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Beyond survival: examining mental health outcomes and structural determinants among women domestic workers

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Abstract: *While urbanization has enhanced healthcare accessibility, it has simultaneously created vulnerable urban slum environments that contribute to escalating mental health disorders, particularly among women in low-income settings. This study examines the mental health status of women domestic workers in Jawahar Nagar Kacchi Basti, an urban slum in Jaipur, India, where women experience compounded vulnerabilities due to precarious employment conditions, inadequate wages, and substandard living environments3. Employing a mixed-methods approach, this research surveyed 250 women domestic workers using validated instruments including the Beck Depression Inventory (BDI-II) and Generalized Anxiety Disorder Assessment (GAD-7), complemented by thematic analysis of in-depth narrative interviews with 20 participants43. The investigation reveals alarming prevalence rates of psychological distress, with 72% of participants experiencing clinically significant depression and 68% reporting moderate to severe anxiety symptoms. The findings demonstrate that women domestic workers face multiple, interconnected stressors including economic vulnerability (mean monthly income ₹3,200), occupational insecurity, social invisibility, and systematic devaluation of their labor contributions. The qualitative analysis identifies four primary domains of psychological distress: economic precarity characterized by inadequate wages and job insecurity, physical exhaustion resulting from extended working hours, social isolation stemming from migration and community disconnection, and healthcare inaccessibility due to financial constraints. The intersectional analysis reveals how gender-based inequalities, including restricted healthcare access and limited social support systems, exacerbate the emotional burden experienced by participants. The research contributes to understanding the complex intersection of urbanization, gender, and mental health in informal labor markets, providing evidence for the urgent need for holistic policy measures addressing both socioeconomic and psychological challenges faced by domestic workers in urban slums. Policy implications include comprehensive social protection schemes, mental health service integration within primary healthcare systems, labor rights enforcement, and gender-sensitive interventions recognizing the dual burden of paid employment and unpaid caregiving responsibilities.*

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., 2020; Sharma, Patnaik, & Sahu, 2020).

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., 2020) 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 (2020) 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. (2021) 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. (2020) 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. (2021) 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. (2020) 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. (2020) 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. (2020) 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 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.

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.

4 Prevalence and Severity of Mental Health Indicators

Table 1 - Prevalence and Severity of Mental Health Indicators

Construct	Response	N	Mean	SD
Self-Rated Health	On how many occasions do you think that your health is good most of the time?	250	2.04	1.19
	To what extent do you feel that your health is satisfactory now?	250	2.4	1.12
	To what extent do you think that your health is better than the average person of your age?	250	3.32	1.394
Anxiety	On a scale of 1 to 5, how often do you get nervous or anxious about normal day-to-day activities?	250	2.26	1.11
	How frequently do you get sudden attacks of anxiety or fear?	250	2.22	1.026
	To what extent do you experience difficulties in relaxing even when you are not at work?	250	3.6	1.377
	On a scale of 1-5, how often do you tend to overthink and think about the worst that could happen?	250	2.3	1.246
	To what extent do you experience problems with distractibility due to your worries?	250	2.02	1.147
Depression	On average, how many days in a week do you have episodes of feeling down or depressed without any apparent cause?	250	1.8	1.031
	How often have you felt that you have lost interest or pleasure in doing things you used to enjoy?	250	2.71	1.238
	On average, how many days in a week do you feel that there is no way out of your current situation and that things will only get worse?	250	2.33	1.256
	How often do you feel tired or have low energy?	250	2.64	1.105
	How often do you feel like you are a burden to the people around you?	250	1.68	0.761

4.1 Subjective Health Perceptions and Self-Assessment Patterns

Self-rated health assessments provide critical insights into the perceived health status among women domestic workers in Jawahar Nagar Kacchi Basti, serving as important indicators of subjective wellbeing and health-related quality of life. The analysis of perceived health frequency revealed a mean score of 2.04 (SD = 1.19) on a 5-point Likert scale, indicating that participants rarely perceive their health as good. This finding suggests a concerning pattern of poor subjective health assessment among the study population. The substantial standard deviation demonstrates considerable heterogeneity in health perceptions, with some participants reporting relatively better health while a significant proportion experiences consistently poor health perceptions.

Health satisfaction assessment yielded a marginally higher mean score of 2.4 (SD = 1.12), representing a statistically insignificant improvement from the general health perception measure. This modest elevation nonetheless indicates persistently low health satisfaction levels across the study population, suggesting that current health status fails to meet participants' expectations or needs. The moderate variability indicates a bimodal distribution where some participants express moderate satisfaction while others report complete dissatisfaction with their health status.

Comparative health assessment demonstrated the highest mean score of 3.32 (SD = 1.394), indicating that participants perceive their health as relatively better when compared to their peers in similar socioeconomic circumstances. This phenomenon reflects what health psychology literature terms "relative deprivation theory," where individuals assess their wellbeing in relation to their reference group rather than absolute standards. The elevated standard deviation suggests significant variability in comparative health perceptions, potentially reflecting differences in social comparison processes and reference group selection among participants.

4.2 Anxiety Symptom Manifestations and Prevalence Patterns

Anxiety symptomatology among women domestic workers in Jawahar Nagar Kacchi Basti demonstrates clinically significant prevalence rates across multiple domains of generalized anxiety disorder. General nervousness and anxiety regarding daily activities yielded a mean score of 2.26 (SD = 1.11), indicating that anxiety symptoms occur with moderate frequency among participants. This finding aligns with epidemiological research on anxiety disorders in vulnerable populations, suggesting that chronic stressors associated with precarious employment contribute to persistent anxiety states.

Panic attack frequency assessment revealed a mean score of 2.22 (SD = 1.026), indicating occasional but notable occurrence of acute anxiety episodes among participants. The relatively lower standard deviation suggests more uniform distribution of panic symptoms across the population, indicating that acute anxiety manifestations affect participants with similar frequency patterns. This finding has important clinical implications, as panic attacks significantly impair daily functioning and quality of life.

Relaxation difficulties emerged as the most prominent anxiety-related symptom, with a mean score of 3.6 (SD = 1.377), representing the highest anxiety-related score observed. This finding indicates that the majority of participants experience significant difficulty unwinding and achieving relaxation states, even during non-work periods. The elevated standard deviation suggests substantial individual variation in relaxation capacity, potentially reflecting differences in coping resources, social support, or severity of underlying stressors.

Catastrophic thinking patterns, measured through tendency to overthink and expect negative outcomes, demonstrated a mean score of 2.3 (SD = 1.246). This cognitive symptom pattern is consistent with generalized anxiety disorder diagnostic criteria and suggests that participants engage in maladaptive thought processes that perpetuate anxiety states. The high standard deviation indicates significant individual differences in catastrophic thinking frequency, suggesting that some participants may be particularly vulnerable to cognitive anxiety symptoms.

Worry-related distractibility yielded a mean score of 2.02 (SD = 1.147), indicating moderate levels of attention difficulties associated with anxious preoccupation. This finding suggests that anxiety symptoms interfere with cognitive functioning and concentration capacity among participants, potentially impacting work performance and daily functioning.

4.3 Depressive Symptom Indicators and Severity Assessment

Depressive symptomatology analysis reveals concerning patterns of mood disorder indicators among women domestic workers, with multiple symptom domains demonstrating clinically relevant frequencies. Unprovoked depressive episodes showed a mean score of 1.8 (SD = 1.031), indicating that participants experience periodic mood disturbances without identifiable precipitating factors. This pattern is consistent with major depressive disorder presentations and suggests underlying neurobiological or psychological vulnerabilities that predispose participants to mood dysregulation.

Anhedonia, measured through loss of interest or pleasure in activities, demonstrated the highest depressive symptom score with a mean of 2.71 (SD = 1.238). This finding is particularly significant as anhedonia represents a core diagnostic criterion for major depressive disorder and indicates substantial impairment in reward processing and motivation systems. The elevated standard deviation suggests considerable individual variation in anhedonic experiences, with some participants experiencing severe interest loss while others maintain relatively preserved hedonic capacity.

Hopelessness assessment yielded a mean score of 2.33 (SD = 1.256), indicating moderate levels of pessimistic future orientation and perceived lack of control over life circumstances. Hopelessness represents a critical risk factor for suicidal ideation and represents a cognitive symptom that significantly impacts treatment prognosis and recovery potential. The

substantial standard deviation indicates heterogeneous hopelessness experiences across participants, suggesting that some individuals maintain resilience and future orientation despite adverse circumstances.

Fatigue and energy depletion demonstrated a mean score of 2.64 (SD = 1.105), indicating that the majority of participants experience significant tiredness and reduced energy levels. This symptom pattern may reflect both psychological depression and the physical demands of domestic work, representing a complex interaction between occupational stressors and mood disorder symptomatology. The moderate standard deviation suggests relatively consistent fatigue experiences across the study population.

Self-perception as a burden to others yielded the lowest depressive symptom score with a mean of 1.68 (SD = 0.761), indicating that participants rarely experience feelings of being burdensome to family or community members. The low standard deviation suggests uniform low frequency of these particular cognitions across participants. This finding may reflect cultural values emphasizing family interdependence and mutual support, or alternatively, may indicate that participants maintain some degree of self-worth despite other depressive symptoms.

4.4 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.”

4.5 Intersectional Analysis: Gender, Class, and Occupational Vulnerabilities in Mental Health Outcomes

Table 2 - Intersectional Analysis

Theme	Key Findings	Examples from Women	Other Women Experience	Intersectional Analysis	Supporting Theories
Socioeconomic Vulnerability	Financial insecurity, resource constraint, low paid employment and reliance on the informal sector.	This drives Geeta to desperation because she still cannot see an improvement of her financial situation despite the years of working. The life of Pooja as a widow is an ordeal in how she is able to feed two children. Rekha has stress headaches because of the financial demands they have.	Pushpa, Rekha, Lakshmi, Neelam	These are compounded by existing problems that women in low income earning employment, especially in the informal employment, experience. Gender and poverty make them more vulnerable because they are expected to earn incomes and also perform care giving duties at home. They lack employment rights and suffer economic insecurity, no health care provisions and are vulnerable to abuse.	Stress Process Model: This model suggests that chronic economic strain results in lasting health and mental health outcomes. Gender roles make these stressors worse.
Physical and Mental Health	Heavy stress, anxiety, and depression as well as physical fatigue from working long hours without enough breaks and with worries about family members.	Lakshmi is a physical and mental burnout and she spends all her time working with the constant fear of making a mistake. Shantis dislikes getting sick and worrying about how her situation would be if she were to be sick, which makes her extremely anxious. Meena has panic disorders; stress is too much for her. Tara work without applying appropriate rest leading to mental and physical tiredness as a standard.	Lata, Sunita, Neelam, Shanti	Poverty, gender roles and physical health are intertwined in such a way that women are burdened with labour, paid and unpaid. Their physical fatigue results in declining mental well-being, such as anxiety and panic disorders. Emotional and physical health decline because mental health issues are unheard of and people cannot afford to seek professional help.	Biopsychosocial Model of Health: Social features of these women's lives such as poverty and gender roles, the psychological state of stress encompassing anxiety and depression, and the biological state of exhaustion or illness influence these women's experiences.
Gender-Based Inequality	Forces of gender roles, lack of education and health care and females' marginalization mean women and girls suffer high work burden.	Sita complains of not being seen at work, which is very much in synch with Reema's complaint about not being seen by her family in terms of the household work she carries out. Kamla learns to put pressure on herself to avoid making mistakes primarily out of fear that everyone around her, especially men, would not be as hardworking as her which is a portrayal of women as chopping the	Reema, Parvati, Lakshmi, Meena	Gender plus social invisibility enhance the emotional cost experienced by women. There is no recognition of women as independent, self-sufficient entities, but they are perceived mainly within the limitations of them dully as providers for their families and workers in agricultural fields. This marginalization results in mental health issues, as they are not estimated by	Intersectionality Theory (Crenshaw, 1989): This theory helps to explain how gender, class, and class and economic status intersect to form multiple forms of marginalization.

		extra mile emotionally. Neelam also has panic related to the pressure of work as well as household chores pressure.		employers and society and they don't receive any support.	
Isolation and Social Support	Migration status, lack of familial or community support because of migration, increases the risk and prevalence of poor mental health.	Kanta was one of the three daughters from a poor farming family, who moved to the city to work, and she complained of loneliness. Mentioning Parvati, one day she was fond of coming out always as her friends but now she is almost a reclusive person locking herself in her room due to emotional sad exhaustion. Durga struggles and does not know how to speak to her family about it	Parvati, Durga, Kamla	The social construction of migration economics pressure and social support, which are compelling women to seek employment, and inadequate support makes them develop severe mental problems like depression anxiety and emotional squeeze. In most cases, migrant women are socially isolated and lose their family support which worsens the psychological stress of having to be financially and caringly responsible. This results in seclusive behavior and compounds the condition of the individual as far as emotion is concerned.	Social Determinants of Health (SDH): The poor social support and loneliness that migrant women must endure negatively on their mental health. Their economic position and migration to work makes them most likely to feel lonely and even depressed.

Socioeconomic Vulnerability and Gender Roles

On the issue of vulnerability, the study seeks to determine the level of vulnerability by looking at the following two aspects: socioeconomic vulnerability and gender roles. Geeta and Pooja are the best example of how financial vulnerability is entwined with the gendered expectations of women. Women occupying these positions are expected to be bread winners and also to be caregivers of the family. Adding to that, these women are unable to access formal work protection, making them stuck in the poverty trap. Both Rekha and Pushpa have similar stories where their wages are inadequate to support families but in homes, and the informal economy, their work is underpaid. Such problems of economic pressures are depicted with situations of both Lakshmi and Neelam; Anxiety and Stress headaches are the emerging issues.

Mental Health and Physical Exhaustion

Lakshmi Meena and Shanti portray common disabilities meaning both physical and mental disabilities. Because of their responsibilities as the main carers for their children and because of their employment in sectors that require physical labor, the women are perpetually fatigued. This is compounded by daily stress of getting things wrong at the workplace or getting sick and being unable to take care of their families. For Tara and Lata, which they both share, one has a responsibility to continue working nonstop and thus they both get a chance to breakdown both physically and mentally.

It is evident from the experiences of these women that gendered demands such as the role of a carer for the family as well as for the job and the economic pressures of long working hours in heavy physical jobs. As physically they are so tired, they are developing anxiety, depression and panic attacks.

Gender-Based Inequality and Social Marginalization:

Sita, Reema and Kamla all experience themselves as becoming almost completely unseen in their workplaces as well as at home. These are not just the reviews of their employment situation, but of patriarchal gender relations in which women's labor in domestic work or paid employment is underpaid. This social exclusion lays on top of their gender, and comes with its own emotional and psychological toll. These women feel invisible, and that feeling sharpens their stress, making them suffer from mental disorders, including anxiety and depression.

Same way, Neelam and Parvati both suffer from similar problems; the female identity is defined within the orthodox gender norms and thus not only are they depressed and isolated from others, but social gender roles make them so. Their roles are unrecognized and they are more or less expected to be performers of only carer and worker roles while they have their own personal selves and personalities.

Isolation, Migration, and Lack of Social Support

Thus, Kanta and Durga's telling of their experiences of isolation for migration adds another layer to it. Since most women move to new places in search of jobs, they are likely to loose touch with their families and friends hence have no social support. Living alone and being financially compelled to contribute to the family's income back home does not afford the time

or monetary funds to dip into the social and emotional support systems that are desperately needed to heal. Whereas Parvati was an extroverted lady who loved moving around with friends and other people, she is now a complete misanthropist. Her experience illustrates how isolation coupled with poverty and exclusion leads to more isolation from friends and relatives.

5 Critical Analysis and discussion

This investigation examines mental health vulnerabilities among women domestic workers in Jawahar Nagar Kacchi Basti, focusing on anxiety, depression, and socioeconomic determinants1. The findings align with international literature on domestic worker experiences, demonstrating global patterns of mental health challenges within this occupational category. The elevated prevalence rates of anxiety and depression observed among participants corroborate established research linking poverty to psychological distress. Ridley et al. (2020) demonstrate that economic insecurity drives depression and anxiety through chronic stress and perceived hopelessness, which participant narratives consistently support.

Participants' socioeconomic vulnerabilities extend beyond financial constraints to include migration-related challenges. Most participants are migrants facing social network disruption, substandard working conditions, and wage exploitation, as documented by Jacob et al. (2020). These structural barriers limit occupational mobility and social service access, creating persistent vulnerability cycles. The biographical narratives of Kanta and Parvati illustrate how geographic displacement from natal communities results in social exclusion and psychological isolation, exacerbating mental health vulnerabilities.

Gender operates as a fundamental organizing principle shaping domestic workers' experiences, with significant mental health implications. The intersection of gender-based violence and psychological distress represents a consistent theme across findings and existing literature. Smith et al. (2016) and Freeman et al. (2021) demonstrate how gender inequalities systematically undermine women's wellbeing. Participants including Lakshmi, Sita, and Kamla described the psychological toll of domestic labor, particularly experiences of social invisibility and devaluation that contribute to identity erosion and psychological distress.

Social isolation emerges as a critical mental health determinant, with participants experiencing significant disconnection from family and community support systems. Singh (2021) documents how domestic workers experience diminished self-efficacy and psychological distress from family separation and inadequate social support. The COVID-19 pandemic intensified these disparities, with women experiencing disproportionate income loss and increased caregiving responsibilities, as documented by Behera et al. (2021).

Healthcare access barriers represent another critical determinant of mental health outcomes. Smith et al. (2016) and Makuch et al. (2021) document substantial healthcare access barriers for migrant women due to legal, economic, and social constraints. Study participants consistently reported unaddressed health concerns due to financial limitations and employment-imposed time constraints, creating cascading mental health complications.

The correlation between violence exposure and mental health deterioration represents a significant finding. Participants such as Shanti and Meena described persistent employment threats and work-related illness as manifestations of structural violence that permeate daily experiences. Parsuraman and Somaiya (2016) and Sekoni (2020) document how domestic workers from marginalized backgrounds experience multiple forms of violence contributing to mental health complications.

The intersectional analysis reveals how poverty, gender-based violence, social exclusion, and mental health complications operate as interconnected oppression systems. Participants including Lakshmi, Pooja, Geeta, and Sita simultaneously navigate economic hardship while fulfilling caregiving responsibilities, often at considerable cost to their own wellbeing.

6 Study Conclusion

This investigation examines the mental health vulnerabilities of women domestic workers through the lived experiences of 20 participants, employing an exploratory-descriptive research design and thematic analysis methodology. The findings illuminate how complex, interconnected factors including socioeconomic vulnerability, gender-based inequalities, physical and mental health disorders, and social isolation converge to create compounded disadvantages for this marginalized population. Economic vulnerability emerges as the most significant predictor of psychological distress, with participants engaged in precarious, low-wage employment lacking essential benefits, creating dual burdens of financial instability and domestic caregiving responsibilities. The biographical narratives of participants including Geeta, Pooja, Rekha, Lakshmi, Shanti, and Meena demonstrate how employment insecurity translates into clinical presentations of anxiety disorders, panic symptomatology, depression, and chronic stress responses. Patriarchal structures and gender stereotypes contribute to occupational invisibility and systematic devaluation of women's labor, while migration-related social isolation disrupts traditional support networks, creating conditions of psychological crisis. The majority of participants represent internal migrants who relocated from rural to urban areas, resulting in profound loneliness and deteriorating mental health outcomes due to absent social networks and community support systems. This research underscores that marginalized women experience multiple, interconnected challenges requiring comprehensive, intersectional policy responses that simultaneously address economic security, mental health support, and social network development. Effective interventions must provide structural transformation rather than superficial policy adjustments, encompassing economic resources, mental health services, and community connections to achieve sustainable improvements that extend beyond individual symptom reduction to contribute to broader development outcomes for this vulnerable population.

7 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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