Introduction

The question of women’s labour has been central to feminist theorising of patriarchy, given that across many cultures women’s reproductive labour has been unrecognised and undervalued. These processes, Marxist feminists have pointed out, were exacerbated with industrial capitalism, which separated home and work, use-value and exchange-value and production and reproduction. Over the past few decades, women’s movements in many parts of the world have struggled for recognition and valuation of women’s reproductive labour. A critical moment in this struggle was the ‘wages for housework’ movement, which sought some economic reward for the housewife. In the 1980s, feminist scholars from the Third World brought into sharp relief the very different trajectories taken in the relationship between productive and reproductive work in developing economies. In India, for instance, in the bulk of the agricultural sector, there has been no sharp disjunction between productive and reproductive work. Women and children work as unpaid labour in peasant and artisan households, the family’s productive work constituting for them an extension of their housework responsibilities. These patterns have resisted change. A recent report has drawn attention to the high numbers of unpaid women workers in the economy.¹ The reverse is also true. As many feminist scholars have pointed out, capitalist development has involved a gradual marketisation of activities previously undertaken by women in the household as part of unpaid reproductive work. Thus, restaurants, laundries, crèches and play-schools have commodified elements of housework and childcare. One most striking—in part because of spectacular expansion in the past few decades but also in part because of the ideological investment of such work in femininity—is the work involved in the care of the sick. In Kolkata, in the past thirty years, there have been many new hospitals in the

private and public sectors and a mushrooming of small nursing homes in lanes and by-lanes of the city to enable institutional care rather than home-based care of the sick.

The social and economic significance of nursing in the burgeoning health sector can hardly be denied. Nursing is an example of social reproductive labour (or use-value labour) being increasingly commodified and brought into labour market as exchange-value labour. How does this change affect the cultural and economic value of this kind of work? What are the complexities that arise when traditionally devalued work is now given an economic value? Does it lead to any kind of radical altering of societal perception of women’s work or does reproductive labour, even when commodified, continue to be ranked much lower than men’s work? The purpose of this research is to explore these questions in the context of major debates about women’s work in many parts of the globe. The migration of nurses, the expanding opportunities of employment for women, issues of regulation, increasing informality within the sector—all these have raised questions that we are unable to answer because of the paucity of research in the field. This thesis will attempt to address some of these concerns.

The intellectual context for discussion of women and work has been for the past few decades the debates around questions of ‘feminisation’. In India, the fears of a feminisation of labour (as in South-East Asia) in the wake of liberalisation of 1992 led to considerable debate over whether established patterns of masculinisation were about to be breached. The myth was busted quite early. It became evident quickly that while there was casualisation and informalisation, there was no change in the gender balance in the workforce. Quite the contrary. Researchers have shown that within a decade of liberalisation, women’s share in the economy began declining. It has now become an accepted fact that women are being pushed out of the labour market both in the formal and the informal economy. The focus, in considering women’s work, therefore, remains on female-intensive occupations such as domestic workers, sex workers, airhostesses, nurses, and attendants. These occupations remain feminised though men have made
inroads into some of them. These feminine professions are mostly those which have commodified previously unpaid reproductive labour. In very recent times, scholars have termed these ‘care work’. Despite many attempts to understand these many kinds of work under a single theoretical rubric, in fact this is anything but a homogenous sector. There are vast differences in status, pay and social security. On the one hand, some professions like airhostessing, teaching and nursing have undergone processes of formalisation and are now seeing a reverse trend; on the other hand, occupations like domestic work, ancillary nursing work and sex work have always been within the informal economy and continue to remain so. Recent studies on employment patterns have pointed out that it is this heterogeneous field called care work which provides the maximum employment, especially to urban women.

If we look at all-India figures, it is agriculture that provides the maximum employment for women (73 per cent), followed by services (14 per cent) and industry (13 per cent); however, according to NSSO data (2006), urban women have found the maximum employment in the category of ‘other services’ (35.9 per cent) which includes anything from low-paid, irregular employment to highly remunerated public and private services. A further disaggregation shows that it is menial, low-end jobs, such as domestic work, which has seen a concentration of women (12 per cent), while high-end, skilled jobs like banking, insurance etc provided employment to a minuscule 1.7 per cent of urban women. Feminist scholarship has been highlighting that over the last couple of decades, women are increasingly getting concentrated at the lower end of the informal economy. In the context of waged work, even within the informal economy, women have been losing ground, except in rigidly defined ‘women’s sectors’ such as the care work sector. Though, there has been an increase in employment for educated women in education,

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medical and health services, it has been at the informal end. For instance, nursing has shown a decline in absolute numbers from 2000 to 2004 and it is possible that the increase has been either at the level of ancillary nursing staff or women doctors. It has been pointed out that 91 per cent of women workers are in various forms of manual work— whether it is agriculture, industry or services. In fact, even within the service sector, notwithstanding the increase of women in the upper echelons, most women are concentrated in manual service in poor income sub-sectors.\(^5\)

It is this part (the poor income sub-sectors) of the ever expanding care sector that has all the hallmarks of a feminine occupation— low paid, constructed as semi/un-skilled, exploitative and stigmatised— and within the informal economy. When I started exploring this particular segment of the labour market, care work had not yet emerged as a burgeoning field of intervention and analysis. Of course, now it is matter of considerable debate. In the West the debate on care work was inaugurated by Arlie Hochschild’s seminal publication on the emotional, affective labour of what she calls the ‘pink collar’ service workers.\(^6\) Within a couple of decades, race and ethnicity became an important category in understanding the continuing devaluation of care workers. Currently the debates in the west regarding care work focuses on race, class and gender composition of care workers, especially in non-institutionalised settings.\(^7\)

However, the care economy per se remains undertheorised. There seems to be no consensus on what care work stands for— the current debates by feminists in the American Marxist tradition focus on the cultural and economic devaluation of care work. Nancy Folbre and Paula England conceptualises ‘caring work’ as an occupation, in which workers provides services, which involves face to face contact. The word ‘caring’ is


based on the assumption that the worker is responding to some need of the recipient. This would include child care, teachers, nurses, sales clerk, physical and psychological therapist etc. However, it does not include services, which have incidental contact with the client, like maybe a carpenter. They go on to argue that most care workers are women with lower pay than workers in other sectors and use the term ‘care penalty’ to explain the difference. They argue that because care work is associated with women’s work, patriarchal norms devalue it.\(^8\)

Another research paper points out that care work is something that is traditionally done by close female kin (for example, mothers and wives); which implies that care service is a ‘labour of love’ rather than a commodity exchanged for money. This emphasis on use-value rather than exchange-value essentially feeds into an expectation that caregivers have to accept a wage penalty. The assumption is that since altruism and job satisfaction are powerful motivators, wages remain low. This coupled with care work seen as unskilled work may explain why care workers are often paid even lower than other female-intensive administrative work.\(^9\)

Folbre and England’s conceptualisation of care work as an occupation that responds to the recipient’s needs is too broad— it can include women’s reproductive labour, as well as barbers, doctors, sports trainers — all of which are masculine professions. This would then make the proposition that care work is done mostly by women and is devalued because of its construction as ‘unskilled’, problematic. This theorisation of the care worker as a ‘service provider’ misses the point of gendering— atleast in India, where most barbers, teachers, therapists, sports trainers and even professional chefs for that matter, are men. While ‘care work’ has become the new buzz word to signify women’s paid and unpaid reproductive labour, its genealogy is still largely unknown. As Samita

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Sen argues that one of the ways women’s work have been theorised is by the binaries of productive/reproductive, factory/home exchange/use-value labour, where the first part of the pairing has been associated with men and the second with women. This theorisation has ignored commodified reproductive work like domestic work, which has been constitutive of understandings of class, especially in the history of early capitalism. Care work fuzzes this division between productive and reproductive labour.\(^\text{10}\) There are two schools of thought that approach debates in care work: first, American Marxist scholars such as Nancy Folbre and Paula England who argue for a revaluation of women’s reproductive labour; second, European post-Marxists scholars such as Michael Hardt and Antonio Negri who argues that the division between productive and reproductive labour has never been rigid and proposes a new theory of value where economic production and social reproduction are indistinguishable. Their theorisation of affective labour, a component of immaterial labour, is central to their understanding of a post-modern economy where manipulation of people’s emotion is mostly achieved through virtual or actual human contact, mainly associated with health services, caring work, entertainment industry, and other kinds of services.\(^\text{11}\) Hardt is quite clear that the theorisation of affective labour is not new; feminist challenges to Marxist theory of value has been based on the theorisation of reproductive labour as productive but what is new is that in the Post-Fordist regime, affective labour has become central to the economy.\(^\text{12}\)

However, these two schools of thought remain disparate and do not speak to each other, therefore, leaving us where we started: What is care work? Is it paid and unpaid reproductive labour traditionally understood as ‘women’s work’ and therefore undervalued? How do introducing new terminologies like ‘care work’ increase our understanding of productive and reproductive labour, which has already been well

\(^{10}\) Samita Sen, ‘The Debate that Never Was: Gender and Class in Indian History’, paper presented at ‘Women and Labour Conference’ at Tata Institute of Social Sciences, Mumbai, 2014.


\(^{12}\) Michael Hardt, Affective Labour, Boundary 2, 26:2, 1999.
schematised and how does it further our understandings of the burdens that women in poor households bear? Is care work and reproductive labour only a matter of overlapping descriptions or is it a third value that is neither productive nor reproductive labour but a little bit of both? Samita Sen argues that more than affective labour, care work comes close to reproductive work, with its emphasis on the invisible emotional content. However, she is also quick to point out that the term ‘care’ with its emphasis on emotional labour detracts from the harsh labour content of such work. Despite knowing the limitations of the term ‘care work’, I continue to use it as first, nursing is caring work in its most literal sense; second, nursing and health care is also affective labour—that it affects the well-being of other human beings through human contact. In this sense it is as much as affective labour as it is reproductive labour, if I can locate the latter as a subset of the former.

Research in care economy in the international arena has brought to light that care work is mostly done by immigrant women workers. A global care chain has evolved where care deficiencies in western countries are being met with women migrants from the Third World who work as caregivers. Lynn May Rivas argues that one of the most important components of care work is the erasure of the self of the worker. Her study of immigrant women working in USA (United States of America) as personal attendants of sick and disabled people has demonstrated that both the worker and work has to be invisibilised so as to give a sense of autonomy and independence to the recipient. While immigrant women themselves belong to a social category that is socially invisible; essentialised and naturalised understandings of care giving skills of Third World women further

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invisibilises their work. The composition of this segment of the workforce is never stable and is determined by immigration flows; some of the determining factors are race, immigration status, lack of knowledge of English and education. Though most research on care economy has focused on immigrant workers in the West, especially within the household, nurses and attendants in institutional settings have also been included in this badly paid, invisible workforce.

In the Indian context, it is domestic and sex workers, who have attracted the most attention. Though recently there has been some work on nursing. However, I chose to look at nursing, rather than domestic or sex work as it has its own specificity. First, nursing, unlike domestic or sex work, has and continues to undergo, modernisation and professionalisation which throws up a distinct set of concerns. With professionalisation, it becomes a legitimate occupation, though stigmatised as I will argue later, for (lower) middle-class women. Second, the nursing profession is linked to larger labour processes of informalisation and casualisation of the formal economy. While both domestic and sex work have always been a part of the informal economy, marked by invisibility and high levels of exploitation, modern nursing from its inception, or at least certain segments of it has been much more organised.

The trained nurse has always been a figure at the center of processes of formalisation, modernisation and professionalisation. In the West, she came into being with Florence Nightingale’s reforms— earlier nursing in public hospitals was in the hands of nuns or

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19 Sreelekha Nair, Moving with the Times: Gender, Status and Migration of Nurses in India, Routledge, New Delhi, 2012.
untrained women like the domestic worker—and the progress of nursing into a modern profession has been informed by the struggle to eliminate the untrained working-class woman from this occupation. In India, the *Sushruta Samhita* and the *Charaka Samhita* does mention that nurses should be of the same sex as the patient, but there are no records of the class or caste background of the men and women who did nursing. Some scholars have also argued that with the decline of Buddhism and revitalisation of Hindusim and strengthening of the caste system, nursing (with its association with body fluids and detritus) started being seen as polluting. The rigidity within which the medical profession had to function demanded that nursing be done by a certain caste under the *jajmani* system (a system which arranged an exchange of goods for services rendered). This relegation of nursing to low castes socially degraded the profession as a whole. However, we do not have records of who actually did the nursing in public hospitals. During the colonial period we have records of nurses in military hospitals being male *coolies* or army orderlies opting for nursing as a change of duty. However, most women, especially those from upper caste and/or middle class did not go to public hospitals and went to the hereditary *dai* (midwife) for advice or healing especially in relation to reproductive health.

The demand for trained women nurses in India arose with British army officials wanting proper health care in the military hospitals. Consequently, there were attempts to professionalise nursing and induct Indian women as staff nurses. In contemporary times, nursing is still considered a profession for (lower) middle-class women, while middle-class women aspire to the more prestigious profession of the doctor. While most female-intensive occupations are stigmatised (masseurs, beauticians, flight attendants, secretaries

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22 Alice Wilkinson, *A Brief History of Nursing in India and Pakistan*, Trained Nurses’ Association of India, Delhi, 1958.
nursing has its own specificity— first, historically nursing is closely linked to the ‘sexually licentious’ lower-caste, working-class women. As far as the records go, the only women in medicine are the hereditary *dai*; who came from the rural, working-class, lower-caste family, and occupied the lowest rung within the indigenous medical hierarchy. Second, with colonialism also came a very different medical hierarchy where doctoring and nursing were clearly divided, even in the field of gynecology and obstetrics. In the colonial medical apparatus the demand for doctors was paralleled by a demand for nurses. However, despite there being many middle-class and/or upper-caste Indians (mostly men and some exceptional women) who transgressed caste norms to become doctors, middle-class and/or upper-caste Indian women did not take to nursing. It was the lower-caste, working-class, or Christian convert Indian women who could not find other suitable careers, were recruited into nursing through the military, medical-missionaries or philanthropic organizations. While the social and economic profile of nurses has undergone dramatic changes in India, this association from the colonial era survives even today.

In a society dominated by Brahminical patriarchy, menial and stigmatised work is assigned to the lower castes. The association of nurses with lower-caste women meant that association of nursing with servile, menial work which needs no scientific knowledge or training and this representation survives. Even in colonial India it was understood that to break such associations, middle-class and/or upper-caste women needed to be recruited. Towards that end, the nursing occupation had to be modernised and professionalised enough to make it a lucrative career choice. So emerges the trained nurse, armed with a degree/diploma, uniform and claim to scientific knowledge as against the untrained nurse, attendant or *dai* who purportedly has no education, hygiene or professionalism.

Nursing in colonial India was mediated by race; the modern European nurse rose up within the hierarchy as against the trained but supposedly incompetent and inefficient
Indian nurse. After Independence, India saw the progress of nursing into a modern profession with Indian women taking the lead. However, various forms of discriminations remained; new hierarchies were created within the profession mediated by caste and class. Today in West Bengal, the health care workforce, particularly the nursing staff, operates within a triple-tier labour market, with well-paid, formally employed, registered, ‘trained’ nurses at the top; ill-paid, contractually employed, unregistered, ‘untrained’ nurse known as ANM and attendants at the middle tier; and daily-waged attendants and the unregistered, ‘untrained’ nurse known as ‘private sister’, employed on a ‘no work no pay’ basis at the base. This triple-tier labour market, takes the shape of a pyramid, with increasing numbers but descending status, benefits, wages and job security. The deployment of different categories of workers across the industry (both public and private) is not uniform; it reflects individual organisational behavior allowing manipulation of labour processes that facilitate capitalist exploitation. There is, thus, a niche workforce of trained nurses who are formally employed at the top of the pyramid at the expense of a bulk of informal employees, occupying the middle and bottom layers. My thesis looks at how such a triple-tier labour market is produced and the politics that arise from these processes as work hierarchies and social identities come together in a complex play. This production, though a part of capitalist processes, is with the active agency, consent and complicity of a segment of the labour force, which results in exploitation of other segments of the labor force. While capitalism thrives on dividing the workforce on lines of class, caste, gender and community, amongst others, I argue, that the workforce is not a passive, inert mass on which such policies are made operational. These divisive politics are produced with the consent, complicity and active

\[GNM\] General Nursing and Midwifery- A nursing diploma awarded after a coursework of 3 years and 6 months. Unregistered ANM- Auxiliary Nursing and Midwifery- 6 months to 1 year coursework done in unlicensed private centers and women graduating from these courses do not get registration numbers and their qualification is not recognized by market forces. Private sisters- Women who have done the same courses as the ANM but have got employment on a daily-waged basis instead of joining as a regular workforce.
agency of that segment of the workforce, which seeks to aspire to or maintain its position at the top of the pyramid. The result is a differentiated labour market that benefits some workers but becomes more exploitative for others.

The figure of the trained nurse needs to be located within three discernible trends: first, growing informalisation and casualisation within the formal economy; second, reconfiguration of the profession itself—what constitutes nursing care—which is closely linked to establishing the occupation as a respectable profession; and third, the ‘export’ of care workers from developing to developed nations resulting in supply crunch within the local market. The recent debates on the nature of the Indian economy and the labour market, points to the processes of informalisation within the formal economy, i.e. increasingly casual employment in formal sector establishments. This phenomenon has not left nursing services untouched. While the existence of untrained nurses and attendants working as ancillary nursing personnel at unregistered hospitals and residences as well as registered hospitals is historically not a new phenomenon, what is startling is its magnitude. Increasingly, the volume of trained nurses is decreasing vis-à-vis the increase in casually employed unskilled or semi-skilled nursing aides. In the private sector, there are only a handful of trained, registered nurses; most of the nursing staff consists of unregistered, untrained ANMs, private sisters and attendants. Even in public sector, this is increasingly becoming a trend, where lower level employees are being hired on a casual basis. This brings us to the second point, how do medical enterprises function efficiently and professionally if the numbers of employed trained nurses are decreasing vis-à-vis ancillary nursing staff consisting of untrained nurses and attendants/ward boys? The art of healing is organised in a manner where both doctors and nurses are caregivers. However, there are internal hierarchies based on oppositional binaries—cure/care, technical/menial, skilled/unskilled, reason/emotion,

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24 There has been a decrease in absolute number of nurses from 2000 to 2004. Indrani Mazumdar, Women Workers and Globalization, Stree, Kolkata, 2007.
masculine/feminine—where the first of the pairing corresponds to the doctor and the latter with the nurse. While it is true that increasingly women are becoming doctors and men nurses, which challenges the application of such easy binaries, the cultural understanding of doctoring as a masculine profession that is highly skilled (with claim to scientific knowledge and integral to healing) vis-à-vis nursing as a feminine profession which is semi-skilled (based more on affective labour that comes naturally to women and peripheral to the process of healing), is dominant. On the one hand, a doctor comes across as an authoritarian figure and therefore irreplaceable, a nurse, on the other hand, is constructed as a menial labourer and therefore easily substitutable. This reflects in the pay structure, policies, budgets and the status of nurses and doctors. One of the ways, nursing can establish itself as a respectable profession, demanding better pay structure and facilities, is to establish itself as a skilled job. So as the trained nurse starts to professionalise, she also starts to change the nature of her work—from menial hands-on care work, she takes on a more administrative and managerial role where she supervises an ancillary work force. The medical work that she retains is ‘respectable work’—such as dressing, bandaging, cannulation etc— which even a doctor does. This fits with other labour processes, where a niche, formally employed, well-paid trained staff is being employed on one end, while on the other end, a large, casually employed, ill-paid untrained work force who learn on the job are being taken on under the supervision of the former. The discourse on skills justifies the pyramid-shaped labour market and the cultural and economic devaluation of those at the bottom.

This directly leads us to the third concern—that of nurses migrating to the west leading to a supply crunch in the local market. The search for social and economic mobility has led many young, unmarried, trained nurses to migrate to U.K., U.S.A and more recently, to the Gulf—something that India has in common with other developing nations like Sub-Saharan Africa, Philippines and Malaysia. Though there has been a lot of concern raised by activists, academics and policy-makers regarding the adverse effect of the
migration of skilled workers on local health services, it has not led to a commensurate increase in the local nurse’s bargaining power. The low supply of trained nurses is offset by a hiring of un/semi-skilled, untrained nurses and attendants who work as nursing aides and do the lion’s share of care giving. For instance, in the government hospital, where I did a part of my fieldwork, more than 30 per cent of its sanctioned nursing posts are lying vacant. These processes culminate in the nursing profession taking on a pyramid like structure with increasing numbers as you go down, but decreasing pay, benefits, job security, respect and status.

This fragmented labour market overlaid with tensions of professionalisation feeds into and in turn is fed by inequities produced both historically and in everyday practices of class, caste and gender. Nursing is increasingly laying claim to a modern profession through differentiation and distancing from the informally employed ancillary nursing workforce who does the menial side of care giving. Markers like uniform, training, degrees and qualifications, nature of work, etc as well as class and caste differences are foregrounded to distinguish a trained nurse from an untrained one. The politics of both differentiation and distancing imposes hegemonic notions of gender, class and caste to mark out trained nurses as middle-class, upper-caste women, who are part of a modern, skilled profession as against the working-class, lower-caste women working as menial labourers in the wards of hospitals and nursing homes in Kolkata. A small number of trained nurses take on the managerial, administrative and medical tasks of the wards in private hospitals and nursing homes, and the larger hands-on nursing care is given by untrained nurse and attendants. While trained nurses come from (lower) middle-class families with all the anxieties of social and economic aspirations, the untrained nurses and attendants are recruited from working-class families. Though my research shows that caste divisions are not clearly demarcated, what it also highlights is the ideological

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25 Interview with the Nursing Superintendent. The figures are for February 2010.
configuration of an untrained nurse as a lower-caste woman as opposed to the trained nurse.

Scholars have been arguing that the new middle class that has emerged after liberalisation does not derive its status from structural privileges as much as from its access to education, skills and aesthetics. This also means that the middle class has become more porous than ever before and open to challenges by historically subordinate groups, especially lower-caste groups. The anti-Mandal agitation (1990) is a case in point where middle-class, upper-caste men and women rallied together to oppose reservations (for lower castes and backward classes) in government employment. Similarly, in hospitals and nursing homes in Kolkata, the complex relation between social identities and occupational hierarchies come into play. Trained nurses close rank and strategise so that hierarchical social identities are grafted onto occupational hierarchies and the dominance of class and caste remains unchallenged. However, reservations as well as lack of suitable employment for women have ensured a reorganisation of the caste and class composition of the nursing staff, which challenges any easy translation of social identities into occupational hierarchies.

The attempts to impose hegemonic norms of caste, class and gender are not accepted unquestioningly and are challenged and contested by women in their everyday lives. Labour practices in the wards therefore reflect imposition and enforcement as well as contestation and resistance to capitalist patriarchal norms which aim to fashion women workers as docile, obedient and passive and at the same time as productive, efficient. My thesis explores the everyday rituals at the work place to try and locate women’s agency

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27 The Mandal commission constituted in 1978 under the chairmanship of B.P. Mandal to look at the question of seat reservation for backward classes and castes passed a recommendation of 27 per cent reservations for Other Backward Classes (OBC), in addition to the 22.5 per cent reservation already existing for Scheduled Castes (SC) and Scheduled Tribes (ST). This was announced in 1989 leading to nation-wide protest in 1990. Large number of middle class, upper caste women came out in the streets to protest the ‘death of merit’.
and resistance to both capitalism and patriarchy. I argue that large-scale, organised collectives, for example trade unions, have not been successful in bringing about any foundational changes. On the contrary, it has created newer margins and differences. For the last few decades scholarship has been focusing on resistance that is local, diffused, subversive and not necessarily tied to any emancipatory goal.\textsuperscript{28} Scholars like James Scott have been arguing that those who are subordinated can hardly afford to disobey those who are in power; however, this does not necessarily mean that they are obedient and subservient. He distinguishes between what he calls ‘on-stage behaviour’ and ‘hidden transcripts’, where the former is the public behaviour displayed by the subordinate in front of those who have power over them and the latter is ‘a critique of power spoken behind the back of the dominant.’\textsuperscript{29} In this ethnographic study, I have explored how power is critiqued by those who are relatively powerless and I argue that women’s agency is located in these small acts of displacement and subversion of norms that constitutes them as ideal workers as well as good women. The cultural field that bestows intelligibility to human beings depends on norms and as Judith Butler argues norms have no independent existence and depend on being reiterated. Within this constant reiteration lies the possibility of displacement and resignification.\textsuperscript{30} I argue that women’s ad hoc and subjective resistance to both capitalist and patriarchal disciplining constitutes agency and resistance to hegemonic power structures.

Therefore there are two contrary trends that I explore in my thesis; first the multiples axes of oppression (gender, class and caste) that function in tandem to construct a woman as a docile body that supplies cheap labour in the informal economy of the medical


establishments and second the equally strong movement from below that questions such constructions.

**Nursing in India: Laying out the Field**

There have usually been two strands within the scholarship on ‘women and medicine’, both in the context of colonial India; first, historiography that questioned the colonial medicine discourse which posited the *dai* as a symptom of India’s primitiveness that either needed to be eliminated or co-opted within the hegemonic aspirations of the colonial state[^31] and second, on the exceptional Indian women who braved all odds to become lady doctors in the colonial medical apparatus[^32]. The question of the nurse has been seen in context of either replacing the *dai* or as an assistant to the (white) female doctor who was trying to make in-roads into the field of gynecology and obstetrics. The nurse has been posited differently by different scholarships: those examining the hegemonic aspirations of the colonial state via medicine pose nurses as instrumental in reaching the heart of the *zenana* which was outside the pale of imperial domination[^33], as a signifier of European modernity[^34], or as instrumental figure within the colonial discourse of the ‘white woman’s burden’.[^35] More recently studies on nursing in colonial India have

[^33]: Samiksha Sehrawat ‘The foundation of Lady Hardinge Medical College and Hospital for Women at Delhi: Issues in Women’s Medical Education and Imperial Governance’ in Shakti Kak, Biswamoy Pati (eds.), *Exploring Gender Equations: Colonial and Post Colonial India*, Nehru Memorial Museum and Library, New Delhi, 2005.
focused on why nursing did not have any takers amongst middle-class, upper-caste Indian women. Despite the attempts to fill rank and file nursing services with a ‘better class’ of Indian women, it was never considered a respectable career. The menial and polluting nature of nursing (cleaning of bodily detritus) purportedly kept caste Hindu women away, along with having to work with men in hospitals. Scholars such as Madelaine Healey have focused on the lack of opportunities that acted as disincentives for Indian women to take nursing seriously as a career.

Scholarship on nursing in contemporary India can largely be grouped around two issues; professionalisation of nursing and more recently, migration of women working as nurses. The approach to nursing and its levels of professionalisation has been within the discipline of sociology. The first study on nursing, in independent India was published in the 1970s which was a comparative study of levels of professionalisation achieved by medical workers: where doctors were considered ‘full-fledged professionals’, and nurses were labeled as ‘semi-professionals’. The study, whose underlying hypothesis is that levels of professionalisation will affect the behaviour and efficiency of the individual, starts with an assumption that doctors will behave professionally while nurses will be ‘bureaucratic’. Nursing continued to be labeled as a ‘semi-profession’ in academic writings. Molly Chattopadhyay, in her in-depth research on the nursing profession, explores how adverse nurse-patient ratio, lack of proper medical equipments, and non-cooperation from Grade IV staff are the three main organisational constraints in effective

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occupational role performance of the nurse. She argues that the low status and lack of respect associated with nursing is in context of the low pay nurses receive as compared to women doctors or teachers. This lack of prestige, arduous state of duties which include night shift, coupled with low pay, prevents a lot of middle-class women from coming into the profession.\(^{40}\) Recent scholarship has highlighted how nursing is gradually turning into a more acceptable profession with increasing social and economic mobility. Though nursing is generally devalued worldwide, the stigma that nurses have to face in India, unlike teaching or other female-intensive professions, is the peculiarity of Brahminical patriarchy. While doctors in both pre-colonial and colonial India usually came from learned castes, nurses had no such antecedents. Coupled with the constant contact with men (one of the premises of female respectability is not to have contact with unknown men), led to the continuing identification of nurses with women of disrepute. However, more recently, with increasing modernisation and professionalisation of nursing and the opportunities to go abroad, as well as growing dowry demands and increase in the ideology of the double income family, more middle-class, upper-caste women are coming into the profession.\(^{41}\) This relationship of class and gender gets further complicated by considerations of race and ethnicity, especially, when we look at the intersections of scholarship on care work and migration studies.

This leads us to the second trend in scholarship on nursing— which intersects with migration studies leading to academic and political engagements with the highly complex relationship of gender, class, race and ethnicity. The migration of Third World women to the First World— which has been termed as the international division of care labour or the new service economy— has had as its focus unskilled care work like ‘nannies, maids


and sex workers’, however, recently, there has also been an increasing focus on nurse migration from poorer to richer countries. The ‘global care chain’ has been explored to include at one end of its continuum, skilled care work such as nursing in institutional settings. This focus has largely been the result of a growing alarm amongst policymakers, nursing administrators and health officials at the large flow of nurses from Third World countries to First World, impacting health services in the former. This increasing demand and mobility of Indian nurses to the west has seen a large number of women taking up nursing, especially in the southern states such as Kerala. While some scholars have pointed out the empowering potential of international migration for nurses in terms of social mobility, status, autonomy and economic stability, other have been highlighting the stigma faced by women migrating for care work. There is a considerable amount of sexual immorality associated with women who migrate to foreign shores. Moreover, the supply crunch of nurses has not increased their bargaining power; on the contrary, salaries continue to remain low and there is high unemployment among nurses after they have finished their training. Despite, a large number of nurses

completing training every year, there are vacancies in government hospitals that are not being filled. Freshly trained nurses work in private establishments for dismal salaries waiting for postings. Studies done on nursing show the immense dissatisfaction that nurses feel regarding low wages, poor working and living conditions, lack of job prospects and low status of the nursing profession. This becomes an incentive to migrate. Nurses in private hospitals, rather than government hospitals, are more likely to migrate as the former pays considerably less than the latter.  

Sreelekha Nair’s recent book, ‘Moving with the Times’ fills up a lacunae that has been existing in the scholarship on nursing— that is nurses migrating within the country and their experiences of a profession and that it is still largely perceived as ‘dirty’. While nursing education was seen as a ‘life-strategy’ for women, coming from a state (Kerala) where 50 per cent of women waged workers, are nurses who have migrated to the Gulf, Nair’s study foregrounds the acts of resistance by Malayali nurses working in Delhi, who negotiate and challenge the powerful social structures and the hierarchical inequities of their everyday lives. While on the one hand, the patriarchy of the Malayali community is recreated in Delhi, on the other hand, women both comply and resist such gender norms in search of ‘a better life’, somewhere in the west.

This large scale movement of nurses to the west has, however, not been accompanied by an increase in bargaining power of the locally employed nurse. The supply crunch of trained nurses is offset by the employment of a large number of untrained nurses. While scholars like Nair and Chattopadhyay do mention the presence of un/semi-skilled women working as nurses, their experiences have found no voice in their work. If nurses are marginal, semi-professional personnel within the health sector, these untrained nurses are doubly marginalised— first by the trained nurse who sees her as a threat in both the

51 Sreelekha Nair, Moving with the Times: Gender, Status and Migration of Nurses in India, Routledge, New Delhi, 2012.
employment market as well as detrimental to the image of a nurse as an educated, skilled personnel and second, by the larger medical establishment which treats her as cheap, dispensable labour. The patient is usually unable to differentiate between a trained and an untrained nurse.

The anxiety and threat experienced by trained nurses by the continuous presence of the untrained nurse is neither a historically new phenomenon nor is it specific to India. As Abel Brian Smith’s ‘A History of the Nursing Profession’ has demonstrated that one of the reasons for call for registration of nurses (world-wide) was to eliminate the working-class woman from the occupation. In the Anglo-American world, before 1840, nursing was in the hands of the untrained nurse— mostly domestic workers and prostitutes—who had much less responsibility than nurses have now. It was first the clergy that tried to organise nursing into a modern profession drawing from middle-class respectable women, closely followed by Florence Nightingale and her school that imparted secular nursing training. The organisation and gradual evolution of nursing into a modern profession foregrounded the question of the untrained nurse, who was often a widow, or a married woman in distress, who turned her hand at nursing as she would to domestic work. The introduction of training led to an extremely varied group practicing nursing: at one end was the working-class woman with no training and on the other end, the highly trained middle-class woman— both belonging to the same occupation and there was little by which the general public could make the difference. Thus, the drive for registration by middle-class nurses was fuelled in part by the desire to make a distinction between trained and untrained nurses. The move for registration fulfilled a surveillance function of deciding who could practice and who could not. The idea was that nurses should ideally come from women of higher social order, and the presence of working-class women in the profession acted as a deterrent. There was also the desire to protect (upper) middle classes from criminalised women who took advantage of working in private residences. The call for registration was also linked to the larger feminist movement which was
interested in seeing the profession gain upward mobility and, therefore, parity with other medical personnel.\textsuperscript{52} Even in India, the call for registration of nurses and midwives was motivated by the desire to eliminate the working class, lower caste, untrained nurse as well as the hereditary \textit{dai} who was favoured by Indian women over the western trained nurse.\textsuperscript{53}

Despite the registration, untrained nurses continued to thrive in the profession, and newer hierarchies were formed. Untrained nurses and attendants did the large volume of the hands-on nursing care as against the more medical/supervisory function of the trained nurse. This phenomenon has to be seen in context of two debates: the nature of ‘work’ and increasing informalisation of the formal economy. Nursing falls under the larger rubric of ‘care work’ which is traditionally use-value labour and in a patriarchal society, it is mostly women who do this labour. In the 1970s, feminist challenges to Marxist theorisation on labour and work was based on the premise that the latter did not account for women’s unpaid labour or reproductive labour. Use-value labour has traditionally not been counted as ‘work’ either by Marxist theory or mainstream economists. The current theorisation on care work foregrounds how use-value labour, even if brought into the labour market, continues to remain culturally and economically devalued. There have emerged five major conceptual frameworks in understanding care work: the ‘devaluation’ framework, which suggests that because care work is associated with women’s work, it is considered un/semi-skilled and therefore has less market value; the ‘public goods’ framework, where it is argued that the benefits of care work percolate further than the recipient and add to social welfare, hence making it difficult to pay care workers adequately; the ‘prisoner of love’ framework which suggests that altruism more than money is what motivates care workers justifying low wages; the ‘commodification of emotion’ framework that argue that under global capitalism, underprivileged women are

\textsuperscript{53} Alice Wilkinson, \textit{A Brief History of Nursing in India and Pakistan}, Trained Nurses Association of India, Delhi, 1958.
forced to sell their emotion to care for privileged recipients in the new international
division of care work, which results in an alienation of feelings. And lastly, the ‘love and
money’ framework which rejects the dualism between altruism and economic benefit.54
What emerges clearly from all the five frameworks is that care work is ill paid, devalued,
connected to femininity and done by underprivileged women who may not have other
options.

What is interesting is, that most care workers (domestic workers, sex workers, nurses,
ayah, etc), at least in India, have never been a part of the formal economy. While in the
case of nurses, we have seen attempts at formalisation, it has only been for a small
section of elite, trained nurses and the processes of formalisation and, therefore,
professionalisation has also seen a reconfiguration of the work of a nurse. The trained
nurse takes on a more managerial-administrative-medical aspects of care work; she is
now an expert-consultant, whereas the menial hands-on, day-to-day care of the patient is
left to untrained nurses and attendants who are usually located at the informal end of the
labour market. The earliest ideas of informal sector is informed by dualism which means
that while the formal sector is modern, with a capitalist mode of production, the informal
sector is seen as traditional and pre-capitalist. This notion has been challenged by
scholars who see the formal and the informal sector as two ends of a continuum. They
prefer to lay emphasis on the fragmented nature of the entire labour market, instead of
dividing it up in two water tight compartments.55 In its initial conception, the informal
sector was also seen as defining feature of underdevelopment by the International labour

Organization (ILO).\textsuperscript{56} It saw the informal economy as comprising of marginal activities which is distinct and unrelated to the formal economy. The structuralist school spearheaded by Caroline Moser and Alejandro Portes felt that informal economy was subordinated to the formal economy and the former subsidised the latter. This allowed capitalist firms to increase its competitiveness. The legal school popularised by Hernando de Soto in the 1980s and 1990s celebrated the informal economy as an arena of ‘plucky’ entrepreneurs who preferred to operate informally to avoid unnecessary registration.\textsuperscript{57}

From the late 1990s there was a movement towards broadening the definition of informal sector where certain types of employment that existed in industrialised, transition and developing countries, previously excluded, would now get included. This shift towards types of employment from a narrow focus on nature of enterprises was reflected in a change in nomenclature by the International Conference of Labour Statisticians (ICLS) in 2003. Informal sector became informal workers— this shift also implied a focus on employment, even within formal enterprises that were not regulated or protected by labour laws.\textsuperscript{58}

Jeemol Unni argues that the dichotomy between formal and informal economy tends to hide the real picture. Such a view fails to capture three important points: informalisation within the formal economy; the diversity within the informal economy; and the linkages between the formal and informal economy. Exploring the composition of the informal economy, she broadly distinguishes between wage and non-wage employment. Non-wage workers include owners of informal enterprises with at least one hired worker, self-employed as well as unpaid family workers. Waged workers are those who work in above-mentioned enterprises, home-based workers, contractual workers, independent wage workers who provide services to many enterprises/households (domestic workers).


\textsuperscript{58} Ibid.
and informal workers in formal economy enterprises (i.e. those whose pay and benefits do not conform to existing labour laws). Unni goes on to argue that there are two processes of informalisation; one is when work is shifted from the formal to the informal economy leading to both non-wage employment as well as wage employment. The second process of informalisation leads to an increase in informal workers in formal enterprises with lesser pay and/or no benefits.\(^{59}\) My thesis focuses on this category of informal workers.

Informalisation has been closely linked to feminisation. The dualistic framework would suggest that the formal economy which is modern and capitalist is also masculine, whereas the informal economy, characterised by ‘under development’ or a ‘lack’ is feminine. However, this association of informalisation and feminisation has not been empirically grounded. While Guy Standing’s thesis based on the international division of labour, claimed a feminisation of the labour force on two counts—first increasing number of women taking on men’s jobs and increasingly employment becoming casual and irregular—trends associated with women’s work, it has been strongly contested by feminists in India. Although in the Indian context, there has been an increase in informalisation of employment, there has not been an increase in women gaining employment. On the contrary, Nirmala Bannerjee has pointed out, that since the nineteenth century with de-industrialisation women have been the most adversely affected, steadily losing ground in the labour market.\(^{60}\) Samita Sen has argued that formalisation which started around the 1930s went hand in hand with masculinisation.\(^{61}\) The 1970s and 1980s have seen a slight jump in women’s employment, both in the rural non-agricultural sector and export-oriented industries, however, it has largely been at the

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informal end of these sectors. However, after the 1990s, there has been a sharp decline in women’s employment and the gains of the 1980s were lost in the following decades. Scholars have argued that most women’s employment has happened at the lowest end of the informal economy— home-based piece-rate work and industrial outsourcing etc. It is generally agreed that women are losing employment, even within the informal economy.

These processes, however, do not impinge on the nursing profession directly. The formalisation of nursing had been restricted to the top most layers of the profession where there has not been any significant masculinisation. Nursing continues to remain a female-intensive profession; instead, increasing informalisation and casualisation from the 1990s led to an increasing induction of untrained nurses and attendants as against formally employed trained nurses. The nursing profession strongly contests the dualistic understandings of formal and informal sector. Formally employed trained nurses coexist along with informally employed untrained nurse and attendants in the government sector, whereas, in the private sector, casual and informal employment of nurses (both trained and untrained) is the norm, even in a formally registered medical establishment. Seen in context of earlier debates of the formal/informal sector as two separate distinct spheres the nursing profession appears a contradiction. The global pressures of informalisation and international demand for care workers have played against each other to ensure that the nursing profession has an increasingly differentiated work force— differences based on class, caste, skills and knowledge.

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Some Notes on Methodology

Feminists have been pointing out the fault lines in knowledge production in both natural and social sciences, which mark it out as androcentric, i.e. it excludes women’s voices, day-to-day lived experiences, contexts and women as both producers and subjects of knowledge. My research uses feminist ethnography to give voice to women’s experiences as care workers in institutionalised settings. The fragmented nature of the labour market, along with the social identities of the workers has ensured that the experiences of care work have not been homogenous for all female care workers who participated in the research process. Seen within the larger context of informalisation and casualisation, women marked by class and caste, have experienced work differently. Feminist ethnography documents women’s lives, focusing on those aspects that are considered trivial by mainstream research. It tries to understand women in their cultural specificity, which is the context that constitutes women and their choices. Thus my research questions chose to focus on women’s lives, their experiences of work in a stigmatised sector. I have tried to give voice to women’s experience of oppressive hegemonic structures, their daily negotiations, social and professional identities and their resistance to such oppressions.

The research was conducted in three medical establishments— a government hospital situated in the heart of the city, a private hospital located at the fringes and a private nursing home, in a more suburban neighborhood— all three are formal establishments. Over a period of 11 months I was able to interview 94 women from different categories of the workforce. I also interviewed 18 male Group D staff (6 from each organisation) and 1 male nurse, 9 women supervisors (ward-in-charge) and matrons of all 3 organisations. I also held 8 group discussions with students from different years of schools and colleges of nursing, both in the private and government hospitals as well as 3 departmental heads, principals and 3 faculty members of schools and colleges of nursing. I was also able to interview the owners, managing directors and medical supervisors of
the hospitals and nursing homes, sometimes more than once. Some of the women I spoke to were active members of unions and were more than willing to talk about union activities, but I was not able to get any male union member or leader to grant me an interview.

One of the aim of my research was to explore the growing informalisation and casualisation within formal enterprises, both government and private. My respondents consisted of four categories of workers. Registered GNM (General Nursing and Midwifery) nurses, unregistered and privately trained ANM (Auxiliary Nursing and Midwifery) nurses, unregistered and privately trained private sisters and attendants who had no training. Among the first category (GNM nurses), those in the government hospitals are in formal employment—permanent workers with all amenities, leave and benefits. Those employed in the private formal enterprises are however informally employed but as regular workers—contracts that are renewed every three years, some leave and some benefits. The second and the third category (ANM Nurses and attendants) were all informally employed but as regular workers. There are, however, certain distinctions. ANMs are given certain amount of leave which are denied to the latter. Attendants have a ‘no work no pay’ policy and are given only one day-off in the week. These three categories correspond to regular wage earners while private sisters correspond to casual wage earners among informal employees. Private Sisters are not on contract and are employed only when they are needed. They have no benefits, leave (not even a weekly off) and are not assured of regular employment. While the first three categories have eight-working hours in a day (with the exception of attendants employed in the private nursing home), private sisters are on duty for twelve hours. The nursing service in Kolkata, even in the formal sector (both private and government) is a triple-tiered labour market—permanent formal, regular waged informal and casual informal workforce.
The reason I chose this particular government hospital is because it is one of the oldest and most prestigious hospitals in Kolkata; second, it has both a college and school of nursing attached to it; third, it is also one of the first (maybe the only) government hospitals where nursing aides, more popularly known as private sisters, are recruited on a daily-wage basis. One of the most difficult tasks that I faced when I started on my research was to gain access to nurses and attendants working in hospitals and nursing homes. The reason these particular private establishments were chosen was because the owners and share holders are people known in my social circle. Having been rejected permission from owners and administrators from two hospitals and nursing homes, I was forced to look within my own social group for help. My methods included both archival work as well as in-depth interviews. I used the archive to trace the nursing profession as it evolved in the nineteenth century, and then conducted an ethnographic study to look at the complexities of the contemporary nursing profession. I chose my interviewees using the snow-balling technique—after each interview I would ask my interviewee to introduce me to a colleague. Sometimes nursing staff would volunteer to give interviews of their own accord. I also faced disruptions from ward boys, who would walk into the room in the middle of an interview and start asking questions or cracking jokes. These interruptions were filled more with curiosity than humour. This happened mostly in the government hospital and I dealt with it with a firm hand, asking them to leave, as the interviews were confidential.

The government hospital is one of the most prestigious tertiary referral hospital and a national research institute in Kolkata. It is the first hospital in Eastern India to house postgraduate medical studies dating from 1957. It is also the first hospital where training of nurses started during 1926 and by 1955 the School of Nursing was established. Currently it houses both a school and college of nursing. Located near the race course ground it is well connected with metro railway, buses and autos rickshaws. The 1770 bed hospital has 17 operation theaters, and departments like Medicine, Surgery, Ophthalmology,
Cardiology, Nephrology, Endocrinology etc as well as specialised facilities like Dialysis Unit, a 30-bedded ICCU, an NICU, an ICU, a Burns Unit etc. It has both Indoor and Outdoor departments and state-of-art equipments. It has more than 100 per cent occupancy, especially in the surgical, maternity and medicine wards where, due to paucity of beds, patients are given cots and mattresses to lie on. Though I was unable to get any official record of how many people worked in the hospital, I was able to piece together bit and pieces of information gained from interviews to get an idea of the workforce. There are about 1087 nursing posts sanctioned, however, only 68 per cent posts have been filled and only 653 posts are properly filled— i.e. who were reporting on duty. Other than that, there are 270 student nurses from both the college and school of nursing who do their practical exercises in the wards. There were about 500 private sisters (who work in the cabins) and more than 2000 attendants and sweepers who work as nursing aides. The hospital was built in the early twentieth century and over the years more buildings have been added to it. Spread over a sprawling campus, it is built in a circular manner with a pond and large open grounds in the center. Though touted as one of the premium medical institutes of Eastern India, it is not exactly well maintained, similar to other government establishments. Portions of it has seen recent work— modern buildings, haphazardly added wings and some maintenance work where the walls were almost collapsing. The hospital at any given point of day seems to be bursting at its seams— there is always a sense of too many patients, too little resources. There are people cramped everywhere— the lobbies, the OPD, the Emergency and even the grounds outside. Corridors are filled with sick people waiting for treatments with stray cats and dogs for company. Wards are overflowing with patients and their families who have camped there to take care of sick relatives, given the paucity of nursing care. Though there are security guards posted at every ward entrance, they do not pay much attention to the traffic of people. During the entire length of my field work I was not stopped or questioned even once, from entering the wards or the nurse’s hostel, though I
rarely went during visiting hours. It is only in the intensive care units and the VIP wings that there seems to be a semblance of peace and order.

Each ward has a nurse’s changing room, with a bed and toilet, to allow them to rest and change. In the government hospital nurses wear white *saris* and white caps, with name badges and different lapels that signified designation. Private sisters wear brown *saris* with name badges, but no cap or lapel. Attendants also wear khaki coloured *saris*. Earlier, private sisters in the hospital would also wear white *sari* and caps. A prolonged agitation by trained nurses for their removal from nursing services did not lead to their expulsion but led to them being ‘stripped’ off their uniform. They could not wear white uniform anymore and were not to be addressed as nurses; they were given a different name and officially became untrained nursing aides. In this manner, within the government establishment, trained nurses differentiated and distanced themselves from untrained nurses.

Before starting my field work, I had already gone through government reports on working conditions of nurses, where special mention had been made on their inadequate living conditions, but nothing prepared me for the reality. The nurse’s hostel is a tall building with large corridors and steep, wide staircases. However, the sense of spaciousness ends there. The interior of the building is damp and dilapidated, and each room has been further divided into smaller rooms by false partitions. The rooms can barely hold two to three beds and cupboards, maybe a rickety chair and a small gas oven where nurses cook their meals. There are common bathrooms for each floor and close to 30 nurses share two to three bathrooms. The student nurse’s hostel is even worse—the building is a new construction and no sunlight comes inside; even during the day, electric lamps have to be lit. The staff nurse’s hostel has no security; however, the student nurse’s hostel has a warden, who is usually never around. This is not unique to the government sector alone, even the private establishments have similar accommodation for nurses.
The private hospital is located in the Howrah district of West Bengal, and it has recently opened another unit at the fringes of the city of Kolkata. It is a subsidiary of a public limited company which was founded by a group of NRI doctors and is funded by an NRI businessman who runs a chain of hotels and pubs in a European country. Currently the company has 7 directors. Located just outside the metropolis of Kolkata, it draws clients from both the suburbs of the city as well as from the districts. It is a 150 bed hospital, 16 wards with 4 operating theaters, and all major medicine and surgery departments and state of the art equipments. It has a nursing strength of 172 nurses and approximately 170 women attendants and ward boys. It has about 120 private sisters on duty at any given point of time. Though I was refused any information on financial matters including annual turnover, breakup of costs, etc, the managing director did tell me that worker’s salaries constituted 18 per cent of their expenses. The hospital is like any other private hospital— with large glass paneled swinging doors, squeaky clean floor, and a large lobby with a reception desk which is buzzing with activity at any given moment of the day. The campus of the private hospital cannot be more than one tenth of the government hospital— its growth is more vertical. There is one main building with all the wards, operation theaters and doctors chambers and a car park at the back; adjacent to the car park is another block— much smaller which houses the administrative and managerial staff. Under strict security, even workers from the hospital cannot enter without prior appointment or permission. However, unlike a government hospital, there are no overflowing wards, or families camping on hospital premises. Heavily guarded with security at every conceivable turn, one cannot enter a ward or floor at will. Visits to patients can only be made during visiting hours and that too with proper passes. Having secured permission to conduct my field work at the hospital, I was given a special pass which allowed me to come and go at will. At first I was stopped and there was curiosity as to who I was, and then I became a part of routine and no one raised an eyebrow when I went around wards. Each floor had a main lobby of its own with a nurse’s table and ward manager. Each floor had its own uniqueness, in terms of interior arrangement. Some
floors had wards on them, all the intensive units were on one floor, one floor was divided up into private cabins, etc. I conducted the interviews in empty cabins, behind closed doors.

The nurses wore loose trousers and shirts and there were no caps, lapels or badges. Different coloured uniforms signified different levels of training and expertise; navy blue for unregistered ANM, sky blue for registered GNM, full green for those working in intensive care units (could include trained and untrained nurses), green and white for sister-in-charge who were usually registered GNM nurses. Private sisters wore white saris without any caps and attendants wore brown saris. Though there are different uniforms for differently skilled staff— it is not obvious to either hospital clients or outsiders. These different levels of hierarchies can only be interpreted by those who work in the hospital and know the colour coding beforehand. Simultaneously, hierarchies are both established as well as not made obvious to those who pay for it.

The private nursing home is located in north-central Kolkata, on the main road that connects the city to the airport. Owned by a doctor-couple, it is a private limited company established in the year 2001 and by 2008-09 it was recording an annual turnover of rupees 400 lakh. It is a 60 bed nursing home, with 2 operating theater, and some of the major medicine and surgery departments. It has a nursing staff of 46 personnel with 3 GNM and 43 ANM. There are about 70 to 75 attendants and approximately 20 private sisters at any given point of time. Its main expenditure is on medicine purchase (60 per cent) and worker’s salary constitutes about 9 per cent of its expenses. The nursing home is one building, cramped between a bar and a large furniture shop. There is no parking lot and its one ambulance is usually parked outside the main gate. The ground floor houses the reception, the doctor’s chambers, the pharmacy and the laboratory. The next three floors are the wards, operation theaters etc. The topmost floor is the administrative block, the canteen, the nurse’s changing room etc. The floors that consist of the wards and cabins have a nurse’s table, located at a point where either the whole ward or the entrance
of all the cabins can be centrally observed. Though there was strict security, I was not given a pass. Instead I was introduced to the head of the security forces who in turn informed the guards, and I could come and go at ease.

All the nurses wore green trousers and shirts, and no caps or badges. The attendants wore brown saris and the private sisters a white one. There was no way to distinguish between a trained and an untrained nurse. During the day, I was not able to take any interviews as there was no private space or an empty room available. The nursing home usually had 100 per cent occupancy. It was only when I started visiting during night shifts that I could sit in the matron’s office, and take interviews behind closed doors.

The interviews had no planned structure; it took on the life history method. While some would talk about themselves from their childhood, others would start from their marriage, and yet others who would start from the present and reminiscence back to their childhoods. To ensure that I was able to tabulate certain facts and figures of the social and economic background of the respondents, I kept a fact sheet with me which I checked time to time, to make certain that I had not missed any factual information like caste, region, age, family structure etc. In the beginning I went to the hospitals and nursing home during the day but met with little success. Interviews were interrupted because the nurses, attendants were needed back in the wards, women were not too forthcoming and would keep glancing at the door expecting someone to come in. At one of the attendant’s suggestion I changed my interview hours and went during night shifts. This brought a remarkable change as the interviews became longer and more intense. Most women expressed surprise and happiness that someone was ready to listen to them, and that their voices mattered. The interviews could go on for as long as two to three hours while some (very few) ended in less than thirty minutes. Surprisingly, no one objected to a tape recorder after being promised complete anonymity. However, I met with stiff resistance especially in the government hospital. There was a whole ward where all private sisters refused to talk to me, because the sister-in-charge of the ward directed them (rather
rudely) to grant me interviews. It escalated to a point where the matron called the ward and ordered the private sisters despite my protests. I realised that I was witnessing a power play between permanent nursing staff and casually employed private sisters, and beat a hasty retreat. While this made me acutely aware of the constant tensions and negotiations between different categories of workers, it also nudged me to a direction in the research— that power is not necessarily unidirectional (permanent staff dominating contractual workers) and that within every power laden situation, there is also resistance.

One of the political aims of feminist ethnography is to breach the unequal and hierarchical divide between the researcher and the researched. Self-reflexivity becomes the core of feminist research methodology. How was I to negotiate my upper-caste, middle-class, educated, urban identity? Ethical discomforts also emerged during my fieldwork. When I interviewed nursing administrators and faculty members of nursing schools and colleges, certain solidarity of belonging to the middle-class, upper-caste group was assumed. Sometimes respondents started conversations with ‘women like us…’ or ‘our kind of family…’ and then moved on to make disparaging comment on working class attendants assuming a shared world view which made me cringe. On the one hand, working-class and/or lower-caste attendants routinely refused to engage with me and on the other hand, they made me stop and think, when they blatantly asked why they should divulge information about their lives to me so I could advance my career. ‘… you will get marks for this assignment… then you will get a job. What difference will this make to my life…?’ This sort of questioning led me to rethink post-colonial feminist concerns with difference and the impossibility of universalities based on gender. I responded by telling them that within the rubric of my doctoral work, I could do no more than give their experience a voice. I was well aware and communicated to them the limitations of this research. While I insisted that I just wanted to highlight their experiences as women and as workers, these moments were disconcerting.
However, most women were happy to speak of their lives, experiences, hopes and disappointments and were surprised that their voices mattered. While almost all women, especially the older ones had a lot of questions for me regarding my education, marriage plans and family background, it was the fact that I could move freely in the middle of the night that intrigued them the most. Answering their queries of how I escaped patriarchal control at home, which allowed me so much mobility, also compelled me to share details of my family structure and the way patriarchy functions within my home. These conversations did displace, I hope, some notions within mainstream (and therefore masculine) ethnography of the relationship between researcher and the researched and helped me move towards a more egalitarian process of knowledge production.

**Description of chapters**

In the first chapter, I use archival material to construct a history of the trained nurse in colonial India. The chapter focuses on the emergence of the figure of the nurse in its post-colonial specificity, not just in terms of caste, class, gender but also racial tensions. In pre-colonial and colonial India, gynecology and obstetrics was the forte of the *dai*; and to challenge her centrality in Indian women’s life, it was the western trained nurse rather than the woman doctor, who came handy. My chapter focuses on the construction of the trained nurse, who I argue, was perceived as central to undermining the *dai* and increasing the sway of colonial medicine over the Indian sub-continent. The colonial administration, medical missionaries and philanthropic organisations brought trained nurses from England to run hospitals and nursing homes and pay visits to Indian homes in an attempt to persuade Indian women to seek western medical aid. However, the colonial economy demanded that Indian women enter nursing services, as it was too expensive to bring European women to fill rank and file of nursing services. This demand met with little success; Indian nurses’ ambitions were thwarted by racial biases of European nursing leaders and the association of the profession with low-caste, working-class women acted as hindrances for middle-class, upper-caste Indian women to take up
nursing as a profession. My chapter traces the emergence of the trained nurse (modern, western, scientific) as opposed to the dai (primitive, eastern, superstitious) and to make nursing a respectable profession so as to attract a ‘better class’ (and, therefore, upper caste) of Indian women.

In my second chapter I look at government and various other nursing committee reports to look at how hegemonic agendas consolidates itself through government policies and institutions, and in this instance, constitutes nursing as an ancillary service within the medical hierarchy. Despite all attempts by the Indian Government, nursing organisations and leaders to organise nursing services in lines of a profession, it was plagued with low-caste, working-class associations. As further attempts were made to professionalise and modernise nursing, various committees were formed to look into nursing practices; most recommended institutionalising material gains which would convince upper-caste, middle-class women to transgress class and caste norms to take up nursing as a profession. However, the Government did not give the profession any budgetary priority. Caught in a hierarchical binary of cure/care, technical/menial, rational/emotional, masculine/feminine vis-à-vis doctoring, nursing remains constituted as an ancillary service within the medical hierarchy. While at home, the trained nurse fights to establish herself professionally, her demand in western counties has been increasing rapidly. International immigration of nurses, especially from poorer (India, Philippines, Sub-Saharan) to richer countries (U.K., U.S.A, and the Gulf), however, has not necessarily led to an increase in bargaining power of the local nurse. The nursing service has been further divided along the lines of medical and menial work, and the latter delegated to untrained nurses and attendants. In a bid to move from a disreputable occupation to a respectable profession, trained nurses in India take on more prestigious administrative/managerial and medical duties and all menial, manual components of nursing are delegated to working-class women with little or no training.
In chapter three, I further explore this differentiated labour market, which emerges on the basis of training. I argue that the nursing is a triple-tier labour market which takes on a pyramid-like structure. The first tier is made up of trained nurses, who are formally employed and well protected in the government sector; the second tier is composed of both trained nurses and attendants but informally employed in the private sector as either regular or casual workers, and the base of the pyramid is made up of untrained nurses working as private sisters on daily-wage basis. This emerging three-tier structure is complicated by processes of informalisation across different segments of the industry. The chapter will demonstrate, on the basis of my fieldwork, how the categories of differentiation vary in public and private sector hospitals and private nursing homes. It also includes a description of the research, the choice of establishments and the profile of the respondents. In this chapter I also go into details of the social and economic background of the workers to explore the contexts that constitute individual choices of different categories of nurses located in different strata of the labour market. I also document the wages and working conditions of each of the three segments of nurses and the differences across the varieties of establishments to be able to understand the issues that women working at different grades of nursing face as well as the internal contradictions and contexts that give rise to intra-labour competition.

In chapter four, I open up the family to explore how social and cultural capital is gendered and reproduced in the private realm. I argue that the family, as a principal patriarchal institution, acts as an apparatus to disempower women. Gendered allocation of resources within the family ensures discriminatory treatment in favour of the male child, which allows him to accumulate both social and cultural capital which influences his response to the labour market. Patriarchal norms within the family thus privileges structural position of men over women in the labour market. Though the nursing profession is female-intensive, it is also a differentiated labour market. The figure of the trained nurse as opposed to the untrained nurse or attendant is neither incidental nor
coincidental— she is able to become a trained nurse because allocation of resources within the household favoured her— unlike an untrained nurse or an attendant. In this chapter, I also explore the inter-generational reproduction of gendered inequities and hierarchies. Women who participated in the research process spoke of discriminations they faced in their own families, in terms of intra-household allocation of resources, which placed them at the lower ends of the nursing labour market; they in turn reproduced the same inequities when planning and investing in their children’s futures.

In chapter five I look at the signifying processes of the category called ‘work’ and argue that care work is both culturally and economically devalued as disrespectful work. Against the backdrop of increasing unemployment as well as masculinisation of both the formal and informal economy, care work, however, could possibly be the largest source of employment for women. Though not a homogenous category of work— it could include anything from highly-paid flight attendants, teachers, and nurses to highly exploited sex workers, attendants and domestic workers— it is a sector that remains female-intensive. The processes of informalisation and casualisation have not been able to change the gender composition of the sector but have produced a differentiated labour market which is constituted on the discourse on skills. 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 lower end is an example of how the signifying system functions when it comes to women’s work. Drawing a continuum between the private and public, I argue that the value given to paid work and therefore the worker reflects on her/his 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 but the nature and terms of work, remuneration, etc plays a determining role.

In the final chapter I explore how informalisation and casualisation along with gendering of labour produces differentiated workers within the nursing profession and the politics that arise from this differentiated labour market. The thrust of the chapter is on agency
and resistance; while I examine the failure of trade unions to take cognisance of women’s experiences and expectations, I also explore the possibilities of informal channels of resistance to both capitalist and patriarchal discipline. On the one hand, I explore the hegemonic formations of caste, class and gender and, on the other hand, I try to locate the ruptures that threaten its continuing existence. I locate women’s agency in subversion of norms, where subversion connotes not an overthrow of the existing order, but internal erosion. Across the different strata of the labour market, we see movements of complicity, conformity and resistance, overt and covert, which highlight the subjective and ad hoc agencies of women in the space of an exploitative and hierarchical workplace. I understand those acts as acts of resistance that try to question or invert moral values that constitute women as good women and good workers. In this chapter I argue that as there is no monolithic homogenous power structure that oppresses women, so is there no single resistance. Women respond— whether in terms of compliance or resistance— to capitalist patriarchal norms according to class, caste, regional locations, marital status and occupational hierarchy.

The thesis, thus seeks to open up questions of hegemonies and resistances within the field of nursing. On the one hand, hegemonic formations invest in ideologies of femininity and interpellate women as cheap, docile labour suited to the hospital economy; on the other hand, women actively resist such ideological interpellations to subvert norms of gender, class and caste. In the following chapters I will trace the evolution of the nursing profession, the emergence of the modern nurse and how care work becomes the ideological ground of contests over work, labour, autonomy and empowerment.