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Interpreting the landscapes of care for older men in Delhi and Kolkata: perspectives from care receivers and caregivers

Selim Jahangir, Ajay Bailey and Anindita Datta

Introduction

The geographies of care literature covers care practices in its many different forms and spatial structures (Milligan, 2017; Hanrahan and Smith, 2020; Power and Williams, 2020), including home-based care negotiations (Button and Ncapai, 2019) in everyday care practices. Recently the landscapes of care or caringscapes have started to be mapped, investigating how different spatial cares are practised and perceived by different people (Meier and Bowman, 2017; Bowlby and McKie, 2019). Care and care relationships are located in, shaped by and shape particular spaces and places that range from local to global (Milligan and Wiles, 2010). Similarly, Lawson (2008) argues that the way care is understood, experienced and practised is shaped by socio-economic and political contexts. McKie et al (2002), while defining 'caringscapes', brought up two important points. First, caregiving is a social practice, is gendered and it is determined by the creative strategies of caregivers (largely women) in both professional and family settings (Power, 2016; Williams and Sethi, 2020). Second, care should be viewed as a fundamentally social, economic and cultural relationship. In addition, it is important to mention that caregiving in the Asian context, particularly in India, is mainly carried out by women, especially spouses and daughters-in-law (Ajay et al, 2017; Ugargol and Bailey, 2020). Female family members, traditionally, are expected to take care of older adults and children (Pillai et al, 2012; Ugargol et al, 2016). The synergy between the gendered nature of caregiving and its spatial dimension essentially engender the contextual caringscapes.

Caringscapes are developed through an individual's involvement with varied social landscapes of care, caregiving roles, employment and social policies, and gendered and generational expectations of care and work (McKie et al, 2002). To understand 'care', one needs to consider all those who are involved in the care relationship because the nature, extent and

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form of these relationships are affected by *where* they take place (Milligan and Wiles, 2010). Therefore, care is not only interpersonal relations but also people–place relationships. Critically, landscapes of care are both product of and produced by the social and political-institutional arrangements for care.

Ageing, care and geography

Geographers have long been unravelling the complex relationships between people, place and care through different philosophical and methodological frameworks (Schwanen et al, 2012). Geographers in the field of ageing have termed this interdisciplinary body of knowledge 'geographical gerontology' (Andrews et al, 2009). The work of Rowles (1986) and Laws (1995, 1996) has pushed the boundary of geographical gerontology to the understanding of geographies of ageing. The influential works of Harper and Laws (1995) provided the second wave leading towards the specialisation of 'geography of ageing'. Based on the second wave of inquiry the scope and nature of contemporary geographical research on ageing has tremendously expanded (eg, Andrews and Phillips, 2005; Hopkins and Pain, 2007; Cutchin, 2009; Del Casino, 2009; Hardill, 2009; Schwanen et al, 2012). Geographers working on ageing are contributing to our understanding of the delicate relationships between human geography and social gerontology. Currently 'geographies of ageing' incorporates work on ageing across sub-disciplines, particularly in health geography, population geography and social geography (Andrews et al, 2009), whereas studies on geographies of care have been concerned with relationships between people, place and (health) care (Milligan et al, 2007). Geographers working broadly within this field also address the issue of formal and informal caregiving, relationships between paid caregivers and care recipients within new settings and the changing meaning and nature of home (Milligan and Power, 2010; Milligan and Liu, 2015; Wang, 2019), as well as people's relationships with particular parts of the city, voluntary and community care settings, palliative care settings (Andruske and O'Connor, 2020; Croucher et al, 2020). Other studies have considered the impact of transitions particularly in relation to caregivers and older people (Monkong et al, 2020). However, majority of the studies on ageing and care are in Western contexts and very few have been conducted in the Indian context.

Only recently have social scientists and social work professionals have started working on the emerging issues of the living conditions of older adults in different parts of India. The initial studies were mainly focused on examining the issues related to the social, psychological and health problems experienced by older adults and assessing the impact of various schemes meant for the welfare of older persons. Most of the studies were based on secondary data collected on issues like age and sex structure, rural–urban

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residence, literacy, marital status, work status, dependency status, disability and health status (Ramamurti and Jamuna, 2005 as cited by S. Siva Raju, 2011), whereas the study of ageing through a geographical perspective is rarely found. However, some studies have focused on spatial care practices including institutional care, living arrangements and emotional attachment in India (Ugargol and Bailey, 2018; Pazhoothundathil and Bailey, 2020). In the absence of contemporary work in geographies of ageing couples with changing social and physical contexts of ageing in India, this chapter seeks to interpret the landscapes of care – the spatial expressions of the relationship between the socio-structural processes and structures that shape experiences and practices of care – of older men through the perspectives of care recipients and their caregivers. In this chapter we investigate the landscapes of care or caringscapes of older men living in homes and institutional care centres in two metropolitan cities in India: Delhi and Kolkata. We also explored how care practices are grounded in different spaces over which the older men and their caregivers repetitively engaged in routine activity and (re)shaped caringscapes.

Conceptual framework

Caring relationships can involve varying degrees of emotional attachment in a variety of settings producing complex 'landscapes of care' or 'caringscapes'. Caringscapes develop through an individual's involvement with varied social landscapes of care, caregiving roles, employment and social policies and gendered and generational expectations of care and work (McKie et al, 2002). Therefore, to understand 'care', one should consider care relationships because the nature, extent and form of these relationships are affected by *where they take place* (Milligan and Wiles, 2010). Hence, care combines both interpersonal relations and people–place relationships. Critically, landscapes of care are both the product and produced by the social and political-institutional arrangements for care (see Chapter 11 for the obligations to care for older adults). Landscapes of care are multilayered because they are shaped by issues of responsibility, ethics and morals, and by the social, emotional, physical and material aspects of caring. This includes support, services and the spatial politics of care (Brown, 2003). Hence, caringscapes are embedded in the multilayered genderscapes that are, in turn, shaped by women's lives in spaces that differ widely with respect to their traditional role, degree of mobility, participation in society, agency and autonomy (Datta, 2011).

Here we examine how caringscapes overlap with the genderscapes. Drawing on Appadurai's (1996) concept of the 'scape', Datta (2011) defined genderscapes as a fluid and multilayered space. Akin to genderscapes, caringscapes are complex and dynamic over which care is

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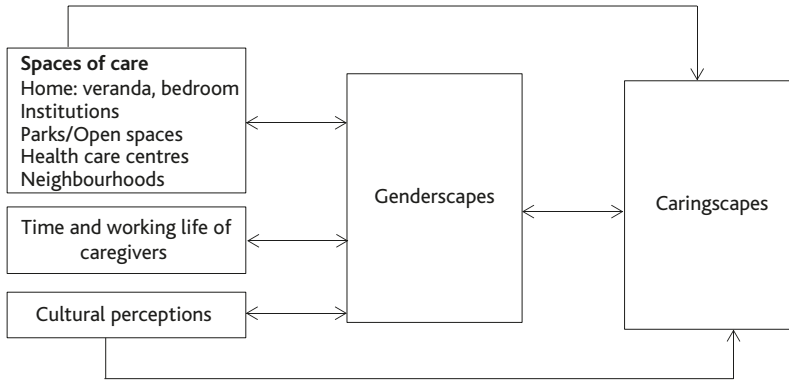
Figure 8.1: Conceptual framework caringscapes of older men embedded in multilayered genderscapes



perceived, performed and transformed. It includes institutions, homes and neighbourhoods and is the product of the space over which it is constructed. In addition, due to changing family structure, the living arrangements and care of the older men are also being influenced as the young generation is engaged in working life to meet the essential needs (Ahlin and Sen, 2020). Therefore, there is an increasing trend to shift to the institutions due to lack of caregivers in the home.

Traditionally care for older adults is gender-specific in Indian society, where women are considered the primary caregivers. The responsibility of caregiving goes mainly to wives, daughters-in-law, daughters living at home (Ugargol and Bailey, 2020) and to female caregivers in institutions (Pazhoothundathil and Bailey, 2020). In this study both the home and institutions are overwhelmingly represented by female caregivers. Lin and Wolf (2020) found that adult daughters are more likely to be caregivers to both mothers and fathers than adult sons. They argued that daughters provide more domestic assistance and personal care to older parents, whereas sons perform more traditional roles for men such as home maintenance chores and financial or managerial assistance (Fingerman et al, 2020; Roth, 2020).

Participant recruitment

The study applied a qualitative research design. The methods employed included in-depth interviews, the non-participant observation and field diaries. A total of 79 in-depth interviews were conducted, of which 47 were older men and 32 were their caregivers. Out of these 47 older men, 25 were from Kolkata and 22 were from Delhi. Among the caregivers 17 were from Kolkata and 15 were from Delhi. Participants were selected through purposive sampling and interviews were conducted until data saturation was

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achieved. The data were collected in the months of June, July and August 2013 in Kolkata and in the months of December 2013 and February and March 2014 in Delhi.

In this study two types of institutional caregivers have been included: those who are paid directly by the care recipient and those who are paid by institutions. We also recruited some paid caregivers who provide care to more than one older adult in the institutions. Seventeen older adults and 13 caregivers have been taken from institutional care centres in Delhi (see Table 8.1). In Delhi, due to constraints in accessing the older adults living at home, five older men and two caregivers have been included (see Table 8.2). The constraints were mainly due to the age and gender of the first author who collected the data. Older adults did not allow the author to interview the *bahu-betiya* (daughters-inlaw and daughters) as it is not culturally acceptable for an unrelated male to talk to the women of the house. In Kolkata 13 older adults and 12 caregivers from institutional care centres (see Table 8.1) and 12 older adults and 5 caregivers from private homes were interviewed (see Table 8.2).

Ethical considerations

The older adults and their caregivers were provided with information regarding the purpose of the study and the interviews. We also sought the participants' verbal consent regarding the recording of the interview and taking of photographs. Participants were allowed to read the introductory part of the in-depth interview guide. Before conducting the interview, the first author had introduced himself with the purpose of the study and produced his university and residential ID to each older adult and their caregivers both in private homes and institutions. In addition, their names and addresses have been kept confidential. In the process of recruiting the participants, ethical issues arose, of which the core issue was the permission for interviewing the participants. The researcher had taken full permission from the New Delhi Municipality Corporation for interviewing the older men and their caregivers living in the institutions in Delhi. In the institutional care centres in Kolkata, we were allowed to interview the older adults and their caregivers with the first author's university card and department letter.

Interviews and observation

The in-depth interviews were conducted in the institutional care centres (commonly known as old age homes in India) and private homes in both cities. An in-depth interview guide was used for the personal interview of the older men and their caregivers. The interview guide was prepared in English but was translated into Hindi and Bengali. There were few participants who

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Table 8.1: Profile of participants living in institutions

Name	Age	City	Previous occupation	Caregivers (interviewed)
Brijesh	72	Delhi	Fruit seller	Carer paid by institution
Charanjeet	90	Delhi	Clothes marketing	Carer paid by institution
Jagdal	75	Delhi	Cycle repairing	Carer paid by institution
Kamal	74	Delhi	Car mechanic	Carer paid by institution
Kirti	76	Delhi	Comptroller and Auditor General of India	Carer paid by receivers
Krishna	76	Delhi	Assistant private secretary	Carer paid by receiver
Madan	86	Delhi	Senior account officer	Carer paid by receiver
Manmohan	66	Delhi	Telegram officer	Carer paid by receiver
Narendrapal	62	Delhi	Businessman	Carer paid by receiver
Piyush	79	Delhi	Managerial post in Railway Ministry	Carer paid by receiver
Praveen	64	Delhi	Worked in food company	Carer paid by institution
Rajesh	73	Delhi	Chief telecomms engineer	Carer paid by institution
Ram Mohan	70	Delhi	Work at cold storage	Carer paid by institution
Ramesh	70	Delhi	Handyman	Carer paid by institution
Sunil	70	Delhi	Plant supervisor	Carer paid by receiver
Vishwanath	84	Delhi	Worked in technology company	Carer paid by receiver
Amit	77	Kolkata	Medical representative	Carer paid by receiver
Subhas	65	Kolkata	Businessman	Carer paid by institution
Subodh	65	Kolkata	Security guard	Carer paid by receiver
Sudhir	87	Kolkata	Politician	Carer paid by institution
Sukumar	80	Kolkata	Teacher	Carer paid by receiver
Tushar	75	Kolkata	Doctor	Carer paid by receiver
Anil	86	Kolkata	P.R.O. in Air India	Carer paid by receiver
Elvin	77	Kolkata	Engineer in railways	Carer paid by receiver
Kalipada	77	Kolkata	Printing department	Carer paid by receiver
Panchanan	87	Kolkata	Worked in Bengal club	Carer paid by receiver
Somoresh	88	Kolkata	Typist	Carer paid by receiver
Shakti	61	Kolkata	Rail controller	Carer paid by receivers
Tushar	75	Kolkata	Medical doctor	Carer paid by receiver

Note: All names have been anonymised.

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Table 8.2: Profile of participants living in private homes

Name	Age	City	Previous occupation	Caregivers (interviewed)
Anil	86	Delhi	Lab assistant	Married son
Harish	76	Delhi	Administrative officer	Divorced daughter (not interviewed)
Mangat Ram	65	Delhi	Chemist shopkeeper	Daughter in law
Subhramaniyam	75	Delhi	Typist	Wife and daughter (not interviewed)
Sunheri Lal	70	Delhi	Farmer	Sons and daughter in laws (not interviewed)
Abdul Kalam	92	Kolkata	Mechanic	Wife and daughter in laws (not interviewed)
Manju Nath	75	Kolkata	Receptionist,	Wife
Ramesh	72	Kolkata	Transport conductor	Wife and daughter in law
Anwar Ali	68	Kolkata	Worked in bakery	Wife (not interviewed)
Bholanath	68	Kolkata	Central government	Wife (not interviewed)
Bimal	103	Kolkata	Worked in timber storage	Son
Koushik	72	Kolkata	Worked at textile factory	Son and wife (not interviewed)
Biswanath	86	Kolkata	Businessman	Daughter (not interviewed)
Dipankar	74	Kolkata	Consultancy firm	Wife (not interviewed)
Joydeep	79	Kolkata	Worked in Steel Authority of India	Wife
Malay	71	Kolkata	Civil engineer	Wife (not interviewed)
Bapendra	75	Kolkata	Chairman, Co-operative Housing Federation	Wife

Note: All names have been anonymised.

preferred English over the local language for the interviews. For older adults living in private homes, most of the interviews were conducted in park spaces where they go to meet fellow older adults in the afternoons. Parks were selected so that they could share their everyday life experiences away from their family members. Some of the older adults living in homes who were unable to walk properly were interviewed in a separate room. The interviews of the institutional care receivers were conducted in their personal rooms and in open spaces at the institutions. Additional information was collected through observation as it was felt that interviews alone could not reveal the differences of what the participants actually do and what they say (Hennink et al, 2020). It also helped to cross-check the information shared by the participants in their interviews on particular issues, such as behaviour

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towards each other. These observations were noted down in the field diary during the field study and incorporated while explaining the contexts.

Data analysis

This study is based on the personal interviews data that were digitally recorded and transcribed into Bengali and in Hindi. All the transcribed data were translated into English. The interviews were analysed with the help of WeftQDA, a software package for qualitative data analysis. This software helped to develop codes and categories from the participants' stories. Then, each of the code families was described comparing different statements and quotes made by the participants. After that, these descriptions were contextualised further with the observation data. The main code families that emerged in the study were perceptions of care, caregivers, medical care, economic care and perception of the younger generation by the present older adults. For this chapter, the code families such as perceptions of personal care, emotional care, medical and economic care and cultural perception of care have been used to explain the context. These perceptions have come out of both the deductive as well as inductive methods of data collection. Perceptions such as personal care, economic care and medical care have been collected through the deductive method, whereas perceptions relating to emotional care and cultural perception of care emerged through the inductive method. The results are analysed with the narratives of the care recipients and the caregivers and their emotional attachments and relationships with the people and place.

Caringscapes of Delhi and Kolkata: narratives of care recipients and caregivers

In this study the caringscapes or the landscapes of care involve the perceptions of care and the perceived appropriate location of care for older adults. Here the caringscapes are mapped and inferred based on the narratives of the care receivers and the caregivers in both the spaces, that is, in institutional (public) spaces as well as in homes.

Perceptions about care and its transactions over varied space

In their in-depth interviews, the participants expressed their varied perceptions of care or *Dekhbhal* (Hindi) or *Dekhasona* (Bengali). Both these terms encompass physical, social, economic and emotional care. Older men perceived that meeting their needs was the care they expected. These needs ranged from small tasks such as bringing tea, exhibiting good behaviour and showing sympathy, to higher-order needs such as food, health care, clothing, cleaning, financial support and emotional attachment. All these care activities

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take place over spaces which range from home to neighbourhoods. Within homes, there are certain spaces where older adults spend more time and develop emotional attachment with those micro spaces. Similarly, in the institutions the older adults also nurture emotional attachment with different types of cherished possessions including material and memorial aspects that act as sense of co-presence (Pazhoothundathil and Bailey, 2020), thus creating unique caringscapes in the older adults' immediate surroundings. The caringscapes, in turn, also produce different meanings of care embodied with perceptions and cultural practices.

Perception of personal care or *seva/seba*

Personal care is perceived to be the most sensitive and is seen to be accompanied with emotional attachments to the receivers and givers. This is known as *seva* in Delhi and *seba* in Kolkata. It includes assisting the older adults with personal hygiene or physical care including bathing and dressing, and with activities of daily living including meal preparation and feeding. Personal care and supportive social relations play a major role in emotional well-being and physical health (Gyasi et al, 2020; Reynolds et al, 2020). In this study the older adults perceived that *seva/seba* have more emotional attachments with each other when compared to *dekhbhal* or *dekhasona* because *seva* or *seba* are associated with personal care including touching and massaging the body. Older men perceived that such kind of personal care is only given by the family members, specifically daughters and granddaughters, which reflect the gendered nature of such care practices. The older adults perceived that geographical distance is not a barrier for care since their children, particularly daughters, can provide care from distance. The older adults living in the institutions also perceived that they get emotional support and care when their daughters visit them.

> 'I have my daughters as well who also take care of me. They know how to take care of daddy. From their childhood days they know what I like and what I don't. Even after marriage they call me every day from their in-law house. I am so lucky with my daughters. My younger daughter is a service holder, and she brought Horlicks and gave me. They called their mother every day that whether I am regularly taking it or not because I forget to take. I cannot disagree. They are doing lots for us.' (Shyam Prakash, 79, institutional care receiver, Delhi)

Older adults living in institutions viewed material care including providing clothes and other gifts as not being *real* care. They perceived that the *real* care can only be provided by own children or family members, preferably spouses or daughters. Here, the care receivers reflected that *seva/seba* has

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emotional attachment which gives them life satisfaction (Lin et al, 2020). But for the institutional care receivers *seva/seba* means spontaneous care from caregivers. Some of the older men living in institutions perceived home as the best place for care but lack emotional and personal care from their children (Chapters 9 and 10 present different experiences of older adults and motivations to choose an old age home). The images of care practices that embodied different roles and responsibilities also shape the caringscapes of the older men as these are rooted in the real spaces.

> 'Actually personal opinion comes from core of my heart. The care which own blood can give we cannot expect from anybody else. I get only economic care. If I need they are ready to give me financial care, rest religious, social, emotional it is all missing. You must have an emotional touch you must have an ethical touch, with your family members. You must interact with them daily on the dining table or whenever or whenever you get time you must interact.' (Brijesh, 76, institutional care receiver, Delhi)

On the other hand, most of the caregivers saw older adults as demanding, and that they have to pay heed to all those demands so that the older adults would not feel deserted and neglected. The results revealed that older men want more time from their caregivers and the institutional caregivers cannot spend extended amounts of time with each individual older man. Instead, they sit on the veranda or in open spaces where the older adults and caregivers talk mostly in the mornings and the evenings. Due to time constraints, the caregivers in institutional care centres manage to support the older men in various creative ways in everyday care practices. Caregivers mentioned that they are more careful about the health of the older adults and that is why they try to ensure that they have a proper diet.

> 'If I feed someone, I will consider that as care. Someone asks me to do something, I do that; it will be a care. If I cook something for them, they become happy. I rub oil in their heads or offered them tea. For me these things are care. I give medicine with hot water three – four times in a day then he gains some energy.' (Madhabi, 42, institutional caregiver, Kolkata)

Cultural perception of care

By 'cultural perception of care', the care receivers and caregivers refer to the practice of traditional forms of care. Historically, family members used to care for the older adults unconditionally – there were no substitutes. One of the care receivers, Manjunath, (see Table 8.1) perceived that in the past

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the older adults had been shown respect which he thought was missing in current society. Some of the societies in rural India guaranteed power, honour and respect to the older adults (Pongiya et al, 2011). One of the major reasons for caring for older adults with veneration and respect lies in the fact that the children would become the heir of the property, land in particular, after the death of the older adults. Older men in their interviews had in general negative perceptions on the cultural care they received and they provide varied reasons for it such as 'lack of *sanskar* [cultural values]', 'fault in cultural upbringing', 'modernity', 'women's work participation' and 'independence and liberty'. Both the older men and their caregivers perceived that the care was much better in the past than in present times. This traditional form of care was viewed to be emotionally closer than what they received now. Chirkov et al (2005) found that cultural care is positively associated with life satisfaction.

> 'We would really look after our parents, love and respect them. We would take care of them before they would ask us to do it for them. But now, we have to tell them if we want to be looked after. We could understand what our parents would need and accordingly we would give them that before they even asked us.' (Manjunath, home care receiver, Kolkata)

> 'See I have taken care of my father and mother with great respect. I used to take care of them before they would ask to do for them. But now, I have to tell them if I want to be looked after.' (Sunheri Lal, home care receiver, Delhi)

The older adults perceived that it is the cultural upbringing of children that will determine whether they will receive care from the next generation and this upbringing encompasses the cultural landscape. Hence, the caringscapes of older adults are fashioned out of the cultural landscapes of Indian society. The predominance of women in care practices has constructed stereotypical notion that care is women's work and, hence, the caringscapes are also perceived to be gendered in nature.

Health care

As older adults are more likely to develop chronic health conditions, they need more health care with increasing age (Dey et al, 2012). In India older adults who are above 65 years spend on average 1.5 times more on health care compared to those in the 60–64-year age category (Mahal and Berman, 2002). Some of the participants, therefore, have given more significance to health care than other aspects of care. It has also been found that those who

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prioritised health care are either suffering from some ailment or condition, or that they are satisfied with their basic needs of food and shelter. On the other hand, it can be said those who are from relatively poor families prioritised the personal care, that is, food and family attachment, leaving aside health care. Even health insurance for Indian older adults is limited by low coverage of populations. According to the National Family Health Survey (2004–05) only 10 per cent of households in India had at least one member of the family covered by any form of health insurance (IIPS, 2007). Previous studies have established that older adults who were in government service, such as the civil services and railways, receive free medical services and feel secure about medical care (Acharya and Ranson, 2005; Pati et al, 2019). This study, in addition, found that the older adults go alone to health centres or hospital for their regular check-ups. Meanwhile, some of the older adults who were not getting free treatment were quite concerned about their health care and dependent on their children's help in this aspect of care.

> 'And for medical treatment I go to a doctor (whom my son told to take care of me) who is our family doctor. He advised me to go through thorough check up in every two or three months.' (Kamal, home care receiver, Delhi)

> 'For me the most important care is health care because I have blood pressure, then I do have a sleeping problem. I have to take the tablet before I have to go for sleeping. I cannot have a proper sleep. For this type of care the medicine is required which my daughter used to bring for me. When I ask for medicine she immediately bring it for me. If I say that this medicine has finished she immediately brings that.' (Malay, 71, home care receiver, Kolkata)

In an exceptional case one of the institutional care receivers in Kolkata responded that for health care he himself makes the medicine from medicinal plants. He reads a lot about medicinal plants for his health as he has very little faith in modern medicines. During the interview he showed his belongings which mostly consist of books and he did not forget to show his bed which was full of medicinal books (see Figure 8.2). He even kept the books under his bed. According to him these are the things which he considers as resources and part of everyday life. This also shows the place attachment of the older adults and the role of books, constituting the part of their landscape of care.

On the other hand, the home caregivers are not so concerned about the medical care of the older adults. Participants revealed that they do not wait for their children's help when they need to go for a medical check-up. In some cases the older adults go alone as they do not want to become a

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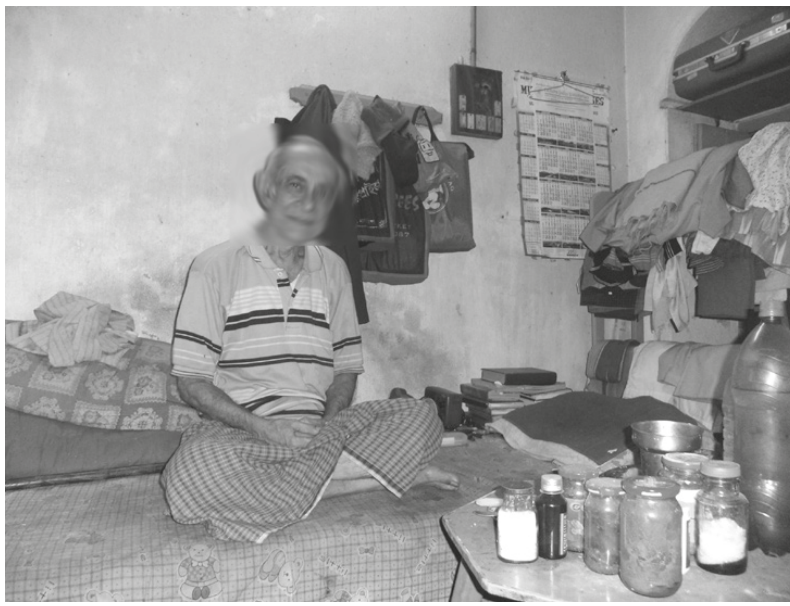
Figure 8.2: Institutional care receiver with his belongings in Kolkata



burden to their children. It was also reported that the family members only accompany the older men when they need to travel far for treatment or to attend appointments for a serious illness. The caregivers perceived that they do not want to take leave from their job to accompany their parents to appointments for minor treatments.

> 'See for medical treatment we go for the University Health Centre. He can go health centre alone but whenever he needs to go outside then I accompany him.' (Suresh, home caregiver of Anil, Delhi)

> 'I buy my own medicine. I have my money to buy them but those are not available here. My sons do not do those works. Since my medicine is not available here I have to go outside and get them. The medicine alone costs me 800–1000 rupees in a month.' (Bholanath, 68, home care receiver in Kolkata)

Economic care

Traditionally the family provides economic support to older adults in India (Rajan et al, 2020). The interviews reveal that the older adults drawing pensions consider that economic assistance as just one part of care. For them

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it is merely a means of surviving; care has other aspect to it, which are more important than this.

> 'Not at all. Money cannot provide you care. You cannot purchase care by money; money is not everything. You need money but it cannot solve my care.' (Anil, home care receiver, Delhi)

On the other hand, there were some older men who considered economic care as the most important element, as other parts of care – such as living arrangements – are dependent on this economic support. Previous research (Bongaarts et al, 2001; Aguila et al, 2020; Mudrazija et al, 2020) on the link between living arrangements and economic care also supports the importance of economic independence. Mahajan and Ray (2013) mentioned that between 60 and 75 per cent of all older adults in India are economically dependent on family members – usually on their children. Here, once more, the gendered nature of care for older adults in terms of economic care reflects the prevailing pattern of caregiving. Many older participants reported that their sons are primarily providing the economic care to them.

> 'My sons do, especially my younger son have done a lot. I had undergone an open surgery at Apollo. My son had spent his money then.' (Manju Nath, home care receiver, Kolkata)

Home caregivers are of the view that it is their duty to provide economic support to the older men as they are living a retired life. Children stated that their parents brought them up and now it is time to return the favour in terms of economic support, along with other forms of care.

> 'We give the money, otherwise who else will give. They are leading a retired life; there is nobody else to look after them other than us. We do this.' (Madhabi, home caregiver of Ramesh, Kolkata)

On the other hand, institutional caregivers perceived that economic support is secondary, and that other aspects of care are more important. Nowadays, most of the older adults have their own source of economic support but for them that holds little meaning, as they seek closeness of family members and other relatives.

> 'People come to my NGO and say that they can give monetary help, but they can't devote time. All that the older adults need is someone to attend to them and talk to them. Money is secondary matter.' (Veena, institutional caregiver, Delhi)

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Depending on their socio-economic status, older adults decide on the location for their care or living arrangements (see Chapter 10 on pathways into care homes). Some of the older adults who are economically better off shifted to high-quality institutional care centres, whereas most of the older adults prefer to stay in government-run institutions. Older adults also develop emotional attachments with the caregivers at the institutions and consider them as family, even sharing their thoughts with them. Therefore care practice has become a normative experience. Care of older adults living in homes, however, still depends on the caregiver's income and other benefits. When a caregiver gives up a job or reduces their work hours, the economic care of the older adults is affected. Besides, the quality of everyday care of older adults living in institutions also depends on their own economic circumstances. Therefore, the economic context operating at the individual to wider society level and in public or private spheres (Wiles and Rosenberg, 2003; Milligan, 2009) shapes the varied landscapes of care.

Discussion and conclusion

In this chapter we have sought to engage critically with some of the geographical debates around care of older men through their interconnected socio-economic and emotional aspects in the prevalent gendered nature of care practices. This is consistent with previous studies that documented the gendered nature of care practices in India, wherein care responsibilities are primarily borne by women (Pazhoothundathil and Bailey, 2020; Ugargol and Bailey, 2020). Such caregiving 'burden', primarily on informal family caregivers (especially women), is embedded in sociocultural norms, wherein caregiving is an obligation for women (Raschick and Ingersoll-Dayton, 2004). A number of substantial studies (see Bauer and Sousa-Poza; 2015; Mosquera et al, 2016; Ugargol and Bailey, 2018) have suggested that such caregiving burden has an adverse impact on the mental health and well-being of the informal caregivers. On the other hand, Mackenzie and Greenwood (2012), contended that caring has positive experiences as well, such as sense of gratification and notion of altruism among the informal home caregivers. These mixed notions of care practices made older adults' care dynamic and complex and, thus, substantiated the gendered nature of caringscapes by entrenching into cultural norms.

We made an attempt to understand the complex spatialities of care and care relationships through 'landscapes of care' in a subjective manner. The micro-level landscapes of care such as the hospital room, the home, open spaces/parks and the neighbourhood, underpins that the care does not only operate at inter-personal level but also at spatial level. These caringscapes are rooted in real space and encompass lived spaces from the micro to macro, that is, from homes and institutions to neighbourhoods, cities and countries. Recent studies

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on new geographies of care practices (see Kofman and Raghuram, 2015; Strauss, 2020) argued that care work is growing increasingly global and is being commodified. Besides, a number studies revealed how these interpersonal and global care relations are shaped by power relations and have fashioned care policies, particularly in economically more advanced societies with a higher proportion of older adults (Connell and Walton-Roberts, 2016; Strauss and Xu, 2018; Schwiter, Brütsch and Pratt, 2020).

It is evident that the caringscapes are shaped by the perceptions of 'care' and dyadic care relationships between the caregivers and care receivers embedded in their social and cultural settings. As Wiles and Rosenberg (2003) argue, care practices shape and are shaped by the social and physical characteristics of the numerous interconnected scales of different geographical locations and places that caregivers negotiate in their everyday lives. The current transformations of care practices globally, and subsequent policy interventions at individual and welfare state level, are giving rise to context specific caringscapes (Power, 2016). Caringscapes in the Indian context are deeply rooted in filial obligation and intergenerational dependence where older adults are entitled to receive care from children in exchange for the care they had provided to their children (Gupta et al, 2009; Ugargol et al, 2016). Once again this illustrates that the practice of intergenerational reciprocal care is strongly gendered and involves inequalities of power. Here, the care relationships between older men and their caregivers are situated within wider socio-economic contexts which influence the power relations between them (Milligan and Wiles, 2010; Kennedy, 2016; Power, 2016).

The results also demonstrated how intergenerational property inherent rights determine the care practices and power relations. Given the privilege of their property inherent rights and contribution to raise the children in India, the older men perceived that it is their right to receive care as the wealth will eventually be transferred to the children. On the other hand, the emotional attachment also comprises the affective dimension of caringscapes, since both the older adults as care receivers and their informal family caregivers traditionally engaged in reciprocal care practices. Hence, it is necessary for researchers and policy makers to understand the 'caring situation' in which the care is practised. Therefore, social and ethical contexts embedded in the cultural landscapes are a prerequisite for the broader framework of the caringscapes.

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