Chapter V: Nursing as Care Work: Skill, Status and Stigma

In the last few decades, debates on ‘care work’, especially in the west, have focused on the cultural and economic devaluation of commodified reproductive labour. Reproductive labour or use-value labour is generally devalued in capitalist societies, and as most of it is done by women, it is women’s work that is specifically denigrated. Even after use-value labour is brought into the labour market as exchange-value, it does not necessarily alter the meanings attached to it. On the contrary, associations with femininity continue to place such kinds of labour at a disadvantage in the labour market. Care work in the west is not marginalised and stigmatised merely because it is a female-intensive sector but is also shaped by race, ethnicity and class of the women who are concentrated in this sector. Predominantly done by women who are immigrants, working class and coloured, it remains low paid, invisibilised, stigmatised and exploitative. In India, however, the context is slightly different.

The devaluation of women’s work and the increasing processes of informalisation of the formal economy intersect to ensure that women remain at the lowest end of the labour market. Scholars have demonstrated that women are finding employment only in the service sectors; with the exception of a few middle-class, educated women, most of them are concentrated in the informal end, engaged in manual, arduous, ill-paid sub-sectors. In the current labour market, where both the formal and the informal economy is increasingly getting masculinised, care work could possibly be a source of employment for women. Care work is not a homogenous sector — it includes well-paid, high-skilled professionals working both in the public and private sector as well as ill-paid, semi/un-skilled casually employed men and women. Some female-intensive care work — such as air hostessing and nursing are higher up in the hierarchy, while domestic work, sex work

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and attendants are at the bottom. The professions which occupy the lowest end of the labour market have never been formalised. Increasingly, even those professions which are relatively at the top are being brought under the ambit of informalisation, such as nursing.

In the context of the larger processes of informalisation and casualisation of the formal economy, the three-tier labour market that operates in the nursing profession deploys categories of nursing personnel in a manner that cuts across private and public medical organisations. The economic and cultural value given to the trained nurse located at the top of the pyramid as opposed to the untrained nurse or attendant located at the bottom is an example of how the signifying system functions when it comes to women’s work. Nursing in particular, which is still an exclusively feminine profession, has its own specificity. Care work, with its close association with menial labour is constituted in such a manner that not just gender, but class and caste mediates understanding of the respectability of the work.

The value given to work, both culturally and economically, reflects on the social identity of the worker and in turn, his/her bargaining power within the workplace, community and family. I argue, in this chapter, that employment by itself cannot increase a woman’s bargaining power vis-à-vis patriarchy; the nature and terms of work, remuneration, etc plays a determining role in constituting work as respectable which in turn empowers the worker. In this instance, nursing is constructed as unskilled or semi-skilled work done by lower-caste, working-class women and therefore devalued. While the trained nurse may enjoy certain amount of privileges or respect as compared to the untrained nurse, on the whole she suffers from the stigmatisation that is shared by the profession.

**Nursing: Menial or Technical Work?**

Nursing, like domestic and sex work, comes under the larger rubric of care work (use-vale labour) and affective labour (that affects human emotions). In the introductory
chapter, I visited the current debates regarding care work and the impasse it faces in both Marxian-American-Feminist thought and European Post-Marxist thought. Here it is suffice to say that the current understanding of care work is inadequate and has become synonymous with women’s paid and unpaid reproductive labour. While it is true of the west, that women engaged in care work may be paid less than women in other female-intensive professions, in India, the story is more complex. Officially, care work per se is not paid lesser than other forms of manual work. For example, in West Bengal, the minimum daily wages for unskilled labour has been fixed at approximate rupees 144 and in Kolkata Municipal Area about rupees 162 and for semi-skilled labour, rupees 159 and rupees 178 respectively. So the remuneration for an ‘unskilled’ and a ‘semi-skilled’ worker in a clinical nursing home is the same as that of the leather and tannery factory, or working in security services, or in the power looms. However, this is only on paper. My research shows that attendants, who are perceived as unskilled labourers are paid anything between rupees 2000 to 2400 a month (approximately rupees 77 to rupees 92 daily if calculated on the basis of 26 days/month). Semi-skilled workers like untrained nurses are paid rupees 2800 to 3000 (approximately rupees 107 to rupees 115 daily). Almost all unskilled and semi-skilled workers in both clinical nursing as well as other forms of care work are increasingly coming under the informal economy; they fall outside the purview of labour laws and regulations. Moreover, gender discrimination in wages is still rampant in India. Though there are laws stating equal pay for equal work, government reports admit that women all over India still earn 75 per cent of men’s wage rates. Even in 2004-05, the all-India average of wages per man-day for men is rupees 212.30, while for women it is rupees 91. The other sectors where women are

concentrated in manual work are the home-based, piece-rate jobs\textsuperscript{366} and where the average earnings are about rupees 680.24 in a week (2009-10) or rupees 2720 per month.\textsuperscript{367} Though the official wage rate, secured under the Minimum Wages Act 1948, does not distinguish between care work and other forms of un/semi-skilled work, the implementation reflects cultural and social norms. The discourse on skills, as well the nature of formality of the employer-establishment determines wage rates.

This association of care work with semi/un-skilled work informs much of the discourse surrounding nursing. My research on nursing in institutional setting in Kolkata points to a cleavage within ‘care work’, which is further divided into technical and manual work. However, this division is not clearly demarcated into watertight compartments and overlaps and contradictions keep surfacing. By manual work one usually understands work done involving the body directly, which is not skilled and requires no training. Nursing is usually perceived as both manual and menial work— it is the ‘care’ component in the process of healing— which is giving bodily service. Technical work is seen as work exclusively reserved for experts, a specialised esoteric body of knowledge that is the prerogative of people who have been ‘trained’ in that particular field. In the medical profession it is doctors who fall under this category. It is true, that doctors are also classified under the broad category of care workers; however, there are significant differences between a doctor and a nurse. First, a doctor is considered a highly-skilled professional, who undergoes intensive, scientific training. Healing in India has two components that stand in contradiction to each other—science and technology and magic that comes from folklore. This means that on the one hand, a doctor has a claim to scientific knowledge that sets him/her apart from other caregivers and on the other hand, they are semi-deified as life givers, i.e., those who have power over life and death.

Secondly, the cure/care divide is gendered; while cure is identified as masculine, care is relegated to the feminine. So, despite a doctor being a caregiver, he is not culturally or economically devalued like a nurse or an attendant.

Nursing has often been labeled as a semi-profession even in academic scholarship. To establish nursing as a respectable profession done by qualified and skilled personnel with higher market value, it has to lose its associations both with femininity as well as menial work. This would include emphasis on training and degrees (recognised or not), uniform (white or otherwise), nature of work (technical or menial), terms of employment (permanent or contract), nature of the organisation (government or private) which demarcates a qualified professional nurse from an untrained menial worker. Both the government and the private sector employ a small number of registered nurses as supervisors and administrators, while the wards are managed by unqualified, badly paid, unregistered nurses and attendants. This dichotomy of trained/untrained, skilled/unskilled, formal/informal employees is deeply contested and resisted by workers. The questions that arise are how does this dualism function? What are the processes that allow nursing to be split into two distinct but hierarchal realms?

Reforms in nursing care, as initiated by Florence Nightingale (1860), clearly laid out the duties of a nurse—she was to take care of all needs of a patient: these include all functions of the body (essentially cleanliness and hygiene) and act as a handmaiden to the doctor and follow his instructions. However in consequent attempts to modernise nursing and to establish it as a profession, the menial component in nursing care has been relegated to auxiliary nursing staff (untrained nurses and attendants). This subsequently translated into a hierarchy of nurses and attendants/nursing aides. While nurses concentrate on medicine, instruments, record-keeping, administration, management and other relatively more prestigious tasks, all menial tasks catering to bodily needs are

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relegated to attendants and unregistered private sisters, who are crowded at the bottom of nursing service. While trying to empower one segment of the medical hierarchy, these processes have created newer hierarchies and refashioned old ones.

Feminists argue that hierarchical binaries are based on the derogation of feminine virtues and the privileging of the masculine. This positing of masculinity as both universal and privileged is what keeps androcentrism (i.e. masculinity in a situation of power) stable and unchallenged. As demonstrated in earlier chapters, medical service is divided along the lines of cure/care, reason/emotion, technical/menial, doctor/nurse which is further linked to gender hierarchies; however, with the politics of increasing informalisation and casualisation, we see differentiation within nursing services on similar lines. Nurses prefer to work with technology which is constructed as masculine or do managerial/administrative work rather than take bodily care of patients. The processes of modernisation and professionalisation of nursing services demanded a certain purging of menial work, which now is relegated to ‘cheap’, dispensable informal workers. The logic of professionalising nursing services and making it respectable, demands that nurses identify with masculine principles and virtues like technical knowledge, reason, science etc. In an attempt to identify and compete with doctors, nurses leave the distasteful part of their job to attendants and private sisters. To masculinise their profession by making it technology-intensive the feminine is relegated to a new ‘other’.

The hierarchies within medical services and specifically nursing services and the desire to move up horizontally is summed up by Annapurna, who works as an attendant in a private hospital.

Why do sisters not help us to do our work? It hurts their pride. They think they are different. They say ‘we are sisters; we have taken a nurse’s training and come, so why should we do an attendant’s work.’ Why do we do a sister’s work— we like it, we will learn something new, we get to
touch a machine. We want to do a nurse’s work. They want to do a
docotor’s work. Everyone wants to rise up.  

All work that has a menial component is now an attendant’s work. For a nurse to give
bodily service is to do the work of an attendant which is demeaning. They rather do the
work of a doctor, which is technology-intensive and has a claim to scientific knowledge.
Attendants aspire to do a nurse’s work, ‘touch a machine’, which would in turn lift them
from associations of feminine and therefore devalued work. To ‘rise up’ then is to do
work that has both cultural and economic value.

Is ‘Care Work’ Considered Work? Negotiating Meanings of Work

Work that is intimately connected to bodily services has always been stigmatised. Martha
Nussbaum argues that stigmatisation of certain occupations is related to gender
hierarchies. Taking the example of opera singers, dancers, masseurs, prostitutes and
surrogate mothers, Nussbaum argues that historically women, who engage in these
occupations for money, were socially and morally suspect. Particularly, the ‘leisure
classes’ viewed wages for certain work as socially unacceptable; Nussbaum is quick to
point out that it in the western context, it was not the work per se, but taking money for
work that was not acceptable in ‘polite societies’.  

Nancy Folbre and Paula England argue that the wage penalty women in care work pay are also because such work is
understood to be part of women’s natural work. The assumptions that underlie this trend
are that women do it out of love, and not for money, and therefore low wages will
suffice.  

In context of health services, while the work of an attendant and an untrained
nurse is devalued as un/semi-skilled labour, a trained nurse with three years plus of

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369 Personal Interview dated 18.11.2009.
370 Martha C. Nussbaum, “Whether from Reason or Prejudice”: Taking Money for Bodily Services’, The
specialised training is also relatively less paid than other medical personnel, such as the doctor.

In our country, the axis of purity and pollution within Brahminical patriarchy spells out that certain manual work is menial and therefore dirty; and are meant to be low-caste occupations. Though the Indian constitution disavows caste system, caste-based discrimination still exists in India. Historically, dealing with the body and body detritus has been the exclusive occupation of lower-caste men and women—such as disposal of dead bodies, sweeping, manual scavenging and night soil work. On the one hand, certain specific caste-based occupations continue, and on the other hand, a general association of lower castes with menial work persists till today. My research in medical establishments in contemporary Kolkata, demonstrates that associations of low caste with menial, stigmatised labour is still a trend. Attendants are specifically employed to take care of bodily needs of patients, something a trained nurse will not do because of class and caste associations. In my conversations with attendants the stigma of menial work was brought up again and again. They feel that the menial nature of their work is what stigmatises the occupation and disempowers them as workers. Ritu, who works as an attendant in a private hospital, feels that because they touch and clean body wastes, they have no respect in society. ‘Cleaning excreta gives me a lot of pain. Because we do this kind of work, we are looked down so much by society.’

This feeling echoes through almost all interviews conducted with attendants cutting across private and government hospitals. Anami, another attendant in the private hospital speaks of her experiences of stigma within her own family. Her sister-in-law holds her in contempt because of the nature of her work.

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Society has an aversion for us. My sister in-law herself tells me … ‘she goes to handle dirt (nongra ghat te jai)’… ‘She goes to the hospital to clean excreta (hospital e goo ghate)’.  

Along with caste and gender, class also constitutes menial work as lowly. In the public realm it is men and women of lower castes who take care of the menial jobs, whereas in the private realm, women’s reproductive labour usually includes menial jobs (sweeping, cleaning, washing, child care, nursing the sick and aged). However, upper-caste, middle-class women usually hire domestic workers. This too has a historical specificity. In Indian society, middle-class, upper-caste women maintained seclusion and did not engage in any form of labour outside the home. Samita Sen argues that the menial component of domestic work was done by servants (lower-caste men and women) and it was a crucial marker of family status. By nineteenth century, the grafting of the construction of the bhadramahila on a society already marked by a caste-based division of labour included, amongst other things, not having to do menial labour, even within the household. Seba, or care/nursing of the sick and aged within the household is the special responsibility of women, even if in bhadralok households actual menial tasks are delegated to working-class, lower-caste men and women who work as domestic servants. Middle-class respectability partially depends on not doing any task that is menial in nature, both for men and women.

It is not just the attendants, who face stigma, but nurses as well. Shirsha, a young nurse working as a GNM who has migrated to Kolkata to work in a private hospital narrates an incident when an elderly woman who was under her care was ill-treating her. Out of frustration when she complained: ‘we are like your grandchildren, why do you behave like this with us? She replied we can never be equal to her granddaughter as we take

money for our work." The implication being that as long as it is *seba* (done for love or as a duty by female kin) within the private realm, it is respected, maybe even revered. But when the same labour is brought into the public realm as an exchange-value commodity, it is denigrated and devalued. What historically counts as unpaid reproductive labour (use-value labour) by women within the household, when commodified and brought into the labour market as exchange-value, is not recognised as ‘skilled labour’ that deserves economic and cultural recognition and respect. *Seba* can be done by respectable women only within domestic confines; the minute she commodifies her labour and takes money in exchange she loses respectability and become equal to that of a working-class woman.

Even in the public realm, the construction of a middle-class professional excludes any form of menial labour. However, the work that doctors do which includes bodily touch like dressing and bandaging wounds is considered respectable work; nurses do not have an aversion towards such work. It is less because of the nature of the work and more the construction of a doctor. Doctors are almost semi-gods, everything they do and anything they touch is sacrosanct and beyond questioning. Doctoring and its rise as a highly coveted, respectable profession has its own historical specificity. It is the power over life and death which deifies doctors and gives them magical skills that co-exist easily with reason, technology and science; and it is also the same power that allows the seemingly contradictory elements of science and mysticism to place doctors above any question. Take for example, surgery which was highly stigmatised in pre-colonial/colonial India, so much so, that it was the low-caste barbers who did it. The high caste *hakims* and the *vaids* refused to partake in cutting open a body. However, with colonial medicine and its focus on science, surgery became a coveted skill in medicine which at present is the forte of upper-caste, middle-class men. And I specifically use the term ‘men’, as surgery is also considered a masculine profession. It is considered to be such a fine skill that women are

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generally considered too inferior, too emotional, too lacking in cognitive capability to learn it. Surgery, with its power over life and death also purportedly gives magical skills to the surgeon. As a consequence, the two contradictory elements— science and magic— come together to deify the doctor as a figure of authority and respect.

Within the grids of gender, class and caste, work and workers mutually constitute each other to define what respectable work is. Such perceived value of work play a pivotal role in justifying low wages for care work which takes care of (non-respectable) bodily functions. Some of the women even report that an attendant’s work is dismissed and is not given any due recognition. As Sujata, working as an attendant in a private nursing home says ‘the first reaction of people is that she works as a mashi (attendant). Is that even work?’ Annapurna, working as an attendant, in a private hospital feels that the nature of the work coupled with low wages does not allow her to assert herself as a worker. ‘Society attaches a lot of stigma to this service. This has so little salary. People will say she works as an attendant and yet she is so vocal (mashir kaaj kore abar boro boro katha bole).’ Just on the perceived value of her income and nature of work, Annapurna has been unable to carve out a niche where she has the right to assert herself in community gatherings and the neighbourhood. Instead of paid work increasing her bargaining power, she has lost legitimacy in the eyes of her community and family. Working as an attendant in a hospital has increased her social isolation, even within her household.

My sister in-law avoids me at home because I work as an attendant in a hospital. She is a teacher in an English medium school. They do not allow their son to come to my room or talk to me. They do not mind if he goes to

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376 Personal Interview dated 2.05.2009.
my other brother or sister in-law, but they do not like it when he comes to me.\footnote{Personal Interview dated 18.11.2009.}

The attendant is located so low within the medical hierarchy, that even respect from clients is not forthcoming. This resonates in women’s pain at being called a ‘mashi’, which they themselves directly relate to the nature of their work. While mashi in Bangla is a term used to refer to the mother’s sister, it is also a generic term used for domestic workers. After the Bengal partition of 1947, with the breaking down of feudal caste society, women refugees from East Bengal looking for paid work entered domestic service. Because they came from the bhadralok society they were called ‘mashi’— a familial name, to ease the transgression from private to public. ‘Mashi’ is also a generic term for mistresses of brothels. While women’s work has historically been constructed as menial, unskilled and sexualised, using the term ‘mashi’ especially for women engaging in bodily service in hospital settings may invoke such meanings. Ritu feels that because the work she does has no respect in society that is why she (with others) is called ‘mashi’. She directly links the name calling with the work she engages in and thinks that calling someone ‘mashi’ is derogatory.

Calling us as mashi— where is it written that because we give bedpans, we are to be called as mashi? I am working, sometimes I feel so proud that I am not dependent on my family. I am living alone and working in a hospital. And then the patients call me mashi and I start feeling so bad. I just cannot adjust to this word. No work is lowly (choto) so why do they need to demean us (choto kora) like this?\footnote{Personal Interview dated 2.07.2009.}

Nurses have similar anxieties; when patients call them ‘nurse’, they are quick to correct them and insist on being called ‘sister’. While sister, like mashi also expresses kinship, it
has other connotations as well. In the west, before nursing reforms were carried out, ‘sister’ was the name given to women who had joined nursing but were ‘persons who lived in respectable ranks of life’ and were previously employed as head-servants of middle-class families. They were of a more senior rank than the nurse and worked as supervisors and were largely responsible for seeing that doctor’s orders were carried out. This tradition continues even in contemporary India. The term ‘sister’ denotes someone in the nursing staff who has managerial and administrative authority. Within the nursing hierarchy, after the matron comes the ‘sister-in-charge’ who is the supervisor of the ward. Under her supervision are the staff nurses. So with modernisation and consequent professionalisation of nursing, the term ‘sister’ has come to signify an administratively senior position within the nursing hierarchy. The other connotation is religious. Historically, nursing was also done by nuns who either nursed the sick in monasteries or supervised women who nursed the sick in hospitals and workhouses. A nurse in contemporary Kolkata could possibly be laying claim to notions of purity and selfless service associated with the term ‘sister’. Nurses insistence on being called a ‘sister’ could either be to lay claim to religious sanction on their work or managerial authority, and therefore professionalisation.

For some women, stepping out of the private realm to go to work is itself a transgression of gender norms. However, the nature of work limits this transgression and on the contrary, it has led in many instances to a loss of status and pride. Some of the women who work as private sisters and attendants in nursing homes and private hospitals report that their families and communities back in the districts are unaware of the work they are doing. They do not deny working as care workers in hospitals; instead they claim to be nursing staff. The comparative advantages of working in a higher rung in the hierarchy outweigh the disadvantages of working in a particularly stigmatised sector. As Radha working as an attendant in a private nursing home put it:

Attendants and nurses do not get any respect in society. But a nurse is better than an attendant. People in my family know that I am working in a nursing home. They do not know that I work as an attendant. They think I am a nursing staff.\textsuperscript{380}

Women are constantly negotiating the relationship between workplace hierarchies and social identities. Lying to their families and communities about the nature of the work, to escape stigma seems a common phenomenon, especially for those women who have migrated from rural countryside to the urban cities in search of work. Equally, there are women who are at the bottom of the hierarchy and who couch their pride and defiance as workers in ideologies of wife/motherhood. Naila Kabeer in her study on women workers in garment factories in Bangladesh notes how women negotiate cultural meanings of \textit{purdah} to fit in with economic necessity. While not challenging the official discourse on \textit{purdah}, women contest its meanings to justify their decisions to work in a factory.\textsuperscript{381}

Women justify their choices of working as a menial worker in a hospital using ideologies of maternal altruism, especially in the face of failure of kin to assist them in times of economic distress.

Sundari, Attendant, Private Nursing home

We are working because of our children. This cleaning of urine, bowel, and vomit – this is lowly (\textit{nicchu}) work. But we do it because we are mothers. When people in society know that I work as an attendant, they dismiss me; they insult me, which is why I do not go to any relative’s

\textsuperscript{380} Personal Interview dated 26.07.2009.

house. I have to live. If society has to accept me they have to accept me like this, otherwise they can go to hell.  

Jaba, Attendant, Private Nursing Home

This line is stigmatized. Society looks down on whoever does this kind of work. They think this is lowly work (*nichu kaj*). I do not care who says what. I have to run a household. Is anyone feeding me? Is anyone helping me? As long as I am not stealing or doing bad work (*kharap kaj*), I do not care what they say.  

In the context of the stigma associated with an attendant’s work, the spotlight is trained on the honesty of the labour, to delink it from either prostitution or thievery. These associations are not surprising, as historically, women workers located in the lowest rungs of the labour hierarchy, have often been working-class, lower-caste women accused of thievery, immorality, licentiousness and prostitution.

One of the ideological foundations of the caste system is the notion of purity and pollution— which materially manifests in a division of labour— where upper castes engage in intellectual knowledge and other cleaner and more prestigious work, and the lower castes engage in menial defiling labour. Scholars such as Uma Chakravarti argue that the caste system has evolved to maintain Brahmical purity that is to protect the upper castes from doing any impure labour, which is exclusively done by the lower castes. The purity of the upper-caste body then is constituted on the exclusion of the lower castes. In the medical institutions in contemporary Kolkata, it is this breaching of caste norms that causes a lot of anxiety and conflict. The caste distribution amongst the respondents is almost equal (refer to table 2.6) with 46.8 per cent belonging to Scheduled
Castes/Scheduled Tribes category and 47.8 per cent belonging to the General category, which means that there are an equal number of upper-caste women working as nurses and attendants as lower castes. For a Brahmin woman, the menial nature of the work of a caregiver in a hospital setting is a transgression of caste, class and gender norms. Cleaning blood, excreta and body fluids is seen as a loss of middle-class, upper-caste respectability and waged work itself of femininity.

Barnamala, Attendant, Private Hospital

I have adjusted to this but I still go through pain. I discuss with my friend that where was I born (in a Brahmin family) and where I have landed up. I am working as an ayah in a hospital.\textsuperscript{385}

Annapurna, Attendant, Private hospital

My sister in-law avoids me. She does not tell me anything but I know she is thinking that a Brahmin girl is working as an attendant in a hospital. She does not talk to me, so I have also stopped talking to her.\textsuperscript{386}

**Culture and Informality: Work Contracts, Employer-Establishments and Professionalisation**

A woman’s bargaining power within the household, community and the labour market is informed (amongst others) by the social and economic value of her work; subsequently, it is not just the nature of her work (menial/manual or administrative/managerial) but also the nature of her work contract that plays a constitutive role in deciding the worth of a job. The triple-tier labour market (permanent, contract and daily-wage) in medical establishments, using qualifications as a basis, operates to constitute certain kinds of work as skilled and others as unskilled. As a result there is a supply of semi/un-skilled,

\textsuperscript{385} Personal Interview dated 9.11.2009.
\textsuperscript{386} Personal Interview dated 18.11.2009.
cheap labour in the wards, leaving the small number of skilled nurses free to function as supervisors and administrators. This also means that the more expensive managers and supervisors do not have to be employed, thereby cutting labour costs at both ends.

My research points to the manner in which working in a low-end, contractual/daily-wage job affects bargaining power adversely. The hierarchy is uncontested—in terms of respect, status, prestige and salaries—permanent government jobs are top of the line. Contractual work at private hospitals and nursing homes are seen as equivalent to permanent jobs; though hire and fire is possible, it is not a general practice and there are certain job securities. It is the daily-wage work, where untrained nurses working as private sisters and attendants are located (including the government hospitals) where the conditions are the most insecure and exploitative.

Most nurses, attendants and private sisters argue that even if the nature of the work is the same, there is more respect in a permanent job, than a contractual one. A government nurse has more respect, not only because she has recognised training or a higher salary, but because of her status as a permanent staff in the public sector. By itself, nursing is a stigmatised profession but being a contractual nurse in a private establishment entails further devaluation. Anuradha who works as a contractual worker in a government hospital, feels that the contractual nature of the work adds to the devaluation: ‘Because I am a Group D staff on contract, people look at me as if I am dirt. But if I was a permanent staff, they would give me respect. It is because we are not permanent, people do not respect us.’\textsuperscript{387} Madhuri, working in the same hospital adds: ‘If I am a permanent staff then the respect would be more. First, it is dirty work, and then contractual job and with such low salary, and that is why there is so little respect.’\textsuperscript{388} The contract of service then is not just merely a piece of paper laying out terms and conditions but also functions as a signifier.

\textsuperscript{387} Personal Interview dated 25.03.2010.  
\textsuperscript{388} Personal Interview dated 16.02.2010.
While the menial nature of care work and its association with class, caste and gender devalues the profession, low salary and terms of employment further signifies such work as un/semi-skilled, cheap labour. While Group D staff (that is attendants and sweeper) as well as some unregistered nursing staff (private sisters) is indirectly hired on contract via an agency by government hospitals, registered nurses still remain as permanent staff. These cleavages within care work (as well as other professions) sends a clear message from the government and administration about which part of care work is skilled and which is unskilled, and therefore, dispensable.

The reverberations of informalisation and casualisation within the formal sector extend well beyond the labour market, and can be felt within the household as well. While workers in informal employment find it difficult to bargain with their employers (regular workers directly recruited find it easier than daily-wage workers who are indirectly recruited), their lack of job security renders claims within the workplace difficult. Starting from changing rooms, toilets and even drinking water, registered and unregistered nurses employed privately on contract, as well as attendants and private sisters employed on a daily-wage basis, are denied even such basic amenities.

Ramala, Unregistered ANM, Private Nursing Home

The sister’s changing room is tiny, next to the canteen boys’ toilet. There is no fan, water seeps in from the toilet and soaks our clothes. Canteen boys can peek into our room. We do not even have a safe and secured bathroom. In these private nursing homes the sisters are most neglected. Even this room is not open to private sister— they are considered inferior (tuchchha). And the government sisters have a cabin, attached toilet and even a bed to rest on.389

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389 Personal Interview dated 2.06.2009.
Basabi, Registered GNM, Government Hospital

In a government hospital, if a doctor insults a sister too much, she can protest. Privately employed sisters cannot even protest, especially when it is someone in a senior position. 390

Even if hierarchies are created on the basis of skills and qualifications, in day-to-day practices they are renegotiated on the basis of work contract. In one instance, a government nurse reported that in a quarrel between registered nurses and Group D staff, the latter retorted: ‘once all of you are put on contract, we will see what happens.’ 391

What underlies this threat is the vulnerability that casual workers face in terms of job security which considerably reduces their bargaining power. It is especially more acute in a government organisation which is considered the bastion of the formal economy. The differences are startling, and therefore of more consequence, in organisations where some workers are permanent and some are not, than in a private organisation, where nobody is a permanent staff, not even the administrators. Some of the private sisters in the government hospital claim that by the virtue of being a daily-wage worker they are reduced to menial workers and face insolence and disobedience from attendants who refuse to recognise their authority. While it is commonplace to see hierarchies being built on the basis of skill, education or qualification, terms of employment can re-signify those hierarchies. So, even if an unregistered nurse is more qualified than an attendant who has no training, the terms of employment reconstitutes these hierarchies. As Malati, working as a private sister in a government hospital puts it, ‘Even a Group D staff can speak to us insultingly because we are not permanent staff and they are. They are uneducated and untrained, yet they give us no respect.’ 392

390 Personal Interview dated 3.03.2010.
391 Personal Interview with Basabi dated 3.03.2010.
392 Personal Interview dated 2.01.2010.
Sumita, Private Sister, Private Hospital

Staff employed on contract still gets some respect. We are on a daily waged basis, and you see how the attendants talk to us. When someone amongst us becomes a regular nursing care staff, their attitude changes. Then they will call her elder sister (didi) and refer to her as apni and with us they will say tui. We were all the same, the only difference being that now she is on contract and we are still getting our wages on daily basis.

Terms of employment can also foreclose choices for women within the family, as well as reduce her value in the marriage market. Even though a lot of women unmarried women have joined the labour market due to family needs, rather than market imperatives, most of them would like to withdraw from the labour market altogether once they are married. Some of the unmarried girls employed as contractual nurses or daily-wage private nurses face the most difficulty and opposition and the constant pressure to find ‘better work’. Nursing itself being stigmatised, the nature of the organisation (private establishments) and terms of employment (contract and daily-wage) add on to the already herculean task of surmounting opposition to waged care work, especially after marriage.

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393 In Bengali language there are three ways of addressing a person: apni, tumi and tui. Apni is usually reserved for someone who is older and respected. It is a formal way of address that takes into account the status of the addressee. Tumi is a more informal form of address used for same age group or when the addressee and the speaker have reached a level of intimacy. Tui is an extreme form of informality used with children, amongst friends or in certain contexts to convey extreme disrespect and disregard. It can also be used with to humiliate addressee.

An initial glance shows that the overwhelming response to giving up current jobs if the financial situation at home improves is affirmative (74.4 per cent), however, the subcategories are telling. All women working as private sisters and attendants would like to leave their jobs; in contrast, most women (17 per cent) working as GNM nurses are adamant that they would not leave their job, even if family income increases. As Mala puts it, ‘even if my family income increases I will not give up my job. There is a dignity in a government job, even if it is just a GNM nurse.’ Contrast Mala’s response to Madhu, who works as private sister on a daily-wage basis in a private hospital.

In this hospital I will never get a proper posting, so my father keeps telling me to leave the job and get married. Nursing is so stigmatised, and then working in a private hospital as a private sister is something my family is against. My father says that you are not even a permanent staff, then why are you continuing? They say that good marriage alliances will not materialise unless I give up this job.\textsuperscript{396}

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|c|c|}
\hline
\textbf{Would you give up current jobs if better situation at home?} & \textbf{ANM} & \textbf{GNM} & \textbf{Private sisters} & \textbf{Attendants} & \textbf{Total} \\
\hline
Yes & 13.8 & 6.3 & 21.2 & 32.9 & 74.4 \\
No & 5.3 & 17 & 0 & 0 & 22.3 \\
Maybe & 2.1 & 1 & 0 & 0 & 3.1 \\
\hline
\end{tabular}
\caption{Distribution of 94 respondents according to aspiration for giving up employment if there is an improvement in family’s finances (in percentage).}
\end{table}

\textsuperscript{395} Personal Interview dated 17.03.2010.
\textsuperscript{396} Personal Interview dated 29.08.2009.
Some of the private sisters who have no recognised training are willing to leave their existing jobs and join smaller nursing homes where they will be employed as regular nursing staff, removing the word ‘private’ from their designations. This would imply less salary but an enhancement in status. This horizontal move would facilitate a vertical move as well, i.e., from the bottom of the pyramid they would come up to the middle. Those who are employed in the government hospital, however, are still hoping for policy change that would make all contract work permanent.

Sushmita, Private Sister, Government Hospital

We are still hoping that the job will become permanent or at least a fixed pay. This ‘no work no pay’ is very humiliating. I am only staying, hoping that something will change. I do not want to leave a government hospital but if nothing changes, then I will join a small nursing home for a fixed pay, even if it is lesser money. At least there is some respect.397

As much as it is true that working as a caregiver in a hospital or nursing home is not status-enhancing, it is also true that working in a hospital allows some accumulation of social capital. This is also true of other kinds of care work, such as domestic work. However, some of the women felt that working in an establishment rather than a private residence, allows them to know more influential people. Tinni’s job as an attendant in a private hospital puts her in contact with senior doctors who would otherwise not be accessible to the rural poor. Therefore, while her work per se may be demeaned as menial, with no economic or cultural value, her location in the labour market— in a corporate institution, rather than someone’s home— puts her in within the circulation of social capital and makes her an important resource for the larger family and community.

397 Personal Interview dated 25.02.2010.
When I worked in house cases, people would avoid me; my relatives would not speak to me. But when I joined a big hospital suddenly I became someone’s elder sister, someone’s sister-in-law. Not because I had a better salary but in case they need my contacts. In case they get admitted and need me to introduce them to some senior doctor.\textsuperscript{398}

Chaitali, Attendant, Private Hospital

Someone who does nursing at home earns rupees 120 a day. Working as a house nurse is of course better in terms of wages but there is no respect in working in someone’s home. There is a lot more respect to work in a hospital, than to work in someone’s house.\textsuperscript{399}

The physical separation between home and work (even if it is someone else’s home) helps in delinking commodified reproductive work from its domestic shackles and to make it more respectable. It is not just paid employment but all the markers of a profession—uniform, work shift and a workplace—that gives attendants the sense of being a part of a professional workforce. As Sujata, working as an attendant in a private nursing home sums up, ‘If I work in someone’s house, people speak very badly about me. At least here I have a fixed time, a workplace and uniform.’\textsuperscript{400} Even the nature of the organisation, whether it is government or private, makes a difference. A government job has more value, even if the work is daily-wage than a regular contractual job in a private establishment.

\textsuperscript{398} Personal Interview dated 10.10.2009.
\textsuperscript{399} Personal Interview dated 17.10.2009.
\textsuperscript{400} Personal Interview dated 2.05.2009.
Kajori, Private Sister, Government hospital

I could have joined a smaller nursing home as a regular nursing staff as a regular contractual worker. But the respect one gets when people know that I am working in a government hospital, I do not want to lose that.  

Nursing and Stigma: Gender, Class and Caste

Almost all women (95.7 per cent) felt that nursing is stigmatised while only a handful (4.2 per cent) felt otherwise. The overwhelming response of nurses as to why nursing is not respected as a profession points to the lack of awareness among the general populace of the training and education that goes into the making of a nurse. It is also the perception that nursing remains a menial occupation done by lower-caste, working-class women. Trained nurses pin the blame on ‘untrained’ nurses whose continuing presence devalues the profession. Other reasons that surfaced are the class groups that nurses and attendants belong to, as well as social taboo on women working closely with men, and that too at night. Gender, caste and class intertwine to feed into a social perception of nursing staff as ‘immoral’ women from ‘lower-class, lower-caste’ families.

Table 4.2: Distribution of 94 respondents according to queries on stigmatisation of the profession (in percentage)

<table>
<thead>
<tr>
<th>Stigma to your profession</th>
<th>ANM</th>
<th>GNM</th>
<th>Private sisters</th>
<th>Attendants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20.2</td>
<td>21.2</td>
<td>21.2</td>
<td>32.9</td>
<td>95.7</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Yes, but it is changing</td>
<td>1</td>
<td>3.1</td>
<td>0</td>
<td>0</td>
<td>4.1</td>
</tr>
</tbody>
</table>

401 Personal Interview dated 13.01.2010.
All registered nurses emphasised on the education and training that a nurse has to go, while an untrained nursing staff insisted that they too had come into service after training, though unrecognised. Knowledge and training differentiated them from the ‘uneducated lower-class, lower-caste women’ who historically worked in hospitals and nursing homes. As Meera, working as a GNM in a government hospital, points out ‘people do not know the training and education that goes into becoming a nurse. They think anybody can become a nurse.’

Harking back to colonial India, a clinical instructor in a college of nursing, observed that ‘in the past, nurses were widowed, distressed women and prostitutes who had no other livelihood options but to take up nursing, which has lead to such stigmatisation of the profession. People do not see what kind of education process a nurse has to go through before she starts practicing.’ This point was emphasised yet again by the principal of the oldest government college of nursing. ‘People think that a nurse is just someone who has walked into a hospital from the streets because of lack of options. She is nothing but an educated ayah. This may have been true many years ago, but today girls from good families achieving good results come into nursing.’

The class, skills and training, the cognitive capabilities of a nurse are the markers that are emphasised on to give nursing service the status and respect that will establish it as a white collared profession. As Sonalika, working as a GNM in a government hospital says, ‘people think that nursing is not a qualified degree. People need to know that nurses are trained and educated. My own sister says that she will not be a nurse, they are uneducated and doing dirty work.’

Even government employed nurses are affected by this devaluation of nursing, despite receiving the best salaries and work contracts in this segment of the labour market.

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402 Personal Interview dated 11.02.2010.
403 Personal Interview with Subrato Sarkar, Clinical Instructor, West Bengal College of Nursing, SSKM, Kolkata, dated 29.10.2009.
404 Personal Interview with Mahasweta Bose, Principal, West Bengal College of Nursing, SSKM, Kolkata, dated 2.11.2009.
405 Personal Interview dated 13.02.2010.
Meera, Registered GNM, Government Hospital

My in-laws never looked at my profession happily. In fact, they looked down on it. They do not understand the education, the training and the hard work that went into getting this degree and job. They have never respected my job, my service at all.\footnote{Personal Interview dated 11.02.2010.}

This perception of nursing being as a menial, un/semi-skilled waged work which needs no training or qualifications has in many ways set the ground for shifting of blame among nurses, nursing leaders and administrators. The logic is circular: modernisation of nursing envisaged an expulsion of working-class women from the profession and bringing ‘respectable’ women on board; however, historically, nursing has been low in the priorities of health budgets, making it an unattractive career option for middle-class, upper-caste women. Therefore, despite all attempts, nursing remains the choice of lower-caste, working-class women. Registration of nursing has not eliminated the working-class woman; on the contrary, it has just made her more exploitable. Professionalisation has not prevented the working-class, lower-caste woman from becoming nursing staff; it has only created newer hierarchies and exploitations. She continues to be a part of the healthcare workforce but not as a registered nurse. Without access to the requisite training, and therefore registration, she is now the informally employed, semi-skilled, ill-paid, untrained nurse under the supervision of the formally employed, skilled, well-paid, trained nurse.

This, however, is not specific to India. In the west, after World War II, the clamor for registration was to prevent poor women without access to elite training from being employed as nurses and instead to work as ancillary healthcare workers. In India, the stigma associated with nursing is constituted by gender, class as well as caste. Similar to colonial discourse on the dai, untrained nurses are vilified and attacked as ‘immoral’,
‘unhygienic’ and coming from ‘lower castes’. The principal of a private nursing school pointed out that women who ‘masquerade’ as nurses (untrained nurses) in hospitals and small nursing homes ‘do not come from good families. They have no sense of hygiene and cleanliness. They do not cut their nails, there is so much of filth under their nails and yet they touch the patients.’  

**Compare this with some colonial records on the dai:** ‘the dai never has the slightest hesitations in putting her unclean hand into the uterus… in goes her dirty hand, which perhaps has just been cow-dunging a floor or attending a case of puerperal fever…’

Basabi, Registered GNM, Government Hospital

Before no educated women would come into nursing. It was done by *ayahs*, prostitutes and women like that. But even now women with no proper education and training come into nursing and do certain things that give nursing a stigma. Even now women from villages come into nursing and do immoral things and give nursing a bad name. These unregistered nurses work even in government hospitals as private sisters— they are untrained attendants (*ayahs*) but when they go out they will tell the world they are nursing staff. They have no sense of hygiene, no training and they do whatever they please. They are like a barber operating a cataract (*napit chani katar moto*).

In practice, the division of labour that has slowly evolved between trained and untrained nurses is where the former does medical/ administrative/managerial work while the latter

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407 Personal Interview with Anjana Sen, Principal, School of Nursing, Apollo Hospital, Kolkata dated 18.05.2009.


409 Personal Interview dated 3.03.2010.
is left to do the entire menial, bodily service that makes up nursing. On the one hand, a nurse’s education and three year plus training becomes the ground for not doing any form of menial, bodily service; and on the other hand, hospital administration does not allow private sisters to engage in any medical or technical work, despite possessing certain (unrecognised) training— whether it is administering medicine, injections, catheter or undertaking intravenous cannulation. Though they are referred to as private sisters, both by patients and hospital staff, just by removing medical intervention from their work, the menial nature of their job has been foregrounded. As Sumita, working as a private sister in a private hospital says, ‘We have come to do nursing but our work is similar to that of an attendant. They clean urine and excreta, and we do the same. We have become equal to that of an attendant.’ As soon as medical tasks are removed from a nurse’s work, she becomes more of an attendant and less of a nurse, bringing into focus how fragile is the base upon which nursing is struggling to establish itself, as a profession.

Apart from the menial nature of the job, night shifts, relationships with men, body touch of male patients add to the stigma associated with nursing. While women in other professions do work in close proximity to men, even at night, such as IT sector and flight operations, nursing as a profession has been peculiarly marked out for its immoral overtones. Some nursing administrators pointed out that even a celebrated, progressive film maker like Satyajit Ray has depicted a nurse as a prostitute.

Zahabi, Unregistered ANM, Private Hospital

The stigma is because people do not know what nursing is. Night duty and then menial work also adds to it. Then there are some women who have

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411 Pratidwandi, Directed by Satyajit Ray, released in 1971 had a scene where it showed a nurse as a prostitute.
relationships with doctors and ward boys and that give the whole profession a bad name.\textsuperscript{412}

Though some nurses and attendants do admit that sexual/emotional relationships happen at workplace, it is the transgression of gender, class and caste norms that create anxiety. Nurses who have relationships with doctors or ward boys imply a class transgression—the former is considered too high for her and the other too low. Sexual relationships at workplace are not uncommon in any profession/workplace that has both sexes; however, women’s bodies (especially working-class, lower-caste) come under the scanner more frequently. Nurses said that though women doctors have relationships with male doctors, they do not face similar disrespect, ‘They are highly educated from good families; no one will talk about them like that. But female doctors also have relationships with male doctors. I have seen it with my own eyes, but no one says anything to them.’\textsuperscript{413} The nursing staff being so heterogeneous and its status constituted by gender, class and caste, sexual transgressions take on a far more serious overtone.

Those nurses who feel that the stigma is changing, cite economic security and dividends of government job. It is especially true for nurses coming from Jharkhand, Manipur, and Orissa who talk of changing attitudes towards this profession, especially with opportunities to go abroad. These young migrant women who work as GNMs in the private hospital come from Scheduled Caste and Scheduled Tribe families, who have studied nursing with the help and active encouragement from their families, communities and churches, so as to get a passport to a better life. The promise of social and economic mobility mitigates the stigma attached to nursing.

\textsuperscript{412} Personal interview dated 30.05.2009.
\textsuperscript{413} An informal group discussion with nurses outside an emergency ward in a government hospital dated 5.01.2010.
Impact of Waged Work on Gender Relations within the Household

One of the most significant sites of understanding evolving gender relations has been the division of labour within the household. With women’s increasing participation in the public realm, no dent has been made in the sexual division of labour within the private realm; on the contrary, the hope of unpaid household labour being equally distributed among both sexes has gradually dissipated. Across class, housework remains women’s work. Women now carry the burden of a ‘double shift’. Working-class women depend on the larger kin system and older women in the family to look after their children while they are away at work, whereas middle-class women depend on paid domestic workers. My research demonstrates that not only has there been no shift in division of labour within the household in favour of women, waged work has, in some cases made it worse. Patriarchal norms of masculinity and femininity represent men as incapable of participating in reproductive labour. Most women feel that their husbands either will not or cannot take responsibility of the domestic. Whether it is supervision of paid domestic workers or going to the market to fetch groceries, men refuse to participate in any form of household labour.

Sundari, Attendant, Private Nursing Home

I do all the work at home and then leave for duty and then I come back and do the rest. My husband is not too well so I do not want to put pressure. Men cannot do housework. They can help a little bit, like getting a little water. Men should not enter the kitchen or cook. They will only make it dirtier, and I will have double work.⁴¹⁴

Manushi, Unregistered ANM, Private Nursing Home

Men cannot do housework that is why I do not ask my husband to do anything at home.\textsuperscript{415}

Consequently, middle-class nurses have increasingly become dependent on paid domestic help, while working-class attendants and private sisters depend on the unpaid labour of other female family members. Feminist research has highlighted how women have always depended on kinship to tide over work at home.\textsuperscript{416} My research has shown that with growing urbanisation, migration and smaller families, some women are gradually losing out on extended family support for day-to-day household chores. Sometimes help is taken from extended family living close by, but only for child care. Even for middle-class women, all housework cannot be left to paid help. A division of labour exists where menial tasks such as sweeping, swabbing, washing dishes and clothes are done by paid help, while cooking, teaching children and shopping for groceries remain the responsibility of the wife and/or the mother. Not one woman claimed to be free from all household chores. Domestic work remains the special responsibility of women.

Basabi, Registered GNM, Government Hospital

I try not to be too dependent on paid help, my child has an ayah who brings her from school, feeds her. I also have a cook. But no one should complain that I do not do housework, so I go home and make an extra dish to keep my in-laws happy.\textsuperscript{417}

The cost of hiring domestic workers to reduce the burden of actual household work is met through women’s paid labour. Household work remains ideologically uncontested as

\textsuperscript{415} Personal interview dated 11.08.2009.
\textsuperscript{417} Personal interview dated 3.03.2010.
women’s responsibility. Some women did report that it was also their low income and private contracts which took away their bargaining power within the household. For instance Anima, working as an untrained nurse in a private hospital says ‘I leave my daughter with my mother-in-law and she is always complaining that I do not take responsibility and I just leave. They do not treat my daughter well but what can I do? Because I have so little money with such a small job, I cannot even answer back.’

Compare Anima’s response with Chitra, who works as a GNM in a government hospital and faces similar antagonism from her mother-in-law. ‘It is because I am in government service, that I get the strength to speak out in my marital home. Whether I contribute to the household or how much does not matter. Working in a government hospital gives you a lot of confidence, not like housewives.’

These divisions, however, are not without overlaps. There are trained nurses working in government hospitals who are unable to carve out a niche for themselves in their families. On the contrary, they face opposition to their continuing employment, after marriage. Shraddha, who works as a GNM in a government hospital reported that because her family is not happy that she is working as a nurse, household work had to be done even more meticulously.

I am not able to work at home and I have to listen to a lot of things. Other women in the family like my sisters in-law have to do all the housework and they taunt me. Because I cannot give time at home they express anger towards me. I wanted to keep a servant for my share of housework but they did not agree. I cannot even take full responsibility for any chore because we have shift duty. My husband also does not like the fact that I

418 Personal Interview dated 19.06.2009.
419 Personal Interview dated 14.02.2010.
do not do any work at home. These are all indirect pressures for me to give up nursing.\textsuperscript{420}

It is commonplace to assume that women’s engagement with paid work will relieve them of some patriarchal control. My research shows that waged work does not determine autonomy. Normative femininity recomposes itself to include women’s economic productivity. Tina Chanter, reading Foucault’s conception of power, argues that power is not a monolithic, top down, centralised force and instead argues for power as something that is administered by the subject him/herself. Instead of it being hoisted on to the subject, it is produced from below. The subjects of modern society discipline themselves. The disciplinarian is also the individual him/herself as much as the social mechanisms that strengthen norms.\textsuperscript{421} In a number of interviews, women responded to queries on sexual harassment, violence and freedom saying that ‘as long as I am good, everything will be all right. (nijeke thik rakhle sob thik thake). Everything depends on us.’ This reasoning that everything is dependent on the agency of the subject obscures the structural violence that working women face. In many ways it even justifies it. Blaming the victim becomes the next step.

Guilt induced by neglect of duties associated with normative femininity (housework, child care) coupled with real threats of violence work as a disciplining tool that governs their lives. Even though, employment opens up avenues to explore new freedoms; patriarchal norms clearly lay out boundaries, and transgressions can invite punishment. Therefore, the freedom earned (however limited) is offset by extra vigilance by women to ensure the continuation of gender norms, whether at home or at work. Women’s subordinate position within the private and public realm is reinforced by patriarchal discipline in both realms.

\textsuperscript{420} Personal Interview dated 22.02.2010.
Meera, GNM, Government Hospital

I felt so much guilt especially because of night duty that I would try and do everything at home, so that my in-laws do not point fingers at me. I would make sure that after duty I would go straight home and not even stop to have tea. 422

Normative gendered behavior still governs the day. Even if women engage in full shifts of paid work outside the household, there is no radical alteration of sexual division of labour within the household. To top it all, threats of violence act as a coercive tool to maintain appropriate gender norms, in the household as well as the community.

Arushi, Attendant, Government Hospital

Women say they are earning and that is why they are independent. We can never have the freedom of a man; we have weakness and that will get taken advantage of. If I try to behave like a man, I will be punished by my husband, by society. People will talk, life will become very difficult. No matter how much we earn, we have to save ourselves. 423

Where Does the Money Go? Distribution of Women’s Income

The logic of engaging in paid work outside the household is not followed by radical questioning of gender relations within the household— the hierarchical oppositions of public/private, masculine/feminine continues to remains operative. While almost all respondents (permanently employed nurses to daily-wage attendants) report that their expectations from their profession have failed, most of them cannot think of withdrawing from the labour market. Their primary responsibilities as mothers, wives, sisters and daughters leave no space for autonomous desires. Myriad responsibilities, mostly linked

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422 Personal Interview dated 11.02.2010.
423 Personal Interview dated 30.01.2010.
with the welfare of their families (marital or natal), prevent them from giving up their jobs. While the reasons for different groups of workers located in different layers of the triple-tier labour market are different, the overarching framework of family welfare cuts across all socio-economic groups. Women work because their families, natal or marital, need their income.

Table 4.3: Distribution of 94 respondents according to reasons cited for choosing waged work (in percentage)

<table>
<thead>
<tr>
<th>Reasons for choosing waged work</th>
<th>ANM</th>
<th>GNM</th>
<th>Private sisters</th>
<th>Attendants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence</td>
<td>2.1</td>
<td>10.6</td>
<td>3.1</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>To support family</td>
<td>19.1</td>
<td>12.7</td>
<td>18</td>
<td>31.9</td>
<td>81.9</td>
</tr>
<tr>
<td>To earn dowry</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Most women (81.9 per cent) chose to join waged work to support their families while a few (17 per cent) aspire for autonomy and independence. Amongst the latter, the largest numbers were the GNM (10.6 per cent). Unmarried women usually take financial responsibility of their younger siblings, whether it is marriage or education. The costs of wedding and dowry for a younger sister are no more the responsibility of the father. With wage work these additional, unproductive expenses are borne by the elder sister. Another noticeable trend is that with unmarried women earning and supporting the family, male siblings have shrugged off all financial responsibilities of their parents. The stereotype of male earners taking care of dependent family members is challenged as one observes a growing trend of men setting up their own separate conjugal households. While distribution of intra-household resources is deeply gendered in favour of the male child in the belief that it will pay future dividends, it is women who ultimately take financial responsibility of their natal homes. Jaba who works as an attendant in a private nursing
home is unable to get married as she has no savings left either for the wedding or dowry, "All my money went into getting my sister married. Now everything gets spent on my mother’s illness. My brother does not take care of my mother at all. He says he has his own family to feed." 

Table 4.4: Distribution of 94 respondents according to perceptions of the self as the main earner (in percentage)

<table>
<thead>
<tr>
<th>Main Earner</th>
<th>ANM</th>
<th>GNM</th>
<th>Private sisters</th>
<th>Attendants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8.5</td>
<td>2.1</td>
<td>7.4</td>
<td>27.6</td>
<td>45.7</td>
</tr>
<tr>
<td>No</td>
<td>12.7</td>
<td>22.3</td>
<td>13.8</td>
<td>5.3</td>
<td>54.2</td>
</tr>
</tbody>
</table>

Table 4.5: Distribution of 94 respondents according to perceptions of self’s income having an important role in the family (in percentage)

<table>
<thead>
<tr>
<th>Income has an important role in the family?</th>
<th>ANM</th>
<th>GNM</th>
<th>Private sisters</th>
<th>Attendants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>18</td>
<td>20.2</td>
<td>21.2</td>
<td>32.9</td>
<td>92.5</td>
</tr>
<tr>
<td>No</td>
<td>3.1</td>
<td>4.2</td>
<td>0</td>
<td>0</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Despite having a separate conjugal home, women continue to work just so that they can send money to their natal homes. Waged work has given them the leverage in their marital families to bargain for a proportion of their income to be sent to their natal families. This also has the effect of reducing their perceived income in their marital home, as income gets divided between two households.

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424 Personal Interview dated 7.06.2009.
Basabi, Registered GNM, Government Hospital

I cannot leave nursing, who will take care of my natal family? I have to send money home. Sometimes I feel like leaving the job, but then who will take care of my family? They are my responsibility. The main earner is my husband not because he earns more than me, but because his whole salary comes home. My salary gets divided into two households. 425

This, however, does not mean that women, who do not have to take responsibilities for their natal homes, enjoy autonomy over their own income. Most women report that their wages get pooled into household budgets. A small amount of money is kept for their own use, just enough to take care of conveyance and lunch. The pooling is different for different women—some hand over the money to their husbands or fathers and some have specific expenses that they take care of in their families. Repayment of loans, investments, savings, and children’s education figure large in the list. Some women claim that their money is not important for their family but theirs for spending on their desires, leading to an impression of it being ‘pin money’. On further questioning, however, these ‘desires’ turned out to be goods that enhanced the status of the family starting from gifts to relatives during festivals, household appliances, savings and investment and children’s educational expenses.

Employment for women, in whichever layer of the pyramid, has become essential for their families. Women needed to work whether for survival or for upward social mobility displayed through consumption. The division of the earnings in a conjugal home has no set pattern. However, responsibility of children— their education, clothes, dowry for their weddings is met by the mother’s paid labour. If she is not earning for the survival of the family, she is earning to ensure that the children are well looked after. Reproductive labour remains the woman’s special responsibility, both through her paid and unpaid

425 Personal Interview dated 3.03.2010.
work. Whether she is a middle-class government nurse or a working-class daily-wage private sister, disparity in income does not have any effect on patterns of income distribution within the household.

Sanchayita, Registered GNM, Government Hospital

I earn rupees 23000 and my husband earns about rupees 50000. He takes care of everything in the house like servants, car, driver and other expenses. I do not need to work but there is always a need for more money. My money is put into joint savings, and my child’s education. Birla schools are expensive. I just paid rupees 32000 for tuition fees this year. My whole income, apart from paying for the child, goes into a joint account which then goes into savings.426

Sita, Unregistered ANM, Private Nursing Home

The money I earn is so less, that it does not make any difference to the household. This money gives me freedom to buy what I want for my daughter. I do not have to ask my husband. My salary goes into my daughter’s education, clothes etc.427

Only one woman, Barnali, working as an unregistered nurse in a private nursing home reports that her earnings are her own. Separated from her husband and with no children, she lives in the hostel provided by the nursing home.

He (husband) keeps asking me for financial help, I do not give him a rupee. My money is my own, why should I give it to him? My whole salary is mine. Most of the money I spend on shoes, cosmetics, clothes

426 Personal Interview dated 22.02.2010.
427 Personal Interview dated 4.06.2009.
and some I put away for the future. The reason I am able to live independently is because of the money I have.428

Choices in Marriage: Conflicts and Mobility

Marriage was a central discussion in all my interviews. Conjugal relations, aspirations for a life partner, fear and insecurities of dowries are seen through the prisms of work and income. For some, working as a paid caregiver is an impediment to a good alliance, for others it is the key to socio-economic mobility. As much as the nature of the work influences choices and opportunities in the marriage market, terms of work contract also has a large influencing role. Again, signing up for paid work, does not necessarily translate into questioning of caste, class and gender norms when it comes to marriage. While some women did flout such conventions and transgressed norms to marry men of their choice, most women chose the middle of the road maintenance of status quo.

Table 4.6: Distribution of 94 respondents according to acceptance of marriage by both families (in percentage)

<table>
<thead>
<tr>
<th>Acceptance of Marriage</th>
<th>ANM</th>
<th>GNM</th>
<th>Private sisters</th>
<th>Attendants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict</td>
<td>4.2</td>
<td>6.3</td>
<td>3.1</td>
<td>6.3</td>
<td>20.2</td>
</tr>
<tr>
<td>Consent</td>
<td>9.5</td>
<td>4.2</td>
<td>8.5</td>
<td>19.1</td>
<td>41.4</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>7.4</td>
<td>13.8</td>
<td>9.5</td>
<td>7.4</td>
<td>38.2</td>
</tr>
</tbody>
</table>

A significantly large number (41.2 per cent) of women married with consent of both families, while some (20.2 per cent) faced objections. Some of the objections were grounded in conformism to caste and/or class norms, some women also faced opposition from prospective in-laws because they worked as nurses or attendants. No one that I spoke to faced objections on the grounds of being a waged worker per se.

428 Personal Interview dated 9.06.2009.
Table 4.7: Distribution of 94 respondents according to perceptions on whether working as a nurse facilitates finding a suitable groom (in percentage)

<table>
<thead>
<tr>
<th>Easier Finding a Groom</th>
<th>ANM</th>
<th>GNM</th>
<th>Private sisters</th>
<th>Attendants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7.4</td>
<td>13.8</td>
<td>4.2</td>
<td>1</td>
<td>26.5</td>
</tr>
<tr>
<td>No</td>
<td>11.7</td>
<td>4.2</td>
<td>14.8</td>
<td>17</td>
<td>47.8</td>
</tr>
<tr>
<td>Cannot say</td>
<td>2.1</td>
<td>6.3</td>
<td>1</td>
<td>4.2</td>
<td>13.8</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Most women (47.8 per cent) felt working as a nursing staff makes it more difficult to find a groom in the marriage market. It was mostly GNMs (13.8 per cent) who felt that being a nurse worked as an advantage when it came to looking for a match. Chhaya working as a nurse in the government hospital felt that she got marriage proposals because she worked in the government sector, being a nurse was incidental. On the contrary, Ramala working as an unregistered nurse felt that both— being a nurse as well as an informal worker— went against her.

So many marriage proposals did not materialise because ‘firstly nurse and on top of that private’. My sister-in-law also works as a private nurse that is probably why my in-laws agreed to this marriage.

Sometimes nursing itself did not prevent marriage proposals but the nature of work contract did. Women working in the government sector get more desirable marriage proposals than women working as nurses in the private sector. A government job was desirable, whether for the post of a staff nurse or an attendant. Most GNM staff in the government hospital felt that their husbands married them because they were in

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429 Personal Interview dated 13.03.2010.
government services. Some women spoke of how after marriage the situation changes and nurses routinely get humiliated regarding night duties and long working hours. While nurses working in government services aspire to either marry doctors, or other well-established professionals, nurses and attendants working in the private sector aspire for a man who has a ‘steady job’ or is self-employed. Marriage is seen as a route to socio-economic mobility. Jaya, working as an attendant in the government hospital wants to marry a man who has a contract job and is not paid on a daily basis like her. ‘I want to marry someone who is earning 10,000 rupees at least and who is in a contract job, not this— no work no pay.’ With the fragmented nature of the labour market that prevents vertical growth, especially for women at the lower ends, marriage may be the only way of gaining social and economic mobility.

All women (across caste, class, religion) expressed a fear of dowry, expensive gifts and exorbitant wedding celebrations expected and even demanded. It did not matter whether their jobs were permanent, contractual or daily-wage. A few women working as GNMs who came from tribal communities outside Bengal, followed the customary bride price, which they admitted was nothing but symbolic. A minimum 10,000 rupees had to be given to the bride’s father. Women from Jharkhand reported that almost all women who belong to Schedule Tribes were nurses and it was the most popular profession for women. Nurses were in great demand in the marriage market, and women were encouraged to take up nursing from when they were in school. This partially explains the demand for nurses as brides in Ranchi.

Amellina, Registered GNM, Private Hospital

Whole of Ranchi and Jharkhand, in every Scheduled Tribe households, everyone pays bride price. My service as a staff nurse will increase bride price but we do not ask for more. It’s not in our customs to increase bride

431 Personal Interview dated 7.01.2010.
price because the girl is earning. 1, 00,000 rupees will be spent on the wedding, apart from that no other expenditure.432

While some women working as GNM’s in government hospitals said that they were politically against dowry as they saw it as a crime against women, they acknowledged that gold, expectations of expensive wedding celebrations and gifts for the groom and his family is demanded and given. Some of the women working as GNM’s, like Shirsha, who has migrated from Orissa to work in Kolkata till she applies for jobs abroad reported that dowry in form of cash will be demanded during her marriage.

When I marry, there will be a lot of dowry demanded. If he is in government service or a doctor, he will ask for minimum 3, 00,000 rupees. And then he will also ask for other things. If we do not give dowry, I will not be able to get married.433

Working class women however were categorical that without cash being given there would be no marriage— the amount could vary anything from rupees 50,000 to 2, 00,000.

Whether it was their inability to pay dowry or familial responsibilities, women who have opted out of conjugal relations express both their disappointments as well as their desires. The opportunity of marriage was gone— bringing up siblings, taking care of sick and aged parents, paying off family debts occupied most of their time and energy. Freed of majority of their responsibilities at a later stage in their lives, wage work did give them the leverage to pursue an independent life outside the institution of marriage.

432 Personal Interview dated 14.08.2009.
433 Personal Interview dated 20.08.2009.
Bijoya, Attendant, Private Nursing Home

I wanted to marry and be a housewife. But I had sisters and before my father died he told me to look after them. Marriage proposals came but they were too far away. I could not take my sisters with me, so I said no to marriage. I loved someone, but he was Brahmin and we were Kayasthas so the marriage did not happen. Now I have no more aspiration for marriage. I stay amidst my work.434

Jayati, Private Sister, Government Hospital

I am in such a situation that I cannot think of marriage. My father is sick for the last eight years. I wanted to marry a man who will take care of me. With this job and these responsibilities it will not happen. If someone wants to associate with me as a friend, then it is okay. I do not think I will ever get married.435

However, most women who were married expressed their inability to leave their marriage despite conflicts which could range from mutual incompatibility, domestic violence, extra-marital affairs, gambling to alcoholism and unemployment of their spouses. The most cited reason was the difficulty of living outside the institution of marriage as a single woman. The welfare of the family which depended on double income also prevented women from rocking the boat. The stigma of a divorcee or a separated woman, threat of violence worked as a powerful tool of social control in keeping women within the conjugal home. The retribution of breaking a norm could cost a life. Patriarchal disciplining with the family, workplace and communities ensure the nexus of hetero-normative patriarchy. Annapurna, working as an attendant in a private hospital observed that nurses would come to hospitals beaten up because husbands were jealous and

434 Personal Interview dated 13.06.2009.
suspicious. So I ventured to ask her why women did not leave violent marriages despite having enough money of their own. She felt that the threat of violence faced by single women if they left home far outweighs the violence women faced at home.

Marriage cannot be broken at any cost. Men can marry again but women once married—very few men will accept her. To break a marriage is not difficult but to survive without marriage is difficult. Family, society will not look at you favourably (*bhalo chokhe*). You tolerate the pain that you are going through in your husband’s home, everyone will support you. But if you leave they will speak very badly about you. The women in our hospital will point fingers at you ‘…that is why she could not stay with her in-laws.’ You cannot live like this; they will speak so badly that you cannot live, the boys in the street will taunt you. And you cannot speak up because you have to live alone, the neighborhood boys may attack you. At least if you are married you are safe, no matter how painful it is.\(^436\)

Marriages are arranged according to strict caste and class rules. Working as waged caregiver is a transgression of both middle-class and upper-caste norms; yet, the boundaries of such norms is stretched to accommodate paid labour. But when it comes to conjugal alliances such norms are strictly adhered to. Caste plays an important role in deciding life partners. Some women said they do not observe the caste system yet their families are looking for alliances within their caste and class groups. Caste rules can be bent to accommodate paid menial work but remain inflexible when it comes to establishing marriage alliances. Kakoli, who works as a private sister in a government hospital, and is a Brahmin insists she will only marry within her own caste. Yet, when asked whether working as caregiver is not a transgression of caste norms and a loss of caste status, she responds ‘I am a caregiver (*sebika*), and I am not breaking any caste

\(^{436}\) Personal Interview dated 18.11.2009.
rules by doing this kind of work, so why should I marry outside my caste?" The trope of *sebika* functions in a manner that allows women’s paid labour to be accommodated within caste rules without questioning its dominance.

However, for some women, paid work has given them the bargaining chip to transgress caste, class and gender norms to marry men of their choice. Women reported defying familial authority to marry men of other castes. Anima, working as unregistered nurse in the private hospital narrated how she met, proposed and married her (now) husband. Being of a lower caste than him, she met with resistance from her in-laws.

> I met my husband through a common friend four years back (previous to marriage) and had overheard him saying that he would only marry a woman who is in service. We traveled in the same train. After four years when I got my job, I went up to him and plucked the pen out of his pocket. He came behind me and accosted me saying ‘why did you take my pen?’ So then I told him ‘I have a job as a nursing staff in a big hospital. This is my salary. Do you want to marry me?’

Another woman working in a private hospital as a contractual nurse uses her job as an excuse to avoid marriage proposals. Already in a relationship with a doctor, she touts her independence which wage work has made possible. Having a paid job also opens up avenues to walk out of extreme violent conjugal homes; domestic violence and dowry demands have become legitimate reasons for women to leave their marital home with their children on the basis of their economic solvency. However, for the latter, the violence had to reach intolerable levels where fear of life and limb made this transgression legitimate in the eyes of society.

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437 Personal Interview dated 15.01.2010.
438 Personal Interview dated 19.06.2009.
439 Personal Interview with Naina dated 20.08.2009.
Conclusion

Feminist scholars have been arguing that patriarchy and capitalism have been mutually constitutive, which ensures women’s subordination both at home and at work. The sexual division of labour in the market creates rigid enclaves of feminine and masculine jobs where the former is both culturally and economically denigrated. The argument by development practitioners that women’s economic independence leads to empowerment has increasingly been questioned. Feminist scholarship has been interrogating both the public and private to explore how women’s dependency is constituted within the context of growing informalisation. In this chapter, I have questioned the dominant development paradigm (which links women’s empowerment to income generation) by bringing the focus on the nature of the work, terms of employment etc to demonstrate that not just waged work but the type of employment also has an important determining role in women’s bargaining power both within the household and the labour market. Not just feminity, but complicated inter-relationship between class and caste renders care work, in this instance nursing, as a disrespectsable, stigmatised occupation. However, these hegemonic understandings of labour, constituted on class, caste and gender is not necessarily smooth or uncontested. In the next chapter, I locate women’s agency and resistance to hegemonic ideals that seek to devalue them.