Social Inclusion
2026 • Volume 14 • Article 12060
https://doi.org/10.17645/si.12060

ARTICLE

Open Access Journal

Senior Care in Wartime Ukraine: A Fragmented Continuum of Arrangements Inside an "Unpromising Sector"

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Submitted: 30 January 2026 **Accepted:** 28 April 2026 **Published:** 3 June 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Care for older people in Ukraine is an "unpromising domain" of social policy, situated at the bottom of care hierarchies and systematically marginalized through chronic underfunding, weak institutional development, and political invisibility. The provision of care for older adults has been shaped by long-term demographic aging, neoliberal reforms, and a strongly familialistic care regime, and it relies predominantly on families operating within a fragmented and poorly regulated landscape. Russia's full-scale invasion in 2022 has resulted in another devastating blow to structural conditions, not only further destabilizing care infrastructures but also disrupting informal networks of support, rupturing family ties, and deepening inequalities in access to care. In this article, we situate current arrangements within a longer historical trajectory from the Soviet period through to the post-independence reforms. Relying on statistical data, policy analysis, and 40 in-depth interviews, we trace how the deprioritization of care for older persons—that is, its decentralization, marketization, and a shift to residual public provision—has produced a fragmented continuum of care rather than a coherent care regime. The war is acting as an amplifier rather than representing a rupture; it is magnifying existing deficits and increasing reliance on unstable ad hoc solutions. These dynamics are profoundly gendered, with middle-aged and older women bearing disproportionate responsibility for both unpaid and low-paid care labor. We argue that the persistent framing of care for older people as an unpromising policy domain risks reproducing its marginalization in the postwar reconstruction.

Keywords

care for older people; familialism; gendered care labor; neoliberalism; social policy; Ukraine; war

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1. Introduction

Like most EU countries, Ukraine has been dealing with the challenges of population aging for decades. A combination of socioeconomic problems, declining birth rates, and the outmigration of the working-age population has been collectively described as "aging from below" (Semigina & Karkach, 2021). Unlike other countries in the region, however, Ukraine has experienced significant military, socioeconomic, and political turmoil from 2014 onward. The war that broke out in Eastern Ukraine accelerated these demographic changes, while Russia's full-scale invasion in 2022 rendered them dramatic.

Marxist feminist theories of social reproduction argue that care for older people is structurally located at the bottom of care hierarchies (Dutchak, in press), though how that plays out depends on complex local contexts. Over the years of post-Soviet transformation in Ukraine, it came to be seen as an unpromising domain shaped by extreme demographic pressures, chronic underfunding, public and political invisibility, and, in recent years, the war waged on the Ukrainian state and society. This neglect, we argue, resulted in care for older people being pushed to the very bottom of care hierarchies in Ukraine, exacerbating pressure on families and especially on women with multiple other vulnerabilities. Here, the gendered cultural norms naturalize care as women's responsibility to further justify the lack of and political apathy towards finding alternative and sustainable options.

In this article, we explore familialized, fragmented, and publicly and politically invisibilized care arrangements for older people. We also consider experiences of care in the context of neoliberal austerity and war. Existing research shows that families consistently and invariably remain the main providers of care for older people in Ukraine (Strelnyk, 2026), despite changes in the political elites, economic models, and demographic conditions. We therefore ask: How do families navigate the existing care infrastructure and arrange care under various circumstances shaped by broader state policies and the ongoing war? To address this question, we first map the historical context of care for older people in Ukraine. We begin by summarizing the current state of care provision for older people and outlining the existing landscape of care infrastructure. We then provide an overview of key transformations in this infrastructure over the decades of post-Soviet transition, cementing the unpromising position of the care sector and policy domain. We also cover the post-2014 period of neoliberal austerity, reforms, and war, which tightened care hierarchies, resulting in increasing neglect and fragmentation (Dutchak, in press) at the bottom of the care sector. This overview allows us to better understand families' options of support regarding care for older people as their care needs evolve over time: for example, the availability and accessibility of options beyond family networks, the fragmenting influence of (or rather lack of) state policies, broader structural processes, and, eventually, war.

We demonstrate how families patch together care from a variety of sources, including arrangements based on kinship and reciprocity as well as those located in the gray areas of social provisioning and the for-profit care sector. While we focus on care arrangements within families, we also examine the solutions families seek out and turn to. This enables us to reflect on the scope of the care available for older people, and on how it is mobilized and shaped by the broader context of a familialistic model of care.

Our article is based on an analysis of statistical data, secondary sources, and 40 in-depth interviews with families (20), care workers (10), care providers and NGOs (10), and experts (2) in the field of care for older people. Numerous obstacles to accessing data in wartime exist: These include delays, restrictions, and gaps in

the publication of statistics, while some data (for instance, from occupied territories) is currently inaccessible. Moreover, during the field research, we discovered that the marginalization of senior care problems in public and political narratives and the trivialization of in-family care make some people reluctant to speak about their experiences: this was especially true for care workers but also for in-family carers. To overcome these obstacles, we drew on extended personal and social networks, using self-selection and snowball approaches to conduct interviews. We rely on a "patchwork ethnography" approach as an inevitable and yet productive way to research in "less-than ideal…conditions" (Günel & Watanabe, 2024). Despite these limitations, the combined methodology allows us to examine care for older persons in Ukraine from multiple perspectives and to situate experiences of care use and care provision within a broader sociopolitical and historical context.

2. Senior Care at the Bottom of the Care Hierarchy

Across the globe, care for older persons remains a relatively neglected care sector. Marxist feminist theories of social reproduction allow us to comprehend both the overall hierarchical structures of capitalist socioeconomic reality and labor (Bennholdt-Thomsen & Mies, 2000, p. 31) and the different values attached to bodies as bearers of labor power (Vogel, 2000). These embedded inequalities create care hierarchies within which resources are distributed unequally, leading to the uneven development of care infrastructure and the fragmentation of care labor, even more prominently under conditions of austerity and crisis (Dutchak, in press). Despite population aging, Ukraine has seen no socialization or outsourcing of care for older people on any significant scale, leaving the familialistic model of care dominant and care arrangements individualized and fragmented. As we will show, these deficiencies stem from decades of neoliberal policies tightening care hierarchies, promoting the privatization of care and halting substantial social reforms. The war has further exacerbated the situation.

2.1. Care for Older People in Ukraine Before 2022

While a detailed historical analysis of care arrangements in Ukraine lies beyond the scope of this article, it is worth outlining that the Soviet model of care for older people is the one that had the most bearing on the institutions and organization of such care in Ukraine. Indeed, the Ukrainian government launched its first comprehensive reform of social services only in 2020. The Soviet model has been described as familialistic and informal (Bezrukov, 2003; Semigina & Karkach, 2021), barely supported by a rudimentary, selective, closed state system, with almost no other actors providing care for older persons outside families (Semigina & Karkach, 2022). When Ukraine became independent, it had an underdeveloped system of residential care for older people and a gradually expanding system of visiting care organized through community centers (Bezrukov & Verzhikovskaya, 1994; Palley & Romanenkova, 2004), as part of the model established in the late Soviet period. During the 1990s, the existing system of long-term care was understood as fragmented, underfinanced, unevenly developed, and insufficient to address the growing demand for care provision driven by demographic change (Bezrukov, 2003). This decade was also marked by the steady development of a private nonprofit infrastructure of care for older persons, including charities and ethnic and religious organizations, as well as international actors such as the Red Cross (Bezrukov, 2003; Palley & Romanenkova, 2004). While for-profit actors likely emerged at that time, this sector grew rapidly in the first decade of the 21st century, chiefly in an unregistered and unregulated form (Semigina & Karkach, 2021).

The existing problems of public senior-care infrastructure have not been addressed to date. Despite a relatively stable number of older people in absolute terms and their proportional increase within the population, there has been a persistent decline in public care provision for older persons. This trend intensified after 2014, when the war in Eastern Ukraine accelerated the socioeconomic crisis and demographic decline. The former triggered neoliberal anti-crisis austerity measures, including cuts in funding and personnel in the public sector. Social workers were among those laid off (Dutchak, 2018). This shift was accompanied by forced population displacement, with older people among the most vulnerable (Kuznetsova & Mikheieva, 2020; Kuznetsova et al., 2018; Mikheieva & Kuznetsova, 2023).

We interpret the fact that the first comprehensive reform in care for older people took place 29 years after Ukraine's independence as demonstrating the lack of political priority assigned to senior care. The reform marked a further move toward a more targeted, cofunded, and decentralized approach to provision and financing, wherein all social services were expected to operate according to quasimarket principles with various providers competing for public funding (Dutchak, 2024; Lomonosova, 2021). Although its implementation was cut short by Russia's full-scale invasion, the reform set up existing trajectories of decentralization, marketization, and fragmentation in public care provision for older people (Semigina & Karkach, 2022).

There is very limited financial support for family carers in Ukraine. With the 2020 reform, the government introduced "compensation for nonprofessional or professional care," for which family carers can apply (Supreme Council of Ukraine, 2019). According to the data we requested, approximately 35,000 people receive "compensation for nonprofessional care," amounting to an average of UAH 2,500 (55 euros as of September 2024) per month, while approximately 770 people receive "compensation for professional care," with an average of UAH 8,300 (180 euros) per month. The latter can be obtained if a person completes a training program and registers as a self-employed social services provider. As is evident, support for those providing nonprofessional care to family members is scant, and only a very small number of people receive the higher professional compensation; in some regions, there are no recipients at all. Notably, in response to our request for information, the administration of one such region stated that this payment is not provided "due to lack of any need." We interpret this as indicating that the support is perceived as too limited to justify the effort required to apply, or that authorities do not promote organizing training and informing people about this program.

Earlier research (Bezrukov, 2003; Bezrukov & Verzhikovskaya, 1994) concluded that the family-based model of care for older persons established during the Soviet period could not continue to dominate under the rapidly changing socioeconomic and demographic conditions (Gutterman, 2022; Slyusar, 2022). In the following decades, recurring scandals emerged around conditions in chronically underfinanced and understaffed public facilities, while private facilities remained largely inaccessible and unregulated (Dutchak, 2024; Tkalich et al., 2025). Family-based care provision also remained the overwhelmingly preferred model among older people themselves: 55.4% stated that care is the obligation of children or relatives (Ukrainian National Academy of Science & Institute of Demographic and Social Research, 2014, p. 250), and 75% expressed negative attitudes toward residential care, including 40% who considered it the worst thing that could happen in old age (p. 258). Given the existing situation in the senior-care sector, population resources, and prevailing attitudes, it is unsurprising that only 2% of older people with care needs in their family use public or private residential care, only 3% regularly use paid carers' support, and 10% use it occasionally

(Strelnyk, 2026). Overall, we conclude that the deprioritization of care for older people and resulting fragmentation lead to the family—and overwhelmingly women—remaining the main pillar of the senior care regime in Ukraine.

2.2. War as Disrupting the Care Landscape and Networks of Support

Russia's full-scale invasion in 2022 brought destruction, a severe economic crisis, and forced population displacement, radically impacting all parts of the social fabric of Ukrainian society. The prolonged war resulted in the destruction of care infrastructure, including damage to and destruction of at least 159 social services facilities (Cabinet of Ministers of Ukraine, 2024), and the killing and injuring of both older people and care workers. With the rapid advance of the Russian offensive at the beginning of the invasion, the authorities failed to evacuate a number of public residential care facilities, some of which ended up under occupation while others found themselves on or near the frontline under heavy shelling (Lomonosova & Babych, 2022). More broadly, safety in public care infrastructure for older adults—including the availability of shelters and their actual use during air raid alarms—has attracted little public, political, or policy attention, especially when compared to other domains of care infrastructure, such as schools and hospitals (Dutchak, in press). A lack of electricity, heating, water, and access to basic medical care further devastated the lives of older people in need of care and basic stability in their old age, often overlooked by both the Ukrainian and international public.

Destruction, danger, and the priorities of the defense economy have all contributed to shrinking care provision for older people and placed additional pressure on existing infrastructure (Amnesty International, 2023; Lomonosova & Babych, 2022). The massive population displacement caused by the invasion further exacerbated this pressure, as host communities are required to accommodate the care needs of growing numbers of older persons and others in need of care. Moreover, existing public residential care facilities—however problematic their conditions—are often the only places on which volunteers can rely to house certain older people, especially those with restricted mobility. While the official policy of deinstitutionalization has been promoted in the context of EU accession, paradoxically, some local NGOs supported by foreign donors and involved in the evacuation of older people have been creating additional places in public residential care facilities, thus expanding their capacity. As one NGO representative explained during an interview, "hampering the creation of new places in geriatric institutions is tantamount to not evacuating these people."

The large-scale population displacement triggered by war has also disrupted existing kinship and other informal networks, which, as described in Section 2.1, traditionally play a major role in family care (Dutchak, 2023; Slyusar, 2022). Older persons are among those least inclined to leave—either abroad or to safer territories within Ukraine—for a variety of personal and structural reasons. As a result, they are often those who "stay behind," but they are also sometimes separated from other family members during evacuation processes because there are fewer opportunities for them to find temporary or permanent accommodation capable of meeting their needs in cases of restricted mobility or intensive care requirements (Amnesty International, 2023).

The breakdown of informal networks has also resulted in a growing number of older people in need of external care provision. This, in turn, increases the workload of visiting care workers, especially in frontline

communities, but also in those hosting substantial numbers of internally displaced people (Amnesty International, 2023; Lomonosova & Babych, 2022). Despite workloads that are sometimes twice the norm, and despite working conditions marked by air raid alarms, shelling, and power cuts, social workers continue to receive low wages, often close to the minimum (Lomonosova, 2024). Amid existing policies and historical developments, public care for older people in Ukraine rests mostly on the undervalued labor of public care workers. This labor is framed as disposable and is retained within the sector through structural factors and the exploitation of gendered affective expectations associated with care (Dutchak et al., in press). These workers, mostly women who are often themselves close to retirement age, continue to provide some level of public care to the most vulnerable older persons, including in war-endangered territories.

Since 2022, substantial resources have been mobilized within civil society—both domestically and internationally—to provide humanitarian relief and other forms of support to various groups in Ukraine. The local NGOs and volunteers whom we interviewed, and who seek to mobilize resources within Ukrainian society to support public residential facilities or advocate for improvements in public provision, reported that they were forced to shift to purely humanitarian assistance in 2022, as needs became urgent amid the invasion. One NGO representative supporting public residential facilities identified the war as a key factor contributing to the further invisibilization of old age in public discourse:

> Those who die in war cannot be old a priori, because they die young. So the war has changed our attitude toward old age—we care even less about older people….Now it is even more difficult to collect money for [their needs].

Another volunteer explicitly described how difficult it is to fundraise in Ukraine for senior care compared to causes such as children's welfare. Referring to a dialogue with potential patrons, she recalled: "They said…'you are dealing with an unpromising sector.' I said, 'My apologies, but in decades to come, you will become that 'unpromising sector.'"

Our research points to the key role of (often externally supported) local NGOs and volunteers in the evacuation and, to some extent, the placement of older people, especially during the first months of the invasion, when the situation with official evacuations was described as "catastrophic" by one NGO representative. There are, however, structural limitations to the provision of meaningful support for older people, and these limitations are embedded in both international humanitarian approaches and Ukrainian social policy. International humanitarian projects are typically limited in funding duration, and so Ukrainian authorities may be reluctant to step in. In an interview, a worker from a large international charity organization described a situation in which they were opening a shelter for displaced older people in a community, and the local authorities explicitly told them, "Just make sure that these people are not left in our care and funding later." Overall, while local nonprofit actors have limited internal resources, international projects—given their current design and funding architecture—are poorly equipped to address the situation for older people, whose need for support tends to increase rather than decrease over time. In other words, short-term grant schemes that last a few months or a year do very little to resolve this situation. Moreover, there are very few nonprofit actors involved in residential care, which may be the only viable solution for displaced older persons with care needs in a context where social housing is virtually absent.

Since the invasion began, many older people have been left without adequate care (Amnesty International, 2023; Dutchak, 2024; Gutterman, 2022). In 2025, 36% of people in Ukraine had an older family member who

required regular care of varying intensity, while 24% had such a person in recent years (Strelnyk, 2026). When combined with shrinking family access to private care options amid an economic downturn, this has resulted in widening gaps in care for older persons that must be managed within families.

This situation has also produced a widening gender gap. Data show that women in Ukraine are more involved in care for older persons within families (Strelnyk, 2026): Approximately every third woman and every fourth man has some experience of providing care for older persons, while approximately every fourth woman and every sixth man has experience of intensive care provision for older people on a daily or almost daily basis. While responses to questions about preferred carer gender highlight the role of stereotypes, Olena Strelnyk (2026) also points to longer female life expectancy, wage inequality, work schedules, and prior care experience as contributing factors.

Yet, such a widespread experience has attracted little research attention. In Ukraine, where the problems faced by older people in need of care have never been significantly present on the political agenda or in public debate (Dutchak, in press), the growing urgency of this problem fades in light of the war and the prospects of a postwar future shaped by rapid demographic change. Today, older people are the only demographic group whose absolute numbers have not declined significantly, while their proportion in the overall population has increased dramatically over the past few years. While the family remains the main pillar of care for older persons in Ukraine, to understand the impact of the fragmented care landscape at the bottom of care hierarchies, it is first essential to disentangle the black box of "family care."

3. In-Family Care Arrangements: Networks and Carers

In this context, we now turn to an empirical discussion of how families arrange care for their older members at the bottom of care hierarchies within a fragmented and poorly accessible support and public infrastructure. We follow how some families find, organize, and combine multiple forms of care provision, including kinship-based, public, private, and charitable options. Through this mosaic of arrangements and experiences, we piece together the puzzle of fragmented care options and analyze how families navigate them to make care arrangements for older people work despite the decades-long neglect of the sector.

3.1. Central Actors and the Gendered Nature of Care Arrangements

Maryna (all names changed to preserve anonymity) is a social educator. She is slightly over 70 years old and lives in a city with her mother, whose health has been steadily deteriorating and who has used a wheelchair for several years. In addition, her mother has hearing problems and early-stage dementia. Maryna's husband suffered a stroke a couple of years ago and has been bedridden since then. While Maryna is the main carer for both her mother and husband, other family members—and even a friend—have been involved occasionally at different stages. Her sons regularly help bathe their father. Meanwhile, they, along with her daughter-in-law, granddaughter, and friend, stay at home from time to time when Maryna has to go to work or when she very occasionally goes on a retreat for a few days. A couple of months ago, with financial support from her sons, Maryna hired a visiting carer through a private agency. The carer comes for six hours two to three times per week to perform hygienic procedures for both Maryna's mother and husband and to manage some basic housework. While the carer is present, Maryna goes out to meet friends, watch a movie, or simply take a walk in the park.

Maryna's situation is fairly typical for long-term senior care, as captured in our research. The initial arrangement of one main carer seems to be the only possibility for the majority of families within the fragmented care landscape and amid the general socioeconomic situation: Some have to earn a living while another person performs the unpaid labor of care. These widespread arrangements are explicitly gendered. Maryna's role as the main carer was never discussed and emerged seemingly naturally, as she was living in the same apartment as her mother and husband and had a relatively flexible working schedule. Although she has a brother, she did not discuss this issue with him, explaining that her role as the main carer came "by default, without saying." Gender inequality in the distribution of care responsibilities is well documented, including recently in Ukraine (Strelnyk, 2026), as mentioned above, and women represent between 57% and 81% of in-family carers, depending on the country (Sharma et al., 2016).

We encountered other cases in which a daughter is the main carer for one or both parents while a son provides material support and engages directly in care only occasionally. The women in our research explained it as something that happened without a clear reason: "Somehow [this arrangement] happened between us, just like that." In all such cases we encountered, there were specific circumstances behind these decisions: A son works full time out of town; he has his own family unlike his sister, or, as in Maryna's case, she was already living in the same household as relatives with care needs. The circumstantial nature of main-carer selection within families is particularly visible in a rarer care arrangement described by another research participant, Kateryna. She lives in a village with her husband and her bedridden father-in-law, who has dementia. A few years ago, while her father-in-law was still living separately, she regularly visited him to help manage his care; when she started a job and her husband lost his, he became the main carer.

While families make circumstantial choices about who will be the main carer in the context of the existing gender inequality, these duties often fall on women. And while there is a rationale behind it for the families, this does not mean that the role of main carer fits seamlessly into a person's life, nor does it imply that in all cases it is taken for granted, without complaints or resentment (as also documented by Strelnyk, 2026). A decision conditioned by preexisting circumstances does not mean that the main carer does not have to make sacrifices—quite the contrary. In many cases, her entire life has to be reorganized around this responsibility. While care for older persons is often a highly demanding task within families, a circumstantial choice of care arrangements, as our research shows, can hardly be described as "the easiest one"; rather, it is often the only possible option within a given family situation that unfolds within a fragmented care landscape.

While gender-imbalanced patterns of in-family care arrangements prevail both statistically and in our research, there are also cases—fewer, but clearly present—where a son becomes the main carer among siblings. We encountered such a case in our fieldwork with Viktor caring for his father. When the previous primary carer—his mother—died, his sister stated that "she does not want to take care of him" and suggested that Viktor either step in or that they jointly hire a carer. After calculating the costs and again taking circumstances into account, Viktor opted for the first solution. Having a small child and having lost his job because of the war-induced crisis, he moved with his family into his father's apartment to become the main carer. We can cautiously assume that the number of such cases may further increase, as the status of main carer is one of the grounds that men in Ukraine can use to defer their war mobilization. Although Viktor did not identify this as a key reason in his decision, he demonstrated extensive knowledge of relevant mobilization legislation, clearly following legal changes and expressing concern about them.

As in Viktor's case, in-family care is often initially provided primarily by a spouse—if they are present and relatively healthy—and later "passed on" to children when this arrangement is no longer possible. This was also evident in Lilia's story. After her mother suffered a stroke several years ago, her father became the main carer, supported by Lilia and her sister in physically demanding tasks such as bathing, while a visiting carer provided by an ethnic organization regularly managed housework. After Lilia's father died of Covid-19, Lilia and her sister negotiated a less typical care arrangement, essentially providing care in shifts: For several months, Lilia and her husband lived with their mother, followed by several months during which her sister took their mother into her home. As Lilia explains, "you could somehow live like that for six months—you do it hard for six months, and then you somehow recover for six months."

3.2. Support Networks and the Effects of War

There is another common pattern present in Maryna's story and in most cases we encountered: the mobilization of family and other personal networks to support the main carer. These may include relatives living in the same household and providing regular assistance, or those living separately (even in another city or country), who step in occasionally. For example, while Lilia was the main carer during her shift, working from home since the pandemic began, her husband regularly supported her, and her nephew could stay with her mother for a day or two if both Lilia and her husband needed to leave the city. Similar arrangements were present in Viktor's case. While his sister refused the role of main carer, she would occasionally step in when he needed to leave the city.

Beyond relatives, friends and neighbors also step in, usually to check on an older person when the main carer has to be absent for a short period, ensuring that the person is well, has taken medication, or has eaten. However brief and scattered such support may be, these nonkinship ties are particularly important when there are no relatives to rely on. Svitlana's story provides one such example. Her family became displaced after the war in Eastern Ukraine began in 2014, and her mother lives separately but in the same apartment building. To manage care during business trips, Svitlana relies on reciprocal support with her neighbor:

> If I'm at home and [my neighbor] is not, I look after her mother. I can jump in, bring her something, help. And if mine feels bad, and I'm not there, and [my neighbor] is at home, then [she] can help. Sort of—we don't have any relatives.

Svitlana's story also illustrates the complexity of in-family care needs and arrangements. This complexity is amplified by war, with the attendant displacement disrupting informal networks and challenging families' ability to establish new networks to meet care obligations. While Svitlana cares for her mother, her mother is still able to support the woman with childcare for two children, one of whom has special needs. In addition, the family manages distance-based support for Svitlana's in-laws, paying their neighbors in the village to keep an eye on them. Since their in-laws would not accept paid help (for example, checking on them, bringing groceries, and assisting with household chores), Svitlana has to pay the neighbors secretly, presenting it to the in-laws as neighborly help. When Svitlana's husband joined the army at the beginning of Russia's invasion, all these care responsibilities were coordinated and managed by her. Later, when he returned to civilian life, she also had to care for him during a period of rehabilitation and adaptation.

Another telling example is the story of Natalia, who left Ukraine with both her parents in search of safety abroad. Although her brother provides material support in the host country, where he has lived for several years, Natalia finds herself almost completely isolated with two older relatives in need of care. Her mother developed severe depression due to war and displacement, and Natalia believes her father experienced a rapid progression of Parkinson's disease as a result of these catastrophic circumstances. While in Ukraine, as Natalia explains, many care-related tasks were done and organized "automatically": in a fragmented but familiar and relatively accessible landscape of care. In an unfamiliar setting, without time for socialization and unable to access any form of care support, she experiences both physical and psychological exhaustion, describing her situation as "impossible" and as "fighting tooth and nail." A similar loss of familiarity and understanding of how things work in a new place was expressed by an internally displaced woman in our research who cares for her mother. In contrast, in another case involving a refugee woman who moved with her mother to a country with relatively developed social provision, the experience was quite different: "in a sense," she explains, "moving to [this country] and access to [local] medicine was life-saving for her, that is, she simply would not have survived in Ukraine." Thus, while war-induced displacement almost invariably makes care for older people more difficult because of broken networks and the challenges of integration, the availability of institutional care support in host settings can make a decisive difference.

While the impact of war on in-family care arrangements is most visible in cases of forced displacement, we also encountered it in other narratives. Job losses, income declines, rising prices, and power outages represent just a few of the many daily, tangible consequences of the war. These factors not only greatly complicate care labor but also create life-threatening situations for both people receiving care and their carers. In all our research case studies, families reported not using proper shelters during air raid alarms. If their older relatives could walk, they would move them to a corridor with two walls separating them from the street; otherwise, they did nothing and hoped for the best. While minimizing precautions has become common practice after years of regular bombardment in Ukraine, in senior care contexts this is also objectively conditioned by older people's inability to move quickly or at all. As a result, a substantial part of war-related narratives centers on fear and the suppression of fear. Some research participants even expressed relief that older relatives with hearing impairments are spared some stress, being unable to hear air raid sirens or distant explosions. For instance, Marina speaks about her fear and inability to imagine what she would do if their house caught fire during shelling, given that two relatives with limited mobility live there. Ultimately, she concludes: "I sometimes think about it, but then I push these thoughts away because they are destructive. I can't change anything."

Overall, the gendered nature of in-family care for older persons is shaped both by stereotypes and by personal circumstances—circumstances that are themselves often gendered. Women live longer. They are more likely to have prior experience with care and housework; they work flexible or part-time jobs more frequently, and thus tend to have more perceived space to absorb responsibilities of care for older persons and reorganize their lives around them, particularly when care is transferred from an often-retired spouse to working-age children. The one-main-carer model has a profound impact on carers' lives and on their mental and physical health; care needs are often so intensive that no single person's time or flexibility is sufficient. In such cases, and for more general reasons, informal networks within and beyond the extended family are commonly mobilized to support the main carer. In some situations, however, there are few or no networks or alternatives to rely on. While this can occur for various reasons, the war has caused radical disruptions to institutions and kinship and local networks, destroying them or intensifying their fragmentation (Dutchak, 2024), leaving individuals who provide long-term care even more overburdened and isolated.

4. Beyond Informal Reciprocity: A Gray Zone of Options

4.1. The Limits of Institutional Care

As Maryna's and Lilia's examples demonstrate, the intensity of care for older persons pushes families to seek regular external support beyond occasional, predominantly kinship, and reciprocity-based networks. As discussed in the previous sections, the marginal positioning of care for older people within care hierarchies has resulted in sustained political neglect and, consequently, in scant, fragmented, and weakly regulated provision. Families' options also depend strongly on available resources, especially financial ones, though social resources matter too. We observed that more accessible public care has become increasingly targeted, understaffed, and underfinanced because of neoliberal reforms, a reorientation to the defense economy, and war-related disruptions.

We encountered only fragments of public care during fieldwork. Families may receive some hygienic products, a wheelchair, or a voucher for a short rehabilitation stay. In other cases, a public social worker visits twice a week alongside hired carers, or a mobile palliative brigade visits occasionally, sometimes offering temporary admission to a hospital facility. Often, however, conditions in such facilities are so poor that families refuse these offers. While this scarcity may partly reflect our research focus on family arrangements, and the relative weight of public provisioning can be more substantial in the cases of lonely older persons, our research nevertheless indicates the general lack and fragmented state of public provisioning because of decades of policy neglect.

Private residential care appeared only in a few cases and remained an option for very few. As Viktor put it, "[Private] institutions are very expensive." Cultural norms further reinforce care choices: For many older people, institutional care is unacceptable. As Maryna explains, "it would be a trauma for my mother…care should be undertaken at home." Thus, families are often predisposed against opting for residential care. Public options are rejected because of poor conditions at the facilities, whereas private options are mistrusted because of informality or conflicting cultural attitudes. As Tetiana, who cares for her grandmother, explained: "I rejected this option because I understand that no one will treat her with such love." Such refusals are tied to feelings of indebtedness and the desire to spend their remaining time together, but they may also be conditioned by the gendered affections attached to care, described elsewhere as part of the care-labor disposability construction (Dutchak et al., in press).

Nevertheless, several families in our research did choose private residential care. Uliana, living abroad, placed her father in a private facility after her stepmother could no longer care for him. Her father's progressing dementia made continued home care impossible, and Uliana describes the situation as one that her stepmother "had to quit…to save herself." Living abroad often enables families to afford such care, especially when intensive, round-the-clock support is required, as is common with progressive neurodegenerative diseases.

This dynamic is visible in Larysa's story of caring for her mother with Parkinson's: "The situation reached a stage where family help turned out to be insufficient. It was not qualified enough; it was not rational in terms of how everyone was involved." Initially rotating care between siblings, Larysa was soon exhausted and searched for a live-in carer unsuccessfully. Eventually, they placed their mother in a private facility.

When Russia's full-scale invasion commenced, Larysa began working abroad, and her brother joined the army. She explains:

> If before it was a question of saving our psyche and making sure that mother received proper care, now it is a physical necessity...even if we imagined that we wanted to break down and sacrifice ourselves, it is now physically impossible [for us to care for her].

In the cases of private residential care arrangements encountered in our research, the informality of the field has a strong impact on families. Families navigate their choices half blind, relying on internet reviews, experiences of people they know, and impressions from short personal visits. Uliana, who visited every facility she could find in her home region, states that she was "choosing the best from the worst," while another research participant described her impression of one network of private facilities as "gangsters." Although families eventually found relatively suitable options, in all cases there were discrepancies between what was promised and what materialized. Unnegotiated changes in conditions also occurred, and these usually reflected the facilities' attempts to increase profit, for example, by accommodating more people in the same space, raising prices, or cutting services that were previously provided or promised. We conclude that while families' low income explains limited access to private facilities, most of their limitations and problems stem from decades of no coherent attempts to regulate this "unpromising" field, resulting in informality and a lack of standards, control, and transparency.

4.2. Visiting Care Options and Access

While private residential care is inaccessible to the vast majority of the population, private visiting care is far more widespread. As a continuum ranging from occasional visits to 24–7 shifts, it offers a variety of options for families with different resources. It is also more culturally acceptable for both older persons and their families, as the person remains at home, in a familiar setting, usually supervised or partially cared for by family members (if the visiting carer works part-time).

In some cases, families reject outsourcing care, even in the form of private visits. For Viktor, the main carer for his father, this was a matter of financial calculation: With one breadwinner earning an average wage, hiring visiting care could mean giving away the entire income. In Tetiana's case of caring for her grandmother, this refusal is narrated through a strong sense of personal obligation and the conviction that no one can do this work better than a family member. In other examples, older relatives strongly reject the presence of "strangers" in their home, especially for bodily care, as with the case of Lilia's mother who "wouldn't let a stranger touch her" and only accepted outside help for housework. This can go so far that families hire a carer or pay acquaintances while presenting them as friends, neighbors, or public social workers visiting for free. As one woman explains, "If [my mother] had known [that I'm paying them], she wouldn't have let them on her doorstep." This reflects a strong cultural belief that care cannot be paid for but must come from kinship, personal networks, or, in extreme situations, public home-based social care.

This combination of factors—cultural attitudes, personal relations, and a lack of material resources—can prevent people from hiring carers. Our research also shows that the influence of cultural attitudes and personal convictions may weaken over time and change as a person's health deteriorates, particularly in cases of neurodegenerative diseases.

As with private residential facilities, those who have the means to hire a carer and consider this an acceptable arrangement must search within a fragmented, largely informal, and unregulated field. In several cases, including Maryna's, carers were found through private agencies. People usually learned about these or recommended them through personal networks. In other cases, personal networks and social resources were used to find individual workers by asking relatives, friends, and acquaintances. Beyond more conventional visiting-care arrangements, we also encountered carers provided free of charge by an ethnic community organization, as in Lilia's story. Occasionally, as with Svitlana's in-laws, families pay a neighbor or acquaintance to fetch groceries, cook, or simply check on older relatives.

Reliance on informal networks and personal experience to find visiting caregivers or even basic information about agencies results from the informality and fragmentation of private senior care and its marginalized, privatized character. As care is pushed out of the public domain, the field is accessed and navigated primarily through personal and informal connections. Information scarcity is so severe that, as one woman told us, she has been asked for carer references ever since she hired one for her mother, even though her mother died seven years ago. This illustrates both the constant demand for such services and the persistent lack and stagnation of available options.

This finding is reflected not only in service users' experiences but also in those of care workers interviewed for this project. In the predominantly informal and weakly regulated field of private visiting care, with limited formal professionalization, personal recommendations play a central role. Common career trajectories in the sector also shape informal benchmarks of professional standards. Given the low wages in public healthcare and social services, workers from these sectors—nurses, junior medical staff, social workers—often become part- or full-time caregivers in private residential settings or in visiting care. In other cases, beyond personal recommendations, participants relied on workers' prior experience, either having worked in visiting care before or having family experience caring for older people or people with disabilities. Structurally gendered, like the senior care labor market itself, this "lived experience" is frequently considered a sufficient qualification for general cases of care for older people.

In our research, there were also families that had virtually no resources to support or outsource in-family care. Here, we highlight the rural–urban divide in access to out-of-family care options quantitatively documented in research (Strelnyk, 2026), but also other divisions including geographical and structural spaces where social reproduction becomes depleted because of war and neoliberal austerity (Dutchak, 2024). In Kateryna's case, where first she and now her husband care for his bedridden father with dementia, there are hardly any options in their village, particularly for a one-income household. Although during the interview she repeatedly said that she could not imagine alternative arrangements because "it's a family matter," she later explained: "I can't imagine it, because it just so happened in my life that in my 40 years there weren't all these different opportunities, and I just haven't seen anything like that, and that's why I can't imagine it."

5. Conclusions: A Fragmented Continuum of Care

Long-term care for older people lies at the bottom of care hierarchies and has been underfunded, underdeveloped, and fragmented in Ukraine for many years, because of both preindependence and postindependence policies in this "unpromising" domain. Over the years, these policies have resulted in a

familialistic model of care for older people dominant in society. The war has exacerbated these chronic problems, destroying public and private infrastructure and disrupting informal networks of reciprocity and support that have long compensated for institutional gaps.

The family-based model of senior care is sustained not only because alternative options are underdeveloped, but also because gendered cultural norms naturalize care as women's responsibility. As a result, and in line with how life courses are understood in Ukraine, care is carried out predominantly by middle-aged and older women—both within families and in paid care professions. This reinforces the structural invisibilization and devaluation of care labor. This becomes more intense when it intersects with ageism, gender inequality, and neoliberal labor market arrangements.

Overall, our research conceptualizes care arrangements for older people in Ukraine as a dynamic continuum of fragmented options rather than as distinct or stable care regimes. The boundaries between in-family reciprocity, informal personal networks, public services, and private residential and visiting care are shifting and often blurred. Long-term neoliberal austerity and the disruptive effects of war have further cemented senior care's position at the bottom of care hierarchies, leaving the familialistic model to dominate and producing a poorly regulated and increasingly fragmented care landscape in which families are compelled to continually reassess and recombine arrangements under changing conditions. In this context, care is not organized through clear pathways but through ad hoc navigation across fragmented and unevenly accessible options. Care arrangements, therefore, remain circumstantial, unstable, and unevenly distributed across households.

In some cases, families deliberately choose in-family care arrangements due to financial constraints, moral convictions, or distrust of existing external options. While such choices place significant burdens on main carers, they can also function as counterfragmentation strategies in a context where external care infrastructures are scarce, unreliable, or inaccessible. These individualized acts of stabilization, however, remain embedded in and reproduced through the familialistic model, rather than challenging it structurally. Fragmentation is further amplified by public and market-based care options, access to which is highly unequal and increasingly shaped by war-related destruction, displacement, and socioeconomic crisis. Our findings reveal a wide variety of care combinations: from reliance on kin networks to rotational arrangements, hybrid family-public solutions, and diverse monetized practices. Importantly, the chronic underfunding of public care institutions feeds into privatized arrangements—through supplying care workers to the private market, functioning as informal recruitment platforms, or creating conditions of scarcity that generate demand for private care.

Reliance on informal reciprocity and informalized paid care creates a fragile ecology of care relations, which war destabilizes even further. While this escalation in the care crisis is predictable, it remains largely absent from policy agendas and postwar imaginaries. The unchallenged neoliberal austerity risks deepening the marginalization of this "unpromising" sector through further marketization and privatization. In such a landscape, care for older people remains familialized and politically invisibilized, leaving older people dependent on relatives and families left to manage, negotiate, and patch together fragmented care arrangements.

Acknowledgments

We express gratitude to the research participants who shared with us their experiences of caring for older relatives. We are grateful to Andrew Hodges for proofreading the text.

Funding

This work was supported by the Volkswagen Foundation within the program Challenges and Potentials for Europe.

Conflict of Interests

The authors declare no conflict of interest. In this article, editorial decisions were undertaken by Ulf R. Hedetoft (University of Copenhagen).

Data Availability

The ethnographic data on which this study is based are confidential and cannot be shared in accordance with research ethics commitments made to participants.

LLMs Disclosure

ChatGPT (GPT-4) was used to improve the text's grammar.

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