



## ORIGINALES

### The family caregiver: the naturalized sense of obligation in women to be caregivers

La cuidadora familiar: sentimiento de obligación naturalizado de la mujer a la hora de cuidar

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#### ABSTRACT:

Increase of chronic diseases and number of dependent people as a consequence of the aging of the population is a fact and also that women are the main providers in family care. Therefore, the **objective** of this study is to show how women accept their role as a cultural obligation because of their sex. It is a qualitative investigation based on a grounded theory descriptive type. Nine participants were interviewed. They were informed of the study and gave their consent. Obtained **results** suggest six categories: sharing family care tasks, decision making, unreal help sensation and proper family care tasks distribution, women cultural and moral obligation in family care, women acceptance of their roles as a caregivers. The main conclusion of the article is how society accepts women obligation in family care without consensus.

**Keywords:** Family caregiver; women; caring

#### RESUMEN:

El aumento de la cronicidad de las enfermedades y de las personas dependientes como consecuencia del envejecimiento de la población es un hecho demostrado, como también lo es que las mujeres son las principales implicadas en el cuidado familiar. Por ello, el **objetivo** del estudio es visibilizar cómo la función del cuidado familiar queda adscrita a las mujeres como parte de un rol de género motivado por un sentimiento de obligación naturalizado por parte de las mujeres a la hora de cuidar. Se trata de investigación cualitativa basada en la teoría fundamentada de tipo descriptivo. La muestra está constituida por nueve participantes a las que se les sometió a una entrevista semiestructurada. Además a las participantes se les entregó una ficha explicativa del estudio y una hoja de consentimiento informado. Los **resultados** obtenidos tras el análisis de los datos surgieron seis categorías: "posibilidades de división del cuidado en el núcleo familiar cercano", "toma de decisión", "falsa sensación de ayuda y fragmentación efectiva del cuidado", "el cuidado por parte de la mujer entendido como algo natural", "cuidado entendido como obligación moral" y "la ayuda en femenino a una responsabilidad asumida como femenina". La conclusión principal del artículo es que la responsabilidad

de ser cuidadora principal recae principalmente sobre mujeres y cómo la decisión se enmascara sobre un falso consenso.

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**Palabras clave:** Cuidadora familiar; mujeres; cuidar.

## INTRODUCTION

The gradual ageing of the population caused by increases in life expectancy and a decrease in birth rates, together with scientific advances, has led to an increased prevalence of chronic diseases in Spanish society<sup>(1)</sup>. Thus it would seem convenient for citizens to be prepared for this inevitable phenomenon and, although many of the elderly may be independent and active, there will be a notable increase in the number of dependent people and, as such, the number of those providing care<sup>(2)</sup>. The problem lies in the fact that, although occasionally there are several members of the family available to attend to dependent relatives, in the majority of cases the workload, or at least the greater part of the care required, falls on one sole person, usually a woman<sup>(3)</sup>. Such a day-to-day responsibility has a great impact (psychologically and physically) on the primary caregiver, leading to one of the most common consequences of stress in these women and other family members, known as Caregiver Burnout<sup>(4)</sup>.

In general, when one speaks of women caregivers one is referring to married women, on average 52 years of age, with no paid employment and whose relationship with the care receiver is, in 57% of cases, paternal-filial, 16% spousal and in 10% of cases it is the daughter-in-law taking care of the dependent person<sup>(5)</sup>. The fact it is mostly women who are in charge of caring for others and this sexually discriminatory division of the workload is understood, by the greater part of society, to be logical and natural is determined by the understanding of care within a dominantly patriarchal context<sup>(6,7)</sup>; caregiving becomes an inherent part of the female role.

Ultimately, this can be considered a form of discriminatory gender division of the workforce since it implies less opportunities for women to access positions of power and wealth, and a way of associating “attachment” to “caring” and undervaluing tasks performed mainly by women, a concept learned through the process of socialization<sup>(5)</sup>. As such, the present study aims to show how the duty of care in families is assigned to women as part of a gender role motivated by a naturalized sense of obligation in women to be caregivers. This in turn hinders the effective division of care-specific tasks and the equitable assignment of primary caregivers with regard to gender.

## PARTICIPANTS & METHOD

### Design and sample

This research was designed based on the qualitative descriptive approach, given the aim of demonstrating how the patriarchal society in which we live has created a sense of naturalized obligation in women to take charge of the care of family members. In terms of sample selection, the inclusion criteria involved participants presenting the characteristic profile of a primary caregiver (Table 1) with the aim of minimizing the differences and bringing to the forefront the basic characteristics of this role. As a first stage, an intentional sampling method was utilized; subsequently, the final acquisition of participants was via snowball sampling since this allows for a reliable relationship to

be established with new participants prior to being interviewed, as well as utilizing social networks to attract new participants

**Table 1: Inclusion Criteria**

<p><b>Caregiver Profile Characteristics</b>          Female (84%).          Family member of care receiver.          Average age 53 years old.          No schooling or primary school (60%)          No personal income (58%).          Not contractually employed (74%).</p>
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**Source:** IMSERSO 2015.

The data collection and analysis were performed in the municipality of Santomera and Murcia capital city between the 23<sup>rd</sup> of October and the 18<sup>th</sup> of December 2015. The initially accessible population involved twelve people, although the final sample consisted of nine participants who satisfied the inclusion criteria.

The sample's sociodemographic data are shown in Table 2. A highlight of this data is the fact that all nine participants were women, with an average age of 52, (min. 44 – max. 66 years old) of which all were married except one and all provided care for family members.

**Table 2: Participant's sociodemographic data.**

Code	Age (Years)	Sex	Marital Status	Schooling	Employment Status	Personal Income	Care Receiver
E.O.1.	56	F	Married	No schooling	Housewife	No	Daughter
E.O.2.	51	F	Married	Primary school	Housewife	No	Mother-in-law
E.O.3.	57	F	Married.	No schooling	Housewife	No	Madre
E.O.4.	44	F	Married	Primary school	Unemployed Housewife	No	Mother and Aunt
E.O.5.	52	F	Married	Secondary school	Cleaner	Yes	Mother
E.O.6.	66	F	Single	No schooling	Carer	Yes	Aunt
E.O.7.	55	F	Married	Secondary school	Housewife	No	Mother
E.O.8.	45	F	Married	Primary school	Butcher	Si	Mother
E.O.9	46	F	Married	No schooling	Housewife	No	Mother

The sociodemographic data of the receivers of care provided by the participants (Table 3) showed an average age of 75.4 years old (min. 29 – max. 86 years of age), four of which were totally dependent, four moderately dependent and two presented a mild dependence, according to the Barthel Index.

**Table 3: Sociodemographic data of those receiving care from participants.**

Code	Age	Sex	Lives with	Diagnosis	Barthel Score
E.O.C.1.	29	F	Caregiver (mother)	Cerebral lesion	Score: 0 Totally dependent.
E.O.C.2.	79	F	Caregiver (daughter-in-law)	Encephalitis	Score: 0 Totally dependent.
E.O.C.3.	83	F	Caregiver (daughter)	Hemiplegia due to Thrombosis	Score: 15 Totally dependent.
E.O.C.4.	82	F	Alone	Senile Dementia	Score: 50 Moderately dependent
E.O.C.5	76	F	Alone	Osteoporosis & Arthrosis	Score: 40 Moderately dependent
E.O.C.6	86	F	Caregiver (daughter)	Dementia	Score: 60 Mildly dependent
E.O.C.7	83	M	Three children	Renal Insufficiency & Anaemia	Score: 40 Moderately dependent
E.O.C.8	82	F	Caregiver (daughter)	Blindness & Arthrosis	Score: 45 Moderately dependent
E.O.C.9	75	F	Son	Alzheimer's	Score: 0 Totally dependent.
E.O.C.10	79	F	Two of her children	Parkinson's	Score: 70 Mildly dependent.

### Data Collection

The collection of data was performed between the 1<sup>st</sup> and the 30<sup>th</sup> of November 2015. The initial contact was made with participants via telephone call in which they were invited to participate in this study, the aim of which was explained and the potential participants were informed of how the data would be gathered. Subsequently, an appointment was made with those willing to collaborate in the study in which the sociodemographic survey and an in-depth interview would take place, at a time and place convenient for them.

Prior to commencing the interview, an "Informative Letter" was provided in which the aim of the study was again explained and participants were advised that the interview would be recorded for subsequent transcription and analysis. Likewise, the letter informed of the right to abandon the study at any time without penalty, as well as guaranteeing anonymity and the complete confidentiality of all data obtained from the interviews. An informed consent form was also provided, the signing of which would confirm the wilfulness to participate in the study.

A semi-structured interview method was utilized as the most adequate means of obtaining information, since it facilitates exploring deeper into the evident existence of the caregiving role in women, with the aim of understanding their perspective and detailing the significance of their experiences. The interview consisted of two parts: the first part contained a battery of questions of a sociodemographic nature divided into four themes; "caregivers' sociodemographic data", "care receivers' sociodemographic data", "caregiving characteristics" and "family structure"; while in the second part, a series of open questions were made in order to encourage participants to speak freely

about their situation. Prior to the interviews a script was elaborated with ample questions to serve as a guide, apart from the available literature. The onset of the second part of the interviews invariably began with a brief introductory comment on the study topic as follows: “I would like us to start this second part by speaking on the situation as discussed among the family when your mother/aunt/daughter’s (insert pathology) reached the point of requiring care”, followed by a general question such as “How was the situation considered among the family?” As the interview advanced, the questions were oriented towards the existence of feelings, the possibility of there being other caregivers and the division of caregiving and housekeeping tasks, depending on the course the interview is taking. The duration of the interviews was between 20 and 25 minutes long, approximately.

## RESULTS

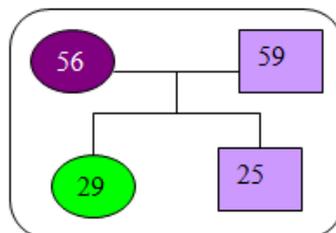
### Possibilities for dividing caregiving tasks within the immediate family nucleus

Analyzing the family nuclei and interpersonal family relationships of the nine caregivers interviewed, in relation to the assignment of a caregiver, or at least the equitable division of the caregiving workload, in terms of gender such a division was possible. The sample’s social/family characteristics were such that real opportunities existed for men to be designated by the family as the primary caregiver, nonetheless an equal division of the caregiving tasks in order to reduce the workload was not as such.

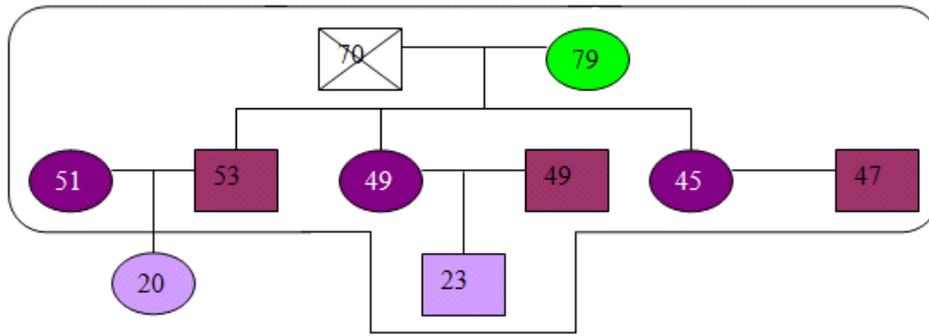
The case of caregiver E.O.2 is noteworthy in that they share no blood ties with the receiver of their care who is their mother-in-law. Equally notable is the cases of families E.O.3, E.O.7, E.O.8 and E.O.9, in which there are siblings of the caregiver who live closer to the care receiver than the actual caregiver: “Yes, my brother lives right above her...” (E.O.3).

The following family trees reflect the network of care as established within the nucleus of the families of the caregivers interviewed, while also representing the possible alternatives to the inequitable situations experienced in each family.

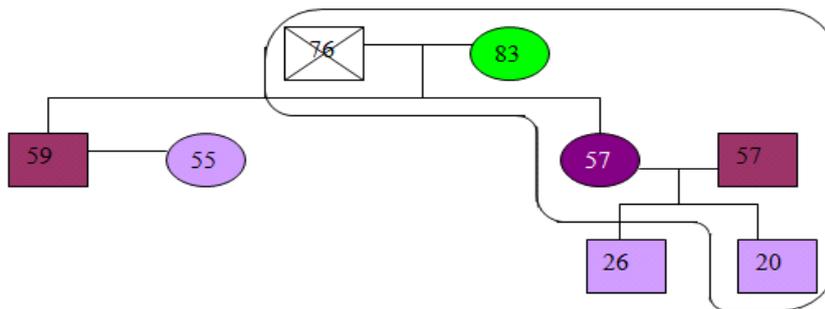
E.O.1 Family Tree



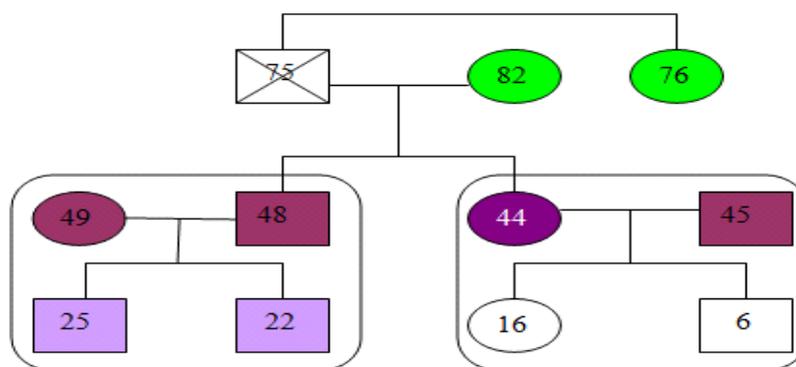
**E.O.2 Family Tree**



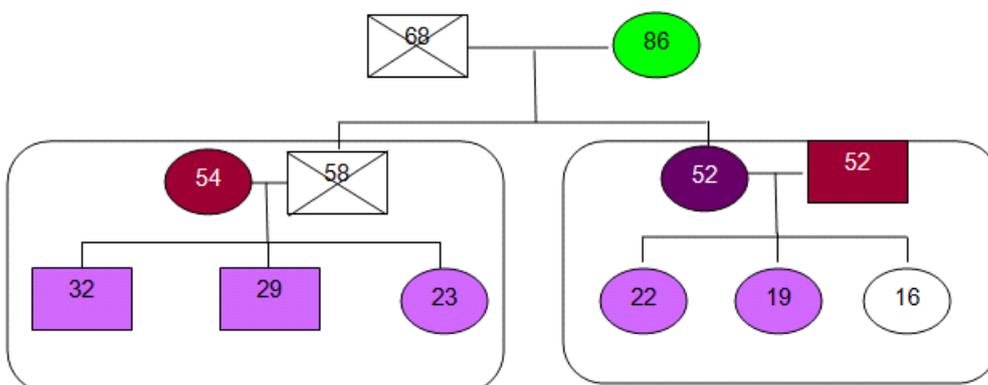
**E.O.3 Family Tree**



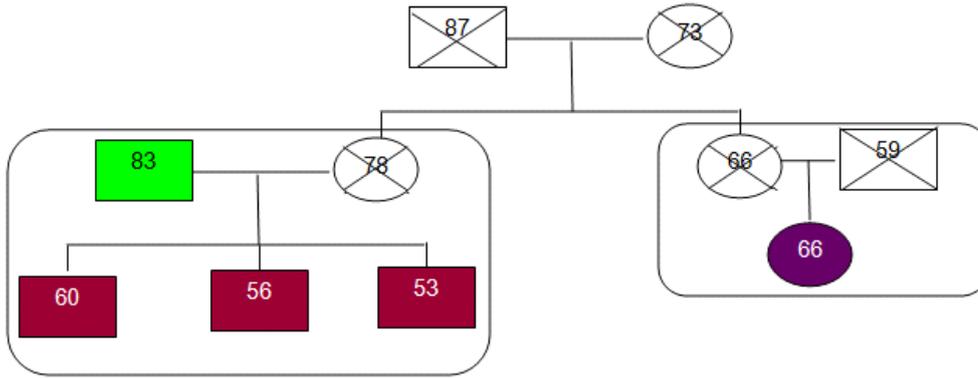
**E.O.4 Family Tree**



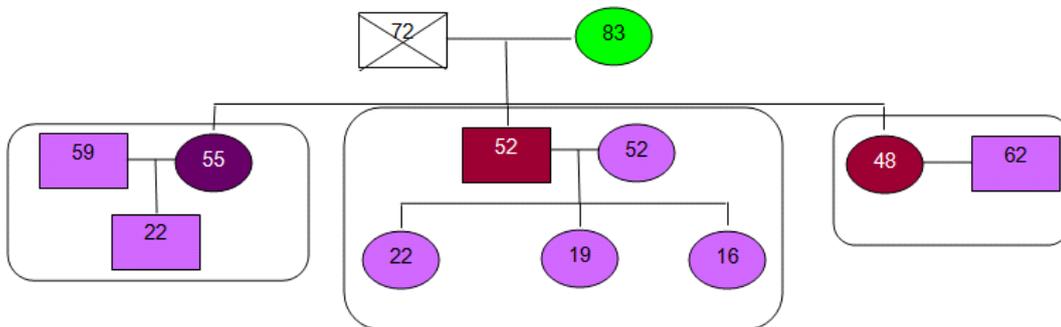
**E.O.5 Family Tree**



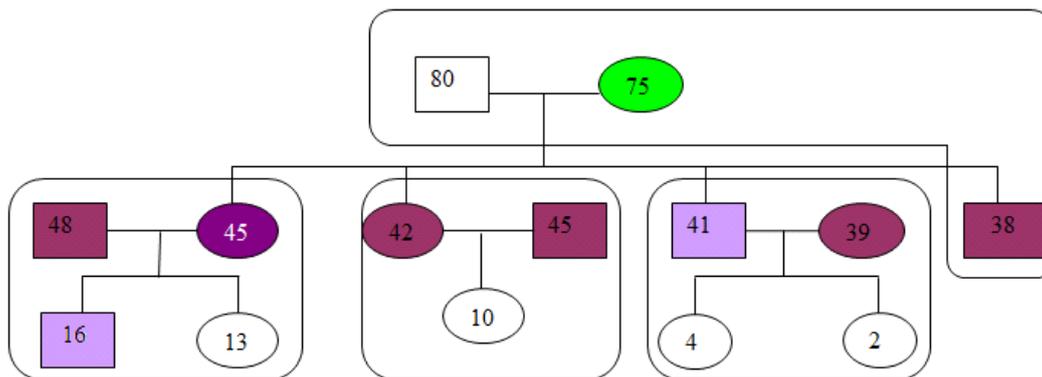
### E.O.6 Family Tree



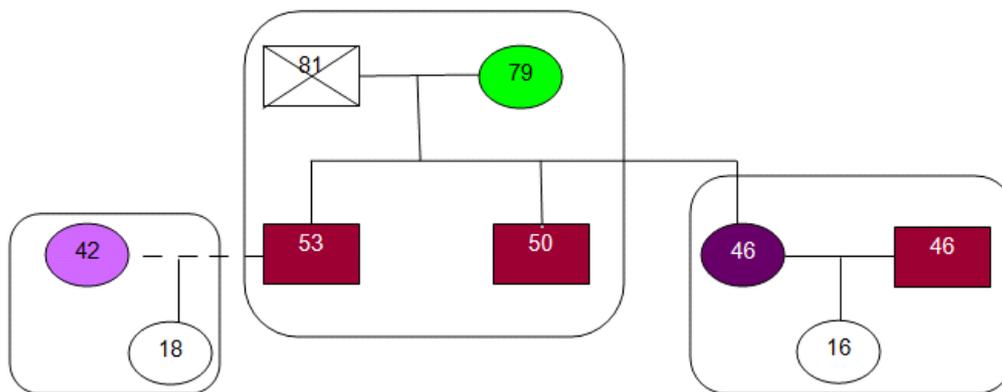
### E.O.7 Family Tree



### E.O.8 Family Tree



## E.O.9 Family Tree



- : Women.
- : Men.
- (green) : Care receiver.
- (purple) : Primary caregiver.
- (dark red) : Family member who could have provided care in equal conditions.
- (pink) : Family member with whom the caregiving workload could be shared equally.

**Source:** Data procured from the interviews.

## Decision making

The decision regarding who should assume the care of the dependent family member was found to be based on a false consensus, since from the onset, the caregiver in all interviews insinuated knowing in one way or another that they would assume, or at least would be involved to a greater degree in the caregiving role. This can be demonstrated by statements such as: *“there was nobody left here but me. So I had no choice but to take care of her myself”* (E.O.1); *“nobody forced us to take care of her, I suppose it was just what we came up with at the time”* (E.O.2); *“I assumed (the role) from the beginning (...) that’s just how it came out”* (E.O.3); *“So we took it as a given that my mother was alone (...). It’s something that’s always been with me because I have seen it. My mother looked after her parents, so I took as a given, thus of course I must take care of her.”* (E.O.5); *“The truth is I didn’t come to look after him. I came to look after his wife (...). This man was completely dependent on her and I have stayed on here, I suppose, as a lady-in-waiting or housekeeper who does everything.”* (E.O.6); *“we decided that I would take care of her because mi brothers did not feel capable (...)”* (E.O.9). Occasionally, this false consensus did not need to be discussed within the immediate family nucleus, since those who did take on the role of caregiver did so of their own natural volition without the option of a male member of the family becoming caregiving being discussed: *“it was not talked about at all, a solution just had to be put in place (...)”* (E.O.4); *“Well my mother wanted to live in her home and so did I (...)”* (E.O.7); *“I started by dedicating my weekends and afternoons to her and that’s how I started looking after my mother”* (E.O.8). Furthermore, despite the social-family situations were similar for men and women, the caregiving role fell on the women: *“because, of course, my brother (...) was working, and I was the one who (...) at the time I was also working (...) but, oh well (...) it was up to me.”* (E.O.4), *“Well it was never discussed with me, nor was it said to me (...) they are comfortable with me. I’ve never been told you can do this or you can’t do that. They know that I am there for him at all times. If he has some sort of wound I know how to do it, I have notions about*

*all this. They rely on me a lot.*" (E.O.6); *"my brothers also had the possibility of looking after her but it had to be done and I offered myself up and that's that, because thinking about it now I see that they could be dedicating more of their time"* (E.O.9).

### **False sense of support and division of care**

Once the decision that the primary caregiver is to be a woman was made, it was found that, in general, there was a pseudo-division of certain aspects of the caregiving tasks. This division was always tainted by gender inequalities, both in terms of the assignment of tasks as well as choosing an appropriate person to help with the caregiving. If the person who was going to help was a man, they would perform tasks such as: keeping an eye on them *"...I tell him to turn his mother over..."* (E.O.2), *"During the holiday season or whenever my mother is with her other daughter then yes, it is my sister who looks after her but the rest of the year it's me."* (E.O.7); providing sustenance *"...on the weekends he provides morning tea..."* (E.O.2), *"some weekends they take charge of making the food because she can't."* (E.O.9); manual handling and mobilizing *"...hold onto her while I wash her..."* (E.O.2); activities with particular characteristics including low-level emotional commitment, short duration and limited responsibility. Yet when the person providing care was a woman, the range of caregiving tasks was greater in scope and the characteristics of such activities were of a more general nature.

This pseudo-division created the sense of effective task sharing in the caregivers, although in reality, it only represented momentary relief of the workload, almost always covering an activity in a particular moment when the primary carer could not due to personal reasons. Thus, a false sense of support and effective division of care is established in the caregiver: *"Do you also receive help? (...)"* *"Yes, I do, I sure do. Well my husband and my siblings-in-law usually take care of things if at any time I need to go out and I ask them to turn her or give her fluids ... or if at some stage I ask them to provide support because she (the assistant) wasn't able to come..."* (E.O.2); *"I will say that they do help me but the person who stays on her own with her, who takes charge of her care is me"* (E.O.1); *"seeing as they have breakfast with her, they prepare her breakfast when I'm at home"* (E.O.9). This effect could be facilitated by female stereotypes propagated by the patriarchy, in this case, the stereotype that the care of family members belongs to the realm of women.

Nonetheless, this ineffective division of the caregiving workload, together with the transitional gender role model of women creates an unmanageable double (care receiver and family) and on occasions a triple workload (care receiver, family and work), which favours physical deterioration: *"...and many issues I have myself not being able to remain standing for long, because I have a slipped disc..."* (E.O.1); *"my arthrosis is very painful ...if you had seen this arm yesterday, I couldn't move my right arm yesterday when I put her to bed, it's so painful I can't find a comfortable position to hold it, it is so painful that... that's why I have to take... pills"* (E.O.6) and emotional wear and tear: *"...I feel overwhelmed, I feel overwhelmed, there are situations and moments of impotence ... to cry"* (E.O.1), furthermore there is a greater risk of social isolation for the caregiver: *"...you lose touch with society..."* (E.O.3); *"...it conditions your life a lot and you can't make your own plans"* (E.O.2). The double workload can be appreciated in statements such as: *"... and I haven't even sat down yet and I still have to wash up and do all the housework"* (E.O.1); while the triple workload can be seen in others such as: *"...I went to work. When she was due to return from*

*rehabilitation at eleven o'clock I had to be there to attend to her, make lunch and do the housework" (E.O.3).*

The term "superwoman", coined by Marjorie Hansen Shaevitz in 1984, defines these caregivers perfectly; they work hard to maintain multiple roles, including their own personal development which is usually hindered in such situations by an excessive, since the greater part of their time is dedicated to caring for others thus unavoidably neglecting their own needs, being obliged involuntarily to place the care of others above their own personal and professional development: "...the time came when I couldn't (do it) any longer and I had to quit work and attend to her 24 hours a day." (E.O.3); "I was working and at the end of the summer holidays work called and I couldn't go because the carer had gone and I had to give up my job..." (E.O.4); "...I began a course to gain qualifications and she was given an appointment for surgery, so once again I had to give that up and go back to the same old situation" (E.O.4).

### **Caregiving by women understood as a natural role**

In the conversations with the participants an unequivocal sense of gender association with caregiving became evident: "...women have usually taken charge of caregiving more often ..." (E.O.2). Thus, caregiving becomes a responsibility assumed naturally by women who perceive it as their duty: "...it's what came out from within us..." (E.O.2); "...but the toughest part, of course, falls on the women..." (E.O.2); "...I was working as well ...but, oh well... it was up to me..." (E.O.4); "We have always thought about it..., we have spoken about when we would get older, that when our parents got older that we would take care of them, because it's something we have seen. In our family we were brought up this way." (E.O.5); "I know how to take care of my mother better than my brothers, I don't think they would look after her as well, yes they do care equally, but wouldn't give care as keenly, we are better carers" (E.O.9). In some cases the perception of the duty to care for others and upkeep the household is so naturalized in women that these duties become "their obligations", relieving other male family members from the caregiving role: "...I take care of the house, it's not their obligation..." (E.O.1).

### **Caregiving understood as a moral obligation**

Another argument which contributes to the creation of a sense of duty to care within the study sample, is understating care as a moral obligation within the family. From the interviews in this study a mixture of this sense of moral obligation: "...I took it on from the beginning because she is my mother and it was my obligation as her daughter to take care of her..." (E.O.3); "...she is my mother and although it was a huge responsibility, I had to do it..." (E.O.4); "I certainly wasn't going to abandon her" (E.O.4); "I know I'm going to feel guilty when I leave because six years feels like a lifetime in which time I have seen her go from a dependent person to almost completely incapacitated. And these are things that we have lived through together." (E.O.6) together with a sense of retribution for the care received from the women in their family: "...she is my aunt, and my Godmother, I was brought up by my Grandmother and my Godmother... not that I had to return the favour to her in that way because they would have looked after me all the same but ... I don't know, I just can't leave her like that, all alone..." (E.O.4), has contributed to building their gender identity based around the value assigned to caregiving by family members.

## Female support for a responsibility assumed to be female

The greater part of the additional support they receive from other people in order to meet the needs of the dependent person is provided by women, either from the family: *"it's normal if there are two children, since the workload is shared between two people, in this case my sister-in-law and I"* (E.O.3), or contracted help: *"So when she is at my place, we have a woman help out, of course..."* (E.O.2). Furthermore, it should be emphasized, the cases in which assistance from a (female) helper is not existent, the expression utilized to look for this type of help is not *"person needed"* but *"very often a woman was needed for more help"* (E.O.2); *"I could really do with a woman"* (E.O.1), demonstrating that a direct association exists between 'woman' and 'care'. At the times when some form of auxiliary care was needed, the primary caregivers always designated to another woman, except for duties considered to be more masculine, almost always involving a lower level of emotional implication.

## DISCUSSION

The essence of the ten participating caregivers' experience can be summarized by the six categories described previously. From the first and second categories: "Possibilities for dividing caregiving tasks within the immediate family nucleus" and "Decision making", it can be seen that despite real possibilities existing for a man to become the primary caregiver, women were always chosen. This phenomenon can be illustrated via data sourced from a study by María Crespo López <sup>(10)</sup>, which reassert the results from the present study in that caregiving is assumed by daughters to a greater degree than sons, the latter taking on the role when there are no daughters available, and they often do so with the help of their partners. Furthermore, based on the aforementioned data, it should be emphasized that the decision was never 'imposed' on them by family members, but was taken on in a totally natural manner, and with a certain degree of resignation, by the sample group of caregivers.

In regard to the making of this decision by the primary caregiver, and in consonance with research carried out by Iratxe Mier et al <sup>(5)</sup>, it is worthy of note how this is based on a false consensus which masks a certain sense of obligation within what is, for those of the female gender, a logical choice. However, an element of controversy exists in terms of how they take on this role, as well as the degree of obligation versus personal choice as perceived by the women themselves. In certain cases, caring for the elderly is for some women an imposition (whether this be due to a range of circumstances or the caregiving role society confers on women) which they cannot avoid <sup>(8)</sup>. As such, the choice would appear not to belong to them, when in reality they do have a voice, albeit silenced by the inequitable yet accepted assignment of roles derived from social constructs on solid androcentric foundations.

The creation of a false sense of support and effective division of the caregiving workload can be associated with the fact that *"modern societies, like many from the past, divide caregiving tasks and assign them according to natural conditions of social organization: gender, class, ethnicity, nation and region-locality"* <sup>(9)</sup>. Thus a pseudo-division of the caregiving workload is produced which can be explained via the theory of socialization, which describes the existence of a differentiation and division of roles between men and women, thus associating, women with the realm of private circles and men with that of the public sphere. This division leads to the idea of women taking charge of the caregiving role as something natural or logical, since this belongs to the

private sphere, being considered unnatural for a man to do so, being as it were outside of his habitual public sphere <sup>(11)</sup>. Based on such considerations, it can be seen how a man collaborating in a task considered socially to be feminine might generate an 'magnification' of the assistance provided since it does not fall within his natural or habitual realm of assigned activities <sup>(12)</sup>.

It might also be stated, that the caregivers who make up the present study group share the impression that the task of providing care falls naturally on their shoulders and is assumed as such seemingly without alternative options for dividing the workload. This is in line with statements by Iratxe Mier <sup>(5)</sup>, in whose research the same perception is held by the women interviewed therein. Furthermore, the latter author goes on to add that they do not conceive of this as a consequence of the social assignment of roles and stereotypes, differentiated and arranged in a hierarchy according to sex or gender. A further argument, as found in the available bibliography, which supports the existence of a naturalized sense of obligation in women to assume the caregiving role, is the substantial element of moral and emotional duty to care for the family <sup>(13)</sup>. These elements, together with the common attribution to the female gender of properties such as solidarity and abnegation, facilitate the socially accepted association of women with caregiving. Such associations, in juxtaposition with the desire for personal development, create an inequitable struggle between that which is understood to be their natural position in society and that which they wish to develop for themselves in their lifetime. The difficulties arising from these phenomena originate a dysfunctional situation in terms of achievability. Such dysfunction is associated almost invariably with problems such as physical and emotional deterioration, which in the case of family caregiving has been extensively documented under the term 'caregiver burnout' or 'caregiver syndrome'. Moreover, it is well established that caregivers are exposed to economic difficulties and are vulnerable to isolation or even social exclusion <sup>(14)</sup>.

Regarding the final category described as "Female support for a responsibility assumed to be female", coincidences can be found with authors such as García-Calvente, Mateo & Egulguren <sup>(15)</sup>, in which women not only assume the role of primary caregivers in the greater majority of cases, but it is also women who help other women in providing care. Thus it is that when looking for help, both paid and unpaid, women are sought almost automatically.

Finally, it should be stressed that statistically the number of male caregivers is gradually increasing and their degree of implication in caregiving roles is becoming greater. Furthermore, the sociodemographic and health-related trends point to the number of male caregivers increasing substantially in the future, with regard to the decrease in number of potential caregivers (associated at the same time with the decrease in the size of families), the rising incorporation of women into the labour market, changes in gender roles and social norms and the greater prevalence of debilitating chronic disorders in women, among other factors <sup>(16)</sup>. Nonetheless, an open discussion forum continues to be necessary, in which to consider new forms of socio-economic organization, with the aim of gender equity prevailing over hierarchical structures naturalized by a dominant patriarchal culture, in the management of family care moving forward into the future.

## CONCLUSION

In conclusion, the following statements can be considered valid for this study's sample group:

- Regardless of real possibilities existing for establishing a male primary caregiver, women were always chosen for the role. Furthermore, this decision was assumed in a completely natural fashion by the caregivers, despite hindering their personal development.

- The decision making process for choosing the primary caregiver was based on a false consensus, since there was no consensus as such but an undisputed acceptance of the situation, on occasion with signs of resignation.

- The fact a man collaborates in a role social traditions consider to be for women generates a magnification of the assistance provided since it does not fall within his habitual realm of assigned activities.

- Caregiving is established as a completely naturalized role and the moral duty of women.

- Women not only assume the role of primary caregiver in the majority of cases, it is also women who provide assistance to the latter group of women in their caregiving role.

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