Intimate Labour, Gendered Violence, and Exploitation among Live-in Home Care Workers in Kerala, India

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Abstract

Paid live-in eldercare in private households in India has expanded, yet the sector remains weakly regulated and offers few enforceable rights. Drawing on qualitative research conducted in Kerala with live-in caregivers, care recipients, and nursing agency owners, this article examines how intimate care is governed within private homes and why harm remains difficult to address. Gendered morality, caste hierarchy, and agency-managed silence set the terms of work. Agency manuals instruct workers to 'love the patient like kin' and to 'be emotionally neutral', which turns affection and patience into conditions of employment and channels disputes back to the agency. Since care is often framed as an extension of family duty rather than formal employment, incidents rarely enter criminal processes and are often overlooked within routine labour oversight. Caregivers respond through quiet resistance, from confronting discriminatory clients and concealing caste identity to setting limits and seeking transfers. However, change remains incremental without collective organisation. By tracing how emotion, caste, and agency mediation intersect in Kerala's home care sector, the article demonstrates that treating this labour as kin-like duty blurs accountability, weakens protections, and reinforces unequal conditions in live-in home care.

Keywords: care work, intimate labour, live-in eldercare, exploitation, caste, Kerala

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Introduction

Across the globe, demographic ageing, the growing prevalence of chronic illness, and strained health and social care systems have produced a crisis of care. Rather than expanding public provision, states and markets often rely on low-paid

women whose labour takes place in other people's homes. What is also clear is that despite its increasing importance for elders, care work remains undervalued and weakly protected, even as it sustains households, economies, and welfare systems.[1] In India, these dynamics are evident in the growth of paid domestic work and newer forms of home-based care for older adults. The state of Kerala is a particularly important site for studying this shift. Its population aged 60 and above was 12.6 per cent in 2011, compared with the national average of 8.6 per cent, and had surpassed 20 per cent by 2024. Ageing in Kerala is shaped by low fertility, rising life expectancy, and continuing migration of younger adults.[2] Studies of emigrant households indicate that adult children's migration influences older people's care arrangements, often shifting responsibility to older spouses, daughters-in-law, female siblings, or paid caregivers.[3] In affluent transnational households, migration has also encouraged the purchase of proximate care through local markets, including home-based paid eldercare.[4] In this context, families increasingly employ live-in caregivers, most of them women, to provide round-the-clock support for older relatives, often through home nursing agencies that recruit, train, and place workers. These workers perform a hybrid role that combines intimate bodily care, basic medical tasks, emotional support, and domestic work. Agencies and most client households often describe this labour through the language of service, patience, affection, and respectability. However, these moral expectations coexist with precarious working conditions, including low wages, long working days, unclear task boundaries, restricted rest and mobility, dependence on agencies for future placements, and limited access to complaint channels or support mechanisms. These conditions are enabled by fragmented regulation, the treatment of the private home as a family space rather than a workplace, and the intimate character of care, all of which allow exploitation, violence, and abuse to persist with little scrutiny or redress.[5] Studies of household

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1 L Addati *et al.*, *Care Work and Care Jobs for the Future of Decent Work*, International Labour Office, Geneva, 2018, pp. 2–11; S Brady, 'Neoliberal Capitalism, Older Adult Care and Feminist Theory', *CLR James Journal*, vol. 28, issue 1–2, 2022, pp. 85–108, https://doi.org/10.5840/clrjames202312797.

2 S I Rajan *et al.*, *Growing Old in Kerala: A Gendered Revisit*, Working Paper XIV, International Institute of Migration and Development, 2025, pp. 1–5, https://iimad.org/wp-content/uploads/2025/06/Growing-Old-in-Kerala-A-Gendered-Revisit.pdf.

3 A P Ugargol and A Bailey, 'Reciprocity between Older Adults and Their Care-Givers in Emigrant Households of Kerala, India', *Ageing & Society*, vol. 41, issue 8, 2021, pp. 1699–1725, p. 1700, https://doi.org/10.1017/S0144686X19001685.

4 Sreerupa, 'Transnational Migration, Local Specificities and Reconfiguring Eldercare through "Market Transfer" in Kerala, India', *Journal of Ethnic and Migration Studies*, vol. 49, issue 4, 2023, pp. 1014–1031, https://doi.org/10.1080/1369183X.2022.2115629.

5 N Neetha, 'Misconstrued Notions and Misplaced Interventions: An assessment of state policy on domestic work in India', *The Indian Journal of Labour Economics*, vol. 64, no. 3, 2021, pp. 543–564, https://doi.org/10.1007/s41027-021-00334-w; X F Zhong

work also document verbal abuse, humiliation, sexual harassment, and the use of kinship language that describes workers as 'like family' while denying clear contracts, social protection, and meaningful avenues for complaint.[6]

Situating live-in care within the home/workplace and public/private divide also matters for anti-trafficking debates. In domiciliary care, the private household functions simultaneously as a site of family life, paid labour, residence, and supervision, making labour harms less visible and harder to regulate. Compared with construction, factories, or sex work, domestic and care labour in private homes receives less attention in discussions of trafficking, forced labour, and severe exploitation. Labour exploitation should not only be understood through exceptional cases of trafficking or modern slavery, since many harms are produced through ordinary labour arrangements and regulatory systems.[7] In the live-in care sector, overwork, surveillance, caste-based exclusion, sexual harassment, and constrained exit may appear routine, but together they form a continuum of everyday abuse. Rather than treating live-in care work as trafficking, this article uses anti-trafficking debates to examine how coercion, dependency, and weak accountability are normalised when paid care is organised through the moral authority and privacy of the family home.

Drawing on research with live-in caregivers for older persons in Kerala, this article examines how women employed in this sector describe pathways into care work, everyday labour and living arrangements, and experiences of abuse, control, and constraint in clients' homes. It contributes to debates on the private home as a workplace by showing how, in the live-in care sector, paid work, residence, intimacy, and supervision are organised within the same household space. It also extends Indian research on domestic and care work by focusing on agency-placed live-in care for older people, a form of work in which caste-based domestic

and S Shorey, 'Experiences of Workplace Violence among Healthcare Workers in Home Care Settings: A qualitative systematic review', *International Nursing Review*, vol. 70, issue 4, 2023, pp. 596–605, https://doi.org/10.1111/inr.12822; S Thakkar, 'Exploitation, Harassment and Violence: Lived experiences of women paid domestic workers in India', *Journal of South Asian Development*, vol. 19, issue 1, 2024, pp. 44–60, https://doi.org/10.1177/09731741231164872.

6 A Vijayalakshmi, P Dev, and V Kulkarni, 'Domestic Workers and Sexual Harassment in India: Examining preferred response strategies', *World Development*, vol. 155, 2022, art. 105875, https://doi.org/10.1016/j.worlddev.2022.105875; Thakkar, p. 47; S Banerjee and L Wilks, 'Work in Pandemic Times: Exploring precarious continuities in paid domestic work in India', *Gender, Work & Organization*, vol. 31, issue 4, 2024, pp. 1505–1523, https://doi.org/10.1111/gwao.12858.

7 J Quirk, C Robinson, and C Thibos, 'Editorial: From Exceptional Cases to Everyday Abuses: Labour exploitation in the global economy', *Anti-Trafficking Review*, issue 15, 2020, pp. 1–19, https://doi.org/10.14197/atr.201220151.

hierarchy is tied to bodily care, emotional discipline, and home nursing agencies.[8] What emerges is an account of exploitation as ordinary and cumulative, in which live-in caregivers are made vulnerable through kin-like expectations, caste-coded household practices, agency mediation, constrained exit, and the depletion of bodily, emotional, and social capacities.

Literature Review

Paid live-in caregiving is a form of intimate labour centred on bodily proximity, emotional engagement, and the management of private aspects of life. In India, it is closely linked to waged domestic labour: both are performed in private households, often by lower-caste and economically marginalised women, and shaped by employer ideas of cleanliness, respectability, and availability. Studies of domestic work show how caste-coded practices structure access to utensils, toilets, seating, and shared space, while marking workers' bodily service as less valued.[9]

Scholarship on the global care economy has documented the gendered organisation of care work and its systematic devaluation. Feminist work on older adult care further shows how market-based care arrangements depend on gendered, racialised, and classed hierarchies to contain the costs of social reproduction.[10] The concept of depletion is crucial here because it explains that social reproductive labour can exhaust workers' bodily, emotional, and social capacities when the costs of maintaining life are displaced onto those with the least power.[11] These debates help locate paid live-in eldercare within wider political economies of social reproduction.

Work on care and domestic labour in India develops these insights in relation to class, caste, and family. As per Choudhury and Das's study of *ayahs* [paid domestic care attendants] in care for older people, families draw on paid carers to uphold ideals of filial duty while distancing themselves from stigmatised bodily care, placing *ayahs* ambiguously between worker and quasi-kin.[12] Other studies of domestic work highlight how intimate care is folded into broader domestic

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8 S M Rai, C Hoskyns, and D Thomas, 'Depletion: The Cost of Social Reproduction', *International Feminist Journal of Politics*, vol. 16, issue 1, 2014, pp. 86–105, https://doi.org/10.1080/14616742.2013.789641.

9 S Sharma, 'Of Rasoi ka Kaam/Bathroom ka Kaam: Perspectives of women domestic workers', *Economic & Political Weekly*, vol. 51, issue 7, 2016, pp. 52–61.

10 Addati *et al.*, pp. 166–167; Brady.

11 Rai, Hoskyns, and Thomas.

12 A Choudhury and A K Das, 'Care as Work: Ayahs and eldercare practices in India', *International Journal of Care and Caring*, vol. 7, issue 4, 2023, pp. 601–618, p. 614, https://doi.org/10.1332/239788221X16704462186238.

responsibilities, blurring the boundary between care, service, and household labour.[13]

Research on household workplaces documents sexual harassment, verbal abuse, humiliation, underpayment, long hours, and workers' reliance on low-confrontation strategies to preserve livelihoods.[14] Studies also show that crises such as the COVID-19 pandemic intensified pre-existing precarity.[15] Although much of this work focuses on housework and childcare, global research on home care workers demonstrates that care in clients' homes exposes workers to violence from patients and family members, as well as blurred expectations around domestic tasks.[16] Green and Ayalon similarly explain how isolated work inside private homes blurs professional boundaries and exposes both live-in and live-out workers to rights violations and abuse.[17] Together, these studies suggest a continuum of violence, from everyday humiliation to overt abuse.

These dynamics are entwined with caste and class. Research on caste and domestic work reveals how employers distinguish between 'cleaner' and more 'polluting' tasks, enforce separate utensils, eating spaces, and toilets, and naturalise the idea that lower-caste and poorer women are suited to intimate or menial work in private homes.[18] Studies of rural domestic workers also demonstrate that claims to dignity and worker status remain constrained by caste-marked service, bodily stigma, and economic dependency.[19] This literature underscores that intimate labour in India cannot be understood apart from caste, class, and gender.

At the level of law and policy, scholars have traced the limited and contradictory ways in which the Indian state has engaged with domestic and care work. There is no central legislation that clearly defines the household as a workplace, determines employer and agency accountability, or guarantees enforceable rights to wages, hours, rest, leave, social security, occupational safety, and grievance redress. Existing interventions have taken partial forms: domestic work has been

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13 Banerjee and Wilks.

14 Vijayalakshmi, Dev, and Kulkarni; Thakkar.

15 Banerjee and Wilks.

16 Zhong and Shorey.

17 O Green and L Ayalon, 'Violations of Workers' Rights and Exposure to Work-Related Abuse of Live-In Migrant and Live-Out Local Home Care Workers – A preliminary study: Implications for health policy and practice', *Israel Journal of Health Policy Research*, vol. 7, 2018, art. 32, https://doi.org/10.1186/s13584-018-0224-1.

18 Sharma, p. 53.

19 D Singh, 'Invisible Toiling Hands: The work and life of domestic workers in rural India', *The Economic and Labour Relations Review*, vol. 36, issue 3, 2025, pp. 691–707, https://doi.org/10.1017/elr.2025.10036.

included in minimum wage notifications in several states; welfare board and social security models have been attempted unevenly; domestic workers have been brought within unorganised worker and social security discussions; and the *Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act* of 2013 formally includes domestic workers. Skill-development initiatives and draft policy proposals have also sought to professionalise the sector. However, these measures remain limited by weak implementation, uneven state-level coverage, unclear employer registration, and the difficulty of inspection and complaint inside private homes. This matters especially for live-in care workers because regulation designed around public workplaces, fixed hours, visible employers, and standard employment relationships does not address residence inside the employer's home, round-the-clock availability, agency mediation, or blurred responsibility between households and intermediaries.[20]

Intermediaries who match workers and households have become increasingly important. Research on placement agencies reveals that they mediate hiring, discipline workers' conduct, impose fees and penalties, and train workers to conform to middle-class household norms.[21] Agencies are therefore reshaping how care workers are recruited, monitored, and distributed, but without necessarily improving worker protection.

Anti-trafficking scholarship helps frame harms that remain hidden in home-based care work. Quirk, Robinson, and Thibos argue for attention to 'everyday abuses' that sit alongside, and sometimes beneath, exceptional cases of trafficking and modern slavery.[22] Palumbo's work on domestic care in Italy similarly illustrates how exploitation can be normalised when the state relies on households to resolve care needs while treating abuse as private or exceptional.[23] This perspective allows

[20] M Poddar and A Koshy, 'Legislating for Domestic "Care" Workers in India: An Alternative Understanding', *NUJS Law Review*, vol. 12, issue 1, 2019, pp. 67–116; Neetha; R Agarwala and S Saha, 'The Employment Relationship and Movement Strategies among Domestic Workers in India', *Critical Sociology*, vol. 44, issue 7–8, 2018, pp. 1207–1223, https://doi.org/10.1177/0896920518765925; A Agarwal, 'Locating the "Nanny" in Legal Theory', *National Law School Journal*, vol. 17, no. 1, 2023, pp. 27–49, https://doi.org/10.55496/VIFS4282.

[21] S Grover, 'Placement Agencies for Care-Domestic Labour: Everyday mediation, regimes of punishment, civilizing missions, and training in globalized India', *Modern Asian Studies*, vol. 56, issue 6, 2022, pp. 1901–1929, https://doi.org/10.1017/S0026749X21000585.

[22] Quirk, Robinson, and Thibos.

[23] L Palumbo, 'Exploiting for Care: Trafficking and abuse in domestic work in Italy', *Journal of Immigrant & Refugee Studies*, vol. 15, issue 2, 2017, pp. 171–186, https://doi.org/10.1080/15562948.2017.1305473.

attention to coercion, dependence, denied exit, and weak accountability without collapsing all exploitative conditions into trafficking.

Finally, studies of domestic and care worker organising highlight both possibilities and constraints for collective action. Worker organisations and unions can create spaces for relief, claims-making, and grievances around wages, care provision, and dignity. However, dispersed workplaces, informal employment, and dependence on employers and intermediaries make collective organising difficult.[24]

Across these bodies of work, there is relatively little focused attention to agency-placed live-in eldercare workers in private homes, particularly in Kerala. Existing Indian research tends to focus either on domestic workers more broadly, *ayahs* in care for older persons, or placement-agency mediation, while global studies of home care often concentrate on nurses, health aides, or migrant care workers in high-income countries. Building on this literature, this article treats live-in care as a distinct form of intimate labour, showing how caste-coded hierarchy, emotional discipline, agency mediation, weak regulation, and household violence make exploitation appear commonplace in care relations.

Methods

This article draws on a qualitative, interpretive research design. It treats live-in care work not only as tasks but as a social relationship shaped by caste, gender, class, intimacy, and agency control. The article is based on a larger study of home-based care of Kerala's ageing population, carried out between May 2018 and February 2021 in southern and central districts: Thiruvananthapuram, Kollam, Pathanamthitta, Alappuzha, Kottayam, Ernakulam, and Thrissur. The aim of the study was to examine how agency-placed live-in care work is organised and experienced inside private homes.

The larger study included interviews with 150 live-in caregivers (referred to as 'home nurses'), 24 home nursing agency owners or managers, and 76 clients or family members using agency services. Of the 150 caregivers, 130 were women and 20 were men. This article primarily draws on the women caregivers' accounts because its focus is gendered violence, feminised expectations of care, and women's vulnerability within live-in intimate labour. Interviews with men were used only to contextualise general work arrangements and agency practices. The mean age of the female caregivers was 48.66 years. Their average schooling and mean work experience in home-based care were 8.3 years and 7.61 years,

[24] P Krishnan, 'Intersectional Grievances in Care Work: Framing inequalities of gender, class and caste', *Mobilization: An International Quarterly*, vol. 25, issue 4, 2020, pp. 493–512, https://doi.org/10.17813/1086-671X-22-4-493.

respectively, and most earned a monthly income of INR 12,000–15,000 (approx. USD 170–215). Caste was treated as a sensitive subject, and participants were not prompted to disclose it. It is therefore not presented as a complete demographic profile, but analysed through accounts of household treatment and everyday discrimination.

Participants were recruited mainly via home nursing agencies identified through newspaper advertisements and online listings. Initial meetings were held with agency owners or managers to explain the study and seek access to workers and clients. Where lists were available, respondents were selected at random when possible. This was supplemented by direct approaches to caregivers at agency offices, client homes, and workers' homes, as well as snowball referrals, to reduce dependence on agency-selected respondents. Interviews with workers were not conducted in the presence of agency owners, clients, or family members. Participants were told that agencies would not be informed about what they said, that refusal would not affect their placement, and that they could stop the interview at any point.

Data was obtained through in-depth, semi-structured interviews conducted in Malayalam, in locations participants considered safe and convenient. Interviews usually lasted between 45 minutes and one hour and twenty minutes. They were not audio-recorded, as early requests to record were declined by some participants, and recording was then avoided to reduce discomfort or any impression that the researcher was linked to a government or monitoring authority. Detailed notes were taken during and immediately after interviews and later translated or summarised in English for analysis. Most fieldwork was completed before the COVID-19 lockdown; later interviews were conducted by phone where participants were willing and reachable.

Analysis was conducted manually. Interview notes were read several times and coded thematically around entry into care work, agency rules, working and living conditions, restrictions on movement and communication, caste-based treatment, verbal and sexual harassment, complaint pathways, and workers' responses. No qualitative software was used. As this was a single-researcher study, formal inter-coder reliability was not applicable. To maintain consistency, the researcher compared themes across worker, agency, and client accounts and kept analytic notes on recurring patterns, contradictions, and emerging interpretations.

Approval for the study was obtained from the Institutional Ethics Committee of the University of Hyderabad. Identifying details of workers, agencies, clients, and households have been removed. The researcher's position as a Malayalam-speaking woman researcher from Kerala helped build conversational trust with many women caregivers. However, differences in education, socio-economic background, and institutional affiliation may have shaped what participants chose to disclose.

Limitations

This article is based on qualitative research in southern and central Kerala and relies primarily on caregivers' narratives, supplemented by agency and client interviews. The findings are not statistically representative and may not capture experiences in other regions, non-agency arrangements, or other forms of home care. Agency and snowball recruitment may have excluded isolated workers, former caregivers, or those who left after severe abuse. Reliance on field notes rather than audio recordings may have limited exact phrasing, although it helped participants discuss sensitive experiences more freely. Men's experiences are not analysed in depth because the article foregrounds women caregivers.

Findings

The findings demonstrate how agency-placed live-in care turns intimate care of older adults into continuous, caste-marked, and gendered labour, while leaving workers with limited ways to contest abuse beyond adjustment, quiet resistance, or exit.

Entering Live-in Care: Life circumstances and social position

Though women entered live-in home care from different life circumstances, most shared economic insecurity, family responsibility, and limited access to stable employment. Agency owners described many workers as hailing from strained households and turning to home nursing when other options were unavailable. Caregivers often entered after widowhood, divorce, loss of earlier employment, chronic illness in the family, debt, or an abusive marriage. For many, live-in care offered one of the few ways to secure a regular income while supporting children, repaying loans, or meeting medical expenses.

One caregiver described live-in care as a necessity rather than a choice:

> *There is no one else to bring money home. My husband drinks and does not work regularly. My children are studying, and my mother is aged. I cannot sit at home and wait for someone to help us. I came for this work because I need a steady income, even if it means staying away from home.* (Malini, age 48)

Such accounts reveal that live-in care is often taken up under compulsion, though not always without attachment to the work. A smaller number of caregivers expressed interest in caring for older or chronically ill people, especially when they had cared for relatives or had basic medical training. Even then, paid care remained tied to household survival. The language of service, patience, and duty coexisted with debt, children's educational costs, and financial independence.

Caste and religion also shaped entry into live-in care and access to placements. Agency owners reported that many Hindu caregivers belonged to lower or backward caste groups, with only a small minority from higher castes such as *Nair* or *Pillai*. Some workers anticipated discrimination and avoided disclosing caste or religious identity to clients.

This was also visible in the accounts of upper-caste caregivers. Vijayamma, a higher-caste Hindu, stated she was often treated with ease in client households and allowed to eat with the family:

> *In most houses, they let me sit and eat with them. I think they look at things like caste, appearance, and cleanliness. Since I am from a good caste and look clean, they do not feel uncomfortable coming close to me or dining with me.* (Vijayamma, age 62)

Her statement establishes how caste can be spoken through cleanliness, appearance, and suitability for intimate bodily work. Caregivers from stigmatised caste backgrounds were more likely to encounter suspicion, distancing, or rejection in clients' homes. Some upper-caste caregivers described their entry into hands-on care only because of financial hardship, while suggesting that lower-caste women were better suited to perform such intimate and bodily work. Live-in care, therefore, draws in women already marked by economic vulnerability. At the same time, access to placements and treatment inside households remain shaped by caste-coded ideas of purity, hygiene, and social proximity.

'Always on Call': Organising work and life in employer households

Caregivers described everyday work in clients' homes as an almost continuous cycle of tasks, with little separation between medical care, personal care, and domestic work. Their day often began before the older person woke up and continued late into the night. Alongside bathing, feeding, administering medicines, and cleaning the patient's room or washroom, many were expected to help with household tasks, especially when no domestic worker was present.

These routines were shaped by agency instructions and household expectations. Some agencies gave written or verbal guidelines requiring workers to remain near the patient, avoid personal phone use, speak politely, smile, and show affection towards older people. Workers were repeatedly reminded to 'treat the patient like your own parent'. In practice, this language of kin-like care often expanded their duties beyond patient care.

Maya, who took care of a paralysed patient, described how extra work became normalised as part of being a 'good' live-in worker:

> *My main responsibility was caring for the patient, but I also cleaned her room and bathroom. If the maid did not come, I helped with cooking and other household work. I never refused. No client has complained about me to the agency. When we stay in their house day and night, I think we should show that much courtesy.* (Maya, age 52)

Her account illustrates how additional tasks were absorbed into ideas of courtesy, adjustment, and maintaining a good reputation with the agency. Although workers were called 'home nurses', the title neither limited their role to nursing the patient nor protected them from being treated as all-purpose household labour. In the absence of enforceable care plans, written task limits, or protections for working hours, duties were often defined by household convenience rather than by any clear employment standard.

The live-in arrangement intensified these demands. Most caregivers slept in the same room as the older person so they could respond immediately at night. Those caring for bedridden, disoriented, or cognitively impaired patients described turning them, changing diapers or sheets, preventing falls, and calming them when restless. Night was not a period of rest but an extension of duty. Georgina, caregiver of an Alzheimer's patient with incontinence, said:

> *I am always afraid that something may happen if I sleep deeply at night. Even if I am tired, I have to work the next morning. The agency says we can sleep during the day if we are awake at night, but it does not always happen like that, right?* (Georgina, age 49)

This constant alertness produced exhaustion but was treated as part of live-in duty rather than additional labour. Even tasks requiring training or careful handling were often devalued as ordinary women's work. Omana, who assisted a post-surgery patient with basic physiotherapy, recalled:

> *They say, 'You are only moving the leg and hand. What skill is there in that?' But if I do it wrongly, the patient will suffer.* (Omana, age 44)

In this way, live-in care blurred boundaries between nursing, bodily service, emotional attentiveness, and domestic labour. Workers were expected to be technically competent, emotionally patient, and constantly available, while the skill and strain involved remained poorly recognised.

Caste, Cleanliness, and Devaluation in Care Relationships

Caste-based distinction appeared in many caregivers' accounts of daily life in clients' homes. On arrival, some women were quietly assessed through questions about their names, hometowns, religions, and habits, followed by instructions that marked their place in the household. These rules often concerned food, utensils, seating, and access to toilets.

Rajani, who worked in an elite upper-class household, described how a separate tumbler was first presented as ordinary household practice:

> *They told me, 'It is better if you use only this glass, because you are new here.' At first, I thought it was only for a few days. Later, I realised no one else touches that glass. It was kept only for me.* (Rajani, age 46)

Such practices were not always named as caste discrimination, but workers recognised them as caste-based distance. Separate utensils, eating after the family, sitting away from the dining area, or being watched in household spaces made caregivers feel that their labour was needed but their presence was not fully accepted. Some recalled overhearing relatives describe them as *ketta vargam* [an awful or degraded category], a phrase that condensed caste, class, and moral judgement into everyday speech.

Caste could shape placement even before workers entered the household. One respondent articulated:

> *Some houses ask the agency before hiring itself, 'Which caste is she?' If they hear our caste, they say they want someone else.* (Bindhu, age 54)

Client interviews confirmed that caste preference was not only a worker perception. Although only ten clients openly stated they preferred someone from their own community, sixteen disclosed that they avoided workers from Scheduled Castes, Scheduled Tribes, or Muslim backgrounds. Some described such workers as 'not culturally compatible', while others associated workers from certain lower castes with a lack of hygiene. These accounts testify to how caste could be expressed through apparently neutral concerns about culture, cleanliness, or suitability.

Bodily care and cleaning were described as another site of humiliation. Caregivers who bathed older people, changed diapers, cleaned wounds, and washed soiled clothes expressed that employers sometimes spoke as if such work naturally belonged to women from their background. A home nurse recalled an employer saying, 'This is the job for people like you, we are not used to it', when she hesitated to clean a dirty toilet. Such comments were experienced not only as criticism of work but as attacks on personhood.

A few caregivers resisted when discrimination became explicit. One of them recalled being asked to use an outside toilet rather than the toilet attached to the patient's room. She confronted the client:

> *You expect me to clean the older patient, but my touch isn't clean enough for your bathroom?* (Sheeja, age 43)

Her question captures the contradiction of caste-marked intimate labour. Caregivers were expected to touch, clean, lift, and comfort older people, yet their own bodies could be treated as polluting. Live-in care made workers indispensable to family care arrangements while exposing them to caste-based distancing, suspicion, and devaluation.

Surveillance, Restricted Mobility and Institutional Silence

Alongside heavy workloads, caregivers described a constant sense of being watched and controlled in clients' homes. Employers often wanted someone 'always with the patient', which meant workers were rarely left alone. Some households used CCTV cameras in common areas or in the patient's room, while others relied on phone calls or surprise visits by relatives. Several caregivers described surveillance as ordinary household life rather than an exceptional practice:

> *Even if I sit for five minutes, someone will call and ask, 'Where are you, what are you doing?'* (Malini, age 48)

Restrictions on mobility intensified this control. Several caregivers were allowed outside only for hospital visits or approved errands, and even short walks or religious visits could be refused. Some were asked not to make long phone calls or speak with family members in a language unfamiliar to the patient. Employers justified such rules in terms of patient safety, but workers experienced them as limits on their time, bodies, and communication.

Leave was also difficult to claim, even when agencies had formally promised it. Leela, who cared for the elderly mother of a Non-Resident Indian (NRI) family, said leave depended on the household's convenience. She also found it difficult to insist because the patient had become emotionally dependent on her:

> *They say we can go home once a month, but when I ask, they say, 'Not now, Amma [mother] is not well' or 'There is no replacement'. Her children are abroad, and she is now attached to me. I also feel bad leaving her alone. But if I insist, they may tell the agency I'm not adjusting. I need this work, so I keep quiet.* (Leela, age 54)

This account shows how exit was restricted by employer control, emotional attachment, migrant family arrangements, and fear of losing a placement. Caregivers who depended on the income to repay loans or support children's education often tolerated restrictions rather than risk being labelled difficult.

When workers complained, agencies often framed restrictions as matters to be tolerated. A home nurse with two years of work experience recalled being told to 'adjust' to the household's demands:

> *When I told the agency that they were not letting me go out or use the phone properly, they said, 'Adjust cheyyanam [You must adjust], this is a good case from a reputed family.' You know, if we make too many problems, they will not send us to good houses later.* (Suma, age 42)

In agency language, such placements were called *nalla veedu* [a good home] or *nalla case* [a good contract], signalling that the worker should not risk losing it. Complaints were therefore routed back into agency mediation rather than formal labour or grievance mechanisms. Restrictions on food, leave, phone use, mobility, and rest were treated as 'small issues' or matters of household adjustment, not as violations of enforceable work regulations. The result was a structure of restricted choice: employers controlled household space, agencies controlled future placements, and caregivers carried the burden of adjusting to remain employable.

Sexual Harassment, Physical Aggression, and Bodily Vulnerability

Caregivers' accounts included physical aggression and sexual harassment connected to the intimate, bodily nature of live-in care. Women caring for patients with dementia, stroke, paralysis, or other neurological conditions described being scratched, hit, pushed, or verbally abused during bathing, toileting, feeding, or lifting. Some recognised that these actions were linked to illness, but the injury and exhaustion remained theirs to bear. Mercy, who cared for a bedridden man after a stroke, said:

> *When I changed his diaper or turned him, he would suddenly hit my hand or push me away. His children said he does not know what he is doing, but the pain is on my body. A few days back, I had bruises on my arms.* (Mercy, age 57)

Sexual harassment was narrated more cautiously, often after trust had been established. Women described unwanted touching during transfers or exercises, suggestive jokes, comments about their bodies, and explicit propositions. Harassment came from older male patients, male relatives, or visitors. One caregiver described unwanted touching by a male relative but said complaining felt risky:

> *If I say it openly, who will believe me? It happened inside their house. They may say I misunderstood or that I am making up a story. Then I will lose the contract, and my name will also be spoilt.* (Shyla, age 44)

The private household made it difficult for caregivers to avoid contact or produce witnesses. Women who spent long hours in the same room as older male patients, especially when family members were away, described remaining alert and uncomfortable. Some tried to manage risk by keeping a light on at night, sleeping near the door, avoiding particular men, speaking sharply when boundaries were crossed, or involving female relatives in intimate care. These strategies offered limited protection because the worker still depended on the household and agency.

When workers requested transfers from such placements, agencies sometimes treated the matter as an adjustment rather than a safety issue. A caregiver recalled:

> *I told the office that I did not feel comfortable there. Our agency owner said, 'He talks like that to everyone, don't take it seriously.' After that, I only asked them to transfer me somewhere else.* (Shyama, age 39)

Although formal complaint routes exist in law, workers' accounts suggest that the private household and dependence on agencies made such routes difficult to access in practice. Safety concerns were more often converted into transfer requests than recognised as workplace complaints. Very few caregivers pursued police complaints or legal action. Many doubted they would be believed, feared reputational damage, or worried about losing future placements. As a result, harassment and aggression were often handled through avoidance, transfer requests, or quiet exit. These accounts substantiate how physical proximity, unequal power, and household privacy expose caregivers to bodily harm while limiting routes for redress.

Negotiating Dignity: Quiet resistance, exit strategies, and constrained agency

Despite these constraints, caregivers did not describe themselves as mere victims. Many spoke of preserving dignity within difficult placements by setting limits, refusing some demands, or leaving households where humiliation became unbearable. Rema (age 48), who had worked as a home nurse for over seven years, described dignity as the ability to occupy household space. She recalled several instances from her years in care work: being made to eat outside (once near the dog kennel), discouraged from sitting with the family to watch television, and kept away from the household's prayer space.

For several workers, dignity also meant distinguishing care work from servitude. Thankamma, who cared for a bedridden woman, explained:

> *I came here for work, not to be treated like a slave. I will do the patient's work, but I will not accept being spoken to as if I have no value.* (Thankamma, age 49)

Caregivers used small tactics to protect themselves: refusing tasks beyond their role, insisting on time to call home, avoiding particular family members, or asking the agency for a transfer. These actions were usually framed politely because open conflict could lead to a complaint against them or loss of future placements. For Sathi, a home nurse with eight years of work experience, caste insult marked the limit of adjustment:

> *If it is about work, I can listen and adjust. But when they bring caste into it, I feel I should not remain in that house.* (Sathi, age 51)

When conditions became intolerable, transfers or exits were often the only available routes. However, walking out without agency approval could mean unpaid wages, a bad report, or fewer placements later. Since live-in arrangements and long hours made formal organising difficult, workers relied on informal networks, sharing information about 'good' and 'bad' houses, and warning newcomers about particular clients or agencies.

These practices corroborate that caregivers were not passive recipients of abuse. They asserted boundaries, protected small areas of time and bodily autonomy, and used transfers or exits when necessary. However, such strategies rarely changed the wider organisation of live-in care. Agency control, household dependence, and the need for income meant that resistance often remained individual, cautious, and temporary.

Discussion

Exploitation in live-in care of older adults is not only produced through isolated abuse, excessive work, or non-payment. It is also the result of how intimate labour is organised inside private homes, where kin-like expectations, caste-marked bodily devaluation, agency mediation, and restricted exit combine to make such conditions difficult to contest. Existing literature has established that care work is feminised, undervalued, and treated as an extension of women's natural capacities. This article advances that argument by demonstrating how affection and kinship become forms of labour discipline in agency-placed live-in care. Instructions to treat the patient 'like one's own parent' or remain cheerful and forbearing make refusal, rest, and complaint appear morally inappropriate. This resonates with Choudhury and Das's account of *ayahs* as ambiguously positioned between worker and quasi-kin, Johnson's argument that care workers' emotional labour can be naturalised to justify economic devaluation, and England's observation that caring motives and attachment can make workers vulnerable to accepting

lower rewards or worse conditions.[25]

The analysis also deepens caste-based accounts of domestic work by depicting that the label 'home nurse' does not undo older hierarchies of purity, pollution, and bodily service. Sharma explains how domestic workers are allocated 'clean' and 'dirty' tasks through caste-based distinctions. This study traces how similar distinctions travel into eldercare, where workers may bathe, lift, clean, and comfort older people while being denied equal access to food, utensils, toilets, and household space. Rai, Hoskyns, and Thomas's concept of depletion helps extend this caste analysis from stigma to political economy. In live-in care, the labour of sustaining older bodies is shifted onto women whose caste and class positions make bodily service appear natural, while the exhaustion, humiliation, sexual vulnerability, and emotional strain produced by this work remain theirs to absorb. Caste, therefore, operates not only through interpersonal exclusion but also through the distribution of care's costs, i.e. who cleans, lifts, soothes, stays awake, absorbs anger, and remains available so that households can secure care without reorganising their own lives.[26]

The organisation of live-in care also depends on home nursing agencies, which appear to professionalise the sector while dispersing accountability between client households and agencies. This article extends Grover's analysis of placement agencies by examining how home nursing agencies in Kerala formalise recruitment while informalising responsibility. They assign workers to households, issue behavioural instructions, and mediate transfers. However, when workers complain about food, leave, surveillance, harassment, or caste humiliation, agencies often translate these claims into an issue of 'adjustment'. This is not merely weak enforcement; it is a labour-control mechanism. Tan's work on live-in domestic workers is useful here: when home is both workplace and site of rest, employers gain control over workers' sleep, mobility, communication, and privacy.[27] In Kerala's agency-mediated care of older people, this control is intensified by dependence on future placements and fear of bad reports.

The article's relevance to anti-trafficking debates lies in its attention to labour harms that remain ordinary, cumulative, and difficult to name within existing

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25 Choudhury and Das; E K Johnson, 'The Business of Care: The moral labour of care workers', *Sociology of Health & Illness*, vol. 37, issue 1, 2015, pp. 112–126, https://doi.org/10.1111/1467-9566.12184; P England, 'Emerging Theories of Care Work', *Annual Review of Sociology*, vol. 31, issue 1, 2005, pp. 381–399, https://doi.org/10.1146/annurev.soc.31.041304.122317.

26 Sharma; Rai, Hoskyns, and Thomas.

27 Grover; S J Tan, 'When the Home Is Also the Workplace: Women migrant domestic workers' experiences with the "live-in" policy in Singapore and Hong Kong', *Anti-Trafficking Review*, issue 20, 2023, pp. 75–91, https://doi.org/10.14197/atr.201223205.

legal and policy categories. Live-in care for older people takes place inside the family home, but the harms workers describe are not merely private disputes or interpersonal conflicts. They are shaped by the organisation of intimate labour across the public/private divide, where the household is also a workplace and where agency mediation, caste hierarchy, gendered expectations, and weak regulation structure workers' vulnerability. Quirk, Robinson, and Thibos call for attention to 'everyday abuses' built into economic and regulatory systems rather than appearing only as exceptional violations.[28] Palumbo similarly argues that exploitation in domestic care can become normalised when care is treated as a private family matter and abuse is addressed only in extreme cases.[29] The responses of caregivers in this study nevertheless remained individual and fragile, offering protection only when they could avoid retaliation or secure another placement. This mirrors research on sexual harassment among domestic workers in India, where women often rely on low-confrontation responses to preserve livelihoods.[30] It also resonates with home-care violence studies showing that isolated work inside private homes exposes workers to abuse from clients and relatives.[31] Krishnan further reminds us that caste, class, and gender shape whose grievances become collective claims.[32] Theoretically, this article demonstrates how live-in care of older adults in Kerala makes exploitation ordinary through the moral, spatial, and institutional arrangements that organise home-based care: kinship, caste, depletion, agency-managed silence, and restricted exit.

Policy Implications

The study findings point to several areas where policy and practice need to change if live-in care workers are to be protected as workers rather than treated as dependants within private households. Since exploitation is produced across agencies and households, responses cannot only focus on extreme abuse or individual bad employers. Home nursing agencies require clearer regulation, licensing, and oversight covering recruitment, contracts, wages, working hours, rest, leave, placement records, payments, and deductions. Agencies should remain accountable after placement by monitoring conditions in clients' homes, not merely maintaining paperwork.

Live-in eldercare needs to be recognised as labour performed in a private household, with enforceable protections such as minimum wages, weekly rest

28 Quirk, Robinson, and Thibos.

29 Palumbo.

30 Vijayalakshmi, Dev, and Kulkarni.

31 Green and Ayalon.

32 Krishnan.

days, paid leave, accident cover, health insurance, and pension access. Rest and leave are safeguards against depletion, not favours to be granted at the household's discretion. Gifts or end-of-contract tokens from clients should not be treated as substitutes for wages, overtime pay, leave, or payment for work beyond the agreed care plan.

Caregivers need safe ways to report violence, sexual harassment, caste discrimination, excessive work, or leave denial without the risk of losing wages, being blacklisted, or missing out on future placements. Agencies could arrange emergency transfers where safety is at risk and refer serious complaints to labour authorities, women's commissions, or other relevant bodies. Caste discrimination in household workplaces needs to be recognised as a labour rights and dignity issue, not a private household custom. Client households could also receive written orientation on duties, rest time, privacy, phone use, anti-discrimination norms, and complaint procedures. Peer networks, helplines, drop-in centres, and off-site meetings are essential for isolated live-in workers to access information, emergency assistance, and collective support.

Conclusion

This article has examined agency-placed live-in care of older adults in Kerala as intimate labour shaped by caste, gender, class, migration-linked care deficits, and weak regulation. It has argued that exploitation in this sector is produced not only through exceptional abuse but through typical arrangements that require caregivers to be continuously available, morally obligate them to 'adjust', and render them dependent on agencies for future placements. Kin-like care blurs the boundary between affection and entitlement, making rest, refusal, and complaint difficult to claim.

The article's contribution lies in showing how caste-inflected devaluation persists within work presented as 'home nursing'. Caregivers may be indispensable to older people's bodily and emotional care, but they remain socially distanced within the households where they live and work. Their labour is also depleting, consuming sleep, bodily strength, emotional capacity, social connection, and dignity, with limited routes for recovery or redress.

The scope of this analysis also points to the need for further work on live-in eldercare across different regions and institutional arrangements. Comparative studies of care organised through hospitals, charities, brokers, agencies, and digital platforms could show how different intermediaries shape workers' vulnerability and bargaining power. Research on male caregivers, migrant care workers in Kerala, former workers, client families, and agency decision-making would further clarify how live-in care of older adults is produced, sustained, and contested.

Caregivers set boundaries, seek transfers, share information, and exit harmful placements where possible. However, such strategies remain constrained when agencies, households, and regulatory systems fail to recognise live-in care as enforceable labour. Addressing exploitation, therefore, requires moving beyond household gratitude, kinship language, and informal adjustment towards labour protections that recognise live-in care as skilled work and caregivers as workers entitled to safety, dignity, and fair terms of care.

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