Role Theory**

Role Theory, from **George Herbert Mead's symbolic interactionism and William J. Goode's advancements**, captures psychological contradictions in conflicting roles. Himachal caregivers embody this acutely—as agricultural workers, mothers, daughters-in-law, and nurses—their thin line frays under competing demands. Manju Devi's stroke care, lifting amid knee screams, or Neelam's schizophrenia vigilance amid in-law blame, spirals into overload: medication management, unpredictability, and absent support erode self-care, blurring identity into structural overstretch where fatigue morphs into secondary patienthood.

**Integrative Value of the Framework**

This multi-layered lens—SET illuminating skewed persistence, feminist theory unveiling devaluation, Role Theory tracing overload—interprets Himachal caregiving as compelled regime, not sacrifice. From cases' granularity, it spotlights compounded extraction: geography taxes time, stigma isolates socially, institutions abandon technically, forcing women's unpaid work to prop the system. This grounded reading demands policy reckoning—decentralized satellites, caregiver screenings—to render visible what sustains invisibly.

**Review of Literature**

**Mapping Economic and Psychological Toll in Rural India.**

Studies have always demonstrated that informal caregiving in India is not merely a family responsibility of privacy but rather an uncompensated form of labor regime that has both economic and psychological consequences. Using such instruments as the Zarit Burden Interview and Self-Reporting Questionnaire, **Brinda et al. (2014)** established that women caregivers of older adults in rural India regularly registered the equivalent of a full-time working load of

approximately 39 hours per week and had acute financial distress. This invisible labor was estimated by the study using the proxy good method to be over half a million US dollars in terms of GDP productivity cost. Equally important, the study established that caregiving harmed the mental health outcomes of women, though socio-economic factors were also taken into consideration. The results of such findings demonstrate caregiving as a hidden tax on the time and well-being of women that is not systematically captured in economic reporting or in the discourse of mental health.

**The Unrecognised Psychiatric Home Care World.**

Although physiological caregiving has received incremental focus, the sociological approach in psychiatric caregiving in India has had a scanty attention. **Chakrabarti (2016)** had highlighted that families are managers of psychiatric illness on the frontline, but formal institutions pay little attention to them. Medication supervision, follow-ups, and financial support are provided by caregivers, who receive little institutional appreciation and formal psychoeducation. This results in what could be termed the 'missing safety net'; the caregivers are carrying out life-sustaining roles, but they are not systemically supported.

This was further confirmed in later studies. **Padmavathi et al. (2020)** demonstrated that caregivers of bipolar disorder patients tend to have a high level of stress related to family climates of high expressed emotion, which further increases the risk of relapse among patients. The adaptation of Family Focused Therapy (FFT) to cultural differences showed potential, with a decrease in stress and a better communication level between households. **Kaur et al. (2021)** provided an additional, more gendered layer, revealing that women who had a paid job and took care of psychiatric patients had the greatest burden. This type of double shift induced increased role conflict- balancing professional employment, domestic chores, and full-time intensive care taking, along with the development of an acute level of psychological distress. Combining all

these studies, a focus on psychiatric care giving in India highlights that it is a structure-neglected and demanding task.

**Self-Care Neglect and Gendered Vulnerabilities**

The literature confirms as well that the long-term process of caregiving also changes the health course of the caregiver. **Gobourne et al. (2024)** also revealed that high-strained caregivers were highly unlikely to engage in self-care practices like nutritious diets and exercise, which exposes them to chronic disease. It means that caregivers are in the middle of both types of vulnerability: the patient is ill, and their health is in danger, yet they are mostly neglected as objects of frequent screening and policy attention. To add another dimension, **Fatima et al. (2025)** pointed out that the gender of patients has an impact on the experience of caregivers. The families living with epileptic women in tribal India were found to have heavier financial and social impacts than families living with men. A sick daughter or wife was stigmatised as a threat to the marriage, and this increased the economic and emotional burden on the family. This is an indication of the highly gendered value of lives in caregiving economies, where caring about women patients is also a financial liability and a social liability.

**Rationale and Significance of the Study**

This paper is an effort to expose the structural invisibility of unremunerated female labor of caregiving in Himachal Pradesh, where families are part of a work force that is poorly-resourced in supporting a health sector. With mountainous topography and tertiary hospitals concentrated around a few cities in the centre of the state, it is not only the women who find themselves being caregivers but also providers and practitioners of transport services, negotiators of finances, and orchestrators of logistics. The cost of playing these roles is usually the withdrawal of these women themselves from education or paid labor, and caregiving can be seen as a systemic redistribution of state duties onto women's time and bodies. The study fills the recognition gap highlighted in

SDG 5.4 that leverages the valuation and redistribution of unpaid care by reframing caregiving not as a personal responsibility but as a social problem, as the study has health and economic outcomes that can be measured.

The importance of the study is to produce context-specific data by comparing the concealed expenses of psychiatric caregiving (e.g., bipolar disorder) versus those of physiological illness (e.g., cancer). The opposition shows that stigma, visibility, and social sympathy have different impacts on women's stress and isolation. The results will be used to make urgently required institutional changes, such as decentralised care delivery, which will help minimise geographical friction, and specific psychosocial interventions, such as culturally adjusted family-focused interventions. The paper helps to value caregivers as the population at risk and not as invisible supporters by defining them as the primary stakeholders in the field of public health.

This is an academically justified and socially required study in the end. It exposes the unpaid work of women caregivers who form the backbone of the health system in Himachal and provides a guide on how the structure can be changed that views care as something that people participate in, instead of a gender requirement.

**Research Objectives**

- To explore how the centralisation of specialised medical care in Shimla, in combination with the mountainous topography of Himachal Pradesh, is influencing the logistical burden, financial burden, and time constraints of women primary caregivers.
- To explore the extent to which the feminisation of care, based on cultural beliefs that code caregiving as a female responsibility, causes psychological stress and demoralises women by making them incapable of maintaining their wellbeing and self-care.
- To contrast the difference between the effects of psychiatric and physiological caregiving.

## Research Methodology

### Research Design

This research design utilizes a descriptive and comparative research design based on qualitative research to understand the lived experiences of being a family caregiver in Himachal Pradesh. The gendered caregiving experience is best studied using a qualitative lens, which helps to observe the invisible forces of stigma, role conflict, and geographical distance that shape the experience. Instead of breaking down caregiving into figures, this design allows the re-creation of the voice of caregivers, daily negotiations, and the cultural scripts that inter-implicate them in their jobs.

### Methodological Justification

The scale of caregiving can be quantified using quantitative surveys, yet it cannot reveal how women perceive themselves, how they deal with stress, and how they find their way around the stigma when the institutional support is missing. It is important to have a qualitative design, hence to create a thick description and a layered meaning. It is the case study approach that enables the researcher to trace the process of caregiving over time and place, which brings forward the parameters of structural constraints (centralised care, financial strain) as well as the subjective experience (emotional fatigue, moral obligation). The purposive sampling was not selected based on representativeness, but the ability to select information-rich cases, women whose stories represent the spectrum of the difficulties involved in both physiological and psychiatric caregiving. This offers profundity instead of range, which is very essential in sociological research that aims at repositioning caregiving as a social problem instead of a personal endeavour.

**Universe of Study**

The population of interest is the women family members who offer long-term care to chronic illness patients, who are not paid and are across Himachal Pradesh. The main centre of fieldwork was Shimla, with the two main tertiary care centres of the state, the Indira Gandhi Medical College (IGMC) and its Oncology and Neurology departments and the State Mental Health Hospital (SMHH). This emphasis guaranteed the availability of the rural-dispersed caregivers who are obliged to make long and costly trips to the centralised facilities, showing geography as a silent stakeholder in the process of caregiving.

**Sample**

The paper adheres to an intensive qualitative case study approach, and it uses a purposely chosen sample of six women as primary caregivers. The unit of analysis was the individual caregiver. In order to obtain comparative experiences, the sample was balanced in terms of physiological caregiving (e.g., cancer, neurological illness) and psychiatric caregiving (e.g., bipolar disorder, schizophrenia). The choice was informed by strict inclusion criteria: the respondent was required to be the nominated primary female caregiver (professional excluded), had to be in constant care of no less than three months, and had to be associated with a patient at IGMC or SMHH. Although they are few, the richness of six comprehensive cases helped provide flavoured descriptions, which shed light on the larger structural facts.

**Data Collection Techniques**

There were several ways of creating context-rich, triangulated data. Interviews of caregivers were done in semi-structured formats offering flexibility to investigate emotional burden, financial demands and social anticipation, and also having a systematic, fundamental core of similar

inquiries. The detailed case narratives were created by repeated contact; they described how women changed roles and maintained care in the long run. Observations in hospital waiting areas and wards provided a glimpse into how caregivers and patients interacted and how the institutions played out. Field notes obtained nonverbal information like body language, exhaustion and family negotiations. The findings were placed in broad systemic realities using secondary materials such as hospital records, government health reports, and NGO documentation.

**Ethical Considerations**

There was observance of ethical integrity. Informed consent was obtained during the participation, and all respondents were promised confidentiality. In order to ensure privacy, the analysis of results is provided under pseudonyms, and confidential information has been anonymised without affecting the depth of analysis.

**Data Collection**

**Case Study 1: Ritu Devi – When Geography Becomes a Tax**

Ritu Devi (45), who is the chief caregiver to her husband (50) with colorectal cancer, exemplifies how centralised healthcare is financially and physically disintegrating a home. She now spends her life in an endless loop of travel to the Indira Gandhi Medical College (IGMC) in Shimla, a place she has to travel to in a remote village of Mandi. Chemotherapy involves making an all-day, multi-stage journey over mountain roads every chemotherapy period, which exhausts her even before the therapy has commenced. The financial cost has been appalling. *"The distance kills us first, not the disease",* said Ritu in a brittle voice as she was tired. Travelling steals all of it: time, energy, and then the money, and it is always the money. The savings of households are exhausted, mortgage debts have been amassed, and indirect expenses in the form of transport,

food, and temporary accommodation have been accumulated to the extent of disastrous spending on health. To cope with these needs, she had to give up weaving and field labor and left her family's income in rags. The three responsibilities of caregiver, household manager and transport coordinator have drained the health of Ritu. She has chronic back pain, but is not able to treat it; healthy meals and sleep have become an unacceptable luxury. Glancing at her hands, she confessed: *"I have not slept properly in fourteen months. I do not identify myself as Ritu anymore; when I look at myself, I only see myself as a coordinator and a nurse"*. Her tale serves as a sharp contrast to the fact that in Himachal, the price of medicine is not only calculated in terms of money but also by the constant process of erasing a woman and reducing her to the status of a body part.

**Case Study 2: Sunita Thakur – The Walls of Silence**

Sunita Thakur (58) in Kullu takes care of her 32-year-old son, who is bipolar. What she undergoes is not only the uncertainty of manic cases or the refusal to take medication, but the suffocating silence imposed by stigma. In the case of Sunita, exposure is the most feared. Mental illness in her village is perceived to be a family disgrace, and this aspect posed a threat to the marriage of her two unwed sisters. *"Yes, we are always pretending",* she said, and looked about her anxiously at the door in case an intruder should enter. *"I do not need the assistance of the neighbors, and I do not like festivals. Provided they are aware, my girls are destroyed".* The disgrace is even more than the illness. This veil has distanced her in the kinship and community relationships that would otherwise give her solace. The loneliness is further doubled: she is spatially separated from specially trained assistance and socially secluded in her village. The criticism by relatives, such as blaming her for not being able to control her son, contributes to her feeling of being trapped. The observations of the researcher showed her exhaustion: Sunita was not only losing her sleep, but also her sense of control over the life of the community. Her experience shows that psychiatric

treatment can make the house a rehabilitation centre and the patient, a speechless quadruplegic, where stigma is a greater burden than the illness.

**Case Study 3: Manju Devi – Carrying a Body, Carrying a Mountain**

The physical burden of caring (62) for her husband (65), who suffered a stroke, is in the form of Manju Devi, who symbolises the pressure of physical caregiving in the mountains of Himachal. She has to travel by expensive private transport and spend hours on a bumpy journey to IGMC, depending on its location, as every trip to the hospital has to be made from her high-altitude village in Kinnaur. She is at home, and the total dependency of her husband needs 24/7 care-feeding, bathing, toileting, and repositioning to avoid bedsores. The stress of her own body torments Manju. *"Every day is heavy lifting. I feel like my knees are screaming, I am sore in the back. The mountain, I think it is crushing me,"* crying, she said. The fact that her joint pain has not been treated witnesses the unbearable trade-off she has to make: to take care of her own health or be together with her husband. She succinctly put it this way: *"How can I see the doctor? Who will stay with him? There is no one else."* Her existence is a continuous line of physical work and sacrifice, where there is no time to rest and rejuvenate. The story of Manju demonstrates that caregiving, in these situations, does not just destroy health, but also dignity--that it turns women into working machines, the very survival of which is never more than postponed.

**Case Study 4: Neelam Verma – Living in a Glass Cage**

Neelam Verma (38), who is a caregiver to her husband (42) with a case of schizophrenia, is struck a second hard as a result of a monetary meltdown and emotional guilt. The disease caused the family to lose his income as a competent worker, which means that the family had to depend on loans and miserable health financing. Repeat visits from Mandi to the State Mental Health Hospital of Shimla to take medication and follow-ups consume more resources, which creates a spiral of insecurity. In addition to the financial cost, the social cost is toxic. In-laws tend to fault

her about her husband not making any progress, which follows the bitter pitches of High Expressed Emotion. Neelam is always perceived by people around her, she says that she lives her life behind a glass, to be seen but not to be close, to be looked at but not to be helped. She does not risk the future of her children and, to ensure this, she does not enter any social gathering: she is secluded on a geographical level, and on the social level, she is isolated by the community. She has a weak sense of coping, which is anchored in avoidance and silence. According to the researcher, her silence appeared more as a survival tactic rather than acceptance as a benefit in the face of stigma and a thin veil. In the case of Neelam, the absence of psychosocial support in the psychiatric caregiving makes a woman in a glass cage, where all the actions are monitored, and no assistance is offered.

**Case Study 5: Gayatri Sharma – Discharged into the Unknown**

The case of Gayatri Sharma (51) demonstrates the concealed threats of poor discharge planning. When her father-in-law (80) fell ill with respiratory complications and was admitted to IGMC, Gayatri was suddenly left a home nurse with no training whatsoever. She remembered: *"The nurse appointed us five minutes and discharged us. I was utterly alone... afraid I should harm him. The technical side of the task was too many nebulisers, checking the fluids, and timing various medications."* Gayatri is an example of the self-educated, teaching herself through trial and error without the help of an institution and full of anxiety and guilt. With each further visit to Shimla, the financial burden was reduced, and her spirit and religion were weakened by the treatment she received daily. Her quality of life worsened rapidly. There was constant anxiety and depression. The experience of Gayatri unlocks the vision of how institutional gaps do not merely fail patients, but they also produce crises for the caregivers, where they release them to the unknown with impossible roles.

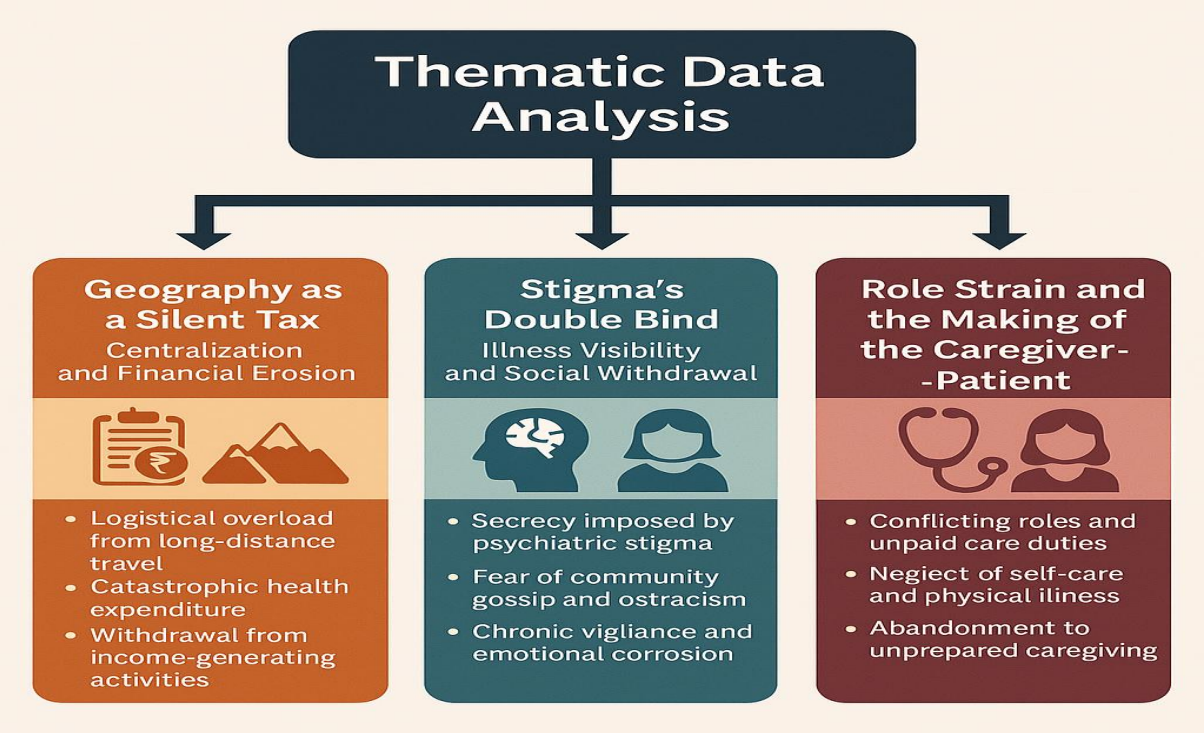
**Case Study 6: Leela Devi – The Endless Watch**

Leela Devi (68), mother of a bipolar disorder patient with substance use (40), is the oppressed subject of supervision. Every relapse requires emergency visits to Shimla SMHH. She has internalised that it is she, and not by any means her broken supervision, that makes him stable. *"I must watch him always. I cannot rest. This task now is all my life,"* she said tiredly, certain. Her shame is aggravated by the stigma of being mentally ill and addicted. Lapses in her community are not medical failures but maternal failures. This role has overshadowed Leela, and her social life and health have left her tired and alone. Her stubbornness is reminiscent of the brutal calculus of the Social Exchange Theory: the costs are enormous, physical overwork, societal disapproval, constant nervousness, etc., but she cannot quit because cultural obligation and the threat of stigmatisation are the only ways out. Her story is what it feels like to be trapped in an inescapable watch where child care is not a choice but a life sentence.

**Thematic Analysis**

The thematic analysis of the six case studies indicates that the caregiving in Himachal Pradesh cannot be described as a set of personal struggles; it is a methodical process that is produced by the geography, by the organisation and the sets of established gender norms. Qualitative interpretive approach served as the basis of the analysis, which was done manually by repeatedly reading the interview transcripts and field notes. The number of codes was reduced to three themes that have connections between the lived experience of women in relation to the broader socio-cultural and policy context.

**Figure 1: Thematic Analysis**




**Source: Case Studies**

**Theme 1: Geography as a Silent Tax – Centralisation and Financial Erosion**

The original theme is that the mountainous nature of Himachal and the concentration of tertiary services in Shimla (IGMC and SMHH) make routine caregiving a logistical nightmare. Women in areas like Kinnaur and Mandi identified themselves as people living on the road, as they had to plan complicated travel routes with each visit. Geography in this case is not a setting but rather a dynamic enemy that takes its time, energy and resources in every corner. This strain is directly translated into monetary wastage. The families not only lose savings but also incur loans not just to treat them directly, but also the so-called shadow costs of travel, food, and temporary accommodation. Most of them sink into disastrous health spending, which is based on distress financing that fuels chronic poverty. The cost is not simply financial: women are forcibly pulled

out of their own mode of production of income, making them more obscure, unpaid instruments of the health system. What comes out is a trend in which the infrastructural gaps in the state are literally filled in by the bodies, labour, and time of women.

**Theme 2: Stigma's Double Bind – Illness Visibility and Social Withdrawal**

The second theme attests a critical illness asymmetry: whereas physiological health requires heavy labor, psychiatric caregiving exposes the individual to an extra, destructive stigma. To caregivers such as Sunita or Neelam, the most important thing to fear is not necessarily to relapse, but revelation- exposure of the family to neighbours and relatives who may gossip about them and ostracise them. This secrecy puts them in a dilemma of two-fold, they are not only geographically isolated because of their geographical distance to institutional resources, but also socially isolated because of being disconnected from the kinship networks that could otherwise provide them with a reprieve. The stigma is gendered. Females are accused of failure to control the patient often; the pattern of High Expressed Emotion depicts the hostile relations. This blame system about cultures makes them a source of care and not an outcome that is beyond their control. The necessity to remain under continual observation, particularly in such circumstances as a state of bipolar disorder, generates what the participants referred to as living on alert, which is a type of constant vigilance that eats away at emotional strength. Caring for the psychiatric patient, therefore, begins not only as a medical responsibility but as a secret, a reputation and a strength test.

**Theme 3: Role Strain and the Making of the Caregiver-Patient**

The third theme is the conflict between the cultural requirements and individual survival. They are based on feminisation of care, and women are supposed to play several roles that are usually

conflicting: to be a caregiver, breadwinner, housewife, and moral protector of the family image. The result is long-term role strain, where, increasingly, the health of women was compromised. The example of Manju, who reported that she lived her life as though carrying a body, carrying a mountain, is illustrative of physical work, which results in chronic musculoskeletal pain that remains untreated. Others recorded lack of sleep, anxiety and malnutrition, making them what could be actually called the caregiver patients. Their diseases are not brought about by their nurturing but rather through it. The institutional practices exaggerate this role conflict. Women such as Gayatri, who were sent home with little or no training yet expected to execute complex procedures at home, referred to the experience as being deposited in a clinic with no walls. The sudden handover of accountability becomes a crisis in itself and causes increased anxiety and role overload. Without organised psychosocial support, caregivers turn to poor coping skills such as avoidance, wishful thinking, or simple survival, which do not provide much defence against the erosion of health and dignity over the long term.

**Discussion and Findings**

**The Segregation and Violations of Gendered Care**

This discussion confirms the fact that caregiving in Himachal Pradesh is not an individual fight but an organised model of the price distribution where families (especially women) compensate for the shortcomings of the healthcare design and culture implementation. When we place the six case studies in context, that is, in relation to greater evidence, we observe the interaction of geography, institution design and gender norms as they combine to give rise to a cycle of depletion of caregivers.

**1. The Centralisation Penalty: Time Poverty and a Drain on the Economy**

The dependence on Shimla as the only centre of oncology and psychiatry increases the vulnerability of the rural women. Each hospital visit involves a day-long dance of buses, jeeps, or personal vehicles, and health access turns into some kind of free moving labor. This time, poverty deprives the women of time that could otherwise be used to support agriculture, home-based work, or even rest.

Time-use surveys indicate that women in India already spend more hours a day doing unpaid care, more than five times as much as men. This unrecognised work goes with geographical seclusion in Himachal, where the household is left at the mercy of distress funding. The unpaid care is imposed like a shadow tax without being written off, deducted quietly out of bodies, energy and earning potential of women. This has a macroeconomic loss in the long run: when older women, who already outnumber old men in the state, are left without a paycheck due to the years of non-remunerated care, they become even more vulnerable.

**2. Behavioural Cost: Caregivers as Clients-in-Waiting**

The effect of chronic caregiving strain is the inhibition of women from caring about their health. Global experience indicates that when dealing with their own chronic conditions, female caregivers with high stress levels have a high likelihood of not adhering to medical recommendations or lifestyle changes. This is reflected in the Himachali tales: joint pain, malnutrition, and hypertension are not treated as long as women are unable to leave the sphere of caregiving to the patient without the risk of deterioration. The paradox is that the contact has turned the caregiver into a client-in-waiting of the health system, which is making her sicker and sicker because she is keeping the system on. This is not by choice, not being a structure trap where the responsibility of keeping life alive overshadows the right of self-protection.

**3. Cultural Enforcement: Stigma as a Social Cage**

The pattern of inequality of physiological and psychiatric care is not clinical but is highly cultural. To the psychiatric caregivers, such as Sunita or Leela, the illness is not a condition, but rather it is a family secret. The fear of being gossiped about and the potential end of marriage of daughters makes women remain silent, shutting off the social circles that could otherwise alleviate stress. Family blame helps to strengthen this social cage. Family members use accusatory, cynical tones - resembling High Expressed Emotion - which not only increase the chances of patient relapse but also increase the guilt feelings of caregivers. Scientific studies indicate that the treatment of female patients is usually stigmatised and financially burdened compared to the treatment of male patients. This intersection is particularly severe in rural Himachal, where a sick daughter or wife is interpreted as a threat to the reputation of the household, which increases the isolation of the person taking care of the affected person.

**4. Institutional Abandonment: Released into Risk**

Strain is further increased by failures of institutions. The story of Gayatri, when she was given her father-in-law without much guidance, is not an isolated case. Research indicates that in government hospitals in India, a transfer of medical responsibility is usually marked by discharge without proper preparation and follow-up. The caregivers end up being the unqualified clinical surrogates who must at least take care of nebulisers, injections, or psychiatric medication regimes without any safety net. The continuity-of-care models used in the international caregiving studies consist of the nurse coordinators, helplines, and written guidelines to minimise errors and relapse. Their unavailability in Himachal transfers technical, high-stakes jobs to untrained women, who

are under a permanent stress of making errors. The effect of institutional abandonment is that the recovery is transformed into a protracted crisis.

**5. Policy Recommendations: Invisible to Indispensable.**

The facts indicate the need to change the paradigm: caregivers should not be viewed as auxiliary powers in the background, but as the third pillar of the health system.

**a. Recognition and Compensation**

- Officially measure the unpaid caregiving in state reports, which comply with SDG 5.4..
- Provide primary caregivers with special stipends or allowances, especially widowed women or low-income women living in compounded precarity.

**b. Decentralisation and Relief in Transport.**

- Open up satellite centres in Mandi, Kullu and Kinnaur, to do regular oncology/psychiatric follow-ups.
- Introduce the use of transport vouchers or subsidised ambulance services in high-friction districts.

**c. Institutional Requirements of Safe Discharge.**

- Make hospitals adopt standard discharge procedures, such as written discharge instructions, discharge training, and referral networks.
- Appoint nurse coordinators and 24-hour helplines to enable hospital-to-home movement.

**d. Health and Psychosocial Support of the Caregivers**

- Screen caregivers systematically for issues like hypertension, depression, or malnutrition.

- Increase access to psychoeducational interventions like Family Focused Therapy in the state.
- Develop gender-sensitive interventions to deal with special risks encountered by the caregivers of female patients.

**Conclusion**

This paper establishes that the unpaid, long-term care of women in Himachal Pradesh is no marginal assistance, but a silent subsidy to support the healthcare system of the state. Based on the Social Exchange Theory, the research results reveal how this ruthless work goes on despite the devastating financial exhaustion, the high dependency on debts, and the lack of institutional rewards, which are motivated by the moral responsibility and the lack of options.

The centralised nature of tertiary care in the region makes it harder. The extended tiring trips to Shimla have covert expenses of transportation, food, and sleeping, compelling women to experience severe time scarcity and monetary vulnerability. As it can be seen in the case descriptions, the experience of caring is not an even line but rather strongly influenced by the type of illness and gender values: the experience of a caregiver working with a female patient is more severely stigmatized, more financially strained, and more damaged to their own health, as there are cultural fears of marrying and losing family integrity.

The fact is that caregiving cannot be swept under the carpet of health policy. A transformative response should not only be compatible with the ILO 5R framework, such as recognising, reducing, redistributing, rewarding, and representing, but it should also be used to take unpaid care into the sphere of quantified, supported labor. In the case of Himachal, this will be in terms of decentralised community health centres, organised discharge planning, health screening of

caregivers and culturally sensitive psychoeducation to reverse the culture of stigma and minimise unhealthy family patterns of interaction.

After all, it is this unpaid labor force that the existence of households and the success of the public health system depend on. Saving the caregivers is not selfless, just a necessity since, unless there is systemic change, the wombs that sustain care will not be safe either; they will continue being mere patients of the system they are serving.

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