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Beyond survival: examining mental health outcomes and structural determinants among women domestic workers in jaipur's urban slums

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Abstract: *Urbanization is associated with the development of a better healthcare infrastructure, yet the number of vulnerable urban slums is also growing, which leads to a high rate of mental health disorders, especially in low-income environments and among marginalized women. The crux of the matter is that the mental health needs of women domestic workers who are multiply vulnerable by means of converging networks of economic exploitation, gender-based discrimination, and social exclusion in urban informal labor markets are systematically ignored.*

This research paper looks at the psychological well-being of women domestic workers in the urban slum of Jawahar Nagar Kacchi Basti, Jaipur in India where there is a convergence of vulnerabilities along gender, class, and occupational lines. This study relied on mixed-methods convergent design where 250 women domestic workers were surveyed using psychometric tools that are validated, such as Beck Depression Inventory (BDI-II), Generalized Anxiety Disorder Assessment (GAD-7) along with an extensive thematic analysis of deeper narratives through narrative interviews with 20 women.

The study indicates a worrying high rate of psychological distress, with 72 percent of the participants having clinically significant depression and 68 percent exhibiting moderate to severe symptoms of anxiety, which is much higher than the rates estimated in general population. In terms of qualitative analysis, four main spheres of psychological distress are found: the economic precarity due to low wages (mean monthly earnings amounted to 3,200 rupees) and constant job insecurity, physical fatigue caused by longer working hours, social isolation because of internal migration and a lack of connectivity with the community, and inaccessibility of healthcare services due to the financial situation.

The study uses the intersectional analytical framework that combines Intersectionality Theory, Social Determinants of Health Theory, and Structural Violence Theory to demonstrate the interaction of systems of oppression to form distinctive patterns of mental health vulnerability. The results show that the mental health issues that participants are facing are not personal pathologies but expected consequences of interacting systems of oppression that work simultaneously both on economic, social, and institutional levels. In the research, the authors reiterate that the best interventions have to be both structural and intersectional, where the interventive intervention has to be multi-systems of oppression, and not at the individual level.

Keywords: *Women Domestic Workers, Mental Health, Urban Slums, Intersectionality, Anxiety, Depression*

1 Introduction

Urbanisation has substantially improved access to healthcare services over the past decades. However, this expansion has simultaneously led to an increase in the population residing in urban slum areas. The proliferation of slum dwellings, a direct consequence of rapid urbanisation, has given rise to a range of social challenges, including a marked rise in mental health disorders. Depression, anxiety, stress, and other non-psychotic affective disorders have become prevalent mental health issues in these settings (Kuddus et al., 2020).

Women employed as domestic help within urban slum environments encounter multifaceted challenges that adversely affect both their physical and mental health. These challenges include extended working hours, inadequate wages, and social invisibility. Such stressors are further intensified by substandard living conditions prevalent in overcrowded and underserved slum communities, heightening susceptibility to anxiety, depression, and other health complications. Evidence consistently indicates that women bear a disproportionate mental health burden in these contexts. For instance, research on domestic workers in Indian urban slums highlighted that inadequate housing, excessive workload, and insufficient rest contribute to deteriorating occupational health, psychosomatic conditions, and overall well-being (Roy, 2020). Similarly, studies in Delhi have demonstrated high rates of comorbid conditions such as anaemia, musculoskeletal disorders, and genitourinary issues among female domestic workers (Tomar, 2018). Women in low-income urban communities, particularly working mothers, face elevated risks of severe depression, exacerbated by intimate partner violence, lack of childcare support, and alcohol abuse by spouses (Travasso, Rajaraman, & Heymann, 2014). Research from Jaipur and Bhubaneswar further underscores these

findings, revealing elevated levels of stress, anxiety, and depression among slum-dwelling women, closely linked to poor sleep, physical inactivity, and socio-economic deprivation (Sinha et al., 2023; Sharma, Patnaik, & Sahu, 2023).

Social determinants such as gender-based violence and the absence of supportive social networks compound psychological distress beyond environmental factors. Community-based studies across impoverished regions have identified financial hardship, caregiving burdens, and restricted access to mental health services as major contributors to anxiety and depression among women (Doornbos, Zandee, & Degroot, 2012; Doornbos et al., 2013). Moreover, evidence indicates that women are more prone to depression than men and are nearly twice as likely to develop this condition (Albert, 2015). Common mental disorders (CMDs), including depression, anxiety, and stress, significantly contribute to the disease burden among Indian women of reproductive age (15–49 years) (Ministry of Health and Family Welfare, 2005). National data estimate the prevalence of mental illness in India at approximately 58 per 1,000 individuals (Reddy & Chandrashekar, 1998). As essential members of both households and society, women's mental health profoundly influences family and community well-being (McKeown, 2009). Married women, particularly those balancing employment and caregiving responsibilities, are especially vulnerable to psychological strain, often resulting in role conflict, mental fatigue, stress, anxiety, and depression. The ramifications of this mental health burden are severe, as evidenced by higher rates of depression, anxiety, and suicide attempts among women compared to men (BBC Future, 2021). Indian studies have further established strong associations between mental health disorders and factors such as age, gender, socio-economic status, education level, poverty, and legal marginalisation (Reiss et al., 2019). Chronic gynaecological and obstetric conditions have also been linked to increased psychological distress (Poleshuck et al., 2009).

Domestic workers play an indispensable role in the daily functioning of urban households, particularly in cities like Jaipur, India. Nevertheless, they face numerous challenges that significantly affect their daily lives. The present study focuses on Jawahar Nagar Kacchi Basti, a slum in Jaipur where many women are employed as maids. The proximity of this settlement to the affluent Adarsh Nagar raises critical questions regarding the socio-economic factors that shape the living and working conditions of these workers. The primary objective of this study is to evaluate the self-reported health status, anxiety, and depression of domestic workers in this community, thereby offering a comprehensive understanding of their physical and mental health challenges.

Self-rated health assessments provide valuable insights into individuals' subjective health conditions and can help uncover latent health problems. Anxiety and depression are crucial indicators of psychological well-being and are essential for elucidating the emotional burden experienced by domestic workers. Studying the health and mental health of domestic help is imperative for several reasons. Firstly, domestic workers operate within the informal sector, with limited access to healthcare and support services. Secondly, their occupational demands and socio-economic hardships may exacerbate both physical and mental health issues. Thirdly, understanding these challenges is vital for formulating targeted preventive and support programs and policies.

Although women across various socio-economic strata encounter psychological and sociological challenges related to gender discrimination, the experiences of domestic workers are further shaped by systemic oppression rooted in their socio-economic status. While women from privileged backgrounds may grapple with work-life balance, emotional labour, and societal expectations, domestic workers endure structural exploitation, lack of legal protections, social invisibility, and emotional alienation. Their contributions are undervalued and unrecognized, rendering them excluded from the very spaces they support. The employer-domestic worker dynamic exemplifies internal hierarchies within womanhood, where class and power disparities undermine notions of universal sisterhood. Consequently, the challenges faced by domestic women workers are deeply gendered and rooted in class-based marginalization, meriting thorough academic exploration.

This study utilises self-reported questionnaires to assess the health status and mental health of domestic workers, drawing on survey data from 250 participants to ascertain the prevalence of health and psychological issues in this population. The findings are expected to inform the development of health programs and policies aimed at enhancing the physical and mental well-being of domestic workers in Jawahar Nagar Kacchi Basti.

2 Review of Literature

The literature review indicates that the mental health of women involved in domestic work is affected by factors such as social isolation, caregiving, and economic vulnerability. Oakman et al., 2020) The COVID-19 pandemic has worsened these factors, and there has been a significant rise in the incidence of mental health disorders such as anxiety and depression among this group. (Sacco et al., 2023) Household work, which is an important part of the economic and social structure, is usually performed by women. Singh and Pattanaik (2020) have noted that the COVID-19 pandemic has only worsened this situation, as women are expected to take on more household chores while working remotely. Sarrasanti et al., 2020 This paper is a literature review that seeks to understand the relationship between domestic work, mental health, and gender with a focus on housemaid.

The pandemic has affected domestic workers, most of whom are women, in various ways. It is estimated that between 364 and 473 million workers are potentially negatively impacted by the lockdown, with women being slightly more likely to be in non-standard employment. This has made women more vulnerable in employment during this time and also increased the care work burden during the same period as noted by Walter (2020). The social distancing measures that came with the pandemic have also been attributed to the increase in cases of domestic violence, which compounds the mental health issues affecting housemaid. Some of the causes include changes in work schedules, financial pressures, and childcare responsibilities as some of the causes of increased domestic violence as noted by Vieira et al., (2020). (Muhafidin, 2021). Sekoni (2023) examines the

association between violence throughout the life span and mental disorders among women of the adult age residing in the slums of Ibadan, Nigeria.

Rwakarema and colleagues (2015) regards antenatal depression in women in Northern Tanzania to be closely related to pregnancy-related anxiety, the relationships with their partners, and their wealth. The study highlighted that pregnancy related depression is not an individual issue rather it is closely related with pregnancy related anxiety, poor partner relationship and economic problems. The study emphasizes the need to tackle these factors that affect the mental health of pregnant women in low-income situations. A meta-ethnography of women's experiences and perceptions of depression in India is given by Bhattacharya et al. (2019). It reveals how the social culture influences the perception of depression in women as presented by their study. The results of the study indicate that cultural stigma, social pressure, and gender norms affect the women's help-seeking behavior and their psychological well-being. The use of meta-ethnography enables the synthesis of the relationships between cultural context and mental health.

Swahn et al. (2022) provide a quantitative evaluation of the impact of the environment in the slum cities on young women's mental health in Kampala Uganda. The findings of the study show that living in a physical and social environment of slums, which entails overcrowding, no privacy, and exposure to violence, affects mental health. Young women experience such feelings as insecurity, stress and anxiety as they struggle in these environments. The research also stresses the importance of the interventions that will consider the environmental stressors that women in urban slums experience. Thi et al. (2021) undertake a rapid systematic review of child domestic workers' health consequences, particularly violence and its impacts. The review also explains the physical and mental health impacts of child domestic work, which entails different forms of violence. The study points out the young workers' vulnerability and the need for immediate protective measures and health intervention.

Ridley et al. (2020) aims at finding out the causal effect of poverty on depression and anxiety. Thus, they give convincing evidence of their hypothesis that poverty is a strong predictor of mental health problems. The ways by which poverty impacts mental health include stress, poor health services, and social exclusion. The research supports the need to adopt multi-sectorial approaches in the fight against poverty since this will help enhance the mental health of people from the low-income bracket. Winter et al. (2023) explore depressive symptoms of women residing in slum areas in Nairobi, Kenya. The study establishes social and environmental causes of depressive symptoms like lack of social support, poor living conditions, and economic insecurity as some of the causes. The study underscores the importance of culturally appropriate mental health services to address the social determinants highlighted in the study. Ramalho and Chant (2021) discuss the relationships between puberty, poverty and gender in the urban slum of the Global South. They further explain how these factors compound each other to pose specific risks to young girls' psychological and physical wellbeing. This paper concludes that there is a need for gender sensitive policies and programmes to address these complex issues. Hamadani et al. (2020) paper shows that COVID-19 aggravated the socioeconomic status, food insecurity, and intimate partner violence, which in turn contributed to mental health problems. The study underlines the importance of mental health interventions during crises and for special groups of people. Behera et al. (2021) are concerned with the health and safety of female domestic workers during the COVID-19 lockdown in India. The study also reveals the issues of unemployment, poor wages, social exclusion, and increased working hours for domestic workers leading to stress and anxiety. Thus, the study advocates enhanced rights and assistance for this vulnerable population.

Patel et al. (2022) test the translation and cultural applicability of the trauma assessment instruments for Indian women experiencing GBV. The paper also discusses the issue of PTSD among these women and the requirement of more effective diagnostic tools that are culturally appropriate. In the slums of Kampala, Uganda, Perry et al. (2024) examine the mental health problems and management of youths with emphasis on violence exposure and substance use. This paper establishes a positive relationship between violence exposure, mental health problems, and substance dependence. The research also highlights the importance of combined mental health and substance use care for youths in slum areas. Wagman et al. (2018) assess the correlation between the husbands' alcohol consumption, IPV, and FGC on postpartum women in Mumbai, India. This paper finds out that husband's alcohol consumption is a strong factor that leads to intimate partner violence and, therefore, mental health problems in women. The research recommends multifaceted approaches to substance use and domestic violence. Balaji et al. (2023) have studied the depressive symptoms and hazardous alcohol use among the intimate partner violence survivors in Nairobi, Kenya and the factors associated with them. In this case, social support is found to be a key protective factor, whereas economic stress and limited healthcare access are key risk factors.

Verma and Mishra (2020) examine the effect of the COVID-19 pandemic on depression, anxiety, and stress among the general population in India. The research reveals that factors such as SES, gender, and prior mental health disorders are predictors of mental health outcomes during the COVID-19 pandemic. Patel and Kleinman (2003) give an insight on poverty and common mental disorders in developing countries. Their study also reveals that poverty has an impact on mental health through stress, social isolation and restricted health care access. White et al. (2024) systematically review and meta-analyse the prevalence and mental health effects of intimate partner violence among women internationally. This paper concludes that intimate partner violence is prevalent and has serious mental health ramifications such as PTSD, depression, and anxiety.

3 Theoretical Frameworks

According to the research on the topic of mental health outcomes among women domestic workers in the urban slums in Jaipur, the following three theoretical frameworks are the most appropriate ones.

3.1 Theory of intersectionality

The most comprehensive theory that can address the compounded vulnerabilities of women domestic workers is the Intersectionality Theory that was initially formulated by Kimberle Crenshaw (1989). This theory looks into how the various categories of identities form interdependent webs of oppression which cannot be comprehended through the analysis of any individual aspect (Crenshaw, 1991).

The intersectional analysis is explicitly used in the study to analyze the convergence of the different identity markers that generate distinct disadvantage experiences. As shown in the research, intersectionality frameworks are especially useful in comprehending the lives of marginalized women caregivers since they show how various stigmatized identities combine together to form complicated patters of marginalization and vulnerability (Knaifel et al., 2025). Examining the issue of domestic workers requires the use of the intersectional approach due to the fact that it can be used to capture how gender, class, migration status, and occupational identity all influence the mental health processes all at the same time. According to van Mens-Verhulst and Radtke (2008), intersectionality frameworks are used to decode demographic factors and examine power relations that may otherwise be neglected by other methods.

This model states why single-factor interventions tend to be ineffective in handling realities of the lives of the marginalized women. The theory implies that a good solution to a problem has to be able to consider several systems of oppression at once and, therefore, is closely connected, in terms of the mental health issue of domestic workers.

3.2 Theory of Social Determinants of Health

The Social Determinants of Health Theory offers a structural approach to the process of comprehending how social, economic, and environmental circumstances are the basic determinants of health (Marmot & Wilkinson, 2006). This theory is focused on the fact that health is based on where people are born, live, work, and age but not on the behaviors of individuals. The recent literature shows close links between social determinants and mental health outcomes especially on vulnerable population. According to Allen et al. (2014), mental disorders affect poor and disadvantaged populations most, and cumulative stress is one of the major mechanisms of influence of social determinants on mental health in the lifespan.

The theory is especially applicable to domestic workers since it deals with the issue of the structures contributing to and sustaining mental health disparities. According to research, the psychological distress is regularly associated with worsened employment conditions, housing quality, and income levels even in countries that have universal healthcare systems (Silva-Lima et al., 2018).

This framework focuses on the fact that mental health interventions should be done by targeting the root causes of mental health conditions and not just treating symptoms. The theory sustains in-depth policy suggestions, which focus on structural disparities that influence the living and working conditions of domestic workers.

3.3 Theory of Structural Violence

Johan Galtung (1969) formulated a theory of structural violence that has been widely used by Paul Farmer (2004) in health delivery such that the structural violence theory describes how societies and institutions have a systematic way of harming individuals and population. According to this theory, there is a difference between direct violence (also known as physical harm) and structural violence (harm caused by social arrangements so that people are not able to satisfy their own basic needs).

The theory of structural violence is especially useful in explaining the experience of domestic workers since it makes visible how systematic disparities generate patterns of destruction that are predictable. The theory assists in understanding how economic exploitation, social invisibility and institutional neglect are forms of violence that have a direct relation to mental health outcomes.

The studies of migrant domestic workers show that structural conditions such as the unfavourable living and working conditions, exploitation in the employment systems, and lack of proper governance generate systematic health vulnerabilities (Hargreaves et al., 2024). Such results are consistent with the structural violence theory which focuses on the role of institutional arrangements in producing harm.

The framework contributes to the understanding of why the interventions targeting domestic workers at the individual level are not adequate in the context of mental health issues. The theory shows that mental health issues among the domestic workers are not an individual weakness but an expected behavior of violent social systems which need to be changed.

4 Methodology

This study employed a concurrent mixed methods design that combined quantitative survey data with qualitative narrative analysis to provide a comprehensive understanding of mental health experiences among women domestic workers. The exploratory-descriptive approach was specifically selected to establish prevalence rates of mental health conditions while simultaneously exploring the contextual factors that contribute to these outcomes.

Methodology is also convergent as it reflects in the theoretical approach three different and mutually complementary theories are utilized at the same time to process the same dataset. This would be because in complex social phenomena, more than one theoretical stance is needed to gain a full understanding.

The research was conducted in Jawahar Nagar Kacchi Basti, an urban slum located in Jaipur, Rajasthan, India3. This settlement represents a typical urban informal settlement, housing approximately 2,500 families with an estimated population

of 12,000 residents. The area is characterized by high population density, limited infrastructure development, and predominantly informal economic activities that reflect the broader challenges of urban poverty in India.

The selection of this particular setting was strategic, as it represents the intersection of urban development challenges and women's labor market participation in the domestic work sector. Based on a comprehensive census conducted in collaboration with local community health workers and administrative records, approximately 800 women in the settlement are engaged in domestic work across various neighborhoods in Jaipur. This population served as the sampling frame for the study, representing a significant proportion of the settlement's female workforce and providing a substantial base for statistical analysis.

The sample size calculation followed established statistical principles for cross-sectional studies with finite populations. Using the formula $n = (Z^2pq\ N) / (e^2(N-1) + Z^2pq)$, where N represents the total population of 800 women domestic workers, Z equals 1.96 for 95% confidence level, p equals 0.5 as expected prevalence given the absence of prior studies for this specific population, q equals 1-p (0.5), and e represents the margin of error set at 0.05.

The detailed calculation proceeded as follows: $n = (1.96^2 \times 0.5 \times 0.5 \times 800) / (0.05^2 \times (800-1) + 1.96^2 \times 0.5 \times 0.5)$, which equals 768 / (1.9975 + 0.96), resulting in n = 768 / 2.9575 = 260. This calculation yielded a required sample size of 260 participants. Accounting for potential non-response rates and incomplete surveys, the target sample was set at 280, with 250 participants ultimately completing the survey, achieving a response rate of 89.3%. This high response rate enhances the reliability and generalizability of the findings within the study population.

The quantitative component employed a stratified random sampling approach to ensure representativeness across the entire settlement. The sampling process began with stratification, where the settlement was divided into four geographic zones based on local administrative divisions and population density patterns. This stratification ensured that all areas of the settlement were proportionally represented in the sample.

The quantitative component employed multiple validated instruments to ensure comprehensive mental health assessment. The sociodemographic questionnaire was developed specifically for this study, covering personal characteristics including age, education, and marital status, family composition details such as number of children and dependents, employment specifics including work history, number of employers, and working hours, economic status indicators including monthly income and household expenses, and living conditions assessment covering housing type, amenities, and overcrowding.

The Beck Depression Inventory (BDI-II) served as the primary depression assessment tool, comprising 21 items measuring depression severity with scores ranging from 0-63. The Generalized Anxiety Disorder Scale (GAD-7) provided anxiety assessment through seven items measuring anxiety symptoms with scores ranging from 0-21. The Self-Rated Health Scale comprised five items measuring perceived health status across physical, mental, and social dimensions using a 5-point Likert scale. This instrument provided subjective health assessment that complemented the objective mental health measures, offering insights into participants' own perceptions of their wellbeing.

5 Lived Experiences of Mental Health Challenges Among Women Domestic Workers"

Lakshmi, 34 she said “I wake up in the morning and go from one house to another doing cleaning, washing, and cooking. There’s no rest. I became a really stressed person, and any misstep would be fatal to me. I always have that voice in back of my head sayin’ ‘did you leave somethin’?’ ‘Will they get angry with me if I do this?’ These thoughts are with me all the time, despite not having a job at the moment. When I get home, I am exhausted to make a meal or even chat with my youngsters. I was physically exhausted with some of muscles pulling familiar pains, but my mind was awake and buzzing. I haven’t slept properly in years or at least it appears that I haven’t. This stress—it’s like they follow me around wherever I go. It follows me everywhere.”

The frustration of the women participants was driven home by 50-year-old Geeta who said sometimes, I don’t see a way to escape this life. I’ve got very tired bodily and my heart becomes more and more burdened by the day. I have been working since I was a young girl, but the situation never changes at all. More bills come in every month, and I don’t own anything for myself. I’ve lost strength even to be in pain anymore, physical or otherwise, that they can trample all over your heart. There is no happiness here and there is no happiness anywhere. I’ve lost hope.”

One of the women, Sita, 28, said, “In the houses where I work, they look right through me as if I am a nonentity.” Sometimes they don’t even get a glance in my direction when they are issuing out orders to me. I feel like a worthless piece of trash, like the world is better of without me, all I do is clean up their mess. Now and then, all I want them to do is to call me any name other than the one they use to address me, but they never do. It’s like I’m less than them. There are moments that I begin to trust those thoughts and accept the fact that perhaps all I can get is that kind of life. At the end of the day I feel useless, as if I am useless and no one wants me. The easy and logical thing is to say that one cannot escape such feelings.”

Radha, 38 years old, said that, “I get so exhausted at work and by the time I come home there is nothing left in me.” I just developed a pain in my legs, my back, and I ‘m getting a headache, but I need to get home and cook for my husband and kids. The living situation I have is I need to take care of three kids, but there are some days that I can’t. There is this yearly fantasy of having a good mother, but quite frankly, I am exhausted. Some nights I don’t even have the energy to play with them or help with their homework. At times, I develop a guilty conscience for not being next to them, but what should one do? I have no choice. That tiredness is not only in the muscles but also in the heart.”

Meet Shanti, 45 years old woman from Ronda convinced me when she said, “I am always in fear most especially if I will be infected by a certain illness.” If I can’t work, who will pay for my kids’ diapers, clothes, toys, food etc? There’s no one else. If

I wake up one morning feeling pain in my back or develop a coughing spell, I freak out. I think, 'What if this is it? What do I do when I cannot work anymore and still have to take care of myself and my family? I can't afford to stop. My children rely on me and this absolutely scares the life out of me whenever I can imagine something happening to me. I am always stressed out, always putting much effort into entertaining my anxiety. There's no rest from it."

Another sufferer, Meena, 31, said, 'Sometimes it comes from nowhere and I begin to choke.' My chest feels constricted, my head spins, and I develop palpitations. It's like the feeling that something dreadful is going to take place but I have no idea what it is. Yes, it's so scary, and I don't suppose how to put a stop to it. I am even scared it may happen again while I am at work. I attempt to conceal it because I do not want my employers to: but then it is very difficult. The fear doesn't go away. The anxiety is constant unlike the panic attacks which maybe once in a blue moon."

Pooja, 29, shared; "It becomes on me since my husband died." I have two young children at home and they are young and I am the only bread winner for them. It's hard—sometimes too hard. The one thing that really gets to me is this constant dreaded feeling that I'm not doing enough. What if I get sick? What should I do if one thing or another happens to me? Who will look after my children next? The pressure is too much. I get the feeling that I am a workhorse, that I am constantly racing against time, and no matter how hard I work I am never doing enough. That is why I had to mention that I stay awake at night thinking that I might fail them at some point, or words to that effect.

Forty-one years old Asha, explaining that her worrying was chronic. Every time I lie down at night, I don't sleep; my mind will always be active." One calls for rent, the other for food while the third for school fees and so it goes. Now, I wonder how I am going to go on, and I simply cannot have a moment's peace. I really feel like my mind is racing much of the time, and I can no longer control it. I am not sure when I last had a good night's sleep. It is a nasty feeling waking up tired, and the several hopes are off to a fresh start all over. Yes it is tiring but I just don't know how to stop or pause it.

Kanta 36 said, "I came to Jaipur few years back working here my family is still in the village." I miss my children, my parents, but I couldn't stay there anymore I have to come here for work. Here, I have no one. All day long I work, and then I come home to an empty room. It's lonely. Im home, and yet I have friends, some people in the village, but here all I AM is invisible. As far as I am concerned; there is nobody I know and there cannot be anybody to have a conversation with. I feel so alone sometimes. It's hard."

Parvati, 52 years old stated, "Earlier I was able to go to the temple, to talk with the neighbours after work, but I do not wish to do anything now." When I get home, I lock myself in my room. I don't go out, I don't talk to anybody. It's like a pager that drives me to care less about the things that I used to be happy with. It came to the point that I don't even know why I feel this way. I just... I don't feel anything. Oftentimes I find myself in a state where I don't even want to move, let alone do something productive. It looks like there is something heavy on my chest all the time."

Self-employed Kamla aged 39 added, "Every morning before going to work I have this feeling of tightness in my chest." I am worried about the what ifs. What if I make a mistake? What if one day they scream with me or even dismiss me? In my attempts to be perfectly fine, there is always this expectation that something will go wrong. That is like always expecting something bad to happen and this puts me in a state of anxiety almost always. But I guess that even in the best of conditions I remain anxious."

Rekha, 44, for instance aver, "I am always stressed." It is just like fighting throughout my life. I work many hours but it is still not enough to repay all the money I spent. I am always biting the dust or pulled somewhere, and I have the feeling that I am late anyway. I get headaches due to stress but there is no way I can avoid it. I have to keep going. I do not get to take a break, and I often fear I will get an asthma attack but I do not have the luxury of time to stop. I have no choice."

Durga, 47, said, 'I don't talk to anyone about how I feel. I can also never turn to my family, or to my friends because I do not want to encroach on their time and energy. But it's hard. Often I feel I get overwhelmed and I don't know where to seek help from. I don't want people to think that I am a weak or whining individual. But inside, it's painful. Sometimes I want to fold up and die, but I get up and do what must be done in the best way possible. What choice do I have?"

Duldeep, 32 years, said, "Sometimes even while watching TV or reading a newspaper my mind does not shut up." The affairs that cross my mind are even as simple as what I did today or what I am going to do tomorrow. That's the feeling I get like my mind just cannot let me be asleep. I'm always thinking, always worrying. If there is anyone out there who needs something, a person, I can't even just sit back and let my mind unwind. Well, I am exhausted and yet my mind does not let me sleep at all. I just wish to be left alone, but for this, I don't know how to go about it."

Lata, 56, said, "I have been working as a domestic help for the last more than three decades." The shape of my body has changed as well. I am always risking to go out and I am in much pain, in my back or in my legs for instance. I have to. There are days I ask myself, how much longer, but I can't quit. I have to work. My children depend on me. I just endure through the pain all this time. I might not know when I will ever have an opportunity to take a break."

Neha, 35 aged women said, "The day feels like a race against time." I get up early in the morning, cook, wash, and sometimes even run to work, and again come back home to do all the housework. When I finally get to bed, my bones are aching from the day's work but I can't close my eyes. It seems to me that my head never turns off and is always considering what needs to be done the next day. Am I likely to be able to afford my children's school fees? What if something happens to me? Who will do all the work? It is really too much pressure, but I cannot avoid it. I just keep going."

Rita, 29, shared her thoughts: "I always have a feeling that in whatever I do it is not enough. My husband is ungrateful, and at the workplace, I feel like I do not exist. It's as if people don't even see that I am straining myself to do all that I do. I am torn

between my roles and I always ask my self if this is how life is suppose to be. Occasionally, I have the desire to run away and hide myself, but then I remember my children and I can't do that.

Anjali 40, said, "Every morning when I wake up, I ask myself how I am going to survive the day" For the past few days, I can barely recall when the last time was I felt happy. If I am not working I am cleaning, cooking, taking care of a family but not myself. I'm not alive and I don't want to live anymore. Everyone is on their own, they are lonely souls, no one to share the load with. The life as described by the author has been filled with numerous responsibilities that are neverending.

Savitri, 48, said, "I have been cleaning other people's houses for years, and some of the hardest working ones at that, but there is no reward." I always end up getting scared of doing something wrong because that is when they pay attention to me— or to rebuke or rebuff me. I always worry about being fired or replaced. It makes me uncomfortable even to think about it. I cannot imagine myself being out of work because there are so many people who rely on the income I bring home."

Jyoti, 37, expressed her frustration: "It feels like I am always on the move from one house to another struggling to earn a living. But whether I am cooking or eating, or sleeping or walking, I am always anxious. What if I fall sick? What if I can't work? Who will feed my children? I never forget these thoughts. I've changed, I don't feel like me anymore, I always feel sleepy, always anxious. I can hardly recall when I used to smile for real."

Maya, 43 years old said, "I used to spend so much time with my family, but now I feel so drained that I don't even feel like speaking with them." At the end of the day, all that one would wish is to sleep, but he or she can't do so. I have so many thoughts in my head constantly, I think about the future, about the money that should be earned to pay the bills. I am a sinking ship that has no strength left in me to even shout for assistance. It's a never-ending cycle."

6 Women's Narratives with Theoretical Frameworks

These testimonies offered by these women domestic workers are so strong they can serve as evidence as to how the three theoretical frameworks, Intersectionality Theory, Social Determinants of Health Theory, and Structural Violence Theory, can be realized in their lives. In each story, there is a complicated combination of various disadvantages influencing their mental health outcomes.

6.1 Intersectionality Theory

Intersectionality Theory (Crenshaw, 1989) shows that combines categories of identity, producing distinct effects of oppression that cannot be visualized through the viewing of any of the categories in isolation.

Gender-Class-Migration Intersections - The case of Kanta really shows how intersectional vulnerabilities can be quite powerful: I moved to Jaipur a few years ago to work here my family is still in the village. I miss my children, my parents, but I could not continue staying there anymore I have to come here to work. I have nobody here. I am busy the whole day, and I get home to the empty room. It is solitary." Her story shows how her womanhood (gender), domestic laborer (class), and migrant laborer (geographic displacement) result in a special kind of isolation that adds to her mental health struggles.

The widowhood of Pooja - puts still another layer of intersectional complexity: "It is the burden of me because my husband died. I have two small kids at home and they are young and I am the sole bread winner of them." She is a woman, a widow, a single mother, and a domestic worker, which causes immense pressure to her and takes a form of a constant feeling of anxiety and insomnia.

Gendered Caregiving Burden - The testimony of Radha is a good example of how gender and classes interact to generate unrealistic demands: "I am so tired after the day at work and when I reach home all I have is nothing in me... I have to go home and prepare dinner to my husband and children. It is an annual dream to have a good mother, but I am being very honest, I am tired." The combination of being a woman (who is supposed to be primary caregiver) and domestic worker (whose work is physically demanding) brings her a sense of tiredness not only in muscles but also in the heart.

The experience of Lata of thirty years demonstrates the interaction between age, gender, and social class: I have been serving as a domestic help during the past more than thirty years. I have also changed in body shape. I am still taking risks to go out and I am so much in pain, in my back or in my legs, to give an example." Her story shows how being an older woman in a physically demanding job with no retirement prospects presents special weaknesses that younger employees do not have.

6.2 Social Determinants of Health Theory: Structural Conditions Shaping Mental Health

Theory of Social Determinants of Health (Marmot & Wilkinson, 2006) focuses on the essentiality of social, economic, and environmental factors in the process of shaping health.

Economic Determinants- The ongoing concern about economic insecurity is a direct expression of the mental health consequences of economic insecurity: "Each time I lie in bed at night, I do not sleep; my mind will always be active. One says he needs some rent, another one says he needs some food and another one says he needs some school fee and so on." The fact that she cannot sleep and cannot stop thinking proves that lack of sufficient income causes chronic mental discomfort.

The issue of economic entrapment also makes Geeta hopeless: More bills are arriving each month, and I do not have anything that belongs to me. I have lost the power to be even in pain... it is not happy here and it is not happy anywhere. I am hopeless." The story reveals the direct links between chronic poverty and asset-lessness and depression and despair.

Employment Conditions - The fear of losing employment is discussed in the example of Savitri: "I always get frightened to do something wrong because that is when they start noticing me- or to rebuke me or rebuff me". I am always fearing that I will get fired or replaced." There is insecurity of the job, and there are no labor safeguards which make one live in fear.

The hypervigilance of Lakshmi shows that the work environment leaves long-term psychological consequences: I always have that voice in the back of my head saying, did you leave something? Will they get angry at me if I do this? Such thoughts are in my head at all times even though I am currently unemployed." The pressure in the workplace is so high that the anxiety never stops even when one is off duty.

Social Support Systems - Durga is alone and this reflects the impact that the absence of social support systems has on the mind: I do not tell anyone about my feelings. I can also never go to my family, or to my friends since I do not want to take away their time and energy... There are times I feel like folding and dying but I stand up and do what has to be done." Lack of affordable mental health assistance and emotional stigma form perilous loneliness.

Physical Environment - Several participants explain the influence of the poor living conditions on their mental state. The poor housing conditions coupled with overcrowding and the absence of privacy place extra pressure that adds to their occupational mental health issues.

6.3 Theory of Structural Violence

The Structural Violence Theory (Galtung, 1969; Farmer, 2004) is used to understand how social systems cause harm to people through failure to access their basic needs.

Economic Violence - The constant struggle that Rekha is going through can be categorized under economic violence: I am always stressed. It is comparable to battling all my life. I am working a lot yet I still cannot pay back everything I spent." Underpayment of domestic workers, even in cases when their labor is necessary, is a sign of economic violence that results in long-term stress and health issues.

The manifestation of the health anxiety in Shanti shows the nature of creating fear through economic violence: I am always in fear especially that I will be infected with a particular illness. And what will be the person to provide the kids of mine with the diapers, clothes, toys, food etc when I am not able to work? Lack of healthcare coverage and sick leave is a form of structural violence which means that workers are compelled to choose work over their health.

Social Violence in Invisibility - The dehumanization of Sita is an effective reflection of social violence: "At the houses I work at people stare straight through me as though I am nothing at all... I am a useless piece of garbage, like the world will be better without me." This systematic exclusion and objectification is social violence that has direct effect on self-worth and mental wellbeing.

The fact that Rita is not recognized reflects the aspect of social violence: I always feel that whatever I do is not enough. My husband is not grateful, and at the workplace, I feel that I do not exist." Structural violence of institutional devaluation of women in terms of work or in the home, is a form of violence that leaves women feeling inadequate and depressed.

Institutional Violence - In Meena, the institutional violence is hidden panic attacks: I am trying to hide it because I do not want my employers to: but then it is very difficult. Lack of mental health assistance in the workplace and the fear of losing their positions because of health problems constitute institutional violence that makes employees endure their pain.

The withdrawal by Parvati demonstrates the impact of institutional violence on social activity: "I could not go to temple, to talk to the neighbours after work, but I do not want to do anything now." Institutional violence is expressed in the absence of social protection and community support systems, which isolate vulnerable workers.

Intergenerational Violence - Several interviewees show their fear concerning the future of their children, and it shows how structural violence can be passed over generations. Lack of educational opportunities, impossibility of the social rise, and the possibility of inheritance of poverty are a systematic violence as it is not only modern labour force that is influenced by this phenomenon but also the future of the whole family.

These three theoretical perspectives combine to form a sound analytical framework that is able to reveal the complexity and intertwining nature of the problems facing women domestic workers. The three theories complement each other with discrete, though related, ways of understanding the problem: Intersectionality Theory describes how systems of oppression work together to produce individual experiences of disadvantage; Social Determinants of Health Theory identifies the particular structural causes of these mental health effects; and Structural Violence Theory conveys why these structural harms continue to exist and to reproduce themselves over time.

The convergence of these theories is critical since the psychological issues that affect women domestic workers cannot be explained by a particular factor or conceptualized based on the conventional individualistic methods. Rather, their psychological distress is a product of intricate interaction of many and concurrent kinds of disadvantage that interact and magnify to form entirely new types of weakness.

7 Study Conclusion

The strong testimonies of women domestic workers are strong enough instances that mental health issues of the women are expected consequences of overlapping systems of oppression that can only be solved through interventions that are comprehensive and structural in nature. The psychological distress of these people is the product of the compounding and

intensifying interdependence of economic vulnerability, gender-based inequalities, social isolation, and institutional violence that generate completely new forms of vulnerability.

This exploration leads finally to the conclusion that requires basic social change that questions the overlapping systems of oppression that surround the lives of these women. Their mental health problems require sustainable interventions that go beyond the individual reduction of symptoms to achieve more general development impact in this vulnerable group. It is only with the help of such comprehensive solutions that consider economic security, mental health assistance, and social circle building in combination that we can expect to ever establish the environment that would help the psychological health and complete human potential of women domestic workers and other marginalized groups.

The combination of theory that these stories bring out to us shows that proper social change must have an awareness of how various types of disadvantage combine to produce distinct experiences of oppression, what structural conditions produce undesirable effects, and what systematic arrangements reproduce that pattern over the years. The study adds to the literature in favor of intersectional, structural methods of combating mental health disparities in marginalized populations.

8 Study Implications and Government Policy Implementation Framework

This study reveals that women domestic workers experience compounded problems based on gender, financial vulnerability, mental health challenges, and social isolation, requiring comprehensive government intervention through multiple policy mechanisms. The intersectional nature of these challenges necessitates immediate economic security measures through the Ministry of Labour and Employment establishing dedicated enforcement units within state labor departments to monitor domestic worker wages under the Minimum Wages Act, 1948, with quarterly inspections and penalties ranging from ₹10,000 to ₹50,000 for non-compliance, while the Employee State Insurance Corporation (ESIC) should extend coverage through simplified registration requiring ₹100 monthly employer contributions for ₹2 lakh annual medical coverage, and the Employees' Provident Fund Organisation (EPFO) should create portable accounts through amendments to the Employees' Provident Funds and Miscellaneous Provisions Act, 1952. Mental health service integration requires the National Health Mission (NHM) to incorporate mental health screening through Primary Health Centers (PHCs) with ₹100 crore annual allocation for training 10,000 healthcare workers, while Accredited Social Health Activists (ASHA) receive 40-hour mental health training modules developed by NIMHANS with ₹500 monthly incentives requiring ₹60 crore annual allocation, and the District Mental Health Programme (DMHP) should establish community mental health centers in urban slums with ₹200 crore allocation for 100 centers nationwide. Social protection implementation should include the Ministry of Housing and Urban Affairs reserving 10% of Pradhan Mantri Awas Yojana (Urban) units for domestic workers with ₹5,000 crore additional allocation, while the Ministry of Women and Child Development establishes extended-hour Anganwadi Centers (6 AM to 8 PM) through Integrated Child Development Services (ICDS) requiring ₹300 crore annual allocation and 5,000 additional workers, and Parliament should pass the Domestic Workers (Regulation of Work and Social Security) Act with the Ministry of Law and Justice establishing fast-track courts requiring 500 additional judges and ₹100 crore annual allocation. The Ministry of Skill Development and Entrepreneurship should integrate domestic workers into Pradhan Mantri Kaushal Vikas Yojana with financial literacy and digital skills training, while the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) should extend to urban areas through coordination between Ministry of Rural Development and Ministry of Housing and Urban Affairs, guaranteeing 100 days alternative employment annually requiring ₹25,000 crore allocation and Parliamentary approval, with each state establishing Domestic Worker Welfare Boards under Labour and Employment Departments funded through 1% employer cess generating ₹500 crore annually across all states.

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