Chapter 6: *Ayahs*: The Underbelly of Care Economy

On 20 June 2018, Mitali Jana, a staff nurse with SSKM Hospital, Kolkata, in a letter to the editor of a leading Bengali daily, *Anandabazar Patrika* wrote that along the roads, in various walls and pillars and almost everywhere, these days we find small posters or leaflets pasted or writings on the wall offering the services of nurse and *ayah*. "*Nurse ebong ayah chai",* ('Nurse and *Ayah* wanted'), these words are highlighted in bold, in most of the advertisements. Her writing wanted to make the readers aware that it is not easy to 'hire' the services of trained nurses, who become trained nurses only after attaining over 90 per cent marks in high secondary examination and qualifying in Joint Entrance Examination. She further emphasised that after scoring well in public examinations, they are required to go through rigorous training for four years, after which they 'qualify' to become a 'nurse'. So, various outfits that promise the services of trained nurses are "lying" and at no point should an *ayah be mistaken to be having the same status or expertise of that of a nurse*. She concluded that nurses should be respected, and *nurses are not synonymous to ayahs*. This act was hailed by her peers and this letter was posted on social media platforms and shared widely.

At the very outset, it needs mentioning that though there might be other careworkers providing direct or indirect care like the *safaikarmacharis*, ward boys and so forth, this chapter focuses on *ayahs*. *Ayahs* performing the act of direct caring for patients, are considered to be performing "dirty" work, as they handle the body fluids of their patients. They have become crucial in both domestic as well as institutional spaces, but continue to be mostly dis-acknowledged and mistrusted by nurses and other trained healthcare workers. Despite their growing importance in providing at-home care, they are for the most parts ignored in policy documents. Even when they are noticed, for instance in the High Power Committee on nursing on 1989, they are looked down upon. While highlighting the problem of loss of status among nurses, this committee expressed the plight of nurses wherein, they had to perform the task of *ayahs* as well. Thus, clearly stating that *ayah*s are not only subordinate to the nurses but also *inferior to them*. This makes it interesting as well as imperative to study them.

Sushila Mitra, a senior nurse working at a private hospital in Kolkata had expressed relief when the above letter was published in the Bengali daily. She had stated that it was very much necessary to make people understand that nurses are associated with a respectable profession

and should never be compared to *ayahs*, who at best can be referred to "*shastar bedside nurse*" ('cheap bedside nurses')[1]. Just as nurses in South Africa, needed an 'other' – the low class Afrikaner women who were involved with low grade nursing work, to form a distinct class and a profession identity for themselves (Marks 1994) – nurses too in institutional set-ups in West Bengal needed to proclaim their position and standing as different from that of *ayahs* or bedside nurses.

The above sentiment to a large extent creates an 'us', comprising nurses, who are trained, educated, dedicated, specialists, who are crucial in providing healthcare and then there is 'them', comprising *ayah*s, those who are not skilled, not educated, nor trained. The strong statement also came at a time when in different places, news of *ayah*s' involvement in illegal activities like helping doctors in abortions in private clinics or nursing homes or their involvement in trafficking new born babies from both government and private hospitals had led to loss of faith and increased suspicion pertaining to institutions delivering healthcare, in the minds of general public (*The Times of India*, December 4, 2016; *Firstpost*, April 17, 2017). However, the relationship between these two categories cannot be understood in terms of hostility alone, as there are places where both these categories work together/interact, albeit in a hierarchical setup. Against this backdrop, we have to understand the realities of *ayah*s in providing healthcare.

Following the '24x7 Health helpline Operation Guide', of government of West Bengal, the *ayah*s, though not labelled as such, but can be categorised as providers of 'supportive healthcare services', like those associated with cleaning, housekeeping, providing amenities to patients or 'other hospitality related support services' which are needed to provide care to the patients. The reason why the category of *ayah*s does not find explicit mention, might be because as per rule (Vide: No: A8636, Kolkata, 13.11.2001), *ayah*s or special attendants are not allowed in government hospitals. However, if the patient's family feels it necessary to have someone with the patient, they can nominate someone or in most of the cases, they keep an *ayah* to look after the ailing family member (Government of West Bengal, 2013, 12, 21). This is how *ayahs* come in to operate in formal spaces, though the nature of their job remains highly informal. This is a practice in both government and private hospitals and private nursing homes. At a time when home care or nursing services are economical alternatives to prolonged hospital care, *ayahs* are also finding work in private spheres or households. Further, as more and more

[1] Interview conducted on 05.08.2018, in Kolkata.

women are entering the labour force, the time they used to devote for unpaid care work is shrinking, thus creating space and demand for paid care work (Razavi and Staab 2010, 408).

6.1 The Beginning:

Henry Yule and A.C. Burnell, in their work of 1886 noted a heavy borrowing of Portuguese words in Anglo-Indian English, and the word *ayah*, is one of them. According to Mary S. Serjeantson (1986), *ayah* (*aia*) got loaned into English from Portuguese in 1780, to be precise. The word meant a native lady's maid or nursemaid. The Portuguese had well established themselves in the ports before the advent of other Europeans, hence the natives learnt a 'bastard' variety of the language and it acted as a bridge between natives and Europeans and was also a medium of exchange among other Europeans, hence, those words in many cases are still in use (Bolton, 2003, 136-37). There have been accounts and various documents like court orders indicating that families took back *ayahs* to England and in 1897 an *Ayah*'s Home was set up for women waiting to come home to India (Riaz, 2013). The references of *ayahs* or *dyes* or *dais* can also be found in exhortative texts or advice manuals written for British wives coming to India along with their husbands (Banerjee, 2010,779). Suzanne Conway believes that the word *ay*ah has come from Portuguese *aia* as well as *aya* in Hindi and Urdu, both meaning nursemaid. These women were hired as cheap labour caring for young British children (who couldn't be sent off to boarding schools in Britain because of their young age), working round the clock. *Ayahs* in India gave their memsahib (the British mother they worked for) advice on how to endure and prosper in the colonial setting. For the white children, they provided full-service day-care, including feeding, bathing, dressing, and engaging in play. Due to their positioning in the employers' household, she argued that both the care givers and care seekers were 'at the most intense point of intersection, between the colonial masters and their servants,' (Conway, 2016, 41). The irony lay in the fact that though wanting separation from coloured natives, the masters had to heavily rely on native household helps, who resided in the premises. In case of *ayah*s, they operated in more personal, intimate spaces.

During colonial days, in well-off Indian households we find lot of household helps being employed like the wet nurses or *dais*. *Ayah*s were not hired in Indian households during this time. There are many writings-fictional and real talking about the *dais* in providing care for infants. While there were families that relied on hired help, and one can look into the biography of Sarlabal Debi (2011) or Mahasweta Debi's *Stanyadayini* (Breast-giver) (Tr. Chakravorty

Spivak, 1997), for instances, there were other households where 'caring' was chiefly seen to be a woman's responsibility. For example, Rashashundori Dasi, in her memoir, *Amar Jibon*, wrote that after marriage she had to do all housework like cooking, serving food, looking after the children, caring for the sick and so on. Though they were well off, and had eight women servants, they did not contribute to any such intimate activities like cooking, caring for the sick and children or other family member cause, they were outsiders (Ghosh, 2011, 30-31). There are many articles, exhortative texts (written at times by men), urging women to provide care in the inner or personal space. Towards the beginning of the twentieth century, many felt the need to have enlightened women members in a household in charge of the inner domain. As imparting education and transforming the private domain became an important part of the nationalist project, a lot of 'advice for women' books were written for the 'new women' or *bhadramahilas*. Between 1880s and 1890s almost twenty 'advice for women' books were written in Bengali, targeting middle class women and telling them what they ought to do (Walsch, 1990). There were many that preferred women of the family, mainly wives and mothers looking after household chores, infants, elderly, sick and so on. It was also argued that though the women could not be expected to offer prescriptions or treat patients, they were expected to be aware of *totka* s or home remedies for certain illness, nonetheless (Biswas, 1885,15-19; 55-58; Dutta, 1900, 67)[2].

6.2 The situation now:

From colonial days to now, though much has changed, but still the act of caring is still very much a woman's job. Earlier a certain section or class could employ an *ayah* like Europeans or households of British officials and aristocratic Bengali households could employ *dai*s but now, several middle and upper-class households rely heavily on the services of *ayahs*. In the domestic front, at the present time, the *ayah*s of today have made their way to middle class households, mostly in the urban areas. As more and more women from middle class households stepped out to do work, women from another class, stepped in to fill the void. In doing my research, I have been greatly benefitted by the work of Mandar Mukhopadhyay. Based on her experience of hiring *ayahs* from various centres, for her ailing mother, she tries to share their individual stories as told to her or as they unfolded before her. She offers a phenomenological

[2] See Taraknath Biswas' *Bangiya Mahila Arthat Nari Jatir Sikhsha Bishoy Prostab* (roughly translating to *A Suggestive Text for the Education of Bengali Women;* Nabakumar Dutta's *Ramani Aishrya* (roughly translating to *Woman of Many Talents*, in this context)

study of her interaction with the *ayahs* through a long period of time, since 2004, to be precise. Her study has documented with great detail, the everyday work of *ayah*s, in their workspace, which is the author's personal space or home, the nature of their personal relationships as read by the author or at other times as unfolded in front of her; her and her mother's interaction with them. She writes that 'we', that is people hailing from the middle class, are tied to the *ayah*s, in a relationship laden with suspicion and mistrust. Though we are dependent, on them, however we are cautious at every step. In other words, both the employers and the employees are bound in a relationship where there is dependence, helplessness and mistrust ("*Eder songe satorko samporke ongshidar amra/ Nirbharatar songe tai songshoy ebong sondeho"*) (Mukhopadhyay, 2017,9).

Agreeing about the dependence, Swapna Banerjee stated that the success of the many women stepping out to make a name for themselves in modern India has been made possible not by supportive or "sympathetic partners" but by the support extended by female family members or "distant companions", the term she borrowed from Karen Tranberg Hansen, referring to the help or labour provided by paid caregivers, who hail from another class (Banerjee, 2010, 775). The inability of scholars to see carework in general and carework in domestic spaces as feminist concern got echoed in the work by Banerjee.

In various writings, it becomes clear that *dais* or *dhais* were/are women hailing from low castes as they had/have to deal with unclean or impure elements of the body mainly blood, water of the womb, other body fluids etc. Thus, they were involved in something that is 'profane'. Though women caregivers like *dais* in Bengali households did hail from caste backgrounds like that of *hadi* and *bagdi*, it was not necessary for *ayah*s to hail from any particular caste and their pay in earlier times was determined by 'inter-personal relationship with the employers, their negotiation skills', which was again dependent on the extent the employers considered these women to be crucial. (Banerjee, 2010, 781). However, this picture has undergone a change as will become evident in Mukhopadhyay's work and the current research, that women with limited skills and knowledge about care giving, hailing from various socio-cultural backgrounds are entering the profession of caregiving. Dorothy E. Smith uses two concepts of 'relations of ruling', referring to a power structure in simple terms and 'ruling' as a set of practices, which is needed for the sustenance of the power structure/ relations of ruling seemed relevant. Thus, what became clear is the fact that the ideas, concepts, practices, traditions, texts etc. that establishes the "relations of ruling" have to be in constant circulation (Smith, 1987, 3). Smith reiterated that education from the start was meant for men and women were given

knowledge only in a limited way. Knowledge, which could enhance her work as a daughter, wife, mother, within the peripheries of the 'private', was made available. While talking about an everyday phenomenon like providing care, she noted that at times, women's knowledge of their own bodies, or sexual or procreational functions were being undermined.

Many things have undergone changes over the years but perhaps, neo-liberal urban spaces also require new forms of 'servitude'. On being asked, if she could use warm water from the geyser, one of the correspondents had told Mukhopadhyay (2017), that she knew how to use mixer, grinder, washing machine, micro-oven etc, or in other words, items that Ursula Huws had referred to as 'reproductive commodities' (Huws, 2004, 44), as this knowledge is necessary in order to work in small apartments accommodating nuclear families. Henrike Donner dubs these spaces of middle-class families in Kolkata as homes trying to incorporate 'global lifestyles' (Donner, 2016, 153). She also highlights the fact that though there have been few studies on other Asian countries like China, Japan and Malaysia that deal with everyday lives of middleclass families, such studies set against the backdrop of economic change, neoliberal politics, changes in family structure bringing about a new regime of care, is taking place recently. 'The bias against the family, parenting and the domestic sphere also prevails in the literature on globalization and economic liberalization…', she concurs (33).

With the agricultural sector becoming increasingly incapable of supporting the large masses of people dependent on it, men have been migrating in ever-larger numbers to labour in towns and cities. Women remain the only people who can take care of the old and the infirm, and the children in the family. And since opportunities for agricultural labour are also shrinking (and not paying), many of them, as found in this study, especially those living near urban centres go there for various odd jobs. With technological innovations in the agricultural sector, that has taken place in areas where in general female labour was used and in particular, with the rise in use of husk-fired mechanical driers, female casual labour has been negatively impacted, though they continue working 'without wages for the home-stead-based pre-milling processing of custom-milled rice for subsistence' (Harriss-White, 2011,70). Even labour that earlier got absorbed in rice mills of West Bengal are now finding employment in 'brick kilns, in construction' and in agriculture that Harriss-White would refer to as 'residual shock absorber'. However, citing work done by Kapadia and Lerche, she upholds the possibility where mechanisation in paddy cultivation has led to displacement of male labour, which ultimately force women to go back to agriculture and work for even lower wages (72). However, both the cases have to some extent led women from agricultural background take up job in the

caregiving sector, at least this happened in post-Aila Sunderbans, in West Bengal. For instance, the increase of salinity in the soil in Sunderban region of South Bengal, has forced many women to work as domestic helps, *ayah*s in various households across the city. These women had small plots of agricultural land that belonged to the family. Similarly, in Burdwan, women hailing from humble backgrounds from that district not only work as nurses in private nursing homes as well as *ayah*s in placement centres. With the decline in agricultural productivity in the district, women have been forced to work round the clock for very low wages.

Though in western countries, as Huws writes, one finds a shrink in so called unprofitable tasks as a result of which one can see self-service gas stations and so on, it is perhaps a known fact that in case of third world countries, experiences are different. While in the west, industrialisation of domestic work coupled with 'reproductive commodities' have not been able to guarantee leisure but managed to give employment in service centres like call centres situated in India, offering to help customers situated in the western countries (Harriss-White , 2011, 76). However, Indian urban households or urban Bengali households are somewhere in between. Due to the availability of cheap labour, most of the households get help from poor women.

Probing if the labour market in West Bengal was segmented along age and gender lines, Chakravarty and Chakravarty (2008), found out that the scope for growth for adult women in the labour market was not at all promising. When compared against the conspicuous presence of girl child labour, this seemed 'paradoxical' (94). However, it needs to be stated that while seeking the service of care, children or teenagers are not preferred, due to their lack of experience, their perceived fickle-mindedness, lack of wisdom, patience and propensity to fall in love and leave the service. Another reality being the fact that even when there are adequate 'reproductive commodities', *ayahs* who often perform various daily chores along with taking care of the old or infants or patients, are not allowed to use them, as they are considered to be 'unskilled'. The sectors that are no longer absorbing female labour are thus exporting labour in order to provide services like care. This was proved to be true as during the field work, the researcher had come across many *ayahs*, who were previously associated with farming activities.

As per Government of West Bengal, Statistical Abstract 2015,[3]the categories of main and marginal workers, in the report were further subdivided into groups like cultivators, agricultural labourers, household industry workers and other workers. These sub-sets under the category of marginal workers saw relatively more women in employment than in the subsets under main workers. It is indicative that when it comes to work distribution among men and women in the state, skewed trends are visible. For instance, recruitment agencies/authorities favour women as temporary workers and men as main workers and thus the work distribution among male and female workers is relatively better, in case of marginal workers.

Liberalization did not bring along more choices for women, but on the contrary, many women were forced out of work during this period of time. Further, the structural adjustment programmes and various policies to open up the market have affected poor women as they have created two disadvantages that are operating simultaneously for them. Their unskilled status leaves them with little choice. Most of the time women are forced to find meagre forms of self-employment or they find employment through home-based work for a certain type of industry, say *bidi* making industry or by working as unskilled workers in construction sector or hospitality sector. Further, various life events coupled with the absence of socio-economic securities 'force them to be primary caregivers and responsible for the well-being of their communities…Globalisation thus demands ''squaring the circle'' by making women "choose" to work within the home and in the informal sector' (Harriss-White, 2011, 96).

Evidently, with the rise of several institutions, of various sizes and forms (public/private), providing healthcare, one can see an increase in the number of women involved in carework. The caregiving system is a bottom-heavy system, where more and more women who join carework are found at the bottom of the pyramid, which also overlaps with the informal market. Different adjectives assigned to women careworkers like "semi-skilled" or "unskilled" add complex layers in an already hierarchical framework. Further, in order to deal with the huge number of people coming to avail healthcare services in several institutions, one cannot notice a concomitant rise of trained nurses being in employment. However, there is an increase in the number of women joining this work and needless to say, most of the women can be found to be working as untrained nurses or attendants or *ayah*s. The nurses thus find themselves handling managerial duties and responsibilities. While the Bhore Committee recommended a

[3] Table 9.1, P.469.

nurse- patient ratio of 1:500, according to a report by the National Institute of Health and Family Welfare, the nurse-patient ratio was 1:2250 in India and 1:100-150 in Europe, in 2004.[4] As per a recent study, percentage of *ayah*s have risen from 15.9% to 64.7% in the 55th to 68th rounds NSSO, implying that an increase in women careworkers has taken place, however the increase can be seen in the lowest tier of careworkers (Basu 2020).

6.3 *Ayahs* and *Ayah* Centres:

6.3.1 Up Close and Personal:

Anecdotal- I was looked after by an *ayah*, (I was taught to address her as Maya *mashi*), as my mother had to leave for work and my grandparents worked as well. *Mashi* is used to refer to one's maternal aunt and she resided in the liminal space of familial and non-familial, unlike *ayahs* appointed through various placement centres (at that time, in late 1980s, *ayah* centres were yet to mushroom). Instead of salary, she got daily wages; unlike permanent helps her position was short-term/contractual. As trained *ayahs* were very much in demand, back then, Maya *mashi* was too much sought after and was super busy and charged more than other *ayahs.* However, many years later, when her services were again sought, for another infant in the family, she was easily available, as the setting up of countless *ayah* centres, had already changed the scene.

As stated earlier, the hiring of *ayahs* to provide care is not a new phenomenon, however, the rise of nuclear, middle-class urban families and a concomitant rise in the demand for the services of unskilled, barely educated women (in most cases) is a recent phenomenon. So, is the feature of 'mushrooming' of placement centres for *ayahs* (along with domestic helps/ gardeners/ nurses and so on). I deliberately use the word 'mushrooming' to describe the phenomenon, where the walls in various places in Kolkata are filled up with advertisements, announcing the services of the *ayahs*, nurses, domestic helps and *thike* workers. Such centres exist in abundance, operating in small stalls in a market, a garage or in a room in someone's home. The huge number of middle-aged women, wearing a well pleated mostly faux crepe, cotton saree or sarees made of synthetic material, with two bags, one with changing clothes another with tiffin careers and other objects, heading towards Ultadanga station or Bidhannagar

[4] http://nihfw.org/pdf/Nsg%20Study-Web/West%20Bengal%20Report.pdf. Last accessed 15.3.19.

station around eight in the evening is indicative of burgeoning or 'mushrooming' of such placement centres.

Further, a shift in the nature of job that is from a full-time service based on loyalty, intimacy etc. has taken place. However, though services have become contractual in nature, but I would like to argue based on interviews that, a certain form of 'servitude' still affects the work of *ayah*s, especially for the ones, working in domestic spaces. Servitude might be understood as a form of ideology which includes a sense of cultural superiority of one over the other – that is superiority of the employer. It also entails the development and sustenance of a sense of dependency on the employers (Ray 2000; Qayum and Ray 2010). However, these women have not benefitted from the current prevailing system of service through contracts as they are tied in a relation of 'pragmatic intimacy' (Sengupta and Sen, 2013, 59). Though the term was used in the context of domestic workers, it can be used in order to understand the case of *ayahs*. Pragmatic intimacy involves "love" and "belonging" that is not divorced from 'awareness of social distance' (59). What also becomes crucial in understanding the nature of job and the remuneration for such job /services is the fact that not only wage factors, but non-wage factors like 'food, bonus and credit', determine women's entry in this sector. Though in the work of Sengupta and Sen, 'food' was least of the important non-wage factors (as it dealt primarily with part-time domestic workers), in case of *ayahs*, food is an important factor, as they spend around 8 to 12 hours in their workplace. The contractual nature of their job, excludes them from the benefit of bonus during *Durga Pujo* (festival to worship goddess *Durga*) that other domestic helps or part-time workers are eligible to. Any kind of financial aid, not necessarily a credit, is well appreciated by these women.

Ayahs working in someone's house may be employed through a mediating agency like the *ayah* centres or other placement centres. They also use a contact or a referee to get the job. Apart from caring for the sick, elderly or even babies or kids, *ayah*s end up participating in other types of domestic work like cleaning the clothes of the sick or the ones the care is being provided for. She would also have to clean up her utensils if she had used any. It goes without saying that relationship between various categories of women in a private space is complex in nature. There can be instances of a sisterhood but there are also instances of competition, rivalry. Say for instance the relationship between a *thike* (part time) domestic help an *ayah* would not be an easy one. Thus, someone's home ends up creating layers of feminine exclusion, where despite hailing from almost similar socio-economic background, one category of women, due to the very fact that they are exclusively employed to care for specific member of

the household, sets them apart from other women doing paid domestic work. Even the relationship between the employer and employees is a complex one as is evident from Mukhopadhyay's work. As Neetha N. writes, such relations often are 'not limited to work but spill over as large support systems' (Neetha N., 2019,7). However, engagements or interactions between different categories of women working in a highly privatized space not necessarily blurs boundaries, but reinforces them (7).

Ayahs are controlled by familial and social obligations while working and it greatly affects their decision to enter the labour force. Many women join the labour force after marriage, especially when regular sources of income of male members of the family are interrupted or perhaps when they have faced desertion or death in the family. For instance, Sima Naskar[5] hailing from the *Sunderbans* was forced to come to Kolkata for work. The family in the face of financial crisis took loans from local money lender, as productivity in the family-owned agricultural land declined substantially, following the onslaught of cyclone Aila, after which soil turned saline in nature and farming was no longer an option. Unable to repay the loan and being faced with the threat of losing their family land, she was forced to seek employment either as a domestic help or an *ayah*. Since she hailed from a relatively 'respectable family' and was not a 'destitute', working as an *ayah*, was any day preferable to her. During my interviews with the *ayahs* across various centres, I realized that looking after the sick or babies and cleaning human excreta is considered to be a superior job than that of cleaning utensils or washing clothes, works that are done by full time or part-time domestic helps.

Jaba Majhi and Reba Bachhar of the Goasaba block of the Sunderbans have also been impacted by Cyclone Aila[6]. To paraphrase Basanti, the assistance or help that came their way was insufficient to 'build back what was already lost'. Furthermore, because their families were Trinamool supporters in a Left Front-dominated region, it was challenging for them to receive aid due to the competition between the former Left Front government and Trinamool Congress in terms of offering aid and relief.

Sumita Roy[7], had come to the city with her husband after marriage from Cooch Behar district in north Bengal. She was forced to find employment through a placement centre after her husband passed away in an accident. She was entrusted with the duty of looking after an old lady and also cooking food her. She firmly stated that her status was superior to that of a *thike*

[5] Interview held on 25. 09.16. in Gari, South Kolkata.
[6] Interview conducted on 12.09.17, Baruipur, South 24 Parganas.
[7] Interview conducted on 23.12.18, in Salt Lake, Kolkata.

(not full time) or a full-time domestic worker as her responsibility was to care for the patient. '*Sobai ki bed sore howa patient ke jama change korte parbe, chador paltate? Kibhabe dhorte hoy kon patient ke shobai jane na*' ("Do you think everybody knows how to change clothes or bed sheets of a patient who has developed bed sore? Everybody does not how exactly a patient needs to be held".) She was compelled to give the centre the necessary sum of Rs 40 per day, as commission for a few months. However, the family and she have since come to an informal agreement whereby the centre is excluded from the transaction. Kajol Sarkar, Dulali Hela, Brihashpati aka Debi Shunri, Shabitri Hari, Pushpo Sarkar, Madhu Bagdi, all aged between 33-53 years, were forced to work in the city because they were deserted by their husbands. Some moved away from their marital homes and were living elsewhere. Even when, some of them had gone back to their paternal homes, in order to not be a burden on their brothers and other members of the family, they started working as *ayah*s in the city primarily because of three reasons: first, would be the fact that wage rates in cities are higher; second, the work of an *ayah* is more respectable than that of a domestic help; third, there is a perception that working an eight hour or twelve hours shift entails that there is flexibility, as in they can do anything after the stipulated hours of work. Since their entry into the labour force is dictated by the needs of their families, their familial roles as wives and mothers remain a part of their working identity and, therefore, they are less mobile and unable to commit longer hours to paid work (Sen, 2001). According to National Sample Survey (NSS) definitions and estimates, every woman provides service to 1.5 men workers and still they have to provide care for children, and old and disabled people (Ruwanpura, 2004). Additionally, as more and more women work in the formal sector, their societal roles of caring for the elderly, raising children, cooking, and doing other household chores frequently fall by the wayside. According to the data that is available, the number of women working in the organised sector rose from 1.9 million in 1971 to 4 million in 1993 (Desai and Thakkar, 2009, 31). Since then, the number of women working in the formal sector has grown even more due to the employment of more women in the information technology industry.

Though low *claste* (class plus caste, results in *claste*; the term is being borrowed from Charles Bettleheim[8] (1968) identity and carework in patients' households have been considered to be going hand in hand, there have been cases in course of my work, where women from upper castes have been forced to work as careworkers. The same experience has been shared in

[8] Bettleheim, in his work, *India Independent* had stated that in order to understand the realities in India, one must know about class as well as caste.

Mandar Mukhopadhyay's work. Sangita Jha[9] , started working at Soham *Ayah* centre at the end of nineties. The centre was in Karunamoyee and catered to patients who were admitted to Anandalok Hospital. She had migrated from Bihar to Jagaddal in West Bengal, where her brother-in-law used to work in one of the jute mills. Her husband had deserted her and her children. A Maithili Brahmin, Sangita was denied work of an *ayah* by a number of Marwari households in Salt Lake area. Her caste acted as a deterrent and the households that denied her told her that they could not employ a Brahmin to do menial work. The owner of the centre suggested changing her name and in the centre's register she became 'Manisha Mandal' and this name change, albeit unofficially, helped her find employment. At that time, she would get Rs. 50 for a 12-hour shift and give the centre Rs 5 as commission. She had also introduced Sushila Mishra, wife of a closed down jute-mill worker to one of the centres. Sushila is from Uttar Pradesh, and both of them expressed that at the beginning, language acted as a hindrance, but co-workers helped them a lot and there was a sense of camaraderie.

A similar incident of changing one's surname in order to find employment was also reported in Ballygunge area (South Kolkata), where Rupa Banerjee, in her late forties had to change her surname into 'Mandal' in order to find work in non-Bengali households. It needs to be mentioned here, that as per the narratives of the *ayah*s, Bengali clients hiring the services of the *ayah*s, did not have a problem with the caste of the *ayah*s. Three respondents stated that their old relatives, for whom the care was sought, initially refused taking medicines from the *ayah*s, because of their caste, but later, upon counselling by family members, the hiccups were overcome. In both Sangita and Rupa's case, they were denied work by Marwari households and that too not by the old patients but by young family members hiring their services. Diana Elson and Lourdes Baneria's works show that women in the age group of 30-45 years, having no skills or education and who are increasingly being out of job options, form a major part of the informal economy and also form its lowest tier as they are in desperate need to sell their labour (Elson, 1992; Baneria, 1992).

6.3.2 Up Close and Distant:

According to a missionary doctor who served in India (1928-1950s) had observed about the nurses in his hospital at Ongole that when it came to doing menial works, they delegated these duties either to the probationers, family members of the patient or some 'scrub-woman'. Even if their fore fathers had to do such a thing before their conversion into Christianity, they did

[9] Interviewed on 09.09.16.

not want to be equated as sweepers. The Western nurses had to fight against their Indian students, trying hard to make them see that caring for every need of the human body, made this profession noble. However, the Indian students or nurses delegated 'polluting' works to other people like even sweepers (Healey, 2013,51). It is precisely here that the *ayahs*, working in hospitals, nursing homes come into the picture. Though nurses in the early days faced competition from *dhais* or *dais*, they shouldn't be compared with *ayahs*, even though both the categories of women deal with 'polluting' agents of human body.

The Services of the *ayahs* are required in hospitals or nursing homes. The private organisations contact empanelled *ayah* centres or at times, the patient's family might contact an agency for assistance to hire an *ayah* while the patient is in hospital. In two private hospitals that were visited for the research in south Kolkata, it was seen that women who work as cleaning staff are also recruited through the placement centres. Their names are not listed on the payrolls of the hospitals. As mentioned earlier, *ayah*s are not employed by state government hospitals; their names do not appear on the payrolls. Similar rules apply to nursing homes and private hospitals. However, there are also exceptions. As an illustration, the Central Hospital of South Eastern Railways has added *ayah*s to their payroll as Group D employees. Since there are not enough officially employed *ayah*s, it is occasionally necessary to use the services of *ayah*s who are not on the payroll.

Before 2000, *ayahs* were technically part of care service that was being provided by government hospitals. Their services were acknowledged by the then Left Front Government. They were dubbed as *anubratis* (special duty attendants) and had been in existence since the early years of 1980s. It was from then onwards that they started accompanying patients with the green card which was assigned to the family members of the patients. Their names had to be registered with the Super of the hospital. If need arose, the registered *anubratis* would be contacted for work. They were supposed to submit their ID proof and phone numbers to the Super. However, in 2001, faced with innumerable complains against them, and the police patrolling SSKM premises to keep the attendants away, their services were no longer welcome in government hospitals. At that time there were 4000 *anubratis* working in several government hospitals (*The Telegraph*, November 21, 2001).[10] Henceforth, their services got officially derecognized. They remained 'necessary', however they were not considered to be an 'insiders'. After the change in government, *anubratis* can be mainly seen in a government

[10] https://www.telegraphindia.com/india/attendants-strike-fear-in-patients/cid/912292.

super-specialty hospital in Kolkata[11] (ABP, 2017) and during field work, a visit was made to the *Anubrati* office next to the Academic Building in the hospital premises, that keeps a tab on *anubratis* registered with it. On being hired by the patient party, they have to pay a commission to the office. Unlike *ayah*s they get six months training from organizations like Red Cross or St John's Ambulance Association etc.[12]. In order to demarcate themselves from the 'unskilled', they also wear a uniform, perhaps to look similar to the nurses.

An *ayah* working in one Government Medical College and Hospital in Kolkata, informed that there are approximately 200 *ayah*s working in several wards, working 12 hours shift, charging a minimum amount of Rs. 150 per patient. Reluctant to divulge her identity, she further revealed that she has to pay Rs 20 as commission and the workers union and local political leaders have a share in it. In another instance, while going to another Government Medical college and Hospital, to meet a nurse for the study, I had witnessed non-Bengali *ayahs*, sitting in patients' bed, negotiating hard with the patient's party or the family of a patient. When asked if they would like to answer a few questions, they asked if I was from media. On answering them in the negative they had asked for money to answer questions. One of them said, '*Kichhu hole amader e toh matha jabe. Amra khabo ki*?' ["If something untoward happens we would be worst affected, how would we survive then?"].

The presence of *ayah*s in various government hospitals in and around the city is a reality from which the authorities cannot shy away. However, things become interesting when one looks into the case of *ayah*s who are functioning in a unit where there is general as well as private wards. Such is the case of 'Specialized' Municipal Hospital in the North 24 Parganas. The first two floors are open to subsidized medical treatment and care and the other floors are designated as 'private', out of the limits of common men, where special packages are offered for people who are willing to pay more and avail 'better' care and services. In the general wards the presence of *ayah*s was conspicuous. Clad in white and red bordered sarees or white and green bordered sarees they are present even when there is no patient to attend to. In the subsidized section, the patients are charged only the fees for the bed, specific tests if they have to undergo any or surgery, the rest is free. The hospital also does not provide food for the patients in this section, which is brought by the patient's family. Feeding the patients thus, is a responsibility

[11] See https://www.kolkata24x7.com/nirmal-maji-wants-avoid-about-extreme-offended-anubrati-issue-at-sskm-hospital-but-madan-mitra-interested/

[12] Field visit 23.09.17

of either family members or appointed *ayah*s. Most patients have *ayah*s taking care of them feed them, clean bed pans, call ward nurses if the need be. Mr. Nag, having the position of Emergency in-charge, stated that they are lazy, undisciplined and soil various walls by spitting gutkas or pans (chewing tobacco and beetle leaf). However, the same *ayah*s behave differently if they are called to provide for care in the private wards.[13] While hospital administrations are at times frustrated due to the presence of *ayah*s, there are many who are much sought after, even in institutional setups.

Mira Haldar, who has worked as an *ayah* for over 20 years, prides herself for being attached to one placement centre during all these years. Indeed, when very often placement centres in various parts of the city spring open and then shut down due to various reasons, this is indeed a rarity. After migrating from Barisal, Bangladesh, after series of attacks on minorities in Bangladesh, following the demolition of the Babri Masjid in India, as a young girl, to having to find work after her husband injured himself, she had interesting tales to offer. She has been associated with a centre that provides *ayah* to a private hospital in Hudco area, Kolkata, near Bidhannagar Railway Station, and has seen the rise in demand for the services of *ayah*s. She said, "*Jokhon ami shuru kori tokhon 12 ghantay 50 petam, centre 10% rakhto, ekhono bere jokhon 350 taka, oi centre ekhono 10% e rakhe" (*'When I started working for 12 hours service, I got Rs.50 and I had to give a 10% commission to the centre, even now, when the amount has increased to Rs 350, even now it charges the same share'*).* Her story was a rare one. She is one of the few respondents who stuck to the same placement centre for twenty long years. If there is a patient who needs an experienced *ayah*, the hospital always asks for her services, she had boasted.[14]

On another occasion, the Chief Executive Officer of an old Calcutta private hospital, which was established in the sixties, by an industrial family, brought to the fore that a large number of nurses quit every year. Though it has had attendants (skilled *ayahs*) before, they did not have to rely on them for caring for their patients. Even when faced with scarcity of nurses, the nurses though less in number had managed to provide supervision to the attendants. They are not even allowed to administer medicines without the nod from a nurse. Both the above interviews have one thing in common. From the administration's point, these women unskilled/semi-skilled workers do not demand much respect, (due to the nature of their work and because of the

[13] Based on interviews conducted between 24-26 March, 2019.
[14] Interview held on 09.09.22 in Kolkata.

perception around the work they do) however, they are perceived to be essential hence the administration cannot dis-acknowledge them.

In the literature on women and work, there has been a great deal of discussion on the 'supplementary' nature of women's earnings. Such perceptions underpin the differential wages paid to men and women for the same work. And the assumption of women earning a supplementary wage is grounded in the employment of married women, the husbands being expected to play the role of the principal breadwinner, the women's earnings being constituted as 'supplementary', less significant for household subsistence and therefore susceptible to being pegged at a lower level than men's. In this sample, more than half (51 per cent) of the respondents are married, however, this does not mean that their husbands are the breadwinners of the family. Many married women reported emotionally and/or financially dysfunctional marriages, and are therefore primary earners. Technically, however, very few report of being divorced or deserted (5.3 percent) and therefore would not correspond, statistically, to being counted as 'female-headed' households or 'single' women.

Nirmala Banerjee, well-known social scientist, argues that in this context the typical woman worker was married and with children, responding to familial rather than market imperatives in labour market decisions (Banerjee 1991). Further a large proportion of unmarried women are also expected to be able to withdraw from nursing and indeed from work altogether upon marriage. As per labour Commissionerate's declaration on 1 July, 2015, in clinical nursing homes, an unskilled worker's daily wage was Rs 268 (Zone A) and Rs 251 (Zone B). However, what needs to be stated here, that these women, do not find employment every day, so evaluating their situation based on per day wage would not do any justice. As per the Minimum Wages Act 1948, ideally speaking there shouldn't be any difference of wage rates between someone doing care work and other unskilled workers, however, location, people's mind-set (care is mot real work), social settings have greatly impacted its implementation.

The below table shows how much the *ayah*s get in Kolkata: [15]

Table 1: Earning of *ayahs* in Kolkata

Area of providing service	Rate of the *ayah*s (with food) in Rs in 2014-15	Rate of the *ayah*s (without food) in Rs in 2014-15	Rate of commission charged by *ayah* centres in 2014-15 in percentage
New Alipore	180-190	220-270	10-12
South Kolkata (Jadavpur, Garia, Tollygunge)	180	200	10
Salt Lake	180-200	210-250	10-15

At present *ayah* centres are also operating in Burdwan, Durgapur, Malda and Siliguri towns. Sushmita. Centres away from Kolkata currently charge something between Rs. 200-300 per 12 hours shift. Aloka Mukherjee[16], who runs an *ayah* centre in Malda stated that though *ayah* centres are present, it cannot be compared to the phenomenon of 'mushrooming' of centres. Though people hire services of *ayah*s in hospitals, very few hire them to look after one's family member in their homes. " *Ekhane oi cultureta sherom suru hoyni*" (the culture of hiring the services of *ayah*, to care for a family member in one's home has not yet developed here') . During field work, I have come across a handful of centres in the above- mentioned cities, which might be indicative of the fact, that the phenomenon of 'mushrooming' of centres have

[15] Data collected by the researcher.
[16] Interviewed on 15.08.22 in Malda town, north Bengal.

not started taking place in cities away from Kolkata. There, in private spaces, caring for a family member is a shared responsibility of other members of the family.[17]

6.4 Responses:

A total number of 85 *ayahs* were interviewed during the course of research. While 42 *ayahs* were interviewed in hospitals and nursing homes, 43 were interviewed in private spaces. 61 respondents reported that they found work through the placement centres. It needs to be mentioned here, that in most of the cases, the place of work for these women is never permanent or constant but always changing. For instance, an *ayah* might work in public spaces, but she can easily start working in the domestic spaces, depending on the need of the clients. Thus, there is some kind of non-permanence when it comes to the workplace of these women, Further, there is no guarantee if they would find regular work. Thus, when they find a patient needing at home care and the family is good to them, the *ayahs*, tend to agree to work at even lower rates, if any such need arises.

The respondents belonged to the age bracket of 31 to 54 years, with an average monthly income of six to nine thousand rupees. On an average the daily commission (for centre-based *ayahs*) ranged between Rs 50-80. Out of 42, 30 respondents stated that the behaviour of doctors and nurses towards them was 'okay', while 12 stated that they were ill-treated. Further, 25 respondents working in hospitals had stated that they were 'okay' about client's behaviour. On the other hand, 23 respondents working in private spaces stated that patient's party treated them well, ensured they had privacy, had access to clean washroom and also offered them food and so forth. The rest expressed negative attitudes towards the patient's party. Many of them pointed out that they did not have access to clean washrooms.

When asked if they had any idea if the healthcare situation in the state has improved or has remained unchanged since 2011, an overwhelming number of 62 women stated that they thought that the situation has improved, since all of them had Swasthya Sathi cards for themselves as well as their family members and had also recently registered their names for getting monetary benefits through the Laxmi Bhandar scheme of the current TMC government.

[17] Personal interview with Sonam Rai, owner of Mother Ayah Centre, Siliguri, north Bengal.

Women whose everyday struggles are laced with financial instabilities, such small assurances from the government mean a lot to these women.[18]

It needs mentioning here that who can hire the services of *ayahs* is completely dependent on one's socio-economic status. For instance, none of the residents of urban slums, nor tea gardens nor charlands acknowledged ever hiring services of *ayahs* in their domestic spaces. Though, urban residents reported hiring *ayahs*, while being hospitalised in government facilities, such a thing was unthinkable for residents of charlands and tea gardens. Again 3, out of 8 respondents in government hospitals had stated that they had hired services of *ayahs* both in hospitals and in private spaces.

6.5 Perception of the clients:

Mandar Mukhopadhyay as already mentioned earlier has penned down her experience as a client, while hiring the services of *ayahs* in the domestic setup. From dependence, to mistrust, her narratives captured an array of sentiments that clients often face while hiring an *ayah*, be it in institutions or be it in domestic spaces. Out of 34 respondents, (who had hired services of *ayah*s in domestic space – home of the patients) 29 stated that they were not satisfied with the services that the *ayahs* provided yet all 34 responded that these women were crucial or seen to be a necessity in their households. Out of 34, 29 clients did not hire the same person and had changed centres and only 17 had informed the local authorities that they have hired the services of these women. Out of 34, only 19 clients reported that *ayahs* they had hired, could read and this helped in the administration of medicine. Out of 34, 27 respondents said that the *ayahs* knew how to massage, and only 11 responded that they had hired services of women who knew how to take care of different types of patients like patients who had suffered a stroke or patients suffering from Alzheimer's.

Mukhopadhyay's mistrust was echoed by one client who was apparently threatened by the hired *ayah*. The client had allegedly caught the *ayah* stealing her gold earrings from the almirah and on being confronted was threatened that her grandson (for whom she was caring), would be kidnapped if she dared to go to the police. Nothing could be done by lodging a complaint with the *ayah* centre as her documents that she had submitted turned out to be fake. From the above account, it gets clear that these centres also operate in liminal spaces. Complete different

[18] Based on interview with the owner of *Ayah* centre Maya, in Kolkata , on 17.9.21

experience it has been for another client, who had sought the services of two *ayah*s through centres, but then had set out new contracts bypassing the centre. Even after the passing away of his wife die to Alzheimer's, he did not want them to be out of work, hence re-employed them as domestic workers, because of their services.

6.6 Pandemic and the *Ayahs*[19]*:*

Since, much of the writing was done during the pandemic, not documenting the role of *ayah*s during the pandemic seemed unjust. The suggestion by the PhD committee to incorporate experiences of the pandemic was thus, taken into account. During the pandemic, getting non-COVID critical care became very difficult as the number of COVID patients increased in both private and government hospitals. Patients suffering due to cancer, kidney problems, cirrhosis of liver, dementia etc. who needed urgent attention, had to settle for home care. While the demand for paid, at-home care increased, there was a shortage of careworkers in the placement centres. Though most of the placement centres continued operating, they did so with few *ayahs* and a few had to shut down. Three placement centres in Salt Lake area (Bidhan Nagar), which were surveyed earlier for this work stopped operating as *ayah*s working in them could not join work amidst pandemic. In order to check the spread of the virus, lockdown was declared and the *ayahs* who commuted by train could not come to their work places, located mostly in the cities.

Sampa Mondol, an *ayah*, working in a placement centre in Salt Lake Sector 1 area and living in Barrackpore, regretted and said, '*Kolkatar ar ektu kachhe thakle manage korte partam'* ["Had I lived closer to Kolkata, I would have found out a way to go to work"][20]. There is a constant demand for the *ayahs*, and where the daily commuters failed to join work, the 'locals' or the ones living in and around the city, benefitted. This statement by Sampa, seemed to be correct as Shipra Majhi, living in Sodepur, close to Kolkata (takes around 30 minutes to reach Bidhannagar Railway Station), working with one of the oldest placement centres in Salt Lake, could continue working at her client's place in Salt Lake, as she could come to work, riding a scooty. For someone who left formal education at the age of twelve, learning to ride a scooty in her forties was an achievement in itself. Similarly, Parul Naskar, benefitted from living in the suburbs. Parul living in Belghoria, could come to work, riding a bicycle, which was gifted

[19] Telephonic interviews conducted between 15.03.21 and 09.07.22
[20] Interview conducted on 17.10.20

by the patient's family. The octogenarian dementia patient she has been caring for the last five years is so dependent on her that her services are invaluable. Again Jyotsna Gayen, working for an octogenarian patient, who lived alone, walked all the way from Narendrapur (south suburban Kolkata) to a residential complex in Kasba (South Kolkata), walking over 20 kilometres every day. She being the only bread winner of the family had the option of either walking 20 kilometres every day to her workplace or being jobless. To run her family, she chose the former.

Ayahs working in hospitals and nursing homes also faced the impact of the pandemic. During the pandemic access to private hospitals and nursing homes got limited for most of them, as the number of infected patients increased rapidly. The patients' party or the family of the patients who normally hire the services of these *ayahs* and hospital administration were somewhat sceptic in giving them work in the institutional set-up, in order to prevent the spread of the virus. The perception of them residing in unclean ghettoes, where mass-scale contamination can easily take place due to their poor hygienic sense, got reinforced. Here lay the irony. While the middle class and upper-middle class looked at these women doing carework, hailing from the informal economy as unclean and as possible bearers of the virus and thus, as a threat, the complex healthcare situation, which took form after the outburst of the pandemic led to a rise in demand for at-home care, which was mostly provided by these women or *ayahs* as they are popularly referred to.

Parul Nashkar's aunt, Maya Sarkar works as an *ayah* in a Sub-division hospital in Hoogly district, adjacent to Kolkata and with the ongoing pandemic had lost her source of livelihood as they were no longer allowed to work there. As more and more government hospitals were being designated as COVID hospitals, the livelihood of *ayahs* in government institutions was seriously getting affected. Nurses were overburdened and the *ayahs* wanted to work and were ready to give an undertaking that nobody would be held responsible if they got infected or if something happened to them, Maya informed. '*Nursera khayiye debe, bedpan debe? Patient partykei korte hochhe dekho giye noyto omni e pore achhe*' ["Do you think nurses would feed these patients, give them bedpans? Go and check it's the patients' family who are doing all of it or else they are lying in a sorry state"], she said.[21] Protesting in front of the hospital administration or committing suicide were the only options in front of them, she said.

[21] Telephonic Interview held on 26.4.21

A few of the interviewed *ayahs* working in government hospitals of Kolkata and adjacent districts, reported sleeping on a bench in the hospital premises as they could not return home from their *duties* (work) because of the lockdown. They worked on multiple shifts continuously and had to depend on stale home food or biscuits and puffed rice, which left them hungry or half-fed, as temporary food stalls from where they bought their simple meal of *ghugni- ruti* [beans and flat bread] or *bhaat-tarkari* [rice and vegetables], at reasonable prices, were all closed.

6.7 Negotiating society, State and the Pandemic:

Lockdown, night curfews, vigilantism forced *ayahs* to stay in their places of work, be it a patient's home or hospital. Some of the respondents stated that they could continue working for 12 hours shifts daily, only because they were hosted by family members, situated in other parts of the city. They could not continue working from their *para* (locality where they lived). Being perceived as the bearers of the virus, they could either stay in the *para/ mohallah* and not take care of patients (who were always perceived to be infected by the virus) or, they could continue working and not return home after work. There is already stigma attached to the work that these women do. Since the carework, they offer entails coming in contact with a patient's excreta, they are perceived to be 'dirty'. During the pandemic, the image of *ayah*s as careworkers who are not clean, got reinforced which coupled with the perception that they were the bearer of the virus, severely affected them and their family members.

As already mentioned, the central government had declared a blanket lockdown, to prevent spread of the virus. Though steps were taken to safely bring other categories of healthcare workers to the places of work like doctors, nurses, radiologists and others, no such attempts were made for this category of workers. Neither were they treated as frontline workers, even when they were working in general wards of government hospitals which in the initial days did not test non-COVID patients. This increased the risk of contamination for the *ayah*s working in general non-COVID wards, where asymptomatic COVID patients were also admitted. Though only two of the *ayah*s, interviewed for this research, admitted that they had COVID, most of them knew of someone who had contacted the virus while at work. The placement centres also did not want to furnish any details, though they wanted to highlight that at the time of the interview, most of the *ayah*s, were partially vaccinated and a few were fully vaccinated.

A few respondents, living close to Kolkata, reported riding a bicycle to work. In one case, it was the patient's family who got her a cycle as they are dependent on her for caring for their octogenarian family member. During the pandemic, where police atrocities were reported from various parts of the country, *ayah*s carried letters from the patient's family, requesting for free passage as what they were providing was nothing short of 'essential services' to the patients. When asked if the placement centres had provided with an identity card identifying them to be a provider of essential service, care, the answer was in the negative. Further, many *ayahs*, residing in peri-urban areas, also reported that they could not come to work as railway services were suspended and their situation got worse as many of the male members who were migrant workers were stuck elsewhere and were without work and without any source of sustenance. Further, in families where these women were the sole bread winners were also hit hard during the pandemic. Two of the interviewed *ayah*s stated that they had to withdrew their children from school as they could not afford smart phones or paying for data in order to avail online classes.

6.8 New hierarchies:

Carework in both private and public spaces is in general hierarchical in nature. For the *ayah*s, working in both these spaces, and either one of these spaces, the situation almost remains unchanged--- they form the lowest tier of direct carework. Presently varied courses of nursing are run by various organizations. St. Johns Ambulance Association, Red Cross and others conduct courses which provide short-term and diploma certificates in nursing. Many young girls fresh out of school or after completing graduation, are getting trained to be bedside nurses. However, on asking a senior nurse, associated with a well reputed government super-speciality hospital, she bluntly said, that they are not proper nurses, though many private healthcare institutions might give them employment as nurses, due to paucity of trained nurses and also because they cannot afford to employ the services of trained nurses for all nursing related work.[22] These new categories of careworkers are more skilled and trained than the *ayah*s, however can be no match to trained nurses. Thus, increasingly we find new tiers of healthworkers coming into existence, which pushes *ayahs* more and more to the margins. In government set up, *Anubratis,* add to the hierarchical caregiving setup. Those who do not trust

[22] Based on interview held on 26/10/21

*ayah*s, can hire the services of an *Anubrati*, a nurse, in a government hospital stated in an interview.[23]

During the pandemic there was a boom in the demand for caregiving services. While a few agencies came up with arrangements for blood transfusion at home, under a doctor's supervision, some had arranged for regular home visits by doctors, physiotherapists, nurses (mainly who have studied bedside nursing), hospitalization and overall monitoring by health managers (staff in the agencies acting as liaison officer between the patient's party and all other care providers). However, the day-to-day care was undertaken by the *ayahs,* though these agencies prefer using the term 'attendants' instead of *ayah*, perhaps in order to differentiate themselves from other small placement centres, already discussed above. The amount charged was also more than what is normally charged by placement centres.

Some of the above-mentioned agencies were also offering the services of male attendants, who unlike the untrained *ayahs* could read prescriptions, measure blood pressure, pulse rate, administer injections etc. In other words, these male careworkers were presented as trusted and desirable alternatives to the untrained *ayahs* by the new-age agencies. Though, such agencies had already started functioning way back, to the time, when this research endeavour had begun, but it was during the pandemic that they could utilise the vacuum in the care market, created by the dearth of *ayahs* or *ayah mashis*, following the blanket lockdown and suspension of train services. Needless to say, the amount that these male attendants charged were almost double the amount charged by an *ayah*. While hiring an *ayah* in Salt Lake area, during the pandemic cost something between Rs. 380-420, male attendants charged Rs. 800-850 per 12-hour shift.[24]

6.9 Why are *Ayahs* relevant?

Ayahs as already mentioned look after the old and the infirm. They also look after nursing mothers and their infants. As the number of joint families have gone down and the number of nuclear families have gone up, there has been a dearth of non-paid, at-home care providers. This void is filled by paid careworkers like *ayahs*. Another truth is that in India currently, there are nearly 138 million elderly persons, out of which 67 million are males and 71 million females, who require a lot of care and medical attention (NSO 2021, 16). 'It is a curse to live

[23] Interview conducted on 26.10.21.
[24] Telephonic Interview held on 09.06.21.

long…hope I die in dignity', said Mr. Debnath Ghosh, a retired engineer, who worked in the state public works department. All the respondents, over the age of 65, raised concerns about the healthcare costs in India, where insurance becomes expensive as one ages. It needs to be mentioned here that Kolkata is one of the cities with high percentage of elderly population (10%) in India (*The Times of India*, March 1, 2017). This, clubbed with the shift from joint families to nuclear families to a rise of a single-senior-citizen, membered households imply that caring for the old is a sought-after service. As per NSSO data of 2006, only 35% of elderly people were fully independent and 51.8% were fully dependent on their children

Panchali Roy in her work (2019) has avoided including *ayahs* working in private spaces in her study as there is an overlap between work done by an *ayah* and a domestic help. But acknowledging the possibility of an overlap, I feel it is important to include this category of careworkers because their work is directly related to policy decisions that are taken by the government. They are sought after because private healthcare that middle class avails is expensive for elders, insurance is expensive which makes hospital care expensive too. Prior to 2018, when Ayushman Bharat Pradhan Mantri Jan Arogya Yojana was introduced, only 1.6% of elderly population was insured, while for the whole country, the score was 26% (Deloitte 2014, 11). Clubbed with the above is the reality that insurance becomes super expensive as one crosses over to seventy. This increased home care, while hospitalization was treated as a last resort by many of the respondents. After 2018, due to the central and various state governments schemes, 18.9% of the senior citizens were covered under health insurance schemes, and Publicly Funded Health Insurances covered 14.3% population, covering for inpatient care, while the Central Government Health Schemes, covering 2.1% and ESIS scheme covering 0.7% covered outpatient care. The coverage provided by the private insurance companies was estimated at covering only 1.8% population, taking care of inpatient care only (Ranjan and Muraleedharan 2020).

6.10 Role of Agency:

Any work focussing on policies and people should also include the *concept of agency*. In simple sense, it means 'an act of doing'. Let us go through the views of some of the leading scholars on this. Pierre Bourdieu, while talking of the role of habitus and routinized practices have viewed human agency as habitual, repetitive, and taken for granted (cited in Emirbayer and Mische 1998 *passim;* also cited in Navarro 2006, 16). On the other hand, J.C. Alexander opines,

'there is a dimension of free will or agency in every action' (J C Alexander 1992, 8), The Penguin Dictionary of Sociology refers to it as 'the capacity of individuals to act independently of structural constraints' (Abercrombie et al. 1984:6); while the Dictionary of the Social Sciences defines it as 'the ability of actors to operate independently of the determining constraints of social structure' (Calhoun 2002, 7).

Amartya Sen conceives of 'agency' and 'well-being' as two distinguishable but linked aspects of human life, each of which requires some form of aid or protection on the part of individuals and institutions (Sen 1984). Public health policymakers should consider the phenomenon of 'human agency' while framing of policies, during the assessment stage and also during design and implementation. This is a reasonable alternative, which might decrease the risk of developing well-intended, but ultimately paternalistic policies, in which patients are 'passive recipients of interventions designed to meet this goal' (Levine, 2013, p. 55). Not only the agency of patients but the agency of careworkers, their role in bargaining (collective or individual) is crucial in understanding the delivery mechanism of the healthcare system. Their agency vis-a-vis the administration would also bring to the fore their position in the power hierarchy.

From a policy perspective it is important to recognize that a huge section of women work as *ayahs* and thus support their families in keeping their families above poverty levels. Hence, it is utmost important that more protection is given to this category of careworkers. Unlike other female workers hailing from the informal economy and who are also associated with care work like the domestic workers, who have an organization that in 2018, got trade union status---*Paschimbanga Griha Paricharika Samiti* (PGPS-West Bengal Domestic Workers Society), the *ayahs* who were interviewed, do not belong to any union, nor do they have any group. Though during the interviews, it became clear that many *ayah*s, wanted some sort of collectivization, but the centres who find work for them are not too keen about it. Most of the *ayahs* thought in favour of pension schemes, paid leaves including sick leaves and Employee State Insurance (ESI) benefits. It needs mentioning that *ayahs* working in government hospitals at times get patronage from local political leaders, or get "protection" from union leaders of Group D staff, who in turn are also politically well-connected and thus have more bargaining power, when compared to *ayah*s working in domestic spaces.

Though *Nagarik Mancha* has been actively working to organize women domestic workers, little has been done to organize *ayahs* working in the lowest rungs of the care economy.

Research suggests that in a labour surplus economy like India, demand for labour would mean an increase in their bargaining power, but then again, 'product market competition' might affect company's profit earnings which might impact labour's bargaining power (Chakraborty, Chowdhury, Banerjee and Mahmood 2019, 4). Here 'company' implies the placement centres. However, what goes without saying is that neoliberal economy in a globalized world favours skilled, educated workers and unskilled workers are relegated to the margins. In such a situation, it is needless to say that women careworkers like *ayahs* working mainly in the informal sector have little bargaining power, for they are almost invisible in the eyes of the policy makers.

Out of 85 women interviewed in both domestic and institutional settings, an overwhelming majority of 79 stated that there is a need for collective action. 32 women acknowledged facing gender-based harassment in their work places, but there was no forum, which could get them justice. On complaining such an incident to the owners of the placement centres, the *ayahs*, were reassigned to some other household. 'Nobody (implying the perpetrators) ever got a simple warning', said Meetu Kar[25], working with an *ayah* centre, located in Salt Lake.

Out of 42 women, interviewed in institutional settings, all of them said that they did not have access to a changing room, neither could they access washrooms designated for nurses. *Ayahs* in government hospitals had to use old and dirty washrooms, while the ones working in private hospitals had access to cleaner washrooms. In patient's home as well, a lot of *ayahs*, reported that they had to use washroom for domestic workers or drivers located in the terrace or parking areas (in case of apartments).

6.11 Is it a journey from informalization to some form of proto-formalization?

As stated earlier, more and more placement centres started operating after women's involvement in the agricultural sector diminished. Change in family structures and with more upper- and middle-class women, coming out to work, their reproductive work is being taken care of, by another category of women. Earlier *ayahs*' entry in government hospitals was considered to be legal. They were always hired by patient parties but currently, they are illegally operating in hospital premises. People hired services of *ayah*s from hospitals or

[25] Interview conducted on 05.09.21. in Salt Lake.

nursing homes. Then centres started coming into existence and rise in demand for care at home coincided with more women entering informal care economy. Various unfortunate events forced the *ayah* centres to keep some form of identity proof for the *ayahs*. As a result of which these women had to submit a copy of their voter card or recently a copy of the Aadhar (Identity card for Indian citizens) card to the placement centres. It is also necessary to share the list of registered *ayah*s with local police stations, but this is something that is rarely done by the placement centres. The state through various mechanisms might try to do surveillance on this section of informal workers, by asking for various identity proofs, but the fact remains that many women do not have relevant documents. A few women reported having fake voter cards in order to get employment. So, despite attempts to reach a formal arrangement, this category of women operate in the informal economy, through informal contracts.

6.12 Wrapping up:

Nurses and *ayahs* are bound by such dichotomous relationship. One staff nurse associated with the Bankura Medical College, after the interview had said, *Shotti katha bolte amra oder* (*ayah) ghenna kori. Amader naam kore patient party er theke nana kajer jnyo taka tole* [To tell you the truth we hate them as they ask for money from the patient parties in our names]. However she did accept that when there is rush, *ayahs*, fix catheters for patients and get Rs. 10 from the patients, which the nurses do not mind. Annapurna Mondal, an *ayah* working in a government medical college and hospital in Kolkata had told me when I had asked how she feels when people say that they work there illegally, without any official designation, '*Eto tyak tyak kisher go? Nurse didira kokhono patient er pan ba chador dhorbe?*' ["What is the fuss? Will a nurse touch the soiled bed pans or would they touch their dirty linen?"] Both these categories of women are conscious of the role of the other, yet bound in an endless, mostly uneven (due to the hierarchical nature of their work) struggle for recognition.

In an attempt to sum up the overall findings of the research and also highlight its limitations, a brief discussion follows in the next chapter.