Conclusion

This dissertation on the employment of nurses in Kolkata, demonstrates the connections between two important contemporary debates among feminist scholars: an older debate on feminisation of labour and a more recent debate on care work as a description for a range of women's labouring activities. There is some shared ground in these debates, even though the feminisation thesis emerged in the context of post-fordism and the new international division of labour pertaining to the manufacturing sector. The issues arising from this debate concern particularly induction of women into factory/workshop modes of production. The debate on care work emerged in more recent times, when manufacturing activity has been giving ground in recent years to a buregoning service sector in many countries across the globe. Despite the differences in the kind of work addressed by the two debates, they do nevertheless raise questions about the gendered nature of labour markets, the specific characteristics of women workers and the relationship between markets, gender and politics. In this wider sense, the case of nursing in Kolkata speaks to both these debates.

The feminisation has been challenged, since the 1990s, by scholars as having limited or no application to India. The new international division of labour had little impact in India and the emergence of export-oriented industries in the 1980s, though they did lead to an increase in women's employment in that decade, was not a sustained process. By the 1990s, women's employment was on a decline, a process, many argue, accelerated by the neo-liberal reforms of that decade. In the Indian context, women's workforce participation has always been low in all sectors, and especially low in the formal sector (manufacturing and service). From the nineties, formal employment has been losing ground to informal employment, but even in this latter sector, women's employment, always lower than men's, has not increased noticeably. Given these trends, questions of feminisation are linked inextricably with wider processes of informalisation. The case of nursing acquires great significance in this context. This is one of the few sectors within

the service economy, which has been and remains almost fully feminised. It has straddled the formal and informal sector, and has been a niche for long-term stable employment of women. The expansion of the sector has meant more employment for women— but this cannot be characterised as feminisation. Equally, the expansion has been more in the informal rather than the formal sector, demonstrating some of the linkages between female employment and informalisation, which has been the thrust of recent debates.

A debate that overlaps with the feminisation/informalisation debate is the new one on care work. So far as nurses are concerned, this new description is clearly appropriate— there is little scope for debate on whether or not their work qualifies as care work. 'Care' is central to the very definition of the profession. It follows that care work is a new name for many existing forms of work already in the domain of the exchange-economy. Theorists of care work have chosen the appellation 'care' to denote the emotional content in women's work across the unpaid, home-based sector and the paid service sector. Nursing is undertaken by women in their own homes in their capacity as mothers, wives and daughters as well as offered as paid work by a small number of women as part of the burgeoning capitalist health service sector. This continuity in women's role as nurses is critical in any understanding of women health care workers. Many of these concerns were flagged in the 1970s by Marxist Feminist scholars who were attempting to theorise reproductive work at the interface of capitalism and patriarchy. The conceptual relationship between reproductive work and care work is as yet not very well understood. In the case of nursing, both terms offer significant insights. In the Indian context, there are additional reasons to take on seriously the debates on care work. Recent data like the NSSO (2006) have pointed to the service sector as a growing source of employment for poor urban women. As scholars have pointed out, that it is specifically the poor-income, sub-sectors with its components of manual and exploitative work that is absorbing the poor urban woman.

Given the obvious description of nurses as care workers, this thesis has not pursued further questions of definition still unresolved in notions of care work. They need to be kept in mind, however, in view of the extension of the term to work such as sex work and domestic work and so on. This then raises the question of the relationship between different kinds of work under the rubric of care work. In some definitions, care work narrows down to women's caring labour, which is problematic given that men too are engaged in a range of care work such as doctors, teachers etc. The gendered assumptions in the naming of 'care' as work thus raises new questions about the characterisations of work and the gender of the worker, in ways that the notion of the reproductive work did not. It draws our attention to the discursive significance of categories and the ways in which we name them and the impact this may have on the work itself and the experience of the worker.

The shift to the discursive, while useful in understanding some of the processes that feminise and consequently devalue certain kinds of labour, does not explain how labouring activities are gendered in the first place. In existing feminist scholarship, the denigration of women's work has been premised on the supposed disjuncture between reproductive and productive labour, home and factory, use and exchange-value, where the first part of the pairing has been associated with the feminine and the second with the masculine. These binaries have followed from the attempt to understand the impact of industrial capitalism. It is the factory system that wrought the separation between home and the workplace and this physical separation was expressed conceptually as a dichotomy between production/reproduction, paid/unpaid, men/women's work. Historically such binaries never held. Early factory labour saw in many parts of the world, participation of women and children in large numbers. This was not so much the case in South Asia. Instead in South Asia, we see the participation of men in what would be considered commodified reproductive labour, such as domestic work.

In different countries, in different periods, these dichotomies have been sustained, despite sometimes large, sometimes numerous exceptions. One would say that the Fordist period in developed capitalism saw some aspects of the binary best in operation. This was followed immediately in the Post-Fordist era by increasing fuzziness in the division between use and exchange-value, home and market, reproductive and productive labour. Over the past century we have seen different kinds of reproductive labour brought into the market in the domain of exchange leading to employment of paid labour in commodified reproductive labour such as domestic work, attendant etc. Nursing is one major example of this process.

An examination of nursing employment in Kolkata shows how cultural and economic value of certain kinds of reproductive labour alters when it is commodified. The activity of nursing the sick when undertaken by women in their homes cuts across classes and castes. When women are employed as nurses in the health service industry, the change in context marks a complete shift in the social signification of this activity. While nursing by women in the family is across classes and castes, the nurse as paid workers is defined not only by gender, but also by class and by caste. Therefore, nursing as a profession is marked (and denigrated) not only because it is women's work or care work but also because of a complex inter-relationship of gender with class and caste.

The class and caste implications of nursing employment are related to the first debate viz feminisation and informalisation. I argue, in this dissertation that processes of informalisation operate within this feminised occupation to unleash processes of hierarchisation, which though not new, have nevertheless acquired a distinctive characteristic. The formal sector in nursing was always small and is now shrinking. It obtains only for trained nurses of specific categories, employed in the public sector. For the vast majority of nurses with different levels of training and skills, jobs are contractual and insecure. The vulnerability of nurses is increased by new hierarchies created by informalisation. In the Indian context, I argue, care work cannot be understood without

reference to these labour processes which contribute to the cultural construction of nursing as low-skilled and demeaning.

These draw as much from macro-labour processes as from entrenched binaries between cure/care, reason/emotion, science/affect within the medical profession. It is thus a combination of economic and cultural processes, which has led to the current situation of increasing casualisation. My research has shown that, in the nursing profession today, there is a three-tier pyramid structure with increasing numbers but descending status, scales of pay, security and regularity of employment. 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 have no training occupy positions that correspond more or less with understandings of skilled, semi-skilled and unskilled. The three-tier pyramid in the nursing profession is a major finding in this thesis. It enables a more nuanced understanding of the structures in of the labour market in the healthcare sector as well as explicating the specificities of the experiences of different categories of workers. It enables us to see how inequalities of gender, class and caste have been harnessed to cheapen labour in a sector increasingly dependent on large capital outlay. The story then is, in part at least, about the shifting balance of capital and labour in the healthcare sector. The other major part of the story is about labour market strategies in which skill and training are deployed as social capital. The hierarchisation within the nursing profession demonstrates something we already know— that labour market strategies are both contingent upon and have consequences for social identities.

The healthcare sector is not homogenous: on the one hand, the doctor is construed as an authoritative (and authoritarian) figure, irreplaceable and by reason of skill indispensable; on the other hand, the nurse is constructed as a manual and menial worker with no or little skill and therefore easily dispensable. This determines who becomes a doctor and who becomes a nurse— these choices are shaped not only by gender but also

significantly by class and caste and the social capital available to individuals on the basis of these social identities. To establish nursing as a respectable profession requires the participation of respectable middle-class workers, even if women, and to do this it has 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-managerial-supervisory role where she supervises an ancillary work force and delegates all menial bedside care to casually employed nursing aides. The medical work that she retains is 'respectable work'—like dressing, bandaging, and other medical work— which even a doctor does. These micro-labour processes function in tandem with macro-labour processes of liberalisation and informalisation of the Indian economy. This hierarchical and differentiated labour market is made possible by a discourse on skills where those located on the top— nurses with recognised training (GNM)— are seen as a skilled workforce, protected by labour laws, while those at the bottom— nurses and nursing aides (unregistered ANM, private sisters and attendants)— are seen as unskilled workers and employed casually, despite undertaking the larger part of hands-on nursing care.

The complex social constitution of nursing by gender, class, caste cannot be understood except as a legacy of the racialised labour policy of the colonial state. Nursing as a modern profession began in the mid-nineteenth century in Britain. The British Indian state in its larger endeavor to modernise medicine brought also the figure of the nurse into play. The nurse became the counter-point to the indigenous *dai,* especially in the field of gynecology and obstetrics. This is the critical context for the development of contemporary nursing practices. The evolution of the nursing profession is linked to modern colonial medicine. Without the western trained nurses along with women doctors, colonial medicine could not have increased its sway. The indigenous *dai* who was central to the lives of Indian women had to be removed and only the western trained nurses could do so. But the western trained nurse had to be set aside from the *dai,*

therefore, it was imperative that she comes from a middle-class, upper-caste background as opposed to the working-class, lower-caste, rural *dai*. However, racism along with class, caste and gender constituted nursing as a poor career option for respectable Indian women and it continued to remain associated with working-class, low-caste or Christian convert women. To modernise nursing and give it contours of a profession and thus make it more attractive for respectable women, nursing leaders and administrators took a few initiatives: associations were formed; registration, standardised syllabi, entrance and passing out exams were introduced; code of conduct and ethics were formulated etc. However, despite all these efforts, nursing remained stigmatised well after India gained Independence. Sixty years plus after Independence, the story has not changed as much as expected.

Despite the deliberations of several committees, slew of recommendations and policy initiatives, the desired outcome eluded the health sector— the uplift of nursing services from a disrespectable occupation of working-class, low-caste women to a prestigious profession for middle-class, upper-caste women has not taken place. Nursing remains an ill-paid feminine occupation, not a career option for upper-caste middle-class women, who are entering the medical profession in much larger numbers than before as doctors or administrators. The failure of policy was due in the main to the low priority accorded to reform in the nursing sector and the lack of resources from either public budgets or private enterprises. These trends were further reinforced with the introduction of SAP (1992), and subsequent withdrawal of the government from public sectors, such as health and education. In the field of medicine, it was cure that was given was more emphasis at the cost of care; which means that training of doctors, import of drugs and machines, etc were given higher budgetary allocations than training and development of nursing. On the one hand, the Indian economy saw increasing informalisation within the formal economy, which meant that more and more nurses and nursing aides are being hired as informal employees; and on the other hand, there is a growing demand in the foreign

markets for nurses trained and educated in Third World countries, who are ready to work at lower rates than domestic nurses. These developments in the nursing labour market have further marginalised nurses and have also intensified the understanding of nursing as stigmatised labour. The gendering of the hierarchical binary (cure/care, technological/menial, reason/emotion, doctor/nurses) ensures that, nursing or care as a component of cure, remains degraded, devalued and invested ideologically in femininity.

Feminist scholars working on labour markets have pointed to the resilience of the family in controlling women's labour. It is not enough to say that women and men enter the labour market as particular kinds of workers. The analysis of why demand for particular labour is met by the supply of persons of one gender rather than the other is to be sought within the family. When we analyse the responses of 3 categories of nursing-workers— GNM (skilled), unregistered ANM and private sister (semi-skilled) and attendants (unskilled)— we see that it is women with support from the family who are able to access higher levels of skill or training and therefore find better employment. Such support can be in terms of higher levels of resources which follow from the class location of the family or more gender equitable distribution of familial resources. In poorer families, where resources are concentrated on male children, daughters are often forced to enter the labour market without requisite education or training. Increasingly such women are expected to contribute to the natal family and increasingly towards the education of the male siblings. In some cases, we see that such responsibilities often continue after marriage. Married sisters and daughters continue in employment as attendants, ANMs and private sisters in order to supplement or contribute towards the income of the natal family.

Strikingly we see an inter-generational continuity in these patterns. Women respondents from all categories invest more in education of sons and marriages of daughters. Their aspirations for daughters are not more skill and better employment than they themselves

have experienced but rather upwardly mobile marriages which will enable them to opt out of the labour market all together. Needless to say, such strategies often fail as they did in their own cases. Clearly, processes of gendering within the family are extremely resistant to change and contribute to enduring gender structures in the labour market. The family mediates adversely women's access to the labour market, and absorbs the consequences of pushes and strains within it. The earlier expectation that women's entry into the labour market and the imperatives of the labour market will transform the family into equitable social institution has been abandoned by feminists some time ago. Diverse trends across the world and in different historical contexts have shown that while labour market compulsions may lead to some changes in structures of family, other aspects of gendering may be resilient or even reinforced. Recent developments in the nursing sector seem to bear out the pessimists. There are new inducements for taking up nursing as a profession— growing opportunities for better-paid employment and emigration to developed countries of the west, and access to more material goods and a higher quality of daily life. Such opportunities do not persuade families to invest more or relax control over women. The larger majority of women, therefore, are able to access only the poor paid jobs in local markets such as ANMs and private sisters or attendants. Only in a few exceptional cases where families have facilitated or allowed women to access better training and education have new horizon opened up in government employment and migration abroad. This research indicates a regional pattern. In Kolkata, it is GNMs from Kerala and Jharkhand, who are mobile and aspiring to immigrate to foreign countries. GNMs from Bengali families, however, seem to aspire no further than government employment.

Capitalist labour processes work in tandem with patriarchal norms to ensure that men and women enter the labour market differently as differentiated labour force. On the one hand, the Engelsian notion of autonomy, that gainful employment will dissipate patriarchy had not taken into consideration how families mediate women's entry into the

labour market. And on the other hand, increasing processes of informalisation has rendered work too exploitative, badly-paid and insecure to become any concrete source of empowerment. However, the dominant development paradigm continues to perceive income generation as a key to women's empowerment. In my thesis I have countered these notions of empowerment, autonomy and freedom by demonstrating that the nature of work, terms of employment etc that are available to most women in the workforce are not ameliorating. It is not *just* waged work but the *type* of employment also that has an important determining role in women's bargaining power both within the household and the labour market. In my thesis I have argued that the ideological (which is also material) devaluation of nursing with it associations with gender, class and caste constitutes the care worker's bargaining power and forecloses any radical altering of gender relations. I have linked the market with the household to argue that as much as families mediate women's entry into the labour market, it is also the value and status of work that in many cases influence women's voices within the household and the community. I have argued that the stigma associated with nursing, especially for those at the lower end of the pyramid, does not allow for any radical questioning of gender norms.

However, this does not mean that women are a passive, inert mass on whom both capitalism and patriarchy script their exploitative practices. As much as there are strong movements to impose hegemonic norms of caste, class and gender, there are also equally strong resistances to such impositions. In my thesis I have traced those moments of hegemonic formations as well as resistances to it. I have argued that women's agency and resistance to both capitalism and patriarchy can be located in the everyday rituals at the work place. Though trade unions exist in two of the medical establishments, women are not represented in equal terms. All agendas and demands are set by men and women's strategic needs are not reflected. Though women are members of the unions, they do not participate fully. In the face of the failure of official channels of resistance, I have explored how power is critiqued by those who are relatively powerless. I argue that

women's agency is located in small acts of displacement and subversion of norms that constitutes them as ideal workers and as good women. Nurses particularly are trained to be 'good women' offering care as part of the definition of positive femininity. Such training combines elements of coercive surveillance and control as well as hegemonic norms that guide women's lives. Such a combination is aimed at ensuring that the nurse remains subservient to the doctor and the medical establishment, the 'hand-maiden', an obedient and docile subject who functions well within the capitalist patriarchal paradigm. This ethnographic study in the everyday labour practices of nurses and attendants shows that hegemony, however powerful and imperative, is nevertheless not total— there are sites of all kinds of resistances in which the nurses take part, against each other but also against norms, against authority, against the family.

Individual acts of resistance help nursing workers to negotiate the oppressive and exploitative conditions of their employment but these do not have the potential to improve their conditions. The kind of collective politics of which these women have so far been part, i.e. trade union politics, has not addressed the issues of gender and caste that underlie the difficulties of the situation. This thesis has shown that nursing workers' participation in trade union politics is sporadic, episodic and mostly disillusioning. It is important to note, nevertheless, that trade unions have addressed in their own way informal workers within formal workplace – such as ANM and attendants in private and state hospitals and even smaller nursing homes. For nursing workers to overcome the limits of such politics, other forms of collective solidarities may be helpful. The women's movement, which has addressed the concerns of informal women workers in some sectors such as domestic work and sex work, remains inattentive to an all-women occupation such as nursing. This is all the more surprising because there is such commonality between domestic workers and nursing workers. There are noticeable continuities between informal workers such as domestic workers and nursing workers, except that the former are dispersed in private homes while the latter tend to be

concentrated in hospitals and nursing homes. In fact that segment of nursing workers who are dispersed in private homes as private sisters are sometimes, but not usually, included in definitions of domestic workers. One implication of this research is the need to address the myriad complexities of the situation of nursing workers. Nursing workers may require political mobilization on multiple fronts— within labour, women and caste-based movements— to be able to meaningfully address or substantially improve the conditions of their employment.