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Sleep and care: Narratives of nurses on caregiving and sleep

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Abstract

This article attempts to locate sleep as a form of care, through the narratives of caregivers. I use sleep as a lens to understand care-work and the lives of care-workers, as well as to locate sleep practices among care-workers. Through everyday forms of negotiations, and interactions with patients, this paper unravels narratives of nurses in Kolkata, India, during the time of the COVID-19 pandemic. This paper addresses the lives of these women for whom caregiving involves emotional labour that constantly spills over outside their spaces of work. Stories of interactions with patients are also narrated, to look at how sleep is not an isolated physiological process but dependent on social conditions as well. The most important part of this discussion is how sleep is a right, as well as a desire, and is demanded as part of the process of care-giving. The care-giver tends to others' sleep, but lacks their own. It is in this context that sleep is a demand made as part of care-giving, not just by caregivers themselves but as a part of the larger social responsibility.

Keywords

Gender, labour, care-work, sleep, pandemic, emotional labour, lived experience, medical care, women, health

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The past two years have witnessed an enormous loss of lives and emotional catastrophes globally. The pandemic disrupted the existing patterns and routines for some, and created new schedules that fit into the dictated rules and regulations of lockdown. The usual sense of 'working hours' shrunk for some, and also left many unemployed. However, this was not the case for frontline healthcare-workers, who had to put in more 'hours' in order to accommodate the crisis that the pandemic created. This essay captures the narratives of nurses in particular, whose labour was significant in saving lives during the time of pandemic, at the expense of their own physical and emotional well-being. The paid and unpaid care-work performed by the nurses during this time, is tied to the performing of sleep, as a matter of central concern. This paper looks at the fraught relation between care-work and sleep, drawing from the fieldwork on night nurses and care-workers in Kolkata, India during the COVID-19 pandemic.

Sleep has gained little traction in social science research, with even less concerned with a discussion on caregivers' sleep. Simon J Williams (2011; Williams, Meadows and Arber, 2010; Williams and Crossley, 2008; Williams, 2007; 2005; 2001; Williams and Bendelow, 1998) laid out the groundwork for allowing the sociology of sleep to flourish. Jenny Hislop,

Sara Arber along with others have put forth the gendered nature of sleep in the context of women in UK (Arber et al., 2009; Chatzitheochari and Arber, 2009; Meadows et al., 2008; Arber et al., 2007; Hislop et al., 2005; Hislop and Arber, 2004, 2003a, 2003b). This article looks at the experience of sleep among women who perform paid and unpaid labour of caregiving during an exceptional time of the COVID-19 pandemic. Through the literature on sleep, care and gender, this article examines how the narratives of sleep offers an insight into the inequities of sleep, that is at tandem with their socio-cultural position. The negotiations made by the women within the institution of healthcare and family, offers glimpses into the lives of these women at the intersections of different forms of labour and social structures. It is the 'doing' and 'event' of sleep that this article examines rather than the biological phenomenon (Taylor, 1993; Aubert and White, 1959).

Methodology

This article is an attempt to highlight the nature of caregivers' sleep through articulating their experiences, and drawing the relationship between care and sleep via qualitative approach. In-depth interviews (Saha, 2021) with 18 nursing aides and attendants (aged 25-53) were conducted within hospitals in Kolkata, India, which included both public and private hospitals as well as outside the premises of workplace[1]. Nursing agents, who were recruited by organisations that provide the service of "at home nurses", were also interviewed along with the others. Five nurses worked at an agency that sent nurses to homes for post-surgical care, or elderly care. Interviewing women was not only intentional but also a result of the fact that the labour force comprised mostly of women. Since most of the interviews were conducted during the lockdown period of 2021, I had to resort to telephone interviews as well. The interviews lasted around forty-five minutes and were later followed up, either in person or via telephone. The questions were open ended, allowing free expression of their perceptions. Women who worked in hospitals or as *ayahs* in home, were recruited through first contacting organisations and hospitals and then via snowball sampling.

The interesting thing about speaking to them on phone during the initial phase, was the time. I had a small window to speak to them, and that was during their commute in the bus while they were returning to their homes. The conversations involved sounds of car honking, people screaming and shouting, network issues, missing phrases and sentences. The time of every conversation could not be more than forty- five minutes, as they had to go for their dinner. For those who had night shifts, my window was the morning hour when they would return, because they would go back and sleep, and then the whole day never had a fixed free time. It required a lot of patience, both on my part to ask questions and on theirs to listen and respond. The entire fieldwork was a patchwork, with intermissions, breaks, disruptions in between, to finally come about as it has. However, some preferred to speak during their night shift duty. Interviews were also conducted in the middle of the night. The impossibility of being present in the hospitals initially, or having these conversations in person, might have resulted in loss of a lot of details, that might have been possible to

[1] The interviews were conducted in Bengali and Hindi, depending upon the convenience of the participant. The interviews quoted here are translated into English. The names of the participants are not changed, as they did provide consent to use it. However, nobody was comfortable in letting me use the name of the hospitals or organisation they worked in.

garner otherwise. Given the short window available every day, it often became exhausting to continue and start all over again. However, I continued to follow up via phone calls along with visiting them in hospitals, that gradually allowed us to develop a sense of familiarity.

Care in feminist thought

Caring or care-work has been into discussion within the forefront of academia for more than fifty years now (Abel and Nelson, 1990). The issues that care-work brings to the fore are those of labour, labour of specific forms interlaced with gender and even race, ethnicity, class and economy. It also brings into prominence questions of morality, ethics and personal relationships (Mason, 1996). "Care is the activity of attending to others and responding to their emotions and needs" (Coltrane and Galt, 2000, pp. 16). However, responding to others needs is not uniform but is rather constantly changing. The emotions and needs are also dependent on the social and cultural norms (Woodly, et al., 2018). Thus, care needs to also be administered based on understanding and interpreting the needs and emotions of individuals as well as social and cultural norms. Care-work is the kind of work that accommodates affective relationships, and is thereby specific and very different from other kind of services that late capitalist economy produces. The work performed is physical, emotional, intellectual, and social.

Care-work, in particular, also involves emotional labour or "emotion work" (Hochschild, 1983), where the caregivers exchange emotions with the recipients. This emotion however is managed for a specific purpose, in this case, as a responsible employee whose role is to provide care duties, without 'feelings'. Care-work also involves body-work, where one assesses, touches, monitors, treats, handles other bodies, where the workers can be a subject of power or exercise power over the bodies that they constantly handle (Twigg, et al., 2011). Care-work often involves a sense of affective connect that might be sustained over a period of time, even when this arrangement is through paid employment. Care-work both formally and informally is performed mostly by women, globally. Silvia Federici in her work, *Wages against housework* (1975), argues how capitalism formulates this kind of work as 'love' and unwaged labour. The invisibilisation of house work, including care-work, stemmed from the absence of any form of social contract. The absence of wage allowed this to be transformed into a natural attribute rather than a socially, rather economically, constructed phenomenon.

Jennifer Mason (1996), on the other hand, tries to conceptualise care as a sentient activity and active sensibility, by bringing together the debates on care as love and care as labour, attempting to transgress the distinct dichotomies. In this context, women are both involved in paid and unpaid care duties, where distinctions between emotional and physical labour become complex, along with the association with organisation (James, 1992). The care duties involved in the workplace and the one performed within the household have differences yet are activities that are sentient, time consuming, detail oriented, and often at par with socially sanctioned norms. The social norms here are associated to women, thereby making this a gendered labour. However, there is pertinent evidence of negotiations in our everyday lives that indicate the numerous choices made even with already prescribed duties.

The work of a nurse, nursing aide or attendant comprises of duties that are also done by domestic workers, like cleaning, or reproductive labour (such as feeding, sponging, tending to any form of bodily discomfort, etc.). But it also involves the skills required to administer medicine, taking temperature, inserting catheter, lifting or carrying the bodies, which require a certain amount of physical strength. This is also accompanied by the requirement to soothe the patients, keep them company, which makes compassion a significant aspect of their work. Thus, their labour involves a range of menial tasks to affective labour which requires a special combination of skill. This article analyses the complexity of this work, that with along professionalization, expects distance and disassociation from patients, but often puts the burden of this on the workers both physically and emotionally. They ensure calm amidst the chaos, and cleanliness amongst contamination. They often not only tend to the patient's bodies but also those of their family members, cleaning not just the body but also the environment. Thus, this kind of work is constituted by myriad forms of labour, which are difficult to sum up within a single rubric.

Care in the Indian context

In India, women's work is complex because of the identities associated to specific forms of labour. The 'dirty' job of cleaning has a history of caste hierarchy and oppression associated with it (Sen, 2009). It is based on a social identity that accompanies abjection, stigma and exploitation. When the conversation on 'women's work' within India comes to the fore, it is cleft into caste and class identities. Thus, not only is the category of 'women' not homogenous, but the kind of labour performed by them is also diverse and often associated with caste and class identities (Ray, 2019). The bodily labour within a family is often outsourced to women belonging to the margins, thereby often creating a crisis within their own families (Bhattacharya, 2017). However, the multitude of kin networks often allow certain tasks to be shared. But even then, there remains a certain distancing of specific kinds of work by upper caste and class women, which are then assigned to women in the labour market. What continues, however, is the feminization of all of the affective, communicative, emotional labour, fractured on the basis of social and cultural identities.

The umbrella category of 'nurses' which is more professional and the informal categorization for instance those of *ayahs* is difficult to distinguish in India. The formalization of the profession, by registering nurses through training is only recent and minuscule. There still remains vast number of unregistered nurses or *ayahs* who continue to work within the informal labour market. A common sight within the hospitals is this hierarchy between the trained nurses and *ayahs*. The nurses are employed formally by the hospitals, whereas the *ayahs* continue to tend to patients and other menial tasks without proper wages. In one of the hospitals I visited, the job of the nurses was only to administer medicines, make hourly check-ups and keep notes on patients' conditions to be reported to the doctor. The cleaning, feeding, changing of clothes, and other menial, 'dirty' jobs had to be done by *ayahs*, who were separately paid by the family of the patients, and not by the hospitals. Thus, this essay tries to locate sleep, amidst this complex socio-political relation, and capture the care-workers' perception of their own sleep.

Sleep and Space

When labour, or work, comes into question so does the issue of rest, or sleep. The body that sleeps is equally significant as the body that labours. This section looks at how sleep is organized around labouring hours, by de-prioritising it.

Among my interviewees, there are two clear demarcations of space- the places they work (hospital or other people's homes) and the place they go back to after work. Some of my respondents live in hostels which are shared by other women as well. Some, on the other hand, go back to their families, comprised of three people or more, which also meant continuing with care duties after work[2].

Those who lived in the hostel did not have cooking, cleaning or any other responsibilities. They only had to change clothes and have dinner (which was made by a cook). They had the liberty to sleep without having to attend to others' sleep needs. But their sleep, or specifically the quality of sleep, did depend on the other people sleeping in the same dormitory. Given so many of them slept together in a room, frequent commotion did cause sleep disruptions.

> **Ranita (30):** Often just as I fall asleep, someone starts talking loudly or closes the door so loud that it wakes me up, and then it becomes difficult for me to sleep again. I am a light sleeper, so the slightest noise interrupts my sleep... sometimes I have to ask them to be quiet.

> **Anjana (28):** After reaching the hostel, I take a bath, wash my clothes, have the breakfast which is given, and then go off to sleep... Usually I am so exhausted, I immediately fall asleep, but sometimes it is difficult. But mostly sleeping at night is more difficult than during the day, which is strange, because initially it was the opposite. Over the years, night shift work has increased, which makes it easier to sleep during the day, rather than at night. After a few consecutive days of night shift, I lay wide awake on days when I have morning shift, and then have difficulty waking up in the morning. So, there are days when I work with very little sleep.

The natures of my participants' sleep were dependent on the circumstances, with no adherence to socially prescribed time. Since their sleep is tied to issues such as the time of commute, time of labour and time of every other quotidian chore, there remains a constant lack/leftover. There remain the memories of pain, injuries, traumas, death, bodily remains of fatigue, commutes and every other movement that culminates at the point of sleep. There is a greater sense of freedom of movement and of stillness in the space of hostels, because of no attachments or relationships that require attention, apart from themselves. They do not quite have to worry about the other's sleep: not in the sense that they might disturb someone's sleep, but more so that they are not responsible for it.

[2] None of my respondents lived alone. Some lived in hostels, where the rooms were shared by others. Others lived with their partner, and children. In most cases in-laws were also residents in the same household.

> **Anjana (28):** This is the only time where sometimes I sleep peacefully, because the bus is not crowded and sitting by the window helps me to sleep. It is better than my own bed. It's not like I don't like my roommates. It's good to come back to people who understand what we go through, but sometimes there hardly is time to think or even listen to music without ill patients around…sorry I don't mean it to sound it like that.

The commute, as I mentioned, becomes an integral part of their lives. Napping in public places is quite common, particularly in a city like Kolkata. So, falling asleep on the bus is quite normal. But what then arises is the guilt that accompanies her statement. This guilt of trying to have little space for themselves seems to stem for the ethics of nursing they have been trained in. The expectation to care, to tend to people and their comfort somehow translates to undermining their own feelings in order to align with what is expected. Somehow saying that they want to a little time alone seems inhumane to them. Being healthcare-workers, they feel that they are supposed to take the burden of everyone's care.

> **Namita (40):** Night shift work became difficult after I got married. I mean I can't sleep during the day, there is so much work. Cooking, cleaning, and after kids… just don't ask (laughs). I used to be so tired, my eyes would burn at times, but thankfully God created afternoons, I slept peacefully. My husband used to be out at work, my in-laws also slept, I had nothing to do. After few years, I sometimes slept for like an hour or two during the day, but then I felt guilty as my mother-in-law then had to cook. Moreover, my husband faces difficulty if I'm not around in the morning, so I stopped sleeping. Now, since I am in administrative duties, I don't have to do night shifts, unless it is absolutely necessary. I think after a while I used to sleep when I can, the rest just continued… Having a kid changed things, especially with respect to time. It was so difficult to manage all at once. I have been in night shifts taking care of patients, so staying awake at night was not the problem, but somehow it was a lot more difficult to have a crying baby in my arms. Caring is part of both my job and at home, in a sense it is my duty. I cannot stop doing that. My mother-in-law helps with cooking, but mostly it's me. The administrative duty allows time for the kids, otherwise I don't know what I would do (laughs). But it's not like I can't manage, I do it all.

Namita's experience of reproductive labour, parenting as well as performing body-work expressed the interlaced reality of the gendered body. This experience was different from the previous ones. Namita's sleeping pattern is not just informed by her own choices but by the kind of gendered labour that she performs. Not only does her formal care-work inform her sleep, but so does her reproductive labour. The distinct form of care that her child needed is distinguished by her, with a sense of urgency, that is both physical and sentient. She needs to tend to the children not only while they are awake, during the day or night, but also pay keen attention to them while they sleep. Not only do crying babies disrupt the sleep of the woman, but so does the need to be constantly attentive. This shift at night is continued from daytime work, housework and emotion work (Venn, et al., 2008). In the cases of nurses with children, the emotional work is a continuous process, thus making it a distinctive kind of labour. Not only do they continue caregiving as part of their

employment, along with housework, but also continue it as long as they inhabit the domestic space. Along with the daily chores that are performed, emotion work for them does not quite end. As Namita states above, her sleep was so pushed to the periphery that she chose to completely obliterate its importance.

The stark difference between living with other members in a household and a hostel is this sense of the freedom to sleep. The women in households prioritise everyone else's sleep, despite their everyday labour which amounts to a lot more time in a day than that of men. Despite the stress from the work, the lingering trauma of witnessing death, pain and illness, they need to carry on the process of social reproduction. They might not be the last one to sleep, but the amount of labour they have to fit in between their waking hours, not just as a contractual/informal labour, but also as a disposal of moral duties, is extensive. The above discussion illustrates the complications of sleep with regard to care-work, in two different as well as overlapping contexts. The night time is not uniform, or tied to uniformity of sleep.

Patient care: Stories of interaction and care

In focusing on the relation of care and sleep in the pandemic, the vulnerabilities that accompanied it cannot be left out. As much as spaces, social roles and relationships inform conditions of sleep, exceptional moments like this provide a different kind of narrative.

> **Subhashree (26):** There was this one lady in the Covid ward, I wasn't attending to her, but one of the nurses could not come in for a night shift that day and I had to work. She was around seventy years old, but she did not seem like seventy. She looked very young; she was beautiful (laughs). Nobody had called asking about her after her admission, she never used to talk much and kept looking out of the window. That night after everyone slept, I came for a round to check whether everyone was doing fine, and she was awake. I asked her, if she needed anything, or whether she was in pain, and she only nodded her head saying 'no'. I took a chair and sat there for some time, waiting for her to say something, but she did not utter a word. Now we are supposed to ensure patients sleep on time, eat their food and have their medication, but we usually do not engage a lot personally. So, I did not know what to do, so I started telling her a story of my first patient. Actually, I made that up, from things that have happened around, I felt like a story writer (giggles). She listened to me keenly and after a while, said "You don't have to do this, I am fine". I told her, "I know, I have nothing to do, nowhere to go, and not many people to talk to, so…" She looked at me for a while and said "You seem lonely, I am lonely too. I lost my husband last week, we only had each other, so I also have nowhere to go." I felt so bad for her, because she was on her way to recovery and would have to leave soon. For the first time, I did not ask her to sleep. I sat there with her, which was anyway breaking the rules, but as I said I did not know what else to do other than keep her company. Keeping people company is what we have been trained to do. I dozed off after a while, it was already 3 am and woke up at 5. I woke up to see her sleeping. I was scared, that she might die on me… I was scared because one patient died around 3 or 4 am,

> like the monitor went "tiiiiiii" (the sound of heart flat-lining) and I intubated him, and the doctors came and it was horrific. I was actually asleep when this happened, it was a slow day, everyone was monitored, doing well, and suddenly this happens... it went from complete silence to complete chaos...

This form of crisis, of losing the loved ones during the pandemic, left so many vulnerable and lonely. This story is not just about patient care, but about care that stems from a certain kind of viscerality. Despite the norm of distance and objectivity that is supposed to mediate this professional relationship, it often spills over outside the frame. This form of social care is not dictated by job expectations, but through emotions that are practised every day. It creates effects of collective companionship and provides hope for solidarities against the mechanization of waged labour. We are always looking for stories of care, emotion, nurture, something that reassures us, provides hope and promise. And more often than not these stories lie in the mundane, not always in the extraordinary or exceptional, not always elaborative, but often simple.

Nurses interact with numerous patients, and each interaction has a history and a context. Every patient has a story, of suffering, and pain. Caregiving by the nurses, even by job description, does involve emotional and psychological support.

> **Rojina (25):** There was this ten-year-old patient who was deaf, she could not speak ... I don't know sign language, but there was a bond that was formed. I had to stay with her at nights, she was very critical. It took her more than a month to recover. But I remember when it was the last day, and she knew it was the last day, she said "don't go" ... I mean not said, but you know, ishara kiya (indicated). I was so emotional, she was such a nice kid, who suffered so much at such a young age. I still miss her, I never had to speak to her, but somehow, she understood what I wanted to say, and I understood her as well. [...] We are trained through role-playing and in many other ways about how to interact with patients, but these kinds of moments are always unexpected. I actually like my job because of times like these.

A few of my respondents/nurses/caregivers did talk about their joy of "serving people". For them, it seems that a deep-seated moral and ethical responsibility comes with the work of providing care. These forms of affective connections are often sustained for longer periods of time and do not fade away easily. These relations then produce stories, which are a result of a deeper form of affective relation that exceeds the normative expectation of what constitutes being a nurse. This is distinct from the caregiving which goes unrecognized as work and is unpaid: the care of children, family, and elderly as is made clear by many of my respondents. Sleep practices are then, associated to the kind of care-work that the women perform. The unpaid care-work in the women's domestic sphere is seen to be almost constant in everyone's lives, that results in constant worry and anticipation of care needs of others. This then informs sleeping habits, or rather the constant sleep disruptions. The paid care-work which also involves different forms of emotional engagement that are unacknowledged, adds layer to their experience of sleep. The sleep disruptions here, are

part of job responsibilities, and the sleep schedule being part of the social role that is performed every day.

Caring in the time of pandemic

It is not always a choice of whether the nurses can or cannot sleep, both in terms of the bodily requirement of it, but also as a sense of obligation. With the particular form of training that they have received as well as the practise of 'not sleeping' that comes with the job, that they have achieved, they do not require sleep or rather do not 'feel sleepy'. Often the tendency to not sleep, is not based on years of practise but based on the consequence that sleeping might bear. Debasmita maintains her fear of bearing the doctor's "scolding" if anything goes wrong, which is also the reason she avoids sleeping at night in the hospital. The hierarchy within the institution gives a sense that to sleep or not to sleep is not just a moral conundrum, but also in the very constitution of the system where nurses are held responsible for most night-time activities. The relation to sleep then is not just directly linked to patient care, but also to the institutional mechanisms.

> **Namita (40):** We get very little opportunity to sleep at night, but it's not like it has never happened. There have been days, when there have been no critical patients, and I just had to go on a round once. If there is no emergency, it is all about maintaining the quiet. The silence at night can just disappear with one little incident of commotion, which can range from sudden cardiac arrest or labour, or a bursting appendix or simply someone falling. We are responsible for everything, doctors do not like to be disturbed unless absolutely essential, so we too try to maintain things as they are. Gradually I got used to it. This is the job, I have to do it, is there any other option?

> **Rojina (25):** There are times when the patient does not sleep, and so I have to stay awake with them. With the pandemic, the protocols are also strict and I have to be very careful with every procedure. I have to constantly think about the safety of the patient because either the immune system is already compromised and if something happens because of me…it is difficult. But the benefit of being a home nurse is that I often do get to sleep, especially when the patient is asleep, and often I know that they might not wake up… Some also like to talk, especially elderly people. Nobody talks to them much throughout the day, once in a while someone comes up and asks how everything is and goes away. I feel bad for them. They tell me a lot of stories, but patients are not advised to stay up the whole night, so I have to draw a line and ask them to sleep. They finally do listen, sometimes they don't, but then their body is usually too tired and they fall asleep.

I looked at the patient-nurse relationship in relation to its association with sleep. It was not only an attempt to loop sleep into the conversation, but also to place how acts of care are also part of negotiating sleep. The association of 'sleep' with 'patients' is linked to the acts of care that are performed in different ways. Often by accompaniment, or consoling, or just by looking over, caregiving is prioritised over sleep. The pushing of sleep to the periphery is

not a mere matter of chance, but a deliberate act of labour, that often seeks respite through modes like storytelling or humour.

> **Rojina (25):** The pandemic has changed the way we used to interact with patients. We see fewer patients but have longer working hours. The people at home also do not feel comfortable. They get concerned about where I have been, which other patients I have seen. Some even demanded that I only visit them and nobody else. But that was not possible, because then we would be paid even less. Now the work feels very frustrating because it seems they do not want me, but I have to be there anyway. New cases also stopped coming in, and we thought we might lose our jobs, but then that did not happen (sighs). A lot of people died and are continuing to die. I feel sad, because in hospitals you see death a lot more than here (refers to her job).

> **Subhashree (26):** The pandemic has been difficult, some days I did not come back home because I had to work for more than twenty-four hours. Sometimes I used to come at 2.30 at night, and it was difficult, so often I chose to stay back. I used to be very tired when I came back, so used to sleep right away. But on some other days, I just could not sleep…usually the days when the condition at the institute was really bad. People were just coming in, and there was really little we could do. So many sisters left because of COVID which increased our workload and all we could do is be there.

> **Tanushree (39):** I was very scared to be honest, working during that time. I had actually thought of leaving so many times. I had children at home, and in-laws who were old. My father-in-law has high blood pressure, diabetes. All of them needed constant care anyway. The pandemic really scared us. I could not leave them and stay somewhere temporarily. But I was scared of what my work could do to them. Every day I used to come back and clean everything. And since then, everything has become all about cleaning… I used to sleep in a separate room though. It mostly was because of fear, even though I knew it would make no difference, but it calmed me.

These three narratives bring out the way the women's work intertwined with the crisis that led to a change in sleeping arrangements and patterns. It changed the ways of interaction with patients due to the strict protocol as well as a change in sleeping habits. But what did not change was the irregularity of sleep associated with care-work. Performing care-work involves disruption of sleep, and that was the scenario even before the pandemic. Healthcare-workers are usually trained and used to crises related to health. Their sleep is usually aligned with the intense kind of work that they do, which usually entails lack of rest, lack of sleep. The pandemic simply added on to the existing dire conditions of labour. Along with the usual distress, it added on to the anxieties about their own lives along with those of others. "The activity of care can be distressing and demanding since it involves emotional work in addition to physical care tasks" (Bianchera and Arber, 2007, pp. 200). In a situation where things were mostly unknown, their caregiving not only involved physical

care tasks but also emotional work, which seemed to be more of a requirement than the prior (as seen in the stories shared above).

When to sleep is almost completely regulated by both the labour demands of the institution of the hospital as well as the family. *Where* one sleeps is also regulated by the kind of work the caregivers engage in. *How* they sleep is definitely not the representative of lying down on a comfortable bed and sleeping, but wherever and however they can manage. Their sleep is fragmented and not unified by the logic of eight hours. What normal time means for most, revolving around work and sleep is completely disrupted, if not destroyed. The pandemic in itself disrupted the logic of time, making things even more difficult for some. With COVID also came a very specific form of trauma from the innumerable deaths witnessed by caregivers. Debasmita had to work for fourteen days and stay in isolation for seven days:

> **Debasmita (29):** It was so weird, I had so much time. I never had so much time for such a long time... I could sleep all day, and I thought it would feel good, because I hardly could get sleep, but on the contrary, it made me even more tired. I am a person who wakes up so early and prays, I have difficulty going back to sleep after that.

Sleeping: An act of Care

I employ sleep as a site in the lives of care-workers/ caregivers located in the city of Kolkata, mostly during the pandemic to bring together the general problem of extraction of labour and the specific nature of care-work. This essay looks at the intersection between these private spaces of disability and recovery, and the temporal cycles of care-work forged *between* the different caregivers over a certain duration of time. What emerges in this documentation is that the forging of these temporal forms of work takes place only through extremely nuanced and delicate affective negotiations between different agents of the field of work including the actual caregivers and the patients. This dense and delicate web of activity consists of the exchange of speech, emotions, debt and obligation that circulate between these agents and patients. The attempt has been to bring out the tenderness and precarity which constitutes the “betweenness” of the individual caregivers as embodied forms of labour, and patients as embodied sites of disability. In this ethnography, the subjectification that results out of this circulation of affects and values (in the strict sense of labour-values), is a gendered subjectification.

I set out to locate the relation that the nurses have with sleep in relation to the kind of work that they do. Being caretakers of patients, children, the elderly, spouses, they themselves do not get to verbalise *their* need for care. The exhaustion that might be carried due to these enormous tasks, affects their emotional and physical well-being, which goes unaddressed. Veena Shatruguna and her colleagues (2008), demonstrate how women neglect their afflictions, in their case, back pain, and how their admission in hospitals create a crisis within the family.

The need to sleep on time, to wake up early and be productive works in the same rubric as working and tiring ourselves to have a good sleep. However, when neither work nor sleep has a fixed temporal placement, things become fuzzy. When the night becomes the time to

work and the day to sleep, especially with shifting duties like that of nursing, which continue to change, the bodily need and their relation to labour become intricate and complex. In most cases, as seen above, there is not quite a distinct demarcation, of work time and sleep time. Whenever asked the basic question of when they go to sleep, most resorted to telling me about the night time, even when they do not have any fixed routine that dictates their everyday. Their sleep is dependent on their labour hours, commute time, chores and responsibilities at home and more. The desire or right to sleep is hindered with the need to do care-work that demands to be prioritised, relegating sleep to the periphery to the extent that it is reduced to a mere necessity. It is not about quantity of sleep and not even the quality, but more about performing a necessary. Sleep, then, occurs with the lingering remains of guilt - of sleeping and not doing the chores, of worry (Arber and Ginn, 1995) - whether everyone is fine and asleep, of fear- that one might get caught while sleeping on duty. Women's sleep is regulated through these modes of indoctrination of social expectations, that also pertain to nursing ethics. But despite these factors, evidence of night time solidarities, of covering for one another, letting others sleep, or just keeping each other company to get through the night, shows the collective processes of bargaining.

"*Waking Up*" (Fo and Rame, 2013), portrays a woman's frustration towards her husband who continues to sleep, without bothering about cleaning, cooking, washing clothes or even talking to her. The play mocks how men tend to get rid of their responsibilities and rather burden women with more work, which isn't even considered work, as all of this continues to be unpaid labour. As several Marxist feminists argue, the economy would fall if women started demanding payment for the unpaid labour that is constituted as part of their 'duty' and 'responsibility' (Vogel, 2017; Kotiswaran, 2011; Pande, 2009). The twenty-four hours which apparently seem to be available equally to everybody, however, seems to be a packaged myth. Not only is the division of labour unequal, but its distribution throughout time is also inequal. Caregiving being an intrinsic part of everyday is allocated as the task of women, and thereby her labour does not end with her working hours of employment. Rather, different kinds working hours spill into each other for women, through the course of those same twenty-four hours. Working women with children, dependent families and housework do not have the same means of using or differentiating time that men do. Moreover, paid care-work adds on to the emotional wear-and-tear that interacts with the emotional work within the domestic space. In most families, women continue to perform housework and caregiving despite their own illness, their deteriorating mental health and with no expectation of reciprocal care.

The lie of 'love', that the dual and interdependent systems of capitalism and patriarchy conveys, disguises this extremely important form of labour as 'instinctive' and not labour at all, even as it forms the basis of the continuance of the economy and society. Can this lie be resisted through the act of sleep? As Jonathan Crary (2013) and many performance artists suggest (Allsopp, 2016), the constant demand of labour and productivity can be resisted through the act of sleeping. This does not mean dissolution of a crisis of care, but rather forming and participating in networks that allow the possibility of resistance. Caregiving does not need to be withdrawn but rather needs to be shared, waged, recognised and practised widely, to allow spaces for negotiation. Isn't letting someone sleep also an act of care, and therefore prioritising sleep negotiates with the demands of labour? It might seem futile, but acts of sleep are not merely passive but can have dynamic and powerful

motivations. Getting the patients (ready) to sleep at night, ensuring they are asleep, keeping them company while they are asleep, are all tasks that involve emotional work. Putting a baby down to sleep is culturally varied and involves fascinating performances, as seen through different lullabies that are used by caregivers across the world. Hannah Reyes Morales (2020) illustrates, through use of photographs in the *National Geographic Magazine*, how different cultures use lullabies to coax children to sleep. She suggests that these lullabies act as windows into the parents' hopes, fears and dreams for the future. Sleep forms a part of care and thus the demand for sleep is one that allows one to rethink the intense form of labour that is extracted from us. The demand for sleep is important in the conversation about caregiving and care-work. Sleeping is social and so is influenced by the factors of gender, class, religious practices, occupation, age and the intersecting relationships amongst these factors, and not only an intimate and private affair as discursively portrayed (Ekirch and Banks, as discussed in Rimler 2017). This essay tried to elucidate the relationship of care-work and sleep, and the gendered ramifications of this in different spatial and temporal settings. Given that sleep is embedded in this web of social relations, the onus of equal, pleasurable and just sleep is not on an individual, but should rather be a collective social responsibility. Resistance through and for sleep can only come about if sleeping rights can also be equal, where everyone will be able to sleep.

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