CHAPTER 6

Crises in Care Work : Between Affinity and Disputed Safety

6.1 Affection and Dissatisfaction : The Underside to Care Work

Approaching the last phase of my fieldwork, when I sought to look beyond the discursive socio-moral and compassionate imaginaries of care, I stepped into a more challenging journey. With time, the complex energies of emotions filtering the binaries between pleasure and ruptures, denial and attention, love and betrayal turned vivid. Observing such emotions as inherent as well as exteriorised by the actors of care (primarily the *ayahs* and their elderly clients), I came to analyse that emotions in care work are channelised as a language of relativity, personhood and the shifting of rigid social boundaries between *ayahs* and their clients. A more frictional and contrasting appeal of care relationship was still in circulation across the private-public evocation of care work, which was suddenly uncovered when an elderly woman client showed me the blood-shot marks on her wrists. This redrew my memory of Samanta's (2019, p. 30) work, where she writes, '… the Indian joint family [*though not a joint family in this case*] is imagined and lived as an emotive space where both positive and negative emotions may coexist'.

Eventually, I opened myself to a heartfelt revelation of a partially paralysed client whose voice connoted the fixtures and fissures of care work practices. Living in one of Ballygunge's two-room flats, the lone elderly woman client, Sokhi *Dida* (elderly client, 72 years), was with her *ayah* Minoti *Didi* (long-term *ayah*, 28 years). When *Didi* went to the nearby vegetable market with the assurance that I was there to look after Sokhi *Dida*, we made use of such an opportunity well. Sokhi *Dida* spoke :

> Minoti is there and she lives with me. I am childless. But whatever you see is not always pristine. You see these marks, she causes it! She twists my hands and I moan in pain. I have no one to listen to! I cannot even fire her … since every time I file a complaint with the manager, it is often left unnoticed. I am looking for an alternative now and my brother living in North Kolkata will help me out!

Such a revelation not merely induced an 'in-between(ness)' in analysing the collected data but also offered ways to explore the dynamic realities of morality, vulnerability,

power and its multi-scalar affiliations to people, places as well as institutions. While existing scholarships project care work as activities to replenish human potentialities and health, a transgression or pull also casts care work as an embedding of social, moral, symbolic and the politico-economic contexts of repression. With the various scholarships equating gendered care work with social inequality where the upper-caste/class employers oppress the marginalised lower-caste/class workers (Banerjee and Raju, 2009; Gothoskar, 2013; Roy, 2019), the undergirds of ageing also induce reversibility of crises or exploitation across the domestic spaces. While it cannot be negated that the commodification of care work practices asserts a structure of social stratification, a subtle glorification of victimised identity for the domestic workers and *ayahs* has been dominantly put forward. As Agarwal (2016, p. 57) writes, 'Domestic workers are considered outside the realm of social norms, where the master-slave relationship subsumes any and all social definitions that may make them human – allowing the employers to create a distinction between themselves and the ones serving them'. But, scholarships across the neo-liberal packages, accumulation of resources and the supply-demand chain of paid care work influencing the familial structures, also limitedly addressed psycho-social traumas, frustrations and emotional weariness of the care workers like *ayahs* (different from domestic help, as discussed in Chapter 1 and 2) and care receivers. Even in intersubjective/participatory forms of care work, the expectations and fragmentations of ageing and dwindling individual-social corporeality of the *ayahs* and their clients, processes the conflictive sites of power practices, bargains, adaptations and recuperation.

The social ruptures, veneering anxieties, panic attacks and emotional distress between *ayahs* and their elderly clients might not always be within the horizon of visuality but are also subtle or mystified. In that case, the emotional intensities that evolve and subdue with care work often turn adaptation to *ayah* work and crises of being(ness) as a sub-cultural ethic[80]. Care work takes into account past continuities as well as the contemporary aspirational changes, locating interconnections and power relationships between the actors of care at the institutional and embodied levels. So, while Wilks

[80] Since the *ayah* work elevated as a cultural discourse in Kolkata, the reactive and mundane crises associated with the actors of care and their emotional appeals in the domestic-public spaces further turn into a sub-cultural process of 'practice' of care, i.e., shared mutuality and resentment between *ayahs*, clients, *ayah*-centre managers and clients' children/affinal-consanguineal kin.

(2022) states that the domestic workers and *ayahs* attune to bargaining power with a shift from the feudal era of live-in work to a contemporary live-out part-time work entailing non-wage benefits, adjustments, avoidances, etc., the ageist enforcements and exasperations of *ayahs* require exploration. Additionally, the persistent struggles of the elderly clients to recover personhood and social status from being collectivised as 'disabled', also require exploration. Underscoring this, the chapter accounts for ways through which relationships of care and power are shaped in the context of the *ayahs*' work of care. Then, it explores how the flow of emotions, communications, affective sensoriality, social indicators and life processes of the *ayahs* and their elderly clients shape the lived experiences and mediation of care work crises? Finally, it discusses how care work and its actors are shaped across the different intersecting institutions of market, health, state, and legality, further reinforcing complex social categorisations and precarious mobilities of care and ageing.

6.2 Experiences of Autonomy and Repression in Care

The care work of the *ayahs* and the mundane flows of care-receiving by the elderly clients portray crises as a socially transactional and experiential force of assembling care. Duclos and Criado (2020, p. 153) in their analysis of the troubles encountered in care interventions, write, 'Care, … is at risk of calcification — of becoming a placeholder for a shared desire for comfort and protection. Second, and perhaps for this reason, care seems to have lost some of its capacity to grasp and respond to troubled times'. However, through observations made in my fieldwork, it has been tracked that care work, its materialisation and the agents performing it accommodate and normalise the troubles associated with caring. The *ayahs* arguing with the elderly clients, leaving their clients' work in a rage, etc., turn into a visible element of care actors' knowing and being across the socio-moral and cultural processes of care work in Kolkata. Such events also assert critical debates on self and social governance of emotional and humane existence.

Characterising my social role as a researcher in several *ayah*-centres, I was once greeted by a zealous and joyful *ayah* named Shonkori *Didi* (part-time *ayah*, 24 years). Reiterating in excitement that she loves performing elderly care more than childcare or care for the 'young' differently-abled people, she was appreciating her client while glorifying her client's pious ascetic nature. Her client, as she distinctly remarks,

performs Sanskrit[81] chants regularly and engages in meditation. Her opinions also objectified her client's appearance relative to client's moral roles, habituality and corporeal staging. It is her being(ness) as an *ayah* with years of work experiences that make her define her client's bodily dysfunctionality as social ageing – ageing by pooling resources of care in a network, both financially as well as instrumentally. This sometimes also moulds the appreciation of what is a pathological or bodily decay, where 'having a lack of something' is normalised for the elderly clients. It positions the elderly clients between being a human and a partial human nearing death. *Didi* states, 'I love my client's work … she looks like a mother. She is old with grey hair and wears spectacles. Her lack of teeth makes her look like a child'. While I was sceptical of her affirmations, I analysed her narrations as legitimising care work and the capability to develop an interpersonal relationship with her client as a reservoir of future reciprocities and market attunement. Once when I met Shonkori *Didi* near a grocery store, I resolved to sit with her for a better act of listening to what was beneath the relatedness of care. Her non-verbal cues of anxiety and blank stares were more strong to be just passed off. Slowly, she opened up, stating :

> My client is good but sometimes she laments and irritates me. Every day I have to request her to take a bath and I keep on pleading, pleading and pleading. But she is too adamant! I really don't understand. When I tell her that I would do it quickly, she also refuses that. It takes more than half of my time. She always asks to sponge her. Nowadays, I cannot take it and just shout at her.

Many of the *ayahs*' expression and outbursts of their emotional and bodily crises which begins with a positive evocation of praising their clients and then gradually moves to a more negative or destructive characterisation, represent care work as a recuperative habitus invested with critical socio-moral meanings. Such a mystification and suppression of crises is persistently attempted to sustain care disbursed from the *ayah*-centres as a 'near to perfect' ethical commodity, shaped across familial and domestic respectabilities as well as the socio-cultural context of Kolkata. However, it is within the crisis of conformity and non-conformity to the elderly clients by *ayahs* that the dysfunctional and marginalised identities of the clients are weaved. In a

[81] Oldest language belonging to the Indo-Aryan branch, used in India.

reverse picture, the elderly client of Shonkori *Didi*, Manoshi *Dida* (85 years) angrily spoke about Shonkori *Didi*'s antics to sabotage the relationship of care :

> I didn't cause any nuisance. My *ayah* is lying. She doesn't bathe me well. *Olpo chaan korie rekhe dei* [She just pats me with some water and leave]. I often complain, but since I am old no one listens to me. What else can I do? I don't know why is she creating a big fuss about me outside!

She was disappointed with her *ayah* who affected not only her experiential relaxation at this age but also unsettled her social image in a public space (my material and symbolic presence as a stranger offered public spatial consciousness). In some cases, the representation of elderly clients' peripherality and the mundane contestations in care services emerge from their bodily liminality and decreased physical mobility. The elderly clients who were suffering from critical health issues like cancer, terminal illness, heart disease, or a decreasing vision, etc., primarily revealed their *ayahs*' ill behaviour and tortures. While having a kin nearby made it much easier for the elderly clients to complain and replace their *ayahs*, the elderly clients who stayed alone were more vulnerable to validate their care-receiving concerns from their *ayahs*. Such shifting social boundaries of reconstructing the 'self' and the 'other' within the adaptive allocations of care, also contest the discursive sanctity of the homes as a 'private' and safe reciprocal space. In other words, the everyday bickering, taking issues to *ayah*-centre managers for a solution, and opting for legal routes in some cases, reinforces caregiving and receiving as involving the multi-sited caste and class entitlements of power. The assertion of repressed autonomy by the *ayahs* who by acts of shouting, twitching and sometimes manhandling the elderly clients, resists their class/caste hierarchies, subordination, and stereotypes associated with it across and within the social practices of care. In a windy month of January, I met an *ayah* Shukonya *Didi* (part-time *ayah*, 34 years) at Bansdroni, buying vegetables for her own home. In a wreck of nervousness or some possibility of future tensions, I still placed a pivotal question, 'Do you know any such cases where a client faced abuse during care work?' Asked in a respectful manner, she replied in a disappointing tone :

> Hmm … we *ayahs* do our work and come back. We just know to serve and do *seva*, not do any wrong things. Family members torture their elderly parents. Upper-class people! Sometimes, I wish I had enough money! I question my

husband and myself … [*sobbing*!], why are we poor and why my client has so much … more than enough! I envy them!

Later on, confirming it with one of Shukonya *Didi*'s former clients, Basonti *Dida* (78 years), whom I initially met during my fieldwork, she narrated :

I chucked Shukonya out! Everyday she used to come, throw her stuff and sleep. I used to cry in pain to take me to the toilet since I could not walk properly and needed to release. In that pain, I used to sit for an hour and then the queen [*spoken displeasingly*] Shukonya would wake up. I know she was not sleeping … just acting!

Often, taking the elderly clients as an accessible body or a 'space' in enforcing one's repressed autonomy, makes care work practices and the consumption of care as an 'emotional exhaustion' (Janssen *et al*., 2010, p. 787). The fact that the elderly clients in multiple situations experience the transgression of the domestic filial ascriptions in receiving care from their own family members or kindred, subjugates their embodied sites of expressing the intrinsic agencies. The dominant representation of the elderly clients by their *ayahs* and the *ayah*-centre managers as the 'economically' lucrative consumers who shape their life courses in deviance by booking the strangers such as *ayahs*, also invites crises in care work. This purports pervading scorns from the *ayahs* while building among the elderly clients a sense of 'self-hatred', self-doubt and contestation in acting out their social values. This can be analysed in a way through which transitions in the dominant cultural expressions and systems often transform the socio-relational experiences and patterns of transmuting emotions. An elderly client, Sobhita *Dida* in her mid-80s, dwelling in a white flowery mansion of Bansdroni, once invited me to her personal lounge to convey her innate emotional perplexities. Sharing green tea, she said :

I have a disturbed [*emphasis added*] life. I just feel people often take me for granted. My son and daughter-in-law stay with me but the kind of behaviour they hurl at me is not only insulting but also psychologically disturbing. My son is growing impatient for property shares. My *ayah* seeing this, also takes me easy. She says, your son does not behave well or look after you. What values did you give him?

Such complex narratives and its outflows within the processes of research tune into developing the social character and world of the *ayahs* and their elderly clients. The clients attempt to save the social prestige of their homes in their neighbourhood by trying to refrain from complaining about their *ayahs* and kin. On the other hand, some *ayahs* mediate their outbursts across their elderly clients' familial crises. So, the way the actors of care differentiate perspectives, gestures of narration, typecasting the bodily images of each other (like the *ayahs* as more leisurely and sensual or elderly clients as demons) as well as restructure the crises of care, all represent care work as a social arrangement and organisation of ageing. In other words, care work portrays the struggle for cultural leadership and ethical subjectivities between the *ayahs* and their clients while settling or unsettling the idealising habitus of care.

6.3 Everyday Crises, Adaptations and Resilience

In the midst of fieldwork instances and adapting to demonstrations of rebukes and care, I found myself either responding to it in some subtle syllables or staying quiet to relieve elderly clients of their *ayahs*' disgust. While on a heyday I was called on by an elderly woman client, Momota *Dida* (79 years) to converse with her in her home, I was taken aback by her disapproving air of approval for her *ayah*. With my entrance into her home, I could sense a busy Sunday. Her *ayah*, Bipasha *Didi* (long-term *ayah*, 30 years) was shouting at the gardener of the home, her driver was trying to stop their unending squabbles and finally her *ayah* was heading me to her (*Dida*'s) room. Later, her *ayah* started throwing in utensils with the highest possible decibel of her voice to express some qualms about her future, her destiny as well as her work with an old lady. It was quite decipherable that she was unhappy with the monotony of her work while *Dida* was in a state of fear, as if hiding from a disciplining parent. Momota *Dida* grabbed my hand for a relief while I tried closing the door of her room. It offered me a vital opportunity to address not merely the social reproduction of the space of care work but also the psychological portraits of people living, dwelling and learning to cultivate their complex emotional framings – censoring or internalising the codes of domestic behaviour and its conflictive situations. The 'closing off the door' was an eventful moment that was not merely reactive but also a symbolic act of subduing the dominance of her *ayah*'s voice and bitter appeals. Such scenarios also made me realise that doing ethnographic research not only involves experiencing the social life of the care workers and their clients but also ensuring them a healthy

'mental' space for recounting subjectivities, the journeys of self-evolution and self-reflection. Such ruptured communication between the *ayahs* and their clients then manoeuvre moments of bio-psychological politics, where the relations of care appear between one's own life and 'the "discourse" on that life that threatens to disappear' (Stevenson, 2014, p. 81).

Continuing with the situation and sensing my awkwardness, the elderly client began, 'It is not new. I wake up and she [*her ayah*] starts with displeasure. I wish I was dead. I too wish I was deaf'. She expands further :

> I actively worked as a teacher and retired. I was a lovable one. I was always happy with my work, my family and me. As my husband passed away, I was alone [*crying*!]. A major share of my husband's property went to my sons and one flat was left for me. After my death, this flat will be donated to a charitable organisation. I willed it already. I kept an *ayah* to stay with me as I was alone and fragile due to the detection of holes in my heart. But, my *ayah*'s shouts and insults for me, deepen my wounds every day!

Such instance graphs the distance and dissatisfaction in care relations. The domestic and public-domestic (near the gate of the house where passersby can hear) expression of 'tiredness' by the *ayahs* not merely disconcert substances of identity regeneration for their elderly clients but also translates such uneasiness on and off the physical-social sensorial bodies. In other words, the fact that some of the elderly participants like Momota *Dida* wished they were either 'deaf', 'blind', 'blank' or had no other sensations like 'taste', etc., offers an ambivalent notion across care work where symbolically negating the sensorial embodiments of the physical body as well as not reacting to anything, act as a coping mechanism towards transitions in age and uncertainties of trauma. The sensorial socialisation of the 'non-sensorial' processes is also about preparing one's 'self' to intake care by *ayahs* and strategically play the social role-relationship of a care receiver while experiencing violence. This can either be 'connected to human's [*clients'*] bodily expressions, to the feeling of fear, … [*or the*] cultural processes of stigmatization' (Endreß and Pabst, 2013, p. 90).

In the months following the saturation of the data and finishing off my fieldwork, I went for lunch with an *ayah* who considered me like her sister. Her gestures and communicatory sense of a shared space with me made me realise the development of

a ‘fictive kinship’ relationship, crossing the caste/class barriers. Drawing from that affinity and mutuality we threaded over the years, Bobby *Didi* (part-time *ayah*, 30 years, discussed in Chapter 3), suddenly emoted :

> I am tired. Really, tired! Thinking about my son and daughter … not much money to save and the pressure of care work! I don’t know what will I do. Yesterday, I had some alcohol with my friends. Now, this is a habit for me. It keeps me off from all night-killing worries and depressive thoughts. You know, my mind swings and I feel relaxed [*emphasis added*].

Despite asking Bobby *Didi* to immediately stop her alcohol intake, her tears shook me to think more about her vulnerability and a lack of time for herself. This pushed me through a paradoxical moment of reflexivity about our variant socio-economic conditions. Hearing some more cases of *ayahs* consuming beer or local wine, it can be analysed how the *ayahs* often adopt negating their own ‘selves’ temporally through regular/consecutive destructive dietary habits which might lead to significant health issues. More relative references can be drawn from Gururaj *et al*. (2021) who attribute high level of alcohol usage and its taxation/pricing disproportionately affecting lower-income households in India.

Such processes of consumption also reflect a habitus of emotional crises emerging through their precarious social lives and financial distress, even if it means the addition of more financial crunches by buying alcohol. ‘Alcohol’ and its meaning-making are enmeshed into the bodies of *ayahs* that oscillate between their momentary pleasures, domain of identity reconstruction, stigmatisation and experiences of ‘personhood’. The drinks shared by the *ayah* colleagues at specific times of the night often attune their social and local worlds as ‘persons’, experiencing temporary respite from their formal work roles as the informally commodified labourers, regularly and incessantly disbursing care. However, such acts also bring to the fore risks associated with care work where *ayahs* conceal their unpleasant information from their clients to sustain their work, demand and livelihood. So, it is within homes and various actions adopted by actors of care relative to their contextual representation of agencies and subjugation across social structures; that care work gets shaped as an interpersonal arrangement of conflicts. It is through everyday care work that the actors of care often utilise their repressed emotions to transgress the moral boundaries as well as gendered

conventions, for instance, consuming alcohol being a woman and a nurturing *ayah* is perceived to be a deviation from gendered care respectability.

6.3.1 Food, Sentiments and Hierarchical Roles

Feeding an elderly relative to the Hindu (pan-Indian)[82] social values have often been equated to feeding a divine body, perceived to be filled with transcendental energies, ascetic authority and the generous temperance for blessing or sustaining a patrilocal familial establishment. Right from procuring or buying fruits, vegetables and meat in the market, washing it, deciding different ingredients to be used in the preparation of the food for different family members[83], and finally feeding it to the 'ill' elderly clients; all subsume into a process of surveillance for sustaining the domestic order, social position, and statuses of the household family members and *ayahs* in Kolkata. But, apart from denoting a quality of *seva*, the act of feeding also moves between the reproduction of hierarchical relationships, the dynamic entitlements to dominance and subversion as well as re-ensuring one's social rights.

Once on a Saturday evening in September 2023, I was extremely eager to join a theatre festival in one of the Kolkata's well-known state-sponsored theatres, the Academy of Fine Arts (Maidan Road). Relishing the theatre plays of Rabindranath Tagore, Saratchandra Chattopadhyay and other new-age directors like Saptarshi Maulick, have been a huge pleasure that I savoured every time I visited Kolkata. In one of the zealous moments of meeting new people and catching a glimpse of the movie/television actors in the 'Academy' (known in common parlance), I found a treasured moment. Observing a group of elderly women chuckling, I mustered some courage to introduce myself to them and initiate a conversation. Surprisingly, they were warm and asked me to have 'fish fry' with them, which is one of the most popular street delicacies in Kolkata.

[82] Across other religions too, like Islam.

[83] Elderly clients' dishes are often prepared keeping in mind their health conditions, further involving the symbolic meanings for their elderly clients' 'differentiated' existence and social de-normalisation. Often, *ayahs* have been observed to be using words like '*patla khabar*' (light food without much spices) for their elderly clients and spicy food to be prepared for the clients' kin.

Having or trying fish fry not merely imbibes acknowledging the cultural sites of Kolkata but also offers a social script to forge one's inclusion as an urban citizen in the crowded spaces of Kolkata. Eventually, I developed a hearty bond with Shoma Patra *Kakimaa*, an elderly woman in her 70s who retired from government service but was now living with her *ayah.* Her only son lives in Bangalore, India and visits twice a year. With a bite of fish fry, she smiled back and spoke, 'I cannot enjoy this meal at home! So, I am quickly having it now. Forget this … I don't even get a decent meal at home!'. She stated displeasingly :

> My *ayah* … and I do not have an alternative! You know, she is good and caring, helping me to cope with my loneliness. Now, I have someone to wait for me at my home. But my difficulty is on a different plane. I cannot cook since I have arthritis and so cannot stand at a stretch. Even if I ask her to cook well, she will feed me '*bishaadh*' [tasteless] food.

In this case, food is not merely a product of consumption but also about inter and intrapersonal exchanges, class, and individuality. The act of consuming flavoursome food enriching Shoma *Kakimaa*'s social 'self' and cultural relationships in the public sphere also reveals a crisis of unfulfilled care across her domestic space. It can be analysed that delicious food like fish fry in a collective and public entertainment space, ensures her to exercise more choices, rights and entitlements while playing out an achievement of upper-class 'modernity' and collectivity – of living with an *ayah*. Besides, her *ayah* in serving 'tasteless' food to *Kakimaa* reorients her moral-market obligation of person-centred care where food with too much oil for *Kakimaa* might harm *Kakimaa*'s health – revealing an ambivalence between health-oriented dietary practices and habits vis-a-vis personalized *ayah* care work.

Experiences of (re)forming affective communities like friendships and displaying of prestige through the spicy 'tasty' food are also symbolic of approving the personhood, which turns more ambiguous, morally regulative, and constrictive across her home. The privileges and mobilities experienced by elderly clients like *Kakimaa*, such as going out for parties and snack treats also commute a crisis between *Kakimaa* and her *ayah*. This also leads to the fluid reinstatement of inequalities through the nuances of appropriating socio-cultural capital and its transformability. Patra *Kakimaa*'s *ayah*, Ratna *Didi* (long-term *ayah*, 36 years), once in anger spoke, 'I have to wait for her.

She often comes late and with a filled stomach. I eat cold food, just for her. This is not right!'. Such complex power practices in (re)organising familial time and caregiving work by clients, often subjugate the caregivers like *ayahs* to a structurally bounded work, like waiting for *Kakimaa*. Ratna *Didi* having cold leftover food in *Kakimaa*'s home, speaks of her exploitation in the refuge of care work practices while *Kakimaa* can enjoy her leisure as a part of her upper-income and class membership. Such domestic routines and embodied materiality across food, ingredients, quality and the patterns of food intake, etc., mobilise the dynamic forms of agency-claiming as well as agency-denial for the actors of care.

Food then works as a social object organised around the critical relationship of care, if not only as moral. It is the care work of the *ayahs* that expands the familial knowledge of food and its sensoriality across the paradigms of the market. The diffused meanings of marketization and empathic solidarity in care work however turn 'food' and its life as a caregiving and receiving product, lying beyond emotions. In other words, it is the market-medical nexus intervening in the lives of the clients that often transform their food culture and sometimes of their families too. The reporting of the *ayahs* to their *ayah*-centre managers on the food intake of their clients further makes food as a 'progress' scheme of their clients' sustenance – remarking the dilemmas of ageing. Brijnath (2014) in her anthropological work on caring for dementia survivors in New Delhi, discusses a similar process where any memorable 'food' dilutes the bitter memories of dysfunctionality among the ill elderly people. On the other hand, she refers to 'food' as the 'management techniques for care and containment, concerned more with fulfilling duties and giving *seva* to an older citizen within the social relations of the household than with the healing properties of these foods on the bodies of the people with dementia' (p. 126).

So, even within the crises of care work, 'care' makes its way to reinforce different enhancements of moral economy. In defining tenets of 'moral economy', Thompson (1971, p. 79) explores it as a combination of the 'traditional view of social norms and obligations' as well as 'economic conduct'. However, today, the morality of feeding is also (re)shaped through the crises contents of care work where subliminal resistances to the imaginaries of the elderly clients as 'divine', have been observed. In other words, it can be argued that morality is not merely shaped through conformity but also by contesting the conforming norms. This appeared in some testimonies of the

elderly participants whose care routines invited rough or forced feeding. The participants revealed about the enormous physical force through which their *ayahs* feed them. An elderly client Saptak *Dadu* (80 years), living in Bansdroni since the last 25 years, spoke when his *ayah* was sleeping in another room. He remembers his own mother who fed him with love and care when child, and glistened some tears from his eyes. He had been an accountant in Kolkata's well-known retail firm and harboured passion as an avid traveller. Travelling in several places and countries like Bhutan, Nepal and Japan for his work and savouring his life in cooking and feeding people Continental, Italian, Chinese and Indian Bengali dishes like '*ilish bhapa*' (Hilsa fish roast), '*rou kalia*' (Rohu fish curry), '*kosha mangsho*' (gravy mutton), '*shukto*' (vegetable dish), etc., he now finds himself struggling with boiled rice and vegetables.

After certain health issues, Saptak *Dadu*'s food habit and lack of agency in deciding the contents of his food, display the transitions in his domestic status from being an authoritative patriarchal figure to being a 'care receiver' of an *ayah*. He often resists this social-familial-market identity by accusing his *ayah* of stealing expensive butter and dry fruits from his home, which his *ayah* often negates and adapts to. His *ayah*, Somita *Didi* (long-term *ayah*, 27 years) once uttered, 'It is his daily habit. He indirectly accuses me of the missing raisins, nuts, jaggery, etc. I know he is old, so his mind is not in his control. I do not really take it to my heart'. This indicates that the process of assembling care work practices with the narratives of ageing as a loss in mind-body simulation, accrues food making and feeding (by the clients and *ayahs*) as a context of social institutionality. This makes care work practice as an act of control and survival strategy for each actor. The escalation of the voices and the act of making one another agitated too redefines what is often known as the 'Third Age'[84] in ageing studies. Saptak *Dadu*'s accusations of his *ayah* and relentless quest to consume dry fruits despite his vulnerable liver condition, make him enjoy agency as an ill elderly where the 'household consumption' turns into a 'defining characteristic of social life' (Edwards, 2000, as cited in Samanta, 2018, p. 95).

[84] Conceived to be elderly people's life-stage with an active engagement of the elderly in the society. This occurs in the form of elderly people accessing information and knowledge, enjoying professional development and participating in social activities to age well (Hori and Cusack, 2006).

Once, while conversing with Saptak *Dadu* he ensured the doors of his room were locked from inside with his daughter-in-law (living elsewhere) accompanying him, and his *ayah* preparing his food in the kitchen. Even if this drifted into a power play and a differential treatment relative to the caste/class and occupational identity of the *ayahs*, such an act also ensured his 'heart out' conversations with some sense of privacy. He stated in a lower voice :

> I always considered my *ayah* like my own daughter. But slowly … [*halted*], she turned abusive. My doctor is repeatedly asking me to eat nutritious food with less oil, but she never listens. In 15 days, the refined oil package is over. Imagine! My cholesterol and blood pressure are high and when she feeds me, she roughly pushes food into my mouth. It hurts! I complained to them [*pointing to his daughter-in-law*] but we already replaced two *ayahs*.

Later, when I received a fair chance to talk to his *ayah* in her allotted room, she talked about the nature of the relationship she shares with her client, Saptak *Dadu* :

> I really care for him, as he is sweet. Yes, sometimes *amar matha gorom hoi*, *kintu theek aache … ki aar korbo. Kaaj korchi toh* [my head heats up, but it's okay … what else should I do? I am working right!]. When a person turns old, he can speak anything illogical! I feed him, whatever he is supposed to eat, like rice and dal, vegetables, etc.

Such testimonies reinforce food and feeding within the politics of the market and the home as an expression and social context of being cared and uncared for in different forms. It also edges situations where care receivers define ageing and care as more than caring for material bodies and things. In turn, care work through affinity and crises involves ensuring a socio-emotional belongingness to the clients' homes where different actors of care too claim self/social identity (Image 15).

Image 15: An *ayah* feeding her client.

Source : Fieldwork, 2022.

Location : Garia, Kolkata.

In this context, I am reminded of what Pollock (2012, p. 154) accounts on the Mesopotamian food practices :

> … commensality draws attention to the social and political relationships that are built, sustained, altered, and broken down through the ways in which food is shared, apportioned, consumed, and discarded – as well as the contexts in which it is not shared, in which food inequalities are constructed, based on gender, social or economic position , and on shortages that may be environmentally related but also constructed politically and socially.

Drawing it back, food, its preparation and differential consumption then constitute the political act of commensality but in negotiating conflicts that associate across care work and its actors. In many instances, the blunt reply of Saptak *Dadu*'s *ayah* and other *ayahs* conversed with, led to an analysis that the extreme workload often makes them turn their clients to 'bed-and-body work' (Gubrium, 1997, p. 123). Starting work in the light of the day, preparing their children's as well as clients' food, feeding their clients and offering their clients medicines to digest food, make the *ayahs* legitimise their social role as an '*ayah*' and report their progress to the *ayah*-centre managers. The *ayahs* regulate the digestive habitus of their clients by asking them to eat less, so

that they can save themselves from cleaning the 'dysentery'[85] waste of their clients and avoid nasty smells, etc. In a conversation, Somita *Didi* once declared, 'I am also a human. If my client eats more, he will have "dysentery" and I have to clean it. I cannot stand the smell'. This bespeaks the ways in which food and its quantity intervene in the everyday lives of the actors of care, relative to portion sizes allotted to different bodies, labour and roles. This further works out the dynamic of humanism where the *ayahs* seek ways to feel themselves as 'human' by sometimes avoiding the 'waste' work driven out of the caste/class identities.

On the other hand, the process of forced feeding by the *ayahs* with the rough use of hands not only keeps the clients unsatisfied but also produces a daily urge to vomit, which is unhealthy. This was more visible when on a fresh Monday morning I went to Saptak *Dadu*'s house to just sit and talk to him, trying to cheer him up. His *ayah* was shooting food into his mouth while he was coughing. It was implied how difficult it is to age with illnesses and I requested his *ayah* to go slow. But she failed to understand, stating, 'I don't have much time! I have some other work'. The fact that most of the *ayahs* are unable to offer the time and care for their own children and have to act as 'paid' workers in some other's homes, adds dissatisfaction and distanced maternal ethos. This also shuffles into playing the role of maternal propriety for the clients, much older than the *ayahs*. So, the jamming of emotive meltdowns and changing maternal practices reveals the dialectical sites of power and (mis)informed agency. This further (re)shapes care work practices as a laborious social relationship marred in fluctuating subjectivities and structures.

6.4 Institutional Landscapes vis-à-vis Ethics of Care Work

In the context of this ethnographic research, it is not only the dissociative worldviews which processes vulnerabilities, but such vulnerabilities also reshape the relationships of care for the actors of care. In other words, such vulnerabilities is socially generative in the work of care. The communication of multi-faceted vulnerabilities between the

[85] 'Dysentery' here is a locally-connoted term, often used by the *ayahs* and their clients, being in the axis of care work. In this context, it is referred to as an all-encompassing possibility of intestinal issues or discomfort of the elderly clients, where the quantity of food consumed by the clients points to a complex intersection of body, care, inhabited self, medicalization of life and the evolving culturally-contingent control of care routines in the context of Kolkata's *ayah* care work.

actors of care then reorders the legal institutionalisation of ageing, flows of power and consumption of care work as a 'resource'.

6.4.1 Legal Discourses across Care Work

The legal-juridical institutions communicate the discursive as well as the ambivalent constructions of care work and healthcare management – i.e., taking decisions on disenfranchising/enfranchising one. In the context of Kolkata, this has specifically been reflected through legal disputes that take place between the *ayahs*, *ayah*-centre managers, the elderly clients and the clients' family members. In the course of my fieldwork, I was diffusely but vocally encountering the cases of elderly abuse with some of the elderly participants such as twisting their hands, pinching them hard, threatening them and in severe cases throwing hot water into their hands by their *ayahs*. Often, the elderly clients were more vulnerable to filing legal cases either due to a lack of proximate kin to support them or due to the fear of stop getting other *ayahs* from the *ayah*-centres. This is a process of informal unionisation where '*ayahs* across the *ayah* centres might assert their voices by collectively resisting services for complainants' (Choudhury and Das, 2023, p. 615). In such cases, the family members of the clients can only vocally protest or further complain to the *ayah*-centre managers about their *ayahs*. This is not without the observation of the elderly women who are more likely to face abuses, emerging from their revelation of gendered position as a subordinate wife as well as being dominated and stratified as an 'elderly' or a weaker 'sex'. Once, an elderly woman client, Roma *Dida* (88 years), with tears in her eyes stated :

> I was a homemaker with no source of financial self-sufficiency. Now, my *ayah* abuses me … since she knows I am living on my son's income. A woman who holds no office work is considered less a human. That's why I do suggest girls like you to take up a job! If I had a pension, I would have lived in a day-care centre!

So, this is no less a fact that the *ayahs* too hold dominant accessibility to power when blood-kinship relationships of clients are unstable and fragile. On the other hand, the abuse by the *ayahs* might be a 'catharsis' of the stigmatisation and exploitation they often endure as the members of the socially conceived subordinate caste/class. This threatens human rights and healthy existence of both the clients and the *ayahs*.

In partly satisfying their unfulfilled desires and wishes, *ayahs* too assert and exercise their autonomy and dominance as market agents as well as highly demandable care workers, if not highly payable. They not only connote their elderly clients as their 'patients' or 'like-children' (without much cognition) but also view them as symbolic agents of their (*ayahs*') marginality. Such as, the clients wearing expensive clothes and living a life of rest while the *ayahs* work. In an instance, an *ayah* working in Shikha *Ayah*-Centre once garrulously spoke, 'I envy the clients' lives. They have no work, just sit, read and rest. Sometimes I wonder, why can't I have that life?' In hindsight, such consistent contrasting narrations and intersubjective evocations of care structures also rupture the relationship between care and security, that are negotiated within the political-legal economy of care work such as through police stations and courts.

On a cold December (2023) afternoon, while living in Baghajatin, I was wondering whether I should visit the police station. Over the years, I heard Kolkata to be a secure, convenient and affordable place for the elderly people, making it their cherished abode. In the local Bangla usages, Kolkata has always been validated as '*briddher jonno upojukto*' (perfect for the elderly people). This is not without the fact that the *ayah*-centres are sought to be a profit-oriented business in the latest pretext of Kolkata. However, the constructions or orientations to such care businesses are not without the jeopardies of crimes and forgeries, that translates into the structured legal disciplining of the quasi-formal *ayah* services. The *ayah*-centre managers route semi-legalisation processes and mundane activities of the *ayah*s to register the *ayah*-centres and the names of the *ayahs* but without much intervention into the *ayahs*' past work records. The para-legal operations and performance of legal forces further produce a complex relationship to the institutionalisation of care work practices. In uncovering such information, the challenges of me as an 'outsider' in accessing the resources from a local police station in Kolkata turned deeper.

The police station not only offers a social statement of protecting the rights of the citizens but over time also curves a political question of fear for one's social identity and familial honour. This can be stressed out in a situation when I was asking a few of my acquaintances to help me with the contact number of a police personnel or accompany me to the police station nearby. This invited some unpleasant glances for me as if they suspected me of committing some crime. As time passed by with no

assuring responses from anyone, I mustered my courage to visit the police station alone. Initially, I met a woman constable who was sceptical about why a woman from another distant state like Assam would arrive at a police station in Kolkata to note cases on the *ayahs*. Even if I showed my identity card, I was provided with a small form to fill in my details in case they would want to cross-check me in the future. After an uneasy hour of waiting, I was asked to inform about my research area to the Assistant Sub-Inspector. Eventually, I was offered a green signal and was assisted by the woman constable to the room of the Inspector. I could listen faintly to their doubts on whether 'the girl' (me) could use those details in media. It was realised that the discursive ideas often stereotype one's regional belongingness and identity as directly proportional to the dominant political ideology and party in one's home state[86].

As I could have it, I talked with the Inspector and Sub-Inspector (from a local police station in Bansdroni, Kolkata) who informed me about several cases they encountered on the *ayahs*. In a way, police stations also participate in structuring social ageing and care by disseminating the standards of consciousness and knowledge across mundane social life of the masses. Such as, the people in the streets and nearby flats, shops, etc., getting a hold of the vision of the *ayahs* being dragged to the police stations, further bounding their representation as deviants and the deceitful informal workers. Ageing then is diffused as a threatened dysfunctional stage of life (not enjoyable), curved within disablement and risks. This problem narrative of ageing attunes to the other terms where ageing as a phenomenon is referred to as the '2030 problem' involving 'the challenge of assuring that sufficient resources and an effective service system are available in thirty years, when the elderly population is twice what it is today' (Knickman and Snell, 2002, p. 849). While in the context of the countries like the U.S. ageing has been perceived to cause economic retardation through state pension investments (ibid, 2002), the micro-political crisis in relation to home care services has been less studied in the U.S. and India, apart from the aspects of caste, race, understaffing, overtime work, and lower salaries. So, certain terrains have been discussed by police personnels through the legal cases that have been booked against the *ayahs* and their clients in the last two to three years (2020 - 2023). While *ayahs*

[86] I was often referred to as coming from a state that is ruled by a different political party, which also has its majority in the centre.

often face certain forms of discrimination and oppression, they also assert their consciousness of 'power' across the spatial and temporal proximities of care work practices. In such cases, some *ayahs* often feel victimised and framed if not culpable, reflecting a complex reproduction of everyday life and negotiating with the politics of self-governance.

1. **Theft –** The cases registered against the *ayahs* have primarily been of stealing jewellery, money and edible items like fruits, vegetables, butter, etc. The Inspector beratingly claimed:

   > Once an *ayah* and her husband planned a theft. Since the *ayah* was a trustworthy person in the house, she gathered knowledge on every other thing such as finding the keys, tracking where the money is often kept, etc. She somehow managed to make a duplicate set of keys for the almirah and stole around 60, 000 rupees. It was no later when the client filed a legal case, she confessed it.

2. **Attempted Homicide** – A few dangerous cases that are lodged against some of the *ayahs* also involve homicide and attempted murder. This involves either using a knife to kill their elderly clients, strangling them or poisoning them. The Sub-Inspector in tune with Inspector discussed the case :

   > We received a case of slow poisoning. The *ayah* used to cook food for the client as well as his wife. They noticed that their *ayah*'s cooked food often makes them sweat and feel dizzy. They would often go into deep sleep. Later, their blood test results showed the effect of some medications that they never took. A case was immediately registered against the *ayah*. The case is still pending.

3. **Molestation** – Since the *ayahs* have to work in different households with diverse people and their personalities, they might face the threat of being molested and sexually abused. One of the officials responded to a case when the Inspector asked him in front of me :

   > We know that case … that one [*in reconfirming from the Inspector*], where a *buro* [elderly client] in asking the *ayah* to bathe him, touched her inappropriately. He also tried to gift her jewellery and luxurious items to

> please her to have a sexual relationship with him. One day, he tried forcing himself on the *ayah* and the *ayah* filed a complaint. The case will be on the court soon.

Such cases allow one to understand the multiple sites of psycho-social crises that are involved in the caregiving and receiving work. This is further provincialized by the legal and para-legal nexus of the agents of the state who market the (re)production of care services as a sanctified commodity but also ensure complex juridical governance of care as a work. Section 381 of IPC pervasively dictates about issues of 'Theft by clerk or servant of property in possession of master'. The Section describes[87] :

> Whoever, being a clerk or servant, or being employed in the capacity of a clerk or servant, commits theft in respect of any property in the possession of his master or employer, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

The Section itself justifies the spectrum of social relations and representation of labour where hierarchies and the politico-economic depreciation of the occupational identity of the clerks or servants are chiefly being reproduced and discerned as a dominant reality. While the reflections from the media institutions socialise us to the thefts and murders committed by the *ayahs*, the visions and perceptions of legality turn myopic when structural effects of the informal workers as 'deviant' criminal workers are socio-symbolically standardised. Rather than offering glances to the asymmetries of gendered care work and state distantiation in organising effective health and social programme for the *ayahs*, the dialectical crises between the *ayahs* and their elderly clients is hardened by the legal institutions to objectify care work practices as illegally oriented. This reminds me of what Breman (1995) analyses that the state is involved in the active control and disciplining of the informal sector workers at a distance if not accommodating them within the consolidative spheres of welfare and employment security. This results in informal sector workers forming a clandestine nexus to access restricted livelihood resources. For instance, the *ayahs* living in rented rooms without any proper contractual papers and the *ayah*-centre

[87] Refer to: https://www.indiacode.nic.in/show-data?actid=AC_CEN_5_23_00037_186045_1523266765688&orderno=438

managers negotiating with different agents to access registration routes for their *ayah*-centres.

But today, with the gradual increase in crimes committed by the *ayahs* like homicide, theft and the mundane physical or mental abuse perpetrated on elderly clients, the question arises - Whether the social identification and categorisation of elderly clients in the moral-cultural and economic context of care work in Kolkata require a shift in reading? The problem persists in glorifying the elderly clients as the economic actors buying the care work of the *ayahs* but contradictorily disabling themselves as socially passive. The fact that the paternalistic voice of the *ayah*-centre managers often defines elderly clients as 'patients', '*norom*' (soft), 'faulty', 'problematic', etc., also socialises the *ayahs* into ingraining sub-human terminologies across the socio-relational work of care. Then, the relationalities and activities exchanged in the meaning-making of care work turn more conflictive and disempowering, affecting psycho-somatic intentions, processes and dynamic subjectivities of care. Once, as I was analysing such forms of enactments in care work, I realised the complex tying and untying between being an 'insider' experiencing a part of my life (Lamb, 1997) in Kolkata as well as knowingly and unknowingly distancing myself as the 'other'. This evolved my ontological stances as I visited the eldest daughter of an elderly woman client who was suffering from liver cancer and replaced several *ayahs* over the course of seven months (in 2023). The lady, Shantinir Dostidar *Didi* (care supervisor, 38 years), was divorced with a son living abroad. She was tossing herself between her formal work role as a human resource professional in a private firm and familial work to look after her ailing mother. Since her mother required extensive care and was using a wheelchair, she booked an *ayah* from a nearby centre, referred to by her friend. Within a week, the *ayah* started complaining that the elderly client always woke her up from her sleep midnight to go to the washroom even if she was not actually urinating, causing the *ayah* to have a breakdown and feeling depressed. Replacing five *ayahs* over seven months, she stated :

> One day my neighbour next door heard our *ayah* incessantly scolding my mother and she saw my mother shivering in fear from the window. I could not stop my tears listening to this! How will you feel if you see your mother weak … unable to protest? I complained about our *ayah* [second] to the *ayah*-centre

> manager and he turned it down saying that the client was problematic and at fault. Fortunately, my mother did not survive much!

To confirm this, I decided to meet the manager, who exhibited a similar account :

> Yes, the *briddha* [elderly client] was extremely disturbing. She was disturbing *ayahs* for washroom visits even if she did not always have a natural urge to urinate at specific times. How should this be taken care of ? I was fed up listening to her daughter's complaints. So, I stopped taking their calls!

On asking the same *ayah* Shompa *Didi* (part-time *ayah*, 27 years), whom I found in the Devi Maa *Ayah*-Centre, I asked her clearly about the issue. In a deeper tone of despair and anger for her former client, she discussed :

> I was done with my client. You say, how long should I bear this act of taking her to the bathroom … every fifteen minutes? I am an *ayah* but that does not mean I am a machine of caregiving. Today, I admit that I stole few things like a pickle packet, a hair clip, etc. I was angry at the client's daughter for bashing me. So, I showed what I can do. Later, I regretted … as my client loved that pickle!

In this diverse range of care relationalities and crises, stealing then turns into an act of showing resistance against the connotations of the *ayahs*' social category and their de-humanisation. In a paradox, stealing as well as verbalising the crises of bodies and its actions across the clients' families and *ayah*-centres, functions as a coping mechanism for the *ayahs* against the failure of their agencies. It also enables them to portray a non-normative social image, bereft of idiosyncratic expectations from them to offer the 'perfect' empathic care services.

The frictional and messier narratives that erupted as a part of the fieldwork, offer insights into the ways in which the socio-spatial sites, disembodied and bodied relations in care work might expand into a more complex reality. Care work not merely means a shared affective habitus for sustaining lives but also diametrically means a crisis of being(ness). The legal apparatuses that translate such crises into the larger social world however re-routes a legal bureaucratism where the work of the *ayahs* is marketized and shaped through a nexus of the market and legal actors. Care

when turned into a 'commodity' driven by moral sentiments and familial changes, drags legal infrastructures to accommodate the para-legal operations, such as police officials referred to a phrase 'gentleman agreement' during fieldwork. In cases of molestations[88], negotiations that take place as an out of court settlement reflect the paradox of de-criminalising the sexual perpetrators by virtue of their 'age' (reinstating elderly clients as people of respect) and 'capital' and reproduce the patriarchal system of gendered objectification. In a view, the criminalisation of the *ayahs* has been more visible within the systemic flows of the state and legal power. Such a proposition can also be analysed through Harris' (1988, p. 247) account :

> … when the state establishes a system for forced accumulation[89] [*in this context through legality too*], this is not simply a set of arrangements that can be changed at will. It constitutes a social order, with a weight of inertia constituted by vested interests, the immediate beneficiaries, that inhibits the creation of any new order.

In some cases, the nexuses within and across the state ensure the *ayah*-centre businesses more flexibility and mobility of financial capital. Gellert (2019) refers to such advances in the course of neo-liberalism and the diminishing of the welfare model as a 'deep marketization' (p. 900) of the state where extractive regimes shoot locations of unevenness. In the areas where bodies and labour are socio-culturally reproduced for running the care markets, the state and the legal institutions also pry on neo-liberal patriarchalism. In the mundane lived experiences of being a researcher and observer in Kolkata, the phone calls, scuffles and visits of prideful *ayah*-centre managers to meet police officials, revealed this. The fact that some managers spilled beans on the ways through which they negotiate or subdue extreme 'crises' between

[88] While cases of molestations were difficult to be directly tracked by the *ayahs* due to the fear of their reputation and molestation being a sensitive affair in itself, some *ayahs* did present their emotional and psychological troubles relative to the affectionate relationship they developed with me over the time. In ways, the moral boundaries are often contested within the dominant paradigm of moralised 'care' work, where class, age, and occupational memberships remain poignant in asserting pleasure for one and subjugation for the other.

[89] In some cases, the *ayahs* have to work with the *ayah*-centre managers in specific *ayah*-centres to repay debts they often take from those managers in emergencies. Fear of being jailed on discrepancies or lack of debt repayment often lurks among the *ayahs*, who know about their managers' access to 'legal' resources.

ayahs and their elderly clients, requires some attention. Upon asking, one of the *ayah*-centre managers Sombik *Kaku* (Maya *Ayah*-Centre, 43 years), he testified :

> Each time, you cannot keep sending the *ayahs* to the police station or lodge complaints. This is a question of the reputation of my *ayah*-centre. So, we somehow manage those things. A client once complained about abuse, but we handled it somehow. We did not let the case roll up much. How can we?

So, certain loopholes do work that might affect the 'rights' of the elderly clients and the *ayahs* as citizens across healthcare participation. The tampering of the *ayah*-centre contracts by *ayahs* and clients, cases of abuse within domestic arrangements, false cases, cases that are negotiated outside the court, etc., might jeopardize the trust and essence of secured living for the actors of care. But, where the care work markets or the keeping of the *ayahs* itself turns into a cultural experience and a normative value expectation to shape the ageing processes, the cycles of deprivation and gratification get entangled continuously. This leads to a complex reality of fulfilling the everyday role expectations in paid care work.

6.4.2 Locating *Ayahs* across the State

Today, the developmental state of India is restructuring a trail of shifts from social welfarism to privatisation, that is entailed for bridging fiscal deficits and debt gaps (Jain, 2004). This has significantly impacted the future of healthcare sectors. While *ayah*-centres in Kolkata operate as a semi-formal sector with some of the regulatory processes, it is still bereft of the state's attention. In fact, the state is latently present in documentation where the *ayah*-centre managers opt for state registration certificates to dangle in the walls of their *ayah*-centres to garner their clients' trust. In the course of my fieldwork, I also decided to visit South Kolkata ward's Municipal Corporation office to gather more information on how the *ayah*-centres are formally registered. Noting down the address in my small blue notepad, it took me two simultaneous auto-rickshaw rides to reach the old office at the Gariahat Lane in Kolkata. The bustling office with officials swamped in a pile of papers, did not seem ready to welcome a researcher. Finally, one afternoon, I received some time as well as space to talk to one of the officials. We talked about the *ayah*-centres and he confirmed :

> Registration of an *ayah*-centre is important. It is done for Trade License. Nowadays, our cyber department handles it. One needs a proper rent agreement for the room [*the ayah-centre*] as a tenant, Adhaar [*national identification*] card and electricity bills. You also need to pay the money relative to the size of the room, measured in square feet. However, there also exist *ayah*-centres where the managers could not furnish proper documents and still awaiting the registration of their *ayah*-centres.

But the processes of waiting for registration even after submitting documents, often centralise urban materiality[90] and the appropriative orders of state agencies. The administrative hurdles the *ayah*-centre managers often experience in their struggles to register their *ayah*-centres, also point to how law can function as well as transcend the everyday social life of the people who lie in the peripheral zones of Kolkata and the paid care sectors. This sensibility emerges from what Vyas (2022, p. 909) in her account explicates :

> "housework not being work" [*or any form of work related to household*] …The reason behind such exclusion has been attributed by economic statisticians to the difficulty in quantification and the non-market nature of household activities [*not producing tangible goods*] which renders no purpose in calculating the GDP.

Further, in the context of state avoidance in ensuring a sustainable and healthy work environment for the *ayahs*, Sarat and Kearns' (1995) analysis remains significant. They discuss that law is not only the ability to follow rules as objects of governmental authority but also denotes the 'symbolic performances' of the agents of the state in distancing laws from some people. In the context of this research, a share of *ayahs* who aspire to open *ayah*-centres in the future often find themselves in crisis situations where few state officials might not explain to them the proper rules and ask them to move across different counters without any clarity. This also reinstates the state's role

[90] The *ayah*-centres registration is turning out to be lucrative for cyber-cafes in Kolkata where the initial processes of registration are handled by the computer specialists working in such cafes. This reflects the characteristic of urbanised governance and the state where the state and new-age digital markets associate together to redefine 'legality' and the neo-liberalised demands of care work.

in the social reproduction of class, where *ayahs* often revealed how their appearance and clothing made the officials avoid or behave bitterly with them. It is the aesthetic appeal of class markers that make state providers as well as consumers (the *ayah*-centre registration fees).

Consequently, the political and moral economy of care work in Kolkata also poses questions on individuals' rights, justice, equality and citizenship, but settling a stark exclusion in the statist figures. The propositions made on the health and care work systems in India hardly seek discussions on developing sustainable and age-friendly care ecosystems. The data on health, most chiefly the NHWA, offers a criterion of workforces that are legitimised to coordinate care across the health industry of India – the clinicians and auxiliary staff. The specific archetypes of the care staff tracked in NHWA involve the allopathic doctors, dental practitioner, AYUSH practitioner, Nurse, Auxiliary nurses and midwives (Diploma, Graduation and Post-graduation in nursing), Pharmacist and Physiotherapist/diagnostic/technicians (Karan *et al*., 2021). But the *ayahs* are primarily shelved as the force of carers. While the auxiliary nurses have often been termed as healthcare workers working at health centres in villages, sub-urban areas and the cities (Pyone *et al.*, 2019), they are not *ayahs.* The *ayahs* are often deemed as the informal workers without any specific certified skills required. Of the scant public records on *ayahs* that exist, the Office of the Labour Commissioner, Government of West Bengal offered a table on the wages of the *ayahs* at sanctioned institutes or nursing homes but not for the *ayah*-centres (Table 3) (Government of West Bengal, 2023). This also shapes an intra-occupational stratification of care work. The *ayahs* working across the hospitals and the multi-specialty nursing homes in designated uniforms[91], occupy an upward social status and hierarchy than the *ayahs* who work through the *ayah*-centres and domestic homes.

In hindsight, it is also important to state that the healthcare institutions in India are still bereft of effective and highly-compact geriatric units that would train and propose planning of care, age-friendly health treatments and functionality of the elderly in a multi-approach environment. Tripathy (2014, p. 205) in the context of India, states :

[91] An interview was conducted with few *ayahs* at the Manicktala ESI Hospital, Kolkata.

> Geriatric care is conspicuously missing from the medical education curriculum … Geriatrics is a low-profile specialty that lacks visibility in academia and finds least favor among the medical students. Only selected facilities have a dedicated geriatric unit, but concentrated in urban areas and highly expensive.

Even if certain age-friendly modules of development are shaping the relationship between class and urbanised cities like Kolkata today, the ideological underpinnings and the objective nature of such programmes are limited to elderly people's clinical care activities, such as swimming or physiotherapies.

It was in the midst of March 2022 when Kolkata was breaming with fresh curd and cream, I met an elderly client, Rupok *Dadu* (90 years) who was quite ecstatic while talking about food. Having been a victim of forced migration in his childhood during the historic Partition of India in 1947, his longing still flows to the land of Dhaka (now in Bangladesh) where his ancestors lived and lost their lives. Today, he recognises his ability to bear suffering and pain from his historical experiences during the Partition, which made him work day and night to arrange food for his mother and smaller siblings in their allotted refugee camps[92]. Now, an elderly client of an *ayah* due to the diagnosis of his epilepsy and hip bone tumour, he speaks, 'I didn't really want an *ayah*. At this age too, I stand and cook. That's my passion. I asked my son to keep an *ayah* when the pain in my hip bone turned unbearable. The *ayah* help me to walk and stand!'. This explains that the *ayahs* [93] are however an accessible resource in the urban centre of Kolkata and offer optimal utilisation of the effective care services, adjusting to either long-term or short-term healthcare needs of the elderly care receivers. Hedman *et al*. (2007, p. 2) would refer this as the 'deinstitutionalisation' of elderly care, integrating social and medical health approaches. However, scenarios in India are different from countries like Sweden (a Scandinavian country) where the

[92] The survivors of horrific violence of the Partition of India 1947 were accommodated as 'refugees' or stateless people in parts of Assam and West Bengal. The client (survivors) here remembers his family staying in one of the refugee camps in Ranaghat, West Bengal.

[93] There exists varying categories of *ayahs* (as discussed in Chapter 3) and the middle-income elderly clients often have options to decide whether they would like to receive care services from the daily-wage *ayahs*, part-time *ayahs* or long-term *ayahs*, depending on their affordability.

'Swedish home care organization are actually structured through negotiations between county councils and municipalities' (ibid, p. 3), networked at the regional and local levels. For instance, the Care of the Older Reform (A¨del Reform) of 1992 in Sweden worked out a way to bring the elderly care resources under one authority (Jacobsson, 1996). This involves the clinical treatment by medical professionals and the care services offered by domestic workers[94]. But, in the context of Indian developmental structures, elderly care has either been translated to the old-age homes running on charities, state support or families. And today, the increasing population in India is also making it difficult for the state to regulate and offer the subsidised care services. The state partially constructs and proposes the *ayah*-centres as 'businesses', attracting regional revenues.

On the other hand, a humongous set of scholarly accounts focussed on federal policies of paid leaves and mental health for familial caregivers in countries like Canada, U.S. and Japan, but not on the paid care workers (Gimm and Yang, 2016; Kim and Waldfogel, 2020). A similar lag in policy-making and implementing the structures for paid care workers in different countries where elderly population is increasing, brings debate across the objectification-mechanisation of the paid care workers. In India and specifically West Bengal, while the *ayahs* are addressed through cash and healthcare schemes, the precarious non-administration of their social 'health' disintegrates their long-term sustenance. This makes care work riskier with emotional tussles.

At this point, it is imperative to relay the social ambivalences of the state and the biopolitics it involves itself in making the *ayahs* as surplus workers but with minute investments. Drawing from Foucault's (1973) analysis of biopolitics where power is exercised and inflicted upon the bodies of the individuals and populations through sanctioned control, the welfare schemes like Swasthya Sathi (and card) for *ayahs* explicates a similar tangent of power. Although the scheme ensures the distribution of medicines and management of health by making it applicable for the eldest female member of lower-income families, its social and administrative underpinnings also normalise the precarity of women's lives, specifically the *ayahs* who avail it. This affects the quality of care for the paid care workers and the emotive practices of care

[94] In the Indian context, the *ayahs* are different from the domestic workers or helps (as discussed in Chapter 3).

work. The scheme Swasthya Sathi was announced on 17th February, 2016 (in the Cabinet) and on 25th of February, 2016 (in the Finance Department). The scheme was devised to cover the secondary and tertiary care for lower-income female members and their families to up to Rs. 5 lakh per annum, and offer a paperless biometric system of transaction for treating the various diseases (West Bengal Health and Family Welfare Department, 2019). While this arrived as a boon to many *ayahs* and their families, there also exists a paradox of locating the *ayahs* as mere beneficiaries or voters vis-à-vis *ayahs* as labour-intensive workers who can biologically immunise themselves to bodily crises and pain. This functions as a materialisation of extrinsic socio-political accounts, shaping the class entitlements and macro-identities. A few *ayahs* once sitting in the Sebika *Ayah*-Centre were discussing about the medicines they received as a part of the Swasthya Sathi cards. Taking an opportunity to enter into discussion, an *ayah* Rojoni *Didi* (part-time *ayah*, 30 years) clarified, 'We are always despised. In the name of all big promises, we mostly receive only few fever … *parchitamol* [95] tablets'.

In another focus group discussion conducted with *ayahs* in January 2024 where they revealed positions of meaning-making across the state and public social order, one of them forwarded an interesting detail. It was interesting to view how *ayahs* also work out some form of everyday analysis as a responsible and aspiring citizens of the country. Filled with pride in glorifying the immense pain through which they undertake hard care labour and sleep deprivation, their bodies seemed to lie with discontinuities. An *ayah* Rumika *Didi* (part-time *ayah*, 42 years), who is a Christian but married to a Hindu Bengali man, claimed that she became an *ayah* not merely for work but due to her familial missionary enculturation of offering help and services to the needy. But, on talking about everyday transitional care spaces and the presence of the state in welfare work, she began, 'State promises and we are pawns of

[95] The *ayahs* were often encountered using Bengali pronunciations for English words, in the fieldwork. Learning from their doctors, '*parchitamol*' are 'paracetamol' tablets used for fever. The *ayahs* in using such vernacularised words often synchronise the social economy of care work, to acquire knowledge about medicines and make themselves more demandable to the clients as knowledgeable care workers. Here, '*parchitamol*' also reflects their vulnerabilities when they are offered this medicine, often without much of the testing interventions – defining governmentality of avoidance and normalising the *ayahs* as possessing more bodily strength than the upper-income/class people.

experiments. Swasthya Sathi is good, but there are certain discrepancies which are no less'. She continued :

> Sometimes, allotted hospitals are located far away. I don't know why we have to travel so much. They feel we are inherently strong and mechanical. Once … one of the doctors there told me, I would not need much than a capsule for my stomach. When I showed another doctor in a private clinic, I was diagnosed with gallbladder.

Such a form of arbitrary categorisation of *ayahs*' bodies also connotes retrogressive processes in which the state not merely endows citizenship but also alienates *ayahs* from it. Looking from the operationalisation of the state structure and its movement into the mundane social realities determining caste-class orientations, the state then acts as a cultural machinery to reproduce the diverse inscriptions of power across care work. This perspective can also be understood from Means' (2022, p. 1969) words and analysis of biopolitics, where :

> … power became exercised not only through specific technologies of knowledge, but also, decisively, through practices of security underwriting a distinct political economy: enabling and allowing certain types of circulation to occur within a territory by respecting the quasi-natural basis of the economy through State inaction.

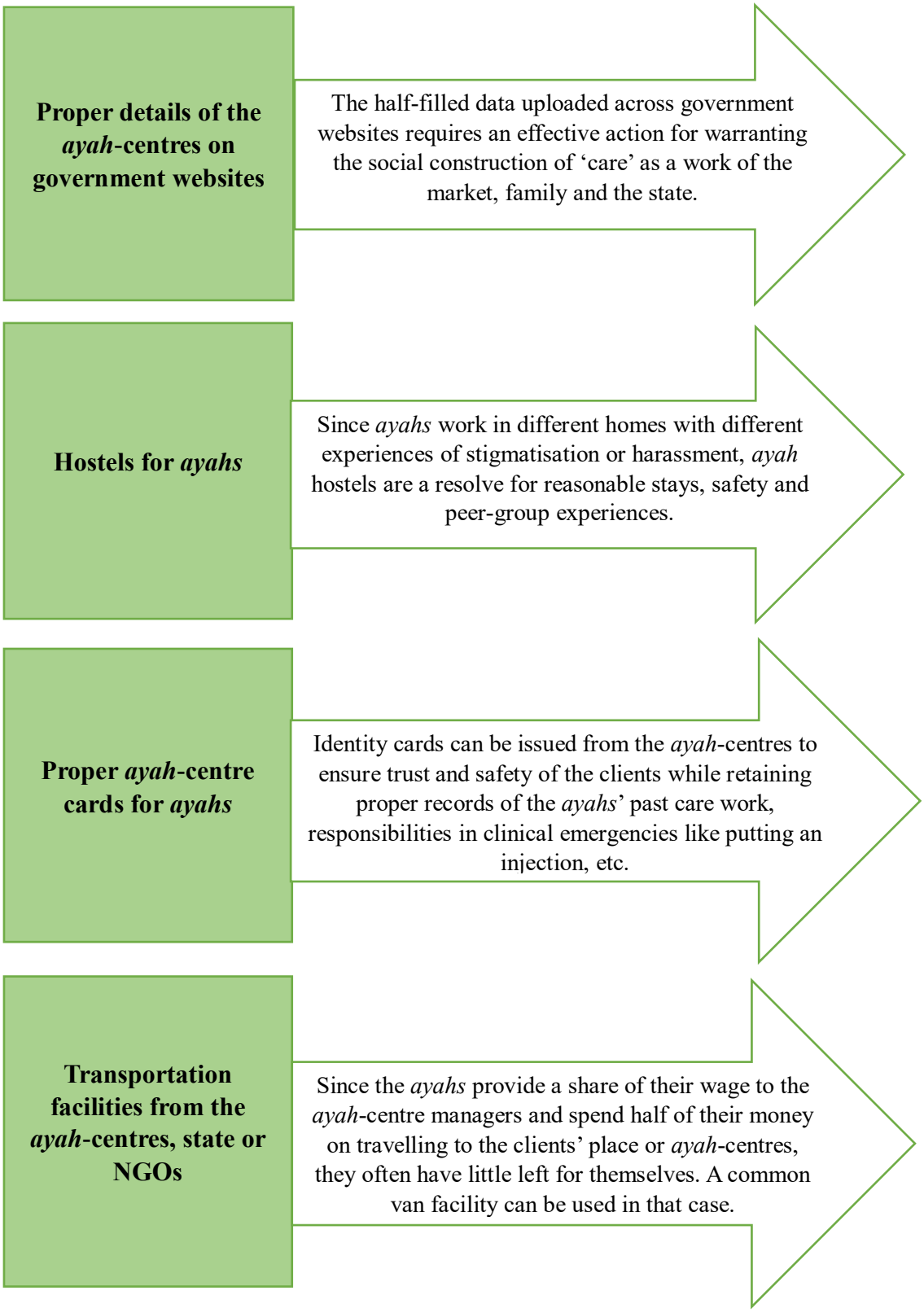
Nevertheless, it is in the interest to understand that the post-independence period (after 1947) in India organised a few political initiatives to ensure the social and economic rights of 'women' caregivers (specifically working mothers), offering better output of care and family integration. But attention was not offered to women's bodies and opportunities. Later in 1974, the Indian state implemented a report titled 'Towards Equality: Report of the Committee on the Status of Women in India' (Bagchi, 2013), addressing some of the concerns on gender inequities, rights and socio-cultural gender roles. Rethinking on the child creche policies for working mothers and expansion of women's opportunities in health and education, co-existed with denigration and categorisation of women as only suitable for specific professions. This led to the significant disparities in incomes and the confinement of women to the lower-end of job hierarchy, having a double burden of home and formal

work shifts (Dungdung, 2018). Besides, it imposed the casualisation and informalized growth of domestic labour for women belonging to the lower-income families, often arriving from the rural areas (ibid, 2018). Today, with the economic liberalisation and the global debates on the educated and intelligentsia categories of women workers, Budhwar *et al*. (2005, p. 180) state, '… the new work dynamics are changing the social values and mores of woman in Indian society; on the other, … increased global focus on women's issues is significantly affecting the woman's role and career progression'. But *ayahs* who functionally assist the women white-collar workers to sustain their work by dawning the responsibilities of day-to-day care for their elderly kin and children, has been largely under-represented across the state records. This also projects 'democratic deficit', arising 'from a lack of institutionalised local accountability and an absence of direct local electoral control, with regard to decision-making in health care planning' (Milewa *et al*., 1999, p. 446). So, while the *ayahs* are active participants in the social evolution and development of care work activities, their position in the context of Kolkata's care economy is jolted across the power blocs of legal, administrative and juridical institutions.

6.5 The Way Forward

Today, urbanised Bengali families blurring the traditionally ingrained norms of dwelling with their affinal and consanguineal kin, are inviting *ayahs* in their domestic exchanges. Care work for elderly people in Kolkata is not merely about accumulating commodities of well-being but also about coping with the ruptured familial spaces by offering *ayahs* to be like their near ones who can empathise with their pain and joys. This also does not ignore the possibilities of feeling safe as well as secured against the relational crises by necessitating the involvement of legal agents, whenever required. But a deeper issue lies in the structure of power and consumerist rhetoric of the neo-liberal state that reproduces *ayahs* as a 'surplus' in itself and yet offers less humane recognition to their socio-psychological well-being as caregivers. Hence, throughout the phases of my fieldwork, while I communicated with the *ayahs*, elderly clients, *ayah*-centre managers, *ayahs*' husbands and elderly clients' kin, I got to know about certain measures the *ayahs* would like to get implemented in the care work practices while making collaborative efforts between *ayah*-centres, governmental functionaries

and civil societies. The shared suggestions between the *ayahs*, *ayah*-centre managers and me as a researcher involved (Figure 4) :



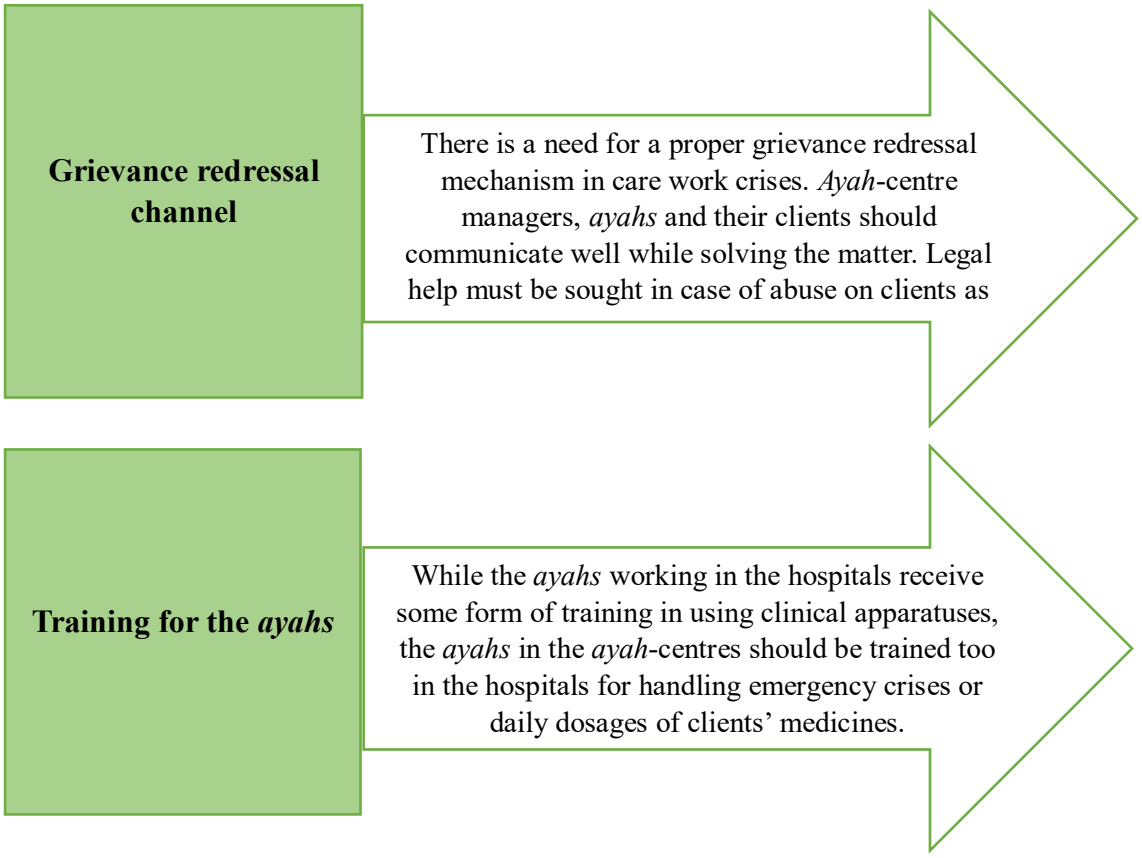


Figure 4: Measures for Safe Care Work and Well-Being (Source : Researcher's own)

Therefore, the ethnographic work on the *ayahs*, their practices of caregiving and the influences on ageing involve the intricate embeddedness of mutuality, socio-cultural hierarchies, memories, legal fissures as well as objective-subjective complexities. The relationships of care developed in care work configures multiple actions that pervade social institutions. All of these multifactorial ties shape the care work practices and social interactions between the actors of care, within the cultural and material space of Kolkata.

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