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‘You Don’t Need Santa Monica!’ The Objectification of Elderly Care Receivers in Russia

ARTURS HOLAVINS

Abstract

The article presents the case of non-governmental elderly care provision in St Petersburg, Russia. In an attempt to fill the gap in existing care research, it discusses the objectification of care receivers and the inequalities between caregivers and care receivers in the case of caregiving under circumstances of non-governmental sector professionalisation. The empirical part of the article is based on fieldwork carried out in 2014–2015 in St Petersburg, consisting of 48 interviews, numerous observations and document analysis.

OBJECTIFICATION—THE CREATION OF ‘DEPENDENCE UPON OTHERS FOR care and [the loss of] autonomy over areas of life where one had previously been in control’ (MacQuarrie 2005)—and depersonalisation (of a patient) (Timmermans & Almeling 2009) are crucial concepts in the sociology of medicine. Feminist scholars have often criticised the process of objectification, seeing it as the source of inefficiency and moral dilemmas in care work (Gilligan 1982; Tronto 1993), and have proposed a philosophical concept of care as an alternative to the ‘cold’ and ‘professionalised’ labour associated with objectification (Hochschild 1995; Moser & Pols 2009). Care theorists have largely seen dependency as resulting from economic and societal gender inequalities that female caregivers face in their work (Kittay & Feder 2003, pp. 257–77). The central figure of these studies was usually a socially disadvantaged female caregiver (Sevenhuijsen 2000; Chernova 2011; Lewis & West 2014). At the same time, the vulnerabilities of those receiving care were often overlooked.

I find this interpretation to be problematic for several reasons. Firstly, intersectionality theory has shown the importance of examining various dimensions of inequalities, such as race (Lykke 2010) and age (Calasanti & Slevin 2013), rather than focusing solely on gender. Secondly, the female caregiver still typically holds the power in the relationship with the care receiver, who often has even less capacity for agency (Tronto 2002, p. 40). After all, care, being an umbrella term for a wide variety of social services and other interactions aimed at improving the lives of ‘socially disadvantaged’ citizens, presumes a receiver as being in need (Barnes *et al.* 2012, p. 151). Thirdly, the few studies that problematise care receiver vulnerabilities (Bruckner 2012; Park & Schumacher 2014;

Näsström *et al.* 2015) focus on elderly people with life-altering medical conditions; the perspective of so-called ‘young pensioners’—many of whom are healthy, financially stable and socially active individuals—is not in any way covered. The result is a blind spot in care studies, namely the objectification of elderly care receivers, especially the younger ones, who are deemed to be in the ‘third age’—namely, younger than 65—and to have a relatively healthy life.¹

Simultaneously, the transfer of social care functions to the third sector—comprising volunteers but also paid professionals belonging to non-profit organisations—has become a global trend (Cammett & McLean 2014), which also applies to Russia (Cook & Vinogradova 2006; Kulmala 2016). Thus, focusing solely on the state does not provide a comprehensive understanding of the current reality of emerging caregiving practices. Like other social groups, aged people—care receivers—experience a gradual ‘recommodification’ (dependency on the market) and ‘refamilialisation’ (dependency on family) (Esping-Andersen 1990). Old people are particularly likely to be treated as dependent and vulnerable, thus becoming objectified by the paternalistic (or, one might well say, maternalistic) attitudes of caregivers. The content and quality of care practices—mostly medical care, social work, health visits, psychological support, material support, educational services, gifts distributed at annual festivities, direct financial support (charity in the form of direct money transfers), the organisation of cultural and social events—are decided upon by caregivers claiming unique knowledge of the needs of their care receivers, who are presumed unable to make the best choice on their own.

In examining the objectification of care receivers, I focus on caregiving in the non-governmental sector. According to the works of many noted scholars in the field (Batley 2011; Jalali 2013; Krause 2014), non-governmental sector civic values of grassroots activism and empowerment stand in sharp contrast to actual processes of third sector professionalisation (that is, the technical and administrative expertise developed by now-paid third sector employers), the development of expert knowledge and the commodification of beneficiaries (that is, the perception of social service receivers as a resource ‘to sell’ to potential grant-givers (Krause 2014)), which is exactly what objectification and the contrast between caregivers’ ideology and practices is about. Notably, the ‘active ageing’ ideology—a policy framework established and promoted by the UN Madrid Plan of Action on Ageing (UN 2002)—was pioneered by the third sector in Russia.² Assuming active ageing to be the normative and practical foundation of care involving the agency of care receivers and their participation in the collaborative decision-making over content and process of care, one must further examine the caregiving undertaken by the actors—namely, non-governmental organisations (NGOs)—promoting the ideology.³

¹See Gilleard and Higgs (2010) for further discussion on the concepts of the ‘third age’ and ‘fourth age’.

²The word ‘active’ refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force, maintaining autonomy and independence (Rudawska 2010, p. 18).

³In practice, active ageing ideology and participatory care practices may or may not correlate with one another. Equally, not all NGOs studied were supportive or even aware of the policy framework concept of the Madrid Plan.

The Russian case fits well in the aforementioned paradox of a disconnect between the practices of care-providing organisations and their proclaimed allegiance to values of civic participation and, in particular, active ageing. This is particularly intriguing given that overall state attitudes towards civil society are perceived as somewhat suspicious and negative in nature, as in the case of the by-now notorious repressive ‘foreign agent law’. Nonetheless, many social NGOs function successfully as service providers, mediators and ‘expert hubs’ (that is, innovators and pioneers of various social pilot programmes) enjoying financial, material, legal and ideological support from the state.⁴ By definition, civil society is concerned with citizen empowerment, which carries over into caregiving practices. Thus, paternalistic state policies are at odds with the intention of NGOs to provide participatory care.⁵

The aforementioned framework for the study leads to the main question of this article, namely: do the NGOs providing elderly care in St Petersburg objectify those receiving this care, despite their status as civil and grassroots organisations supportive of the active ageing policy framework? To answer this question, I supplement care theory by distinguishing between participatory and paternalistic care approaches, for which the consent—or, respectively, the objectification—of the elderly is a determining factor.

In short, the difference between the two approaches lies in the ability of the care receiver to exercise power over the caregiver in the matter of the care received. Participatory care implies that the care receiver is able to alter the caregiving practices to suit their own needs. By contrast, in the context of paternalistic care, a care receiver is an object targeted by the caregiver; to be an ‘object’ signifies that the care receiver has little or no say in how the caregiver fulfils their assigned duties with regards to the assumed needs of the care receiver. Based on the fieldwork, I claim that paternalistic care dominates the care provision practices observed in St Petersburg. In particular, this is due to the professionalisation of caregiving, namely, the claim by caregivers to possess expert knowledge, and the bureaucratisation and formalisation of care.

To summarise, based on fieldwork conducted in St Petersburg in 2015, I present qualitative evidence of a discrepancy between emerging ‘active ageing’ ideology and the reality of caregiving given by non-governmental care providers to elderly care receivers. To put it simply, I discuss how elderly Russian care receivers are unable to influence the process of care. This, in turn, lends itself to a broader discussion of the ‘power struggle’ between caregiver and care receiver and the disconnect between the NGO sector and communities.

⁴Some milestone documents include Federal Law 442 ‘On Social Service Provision’ (‘Ob osnovakh sotsial’nogo obsluzhivaniya grazhdan v Rossiyskoi Federatsii’), State System of Legal Information 2015, adopted 25 December 2013, available at: <http://pravo.gov.ru/proxy/ips/?docbody=&nd=102170561>, accessed 15 January 2020; and ‘Strategy of Actions in Interests of Aging Citizens’ (‘Strategiya deystvii v interesakh grazhdan starshego pokoleniya v Rossiyskoi Federatsii do 2025 goda’), Ministry of Labour and Social Development 2016, adopted 5 February 2016, available at: <https://rosmintrud.ru/ministry/programms/37/2>, accessed 15 January 2020.

⁵This simplistic approach was far from evident after conducting the fieldwork. There are plenty of examples of state institutions using participatory care in relation to the elderly and much paternalism in caregiving dyads in the third sector.

Methodology

This article is the result of a qualitative sociological study of non-governmental elderly care provision in St Petersburg. Several factors influenced the selection of St Petersburg as the main concentrated area for fieldwork; most notably, its relatively developed third sector presence, one of the highest number of pensioners across the Russian regions (Rosstat 2016), and a marked economic inequality amongst the elderly, which is a proxy for the diversity of trajectories and strategies of ageing in Russia. Additionally, many Russian governmental and non-governmental projects (such as internet services for the elderly and volunteering by old people) are either initiated or developed up to the federal level in St Petersburg. As such, the city provides extensive and sufficient data on non-governmental elderly care provision.

The fieldwork focused largely on several St Petersburg-based NGOs involved in the provision of care to aged people in the city and nearby rural areas. These NGOs were different in nature. Some of them were exclusively state-funded ‘veteran’ organisations (notably, anyone can receive help from these organisations not just military veterans) or ‘clientelist’ NGOs (Cook & Vinogradova 2006), while others were well-established ‘professional’ NGOs (that is, third sector organisations which belong to the community of non-governmental elderly care providers, whose employees share common civil society identity, and which claim ‘unique expertise’ in elderly care and NGO work in general). The NGOs studied differed in status (ranging from informal social media-based volunteer groups to organisations with the difficult-to-obtain official status of ‘social service providers’); size (ranging from a small number of volunteers to foundations employing dozens of workers); and wealth (ranging from organisations running solely on in-kind contributions by members to those with budgets exceeding several million rubles).

The differences between elderly-care-providing NGOs (including veteran organisations, whose governmental source of income does not alter their official NGO status and is comparable to state-funded volunteer organisations in Germany and Sweden) corresponded to their position in the third sector expert community. State-supported clienteles have no intention of getting recognition of own expertise from other NGOs, being part of civil society or learning ‘third sector professional skills’. They were unaware of the active ageing policy framework, though still claimed to take the interests of their care receivers into account. Professional NGOs, by contrast, build their organisational identity upon expert knowledge and serving as gatekeepers of such knowledge. They are strong proponents of active ageing and claim to value the empowerment and independence of aged people. Accordingly, it was expected that those NGOs studied would apply the principles of participatory practice. Instead, it turned out that professionalisation prevented them from letting ‘non-professional’ care receivers decide where, when and how they were to receive care.

The empirical data used in this article come from semi-structured interviews and participatory observations. Access to the field was not as difficult as expected, and the only reluctant potential informants were those based in private facilities. Otherwise, step-by-step involvement in focal point events (key events organised by NGO workers for other NGO workers, governmental officials or elderly care professionals), snowball tactics and overall good relations between organisations helped the author to establish trustworthy

and strong personal relations with many people involved in non-governmental elderly care provision, be they project managers, caregivers or care receivers themselves. The tightly knit network that links third sector professionals allowed me to refer to my previous research participants in other organisations when approaching each new NGO.

This study is largely a snapshot of state-of-the-art non-governmental care provision in St Petersburg immediately following the adoption of the 2013 federal law ‘On Social Service’ that took effect in 2015.⁶ The law brought about an important shift in social care, as NGOs were given the legal rights and practical instruments to provide social services to various groups in collaboration with or independently from the state. Simultaneously, within state institutions at various levels, there has been a policy shift towards the UN-backed ideology of active ageing, overwhelmingly supported by professional aged care NGOs in Russia. Empirical data were mainly gathered in St Petersburg, with the exception of several care provision events in Leningradskaya *Oblast*, the region surrounding St Petersburg. Data collection can be roughly divided into two periods: most of the interviews were undertaken in autumn 2015, while most of the observations were made in spring the same year. All the observations are the author’s and nearly all of the interviews were carried out by the author, although additional data were gathered *via* email and social media with the help of informants and colleagues, which included useful links to reports, photos, draft documents and legislative changes to elderly care provision.

Overall, I conducted 47 semi-structured interviews with 50 informants. Each interview lasted between 30 and 150 min.⁷ The list of informants includes representatives from 16 NGOs (seven professional, four self-help support groups (that is, those run by aged people themselves), three state-dependent ‘clientelist’ associations and two volunteer groups), two Moscow-based grant-givers, two state social providers (the state social service providing entity and the local branch of the city library), one private organisation and one hospital owned by the Russian Orthodox Church. In terms of informant status, I interviewed six care receivers, 23 caregivers and 29 care organisers. Notably, some informants simultaneously fell into both respective categories. Most of the interviews were recorded and transcribed; others were written down in a field note diary, which also was used to record all participatory observations mentioned in the following paragraphs. All names of research participants, their organisations and other circumstances which might lead to identification of participants were changed for the purposes of anonymisation.

The main criterion applied in the selection of interviewees was the role of the informant within the organisation. Therefore, I prioritised as the focus employees and volunteers carrying out both organisational and care functions. The informants were 19 men and 31 women, with ages varying from 19 (a volunteer) to 88 (the head of a veterans’ organisation). The majority of informants had a higher education, with the exception of two care receivers, as well as four younger caregivers who were still studying at the time of interview.

⁶Federal Law 442 ‘On Social Service Provision’ (‘Ob osnovakh sotsial’nogo obsluzhivaniya grazhdan v Rossiyskoi Federatsii’), State System of Legal Information 2015, adopted 25 December 2013, came into effect 2015, available at: <http://pravo.gov.ru/proxy/ips/?docbody=&nd=102170561>, accessed 15 January 2020.

⁷See Appendix 1 for a detailed list of organisations and interviews.

Observations were made in different ways: by attending key events, including grant competition decision-making meetings, charity fairs, conferences and round tables hosting elderly care professionals, third sector employees, volunteers, care receivers and experts; by spending time in care provision spaces such as cultural centres, classrooms, nursing homes and hospitals, and observing various caregiving practices; and, finally, by volunteering as a caregiver at several organisations.

Theory

Care theory is applied to two broader spheres: the sociology of everyday life, focusing on physical and interpersonal practices of caregiving, and social policy research. In light of my research aims, I place the concept of care at the intersection of the two approaches, studying non-governmental elderly care as a sub-type of social policy more broadly. Participation and/or paternalism are features of the caregiving dyad, namely, the interpersonal relations between caregiver and care receiver, which consist of physical practices, emotional labour (Hochschild 1983) and, in particular, Tronto's (1993, p. 106) 'caring for' process of needs identification and elaboration. However, I do not limit care to 'life-sustaining practices' but include any 'activity or practice aimed at meeting the needs of others' (Kittay & Feder 2003, pp. 163–64). Thus, care is a variety of daily practices at the interpersonal level with a strong normative (ethical) component of mutual support. At the same time, the concept of care cannot be limited merely to medical care or social work but should encompass any practice intended to fulfil the needs of an elderly care receiver.

An important distinction is made between participatory and paternalistic care. Participatory care is a type of care based on the principle of equality between the caregiver and the care receiver; paternalistic care reproduces inequality between the caregiver and the care receiver. In this sense, the term 'equality' denotes the opportunity to influence the process of caregiving. In this regard, I find the 'ladder of participation' (Rimashevskaya 2013, p. 13) to be a valuable concept, wherein participation requires access to information. However, according to the 'ladder' theory, relations cannot be considered participatory until both the needs assessment (elaborating interests, communicating them to the caregiver and legitimately expecting care with regards to these needs) and, more importantly, collaborative decision-making, take place. Rimashevskaya furthermore asserts that paternalistic care signifies control over care content (Rimashevskaya 2013, p. 13). Finally, opportunities for care receivers to exercise initiative regarding the implementation of care (for example, to request changes to the caregiving plan) is a crucial component in participatory care. Essentially, such opportunities give the care receiver the ability to exercise power over the caregiver. The question of equality is thus about power relations.⁸ When care receivers do not have such power and have no say in what care they receive, caregivers are fully and solely in charge of the process. This is exactly what I understand by 'objectification', the state of being an object in contrast to being a subject (actor).

⁸See Table A2 in the Appendix for a detailed summary of the differences between the types of care.

To describe further the two care approaches, participatory care—unlike paternalistic care—involves emotional labour. In this sense, emotional labour does not refer to the application of ‘emotion management’ as a professional skill (Hochschild 1983), but is rather used in another sense, denoting a dichotomy between ‘cold’ and ‘warm’ care (Hochschild 1995). In this regard, ‘warm’ care signifies familial-like relations, building trust and investing in personal relations, while ‘cold’ care is characterised by medical discourse, formality, technological support and a focus on physical rather than emotional needs; thus, the caregiver keeps a certain distance from the care receiver. Agency and empowerment are not important in cold care (Moser & Pols 2009). Such interpersonal relations create the conditions for the objectification of aged care receivers. Notably, warm care can also be paternalistic, as emotional engagement does not necessarily denote recognition and acceptance of equal relations. However, if done outside the formal scope of duties of the caregiver, it is a proxy indicator of participatory intentions of caregivers, as it involves informality and ‘genuine’ emotions. On the other hand, ‘warm’ care premised on the comparison of the elderly to children (that is, vulnerable and defenceless) is paternalistic (top-down and detrimental to agency).

Finally, it is crucial to underline the difference between empowerment as a goal (an outcome of care) and paternalism in caregiving (the process), which are often mixed in NGOs’ self-representation. NGOs’ intention (normative stance, ideology) to empower care receivers (that is, to enable them to gain social and human resources through care) and allow them to pursue an effective active ageing lifestyle can still be accompanied by paternalistic care, thus giving rise to the aforementioned empowerment paradox between intentions and practices. The debate about participatory and paternalistic care approaches is about the process of caregiving, not its outcomes.

The main explanatory mechanism for the objectification of care receivers is the professionalisation of NGOs (also called ‘NGO-isation’). I apply the ‘power model’ definition of the term. In this framework, professionalisation means the institutionalisation of occupation as a publicly recognised ‘monopolistic control’ and ‘autonomy [from organisation and client] of practitioner’ over certain professional activities (Forsyth & Danisiewicz 1985, pp. 61–5). This is a ‘social process’ that involves the development and recognition of expertise by individual representatives of certain occupations and groups of such representatives as a whole.

At the same time, the professionalisation of NGOs is not necessarily about certification, formal education and a closed occupational community. It is more of a question of organisational transformation, in which individual care organisers and caregivers acquire administrative and technical skills as well as knowledge about elderly care from various sources, including non-formal education, peer support and daily experiences. Thus, the ‘professionalisation’ of the third sector does not merely indicate the recognition of the third sector employees as professionals *via* formal occupational education but also a growth in organisational complexity, bureaucratisation and a reconsideration of the organisation’s ultimate *raison d’être*. This professionalisation process is a widespread feature of third sector organisations across the world, as grassroots movements become formal NGOs and local NGOs change their practices in accordance with the demands of their grant-givers. As already mentioned, it implies primarily ‘formalisation and bureaucratisation’ (Choudry & Kapoor 2014), which gives rise to expert knowledge

claims on the part of caregivers and care organisers and encourages project thinking—that is, an emphasis on achieving the goals of a specific project rather than meeting the individual needs of care receivers (Jalali 2013, p. 60).

Above all, expert knowledge is the principal concept here, meaning that NGOs and individual caregivers working in the third sector claim they are best equipped to offer care based on their experience and involvement in ‘knowledge production’. Expert caregivers engage in information gatekeeping and are able to prevent care receivers from participating in decision-making processes by deeming them to be ‘clueless’, ‘weak’ or even mentally incapacitated and unfit to make decisions, thus effectively objectifying them.

To sum up, expert-knowledge gatekeeping and unequal access to resources influence the process of care practices. Generally, organisational constraints shape caregiving practices towards paternalism. To illustrate this argument, I present below some indicative cases of paternalistic care within the context of educational and other service provision.

Case 1: Google Maps street view of Santa Monica deemed unfit for ‘professionally developed’ computer literacy course curriculum

The clientelist (Cook & Vinogradova 2006)—‘GoNGO’-like—NGO ‘They’ (the clientelist veteran organisation 3 in the list of interviews) is an organisation found throughout Russia, and its chairman is a member of the St Petersburg Legislative Assembly (*Zakonodatelnoe Sobranie*). Formally, there are only five employees working at the central office of the St Petersburg regional branch, though in practice there are also district branches with additional employees, as well as numerous contractors and volunteers. Owing to friendly relations with the regional governor, the chairman easily secures stable financial support (both formal and informal) for his spare-time hobby of running ‘They’.

The main office of the organisation, which is far from spacious or luxurious, is situated in a typical Soviet-style kindergarten building shared with unrelated private companies. There are only a few rooms in the office, some of which are used for administrative purposes, while the others are used for third age vocational training.⁹

Notably, ‘They’ is not a member of the independent third sector expert community. Like other state-supported veterans’ organisations, it is a self-sufficient organisation whose relations are limited to patrons within state institutions. For instance, employees are simply not aware of the active ageing policy framework: when asked directly during the interviews, none of the three research participants could say what it was.¹⁰ Nevertheless, ignorance of the concept does not necessarily mean that the participatory care approach has been discounted. The notion of equal relations with care receivers—taking their wishes into account and exhibiting warm personal relations based on mutual trust and respect—is widely shared by Russian geriatric medical experts, trainers, social workers and nurses distinct from any discussion about the civil rights of care receivers or ‘civic’

⁹Photos of ‘They’ aged care receivers and employees attending various pro-governmental meetings (making them effectively a so-called ‘transmission belt’ between Russian government and society (Gibson 2002)) and ‘calendar care’ (that is, mean special care provided on public holidays, such as the distribution of Victory Day gifts or a concert on Aged People’s Day) celebrations adorn the walls of the main corridor.

¹⁰Interviews #35–37; see Appendix 1 for full details.

empowerment as undertaken by NGOs promoting active ageing approaches. Similarly, project managers and trainers at ‘They’ proudly stated that they took the wishes and interests of their care receivers into account. According to one of the project managers and interviewees, Mikhail Supov, it is possible to change the curriculum of his courses:

[There is a group dynamic that] we communicate non-verbally. They see I am kind by my character and [ready to listen to their ideas for improvement]. Now this is a routine [at our classes]: I succumb, we watch a movie, or something. They watch a movie or learn about another topic they found themselves on the internet with great pleasure. For instance, they say: ‘Mikhail Vitalyevich, I want to know the recipe ...’ and all women in the group get enthusiastic about it.¹¹

Supov also claimed that his approachability and receptiveness to input from care receivers allowed them to adapt the content of the care programme and propose ideas for cultural events and potential improvements. In this sense, his caregiving practice can be described as participatory.

However, an informant’s statements cannot be taken at face value. To ensure an unbiased and factual representation of the situation, I embedded myself as an observer, participant and lecturer of computer literacy courses. I gave lectures to beginners and observed lectures given to advanced-level students, at which point I encountered Lida Lvovna—a well-dressed woman in her early sixties—and helped her and her neighbours with a task given by Supov: to attach and send photos to the lecturer and classmates using the social platform V Kontakte. Usage of this social network, a Russian analogue of Facebook, was the focus of the level 3 course curriculum. Based on informal conversations with course participants and informants from other organisations, I discovered that the social network is quite popular amongst aged people, allowing them to socialise with friends and keep in touch with younger family members. At the same time, there were also complaints about the course’s emphasis on V Kontakte; students wanted to learn more about other cyber topics such as search engines, online banking and event aggregators. Contrary to Supov’s previous statement, these desires had not been considered or realised. All three employees interviewed underlined the ‘high-class quality’ of the curriculum, claiming expert knowledge on what should be taught to the elderly, and how it should be taught.¹² The development of expert knowledge amongst educators has been discussed elsewhere (Lampert & Clark 1990). Notably, neither of the ‘They’ trainers had formal teacher training at the time of the study. Despite having no professional education, they still disregarded attempts by their care receivers to influence the programme of activities as meaningless and unnecessary. In this way, the ‘They’ caregivers clearly alienated and objectified their care receivers.

This is precisely what happened in the case of Lida Lvovna. At one point, she quietly asked me if I could help her with something. She explained that Supov had refused to show her how to use Google Maps on several occasions, and furthermore stated: ‘he starts to yell whenever we ask something outside the curriculum’. The unwilling response to—

¹¹Interview #37, Mikhail Supov, in his twenties, project manager and lecturer, clientelist veteran organisation 3, St Petersburg, 30 November 2015.

¹²Interviews #35–37; see Appendix 1 for full details.

or in this case, flat-out dismissal of—the care receiver’s initiatives is a clear expression of paternalism, as it highlights a situation wherein a caregiver viewed elderly students as passive recipients rather than equal partners. Lida Lvovna explained that she wanted to access the street view feature of Santa Monica, California using the Google Maps application, but Supov had dismissed her request as being ‘too complicated’ and ‘unnecessary’ for a third semester student. Her desire to see Santa Monica was further met with hostility by Supov, who said: ‘why would you want to look at an American city? Why don’t you take a look at Sevastopol!’ The clientelist NGO had a certain agenda—in this case, a patriotic one—and Lida’s request did not fit the wider ideology of the organisation. She was ridiculed by both Supov and her fellow classmates, and having no allies to support her initiative, as an individual care receiver, she was left powerless before the caregiver. She was embarrassed and tried to hide her initial interest on this occasion. After hearing the story, I swiftly helped Lida Lvovna open the Google Maps street view of Santa Monica. She spent the rest of the class session ‘walking’ down the streets of the Californian town while the class in St Petersburg carried on around her. At the end of the class session, Lida Lvovna stayed behind to chat with me for a further 30 min, at which point she thanked me again profusely for my help and shared her life story.¹³

Satisfying the need of this particular care receiver was very easy. In this instance, however, organisational constraints and the caregiver’s claim to ‘expert knowledge’, gatekeeping and lack of interest in allowing an elderly care receiver agency, combined with a negative attitude towards the content of the request, deemed ‘unpatriotic’, proved insurmountable to the individual care receiver. Prospective students were given no prior information about the course. There was also no assessment of the kind of training the care receivers needed or indeed wanted: caregivers created the curriculum based on their own knowledge and understanding of qualitative training. Furthermore, warm care practices (claimed by Supov) were overshadowed by an authoritarian and emotionally abusive (‘yelling’) teaching style. There were also very few ‘collaborative decision-making instances’ (Rimashevskaya 2013, p. 13) with no ongoing control of care receivers over the caregiver.

Case 2: aged volunteers: empowered and objectified

This case covers aged volunteering, that is, providing opportunities for the elderly to be volunteers, as a way of socialisation, battling loneliness, social deprivation and feelings of worthlessness. As found over the course of the study, volunteer coordinators typically have a professional or educational background, which allows them to claim expert knowledge and establish ‘autonomy from clients’ (Forsyth & Danisiewicz 1985, pp. 61–5). Usually difficult to achieve in the case of social workers (Forsyth & Danisiewicz 1985, pp. 61–5), such autonomy flourishes when it comes to the management of volunteering, a service aimed at seemingly more resourceful seniors of younger age and better health. Thus, paradoxically, in social work autonomy is low, while in aged volunteering coordination is high. This is despite the fact that social work targets

¹³Interview #51, Lida Lvovna, in her sixties, care receiver, clientelist veteran organisation 3, St Petersburg, 25 November 2015.

vulnerable pensioners, while volunteering is open to everyone, and is mostly the preserve of the wealthy and healthy.

This is true for non-governmental initiatives aimed at vulnerable groups in general (Eliasoph 2011), and also applies to the management of aged volunteers. Neither the ‘objectively’ high human capital of care receivers (who are often healthy, though not necessarily well-educated or relatively wealthy), nor stated adherence to active ageing ideology by the caregivers, guarantees participatory care. The loss of status through retirement affects self-esteem and self-perception (Kim & Moen 2002, p. 212; Demakakosa *et al.* 2008). As a result, aged volunteers often give up their own agency and thus have no say in choosing where and how to volunteer. Instead, they obey orders issued by coordinators and discard their own expertise:

I am just a volunteer now. I try not to argue and stay quiet; this is my role. I come, do my job, and if I disagree, I won’t argue. I am prepared internally to feel myself obeying. I am a performer not a decision-maker and I am ready [for] that.¹⁴

Furthermore, many volunteers felt that they owed the rise in their quality of life to their caregivers. Sometimes it led to a feeling of ‘duty’ to ‘pay back’ by suppressing their own feelings, interests and wishes. For instance, Vera Sergeevna, an informant and active member of the ‘Snowflake’ community—a resource (educational) centre—explained that she ‘couldn’t refuse’ seemingly complimentary pleas by project managers to attend one or another event as a volunteer.¹⁵ Vera Sergeevna admitted that she often felt tired, overloaded or even sick after volunteering. Nevertheless, she explained that she rarely rejected appeals from the ‘Snowflake’ staff as she was ‘responsible’ and felt a strong sense of ‘duty’ to both the organisation, as well as the project manager, hereinafter referred to as ‘Polly’.¹⁶

‘Moral obligation’ has been proven to have an effect on volunteering intentions (Warburton & Terry 2000, pp. 255–56). Notably, Vera Sergeevna’s sense of obligation did not stem from an internal, moral urge, but rather, was a feeling consciously developed by the ‘Snowflake’ managers to benefit the organisation. During various focal point events—such as methodological seminars and roundtables where ‘Polly’ and her colleagues were present as experts—the technology of ‘aged volunteering’ was explained and promoted. ‘Snowflake’ managers, having a background in business coaching, developed their NGO strategy based on private sector marketing business models. In one of the presentations, ‘Polly’ explicitly stated that ‘aged people’ were a ‘resource’ that organisations using ‘aged volunteering methods’ can use as a ‘selling point’ during partnership negotiations.¹⁷

¹⁴Interview #17, Roza Josephovna, in her seventies, care receiver, care-providing charity foundation 4, St Petersburg, 15 October 2015.

¹⁵Interview #15, Vera Sergeevna, in her sixties, care receiver, resource centre 1, St Petersburg, 14 October 2015.

¹⁶Interview #15, Vera Sergeevna, in her sixties, care receiver, resource centre 1, St Petersburg, 14 October 2015.

¹⁷Interview #4, female, in her thirties, vice-president, project manager and lecturer, resource centre 1, St Petersburg, 10 February 2015.

The empowerment of aged people and active ageing were part of the ‘Snowflake’ discourse (as seen from numerous conference summaries, methodological materials and the language used at the key events). Yet, with regard to its aims and the measurement of success, the number of collaborative projects and aged people acquired was of higher importance. Therefore, to achieve the organisation’s operational goals, ‘Snowflake’ caregivers largely disregarded the feelings, wishes and interests of care receivers and proceeded with their own expert, knowledge-driven and market-dictated caregiving tactics, practices and activities. In this sense, the organisation of aged volunteering by ‘Snowflake’ is just as paternalistic as much of the aid provided by humanitarian relief organisations,¹⁸ as the elderly volunteers were given virtually no agency in their activities. A focus on completing projects dispensed with assessment, while control and initiative rested with caregivers (paid employees of the resource centre). Even projects by the ‘initiative groups’, which were developed for the small grant competition by ‘Snowflake’s’ non-governmental partner, ‘Space Shuttle’, were revealed by the volunteers to be mostly written by ‘Polly’, despite being presented as the creation of aged volunteers.

To summarise, even the most resourceful care receivers, such as aged volunteers, are objectified. Furthermore, in the case of ‘Snowflake’, care receivers are treated as a resource, since the NGO seeks to ensure its financial sustainability by offering aged volunteering services to its numerous private, non-governmental and governmental partners. Similar sentiments and power relations between caregivers and volunteer care receivers were also present in organisations providing humanitarian aid. It would appear that (aged) volunteers for St Petersburg NGOs that also have paid staff members are by default not encouraged to participate in management (decision-making).

Case 3: project-level and home-based objectification

Other indicative examples of paternalistic care emerged from the observation of caregiving practices and through interviewing employees of ‘Space Shuttle’, an infrastructural NGO that primarily assists other similar organisations rather than any external beneficiaries. I refer to these cases as the ‘well of discord’ and the ‘two worlds’ conflicts, with conflict meaning a contradiction between proclaimed participatory, active ageing ideology and the actual paternalistic handling of the ageing care small grant competition.

The ‘two worlds’ case is based on the observation of a final planning session for an event taking place in a small regional town located two hours outside St Petersburg. Following presentations of the best cases and several capacity-building exercises, a venue was clearly divided into two separate spaces. One was open for care receivers: a lunch area in the main hall and courtyard for the celebration of the traditional ‘Maslenitsa’ festival outside the local cultural centre building. The other space was for care providers and organisers, all of whom were non-aged and formally affiliated with the grant-giver, operator (the NGO organising grant competitions and managing the finances of larger funding bodies) or the leadership of the care-providing organisation. The second space included a classroom, to which entry was restricted. When I asked to participate in the meeting, the NGO’s project

¹⁸See Jalali (2013) and Krause (2014) for examples of such professionalisation.

manager refused to allow me entry, on the grounds that the care organisers were discussing ‘sensitive topics like finances’. None of the care receivers was present at this meeting.

The common space was initially divided into two ‘worlds’: caregiving and the organisation of care. Effectively, this meant care receivers were kept separate from the decision-making processes, and any opportunity to influence care content was limited by the closed doors. In some way, care receivers were objectified to the level of commodities ‘sold’ to the grant giver (Krause 2014). In other words, care provision became a product and a matter of negotiations between care-organising NGOs and their grant-givers. Despite the collection of feedback by care-providing organisations on the ground, this was not the main content of project reporting. Instead, heavy emphasis was placed on media visibility, dissemination capacity and quantitative measurements, such as financial efficiency, the number of recipients and other standard ‘logical framework’ assessment criteria used by professional NGOs worldwide in their projects (Jarvis 2014).

In the case above, all decision-making regarding caregiving was made by care organisers, grant-givers and, to some degree, caregivers. However, most care receivers were not present at the main event discussing the results and planning for next year’s grant competition. Furthermore, some elderly, mostly self-help group representatives, were not given access to information about the detailed results of the competition. Instead, they were entertained together with care receivers (including the local host organisation representatives). Similarly, at the grant competition selection commission, the expert knowledge of professional NGOs dominated the agenda. For example, a request by an aged self-help group regarding improved drinking water access in a small, rural area (effectively, digging a well) was dismissed on the grounds that it was ‘unsustainable’ and did not fit the aims of the grant competition, which was to promote active ageing. In reality, the actual need was too simple for the highly professionalised experts at ‘Space Shuttle’ and their grant-giving foundation. The way in which projects were selected for grants shows how professional, caregiving NGOs prioritise their own operational considerations over the interests of those receiving care (Batley 2011).

In shifting from the organisational level to the individual level of actual care provision, it is important to note instances of caregivers’ absolute power over care receivers in a home-based nursing environment (health visits, long-term socio-medical assistance). However, it is not always the case that caregivers hold all the power and receive little resistance from the care receivers. On the contrary, there have been several instances in which caregivers were vulnerable to abuse at the hands of their care receivers (Kay 2013; Lewis & West 2014; Saralieva & Petrova 2018). It is also not always the case that nursing is paternalistic. For instance, nurses and doctors at the charity hospital based in St Petersburg (run by a religious organisation) aimed to treat the most fragile elderly—those with diagnoses such as aphasia, dementia and apoplexy—and negotiated treatment and care content with individual patients. Even the severe cases of aphasia did not present an obstacle to this participatory approach. As explained by Elena, who works both as the hospital’s secretary and as its speech therapist, ‘The only way to go on is to get pure, true, positive feedback’ from the patients, otherwise, she said the job could lead to burnout.¹⁹

¹⁹Interview #42, Elena, in her thirties, office administrator and social worker, charity hospital, St Petersburg, 17 December 2015.

Thus, hospital employees tried to directly communicate and personally collaborate with patients instead of ‘simply doing their jobs’. This was evident in how Elena described her follow-up with a fellow female patient: ‘one hand is functional; she talks, smiles. Of course, our nurses have learned to understand her signs, facial expressions. She might get angry or demand one thing or another’.²⁰

Furthermore, Elena elaborated: ‘it is extremely important to explain each movement, each of your actions. The person calms down then. The world becomes clear and understandable to her, which would not be the case without explanations’. For professional medical reasons, hospital-based caregivers are obliged to consider the care receivers’ wishes and emotional state. If a patient refuses the medically prescribed treatment, there is not much that medical staff can do. Consequently, despite being largely incapacitated, an aphasia-stricken patient in a hospital setting can effectively influence the caregiving process by her reactions, exerting influence over everyday bodily care if not over medical treatment. When observing the daily lunch distribution, I directly witnessed Elena in her working environment and observed that nurses patiently explained their actions and asked the aphasia-stricken woman what exactly she would like to eat. When she refused the porridge, they brought her an apple.

A previous comparison of home-based and institutional care showed evidence of agency and ‘self-preservation’ by care receivers in a long-term home environment (Timmermans & Almeling 2009). In the case of the St Petersburg elderly care facilities studied by the author, the opposite is true. Nurses hired by the social welfare-providing NGOs ‘Beser’ and ‘Hoot’ provided mostly paternalistic care to their patients. As seen from the interviews with health visitors,²¹ caregivers are taught to keep a distance from care receivers at professional development courses, nurses limited their own warmth and psychological engagement. In both organisations, the balance between warm relations with patients and the preservation of staff wellbeing favoured the latter. To some extent, ‘ideal care’, according to professionals in both organisations,²² was ‘robotic’ (mechanical, detached and working strictly according to a pre-set programme) (Sharkey & Sharkey 2012). Being wary of the negative consequences of familial-like relations (Rutman 1996; Kay 2013), the nurses used various manipulative tactics to provide what they perceived as quality care, as can be seen in the case of Aglaya, a nurse with 15 years’ experience, describing a female patient:

Take for, example, her old crutches ... she had been falling with them all the time. She said they are broken. You can’t take them away though, she panics, she is used to them, is afraid of changes ... so, instead, you say that you took [them] for repair service, but the repair is delayed. Meanwhile, I give her new ones. After some time, she forgets about the old ones.²³

²⁰Interview #42, Elena, in her thirties, office administrator and social worker, charity hospital, St Petersburg, 17 December 2015.

²¹Interviews #48–50; see Appendix 1 for full details.

²²Interview #8, Judith, in her thirties, case manager at care-providing charity foundation 4 (‘Beser’), St Petersburg, 27 September 2015; interview #28, Faina Martynovna, in her fifties, head of health visiting service, care-providing charity foundation 5, St Petersburg, 11 November 2015.

²³Interview #48, Aglaya, in her sixties, nurse and health visitor, care-providing charity foundation 4, St Petersburg, 30 October 2016.

In this quote, the necessity to get new crutches outweighed the patient's wish to keep the old ones. At the same time, Aglaya tried to take the feelings of the aged care receiver into account by devising a complicated cover story about the disappearance of the old crutches. Some other nurses do not bother to do so, as to them, the elderly are 'troubled objects' rather than equal partners.²⁴ This discourse was so indicative that I had to formulate a separate category for it during the analysis stage of the interviews. In the case of 'troubled object' paternalistic care, all communication and negotiations were done with family, external professionals and colleagues, never with the individual aged care receiver. 'Troubled object' discourse can be linked to 'infantilisation', a belief that aged people lack the mental capacity to make rational decisions (Gresham 1976; Salari & Rich 2001). When describing their patients, these informants would share troubling stories about acts committed by said patients, such as turning on and forgetting gas stoves, accidentally locking doors, hallucinations, and a refusal to use the washing machine. When relaying these stories, the tone of the informants was critical and sardonic, and to a certain extent, amused, as they often laughed when recalling specific instances. In these cases, the framing of elderly care receivers was antagonistic: caregivers presented the care receivers as unpleasant, irrational creatures, incapable of understanding. In cases where it was necessary to adjust caregiving practices, introduce an innovation or change something, the decision was made in consultation with family or colleagues, but never the care receivers themselves.

Analysis

Overall, only two self-help support groups out of all the groups and organisations studied predominantly took the participatory care approach. Both were small, with just a few employees each, and were longstanding grassroots NGOs with a relatively stable financial base; they did not engage in the third sector expert community. Observation of how these NGOs communicated with care receivers, and field interviews with care receivers themselves, revealed that initiatives by care receivers were taken into account and transformed into activities. This fits the expectation of third sector professionalisation wherein community and civil society organisations become separated, with the latter more engaged in an arena of power struggle than they are in grassroots citizens' activism (Kauzya 2003). There were, it is true, several instances of participatory traits within different organisations (such as the charity foundation involved in care provision that allowed care receivers to suggest cultural events). However, more comprehensive care, such as medical services, health visits, social work, material and financial support, is a domain in which caregivers have exclusive control over decision-making.

Overall, based on the findings of this research, paternalistic care clearly dominated non-governmental elderly care in St Petersburg in the period studied. This was especially true for types of care involving bodily practices (health visits, medical care) and the care of fragile

²⁴Interview #48, Aglaya, in her sixties, nurse and health visitor, care-providing charity foundation 4, St Petersburg, 27 October 2016; interview #50, female, in her fifties, nurse and health visitor, care-providing charity foundation 4, St Petersburg, 27 October 2016.

fourth-age (older than 65 years) clients and socially disadvantaged groups. However, paternalism was also widespread during the implementation of various educational services such as computer literacy courses and aged volunteering driven by ‘active ageing’ ideology. Both innovative pilot projects on these topics run by the two organisations studied (respectively, the clientelist veteran organisation 3 and the care-providing resource centre 1) were launched in St Petersburg. At first glance, educational and socialisation projects empower care receivers. Yet, the actual caregiving, as shown in the cases above, was usually far from participatory.

There are also grant-giving members of the third sector expert community (charity foundations 1 and 2, both Moscow-based, yet funding numerous projects in St Petersburg), whose function within the professional third sector community is to provide care-providing NGOs with financial, material and informational support. In the rare cases when they became directly involved in project management, their high level of technical and administrative expertise in running third sector organisations and very strict project requirements lead to a top-down view of care receivers as incapable of suggesting anything meaningful to non-governmental caregivers. This view and the decision-making practice align with the NGO professionalisation theoretical debate (Batley 2011; Shrestha & Adhikari 2011; Choudry & Kapoor 2014). Other professional NGOs providing elderly care, such as ‘Snowflake’ and ‘Space Shuttle’, consist of small, dynamic teams of paid NGO workers. Despite their claim to follow an active ageing approach, actual relations with their aged beneficiaries were less than equal. Care receivers were perceived as a commodity, a resource to be used to sustain organisations’ operations. Relations between the caregiver and care receiver were just part of a wider process of civil society development for these NGOs. Namely, professional NGOs do not give much thought to the individual service receiver, his or her needs and circumstances, but rather aim at improving society in general, measuring success in terms of general quantifiable achievements at the macro-level. At the same time, putatively empowered aged care receivers become burdened by ‘moral obligations’ (Chappell 1997) towards project managers rather than being able to cultivate their own genuine interest in participating in organised events. Furthermore, professional NGOs offer care that they consider ‘sustainable’, which can again be taken as a reference to bringing about society-wide change, but also as denoting a high level of administrative and technical expertise in caregiving. They are reluctant to satisfy the simplest of needs, be that access to drinking water or afternoon tea gatherings. For instance, in the eyes of some St Petersburg third sector professionals, ‘drinking tea’ denotes an anecdotal (yet, also quite real) example of the basic activity of self-help support and veteran organisations.²⁵ Similarly, Ivan Ivanovich, the director of the professional infrastructural NGO ‘Big’ admitted that ‘[drinking tea together] is the main need of an old person’.²⁶ However, he also emphasised

²⁵While admitting that some aged people would prefer drinking tea to complex social participation projects, the project manager of the charity foundation pointed out ‘Nevertheless, the person should have some training before coming [and] drinking tea’. (Interview #3, female, in her thirties, project management, grant-giving charity foundation 2, St Petersburg, 3 March 2015.)

²⁶Interview #27, Ivan Ivanovich, in his fifties, director, infrastructural resource centre 2, St Petersburg, 9 November 2015.

that NGOs should not blindly obey the wishes of their beneficiaries. The third sector has the capacity to do something for a wider society:

You understand that these [self-help] organisations are helping a very narrow group of people—their members. For a wider public, this doesn't work. On the other end of this hierarchy are organisations which provide services to the outer world, seeing social services to individuals and assistance to other NGOs as a strategic work for society-wide transformations.²⁷

According to this logic, for the sake of bringing about social change, one should go beyond tea-drinking and the interests of individual care receivers. In this view, individual care receiver–caregiver relations are of lesser importance. Thus, in the case of the St Petersburg elderly-care-providing NGOs, the individual interests of care receivers are often disregarded for the sake of major societal goals or—when an individual caregiver's request contradicts 'expert knowledge'—what is 'better' for aged people.

To summarise, St Petersburg professional NGOs largely avoided giving access to information about caregiving to their beneficiaries. They also rarely carried out a needs assessment, citing their own expert knowledge as to what receivers require.

One might wonder why educational services, self-help support group meetings and comprehensive medical care are conflated. However, my study of St Petersburg elderly-care-providing NGOs suggests that these different types of care can and should be compared. When considering the agency of older people, the type of care appeared to be less important than the type of organisation (namely, whether it was a professional member of the third sector expert community). In fact, medical care provided by organisations not sharing expertise in running NGOs can sometimes be participatory (as in the case of the aforementioned charity hospital). And, conversely, active ageing-based empowerment projects aimed at third age people from a relatively privileged background can still be overwhelmingly paternalistic when it comes to decision-making over the content and process of caregiving. Finally, the concept of care denotes more than simply the duties of a nurse or a social worker: many other services aimed at improving other's lives are an inseparable part of care practice.

Regardless of the specific activity, the formalisation and bureaucratisation of caregiving led to the development of expertise and, consequently, the autonomy of caregivers in their decisions from any care receiver input. As a result, elderly people were positioned as objects, denied agency in the caregiving process.

There were some noteworthy instances where elderly care receivers were able to control the caregiving process or propose initiatives. Occasional cultural events suggested by care receivers were, however, rare exceptions to otherwise widespread paternalism. Furthermore, there are 'self-help support NGOs'. The three studied here were veterans' organisations which, with one exception (self-help support veteran organisation 3), were financially dependent on the regional authorities. Compared to their larger counterparts,

²⁷Interview #27, Ivan Ivanovich, in his fifties, director, infrastructural resource centre 2, St Petersburg, 9 November 2015.

though, these organisations did not bother to translate regional government ideologies and policies. Instead, they used connections to the state to improve the quality of life of their own members. So, the smaller veterans' organisations were in terms of budget and number of employees, the more opportunities elderly care receivers had to exercise agency.

Those who run their own NGO and do not involve public authorities or ask for funding are under no obligation to follow 'best practices' or state policies. This is true for all three self-help support organisations. Instead, self-supporting veterans were quite content with irregular computer literacy teaching and tea-drinking. When doing participatory observations, I witnessed various instances of self-help support NGOs' workers adopting suggestions from their beneficiaries in order to keep the community consolidated and minimise the risk of losing clients.

In contrast, clientelist veteran organisations did not let aged people participate in the organisation of care. Instead, the role of the latter was to be silent 'service receivers', be that of educational services, home-based care or 'calendar' support. I refer here to the Santa Monica case, as one of the most indicative among other similar and numerous examples of paternalism in caregiving practice by clientelist NGOs.

To sum up, there was not much of a difference between openly paternalistic leadership and 'ideologically participatory' caregivers. In practice, aged people were objects in the process of care provision; they were entitled to accept what was offered, but not to control and intervene in the process with their own initiatives.

Conclusion

Based on the qualitative sociological research of non-governmental elderly care organisations in St Petersburg, this article has explored ways in which professionalisation prevents caregivers from allowing care receivers agency in the process of care. Despite the institutionalisation of 'active ageing' as the dominant ideology of ageing in Russia, actual interactions between caregivers and care receivers—as well as the organisation of care—are still characterised by unequal relations between the elderly and non-profit professionals.

In fact, NGOs largely build their third sector identity on own expertise and gatekeep decision-making from care receivers. As a result, their accountability and assessment of caregiving success depends not on care receivers' feedback (which is often the case for community-sourced grassroots self-help movements) but, rather, on formal quantifiable performance characteristics (number of clients served, number of publications covering the project, amount of money raised etc.) and bureaucratic quantitative reporting tools. This is true both for members of the St Petersburg professional third sector and for state-dependent 'clienteles'. Organisational matters—in the sense of bureaucratisation, formalisation and a concern for self-preservation (the survival of the organisation as such)—start to dominate NGO operations. Consequently, care practices have become dependent on formal quality and accountability requirements, the opinion of grant-givers and the expertise of project managers. The result is the objectification of aged care receivers.

Similarly, expertise is developed by individual caregivers who interact with the elderly on a daily basis. As a result, many St Petersburg elderly caregivers find themselves in a position of power; perceiving care receivers as socially deprived individuals who lack human capital,

they thus feel obliged to be their ‘saviours’ by providing non-governmental social services.²⁸

Furthermore, a perception of caregiving as merely a component of wider social transformation efforts—and the elderly as troubled children—leads to objectification of care receivers. Equally, the third sector expert community members and clientelist NGOs behave in this way, reproducing paternalistic care. In the case of my study, these organisations stopped performing needs assessment; lost interest in feedback; started to run projects for the sake of running projects, that is, for organisational and financial reasons. Consequently, St Petersburg NGOs do not allow much space for aged care receivers to influence decision-making or the implementation of care. In other words, they objectify them.

The only type of NGOs using participatory care in their practices are self-help organisations, that is: veteran-run civic and clientelist NGOs. Although their activities are usually based on ‘calendar care’ and ‘informal social activities’, a range of other services are developed in a direct collaboration with their care receivers. In these self-help support organisations, caregivers are often aged people themselves. These NGOs are on the fringes of the professional third sector community in St Petersburg. Nevertheless, they constitute an important institution for the empowerment and agency of aged Russians (Kulmala & Tarasenko 2016).

This article aimed to raise questions about the mismatch between the empowering goals and paternalistic procedures of professional NGOs in Russia. In broader, theoretical terms, this study contributes to a current debate on the professionalisation of NGOs as well as bringing a focus on care receivers back onto the agenda of care studies. There is a need for further research on participatory caregiving practices. Until this is accomplished, it seems there is very little chance of aged care receivers in Russia ever having the chance to walk virtually down the streets of Santa Monica.

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²⁸See Krause (2014) for a similar story about humanitarian aid recipients in general.

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Appendix 1

TABLE A1
LIST OF INTERVIEWS

Interview number	Identifier	Organisation type	Location	Date
1	Male in his forties, project manager	Grant-giving charity foundation 1	Moscow (via Skype)	21 December 2014
2	Female, in her thirties, project manager	Private elderly-care-providing company 1	Moscow (via Skype)	5 February 2015
3	Female, in her thirties, project management	Grant-giving charity foundation 2	St Petersburg	3 March 2015
4	Female, in her thirties, vice-president, project manager and lecturer	Resource centre 1	St Petersburg	10 February 2015
5	Female, in her thirties, director	Grant-operating and care-providing charity foundation 3	St Petersburg	6 March 2015
6	Male, in his fifties, director	Care-providing charity foundation 4	St Petersburg	10 February 2015
7	Female, in her thirties, communications manager	Care-providing charity foundation 4	St Petersburg (not under record)	10 February 2015
8	Judith, in her thirties, case manager	Care-providing charity foundation 4	St Petersburg	27 September 2015
9	Male, in his sixties, vice-president and project manager	Self-help veteran organisation 1	St Petersburg	6 October 2015
10	Male, in his fifties, project manager	Self-help veteran organisation 1	St Petersburg	6 October 2015
11	Male, in his fifties, project manager	Self-help veteran organisation 1	St Petersburg	6 October 2015
12	Male, in his forties, hired psychologist and lecturer	Resource centre 1	St Petersburg (not under record)	7 October 2015
13	Male, in his thirties, public relations manager	Care-providing charity foundation 5	St Petersburg	9 October 2015
14	Female, in her fifties	Director self-help veteran organisation 2 and administrative committee chairwoman, clientelist veteran organisation 1	St Petersburg	13 October 2015
15	Vera Sergeevna, in her sixties, care receiver	Resource centre 1	St Petersburg	14 October 2015
16	Male, in his fifties, head of volunteering department	Care-providing charity foundation 4	St Petersburg	15 October 2015
17	Roza Josephovna, in her seventies, care receiver	Care-providing charity foundation 4	St Petersburg	15 October 2015
18	Female, in her twenties, project manager	Care-providing charity foundation 6	St Petersburg	29 October 2015
19	Male, in his sixties, vice-director	Clientelist veteran organisation 2	St Petersburg (not under record)	4 October 2015
20	Female, in her twenties, cultural event manager	Clientelist veteran organisation 2	St Petersburg	28 October 2015
21	Male, in his twenties, project manager	Clientelist veteran organisation 2	St Petersburg	28 October 2015

(Continued)

TABLE A1 (Continued)

Interview number	Identifier	Organisation type	Location	Date
22	Female, in her eighties, head of the local level 'pervichka' branch	Clientelist veteran organisation 1	St Petersburg	28 October 2015
23	Female, in her seventies, vice-head of the local level 'pervichka' branch; also two other volunteering veterans assisting the vice-head (all female, in their seventies) were present in the office and participated in the interview	Clientelist veteran organisation 1	St Petersburg	15 November 2015
24	Female, in her twenties, volunteer	Grassroots informal activist group 1	Leningrad Oblast' (not under record)	3 October 2015
25	Female, in her twenties, volunteer leader	Grassroots informal activist group 1	Leningrad Oblast' (not under record)	3 October 2015
26	Female, in her thirties, volunteer leader	Grassroots informal activist group 1	Leningrad Oblast' (not under record)	3 October 2015
27	Ivan Ivanovich, in his fifties, director	Infrastructural resource centre 2	St Petersburg	9 November 2015
28	Faina Martynovna, in her fifties, head of health visiting service	Care-providing charity foundation 5	St Petersburg	11 November 2015
29	Male, in his thirties	Founder of informal group transformed into care-providing charity foundation 7	St Petersburg	11 November 2015
30	Female, in her twenties, project manager	Grant-operating and care-providing charity foundation 3	St Petersburg	13 November 2015
31	Female, in her forties, head of research	Grant-giving charity foundation 2	St Petersburg	19 November 2015
32	Female, in her seventies, director	Self-help veteran organisation 3	St Petersburg	20 November 2015
33	Male, in his thirties, project manager	Infrastructural resource centre 2	St Petersburg	20 November 2015
34	Female, in her twenties, volunteer	Care-providing charity foundation 6	St Petersburg	24 November 2015
35	Male, in his thirties, project manager	Clientelist veteran organisation 3	St Petersburg	25 November 2015
36	Male, in his sixties, director	Clientelist veteran organisation 3	St Petersburg	29 November 2015 & 12 December 2015
37	Mikhail Supov, in his twenties, project manager and lecturer	Clientelist veteran organisation 3	St Petersburg	30 November 2015
38	Female, in her seventies, care receiver	Resource centre 1	St Petersburg (partly not under record)	4 December 2015
39	Female, in her forties, librarian	Local city library branch	St Petersburg	15 December 2015
40	Female, in her twenties, volunteer	Care-providing charity foundation 6	St Petersburg	15 December 2015
41	Female, in her thirties, volunteering coordinator	—	St Petersburg	16 December 2015

(Continued)

TABLE A1 (Continued)

Interview number	Identifier	Organisation type	Location	Date
42	Elena, in her thirties, office administrator and social worker	Charity hospital	St Petersburg	17 December 2015
43	Female, in her teens, volunteer	Grassroots informal activist group 2	St Petersburg	17 December 2015
44	Male, in his forties	Volunteer, grassroots informal activist group 2	St Petersburg	22 December 2015
45	Male, in his thirties	Grassroots informal activist group 2	St Petersburg	23 December 2015
46	Female, in her forties, head of the information services	Local CSSC branch (state social service providing institution)	St Petersburg	25 December 2015
47	Female, in her sixties	Care-providing resource centre 1	Leningrad Oblast' & St Petersburg (not under record)	4 October 2015 & 26 December 2015
48	Aglaya, female, in her sixties, nurse and health visitor	Care-providing charity foundation 4	St Petersburg	27 October 2016
49	Female, in her sixties, nurse and health visitor	Care-providing charity foundation 4	St Petersburg	30 October 2016
50	Female, in her fifties, nurse and health visitor	Care-providing charity foundation 4	St Petersburg	27 October 2016
51	Field interview, Lida Lvovna, in her sixties, care receiver	Clientelist veteran organisation 3	St Petersburg (not under record)	25 November 2015

Appendix 2

TABLE A2
TYPES OF CARE

Participatory care	Paternalistic care
Participation in organisation of care	Deprivation from organisation of care
Accessing and negotiating changes in the process of caregiving	No negotiations about content and process of care
Elaboration of needs (assessment, feedback, channels for communication)	Needs disregarded (no assessment or feedback collection, no action despite knowing needs)
Access to information	Gatekeeping of information
Resources for autonomy (active ageing)	Limited resources (no active ageing)
Recognition as subject (autonomy, decommodification)	Objectification (dependence, commodification)