

Gender inequalities among caregivers of dependent older adults¹

Iniquidades de gênero entre cuidadoras de idosos dependentes

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Abstract

This research aimed to understand the experiences and meanings that women attributed to becoming caregivers of dependent older adults, considering the analysis of gender socialization. Qualitative study with 53 family caregivers, carried out from June to September 2019, in the cities of Belo Horizonte, Rio de Janeiro, Porto Alegre, Araranguá, Manaus, Fortaleza, and Teresina. The analysis of the information was guided by the theoretical-methodological framework of hermeneutics-dialectics. The findings were organized into four categories: the caregiver role as something “natural” for women; men absent from the act of caring and maintenance of masculinity; the marital responsibility of wives and gender identity for care; and the economy and cisheteropatriarchy as determinants to undertake care. Women exercise care due to gender socialization. This fact is reinforced by the circumstances of being single, living with the older adults, male absence from sharing care, marital responsibility, and pressure to withdraw from the job market. In conclusion, the family-centered care model is sustained by women, due to the social dynamics built in a capitalist, cisheteropatriarchal-centered society. This indicates the need for society to intervene, reflect, and propose actions for balanced care between men and women.

Keywords: Family caregiver; Frail older adults; Geriatric nursing; Genre; Women.

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Resumo

Esta pesquisa tem como objetivo compreender as experiências e os sentidos atribuídos pelas mulheres para se tornarem cuidadoras de idosos dependentes, à luz da análise da socialização de gênero. Estudo qualitativo com 53 cuidadoras familiares, realizado de junho a setembro de 2019, nas cidades de Belo Horizonte, Rio de Janeiro, Porto Alegre, Araranguá, Manaus, Fortaleza e Teresina. A análise das informações guiou-se pelo referencial teórico-metodológico da hermenêutica-dialética. Os achados foram organizados em quatro categorias: a função cuidadora como algo “natural” da mulher; homens ausentes no ato de cuidar e a manutenção da masculinidade; a responsabilidade marital de esposas e a identidade de gênero para o cuidar; a economia e o cisheteropatriarcado como norteadores para assumir o cuidado. As mulheres exercem o cuidado em decorrência da socialização de gênero. Esse fato é potencializado pelas circunstâncias de estarem solteiras, residirem com a pessoa idosa, ausência masculina na partilha do cuidado, responsabilidade marital e pressão para se retirarem do mercado de trabalho. Em conclusão, o modelo de cuidado centrado na família é sustentado pelas mulheres devido as dinâmicas sociais construídas em uma sociedade capitalista e centrada no cisheteropatriarcado. Isto sinaliza para a necessidade de a sociedade intervir, refletir e propor ações para um cuidado equilibrado entre homens e mulheres.

Palavras-chave: Cuidador familiar; Idoso frágil; Enfermagem geriátrica; Gênero; Mulheres.

Introduction

In contemporary societies, caregiving has become a relevant topic. In this context, mostly women undertake the care of family members in situation of dependence (Meira et al., 2017; Kuluski et al., 2018; Araujo et al., 2019; Sousa et al., 2021; Cecon et al., 2021). Those who care for dependent older adults have physical, emotional, financial, and social needs, in addition to facing the deficient care provided by health care and social services (Meira et al., 2017; Kuluski et al., 2018; Araujo et al., 2019; Sousa et al., 2021).

Scientific evidence indicates that, in many countries, women who care for their family members have chronic pain; arthritis; hypertension; diabetes; sleep disorders; loneliness; depression; loss of freedom; financial difficulties; and uncertainties about the future (Kuluski et al., 2018; Araujo et al., 2019; Sousa et al., 2021; Costa et al., 2021). Furthermore, self-care is impaired when they remain fully alone in caring for the dependent older adult (Del-Pino-Casado et al., 2017; Fernandez et al., 2018; Araujo et al., 2019; Mendez-Luck; Anthony; Guerrero, 2020).

Accordingly, overburden, burnout, and uncertainties about the future are concerning situations that require analysis from the cultural and historical perspective of the social construction of gender and of gender activism towards a balance between male and female family members.

Gender is a social phenomenon, historically constructed and culturally manifested in unequal and hierarchical power relations, which are incorporated not only through repeated performances of what is expected of men and women, but also through affective pedagogies that are configured in certain devices (Alves, 2013; Butler, 2018; Zanello, 2018).

In this regard, the transformations that have occurred in contemporary times are still insufficient to overcome gender inequalities; therefore, women, at some point in life, are called to undertake the role of caregivers, in a silent social contract that demarcates the return of the stereotype of femininity associated with passivity, domestic chores, and the parental role (Alves, 2013; Fernandez et al., 2018; Mcdermott; Mendez-Luck, 2018). In the case

of men, neglect of parental responsibility is not existentially characterized as abandonment, unlike women, who will be at the mercy of rigorous moral judgment (Fernandez et al., 2018; Pereira et al., 2018; Tavero et al., 2018; Sousa et al., 2021).

Thus, the relation between the exercise of care, the gender roles, and the repercussions on women's lives shows the importance of listening to these people, in order to understand their experiences and needs in the performance of their heavy daily tasks. Therefore, the demands of women caregivers need to be understood within the scope of a reality that involves political, economic, social, technical, symbolic, and cultural aspects.

This study aims to understand the meanings that women attributed to becoming caregivers of dependent older adults, considering the analysis of gender socialization.

Method

Study design

This study is qualitative and integrates a multicenter research on dependent older adults and their caregivers (Minayo; Figueiredo, 2019). The Consolidated criteria for reporting qualitative research (COREQ) guide was applied in order to assess the scientific quality of the research. This research sought to understand the meanings that women responsible for providing care to dependent older adults attribute to the process of becoming caregivers, within the historical-social cultural context of gender. The theoretical framework of this research is based on the studies of social constructions of gender and their developments in feminist studies, relating them to the function of caregiver. Social constructions of gender are understood as the structures that constitute the power relations between men and women, their appropriate roles, the social origins of their identities and subjectivities, and their representation in different discourses and practices of everyday life (Alves, 2013). These are social rules and expectations reproduced by society about what is expected of a woman and a of man (Beauvoir, 1970; Alves, 2013; Butler, 2018; Zanello, 2018).

Population

In this study, we explored the interviews conducted with 53 female caregivers, among the 71 female participants, whose accounts present aspects related to gender issues.

Study location

The participants come from the five regions of Brazil: four in Rio de Janeiro (RJ), four in Belo Horizonte (MG), six in Porto Alegre (RS), six in Araranguá (SC), four in Brasília (DF), seven in Fortaleza (CE), nine in Teresina (PI), and seven in Manaus (AM).

Selection criteria

The main requirement for women was that they were related to and had the function of primary caregiver of the older adult, had provided full-time care for at least six months, and were oriented in time and space to report their experience. There were no refusals to participate in the research.

Data collection

Data collection was conducted from June to December 2019. The research instruments consisted of a questionnaire with sociodemographic data (age, marital status, degree of kinship, and time caring for the dependent older adult) and a semi-structured interview plan. The interview plan was built and validated by the team of researchers with representatives of all municipalities in a in-person seminar in 2018. The focus of this study was to learn how gender issues are involved in the life situations that led the women to become caregivers. The guiding question was focused on: "How did you become the caregiver of the dependent older adult?"

The family women who care for dependent older adults were contacted through health care professionals. All participants were invited by the primary health care team or the specialized service in geriatrics and gerontology, as they were included in the agenda of actions and programs involving dependent older adults and their caregivers.

The interviews were scheduled according to the availability of the participants, held at their home, and lasted an average of 60 minutes. Two properly trained researchers from each municipality conducted the interviews, began with the reading of the Informed Consent Form, obtained permission to record the interview, and ensured confidentiality, anonymity and non-judgment of the accounts. We sought to create a welcoming and harmonious environment so the participants felt comfortable and safe to share their experiences.

Data analysis

For data analysis, the hermeneutic-dialectical theoretical-methodological framework was adopted to understand the accounts in the context in which they are produced, understanding them as interpretations built from social actions based on meanings consolidated in culture (Minayo, 2014). The analysis was based on levels of interpretation and the data were previously organized in steps, which enabled conducting the analysis according to four aspects: (1) gender issues present in the process of becoming a caregiver; (2) selection of interviews excerpts in which the participants discussed this aspect; (3) interpretive synthesis of each aspect, considering all the accounts; and (4) interpretive synthesis, which included all data and aspects. The categories that compose the sections of this article were chosen as a result of these syntheses. These categories were analyzed according to the assumptions of understanding and criticism, with support of the national and international literature.

Ethical aspects

The research was approved by the Research Ethics Committee of the Oswaldo Cruz Foundation (opinion No. 1,326,631), in 2018, and followed all the recommendations of Resolution No. 466/2012 of the National Health Council. The names of the women in this study were replaced by the names of Brazilian feminists. In addition, information was presented regarding their age, marital status, degree

of kinship, time as a caregiver, and municipality where they lived.

Results

Brief characterization of the participants

Of the total number of respondents, there were 31 (57.4%) daughters, 14 (25.9%) wives, 3 (5.5%) sisters, 3 (5.5%) granddaughters, and 2 (3.7%) daughters-in-law of the dependent older adults. Their average age was 54.2 years, with the youngest caregiver being 32 years old and the oldest being 85 years old. Regarding marital status, 33 (61.1%) were married, 15 (27%) single, four (7.4%) divorced, and two (5.5%) widowed. As for the time providing care, the average time was 5 years, with the shortest time of 1 year and the longest time corresponding to 30 years.

Gender script: care as something “natural” for women

When asked about the motivations for becoming a caregiver, the answer “*being a woman*” is unanimous among the respondents. The caregiving daughters mentioned the cultural aspect, norms and customs, in which they were socialized to fulfill the function of caring for their relatives:

I think that in the Brazilian culture, the woman has always been the one who took care of the house, who was close, who has a much greater sense of responsibility than the man even because when the man marries, he will take care of his family, they have their wives and, and often they dedicate themselves to their family, to another family. Women have more sense of responsibility to stay and take care of their parents, we women were raised to take care of the offspring and when we have our parents, our parents become our children [...] (Anita Garibaldi, 58 years old, married, takes care of her father affected by Stroke one year ago, Porto Alegre/RS, Brazil).

The participants' accounts showed the unequal division of work and with greater weight for women, which falls to them especially when it is necessary to decide the fate of the older adult after becoming

dependent on care. In some contexts, there is no room for negotiation of the division of responsibilities between family members and the woman undertakes the care. In other situations, the woman refuses the proposal suggested by the male family members to institutionalize the older adult and, as a result, becomes the caregiver.

According to several participants, care practices were assigned to them because they were considered delicate and sensitive. After all, women are considered as having innate gender skills to perform the basic activities of daily living: *“I take care because I am a woman, because of bathing, changing and everything, so it has to be me to take care of her [...]”* (Elvira Komel, 49 years old, married, takes care of her mother affected by Stroke three years ago, Belo Horizonte/MG, Brazil).

Women’s views on emotional skills to care for older adults are based on their own personal experiences. They comment that since childhood they have received attention, affection and care from their mothers and other women. That is consistent with their belief that the older family member will feel more comfortable and safe being cared for by a woman, especially when the relative in question is also a woman, due to the issue of intimacy with the older person’s body, because being undressed by a female family member may be less embarrassing than by a male family member.

In all regions, the participants said, with resignation, that one of the reasons for becoming a caregiver, in addition to being a woman, is marital status, mainly because they are single:

As I am single, I said: “No, I’ll take care of her.” I even offered to come here because I saw that she was very depressed and it was not going to work out there. My brother works at the Joinville airport, and my sister-in-law takes care of their young children [...]” (Zilda Arns, 48 years old, single, daughter that has been caring for her mother with cancer for 4 years, Araranguá/SC, Brazil)

The participants said that being single was interpreted by them and their families as availability to undertake the responsibility for the care. Her wishes and life projects were never taken

into consideration by the family members. The woman cannot escape her destiny of following the patriarchal dogma. This reality was also present in situations where the caregiving daughter was widowed, divorced, or had adult children.

According to other women, cohabiting with the older adult implied perpetuating the care received from the older family member. They are daughters, sisters, and granddaughters who reproduce the maternal behavior of fostering, caring, and protecting: *“I have always lived with her, since I was born, I really started to dedicate myself to care after I became a mother, she took care of me for so long and now I am reciprocating by caring for her [...]”* (Nise da Silveira, 33 years old, single, has been caring for her grandmother with kidney failure for four years, Manaus/AM, Brazil).

Men absent from the act of caring: maintenance of masculinity

The cisheteropatriarchal cultural model determines women’s way of thinking, acting, and behaving in society. Such model entails that, in the absence of women in the family, sons transfer the responsibility for care to their wives: *“My husband thought it was better for her to stay with us (...) at first, she didn’t like me because I am black, but even so I’m not angry with her, I learned to love her [...]”* (Enedina Alves Marques, 54 years old, married, has been caring for her mother-in-law with heart failure for six years, Teresina/PI, Brazil).

Enedina says that due to the marital union and love for her husband, she took care of her mother-in-law, adapted her routine, and repressed any forms of expression, such as feelings, opinions, desires, and plans for the future. The relationship with the older woman was marked by racism and hostility, but, despite that, she learned to have affection for her mother-in-law. Her husband exercised control over her, treating her as if she were his property, as occurs in more traditional patriarchal societies.

Other women, throughout their account, open up about the responsibility of caring. One of them considers her brother a person who does not take action—*“He never did anything”*—since both were socialized with different responsibilities: he was

meant to be dedicated to his education and she was morally responsible for protecting the life of the older woman, in addition to promoting affective well-being:

He [the brother] is her favorite child, she always spoiled him a lot. He was never much help and male children are like that, he is never very available and I could see that my mother needed help. So, since my father died, I ended up getting stronger, maturing to support her [...] (Carmem da Silva, 36 years old, single, has been caring for her mother with cancer for 10 months, Porto Alegre/RS, Brazil).

The woman takes care in a solitary way, even in situations where male relatives live in the same house as the older person. In addition, the brothers skill for care practices is perceived only as physical strength:

I'm the only daughter, my brother and his wife lived here with us, but he passed by, went up and down, didn't even greet us. Today he is separated, but he takes care in a sense of (...) mom is sick and no one can bear her weight, he can lift her [...] (Nísia Floresta, 54 years old, single, takes care of her mother who has had pulmonary embolism for 14 years, Fortaleza/CE, Brazil).

Men's lives were not changed, they continued with their freedom in the different dimensions of professional and family life. On rare occasions, they offer to take the older person to the doctor or visit on weekends.

"I am the wife": marital responsibility and gender identity for care

In other contexts, the decision to become family caregivers was significantly influenced by the women's marital responsibility, based on the traditional quotidian love experience of romantic love, in which compassion and solidarity are at the center of the daily construction and the feeling perceived as love is the foundation for wives to undertake to care for their partners: *"There is a whole story before, a partner, when we marry it is for the rest of life, we have to endure, as long as I*

have strength, I will endure, it is my responsibility as a wife. The children have their lives [...]" (Nise da Silveira, 69 years old, married, has been caring for her husband with Parkinson's disease for three years, Araranguá/SC, Brazil).

Another theme that emerged from the interviewees' accounts is the obligation to care for abusive spouses. Even when the marriage had been permeated by violence, many women provide care because of charity: *"We take care because he [the older man] is a human being. We have to do charity, if it weren't for that he would have already died from dinking spirit [...]" (Maria da Penha, 72 years old, wife, has been caring for her husband with walking difficulties for 3 years, Fortaleza/CE, Brazil).*

In this case, the effects of alcoholism and physical, verbal, and psychological violence against the children affected the family dynamics in such a way that no bond was built. With illness and dependence, the children refrained from caring for their father. The women who care for their aggressors say they do so because they do not want to see them in degrading situations of illness and abandonment.

The economy and cisheteropatriarchy as determinants to undertake care

Another facet of gender socialization that assigns care to women is based on the withdrawal from the job market due to unemployment, where the possibility of returning to labor activities becomes distant in the face of the new reality: *"I took on the care because I was unemployed, I had difficulty accepting my situation of taking care of my parents, not for lack of love, but the condition of having no income to survive [...]" (Chiquinha Gonzaga, 57 years old, married, has been caring for her father with Alzheimer's disease for 3 years, Brasília/DF).*

Lacking alternatives to see her dependent parents care for, the woman undertakes their care and faces the neglect of her personal life:

I resign myself, because I don't have the financial means to pay for a caregiver (...) I had to commit, I do it, I dedicate myself with love and everything, but in the middle of love there is stress, I give up

a lot, before being involved here I worked in sales, all my life I have worked, and today I live conditioned on others [...] (Bertha Lutz, 60 years old, has been caring for her father with pulmonary embolism for 3 years, Fortaleza/CE, Brazil).

For some families, paying for a formal caregiver is a viable alternative so the dynamics of the woman's life and her work activities are not altered. However, the woman is still considered responsible for managing the care and providing emotional and physical support to the sick older adult. However, most families in this study lacked the financial resources to pay for a formal caregiver. Thus, most family caregivers had to interrupt or limit their social and work activities in order to be available full-time for providing care, consisting in uninterrupted work with a repetitive daily routine.

Only in two contexts of the group interviewed here did women claim, from their brothers, financial assistance to dedicate themselves fully to the care of the elderly parents:

One [of the respondent's brothers] said that he could not do anything because he had no obligation and that the daughters were the ones who had to take care of the mother. Then, okay, it was his thought, but I said that each of them had to give something [financial help], because I'm not retired, I had to stop my seamstress work, it's like I'm her caregiver, so I have to earn for it, because I don't have a salary [...] (Marielle Franco, 59 years old, married, daughter, has been caring for her mother after a stroke 26 years ago, Rio de Janeiro/RJ, Brazil).

Discussion

Scientific evidence indicates that, in most cases, women undertake the care of dependent older adults. They are daughters and wives, aged over 50 years and married, whose function is characterized as a marker of power inequalities between men and women present in society (Rodger; Neill; Nugent, 2015; Fernandez, et al, 2018; Oshio; Kan, 2018; Taverro et al., 2018).

Butler (2018) argues that power should be understood as factor forming the subject,

which influences the very condition of existence and trajectory of desire. Also, it can be understood as that which the person internalizes and accepts to constitute oneself as a subject. Therefore, being in the role of caregiver is usually a fate that women do not choose, but, paradoxically, initiate and sustain in the face of society's expectations of them.

Women fulfill the female social role imposed by the cisheteropatriarchy by accepting and validating the historical and cultural context, which places them as responsible for the care of family members. During socialization, she is exposed to the practice of caring, when observing her mother and other women in the family caring and, thus perceive care as something exclusive to the female gender and do not question it when it is imposed on herself (Meira et al., 2017; Mcdermott; Mendez-Luck, 2018; Pereira et al., 2018; Zanello, 2018).

The care exercised exclusively by women contributes to the maintenance of the family-centered model of care. According to this conception, the female figure is also a protagonist in the high involvement of the family in the care for their dependent relatives in other countries, as found in researches carried out in Spain, Portugal, Greece, Mexico, and Chile (Del-Pino-Casado et al., 2017; Pereira et al., 2018; Mendez-Luck; Anthony; Guerrero, 2019). The beliefs and values in relation to the obligation of care assigned to women make the institutionalization of older adults socially unacceptable; thus, women undertake such care, often in a solitary manner, or with the help of other women of the family (Pereira et al., 2018)

The experience with care since childhood enables women to adopt this practice with feelings of tenderness and compassion, which cannot be offered by anyone else. The reasons that influence them to be affectionate are supported by the traditional female role, which socializes them as responsible for the care they undertake (Beauvoir, 1970; Oshio; Kan, 2018; Bourdieu, 2019).

The male identity as a socio-historical construction occurs through the imitation of prototypical male behaviors that focus on rationality, physical strength, and hard work as provider, placing it at the top of the hierarchical chain. These precepts feed toxic masculinity, which places women in a

subordinate position (Beauvoir, 1970; Costa, 2004; Broady, 2015; Butler, 2018; Zanello, 2018). Therefore, there is the challenge of breaking this pattern, which subjectively introduces the cisheteropatriarchal ideology in childhood and institutes the values of gender inequalities as social constructions.

The social identity of family caregivers is based more on the assignment of the function to the female gender than on the degree of kinship with the dependent older family member (Connell; Messerschmidt, 2005; Taverro et al., 2018). The sexual division for domestic-family care is also reinforced by the attitude of older people, who prefer to be cared for by women (Meira et al., 2017). The emotional labor of performing activities to promote the positive emotional state of another person is a function of women. It is part of a highly gender-sensitive division of unpaid domestic and emotional work in which women have a disproportionate participation in relation to men (Connell; Messerschmidt, 2005; Thomeer; Reczek; Umberson, 2015).

Cohabiting with the older adult and being single were reasons referred to for becoming caregivers. This reality faithfully reproduces the cisheteropatriarchal culture, according to which women's fate consists in marriage and motherhood (Beauvoir, 1970; Costa, 2004). In the absence of these tasks, they are free to take care of sick parents. However, many of them accumulate all these functions. A longitudinal investigation in Japan found that about 30% of women began caring for their parents or in-laws because they lived in the same household (Oshio; Kan, 2018).

The man assigns to the woman the function of caring for the family. This is also a veiled imposition on daughters-in-law to take care of their in-laws, even without having affective bonds with them. Oppression is present in women's lives when they have no decision-making power (Beauvoir, 1970; Butler, 2018). Symbolic violence against women is reaffirmed and reproduced when men reaffirm their place in the world and lead them to fulfill their destiny as caregivers. This symbolic violence that is seemingly mild, naturalized, invisible and insensitive to its own victims is exercised by means of communication and knowledge, or, more

precisely, by means of unawareness of female feelings and desires (Bourdieu, 2019)

The influence of socialization through gender inequality is present when women, despite complaining about the absence of men in care, accept without questioning their distant and sexist behavior in not offering help, which reinforces their lack of freedom and autonomy to break traditional gender roles (Costa, 2004). The effect of that is so strong that female family caregivers relate men with the inability to care (Taverro et al., 2018). The labels of strength and rationality attributed to them, useful characteristics for physical and instrumental work, are consistent with traditional gender beliefs that position them as protectors and providers of the family, even though women have a professional work (Thomeer; Reczek; Umberson, 2015). The absence of men in care contributes to the maintenance of patriarchy, giving them more time and energy to invest in their careers (Bozalek; Hooyman, 2012; Alves, 2013).

Wives are at the forefront of caregiving when physical health problems arise in husbands (Broady, 2015); however, they do so in a solitary manner. There is a greater offer of support when men take care of their wives (Sousa et al., 2021).

It is particularly interesting that wives and ex-wives who had marriages permeated by violence and adultery care for their elderly and sick husbands so they do not die abandoned. These are attitudes of women driven by the ethical and moral responsibility of providing care (Costa et al., 2020; Sousa et al., 2021), which corroborates gender socialization (Beauvoir, 1970; Costa, 2004; Butler, 2018; Fernandez, 2018). No matter the marks of violence that women carry in their life story. They are assigned the act of caring, including for their aggressors.

As for the interviewees, several women had to forgo their financial freedom, withdrawing from the job market. Therefore, if on the one hand there have been advances in female participation in professional life outside the household setting, on the other hand when a family member has a health issue they are directly called to occupy their traditional function of homebound caregiver. Thus, it is observed here and in other countries that there is almost no participation

of female caregivers in the formal job market (Del-Pino-Casado et al., 2017; Oshio; Kan, 2018).

In fact, one of the main consequences in the lives of women caregivers, previously included in the job market, is resignation from paid employment, due to incompatibility with dedication to care (Fernandez, 2018; Taverro, 2018.) This may also explain the lower pay for women compared to men. Female caregivers are more willing to resign from their jobs, modify their work schedules, forgo promotions or career development opportunities to accommodate caregiving responsibilities (Bozalek; Hooyman, 2012). Managing the multiple tasks related to the job and care leaves them with no free time, which becomes a source of tension, stress, and constant concern (Kuluski et al., 2018; Araujo et al., 2019; Sousa et al., 2021).

Women who provide care have a lower quality of life, lower subjective well-being, and are more likely to be affected by anxiety, depression, and physical health problems (Taverro et al., 2018; Araujo et al., 2019). Married women experience increased difficulty in balancing responsibilities between being a caregiver, a mother, and a wife (Rodger; Neill; Nugent, 2015; Thomeer; Reczek; Umberson, 2015)

A concerning finding is that caregivers are less likely to seek health care services to report their problems, either due to lack of available time or because they do not perceive themselves in the process of caring for others (Sousa et al., 2021). In turn, health care professionals focus their care on dependent people and do not usually offer support to caregivers, even in cases where both are older adults (Araujo et al., 2019).

It is interesting to note that, in the interviews, few women saw the work as caregiver as a profession or a job that should be paid. The fact of demanding remuneration would indicate a movement of empowerment of them, even if there were no choice as to performing such function. However, this movement was not observed.

According to the literature, women consider the care activity unimportant, because they naturalize it and, therefore, do not expect any economic or social recognition for performing it, resigning themselves to being dependent on others (Broady, 2015). In turn, society expects them to be the primary caregivers,

although it offers them neither psychological nor financial support. Problems faced by caregivers are perceived as personal concerns. Thus, little attention has been directed to the structural arrangements that create women's dependence and limit their choices, including in old age (Bozalek; Hooyman, 2012).

A theoretical essay on policies to support the elderly in situations of dependence found that European countries included policies on dependence within the framework of their social security system; some offer full protection, providing formal caregivers, capacity-building, training and remuneration to family members, others only partially assist the older adult and the family caregiver. The dependent older adults are never left without receiving the care they need (Minayo et al., 2021). In Brazil, we have two local experiments: in Belo Horizonte, the *Maior Cuidado* (Greater Care) Program offers formal caregivers, funded by the municipality, to older adults with some degree of dependence who have family members and are in extreme financial vulnerability; and, in São Paulo, the *Acompanhante de Idosos* [Caregivers for the Elderly] Program offers home care with professionals and caregivers to older adults in situation of clinical fragility, social vulnerability, social isolation, or social exclusion due to insufficient family or social support (Minayo et al., 2021; Sousa et al., 2022).

Also in Brazil, the Bill 6,892/2010 has been following legal channels for three years; it provides for the institution of a national policy to support unpaid informal caregivers of people in situation of dependence for the exercise of activities of daily living. The proposals include: capacity-building and support for informal caregivers; continually-provided benefit for older adults in extreme financial vulnerability; possibility of financial assistance to informal caregivers and community support for resting periods (Brasil, 2019). The social isolation and the COVID-19 pandemic have certainly deteriorated the contexts of the care provided and the physical and emotional health of family caregivers, as well as their future prospects in relation to old age and retirement, which makes it urgent to expedite the processing and approval of the above bill in the upper and lower houses, in order to ensure some support for family caregivers.

The results of this study cannot be generalized, because it uses a small sample, but it is noted that the findings corroborate the national and international literature, providing new knowledge to design proposals for support and care for women who care for their older family members. The convenience sample was due to the difficulty in locating these caregivers in the official records of health care services, which reinforces the invisibility of these people and of the subject in the Brazilian context. Another limitation was not investigating race and social class—categories that intersect with gender; therefore, it is recommended that future research includes this social differentiation.

Final considerations

The female caregivers in this study are part of a generation that has experienced since childhood the promotion of care as inherent to the female sex. These women were educated differently from men, as if they were unable to perform activities other than domestic ones, so passivity and altruism are observed in the solitary manner in which they undertake care. Cordiality, skill, bond, and closeness to the older adults were justifications referred to by the women in this study to undertake the care of their older family members. In the case of this study, it is important to note single women who lived with the older adult, as, consistently, the obligation of care fell to them. Similarly, we highlight wives who take care of their husbands, even in situations where the marriage had been permeated by violence, even if the men had abandoned them. In all situations, women were not given the possibility of choice, except for undertaking care so the older person was not abandoned or institutionalized, which could lead to the non-fulfillment of the role intended for women in society and make them the target of rigorous moral judgment.

It is necessary to take into consideration that one of the cruelest gender inequalities is the fact that women withdraw from the job market, become financially dependent on others, and become impoverished with men doing nothing to partake in the care of their family members.

The results of this study contribute to the discussion of gender roles in social responsibilities over families, mainly. Moreover, it fosters the reflection of health care professionals so they are care agents also in relation to caregivers. Their schedules could be adapted to include consultations with caregivers, beyond listening and caring for the dependent older adult. From the perspective of education, the knowledge produced about the gender inequality experienced by women caregivers could be incorporated into pedagogical content to train health care professionals who recognize the needs of caregivers and propose interventions to improve their quality of life.

From the political point of view, this study points to the need for public policies geared to caregivers, with increased provision and diversity of services so family members, both women and men, can be empowered and choose whether they want to undertake the care, receiving educational and economic support to do so. The social legitimacy of the caregiver's work should be recognized with the offer of capacity-building, training, and home support; offer of formal caregivers, remuneration or flexibility in paid work for exercising the function of family caregiver. The sacrifices and repercussions of family care, currently so naturalized and devalued, should be minimized. Older adults and their caregivers deserve a life with more care and quality.

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Authors' contributions

Sousa, Silva and Brasil participated in the study/research design, data analysis, and final review with critical participation. Cecon, Reinaldo, and Minayo participated in the data analysis and final review with critical and intellectual participation in the manuscript.

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